Improving Pregnancy Outcomes Program (IPOP)
Alameda County Health Care Services Agency

Healthy Start Impact Report

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I. Overview of Racial and Ethnic Disparity Focused On By Project

The Alameda County Healthy Start Project selected six zip codes as a focus for its activities during the 2001-2005 period. These zip codes had the highest infant mortality rates in Alameda County and were characterized by high levels of health and socioeconomic risk factors for infant mortality. The zip codes were located in the cities of Emeryville (94608), Oakland (94603, 94621, 94607, 94609), and San Leandro (94579).

The overall infant mortality rate for the target area in the 1996-1998 period was 11.1 infant deaths per 1000 live births. African Americans in the zip codes had an infant mortality rate of 17.3 and whites had an infant mortality rate of 11.8 infant deaths per 1000 live births.

The target area had a higher teen birth rate, higher preterm birth rates, and higher low birth weight rates than Alameda County as a whole. The target area had a 10.19% low birth weight rate, a 1.93 % very low birth weight rate, and a 17.48% preterm birth rate. Births to teens were 114.4 per 1,000 live births, and births with late or no prenatal care equaled 6.99% (60.0 per 1,000 late prenatal care and 9.9 per 1,000 no prenatal care).

In terms of income, Alameda County had the largest portion of its households in the middle- income groups, while the target area had a majority of its households on the lower end of the income spectrum. Almost 20% of the household incomes in the target area were $10,000 or less.

II. Project Implementation

Outreach and Client Recruitment

Background

When the project started, Alameda County's Black Infant Health Program had an outreach worker who provided outreach-tracking services to African American women primarily targeting the city of Oakland. Oakland Healthy Start conducted outreach through its family life resource center sites and was also targeting Oakland. It was clear that the loss of Healthy Start funding would mean a significant reduction in outreach to high-risk pregnant and parenting women. Women in other high-risk areas were not being targeted through outreach; therefore, it was important that the Improving Pregnancy Outcomes Program (IPOP) continue providing outreach workers as part of its outreach/recruitment activities.

The Improving Pregnancy Outcomes Program budgeted for four (4) full-time equivalent (FTE) community health outreach workers, two (2) FTE health services trainees and one-half (.50) FTE health services consultant/fatherhood care coordinator to participate in outreach activities, care coordination, and health education activities. All were involved in recruiting for program and community participants; however, the community health outreach workers and health services trainees were primarily focused on outreach to female case management pregnant and interconceptional program participants and reproductive-age community participants while the health services consultant/ fatherhood care coordinator focused on outreach to male program and community participants.

Outreach methodology

Overall, IPOP's outreach methods strived to increase visibility among all reproductive-age women including pre-conceptional, pregnant, postpartum and inter-conceptional residing in target zip codes. While the program aimed to enroll eligible pregnant women during the first trimester of pregnancy, it was challenging to identify pregnant women during this period through IPOP's outreach activities. However, IPOP staff found, in consultation with consumers, that increasing program visibility and awareness among reproductive-age women residing in target zip codes, regardless of pregnancy status, was the most effective approach for street-based, neighborhood-level, and campaign-oriented outreach activities.

The rationale for this blanket outreach strategy was that sexually active at-risk reproductive-age women residing in target zip codes experience high rates of unintended pregnancy, and often suspect that they may be pregnant. For example, IPOP's outreach activities may have increased program awareness among a non-pregnant woman one month, who would later discover she was pregnant the following month, and contact IPOP to initiate case management/care coordination services. Furthermore, IPOP's outreach strategies infused the word-of-mouth referral system with information about IPOP's services by targeting reproductive-age women residing in IPOP zip codes.

Strategies implemented by IPOP community health outreach workers (CHOWs) and health service trainees (HSTs) were based on approaches identified as most appropriate for the target population by IPOP program staff and the IPOP Consumer Task Force. These approaches were identified through a series of strategic program planning sessions with staff and consumers during program years 2002-2005. One of the major accomplishments for this program period

was the establishment of concrete outreach and client recruitment methods. Through piloting and evaluating various approaches, selected methods have been branded as distinctly IPOP activities, increasing program visibility among the target population and providers. These methods were:

Community baby showers. In 2004, IPOP hosted four pilot community baby showers in targeted areas. Community baby showers were intimate, fun celebrations with three purposes: 1) case finding of target area pregnant women for case management services; 2) recruitment of perinatal health workshop participants; and 3) linkage of pregnant women with maternal and child health services and resources. As they became more popular through increased program visibility and word-of-mouth, attendance increased from four to twenty-six pregnant women, and from no fathers to six fathers. As their popularity continued to grow in 2005, an average of thirty-five pregnant women participated in each quarterly baby shower.

In addition to providing important pregnancy education, the workshops served as a venue for women and their male partners to learn about available health and social services as well as case management programs such as IPOP. The format for the workshops blended health education, fun and celebration. Free nutritious lunch, cake, gifts and child care were provided at each baby shower. These events are labor-intensive and are staffed by IPOP HSTs, CHOWs, Public Health Nurses, Perinatal Health Educators, Peer Health Leaders, and volunteers.

The baby showers provided targeted women an opportunity to self-identify as pregnant without the stigma of being labeled "at-risk" for a poor birth outcome. In fact, the opposite is true—the women feel happy, uplifted and excited because their pregnancy was being supported with referrals to services, contacts with professionals who can answer questions, and exposure to perinatal education and information. Evaluations showed that attendees: 1) appreciated knowing that there are people who care about them; 2) had "a lot of fun;" 3) appreciated the gifts and prizes; 4) learned "a lot;" and 5) wanted the baby showers to continue.

Building-by-building campaign. Building-by-building campaign messages and activities were scheduled in advance in selected housing developments, schools, retail centers, child care facilities, churches, and any other designated areas where reproductive-age women were likely to be present in target zip codes. HSTs were equipped with program materials and perinatal health information for distribution to reproductive-age women. Reproductive-age women were approached, and provided with one brief perinatal health-related message and accompanying brochure.

There were six key perinatal health-related messages on the following topics: 1) healthy eating for less; 2) availability of free family planning resources; 3) smoking cessation and second-hand smoke awareness; 4) health effects of maternal depression and stress, and available mental health resources; 5) risk of substance use during pregnancy, and available treatment resources; and 6) tips for reducing risk of Sudden Infant Death Syndrome (i.e., *Back to Sleep* campaign). Additionally, an IPOP program leaflet highlighting case management and care coordination services and a referral number were given to women reached through this approach.

Initially, this affordable approach was implemented to launch an IPOP community-wide campaign in lieu of a more expensive media campaign through radio, television and print. IPOP HSTs found women reached through this approach were responsive to the information, and some of the women reached called them for follow-up information on many urgent issues including housing and shelters, utility shut-off assistance, donation sites for baby supplies and furniture,

food pantries, health appointments, and family legal matters. Upon being reached, HSTs would assist them with information, referral, advocacy and follow-up. Follow-up and referrals were usually completed over the phone, and rarely through a face-to-face visit. Some of the women originally reached through this campaign strategy continue to call HSTs when in need of assistance. This IPOP activity generated both community campaign and outreach contacts for the program period.

Face-to-face outreach. Face-to-face outreach was another strategy specifically utilized for case-finding for case-finding of case management and care coordination clients. CHOWs and HSTs engaged reproductive-age women in a variety of public spaces within the IPOP target zip codes such as health fairs, public transportation hubs, retail centers and shops, laundromats, libraries and parks, etc. Low-income reproductive-age pregnant, pre-conceptional and inter-conceptional women were engaged in a brief conversation about available IPOP case management and care coordination services, and provided with an IPOP leaflet with eligibility criteria and where to call to enroll in the program. Similar to the building-by-building campaign, this outreach strategy "put a face" on the program, increasing prospective clients' and participants' comfort-level with contacting IPOP for follow-up.

Provider-based outreach. In addition, program participants for case management services were outreached through visitations to local medical offices and hospitals by IPOP public health nurses to inform and educate health care providers about IPOP services and seek their referrals. Additionally, visits were made to small clinics, community-based organizations, social service agencies and food banks by IPOP community outreach workers to share the IPOP message and to engage, recruit and enroll eligible women. Ongoing visits were made to WIC offices, Head Start programs, teen programs and other sites where women obtain services. Furthermore, IPOP staff was out-stationed at clinics, private practices and hospitals with large numbers of pregnant clients in order to facilitate referrals.

Peer health leadership. Peer-to-peer outreach was conducted by female community participants trained as peer educators through the IPOP *Leadership Development* community health education module. Peer Health Leaders (PHLs) outreached women in order to increase participation in the IPOP case management and care coordination components, as well as other maternal and child health programs. In 2004, information and referrals addressed: housing, mental health, family planning, crisis intervention, HIV/AIDS, paternity and custody issues, Medi-Cal enrollment, substance use, parenting, child development, nutrition, services for fathers/men, and transitional services after incarceration.

IPOP's *Leadership Development* programming was designed to utilize and support "natural helpers" in order to enhance the informal networks that often have great influence on the health decision-making of reproductive-age women. Through this approach, Peer Health Leaders extended the reach of IPOP outreach activities and campaigns to the target community at the neighborhood level.

Community education newsletter. IPOP's community education newsletter, Healthy Living, Healthy Families, is a bimonthly publication widely that was distributed to past workshop participants, consumer task force members, raffle participants, individuals reached through health fairs, and providers. Each newsletter aimed to increase community awareness in

targeted zip codes and had a theme such as pregnancy options, child safety, healthy relationships, etc. Additionally, the newsletter highlighted corresponding resources related to the theme should a reader desire additional information or assistance. The newsletter also included referral information for IPOP case management and care coordination services as well as other IPOP program services.

Free community raffles and IPOP mailing database. Free community raffles and corresponding mailings consisted of offering pregnant, pre-conceptional and inter-conceptional reproductive-age women in targeted zip codes an opportunity to participate in a free raffle during HST outreach and campaign activities. Women who agreed to participate complete a raffle stub with their name, address and phone number. Raffle winners received educational and/or prevention-oriented incentives for example a Back to Sleep baby t-shirt, pedometers, child passenger seat, baby-proofing gadgets, grocery gift cards, IPOP tote bags, and IPOP t-shirts.

Names, addresses, and phone numbers from all raffle participants were entered into a mail database. This neighborhood-level mailing database allowed IPOP to maintain contact with residents of our targeted zip codes. All raffle participants won a free subscription to the IPOP community health newsletter, *Health Living, Healthy Families*. In addition to the IPOP community health newsletter, half-page leaflets summarizing IPOP case management and care coordination services and program enrollment information, event announcements, upcoming community education workshop series, and solicitation of focus group participants were publicized and marketed directly to residents listed in the mailing database.

This IPOP mailing database played an important role in remaining connected with past IPOP clients and participants, and established program capacity to provide continuity of services in a minimal way. The mailing database has been further developed on Microsoft Access to enhance IPOP's ability to sort and target addressees by specific characteristics in the subsequent program period.

Media campaign. Print advertisements for bus benches and posters, radio spots, and television commercials were designed through a unique partnership with San Francisco State University's Department of Broadcasting and Electronic Communication Arts. During the Fall 2004 semester, three student cohorts conducted research, reviewed the IPOP focus group report, attended an IPOP baby shower event, and met with IPOP staff as a preliminary phase in the development of the media products. The completed media products targeted low-income African American women, and provided a basic message about the availability of IPOP's case management and care coordination services for at-risk pregnant women (i.e., "Connecting you to the resources you and your baby need most" and "Take the first step—we'll help you with the journey").

This estimated in-kind value of the media development services provided through this partnership was $200,000. However, there was inadequate funding to implement the media campaign during the program period. Efforts are currently underway in the subsequent program period to implement posters developed through this partnership through a bus bench campaign.

Successes and challenges

Recruitment goals were exceeded; however, one of the challenges faced in outreach/recruitment was that during the second year of the project one of the outreach staff decided to apply for disability retirement and went on unpaid leave during that process. Once a

staff person applies for disability retirement, he/she cannot be replaced until a determination has been made. The length of time between a request and a decision about disability retirement is quite lengthy and meant that the project was without one (1) of its four (4) outreach staff for over two years. Recruitment goals were reached due to the outstanding efforts of the remaining community health outreach workers, community health education staff, and public health nurses.

Case Management

Background

The major risk factors associated with infant mortality during the neonatal and postneonatal periods include low birth weight, prematurity, and SIDS. In 1998, there were 1,106 births of infants weighing between 1500-2499 grams in Alameda County. Of these infants, 546 (41.7%) were to mothers who resided in northern Alameda County which include the cities of Oakland and Emeryville. Oakland has the largest population base of all Alameda County cities.

Case management services to pregnant women were limited to the Black Infant Health Program (a state-funded program which at the time was able to service 90 pregnant and parenting women annually), the East Bay Perinatal Council (a state-funded program that served teens), and Oakland Healthy Start (the federally funded Healthy Start Program). Oakland Healthy Start served approximately 600 pregnant and parenting women annually.

It was obvious that without the continued funding of Healthy Start there would be a drastic reduction in availability of case management services for pregnant women in Alameda County. There were limited resources available for postnatal case management; however, at the writing of the 2001-2005 proposal, a significant postnatal case management program was being planned for high-risk infants with state tobacco initiative dollars. For this reason, IPOP decided to limit the number of women enrolled during the interconceptional period and to focus primarily on enrolling women during the prenatal period into its case management/care coordination services.

Service methodology

IPOP provided case management/care coordination services to its maternal and infant clients through a home visitation model. Program staff included public health nurses (PHNs) and community health outreach workers. Services included risk assessment, health education, counseling, advocacy, referral and follow-up. Home visits were provided by both public health nurses and community health outreach workers. Public health nurses provide services to clients who were low-income and had medical risk factors (i.e. previous preterm or small for gestational age infants, pre-term labor with current pregnancy, hypertension, under 15 years of age or over 35 years of age, alcohol or drug abuse, multiple gestation, cardiac disease, diabetes mellitus, hemorrhage during previous pregnancy, etc.) Care coordination services were provided by community health outreach workers to women who had social risk factors (food, housing, etc.) Home visits were made on at least a monthly basis during the pregnancy and postpartum/interconceptional period. Community health outreach workers also spent part of their time in outreach and community education activities.

IPOP's case management/care coordination policies and procedures for its home visiting program were based on the procedures established by the California Department of Health Services Black Infant Health Program. The following assessment tools were utilized: Preterm Labor Risk (Creasy) Assessment, Antepartum Flow Sheet, Postpartum Flow Sheet, Infant Flow

Sheet, and Well-Woman Flow Sheet. The flow sheets were reviewed at visits to ascertain problem areas and what type of assistance may be needed.

IPOP directly started providing case management and care coordination services early in the 2004 calendar year. In previous years the service was provided through a memorandum of understanding with the Alameda County Public Health Nursing unit.

Successes and challenges

IPOP was successful in reaching the majority of its case management objectives despite several challenges. There was a late start in the initiation of the case management/care coordination component of the project due to delays in initiating a memorandum of understanding with the Public Health Nursing Unit of the Public Health Department. A decision in the third year of the project to put the case management/care coordination component under the direct supervision of the IPOP director also posed some challenges because some outreach and nursing staff desired to stay with the Public Health Nursing Unit. This caused a need to recruit and train new staff. In addition, several public health nurses left the program over the four-year period due to a variety of reasons such as retirement, a decision to return to school, and a decision to move out of the area. The turnover of staff was significant because some clients decided not to continue to participate in the program when the staff with which they had bonded left IPOP. Despite these challenges, the staff who remained with IPOP and the new staff provided excellent service, which enabled IPOP to meet most of its case management/care coordination objectives.

Health Education and Training

Background

The majority of perinatal education available to the target population was being done in pediatric and prenatal care settings. There were very few free or low-cost smoking cessation classes available for low-income, pregnant women who were not part of a Medicaid managed care plan or did not have private insurance. The two local Medicaid managed care plans offered smoking cessation programs if a physician referral was made. One of the local community heath centers offered smoking cessation classes on a limited basis.

A limited amount of more population-based health education was being done by the Alameda County Public Health Department's Maternal, Child and Adolescent Health program. Alameda County's Perinatal Outreach and Education Program was in the initial stage of implementing a smoking cessation program in cooperation with the Women's, Infants, and Children's program.

County outreach workers were, to a limited extent, providing health information as they reached pregnant women through their outreach activities. With the limited amount of population-based education being implemented, IPOP decided that in addition to the one-on-one education being done with it care coordination/case management client, additional community-wide perinatal education would be a part of its intervention.

In regard to provider training, obstetrical practice providers were a focus of training for the local Title V Agency through its Comprehensive Perinatal Services Program (CPSP). Quarterly trainings were offered to private and public providers of obstetrical care; therefore, it was decided that IPOP would cooperate, where appropriate, with CPSP in offering training to

obstetrical providers, and would identify where it could conduct special training that was not offered by the CPSP.

Curricula development

In March 2003, the IPOP Health Promotion & Community Education staff consisting of the Health Education Supervisor, two Perinatal Health Educators, two IPOP-funded Health Service Trainees (HSTs), and two State-funded MCAH HSTs initiated strategic planning sessions. During the program development sessions, staff utilized the BDI (Behavior-Determinant-Intervention) logic model, an approach that analyzes desired health goals, associated behavioral risks, protective factors, individual determinants, and appropriate interventions. This process was informed by focus group data, several consumer needs assessments, and a literature review of risk/protective factors and best practices in health education.

After six months, the IPOP Health Promotion & Community Education staff piloted a six-module curriculum targeted to reproductive-age women residing in IPOP zip codes. This curriculum is comprehensive and was developed to meet the diverse health information needs of preconceptional, pregnant, postpartum, and interconceptional women residing in IPOP target zip codes. The six modules are:

1) *Pregnancy Basics* series (four 2½ hour sessions);
2) *Healthy Eating and Living for Mom & Baby* series (four 2½ hour sessions);
3) *Parent Education* (topical workshops on child passenger safety, home safety and baby proofing, child development, immunizations, and positive discipline);
4) *Stress and Depression* (community campaign to increase awareness of mental health resources and treatment services);
5) *Substance Use* (community campaign to increase awareness of the effects of substance use during pregnancy and available treatment resources); and
6) *Leadership Development* (a peer health advisor training which enhances existing natural helping systems in targeted IPOP zip codes).

This program planning process facilitated the development of a community health education curriculum that was based on the needs of the target population, timely organized and sequenced for the perinatal period, and promoted repeat participation and leadership among community residents. Furthermore, utilizing this health problem analysis approach grounded the IPOP modules within behavior change theory and the context of psychosocial determinants experienced by the target population, and directly linked program interventions to program goals. Currently in its later phases of development, the process continues to be used to further develop the IPOP health education curriculum in the subsequent program period.

In September 2003, two modules, *Pregnancy Basics* and *Healthy Eating and Living for Mom & Baby* were implemented by the IPOP Community Education staff to pregnant and parenting teens who were students of the Alameda County Office of Education Cal-SAFE Program. IPOP PHNs also participated in the *Pregnancy Basics* workshops and addressed clinical issues and questions from pregnant participants. The series was modified to fit the school schedule so that classes could take place during the students' life skills class, requiring the modules to be delivered in eight one-hour sessions.

Due to the positive response of the students and faculty, IPOP was invited to deliver both series at three Cal-SAFE sites every academic year from 2003-2006. Piloting the two series at these sites provided staff multiple opportunities to adapt, modify and improve the curriculum. Both series will be further developed in the subsequent program period to enhance its relevance to the pregnancy and parenting experiences of low-income women of color in targeted neighborhoods. Some of the changes to the *Pregnancy Basics* series include adding more content on life skills such as money management, goal setting, future life planning, child care resources, adapting to motherhood with or without a partner, creating a support network, and avenues to self-sufficiency. Some of the content that will be minimized or eliminated from *Pregnancy Basics* is child passenger safety seat training, first aid and CPR, which will be incorporated into the *Parent Education* module. The revised *Pregnancy Basics* series will also include more interactive activities, particularly activities that promote women bonding with their unborn child.

The *Healthy Eating and Living for Mom & Baby* module will also be revised based on its pilot implementation from 2003-2005. Topics that will be added or modified include infant feeding guidelines, food and safety, basic math to facilitate reading of nutrition facts labels, more fitness activities, and food and dieting myths. Activities will also be added that are more interactive and better illustrate sugar and fat content.

The *Parent Education* module consisted of topical workshops on child passenger safety, first aid and CPR, home safety and baby proofing, child development, immunizations, recommended health checkup schedules, and family health resources. Workshops topics and the number of sessions were tailored to specific host organizations and audiences such as school-based parent groups, teen parent life skills classes, community health events, and childcare centers. One of the major identified challenges to marketing parent education classes is the perception that they are designed to teach "bad" parents how to be "good" parents; it is challenging to develop positive messages that motivate parents to participate in parenting classes. Also, parenting classes have a stigma among our target population due to past experiences with parenting classes mandated by child welfare services.

In consultation with consumers and HST staff, parents were eager to learn more about how to handle their children's problem behavior. However, parents wanted to learn how to "deal" with their children through skills and techniques that provide them with options, not "how" to raise their children over the long-term with values, morals and a certain parenting philosophy. Also, the facilitator role required a unique individual who can establish credibility in terms of whether parents feel she has faced similar experiences as a parent in regard to ethnicity, socioeconomic status, and life circumstances in addition to formal education and training. A suitable facilitator would have needed to be contracted because current staff did not have this expertise. Thus far, we have successfully implemented parent education workshops as guest presenters for parent groups that met regularly to fulfill the host agency's parent requirements such as the Head Start Program. However, our topics have mainly focused on health and safety rather than positive discipline, for which parents and providers have expressed a specific need. Another important issue was the high prevalence of mental health problems among the target population that make parenting more difficult such as untreated and undiagnosed mental illness, substance use and addiction, and lack of parent-child bonding.

The *Stress and Depression* module was implemented through the building-by-building campaign to increase awareness of and de-stigmatize utilization of mental health resources and treatment services. Initially, IPOP staff intended to implement support groups facilitated by a

Marriage and Family Therapist (MFT), however this budgeted position's time was allocated in providing one-on-one sessions with IPOP clients receiving case management or care coordination. This reallocation prevented the initiation of support groups for both IPOP clients and community participants. While the MFT position is no longer part of the IPOP staff configuration in the subsequent program period, IPOP plans to adopt a community-wide mental health promotion strategy capable of reaching large audiences and engaging them through a multi-session series. The series will specifically focus on African American mental health issues, and be facilitated by a mental health consultant with expertise in this area of practice.

The *Substance Use* module is implemented through the IPOP building-by-building community campaign to increase awareness of the effects of substance use during pregnancy and available treatment resources. Because of the stigma associated with substance use that would make traditional health education workshops challenging to market and implement, a campaign approach was selected to promote community awareness about the effects of substance use during pregnancy and available treatment resources. However, the stigma issue also makes face-to-face contacts regarding substance use awkward and potentially offensive. Further program development is needed to identify alternative and creative strategies for the *Substance Use* module.

The *Leadership Development* module was developed as a peer health educator training program consisting of an initial intensive peer educator training, biweekly booster training sessions and support activities in order to enhance existing natural helping systems in targeted IPOP zip codes. In 2004, peer health leadership was implemented through the a collaborative between the Alameda County Public Health Department Maternal, Paternal, Child and Adolescent Health Faith-based Initiative, Health Promotion and Community Education, and Improving Pregnancy Outcomes Programs, and Acts Full Gospel Church who received $25,000 in funding from the March of Dimes. IPOP community education staff provided training to twelve Peer Health Leaders (PHLs) and primary coordination of their activities. PHLs were community residents trained in various health topics including perinatal health, reproductive health, nutrition, and child health and safety. Additionally, PHLs were trained in helping skills and leadership to increase the community's capacity to promote health.

Trained peer health educators conducted face-to-face individual encounters with reproductive-age women and their families, and provided them with referral information, health education, advocacy and social support. As residents who lived in targeted neighborhoods and shared similar life experiences, PHLs provided perinatal information and referrals relevant to the experiences of low-income African American women.

Peer Health Leaders also planned and sponsored the *First Annual Reach Out for Health Women's Event* in December 2004. Thirty reproductive-age women attended the event along with their children and some male partners. Free lunch and child care was provided at this lively event. The event focused on the health information needs of low-income African American women residing in East Oakland, which were more comprehensive than mainstream audiences and addressed housing, education and employment preparedness, nutrition, healthy relationships and sexuality, mental health, breastfeeding, and parenting. There were eight guest presenters and over a dozen booths representing health and social service agencies serving low-income women. Guest presenters spoke as panelists on a variety of topics and themes including:

- *Putting Stress to Rest: Getting Help When You Are Feeling Overwhelmed*
- *Stop Sacrificing Yourself for Love: Where Is That Healthy Relationship?*

- *How to Lose the Baby Fat: Getting in Shape After Pregnancy*
- *Keeping You & Your Family Happy and Healthy: Resources for Mothers*
- *Getting Ready for the Journey: Transitions to Careers and Higher Education*

The PHLs reached 134% of the projected contacts and were able to provide needed maternal and child health information to many more residents than anticipated. The greatest achievement of this collaborative effort is the establishment of a solid natural helping network in the East Oakland community directed toward promoting maternal and child health. Each Peer Health Leader demonstrated specific interests and skills that they chose to further develop. Some of their specialties were breastfeeding, child safety, maternal depression, HIV/AIDS, housing, and education.

In 2004, Acts Full Gospel Church Healthy Temple Ministry was awarded a three-year grant by the state's Five-a-Day Program to implement a peer education program focused on nutrition. Five Peer Health Leaders will transition into this program. Additionally, through the California Poison Control System's Community Outreach Worker Initiative, the Peer Health Leadership Program (PHLP) was compensated with $10,000 to include child poison prevention messages to their outreach activities. These funds will be used to continue Peer Health Leader stipends not covered through the state's Five-a-Day grant.

This transition permits the original cohort of PHLs to continue to serve as lay health workers in their community, however their focus will be nutrition instead of maternal and child health. This has left a void for a natural helping system focused on the promotion of perinatal health in IPOP targeted zip codes. Sustaining the original PHLP with less day-to-day support and coordination from IPOP staff under the new Five-a-Day grant is a formidable but feasible task for the church. However, the church's capacity would be strained to continue PHLP activities focused on perinatal health in addition to nutrition. The collaboration with Acts Full Gospel Church, in which it served as the lead fiscal agency, was an ideal arrangement that facilitated efficient processing of stipend checks, food purchases, program supplies, and participant incentives. IPOP faces many challenges in replicating a peer health leadership program focused on perinatal health that is operated under the larger, often cumbersome, bureaucracy of the Alameda County Public Health Department.

Community education methodology

These community education strategies and corresponding curricula provided a framework for implementing IPOP community education interventions to the target population at various "dosages." For example, a community participant reached through the building-by-building campaign, participated in the free raffle. Her contact information was then entered into the IPOP community education mailing database. She began receiving and reading the bi-monthly IPOP community health newsletter. Six months later, she discovered she was pregnant and enrolled in IPOP's case management/care coordination program. She received an announcement about the upcoming *Pregnancy Basics* workshop series, and signs up and participated in the workshops. This is just one example of how IPOP' community education programming promoted repeat participation and continuity of care.

IPOP Community Health Education Framework for Dosage and Continuity of Interventions

PARTICIPANT IMPACT	INTERVENTIONS	DOSAGE/ CONTINUITY
Health Leadership & Empowerment	• Peer educator training and support sessions through the implementation of *Leadership Development* module • IPOP Consumer Task Force activities	*high*
Health Education & Behavior Change	• Community health education workshop series including *Pregnancy Basics*, *Healthy Eating and Living for Mom & Baby*, and *Parent Education* modules	
Health Information & Resource Linkage	• Community health information campaign • Community health newsletter • Peer education individual encounters and group education activities	
Health Awareness	• Building-by-building campaign including the six key perinatal health messages, *Stress & Depression* module, and *Substance Use* module	*low*

The IPOP Community Education staff used multiple strategies to implement the six modules and provide targeted residents (both program clients and community participants) with health information and education services. Specific strategies included:

Community health education workshops. This strategy was used to engage participants through a series of curriculum-based sessions and was designed to promote repeat participation. The *Pregnancy Basics*, *Healthy Eating for Mom & Baby*, and *Parent Education* curricula were implemented in IPOP target zip codes using this approach. IPOP Perinatal Health Educators and HSTs coordinated and facilitated these workshop series. Contact information for all workshop participants was entered into the IPOP mailing database for continued marketing of additional upcoming workshops and available services. The implementation of workshops in conjunction with a host agency, such as Cal-SAFE and Head Start, yielded more participants. IPOP staff marketed and piloted the workshop series without a host agency, which produced less community participants. However, it appeared that word of mouth after the initial piloting generated more interest among community residents and providers in the subsequent program period. Also, offering the workshop series after a baby shower sparked more interest and pre-enrollment by participants. To build on the interest and motivation created by the baby shower event, IPOP staff developed a quarterly program cycle in which a baby shower is hosted in the first month, *Pregnancy Basics* workshop series in the second, and *Healthy Eating and Living for Mom & Baby* in the third.

Building-by-building campaign. The community campaign consisted of IPOP and MCAH HSTs engaging reproductive-age women in IPOP targeted zip codes with brief communiqués and pamphlets on six specific prevention-oriented perinatal health messages including: 1) healthy eating for less; 2) availability of free family planning resources; 3) smoking cessation and second-hand smoke awareness; 4) health effects of maternal depression and stress, and available mental health resources; 5) risk of substance use during pregnancy, and available treatment resources; and 6) tips for reducing risk of Sudden Infant Death Syndrome (i.e., *Back to Sleep* campaign). The *Stress and Depression* and *Substance Use* modules were implemented in this manner. These activities were scheduled in advance in selected housing developments, retail centers, childcare facilities, churches, and any other designated areas where reproductive-age women are likely to be present in target zip codes. Targeted women were approached in a friendly, positive manner so as not to feel "singled out" of a crowd. HSTs used culturally and linguistically appropriate communication in English and Spanish, encouraging targeted women to keep or "pass on" the health information materials to someone who they think may need it. In addition, targeted women are solicited to participate in a free community raffle by furnishing their name and contact information on a raffle ticket stub. This contact information is then added to IPOP Community Education mailing database.

Community health information campaign. IPOP and MCAH HSTs conducted tailored presentations on available family health resources including IPOP case management and care coordination services to a variety of audiences. The presentation format emphasized the importance of health maintenance, prevention, and early intervention for reproductive-age men and women and their young children. These workshops are usually delivered to participants of partnering organizations such as Head Start, job training programs, parent groups, transitional shelters, GED classes, church groups, youth centers, and public housing resident meetings. The presenters engaged participants in a dialogue about health issues, concerns, and decision-making, as well as the importance of routine health care and establishment of a medical home. This dialogue was followed by familiarizing participants with the *Alameda County Resource Guide for Men*, *Women, Children and Teens*, a pocket-sized brochure with a comprehensive list of health and social service providers; the *Alameda County Public Health Clearinghouse*, a toll-free telephone help line available to all county residents seeking health resources and services; and IPOP's full range of services. Contact information for all participants was entered into the IPOP mailing database for continued marketing of upcoming IPOP community education workshops and available services. This intermediate approach allowed IPOP staff to engage community residents in more depth than was possible through the building-by-building campaign, while it reached a large number of individuals who were not able to attend a more intensive workshop series.

Community health newsletter. All households listed in the mailing database received IPOP's free bimonthly community health education newsletter, *Healthy Living, Healthy Families*, which further reinforced content from community education workshops and community campaign messages the participant was exposed to previously. Providers also receive a PDF version of the newsletter via email so that they can print copies in-house for their clients, or they contact IPOP and request multiple copies through the mail. Each newsletter had a theme related to maternal and child health was written in an appropriate literacy level in English and Spanish for low-income reproductive age women, and showcased referral

information to access related services. The newsletter was designed, in consultation with the IPOP Consumer Task Force, to further reinforce content from community education workshops and community campaign messages the participant was exposed to previously, and promote utilization of maternal and child health services. Results from focus groups conducted in December 2004 indicated readers felt that: the newsletter topics were relevant; the colorful graphic layout and ethnic-specific images were appealing and enticed the reader to peruse the newsletter; some of the women had utilized services from agencies showcased in the newsletter's *"Did You Know?"* section; and readers would frequently pass on the newsletter to other reproductive-age women such as relatives and neighbors. The newsletter will continue to be published and distributed in the subsequent program period.

Peer health education. Peer educators, trained and supported through the implementation of the *Leadership Development* module, extended the reach of the IPOP community education staff by conveying the same building-by-building campaign messages through individual face-to-face encounters with reproductive-age women in targeted IPOP zip codes. They provided individuals with referral information, advocacy and support, and sponsored group education events such as the *Reach Out for Health: A Special Event for Women*, a half-day health conference for low-income African American women residing in IPOP target zip codes featuring health and social service providers as guest speakers and booth presenters. Peer education made a great contribution to IPOP's health promotion and community education activities. In the absence of funding to publicize workshops and events through media outlets, IPOP staff relied heavily on the Peer Health Leaders to "get the word out" in the community. This network of motivated and trained women, with whom IPOP had established a relationship, could be "alerted" to mobilize according to program needs. IPOP plans to further develop these informal helping networks in targeted zip codes in the subsequent program period.

Personalized health education materials. IPOP staff had access to extensive written materials through Krames On-Demand, an easy to use, print-on-demand web-based health education program with over 3,500 single-topic HealthSheets™ in thirty-four specialty areas. Each HealthSheet™ combined illustrations with easy-to-read text to help staff communicate key points to clients. HealthSheets™ provided staff with standardized, accurate, up-to-date information that could help reinforce instructions and support client education sessions. HealthSheets™ can be personalized with the client's name in the upper right corner after the words "Prepared for" and special / individual client instructions could be placed in a box at the bottom of the sheet.

In general, IPOP staff needed more support and training beyond the initial training session to better utilize this online service. HealthSheets™ could help the PHN and CHOW to answer a client's health questions about herself, her children or other members of her family. Personalizing the HealthSheets™ could also help to build and strengthen the provider-client relationship. Adding the IPOP logo to the HealthSheets™ could also strengthen name recognition for the program. IPOP staff has planned to conduct additional training to optimize the use of this internet-based resource in meeting objectives in the subsequent program period.

Peer Health Leaders were also trained as Krames On-Demand subscribers, permitting them to print out one-page health fact sheets on a given health topic for their contacts. About half of the Peer Health Leaders had internet access at home, and the other half were informed of where they could use computers and access the internet for free such as in public libraries.

Provider training. IPOP's community education six-module curriculum provided a basis for training staff and providers. Senior community education staff and HSTs developed the six-module curriculum, and that process in itself provided initial training for all IPOP community education staff. Community education staff specialized on two to three modules during the development phase, and subsequently participated in cross-training activities. Additionally, IPOP community education staff expanded their impact by providing technical assistance and training to organizations and providers, serving the same target population. Thus far, the IPOP community education component has provided technical assistance and training to providers in childcare centers, school-based teen clinics, and faith-based organizations. In sum, IPOP's provider training services were highly sought and positively received.

Curricula evaluation

During the reporting period, evaluation activities of health education interventions consisted primarily of client satisfaction surveys administered at the end of the workshop. Surveys assessed whether the client felt the workshop content was relevant and answered their questions about the topic. Beginning in 2003, a pre and post-test were drafted by two graduate interns under the supervision of a Perinatal Health Educator. The pre and post-tests were designed to conduct impact evaluations for participants of the *Pregnancy Basics* and *Healthy Eating and Living for Mom & Baby* modules. Further development of these evaluation instruments was placed on hold should they require changes once the curricula are revised in the subsequent program period. Once the surveys are revised, they will be submitted to the public health department's Community Assessment, Planning & Evaluation (CAPE) unit for review and technical assistance before they are finalized. These evaluation instruments will provide IPOP with an opportunity to initiate and conduct an impact evaluation of the community health education interventions.

Fatherhood Services

Background

Fatherhood programs in the area tended to be isolated and not coordinated with other projects or integrated within larger community networks. The programs were sponsored by grass roots agencies and addressed fatherhood in a variety of ways including through schools, churches, substance abuse centers, perinatal case management programs, midnight basketball recreation programs, and child development programs. While the programs were committed to fatherhood issues, they were not part of a comprehensive community approach. The programs were not able to reach all the fathers in the target area and some were single-focused and did not look at all the needs of fathers.

IPOP proposed to expand the number of fathers reached through outreach and education services and to take a more holistic look at fathers' needs by providing care coordination services and linking fathers to the various services/programs that could meet their needs.

Service methodology

IPOP fatherhood services provided outreach, case management, referral and follow-up, community health education, training, and systems improvement efforts. Fatherhood services

were targeted to fathers, father figures, and fathers-to-be with children 0-2 years of age in the IPOP zip codes.

Outreach activities served to invite clients to health education classes and care coordination services, and provided an opportunity to deliver health education messages. Brief group interventions occurred on basketball courts in between games, in recreation centers, and in barbershops. Messages were delivered individually during street encounters and community fairs. These brief interventions included sharing of information verbally and/or exchanging written health information.

Outreach served as the primary mode for recruiting and identifying care coordination clients. Clients were also referred for care coordination services by public health nurses and other sources. Clients receiving care coordination services met in the IPOP office or other locations where the fatherhood services staff assessed their needs. Usually, services involved up to three contacts/visits to assess needs, provide social service counseling, referral, and follow-up to determine if referrals met the needs of the client.

Problems that fatherhood clients faced included lack of transportation, housing, and employment. They also faced legal and child support issues. Transportation barriers included costs, time, and safety issues. Fatherhood and related services tended to be scattered throughout a city or county. Though public transportation is widely available, participants often lacked transportation and parking funds. Participants also tended not to want to travel too far.

Housing is problematic for everyone in the San Francisco Bay Area. It is especially difficult for IPOP clients who live near or beneath the poverty level. Many of the fathers lived in de facto homelessness, moving from place to place, often living with family and friends.

Employment was a barrier for fatherhood participants who were unskilled, with limited work experience, and criminal histories. Healthy Start staff collaborated with Rubicon Program to try to address this issue. Rubicon Programs have a long and successful history with employment through their *Fathers-At-Work* program.

Most of the fathers in the program had legal issues, whether it was criminal, child support arrearages or visitation. IPOP staff provided linkages to Child Support Services, The Men's Family Law Clinic, and the Law Facilitator's Office.

Overall few services exist for fathers or other males. Of those services that do exist, they are not male or father-friendly and tend to be tailored for female and child clients; therefore, male clients tend to feel unwanted in places where services are available. This situation is made more difficult by agencies' inability to handle the special circumstances of men. For example, many of the target population that IPOP served had criminal histories. When referring men for employment services, many agencies were unable to assist these persons in clearing up their criminal records with duplicate and erroneous information.

Fatherhood health education was provided to expectant fathers, parenting fathers, and father figures. Fatherhood education participants received instruction in a variety of formats including: video presentations in waiting rooms, lectures, group discussions, one-on-one instruction, handouts, and pamphlets. Clients received referral to other health education services only when IPOP fatherhood staff lacked the capacity to address the individual's needs (e.g., language barriers, topical expertise, etc.)

Fatherhood health education was provided in a variety of structured, semi-structured and unstructured formats. *Father-to-Father* is a combination of a health education class and support group. The emphasis is on "man talk" that is designed to encourage casual conversation, sharing of relevant issues and peer support. The trained facilitator prepared to lead the class in a

discussion format on a selected plan; however, the group also informally directed the discussions depending on what issues arose during "man talk." Topics presented in the *Father-to-Father* curriculum are listed below:

- Introduction to Fatherhood
- Values
- Manhood
- Stereotypes and Manhood
- Becoming Self-Sufficient
- Communication
- Decision-making
- Dealing with Stress
- Coping with Discrimination
- Fatherhood today
- Understanding the Child Support System
- Understanding Children's Needs
- A Father's Influence on His Children
- Coping as a Single Father
- Building Your Child's Self-Esteem
- Helping Children Learn
- What Do You Want?
- Conflict Resolution/Anger Management
- Getting Help From Your Support network
- Male Female Relationships
- Men's health Substance Abuse
- Sexuality
- Reducing Sexual Risks
- Putting It All Together

In addition to *Father-To-Father* being offered on a weekly basis in the target area, during the past year it was also offered to fathers or father-to-be who were incarcerated on a short-term basis at juvenile hall.

Boot Camp for New Dads is another structured curriculum. It is a one-time, three-hour class offered on Saturday mornings to expectant fathers. It follows a specific curriculum and utilizes a peer-teaching model of veteran dads supported by a trained facilitator. The curriculum addressed the following topics:

- Caring for New Moms
- Importance of Teamwork
- Dad's Role as Protector
- Baby Care and Dad's Bag of Tricks
- Crying Babies
- Preparing for the New Mom/Postpartum Adjustment
- Rookie Concerns
- Safety.

Boot Camp for New Dads was presented as part of a collaboration with Alta Bates Summit Medical Center in Oakland, California, and at Saint Rose Hospital in Hayward, California. These hospitals collaborated with IPOP by offering their sites for the *Boot Camp for New Dads* classes. The class became part of their perinatal health education activities offered to their patients and the community. Additionally, other fatherhood education occurred during special events such as: *Raising Awareness: Men's Health Forum*; *Raising Awareness: Fatherhood*, and at *National Men's Health Week* events.

During the past year, IPOP fatherhood services collaborated with East Bay Community Foundation, Rubicon Programs, Social Services Agency, and Alameda County Child Support Services to deliver services to fathers. To date, this collaboration has resulted in the submission of two grant proposals that are pending a response, and an oral presentation to the Annie E. Casey Foundation. Subsequently, Rubicon Programs and IPOP are examining ways to deliver job services to clients with current funding streams. In another venue, IPOP was part of a group of agencies that explored ways to deliver transitional job services to fathers/clients. Agencies contributing to this effort were Goodwill Industries, Unity Council, Project Choice, and the Alameda County Social Services Agency.

To expand fatherhood services to include men's health and promote fathers within the Public Health Department, IPOP participated in the Men's Health Initiative Planning Group. The group developed a matrix with male health issues and programs. The group provided a forum for identifying any gaps in service delivery. During the past year, IPOP, in collaboration with the larger Alameda County Public Health Department, conducted two forums to raise awareness about fatherhood and men's health.

Successes and challenges

Employment was an important concern for fathers. IPOP may have been able to attract more fathers by developing more program capacity to address their employment needs. For most fathers, the "hook" for their interest in IPOP is IPOP's ability to provide pre-employment services, referral to jobs, and connections to employment agencies. Even so, developing and maintaining interest in services was a challenge.

Another barrier to enrollment of fathers in the program was the lack of an integrated systems approach to dealing with the problems and issues that involve fathers and families. The system disconnections contribute to fewer potential fatherhood clients being referred to IPOP who could benefit from the program. An integrated systems approach might include the public health, social services, child protective services, and criminal justice systems working together in a coordinated manner to address fatherhood issues. The Alameda County Men's Public Health Initiative Group began looking at these issues, initiated developing a plan, and wrote proposals to seek funding to address integrated systems. IPOP's fatherhood coordinator has been helping staff this men's initiative.

Limited funding for fatherhood services was a challenge to providing services to monolingual Spanish-speaking fathers in the target area. Limited funding has made it difficult to hire a bilingual fatherhood staff person. Efforts were made to train bilingual Spanish-speaking staff in the *Boot Camp for New Dads* curriculum; however, those trained did not institute the curriculum in their agencies as expected.

Generally for males, health education was not an enticing experience. Health education, as the primary activity, was often a barrier to participation in health education programs. Many fathers were not interested in health education unless they were targeted at an opportune time.

For most fathers the "opportune time" was when they became expectant fathers. For other fathers it was a crisis, such as child custody or child protection issues, that brought them to a place where they sought assistance. *Boot Camp for New Dads* addressed the former issue, while *Father-to-Father* addressed the latter.

Interconceptional Care

Background

Prior to the implementation of IPOP, interconceptional care services to women were provided by Alameda County's Black Infant Health Program, the Oakland Healthy Start Program, and the East Bay Perinatal Council (primarily serving parenting teens). Children's Hospital, a pediatric outpatient and tertiary care center, offered nursing follow-up to thirty five (35) high medically at-risk infants annually from their neonatal intensive care nursery, and Alameda County's Special Start program serviced about 100 children annually who had moderate medical and social risk factors. At the time of the original 2001-2005 Healthy Start application, the planning for a more extensive pediatric home visitation program called Every Child Counts (ECC) was underway. When fully implemented, ECC's goal was to provide every woman who delivered in Alameda County with at least one home visit. Their needs would be assessed at that visit and additional visits were scheduled if needed.

Alameda County public health nurses were offering one to three home visits to every woman who delivered at two hospitals (Summit and St. Rose) that had large numbers of Medi-Cal (Medicaid) deliveries. Approximately 95-97% of the women wanted visits, but Alameda County's Public Health Nursing unit only had the capacity to serve about 50% of the women. The nurses could offer up to ten home visits. It was expected that the Every Child Counts program would expand the capacity to reach women interested in home visitation.

The aforementioned programs primarily provided home visitation services to women in the postnatal period and were more limited in their efforts to serve women in the prenatal period. In response, IPOP decided to focus on prenatal case management/care coordination that would continue postnatally and during the interconceptional period. There was a smaller focus on postnatal entry into IPOP case management/care coordination services.

Service methodology

IPOP utilized public health nurses and community health outreach workers to serve women both prenatally and interconceptionally. Pregnant clients continued to be served during the postpartum and interconceptional period. In addition, a limited number of women entered the program during the postpartum period and were served interconceptionally. The interconceptional enrollees were women who had high-risk pregnancies or infants with poor birth outcomes (low birth weight, very low birth weight, and preterm birth). These high-risk women and infants were served by public health nurses. IPOP's interconceptional clients also received home-based case management services/care coordination services. There was a postpartum phase and a well-woman phase to interconceptional care services.

The purpose of the postpartum phase of care was to:

- Ascertain the general health and psychosocial status of the mother, infant, and assess mother-infant interaction and bonding;

- Identify problems, needs, and provide interventions as appropriate to ensure optimal postpartum outcome;
- Refer for family planning services; and
- Ensure access to primary health care for the mother and infant.

The purpose for the well-woman phase of care was to:

- Enhance the client's knowledge of and utilization of preventive health practices which promote optimal health;
- Educate the client on the recommended health maintenance schedule;
- Instruct the woman on health maintenance practices for incorporation into her self-care routine; and
- Promote self-efficacy for the women in practicing and attaining preventive health care and psychosocial well-being.

IPOP provided home-based, case management and care coordination services to infants and toddlers in conjunction with visits to their interconceptional mothers. The purpose of the infant/toddler visits were to:

- Ensure that the infant received preventive well-child care;
- Ensure that the infant was age-appropriately immunized;
- Provide for the early identification of deviations from normal growth and development and linkage with appropriate services;
- Educate the parent in recognizing signs and symptoms of deviations from normal growth and development and when to inform the health care provider; and
- Ensure a safe and nurturing environment to promote optimum health and well-being for the infant.

Typically, IPOP case management and care coordination staff made a home visit within one week after delivery (hospital discharge) for women who entered the program and monthly visits thereafter. Women who enrolled in IPOP after their baby was born were enrolled within the six to eight-week postpartum period.

On the *IPOP Postpartum Flow Sheet* it was tracked whether a woman had had a postpartum visit. If a woman did not schedule her six-week postpartum visit with her provider and if there were any barriers to scheduling a visit, the case manager/care coordinator assisted with trying to overcome those barriers. If a woman did not have a postpartum visit within the six to eight-week postpartum period, the case manager and care coordinator would urge the client to have a medical visit for birth control and a pap smear. Some local obstetrical providers would see women up to three months after delivery to facilitate the receipt of a birth control method.

Information about whether or not a client had a medical home was tracked in nursing notes and the IPOP management information system. Typically during the home visit, the case manager and care coordinator emphasized the importance of a medical home. Case management and care coordination staff have found that if a woman felt fine and had no problems, she may believe that she did not need to worry about preventive care. IPOP case management and care coordination staff found that, for some clients, developing an interest in preventive care was a long-term educational process. For women with Medicaid, long waits for appointments or appointments that were offered when a woman may have to work are barriers to obtaining a

medical home. For women with no insurance, the high cost of medical care was a barrier to seeking a medical home particularly if she perceived she had no medical problem.

The *IPOP Comprehensive Case Management Well-Woman Flow Sheet*, which was reviewed during home visits, identified whether a woman had chosen a family planning option. If a woman had not chosen a family planning option or had ceased to use a previously chosen option, she was counseled and advised about her options and where she may find free or low-cost family planning providers and resources.

IPOP provided case management/care coordination services to infants up to two years of age. Information about whether or not the infant had a medical home was tracked in nursing and care coordination notes and in the IPOP computerized management information system. Typically, IPOP staff would visit an infant within one week after delivery. At that first visit, the mother was asked whether or not the infant had a well-baby appointment. This information was tracked on the *IPOP Infant Flow Sheet*. If a baby did not have an appointment, the IPOP staff ascertained whether a pediatrician had been identified and, if not, tried to help the mother identify a pediatrician.

After the initial post delivery visits, during subsequent visits, the *Infant Flow Sheet* continued to be completed. Any problems in reference to ongoing pediatric visits were noted and the mother counseled and assisted with finding a pediatric provider. If the child was not Medicaid eligible, information was provided about the California Healthy Families Program, which can assist parents who earn too much money to qualify for Medicaid. IPOP staff identified barriers to obtaining a medical home and worked with clients to make a plan so that their child could have a regular pediatric care provider.

IPOP tracked the immunization of infants on the *Infant Flow Sheet* that was completed as part of the regular infant assessment. As possible, IPOP staff reviewed immunization cards to see if immunizations were up-to-date and educated parents about their importance. If immunizations were not up-to-date, IPOP staff tried to identify and overcome barriers so that immunizations could be obtained, and gave resource information such as locations and times where immunizations could be obtained free or on a sliding scale, if cost was an issue.

Successes and challenges

IPOP exceeded the number women expected to enroll on an interconceptional basis (women not served by IPOP while they were pregnant). It was expected that only fifty women would enroll during the interconceptional period over the four-year project period; however 151 postpartum/interconceptional women enrolled. This increased enrollment was due to other high-risk infant programs reaching their capacity and interest of perinatal providers in taking advantage of the long-term case management service offered by IPOP's public health nursing staff to high-risk women and infants.

Depression Screening and Referral

Background

At the time of the original application, the percentage of perinatal providers screening for depression across the county was not known. A county-wide perinatal substance abuse survey sent to all possible perinatal providers in the summer of 2000 revealed (from surveys returned) that not all providers screened pregnant patients for substance abuse. Because depression was not a condition usually addressed or as easily measured as substance use, it seemed even less

likely that providers were routinely screening for depression on a large scale.

From a needs assessment conducted by the Alameda County Public Health Department in 2000, perinatal health and behavioral health care providers, as well as clients, felt there were definite gaps in the Alameda County system of care. It was projected that communication and linkages would be created and enhanced in the project, and that barriers to access would be reduced to better assure that more pregnant/postpartum women would be screened and identified early for depression and effectively linked to appropriate services.

IPOP proposed to assure that the pregnant and postpartum women receiving its case management/care coordination services would be screened and receive treatment for depression. It also proposed to develop systems linkages to assure that more women in the target area were screened and treated for depression.

Screening methodology

IPOP case management and care coordination staff was responsible for screening their clients for depression. The case manager (public health nurse) or care coordinator (community health outreach worker) was responsible for referring clients for further assessment and treatment, if needed. The public health nurse or community health outreach worker would then follow-up to see if clients referred for treatment actually receive treatment.

IPOP utilized the *Edinburgh Postnatal Depression Scale* (EPDS) for both pregnant and interconceptional clients. IPOP pregnant clients were screened once during the prenatal period and once during the postnatal/interconceptional period. If IPOP staff observed behaviors that made them concerned between the scheduled screenings, they could consult with the subcontracted Every Childs Counts mental health counselor. The counselor was available by phone and also attended monthly case conference meetings.

In addition to their professional expertise and competence, IPOP case managers (public health nurses) and care coordinators (community health outreach workers) were selected with cultural competence/diversity in mind since the majority of women served were African American. The second largest group served was Latina women. IPOP staff utilized a Spanish version of the *Edinburgh Postnatal Depression Screen* for monolingual Spanish-speaking women. It was either administered by IPOP Spanish-speaking staff or a contracted interpreter.

IPOP case managers and care coordinators provided education on the signs and symptoms of depression during home visits to clients receiving case management and care coordination services. The case management/care coordination staff did this verbally and with written educational materials.

After a positive depression screen, clients who were not referred to the sub-contracted mental health provider were referred for further assessment to organizations that accept Medicaid reimbursement for individual and/or family counseling such as the West Oakland Mental Health Center or the Family Services Counseling Center. Private practitioners who accept Medi-Cal (Medicaid) could be accessed through Alameda County Behavioral Care's Access Line. A limited number of mental health service organizations in Alameda County have the capacity to serve clients who speak Spanish (e.g., La Clinica de la Raza Mental Health Services, Catholic Charities, and Parental Stress.)

While mental health practitioners were trained to deal with depression, there were very few services focused on perinatal depression. There was an organization called Postpartum Assistance for Moms that focused on postpartum depression. Typically mental health services

for low-income individuals are focused on the chronically mentally ill and those not suffering from an acute problem may experience some delay in receiving services.

The Alameda County Fetal Infant Mortality Review Community Action Team (FIMR/CAT), which served as part of the IPOP Consortium, developed a matrix of low-cost mental health services for women in Alameda County. This list identified the type of services provided, eligibility requirements, payment sources accepted, language capacity, and contact numbers. This matrix has been and continues to be distributed so that the case managers/care coordinators are aware of potential providers of mental health services. According to the matrix, there are five mental health providers located in or near IPOP's targeted zip codes that provide services to Medicaid recipients. There are two who provide services for free and five who have a sliding fee scale.

During the last two budget years, IPOP had a contract with Every Child Counts (a program that primarily serves high risk infants and their families) to provide mental health assessment and short-term treatment to IPOP clients. Prior to its contract with Every Child Counts, IPOP referred its clients for mental health services to the Alameda County Behavioral Care Services Access Line, West Oakland Mental Health Center, Children's Hospital (which serves families), the Regional Center (which provides services to the disabled and their families), La Clínica de la Raza, and the Family Counseling Center. Staff also used TeleCare, a private organization that accepts Medicaid payment and provides mental health and substance abuse services.

Successes and challenges

Prior to the initiation of IPOP's use of the *Edinburgh Postnatal Depression Screen*, no case management program targeting pregnant women had included a formalized depression-screening tool as part of its ongoing case management efforts. IPOP increased the number of pregnant and postpartum women in case management programs who were screened for perinatal depression and referred to assessment and treatment. Due to IPOP's long-term case management program, follow-up on referrals and barriers to treatment could be addressed.

IPOP was successful in meeting its depression screening objectives. Many of IPOP's clients were screened, assessed, and treated for depression. This occurred not only due to the screening done by IPOP public health nursing and outreach staff but was also due to IPOP's ability to subcontract for mental health services. The mental health counselor was able to do home visits, and the majority of the women who screened positive for depression were able to receive counseling in their homes. This was particularly important for women who did not want to be labeled as having a mental health problem and did not want to enter the local behavioral care system which focuses on treating the chronically mentally ill.

Local Health System Action Plan

Background

A myriad of local health systems action plan objectives were identified in the original Alameda County Healthy Start proposal; however, based on recommendations made at the national Healthy Start conference in October 2001, and due to limited resources, the Alameda County Healthy Start Program decided to address one primary objective and a limited number of strategies in its local health systems action plan.

The project staff reviewed the local Title V Agency's local systems health plan. Its five-

year objectives included reducing the infant mortality rate to no more than 5.0 infant deaths per 1,000 live births for all racial/ethnic groups and to reduce the infant mortality rate for African Americans to 10.0 per 1000 live births. Major strategies included:

- Reduce the African American infant mortality through a comprehensive community-based effort by assuring that at-risk childbearing age pregnant and parenting women, and their infants and children have access to quality maternal and child health services;
- Reduce the number of African American pregnant women who smoked, used alcohol, and/or nonprescription drugs during pregnancy;
- Reduce the number of African American babies who died due to SIDS; and
- Reduce the disparities in infant mortality and other maternal and child health indicators between different ethnic groups.

Due to limited resources, IPOP decided to focus on the strategy that dealt with reducing substance use during pregnancy. This strategy was important due to the impact of substance use on birth weight and prematurity and therefore, the risk of infant mortality. IPOP decided to promote more consistent screening of substance abuse by perinatal providers.

A 1992 statewide Perinatal Substance Exposure Study indicated Alameda County had the second highest prevalence rate in California, nearly 17.0%. Additionally, a local fetal/infant mortality report of cases reviewed between 1994-1999, cited substance use as the most frequently identified contributor to fetal and infant mortality. No similar, subsequent prevalence studies have been conducted across the state to date so most California counties have virtually no current prevalence data. However, at the writing of the 2001-2004 application, it was known that drug-exposed babies continued to be born in Alameda County, and that substance use is still a factor in approximately 80% of all children brought into the local foster care system.

The prevalence of illicit drug use during pregnancy in Alameda County in a 1992 perinatal study was 6.13%. This translated to approximately 1,200 babies born to mothers using illicit drugs a year. In Alameda County, studies indicated that women who used cocaine were ten times more likely to have a low birth weight baby. Factoring in maternal age and parity, cigarette smoking, alcohol use, socioeconomic status, low pregnancy weight gain, and history of low birth weight (LBW), the relative risk of low birth weight among cocaine users was 4.4. Cocaine use was estimated to account for 10% of cases of LBW in African Americans in Alameda County.

The relative risk for a LBW baby in Alameda County for smokers was approximately 2.5 times that of women who did not smoke. In the 1992 study citied above, approximately 12% of women in Alameda County were smoking at the time of delivery. This translated into approximately 2,200 infants a year born to mothers who were still smoking at delivery. Tobacco exposure has been significantly associated with fetal growth retardation, developmental problems among children, low birth weight, and severe respiratory problems. Primary prevention keeps women of childbearing age from beginning to smoke. Among women who smoke and become pregnant, cessation of smoking before the end of the first trimester results in the same LBW rate as non-smokers. If cessation can be sustained after delivery, it can have a great effect on the baby's health after birth as well, since passive smoking is associated with respiratory infections, ear infections, asthma, and SIDS among infants.

Alcohol consumption in pregnancy is a leading, preventable cause of numerous health

problems such as miscarriages, LBW, intrauterine growth retardation, a cluster of defects known as fetal alcohol syndrome (FAS) in newborns, and the leading cause of mental retardation. In Alameda County, based on the 1992 Perinatal Substance Exposure Study sponsored by the State of California, the overall prevalence rate for alcohol use during pregnancy was 10.3%. The use of alcohol during pregnancy was highest among African Americans (14.6%). In addition, women under the age of 18 had the highest prevalence of substance use during pregnancy (19%) including highest for alcohol use (16.6%).

IPOP considered some research findings in selecting approaches to substance abuse reduction such as:

- Simple reliable screening tools for substance abuse had been developed, but many physicians were reluctant to screen and counsel patients about substance use;
- A study reported 76% of pregnant women either eliminated or decreased their drinking during pregnancy following a supportive counseling intervention; and
- Furthermore it had been found that physicians miss the diagnosis of alcoholism in 3 out of 4 cases.

The local Title V agency initiated a review of gaps in the local system in reference to perinatal substance abuse. A survey of obstetrical providers indicated that while some were assessing for perinatal substance abuse, many were not. Some of those who did screen for perinatal substance abuse only screened women who they thought might be using drugs. In addition, many obstetrical providers thought that there were no substance abuse treatment programs available for pregnant women when the opposite was true. Contrary to the belief of perinatal providers, Alameda County had perinatal substance abuse treatment providers whose services were being underutilized.

Due to the risk of poor birth outcomes caused to substance use, IPOP decided to take a systems approach to reducing substance use during pregnancy. Based on the results of the survey of perinatal providers and the reports of underutilization by perinatal substance abuse treatment providers, it was decided to support a perinatal substance abuse task force composed of public health personnel, Medicaid managed care providers, private/public obstetrical providers, perinatal substance abuse treatment providers, and social service providers to address the lack of consistent substance abuse screening by perinatal providers and linkages between obstetrical providers and perinatal substance abuse treatment providers.

Plan implementation

The primary IPOP Local Health Systems Action Plan objective was the reduction of the number of women who used substances (i.e., tobacco products, alcohol, and illicit drugs) during pregnancy by:

- Promoting the identification by prenatal providers of pregnant women who currently use alcohol, illicit substances, and/or tobacco products and referring them to appropriate treatment programs;
- Promoting brief-intervention pre-treatment therapy by prenatal care providers for pregnant women who are using alcohol, illicit substances and tobacco products; and
- Promoting referral to treatment by prenatal providers.

The IPOP program supported the training of prenatal providers in the use of the *4 Ps Plus Screening and Assessment Tool* developed by the National Training Institute/Children's Research Triangle. The screening and assessment tool can identify women who are using substances and need referral to treatment or brief intervention therapy. IPOP purchased the annual license for the screening and assessment tool and worked with the Alameda County Maternal, Paternal, Child and Adolescent Health (MPCAH) Program's Mental Health/ Substance Abuse Coordinator to organize and support training in the use of the screening/assessment tool, in brief intervention therapy, and in the use of the Link to Recovery Line.

The Link to Recovery Line was a telephone number that had been designated as the number for prenatal providers to call in order to refer clients to substance abuse treatment. The provider made the call, a case manager was assigned to make contact with the client and determine the appropriate substance abuse treatment site. The case manager made the referral and updated the provider on the status of the referral. This line was developed because many providers were not aware of substance abuse treatment sites or did not know the best treatment sites to which to refer their clients. Those prenatal providers that did refer to substance abuse treatment sites indicated that some sites did not follow-up and let them know what happened with the referral.

The primary group over seeing this substance abuse reduction activity is the Perinatal Substance Abuse Task Force. The Task Force, formerly called the Alameda County National Training Institute Team, was jointly developed by the Maternal, Paternal, Child, and Adolescent Health (MCAH) Program director and the IPOP director. It was staffed by the MPCAH Mental Health/Substance Abuse Coordinator, with the IPOP director in the initial years of the Task Force, serving as the back-up staff person to the Task Force. Support for the substance abuse reduction objective occurred throughout the project period.

The Perinatal Substance Abuse Task Force had its beginnings during the Oakland Healthy Start funding cycle. In the last year of Oakland Healthy Start funding (2000-2001), the Division of Perinatal Systems and Women's Health supported a visit by Dr. Ira Chasnoff to Alameda County in February 2001. Dr. Chasnoff is an expert in prenatal substance abuse, and was invited to provide education and training on the issue of prenatal substance abuse, and particularly on the importance of screening women during the prenatal period. As a result of that visit, Alameda County leaders and policy makers participated in a three-day training in May 2001, at Dr. Chasnoff's National Training Institute in Chicago, Illinois, to begin development of a plan to address prenatal substance abuse screening, referral, and treatment issues in Alameda County.

Between July and December 2001, the Alameda County National Training Institute Team (NTI) developed a prenatal and pediatric *Screening; Assessment, Referral and Treatment* (SART) plan with staff support from the local Title V program and the Improving Pregnancy Outcomes Program. The basic goals of this county-wide SART plan were to screen every pregnant obstetrical care patient for substance; assess each of these women for substance abuse treatment needs; connect or refer these women to appropriate treatment facilities; and follow up with the women who were referred for services. A pilot site for the SART process was initiated in March 2001.

It was decided by the NTI team members that it was important that the direct service providers were skilled in doing brief intervention therapy. Dr. Ira Chasnoff's Children's Research Triangle developed a brief intervention therapy tool to be used by practitioners, and

IPOP supported brief intervention therapy training in Alameda County for providers who were using the 4 P's Plus perinatal substance abuse screening tool.

A meeting was also held with other prenatal providers potentially interested in participating as expanded pilot sites. As a requirement for their participation, they requested that there be a place for easy referral of patients who screened positive for substance use. The providers wanted one place to call and refer clients and they wanted to be assured of feedback as to whether or not a referred patient completed the referral and entered treatment. As a result of this feedback, the Alameda County Behavioral Health Care Services Agency's Alcohol and Drug Program helped identify an Alameda County contracted treatment program (the Highland Hospital Options for Recovery Program) to establish a new telephone referral and follow-up services called Link to Recovery. Obstetricians and clinics that participated in the screening, assessment, referral and treatment process or their clients could call the Link to Recovery line for referral and follow-up.

Currently, there are fifteen sites that are using the *4 Ps Plus Screening and Assessment Tool*. The following is a descriptive summary of these sites:

- Two private practices
  - East Bay Perinatal Medical Associates (6 sites)
  - Dr. Howard Daniels (1 site)
- Two community clinics
  - La Clínica de la Raza (3 sites)
  - Tri-City Health Center (1 site)
- Hospitals and related clinics
  - Alameda County Medical Center (a county hospital with 3 ambulatory care sites)

Three additional community clinic sites have expressed interest in using the *4 Ps Plus Screening and Assessment Tool* and will tentatively initiate use of the tool in the latter part of the 2005 calendar year or during the 2006 calendar year. Furthermore, the tool has been translated and used with Spanish-Speaking, Chinese-Speaking, and Vietnamese-Speaking patients.

Current members of the Alameda County's National Training Institute team (now called the Perinatal Substance Abuse Task Force) who continue to oversee the implementation of the plan include the director the Alameda County Health Care Services Agency, the child abuse coordinator for the Alameda County Social Services Agency, the Alameda County Behavioral Health Care Services Agency's perinatal substance abuse coordinator, the deputy director of the Alameda County Children and Families Commission, the director of the Highland Hospital Options for Recovery Program, the local Title V MPCAH Director, the local MPCAH Prenatal Substance Abuse Project Coordinator, the program manager for the local Blue Cross of California Medi-Cal/Healthy Families Program (Medicaid managed care program), the public health ambassador for the Alameda Alliance for Health (Medicaid managed care program), a certified nurse midwife from the East Bay Perinatal Medical Associates (a large high risk obstetrical practice), the MCH director for the City of Berkeley, the Alameda County Public Health Department's health officer, the deputy director of the Health Department, the director of the Public Health Department's Family Health Services Division, and the Improving Pregnancy Outcomes Program director.

Successes and challenges

Overall the implementation of the local health systems action plan has been very successful. Approximately 2,500 pregnant women have been screened to date. The enthusiasm and cooperation of the Perinatal Substance Abuse Task Force members has allowed the *4 Ps Plus Screening and Assessment Tool* to be utilized at medical offices, clinics, and a hospital serving large numbers of Medicaid clients. The approval of the use of the tool by two local Medicaid managed care providers facilitated its use by obstetrical providers.

There has been a linking of a major obstetrical provider and a perinatal substance abuse treatment program. The substance abuse treatment program has out-stationed a case manager at a large obstetrical office to follow-up on those who have screened positive for substance use. In addition, the Link to Recovery telephone line has been established at a perinatal substance abuse treatment site.

Based on the concerns of the Perinatal Substance Abuse Task Force members about the standards of care at perinatal substance abuse programs, Alameda County Behavioral Care hired a consultant to develop standards for perinatal substance abuse treatment sites.

One of the challenges has been to increase the number of sites implementing the *4 Ps Plus Screening and Assessment Tool*. Fewer obstetrical sites are participating than planned despite the number indicating an interest, particularly clinic sites.

Consortium

Background

Based on the history of Oakland Healthy Start, which was initiated in the early 1990s, it was decided to not start a consortium that was focused on funding. As Oakland Healthy Start neared its end, consortium participation decreased as the program was set and there was little opportunity to influence funding decisions. (Oakland Healthy Start primarily funded its activities through a contracting process).

It was decided to have Alameda County's Maternal, Child, and Adolescent Health's Fetal Infant Mortality Review (FIMR) Committee Action Team (CAT) serve as a base for the consortium. Its goals were to look at the issue of infant mortality; review recommendations for change; and to promote activities, policies, and procedures to help reduce fetal and infant mortality.

Alameda County Public Health Department, Maternal, Paternal, Child and Adolescent Health, Fetal Infant Mortality Review (FIMR) Community Action Team (CAT) serves as part of the IPOP consortium. The FIMR/CAT is a large, active, significant and successful collaborative of organizations dedicated to reducing fetal and infant mortality and improving pregnancy outcomes in Alameda County. The work of the FIMR/CAT is accomplished in meetings of the whole body and through ad-hoc sub-committees that focus on specific topics and tasks. Since most of the FIMR/CAT participants were from provider organizations an to ensure that IPOP received appropriate consumer input, an IPOP Consumer Task Force was established as part of the Consortium.

Currently, there are 82 members on the roster. There are currently approximately 35 active members. The categories currently represented, by percentage are:

Categories Represented	Number	Percent
State or local government (G)	32	39.0%
Community participants (CP)	27	33.0%
Program participants (PP)	8	10.0%
Private agencies or organizations (not community based) (PAO)	8	10.0%
Community-based organizations (CBO)	5	6.0%
Providers contracting with the Healthy Start Program (PC)	1	1.0%
Other providers (OP)	1	1.0%
Other	0	--
Total	82	100 %

The racial/ethnic breakdown of consortium membership by percentage is:

Race/Ethnicity	Number	Percent
African American	32	39.0 %
Hispanic or Latino	18	22.0 %
White	16	20.0 %
Eastern Indian/Pakistani	0	0.0%
Asian American/Filipino	6	7.0%
African Descent	0	0.0%
Arab/Muslim	0	0.0%
Other	10	12.0%

Consortium activities and accomplishments

During the project period, consortium accomplishments reached significant levels. There was an increased awareness among members of perinatal periods of risk, maternal conditions, and infant mortality. There was increased awareness of the prevalence of poor pregnancy outcomes such as low birth weight births, preterm births and SIDS deaths. There was increased partnership, service capacity, and an increased integration of services as evidenced by:

- The improved recognition of maternal depression. Maternal depression was identified as an issue by IPOP focus groups and reported to the consortium. The consortium expressed concern for women suffering from depression and several collaborative activities resulted. Every Child Counts (the Proposition 10, Tobacco Tax Initiative-funded organization), the Title V Comprehensive Perinatal Services Program (CPSP), and IPOP supported a provider-training program on maternal depression. In addition, a consortium sub-committee was created to develop and distribute a user-friendly matrix of mental health services to help increase community awareness about available services.

- An increased concern about the number of babies who died inutero. Data revealed many mothers were unaware of decreased fetal movement and physicians were not educating patients on how to recognize signs of fetal distress. The consortium established a Kick Count sub-committee to develop and pilot-test

kick count instructions. These patient and community education materials were finalized in early 2004.

- Increased community awareness about marijuana use during pregnancy and its later effects on infants and children. This area of concern grew out of a Healthy Start Perinatal Substance Abuse Local Action Plan activity. As a result of IPOP supported screening of pregnant women at one high-volume pregnancy care practice, it was noted that over half of the women were marijuana users and unaware of its effect on the fetus. An IPOP-supported provider training entitled "Marijuana: Research and Recommendations," was conducted by Dr. Ira Chasnoff, a perinatal expert from the nationally renowned Children's Research Triangle. Furthermore, the consortium sub-committee developed the language for a new pamphlet, *Marijuana Use In Pregnancy*, and a consortium partner provided the graphic design and fiscal support for its high quality production. The pamphlet was printed in English, Spanish, Chinese and Vietnamese. This resource did not previously exist and was considered an urgent need by the consortium.

- A SIDS speaker's bureau and technical assistance to county birthing hospitals. The consortium established a sub-committee to visit all of the county birthing hospitals and determine their formal protocols on newborn sleep positions; conduct an impromptu survey of the sleep position of infants observed during the visit; gather information of their actual practices; understand what instructions on sleep positions are given to new parents; and link hospital staff to available resources. The Hospital Visitation committee consisted of FIMR/CAT members and local Title V staff. In addition to the SIDS *Back-To-Sleep* campaign, topics discussed were breastfeeding, recently developed FIMR/CAT bereavement resources, and perinatal substance abuse issues.

- The updating and reprinting of the existing resource guide. The guide assists residents in finding services. The second printing occurred in January 2003; and the fourth printing occurred in November 2003. A total of 99,000 copies of this popular guide were distributed during 2004. A new category, Children's Mental Health Services, was added, resulting in two new user partners: Children's Hospital Oakland and the Oakland Police Department. The Second Annual Kickoff for the Resource Guide was held in November 2003, to provide an opportunity for agencies listed in the guide to become mutually familiar with their services. In December 2003, the consortium requested that an electronic PDF version of the guide be put on the Alameda County Public Health Department's website to further increase its availability. Consortium member agencies, county departments and others supported the printing of this guide by contributing $0.20 per copy. The electronic version is being widely distributed via email and through the website. The guide is currently being updated and the fifth printing is scheduled for 2005.

- The development of a pregnancy passport. The consortium agreed to address the issue by developing a pregnancy passport, which could be carried by pregnant women to inform multiple providers about their care and conditions.

Over the last four years, consortium members have worked together to understand and respond to issues, concerns and threats to positive perinatal outcomes. Based on the collective thinking of the members, new tools, materials, products, and training programs have been designed and delivered. Member organizations have provided the fiscal support to bring all of the accomplishments to completion. Albeit, the consortium accomplishments listed here do not adequately describe the synergy that has been produced over the last four years of working together. The FIMR/CAT is a well-known, appreciated organization. Members are committed to its existence and embody their belief in the consortium's motto: **T**ogether **E**ach **A**chieves **M**ore.

Consumer participation

The FIMR/CAT was a predominately provider organization. It was decided that in order to strengthen consumer input a consumer task force needed to be established. In December 2002, IPOP staff initiated the development of the consumer consortium, recruited members, and coordinated monthly meetings. Consumers were recruited by health service trainees (HSTs) through street outreach and attending events where IPOP's target populations could be reached. This method netted members who were representative of the ethnic and cultural makeup of the target zip codes: African American, monolingual and bilingual Latina, Iranian and mixed-race individuals. Community health outreach workers and public health nurses also recruited consumer consortium members among program participants receiving IPOP case management/care coordination services.

The consumer task force met on almost a monthly basis. This enabled the staff to educate consumers about perinatal issues and provided the consumers with an opportunity to give IPOP staff input and direction from their perspective. Consumer Task Force members contributed tremendously to the development of community education programming, curricula, materials, and intervention strategies. Many ideas for program development were generated and reviewed by Consumer Task Force members during the 2002 through 2005 program years. In 2004, consumers participated in two focus groups to identify the most pertinent health education and information needs of low-income reproductive-age women. Additionally, consumers assessed specific health information needs concerning weight management/obesity and gave feedback on the effectiveness of the community education newsletter.

Successes and challenges

FIMR/CAT was an ongoing entity before the initiation of IPOP with the meetings of the whole FIMR/CAT provided with staff support by the local Title V Agency. This means its participants were interested in the issue of infant mortality before IPOP was started and will continue to be interested in the issues of fetal and infant mortality. It also means that FIMR/CAT has the ongoing support of the local Title V agency for its activities as well as support of the participating organizations. In other words, its ongoing support is not based on grant funding and its efforts are very likely to endure.

The Consumer Task Force met on a monthly basis, with few exceptions, from December 2002 through February 2005. Despite cultural differences and language barriers, members

bonded and supported each other during the meetings as they addressed critical and sensitive perinatal issues. Many of the members expressed that they came to the meetings because they offered as respite from their daily routines and enjoyed learning about important health issues and resources. Due to various reasons such as starting a new job or giving birth, many women cycled through the meetings, with consistent participation from approximately ten members. Often, members stated that they wanted to meet more frequently and closer to home so that they could walk to meetings or avoid downtown traffic and parking. It was challenging to identify the ideal meeting place that would be convenient for all members in such a large target area. Additionally, IPOP did not have the staff resources to meet weekly or biweekly as the members desired.

In the subsequent program period, IPOP is planning to reconfigure consumer task force activities and integrate it into the Leadership Development activities, possibly through the establishment of several neighborhood-based consumer groups (i.e., ClubM♥M and/or peer health leadership program) instead of one centralized county-level meeting. As part of IPOP's community education programming, this shift in implementing the consumer task force is anticipated to facilitate increased attendance and meeting frequency, more meaningful participation, leadership development, and stronger relationships between IPOP staff and consumers.

Collaboration and Coordination with State Title V and Other Agencies

Background

IPOP is a part of the Alameda County Maternal, Paternal, Child, and Adolescent Health (MPCAH) program. The MCAH program receives Title V dollars through the California Department of Health Services to implement perinatal activities in Alameda County. The local MCAH program received Title V dollars to support a small Black Infant Health Program to provide outreach and case management services to pregnant African American women. In order to promote standardization of case management protocols and data systems, the MPCAH director asked the State MCH director to allow IPOP to use the State Black Infant Health case management/care coordination protocols and use the Black Infant Health Program's computerized management information system (MIS). Permission was granted for the use of the protocols and MIS system.

In addition to this collaboration, plans were made for IPOP to support statewide MCH conferences and trainings where feasible. Furthermore, it was agreed for IPOP and the MPCAH program (local Title V Agency) to share a Health Promotion & Community Health Education Coordinator in order to make sure that collaboration occurred in population-based health education activities.

Collaborative efforts and coordination activities

The IPOP director reported to the director of the local Title V agency—the Maternal, Paternal, Child, and Adolescent Health Section of the Alameda County Public Health Department; therefore, IPOP was very integrated with local Title V efforts. IPOP and MPCAH were part of the Family Health Services (FHS) Division. FHS also included the local Child Health and Disability Prevention Program and the California Children Services Program (which serves children with special health care needs). Monthly meetings were held with the FHS division managers to share developments in each program. The MPCAH section was

responsible for the following programs. These programs were interrelated with IPOP's purpose, strategies, and activities:

- Title V Needs Assessment. IPOP staff has been involved in the development of the local Title V agency needs assessment for its 2005-2009 Maternal, Child, and Adolescent Health plan. IPOP staff completed literature reviews on major maternal, child, and adolescent health indicators including infant mortality, injury prevention, unintended pregnancies, and immunizations that help in MPCAH plan development. One of the IPOP program specialist, in collaboration with local Title V director and the Maternal, Paternal and Child Health Coordinator, helped lead the development of the local Title V five-year plan needs assessment and other IPOP staff participated in the five-year needs assessment process.

- Comprehensive Perinatal Services Program (CPSP). The CPSP is a state-funded program that provides obstetrical providers with extra funding to support psychosocial assessments and provide health education and nutrition information to pregnant clients. The local Title V agency supported perinatal service providers by providing quality assurance training, nutrition education, health education, and psychosocial education to the perinatal practice staff in order to enhance the provision of comprehensive perinatal services. During the 2003 calendar year, IPOP collaborated with the local CPSP program to provide training on perinatal depression. In the 2004 calendar year, IPOP, in collaboration with the CPSP, supported training of perinatal providers on the issue of perinatal substance abuse. Continued opportunities for joint training will be identified and pursued. Possible topics include obesity reduction, pre-diabetes and diabetes.

- Sudden Infant Death Syndrome (SIDS). The SIDS Program Coordinator promotes education on the prevention of SIDS and works to prevent the effects of second-hand smoke in collaboration with the Women, Infants and Children (WIC) Program. IPOP staff has cooperated with the SIDS Program by providing SIDS education to IPOP clients and SIDS risk reduction information in its community education efforts. IPOP has been and will continue to be a local co-sponsor of SIDS training efforts in Alameda County.

- Fetal Infant Mortality Review (FIMR). The federal Healthy Start program in the mid-1990s provided FIMR funding to Oakland Healthy Start. In 1999, Oakland Healthy Start's FIMR activities were integrated into the Maternal and Child Health (MCH) section of the Alameda County Public Health Department when it received California Department of Health Services funding to implement FIMR activities. The FIMR Case Review Committee makes recommendations about changes needed to reduce fetal and infant deaths. Their findings are important to IPOP deliberations about its program activities.

- FIMR Community Action Team (FIMR/CAT). This broad-based, multi-disciplinary collaborative is comprised of representatives of many different groups, organizations, agencies, and institutions in Alameda County. The

responsibility of the Community Action Team is to review the findings and recommendations of the FIMR Case Review Committee and to promote the implementation of policies, practices, and interventions to reduce infant mortality. The FIMR Community Action Team provides oversight and strategic planning for the Alameda County effort to reduce infant mortality. IPOP staff participated on the FIMR Community Action Team and brought forth findings and issues for discussion. To further integrate Healthy Start and Title V activities, the FIMR Community Action team served as part of the IPOP Consortium along with the IPOP Consumer Task Force. FIMR/CAT decisions influenced IPOP policies, practices and interventions.

- Black Infant Health Program (BIH). The Black Infant Health Program is supported by the California Department of Health Services MCH Branch with Title V funds. Funds to support the program come through the local MCAH program. The BIH Program has four components: (1) case management through home visitations; (2) outreach; (3) male involvement; and (4) social empowerment groups. The program models were developed by the state Black Infant Health Program. IPOP has adapted the BIH case management/care coordination policies and procedures and management information system for its use with the permission and support of the State MCH director. The local BIH Coordinator has provided IPOP public health nurses and community health outreach workers (CHOWs) with training on the BIH policies and procedures and has provided IPOP nurses and CHOWs with an opportunity to participate on home visits with the BIH Program's very experienced nurses and CHOWs. The BIH Coordinator spent part of her time (.10 FTE) as the IPOP nursing supervisor to help support collaboration between IPOP and BIH.

Coordination with State MCH Title V

The California MCH directors participate in a group called MCAH Action. They meet regularly with the state MCH director, Black Infant Health state staff, and the state MCH Branch nurse consultants. Healthy Start issues were taken by the Alameda County MPCAH Director to the MCAH Action meetings. Also, the Healthy Start director is invited to attend whenever relevant issues are planned for discussion. Dr. Susan Steinberg, the Interim State of California MCH Director, continues to support collaboration with IPOP. The State MCH Branch has allowed the IPOP staff to utilize and adapt its California Black Infant Health Program case management/care coordination policies and procedures and will continue to allow IPOP to utilize its computerized management information system application to gather data.

Successes and challenges

Collaboration has been extremely easy with the local Title V agency since the IPOP director reports to the local Title V director. There has been less direct interaction between the State Title V agency and IPOP, primarily because the local Title V director has responsibility for interacting with the State Title V agency. Any issues identified by IPOP are usually taken by the local Title V director to the state level.

The California Healthy Start projects did initiate a perinatal substance abuse needs assessment report with Healthy Start funding. Perinatal substance abuse is still periodically

addressed at the California MCH director's statewide meetings. As a result of Dr. Ira Chasnoff's perinatal substance abuse screening, assessment, referral and treatment activities with IPOP and the Fresno County Healthy Start project, he has been asked to speak at California MCH director's statewide meetings to promote similar activities in other California counties.

Sustainability

Sustainability efforts consisted of looking at the pursuit of funding to sustain case management/care coordination activities. At the end of the 2001-2005 project period, IPOP was able to have one of the Medicaid managed care programs agree to discuss reimbursement for their members who receive case management services from IPOP. They typically only reimburse for one prenatal visit unless there is a medical necessity for additional visits. All visits must be pre-approved. The other local Medicaid managed care program does not subcontract out its case management services.

The IPOP director approached both Alameda County Public Health Department leadership and the Alameda Alliance for Health (a Medicaid managed care plan) about reimbursement for IPOP services provided to Alliance clients. The Alameda Alliance has a contract with the Alameda County Public Health Department to pay for reimbursement for home visitation to clients for whom they have preauthorized home visits. While the contract was initially targeted at reimbursing the Alameda County Public Health Nursing Unit for its services, the Alliance has indicated its willingness to have IPOP be able to be reimbursed for the preauthorized home visits.

The IPOP director has met with the Alameda County Health Care Services Agency director to discuss sustainability efforts. One of the items discussed was possible reimbursement by Medicaid for Targeted Case Management (TCM) services; however, the issue of the need for some local funds being required to support the effort was discussed. Reimbursement by Medicaid is not one hundred percent and therefore, some local dollars are needed. The possibility of local *Measure A* funds being made available was mentioned as a possibility for the future depending on the priorities established by the Alameda County Board of Supervisors.

In November 2004, a local tax measure passed in Alameda County. This measure, called *Measure A* is to "provide and maintain trauma and emergency medical services throughout Alameda County and to provide primary, preventative and mental health services to indigent, low-income and uninsured children, families and seniors, to retain qualified nurses and health care professionals and to prevent closure of county clinics and the Alameda County Medical Center." In light of the recent local financial cuts due to California's budget deficits, the majority of these funds have gone to make up for budget losses in the local health care system with a relatively smaller portion designated to fund chronic disease prevention or other prevention programs.

While there has been a three-year commitment for the current funds, the opportunity will arise within the next three years to propose to the Alameda County Board of Supervisors new or additional ways to spend *Measure A* funds. The IPOP director has spoken to both the Alameda County Health Care Services Agency director and the Alameda County Public Health director about the possibility of their support for proposing that some of the future local *Measure A* funding be proposed as a match for Title XIX funding through the State of California's Title V Agency Block grant or as matching funds for Targeted Case Management activities. Both directors felt that it might be a possibility depending on: 1) the priorities of the Alameda County Board of Supervisors who decide how the Measure A funds are spent, and 2) the status of basic

health service funding when the process begins again for proposing how *Measure A* funds should be spent. The IPOP director will continue to pursue this possibility with both directors.

III. Project Management and Governance

The Alameda County Health Care Services Agency is made up of the Alameda County Public Health Department, Behavioral Health Care Services, and Environmental Health Services. The Agency is also responsible for indigent health care, providing funds to support health services for the medically indigent of Alameda County by contracting for services with community-based health organizations and hospitals.

Organizationally, IPOP is located within the Alameda County Public Health Department's Family Health Services Division. Within the Family Health Services Division, is the Maternal, Paternal, Child, and Adolescent Health (MPCAH) section. The MPCAH section of the Health Department serves as the local Title V agency and the IPOP director reports directly to the MPCAH director.

The MPCAH director has the general responsibility for planning, implementing, evaluating, coordinating, and managing Maternal and Child Health (MCH) programs. The MPCAH director has responsibility for overseeing the administration of all MPCAH programs. Under the direction of the MPCAH director, the IPOP administration consists of a small core staff, which performs overall project management and oversight, program monitoring, contracts and fiscal functions, evaluation and sustainability activities. IPOP administration consists of the program director, the fiscal manager, and administrative/clerical support staff.

The IPOP director's primary responsibilities include: project direction and management; policy development and implementation; compliance with federal and county standards and guidelines; and development and maintenance of collaborative relationships with foundations, businesses, institutions, and other health and social service organizations to strengthen the delivery system.

IPOP is part of the Alameda County administrative structure and must follow Alameda County rules and policies in reference to accounting, contracting, budget development, purchasing, and human resources policies and procedures. IPOP's fiscal manager reports directly to the deputy director of the Family Services Division. She is responsible for assuring that all Family Health Services programs adhere to County policies and procedures. The fiscal manager's responsibilities include assuring that all Alameda County fiscal control systems are in place and that budget development activities occur according to county policy. She assists with contractor fiscal monitoring and assists with fiscal audits for the program and its contractors. She also provides technical assistance related to fiscal compliance.

As part of her management activities, the project director held several key meetings to assure that program objectives were being accomplished. Monthly joint meetings were held with program management staff to review progress in meeting objectives. Managers also met to do strategic planning about future directions. Weekly meetings were held with case management/care coordination staff to identify outreach activities and to identify and understand progress in reaching program participants. These meetings provided an opportunity to hear the issues that were being faced by participants and the resource needs of case management/care coordination staff. The IPOP director met individually with program supervisors to understand programmatic issues, to discuss new ideas, and to determine program progress.

In order to promote collaboration and interaction between MPCAH programs there were two individuals who held supervisory positions in both MPCAH and IPOP. The Black Infant Health Program and IPOP share nursing supervisors. The MPCAH Health Promotion &

Community Education Coordinator is also shared between IPOP and MPCAH to promote non-duplication of effort.

The IPOP director, the IPOP nursing supervisor, and the MPCAH director met on a regular basis to review program activities. The IPOP fiscal manager and IPOP director met to review fiscal issues. The fiscal manager serves as a liaison with the Alameda County Budgets and Contracts Unit and the Fiscal Unit to facilitate budgeting, contracting, and fiscal issues.

Although the IPOP administrative staff is small, it takes advantage of larger support from the MPCAH Section and the larger Health Department and Alameda County fiscal, budgeting, contracting and purchasing units in accomplishing administrative activities.

The only change in management occurred in reference to the direct oversight of the case management/care coordination services. For the first two years of the project, public health nurses and community outreach workers were part of the overall public health nursing unit. In February 2004, the direct supervision of this component was transferred directly to IPOP.

Funds were primarily distributed to focus on case management/care coordination activities, with smaller amounts going to community education, fatherhood services, and project management. This distribution did not change over time.

No additional non-healthy start funds were obtained for quality assurance, program monitoring, service utilization and technical assistance; however, in-kind nursing supervision was provided to assist with quality assurance and program monitoring for the case management/care coordination component of IPOP.

There were no major cultural competency issues in reference to project staff or contractors providing outreach case management/care coordination and health education services to pregnant and parenting staff. The majority of the clients were African American and Latino. Outreach staff and health education staff reflected those cultural groups.

In reference to mental health counseling, the mental health contractor provided an African American counselor but was not able to provide services for non-English speaking clients. Non–English speaking clients had to be referred into the larger behavioral care program. Public health nurses had access to culturally appropriate translators for their visits with their non-English speaking clients.

Limited funding for fatherhood staff meant that monolingual, non-English speaking fathers could not be served by existing fatherhood staff. IPOP facilitated the training of Spanish-speaking facilitators for the *Boot Camp for New Dads* curriculum; however, those trained did not institute the classes in their organizations as anticipated.

IV. Project Accomplishments

Project Period Objective 1

By May 31, 2005, at least 348 high-risk pregnant and parenting women (155 medically high-risk and 193 socially at-risk) who were enrolled during the prenatal period will receive case management/care coordination services according to IPOP policies and procedures.

Degree of success

309 high-risk were enrolled during the prenatal period and received case management/care coordination services according to IPOP policies and procedures.

Strategies

Community outreach was the major strategy to find high-risk pregnant women. Public health nurses and community health outreach workers visited medical providers and community organizations to identify and recruit high-risk women. Case management and care coordination staff was out-stationed at hospitals and offices that regularly saw large numbers of pregnant women. Community health outreach workers and community education staff did street outreach, attended health fairs, developed a community newsletter, implemented community baby showers, and held health education classes to do outreach, health education and case-finding.

The lesson learned was that a program must stay flexible to meet community needs. While IPOP did not meet its projected caseload for pregnant enrollment, it exceeded its projected postpartum/interconceptional enrollment. The reasons will be discussed under the next objective.

Project Period Objective 2

By May 31, 2005 at least 50 new medically high-risk women and their high-risk infants will be enrolled during the interconceptional period and will receive case management services according to IPOP policies and procedures.

Degree of success

155 high-risk women and their high-risk infants were enrolled during the interconceptional period and received case management/care coordination services according to IPOP policies and procedures.

Strategies

Community outreach was the major strategy was to find medically high-risk women and their infants during the interconceptional periods. The details of the strategy were the same as listed under Project Period Objective 1.

As outreach occurred, more and more postpartum/interconceptional high-risk women and their high-risk infants were being referred to IPOP. What occurred in the community was that other programs targeting case management of high-risk infants reached their caseload capacity and could not take on the case management of as many infants as needed. The community perceived that the high-risk infants (i.e. low birth weight, premature, etc.) needed the services of IPOP's public health nurses for long-term case management. Instead of refusing to enroll these high-risk infants and their mothers, IPOP reduced its capacity to enroll pregnant women by serving the high-risk infants and their mothers.

IPOP exceeded its overall objective, which was to serve 398 pregnant and parenting women. IPOP served 464 pregnant and parenting women during the project period.

Project Period Objective 3

By May 31, 2005, at least 170 new fathers or male partners with children 0-2 years of age will receive care coordination services.

Degree of success

64 new fathers or male partners with children aged 0-2 years of age received care coordination services.

Strategies

The major strategies included outreach and care coordination. Staff did street outreach, participated in health fairs, and contacted agencies to let them know about IPOP fatherhood services.

One of the lessons learned, in reference to the difficulty in meeting this objective, is the necessity of providing care coordination services in a locale where the target population feels comfortable. A number of the men targeted were very, very low-income and it was found that the geographic location of IPOP's office put a strain on their limited budgets. Many of the men interested in the program came from West Oakland and the IPOP office is located in another city, San Leandro. Some of the men did not want to come to San Leandro because they did not feel comfortable in the city. Some men who did come were viewed with suspicion due to their dress by authorities. Since many of the target population were on parole or are ex felons they want to stay as far away from the police and other officials as much as possible.

Due to their experience with the criminal justice system, some men also looked at the fatherhood care coordinator with suspicion since he is affiliated with Alameda County; however, once this barrier was overcome, those men who participated in the program were interested in the one-on-one sessions. Many entered care coordination with employment as an issue but as they became more comfortable with the fatherhood staff, they became willing to indicate that they needed help in other areas as well (i.e. substance use, legal problems, child support enforcement, and paternity and custody issues).

One of the issues identified is the need to make more formal contact with agencies (such as the Alameda County Social Services Agency) that could do a formalized referral to IPOP' care coordination services. Tentative discussions have occurred in this area and will be pursued strongly in the next project cycle.

Project Period Objective 4

By May 31, 2005, at least 400 new fathers or male partners with children 0-2 years of age in the target area will be contacted annually.

Degree of success

At total of 911 new fathers or male partners were contacted. The highest number reached annually was 330.

Strategies

The major strategy included street outreach, participation in health fairs, working with public health nurses, community organizations, and other male programs to recruit fathers or male partners into the program.

The fatherhood care coordinator has learned that he has to let the target population become comfortable with him before he talks about the IPOP program. He has learned about the different organizations that sponsor men's nights at youth centers or recreation sites. Important leaders at these types of sites are now asked to introduce him, so that he is not seen as a threat by potential IPOP participants. During his first visit, he may "hang out," play basketball (i.e. midnight basketball), and check out what happens at the organization. The fatherhood care coordinator allows potential participants get familiar with him and then comes back another time to talk about the program. When he returns, he may bring incentives and refreshments to generate interest. He also may set up a table to do a mini-health education session. This approach has helped fatherhood staff increase their contacts.

Project Period Objective 5

By May 31, 2005, at least 208 new fathers or male partners will participate in health education programs.

Degree of success

214 new fathers or male partners participated in health education programs.

Strategies

The major strategy included staff training, the purchase of male-oriented health education materials and the provision of health education to fathers/male partners.

One of the lessons learned is that health education classes are not a draw for the men in the target population. They often, at least initially, do no want to attend health education classes. Formal educational approaches are not as well received as informal ones; however, informal education may lead someone to go to a more formal education session.

The fatherhood staff has started a process called "Stick & Move." As previously mentioned, the fatherhood care coordinator has learned when different organizations have men's nights at youth centers or recreation sites. He may hang out at the first visit, play ball, and check out what happens at the organization. He lets the participants get familiar with him and then comes back another time to talk about IPOP. Upon his return, he may bring refreshments and set up table after recreational activities are finished. He may ask the recreation staff to introduce him and ask potential participants to give an extra 20 minutes of their time to hear about IPOP and its services. The fatherhood staff has found that more men are willing to listen in these mini-group sessions, and thus, plans to do more of them in the future.

One of the issues with the fatherhood care coordinator is that he was part-time (.50 FTE) and had to do outreach, care coordination, and health education during that time period. Now that he is full-time (1 FTE), and based on his past experience, he has more opportunity to do the type of outreach needed to increase enrollment in program activities.

Project Period Objective 6

By May 31, 2005, no more than 33% of pregnant women receiving care coordination and case management services will enter care during the third trimester.

Degree of success

10% (31 out of 309) of the pregnant women receiving case management/care coordination services entered care during the third trimester.

Strategies

The major strategy was to conduct outreach to find pregnant women and to promote their early enrollment in prenatal care. The detail of outreach strategies has been discussed under Project Period Objective 1. Outreach and health education staff knowledge of obstetrical providers and California's presumptive eligibility requirements for temporary enrollment in Medi-Cal (Medicaid) were helpful to early enrollment of clients in prenatal care. Presumptive eligibility allows a provider, with minimal information, to determine if a client is potentially Medicaid eligible. If she is "presumptively eligible," then the provider can be reimbursed for visits for a certain time period until official eligibility is determined.

Project Period Objective 7

By May 31, 2005, at least 50% of the women receiving case management/care coordination services will have an ongoing source of primary and preventive services.

Degree of success

83% (386 out of 464) of the women receiving case management services had an ongoing source of primary and preventive services.

Strategies

The major strategy was case management/care coordination and health education. Public health nurses and community health outreach workers supported their clients in obtaining an ongoing source of primary and preventive services. This was easier to do with pregnant women since the majority of IPOP's clients were Medicaid eligible. A portion of IPOP's population had temporary Medi-Cal (Medicaid) which allowed them to have this insurance only while they were pregnant and up to six to eight weeks postpartum. After that point, they were no longer qualified to have Medicaid pay for their health services. Most could not afford to pay for their own insurance and therefore, were reluctant to visit a doctor/clinic unless they really felt ill. Despite the reluctance on the part of these clients, the public health nurses kept discussing the importance of ongoing primary and preventive services.

Project Period Objective 8

By May 31, 2005, at least 90% of children up to two years of age receiving case management/care coordination services will have a medical home.

Degree of success

96% (462 out of 481) of the children enrolled had a medical home.

Strategies

The major strategy included care coordination/case management and health education. IPOP clients were provided with information on the importance of well-baby check-ups. During the first postpartum visit, the public health nurses and community outreach workers checked to

make sure that the infant had a pediatrician. During the monthly visits, the staff checked to make sure that well-baby visits were being made and that the infants were receiving the recommended immunizations. Due to the fact that most of the children qualified for Medi-Cal (Medicaid), the barriers were reduced to having an ongoing source of care.

Project Period Objective 9

By May 31, 2005, at least 50% of women receiving case management/care coordination services requiring prenatal, postnatal, or WIC services will have a completed referral.

Degree of success

92.1% (223 out of 242) of women receiving case management/care coordination services requiring prenatal, postnatal, or WIC services had a completed referral.

Strategies

The major strategy was to identify clients who needed referrals, make referrals, and follow-up to see if referrals were completed. During monthly visits the public health nurses and community health outreach workers checked to see if previous referrals had been utilized. If referrals were not completed, community health outreach workers and public health nurses identified barriers to the completion of a referral and to tried to help reduce those barriers.

Project Period Objective 10

By May 31, 2005, there will be an increase of at least 3% above baseline of the women in the program who are screened for depression.

Degrees of success

During the baseline year, 20.4% of the clients were screened for depression. By May 31, 2005, 53.8% (250 out of 464) of the women were screened for depression; therefore, the number screened exceeded three percent above the baseline.

Strategies

The major strategy was to conduct perinatal depression screening. The public health nurses and community outreach workers utilized the *Edinburgh Postnatal Depression Screen* to identify women at risk for depression. After the staff were trained on the screening tool, they became more comfortable using it. Their comfort level also increased when a contracted mental health counselor became available to them who could do home visits with their clients and was easily available for consultation. Also important to their use of the screen, was training supported by IPOP on perinatal depression. Staff increasingly understood the importance of their role in helping identify women at risk for depression.

Project Period Objective 11

By May 31, 2005, at least 300 preconceptional, prenatal, postpartum, and/or interconceptional women will participate in community education services and /or receive information on health and mental health topics.

Degree of success

1,212 contacts with preconceptional, prenatal, postpartum and/interconceptional were made with women who participated in communication education services and/or received information on health and mental health topics.

Strategies

The major strategy was to implement community education curricula on a variety of topics. Community education activities included classes on pregnancy basics and healthy eating and living for mothers and infants. Topics included: nutrition; depression; parenting skill building/education; reproductive health including sexually transmitted infections; perinatal alcohol, tobacco and other drug use; and smoking cessation services.

Project Period Objective 12

By May 31, 2005, a public education and information campaign will be conducted to reach at least 1,500 preconceptional, prenatal, postpartum and/or interconceptional women.

Degree of success

5,201 contacts with preconceptional, prenatal, postpartum and interconceptional were made with women reached by a public education and information campaign.

Strategies

Several strategies were used in the public education and information campaign. Community baby showers provided the opportunity for brief education sessions on fetal development, stages of pregnancy, kick counts, and perinatal depression. Attendees at the community baby showers not only included pregnant women but their friends, family and boyfriends/spouses.

IPOP's *Building-by-Building* and *End-of- School Day* outreach campaigns also provided an opportunity for short-term education sessions with women contacted at different locations (such as outside schools when women were waiting to pick up their children). A bi-monthly newsletter was published that reached over 340 pregnant and parenting women with health education message and information about available services.

Also, peer health leaders trained under IPOP's *Leadership Development* module and whose peer-to-peer outreach efforts were coordinated under the IPOP community education team, generated 1,667 (32.2%) out of the total contacts.

V. Project Impact

System of Care

Approaches used to enhance collaboration

The implementation of task forces was one methodology used to enhance collaboration. The most successful task force initiated under the auspices of IPOP and in collaboration with the local Title V agency is the Alameda County Perinatal Substance Abuse Task Force. Current members of the Perinatal Task Substance Abuse Task Force team include the following:

- Director the Alameda County Health Care Services Agency
- Child Abuse Coordinator for the Alameda County Social Services Agency
- Alameda County Behavioral Health Care Services Agency's Perinatal Substance Abuse Coordinator
- Deputy Director the Alameda County Children and Families Commission
- Director of the Highland Hospital Options for Recovery Program
- Local Title V Maternal and Child Health (MCH) Director
- MCH Prenatal Substance Abuse Project Coordinator
- Program Manager for the local Blue Cross of California Medi-Cal/Healthy Families Program (Medicaid managed-care program)
- Public Health Ambassador for the Alameda Alliance for Health *(*Medicaid managed care program)
- Certified Nurse Midwife from the East Bay Perinatal Medical Associates (a large high risk obstetrical practice)
- MCH Director for the City of Berkeley
- Alameda County Public Health Department's Health Officer
- Alameda County Public Health Department's Family Health Services Division Director
- Alameda County Public Health Department's Deputy Director
- Improving Pregnancy Outcomes Program Director

Between July and December 2001, the Perinatal Substance Abuse Task Force developed a prenatal and pediatric *Screening, Assessment, Referral and Treatment* (SART) plan with staff support from the local Title V program and the Improving Pregnancy Outcomes Program. The basic goals of this county-wide SART plan were to: screen every pregnant obstetrical care patient for substance; assess each of these women for substance abuse treatment needs; connect or refer these women to appropriate treatment facilities; and follow-up with the women who are referred for services.

Monthly meetings have been held with the Perinatal Substance Abuse Task Force members to monitor progress, identify ways to overcome barriers and determine the next plan of implementation steps. Staffing of the Task Force was done by the local Title V perinatal substance abuse project coordinator. The coordinator's time was partially supported by the local Title V Maternal, Paternal, and Adolescent Health section of the Alameda County Public Health Department and partially by IPOP. In the first years of the project, the IPOP director also served as back-up staff person for the Perinatal Substance Abuse Task Force.

The result of the Task Force effort has been the initiation of the *4 Ps Plus Screening and Assessment Tool* as a perinatal substance use screening and assessment tool utilized at 15 sites (i.e., private practice offices, community clinics, a county hospital, and county clinics). Approximately 2,500 pregnant women have been screened and assessed for substance use.

Because of the high volume of patients at one of the private obstetrical offices for high-risk women, a full-time case manager was out-stationed there by a perinatal substance abuse treatment program with funding provided by the Alameda County Behavioral Health Care Services (BHCS) Agency. The case manager helped assure that patients were screened and assessed, given a brief intervention, linked to treatment as necessary, and provided follow-up at subsequent obstetrical visits.

Structural changes established for system integration

A result of the screening, assessment, referral and treatment (SART) planning process was the identification of the need to establish standards of care for local perinatal substance abuse treatment sites. The Alameda County BHCS Agency actively addressed the treatment aspect of the SART plan. Two consultants were hired under contract to conduct focus groups, to visit treatment sites, and to write standards of care for perinatal substance abuse treatment programs. The BHCS Agency's perinatal substance abuse coordinator and a Perinatal Substance Abuse Task Force member made this important step possible. The drafted standards of care were completed and are under review by the Alameda County BHCS Agency leadership team.

The *4 Ps Plus Screening and Assessment Tool* was also adopted by the Alameda County Children and Families Commission and was used as part of the screening done by nurses during home visitation assessments with families of high-risk infants. IPOP also uses the *4 Ps Plus Screening and Assessment Tool* as part of its substance abuse screening/assessment efforts.

Key relationships with providers and consumers

Key relationships have developed between the public health department, managed care plans, and the Behavioral Health Care Services Agency's Perinatal Substance Abuse unit. Many of the organizations represented on the Perinatal Substance Abuse Task Force also are represented on the Fetal Infant Mortality Review/Community Action Team (FIMR/CAT), which also serves as part of the IPOP consortium.

The findings of the Perinatal Substance Abuse Task Force are periodically reported to the consortium FIMR/CAT. One result of the findings of the implementation of the *4 Ps Plus Screening and Assessment Tool* in the pilot screening site was that many women were using marijuana and did not understand its long-term effects on an infant and child development. The FIMR/CAT determined that it was important to design a brochure to give this information to pregnant women who were smoking marijuana. The perinatal substance abuse coordinator and a FIMR/CAT subcommittee, in consultation with Dr. Ira Chasnoff, wrote the brochure. The Alameda Alliance for Health, a member of the Perinatal Substance Abuse Task Force and a member of the FIMR/CAT, used their staff graphic artist to design the brochure and printed it for distribution to providers and community residents.

One of the issues brought by IPOP to the FIRM/CAT was the issue of maternal depression. As a result of the discussion held at FIMR/CAT, Every Child Counts (Alameda County's First Five Commission), IPOP, and the local Title V Agency's Comprehensive Perinatal Services Program collaborated to support a provider training on maternal depression. In addition, a FIMR/CAT subcommittee was created to develop and distribute a user-friendly

matrix of mental health services to help increase community awareness about available services. A brochure for the public on maternal depression was also produced and distributed.

As part of its consortium, IPOP established a consumer task force in order to better obtain consumer input. The consumer task force met on almost a monthly basis. This enabled the staff to educate consumers about perinatal issues and provided the consumers the opportunity to give IPOP staff input and direction from their perspective.

Consumer task force members contributed tremendously to the development of IPOP community education programming, curricula, materials, and intervention strategies. Many ideas for program development were generated and reviewed by consumer task force members during the 2002 through 2004 program years. In 2004, consumers participated in two focus groups to identify the most pertinent health education and information needs of low-income reproductive-age women. Additionally, consumers assessed specific health information needs concerning weight management/obesity and gave feedback on the effectiveness of the community education newsletter.

Impact on comprehensiveness of services

IPOP staff have not been involved in eligibility and/or intake requirements for health or social services; however, at the Alameda County Health Care Services Agency level (IPOP is located in the Public Health Department of this Agency), a new universal application (called *One-e-App*) is being developed for use in 2005 within the Alameda County Social Services Agency, the Alameda County Health Care Services Agency, hospitals, clinics, and one of the Medicaid managed care plans in Alameda County. An individual will need to complete one application to enroll in Healthy Families (children's health insurance plan); Medi-Cal (Medicaid); the Medically Indigent Services Program; the Child Health and Disability Prevention Program; Family Planning, Access Care and Treatment Program; and the Women's Infants, and Children (WIC) Program. It is anticipated that the *One-e-App*, web-based application will shorten the social service application process from 45 days to 7 to 14 days. This universal application process will be very helpful to IPOP clients who are enrolled in some of the programs and services listed above.

IPOP's major impact has been helping to promote community awareness of services. IPOP's health promotion and community education coordinator has helped promote the printing, updating, and disbursement of the *Alameda County Resource Guide,* a product of the FIMR/CAT. The guide assists residents in finding a comprehensive array of services. The second printing occurred in January 2003; and the fourth printing occurred in November 2003. A total of 99,000 copies of this popular guide were distributed during 2004. A new category, Children's Mental Health Services, was added, resulting in two new user partners: Children's Hospital Oakland, and the Oakland Police Department. The Second Annual Kickoff for the Resource Guide was held in November 2003, to provide an opportunity for agencies listed in the guide to become mutually familiar with their services. In December 2003, the consortium requested that an electronic PDF version of the guide be put on the Alameda County Public Health Department's website to further increase its availability. Consortium member agencies, county departments and others supported the printing of this guide by contributing $0.20 per copy. The electronic version is being widely distributed via email and through the website. The guides fifth updating and printing occurred in the Spring of 2005.

As previously mentioned, the FIMR/CAT also produced a brochure entitled *Marijuana and Pregnancy* based on the findings of the Perinatal Substance Abuse Task Force after it

reviewed the issues of pregnant women being screened with the *4 Ps Plus Screening and Assessment Tool*. The brochure gives phone numbers to call for those seeking assistance in stopping drug use. Also as previously mentioned, as a result of IPOP consumer focus group concerns about maternal depression, FIMR/CAT also produced and distributed a brochure on maternal depression. This brochure also gives phone numbers to call for those seeking assistance for depression.

IPOP also produced a bi-monthly newsletter called *Healthy Living, Healthy Families.* Through its *Building-by-Building campaign* (outreach and short educational messages) over 300 pregnant and parenting women signed up for the newsletter. In addition to community campaign messages, the newsletter showcased important services and provided contact information.

IPOP's long-term case management/care coordination services have lead to improved continuity of care and an increase in follow-up on client referrals. IPOP can serve a mother and infant up to two years after an infant is born. During the project period, monthly home visits were scheduled with pregnant and parenting women. This allowed for an ongoing relationship between the nurse or community health outreach worker who was assigned to work with a client. It allowed for ongoing assessment of client needs and the development of a plan to meet those needs. It allowed for regular check-ins to see if there were barriers to medical or social service appointments. Client records identified referrals that had been made on previous visits. Nurses and community health outreach workers were able to determine if referrals were completed. If they were not, the staff was able to problem solve with the client and make new referrals if necessary or address barriers to accessing services such as transportation issues.

Quality assurance is based on the established protocols for IPOP's case management/care coordination services. These protocols were adapted from those developed by the California Department of Health Services Black Infant Health Program. IPOP's public health nurses and community health outreach workers provided services based upon written policies and procedures. The IPOP nursing supervisor periodically monitored charts and accompanied selected staff on home visits to determine the quality of care being provided. Quality of care issues were addressed individually, or if common patterns were seen, they were addressed during case conferences.

IPOP did not try to develop a system for sharing data across systems since such a system had already been developed for case management programs by the Alameda County First Five Commission.

Consumer participation in service evaluation

IPOP established a consumer task force in order to insure meaningful consumer input. Consumers played a major role in designing community education services, communication media efforts and IPOP service evaluation. Consumer Task Force members contributed tremendously to the development of community education programming, curricula, materials and intervention strategies. Many ideas for program development were generated and reviewed by Consumer Task Force members during the 2002 through 2004 program years. In 2004, consumers participated in two focus groups to identify the most pertinent health education and information needs of low-income reproductive-age women. Additionally, consumers assessed specific health information needs concerning weight management/obesity and gave feedback on the effectiveness of the community education newsletter. Clients were also asked to evaluate the case management/care coordination services that they received.

All IPOP community education staff shared in the facilitation of meetings, ensuring a culturally diverse facilitation style for a diverse group. Staff involved in IPOP community education activities included primarily African American and Latina representation. All meetings were conducted simultaneously in English and Spanish either through a bilingual facilitator or through the availability of a translator. The consumers embraced the bilingual format and demonstrated remarkable patience, willingness to share opinions, and support for fellow consumer members despite language and cultural barriers.

IPOP case management staff was African American and Latina, reflecting the majority of the population served in the case management/care coordination program. When needed, translation services were provided through a subcontracted agency that provided bilingual/bicultural translators.

An area where IPOP was not able to meet linguistic/cultural needs as much as desired was in the area of male services. Due to the limited number of male staff, services could not be offered to non-English speaking fathers. Monolingual, non-English speaking fathers could not be served unless they brought a translator.

Impact to the Community

Community residents were made aware of perinatal depression through an article in the December 2003 issue of the IPOP *Healthy Living, Healthy Families* newsletter. Over three hundred (346) households in the targeted zip codes received information about the signs, symptoms, and treatment of depression. The article was entitled "Getting Help for Depression."

Community participants were also educated on perinatal depression through outreach and community education activities. Education was done using verbal methods and written education materials such as brochures or the IPOP newsletter. Furthermore, as part of the Boot Camp for New Dads curriculum, expectant fathers/clients discussed the signs and symptoms of postpartum depression and were provided guidance on how to assist their partners in obtaining mental health services.

Comprehensive Perinatal Services Program providers (obstetricians) are paid by the State of California to do enhanced screening and assessment for pregnant women. Part of that enhanced screening and assessment is to screen for depression; however, a major gap has been the lack of obstetrical providers' awareness of where to refer women who may have had a positive screen.

In the IPOP focus group report, low-income African American women indicated that they were depressed prior to pregnancy, during pregnancy, and after pregnancy. This spurred the Alameda County Fetal Infant Mortality Review/Community Action Team, which serves as the IPOP Consortium, to develop a matrix of mental health providers to help obstetrical and other providers identify mental health providers who could provide treatment services for their clients.

In order to increase the capacity of primary care providers to recognize and treat depression, IPOP in conjunction with the local Title V Maternal, Paternal, Child, and Adolescent Health section's Comprehensive Perinatal Services Program, and Every Child Counts supported a training session on maternal depression to increase the awareness of perinatal depression as an issue. This provider training was attended by a multidisciplinary group of 174 perinatal providers including staff from obstetrical practices. Training participants received the matrix of low-cost mental health services developed by the FIMR/CAT. These individuals served as an

informed network of providers within their respective organizations and shared the matrix with interested individuals.

Through IPOP's partnered efforts (i.e., mental health matrix and perinatal depression training) the system of care addressing perinatal depression has stretched beyond its immediate program staff, and has increased providers' knowledge about perinatal depression and their knowledge of mental health resources in the community.

Residents' awareness of services was also increased through the distribution of the previously mentioned Alameda County Resource Guide and the depression brochure developed by FIMR/CAT. These two brochures have been distributed extensively in the community.

IPOP's Consortium has an approximate attendance of 35 members on a regular basis. The group members work very well together toward common goals and do not present competing agendas. Relationships are stable, positive and mutually beneficial. A long history of prior collaborations exists among the providers and while divergent opinions are expressed, these opinions do not keep members from continuing to work as a team towards FIRM/CAT objectives. In regard to the consumer consortium, the core members know each other, work well together, and are enthusiastic about coming to meetings with babies and toddlers in tow.

It was not the intent of IPOP to create jobs in the community; however, IPOP did play a role in supporting job readiness and opportunities to residents of the target area. For example, two residents of the target area, who were previously Black Infant Health clients, were hired as Health Services Trainees and trained to do outreach and give health education messages. Additionally, IPOP hosted a CalWORKS (TANF) intern required to engage in employment or vocational training as part of her case plan. This intern was concurrently enrolled in a health information technology certificate program at a local junior college, and assisted IPOP community education staff with data entry activities during the six months she interned. Also, after their involvement in IPOP's *Leadership Development* activities, two of the peer health leaders enrolled in an allied health vocational program, and another peer health leader received college credits toward her Associate's Degree for her program participation.

Impact on the State

The greatest impact at the state level by Healthy Start is the ongoing interest in the area of perinatal substance abuse. Funding by the federal Healthy Start office promoted an updated needs assessment related to perinatal substance abuse issues. This assessment was sponsored by the California Healthy Start projects, the State of California and the statewide local MCH directors association. Periodically the local MCH directors at their statewide meetings, which state staff attend, have had Dr. Ira Chasnoff, a consultant to the Healthy Start projects in California, come and speak to them on perinatal substance abuse issues and starting the SART process in other California counties.

Local Government Role

As previously mentioned, the IPOP director reports to the director of the local Title V agency, the Maternal, Paternal, Child, and Adolescent Health (MPCAH) section of the Alameda County Public Health Department; therefore, IPOP is very integrated with local Title V efforts. Since the local Title V Agency already had a FIMR/CAT, the local Title V director readily agreed to it forming the basis for the IPOP Consortium. This had lead to an easy transfer of

IPOP ideas, issues, and concerns to the larger community and has brought multiple resources related to perinatal substance abuse and maternal depression into fruition.

One of the barriers faced by IPOP has been the inability of some of the services to be sustained without federal Healthy Start dollars. Due to several years of deficits in the overall California budget, local funding to support additional programs has been difficult to receive since the focus has been on retaining local funding for basic programs.

VI. Fetal and Infant Mortality Review (FIMR)

Fetal Infant Mortality Review (FIMR)

The federal Healthy Start program in the mid-1990s provided FIMR funding to Oakland Healthy Start. In 1999, Oakland Healthy Start's FIMR activities were integrated into the Maternal and Child Health (MCH) section of the Alameda County Public Health Department when it received California Department of Health Services funding to implement FIMR activities. The FIMR Case Review Committee makes recommendations about changes needed to reduce fetal and infant deaths. Their findings are important to IPOP deliberations about its program activities.

FIMR Community Action Team (FIMR/CAT)

This broad-based, multi-disciplinary collaborative is comprised of representatives of many different groups, organizations, agencies, and institutions in Alameda County. The responsibility of the Community Action Team is to review the findings and recommendations of the FIMR Case Review Committee and to promote the implementation of policies, practices, and interventions to reduce infant mortality. The FIMR Community Action Team provides oversight and strategic planning for the Alameda County effort to reduce infant mortality. IPOP staff participates on the FIMR Community Action Team and bring findings and issues for discussion to the Team. To further integrate Healthy Start and Title V activities, the FIMR Community Action Team serves as part of the IPOP Consortium along with the IPOP Consumer Task Force. FIMR/CAT decisions affect IPOP policies, practices and interventions.

[Please see the full list of the FIMR/CAT activities under the Consortium section of the report.]

Appendix

VII. Products

List of Contents in Order of Appearance

IPOP Brochure

IPOP Bus Bench Advertisement

IPOP Community Education Curricula Outlines for Pregnancy Basics and Healthy Eating and Living for Mom & Baby

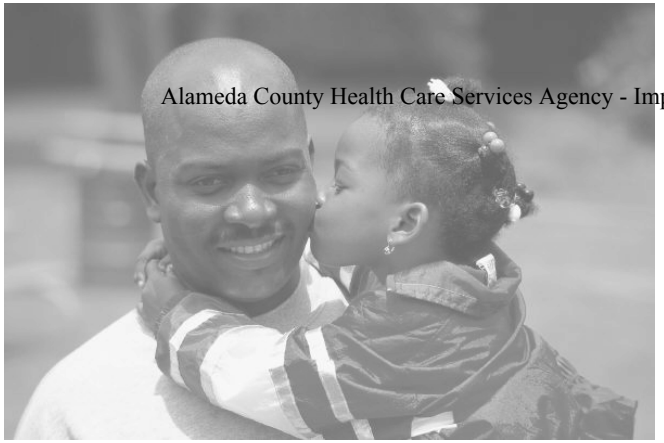
IPOP Fatherhood Brochure

IPOP Health Promotion and Community Education Program Schedule

IPOP Health Promotion and Community Education Program Summary 2005

IPOP Healthy Living, Healthy Families Newsletter (Sample)

IPOP Program Summary 2005



Fatherhood Services

IPOP provides a variety of services for fathers and fathers-to-be including:

- *Helping Hands*—a short-term referral, follow-up, counseling and advocacy service
- *Father-to-Father*—Peer support, life skills, "man talk" and anger management classes for fathers of children 1 to 2 years old
- *Boot Camp for New Dads*—a crash course on fatherhood, parenting and partnering skills. Expectant dads learn about birth, infant care, and co-parenting.

Health Promotion & Community Education Services

IPOP provides information, education and training services to residents, consumer task force members, clients and providers on a variety of topics including:

- Pregnancy Basics
- Healthy Eating and Living for Mom & Baby
- Stress, mental health and depression
- Alcohol, tobacco and drug use
- Parent education
- Leadership development

For more information or referral

Case Management & Care Coordination.....(510) 618-1967
Fax referral forms to.....(510) 618-1989

Fatherhood Services.....(510) 618-2080
Fax referral forms to.....(510) 618-2006

Health Promotion & Community Education Services.....(510) 618-2080

Office hours are
Monday—Friday
8:30 AM—5:00 PM

Improving Pregnancy Outcomes Program
1000 San Leandro Blvd., Suite 100
San Leandro, California 94577
(510) 618-2080 Phone
(510) 618-2006 Fax

IPOP

ALAMEDA COUNTY PUBLIC HEALTH DEPARTMENT

This program is supported in part by Grant No. H49MC00130-05-01, The Healthy Start Initiative, Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services

Revised July 2005

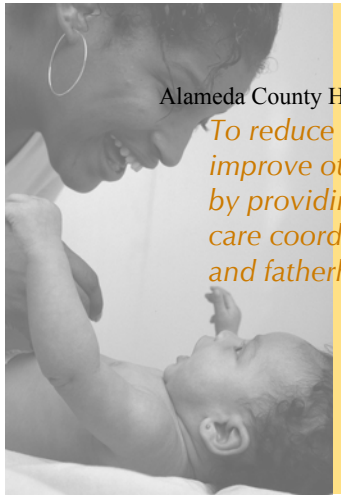
IPOP

Improving Pregnancy Outcomes Program

Dedicated to reducing infant mortality in our community

Serving zip codes
94578, 94579, 94601, 94603, 94605, 94607, 94608, 94609, 94612, and 94621

A Program of Maternal, Paternal, Child and Adolescent Health
Family Health Services Division



IPOP Goal

To reduce infant mortality and improve other pregnancy outcomes by providing case management, care coordination, health education and fatherhood services

Care Coordination Services

Provided by Community Health Outreach Workers to women who:

- Lack sources of ongoing care for their children or themselves
- Lack appropriate support systems
- Need help obtaining services such as utilities, welfare, WIC, child care, shelter, food, and job training
- Need help connecting to resources

Case Management Services

Provided by Public Health Nurses to women who have problems such as:

- A history of preterm labor and birth
- A low birth weight baby
- A history of substance use
- High blood pressure
- Poor weight gain, underweight or overweight
- A sexually transmitted infection
- Diabetes, Lupus or Sickle Cell Anemia
- A baby with birth defects in this or a past pregnancy
- A history of bleeding or hemorrhage during pregnancy
- Had more than one miscarriage or abortion

...and women who are:

- Currently pregnant with twins or triplets
- Experiencing physical or emotional abuse
- Under 17 or over 35 years old

Who is eligible for case management and care coordination services?

Clients must meet ALL four of the following eligibility requirements:

1. Must be African American
2. Must live in one of the IPOP zip code areas below:

94578	San Leandro
94579	San Leandro
94601	Oakland—Fruitvale District
94603	East Oakland
94605	East Oakland
94607	West Oakland
94608	Emeryville
94609	North Oakland
94612	Downtown Oakland
94621	East Oakland

3. Must be no more than 28 weeks pregnant or no more than 6 weeks postpartum.
4. Must have an income at or below 200% of the federal poverty level. The unborn baby is counted as a member of the family.

"When I found out I was pregnant, I worried about so many things. This program helped me get services I didn't even know were available for me and my baby."

—Alisha, 21 year-old mother

Family Size	Maximum Monthly Income	Maximum Annual Income
2	$2,138	$25,660
3	$2,682	$32,180
4	$3,225	$38,700
5	$3,768	$45,220
6	$4,312	$51,740
7	$4,855	$58,260
8	$5,398	$64,780
9	$5,942	$71,300
10	$6,485	$77,820

This income guideline is based on the 2005 US Federal Poverty Measures

IPOP Bus Bench Advertisement

PREGNANCY BASICS
CURRICULUM OUTLINE

*Each workshop is 2½hours in length and delivered in four consecutive weekly sessions.

Pregnancy Basics Workshop 1	1) Physical and psychosocial aspects of the discovery of pregnancy 2) Normal stages of pregnancy 3) Importance of early & continuous prenatal care 4) Resource highlight
Pregnancy Basics Workshop 2	1) Effects of smoking, drinking alcohol and using drugs during pregnancy 2) Eating healthily for two 3) Preterm labor, gestational diabetes and toxemia 4) Resource highlight
Pregnancy Basics Workshop 3	1) Physical and psychosocial aspects of childbirth 2) Stages of labor 3) Preparing to breastfeed 4) Resource highlight
Pregnancy Basics Workshop 4	1) Postpartum care for mom 2) How to care for newborn 3) Birth control methods 4) Resource highlight

HEALTHY EATING AND LIVING FOR MOM & BABY
CURRICULUM OUTLINE

*Each workshop is 2½hours in length and delivered in four consecutive weekly sessions.

Healthy Eating and Living for Mom & Baby Workshop 1	1) Positive Thinking and Goal Setting 2) How to Start an Exercise Program 3) How to Use and Understand what is a Pedometer 4) Importance of Water
Healthy Eating and Living for Mom & Baby Workshop 2	1) Food Guide Pyramid 2) Nutrition Basics 3) Meal Planning 4) Importance of Exercise
Healthy Eating and Living for Mom & Baby Workshop 3	1) Label Reading 2) Determining weight loss goals 3) Making wise food choices 4) How to cut the fat in foods/recipes
Healthy Eating and Living for Mom & Baby Workshop 4	1) Healthy eating and portion control 2) Cooking food with jazz 3) Eating Disorders 4) Body Image and BMI

IPOP isn't just for pregnant women...

INFORMATION ABOUT IPOP's FREE SERVICES

(serving zip codes 94579, 94603, 94607, 94608, 94609 and 94621)

For free classes on Pregnancy Basics, Healthy Eating and Living for Mom & Baby, and Parent Education including positive discipline and child safety call.....(510) 618-2080

For Fatherhood Services, and assistance for men call.....(510) 618-2080

If you are pregnant and need help with accessing medical and social services call.....(510) 618-1967

IPOP

Alameda County Public Health Department
Maternal, Paternal, Child & Adolescent Health
Improving Pregnancy Outcomes Program
1000 San Leandro Blvd., Suite 100
San Leandro, CA 94577
(510) 618-2080 Phone
(510) 618-2006 Fax
http://www.acphd.org/

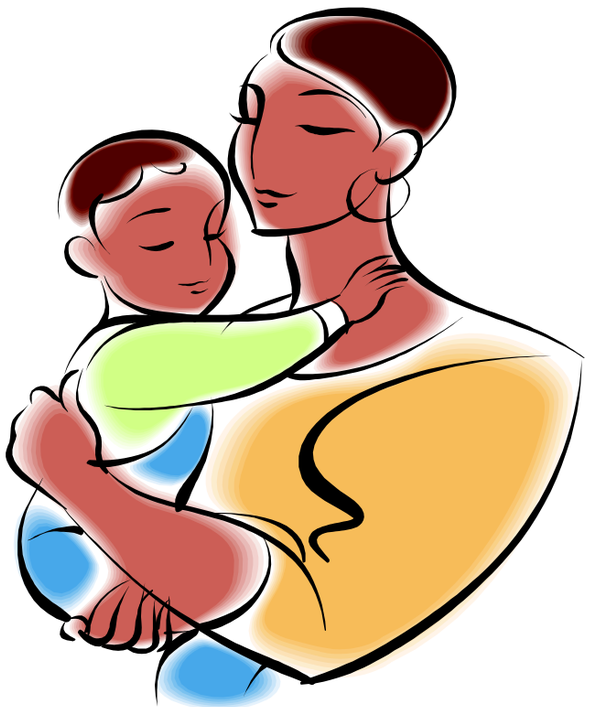
ALAMEDA COUNTY PUBLIC HEALTH DEPARTMENT

IPOP Health Promotion & Community Education
Alameda County Public Health Department
1000 San Leandro Blvd., Suite 100
San Leandro, CA 94577

Improving Pregnancy Outcomes Program

Health Promotion & Community Education Services

MARCH/APRIL 2005



class schedule

Pregnancy Basics

This class prepares pregnant women for a healthy pregnancy and baby. In addition to pregnancy, you will learn about available resources for you and your baby.

Pregnancy Basics is taught in four 2½ hour classes.

Pregnancy Basics CLASS SCHEDULE

Class 1
Monday, March 7 10:30 AM—1:00 PM

Class 2
Monday, March 14 10:30 AM—1:00 PM

Class 3
Monday, March 21 10:30 AM—1:00 PM

Class 4
Monday, March 28 10:30 AM—1:00 PM

Location: All *Pregnancy Basics* classes will be at 1000 San Leandro Blvd. in San Leandro, on the corner of Davis St., across from the San Leandro BART Station

You will learn:

- How to get what you need out of your prenatal care visits
- How to take care of yourself during and after pregnancy
- What to expect during childbirth
- How to care for your newborn, and much more!

HOW TO SIGNUP FOR CLASSES

Please call 510-618-2080 to signup for either or both classes. Our free classes make learning fun, and offer free lunch, child care and prizes. A $25 Safeway gift card is raffled at every class! Participants who complete all classes in either series have a chance to win a stroller and/or baby car seat or a $75 gift card to Lady Foot Locker.

Healthy Eating and Living for Mom & Baby

Healthy Eating and Living for Mom & Baby CLASS SCHEDULE

Class 1
Monday, April 4 10:30 AM—1:00 PM

Class 2
Monday, April 11 10:30 AM—1:00 PM

Class 3
Monday, April 18 10:30 AM—1:00 PM

Class 4
Monday, April 25 10:30 AM—1:00 PM

Location: All *Healthy Eating and Living for Mom & Baby* classes will be at 1000 San Leandro Blvd. in San Leandro, on the corner of Davis St., across from the San Leandro BART Station

This class will focus on how to choose and prepare healthy foods. Also, you will learn simple techniques for staying fit and keeping your entire family in good health for a lifetime.

Healthy Eating and Living for Mom & Baby is taught in four 2½ hour classes.

IPOP

Improving Pregnancy Outcomes Program

Health Promotion & Community Education Services

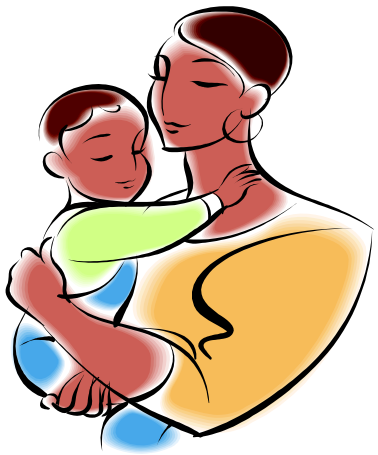
IPOP Goal

To reduce infant mortality and improve other pregnancy outcomes by providing case management, care coordination, health education and fatherhood services.

Health Promotion & Community Education Mission Statement

To assure that healthy babies are born to healthy families by providing community health education programs and services.

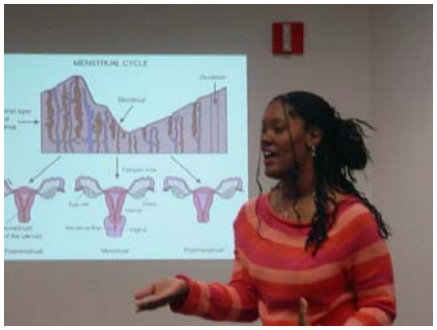
IPOP Health Promotion & Community Education provides information, education and training services for residents, consumer task force members, clients and providers on a variety of perinatal topics.



Group Health Education

IPOP Health Promotion & Community Education staff provides group health education workshops to low-income reproductive-age adults. Workshop topics are based on IPOP's six community education modules.

In addition to providing important health education, the workshops serve as a venue for women and their male partners to learn about available health and social services as well as case management programs. The format for the workshops blends health education, fun and celebration. Free lunch is served and child play groups are conducted during the events.



Program Summary 2005

Community Education Modules

- Pregnancy Basics
- Healthy Eating and Living for Mom & Baby
- Parent Education
- Stress & Depression
- Tobacco, Alcohol & Drug Use
- Leadership Development

Intervention Strategies

- Group Health Education
- Community Outreach
- Information & Referral
- Community Awareness Campaign
- Peer Health Leadership
- Professional Training

Six Common Issues Faced by IPOP Families

- Tobacco, Alcohol & Substance Use
- Stress & Depression
- Poverty
- Lack of Employment & Job Training
- Chronic Health & Nutritional Problems
- Affordable Housing

-Continued on reverse side-

Community Outreach & Information and Referral

Alameda County Resource Guide
for Men, Women, Children and Teens

Guía de Recursos para el Condado de Alameda
para Hombres, Mujeres, Niños y Adolescentes

All area codes are 510 unless indicated

Community outreach activities are conducted at health fairs, community events, public spaces, service agencies, and retail centers. Targeted community residents learn about various health topics and available community resources.

Community Awareness Campaign

Campaign Health Topics

- Eating healthy for less
- Family planning resources
- Effects of stress & depression on pregnancy
- Smoke-free homes & tobacco cessation
- SIDS prevention/ Back-to-Sleep
- Effects of substance use during pregnancy

Campaign activities include a building-by-building campaign, circulation of a free bimonthly *Healthy Living Healthy Families* newsletter, community presentations, dissemination of printed health materials, and free community raffles. These efforts promote community awareness regarding maternal and child health issues, as well as increase program visibility.

Peer Health Leadership & Professional Training

Community residents, teens, consumers, and providers are trained in various health topics including perinatal health, reproductive health, nutrition, and child health and safety. Additionally, participants are trained in helping skills and leadership to increase the community's capacity to help others. Training participants expand the reach of our services to those most in need, and have received awards and recognition for their dedication and leadership.

Alameda County Health Care Services Agency - Improving Pregnancy Outcomes Program
Alameda County Public Health Department, Maternal, Paternal, Child & Adolescent Health

IPOP

Healthy Living, Healthy Families

November/December 2004, Volume 1, Issue No. 5

A free community newsletter published by the Improving Pregnancy Outcomes Program Community Education & Information Services

What If I'm Pregnant? *Women may ask this question at many times in their lives*

Most women want to become mothers when they are ready. Adult and teenage women often face difficult decisions when pregnancy is unplanned. "What if I'm pregnant?" Women may ask this question at many times in their lives especially when their periods are late. If you think you're pregnant, you may be asking yourself lots of other questions too.

- Is having a baby the best choice for me?
- Is raising a child by myself the best choice for me?
- Is raising a child with a partner the best choice for me?
- Is placing the baby for adoption the best choice for me?
- Is having an abortion the best choice for me?

You want to choose what's right for you. But first, be sure you are pregnant. You can have a pregnancy test done at a clinic or at home. Women who take home pregnancy tests often go to clinics to have the results confirmed by a health care provider. If your test is "positive," you will need a pelvic exam. The health care provider will feel the size of your uterus to estimate how long you have been pregnant. Then you will need to decide what you want to do.

What are my choices? You have three choices if you are pregnant.

- You can choose to have a baby and raise the child.
- You can choose to have a baby and place the child for adoption.
- You can choose to end the pregnancy.

There is no right or wrong choice for everyone. Only you can decide which choice is right for you. But deciding may not feel easy to do - there is a lot to think about. How can I decide which choice is best for me? Consider each of your choices carefully. Ask yourself:

- Which choice could I live with?
- Which choice would be impossible for me?
- How would each choice affect my everyday life?
- What would each choice mean to the people closest to me?

REMEMBER: It is your decision!

It may also help to ask yourself

- What is going on in my life?
- What are my plans for the future?
- What are my spiritual and moral beliefs?
- What do I believe is best for me in the long run?
- What can I afford?
- Where do I need to go for services?
- Am I willing to stop drinking, smoking or doing drugs?

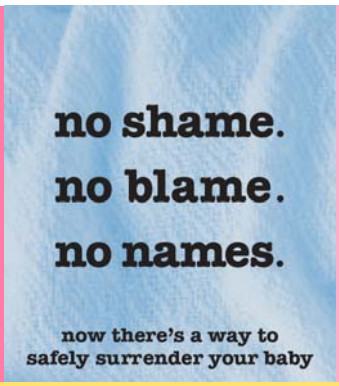
You have three choices if you are pregnant... There is no right or wrong choice...Only you can decide which choice is right for you.

Talk about your feelings with your partner, someone in your family, or a trusted friend -someone you think will be supportive. Family planning clinics have specially trained counselors who can talk with you about your options. Your counselor will try to make sure that you are not being pressured into any decision against your will. You may bring your partner, your parents, or someone else if you wish. You get to decide who will be a part of your decision-making process.

Look for a clinic that will give you complete information about your options. For pregnancy counseling, abortion and family planning services call Planned Parenthood toll-free at 1-800-967-7526. For prenatal appointments or abortion services call Highland Hospital Women's Urgent Care Clinic at 510-437-4778.*

**All sections are adapted from Planned Parenthood "What If I'm Pregnant?", October 2003.*

Did You Know?



Safely Surrendered Baby Law: A Confidential Safe Haven For Newborns

In California, the Safely Surrendered Baby Law allows an individual to give up an unwanted infant without fear of arrest or prosecution for abandonment. The law does not require that names be given when the baby is surrendered. Parents are permitted to bring a baby within 3 days of birth to any hospital emergency room or other designated safe haven in California. The baby will be placed in a foster or pre-adoptive home.

Pregnant: How Soon Do I Have to Decide?

If there is a chance that you will continue the pregnancy - you should begin prenatal care as soon as possible. You should have a medical exam early in your pregnancy to make sure that you are healthy and the pregnancy is normal.

If you are considering abortion, you should make your decision as soon as possible. Abortion is very safe, but the risks increase the longer a pregnancy goes on. While you are deciding what to do, take good care of yourself. If you decide to have a child, it's important to be healthy. Eat enough good food such as fruits, vegetables, cereals, breads, beans, rice, and dairy products, as well as fish, meat, and poultry. Here are some tips to keep your body in good shape:

- Stay active and get regular exercise.
- Get plenty of sleep.
- Do not smoke.
- Do not drink alcohol.
- Limit drinks with caffeine, like coffee and cola.
- Do not eat junk food.
- Do not take any drugs or medications without checking with your health care provider.

You can get complete information about prenatal care and how to pay for it from your health care provider, family planning clinics, women's health centers, and local department of health and social services. Good prenatal care is very important for a baby's health.

For information about available health services, call the Alameda County Public Health Clearinghouse at 1-888-604-4636. If you decide to continue your pregnancy and want support getting services available for you and your baby, call the Improving Pregnancy Outcomes Program at 510-618-1967.*

What About Raising a Child?

One of your choices is to continue your pregnancy and raise a child. Being a parent is exciting, rewarding, and demanding. It can help you grow, understand yourself better, and enhance your life. There are two ways to raise a child.

Parenting With a Partner

Most of us look forward to finding a life partner - someone to share the pleasures, responsibilities, and difficulties of family life. With or without marriage, a life partnership can succeed if both people are deeply committed to make it work and understand what each expects from the relationship.

Parenting Without a Partner

The challenge of raising a child alone can also be exciting and rewarding. It is easier if you find and use all the support you can. Be sure to let family and friends know that you hope for their support before you decide to become a single parent.

Even with the help of your family and friends, being a single parent is not easy. It is often complicated and frustrating. Your child's needs will constantly change and so will your ability to meet those needs. You may want to consider counseling to help you through these changes. You can find out about counseling from your local department of children's services.

Your child will look to you for love and care - all day, every day. And you can take great pleasure helping your child grow into a happy, independent, and responsible adult. But there will be no breaks. It takes years for children to become responsible for themselves. And convenient, affordable childcare is difficult to find.

It takes a lot of money to raise a child. Earning a living for you and your child will be a real challenge - even if you have finished school and can get a good job. Your own parent(s) may find it hard to help you out with all the bills. Welfare payments barely cover the basics.

Because your child will need you so much, you may become more dependent on your own family and friends - for help with the child, for emotional support, and for money. You may have to give up a lot of freedom to be a good single parent. On the other hand, because you will not have to make compromises with a partner, you can raise the child as you wish - with your values, principles, and beliefs.

Parenting requires lots of love and unlimited energy and patience. There will be times when you may feel that you are not doing a good job at it. To feel good about being a single parent, it must be what you want to do - for a long time. You already know what that means if you have other children. If you don't, talk with a single mother or with a counselor who works with single mothers.*

What About Abortion?

One of your choices is abortion. Abortion is a legal and safe procedure. More than 90 percent of abortions occur during the first 12 weeks of pregnancy. Early abortion procedures are safe. Serious complications are rare. But the risk of complications increases the longer a pregnancy continues. Abortions performed later in pregnancy may be more complicated but are still safer than labor and delivery. Uncomplicated abortion should not affect future pregnancies. Many teenagers want to consult their parents before an abortion. But telling a parent is not required in California if you are 12 years of age or older. Counseling is available before and after abortion. To make an appointment with the Planned Parenthood center nearest you for counseling about abortion and other pregnancy options, call toll-free 1-800-967-7526. For more information about counseling after an abortion call Exhale After-Abortion Counseling Talkline, call toll-free 1-866-439-4253.*

What About Placing the Baby for Adoption?

One of your choices is to complete your pregnancy and let someone else raise your child. For more information, contact Alameda County Social Services Adoption Information at 510-268-2444.*

This publication is supported in part by Project number 5H49MC 00130-02, The Healthy Start Initiative, Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services

IPOP

Improving Pregnancy Outcomes Program

A Healthy Start Initiative

Dedicated to reducing infant mortality in our community!

IPOP Goal

To reduce infant mortality and improve other pregnancy outcomes by providing case management, care coordination, health education and fatherhood services.

Case Management & Care Coordination

Above: Advertisement promoting IPOP case management and care coordination services for targeted zip codes.

IPOP case management and care coordination services are provided under the auspices of the Local Title V Agency, Alameda County Public Health Department, Maternal, Paternal, Child & Adolescent Health. Public health nurses and community health outreach workers do home-based visiting to make services accessible to all the families they serve.

Right: Public health nurses and community health outreach workers from left to right, Sandra Tramiel, Delores Richard, Janice Whitley, Elka Jones, Lola Afolayan and Danyale Parrish.

Fatherhood Services

The IPOP Fatherhood coordinator offers a variety of individual and group services to fathers-to-be and parenting fathers. They include counseling, support, referrals, follow-up, advocacy, discussion groups and classes. *Boot Camp For New Dads* brings together dads-to-be and veteran dads through a group session to discuss the joys and responsibilities of fatherhood.

IPOP Fatherhood Coordinator, Reggie Bridges.

Veteran dads show dads-to-be techniques for infant care.

Positive Impact On Young Fathers prepares, supports and encourages teen fathers and fathers-to-be to be responsible, involved, and loving participants in their child's life. It currently serves the incarcerated population at Camp Sweeny, an Alameda County Juvenile Hall, of which 25% of the young men are already fathers. Services most requested by fathers are employment referrals to companies that are ex-felon friendly, and encouragement to cope with stress and depression resulting from the numerous obstacles faced by low-income fathers.

Program Summary 2005

Six Common Issues Faced by IPOP Families

- Tobacco, Alcohol & Substance Use
- Stress & Depression
- Poverty
- Lack of Employment & Job Training
- Chronic Health & Nutritional Problems
- Affordable Housing

Intervention Strategies

- Case Management & Care Coordination
- Group Health Education
- Community Outreach
- Information & Referral
- Community Awareness Campaign
- Peer Health Leadership
- Provider Training
- Health Systems Change

Community Education Modules

- Pregnancy Basics
- Healthy Eating and Living for Mom & Baby
- Parent Education
- Stress & Depression
- Tobacco, Alcohol & Drug Use
- Leadership Development
- Boot Camp for New Dads
- Positive Impact On Young Fathers

-Continued on reverse side-

Health Promotion & Community Education

Group Education

IPOP Health Promotion & Community Education staff provides group health education workshops to low-income reproductive-age adults. Workshop topics are based on IPOP's six community education modules. In addition to providing important health education, the workshops serve as a venue for women and their male partners to learn about available health and social services as well as case management programs. The format for the workshops blends health education, fun and celebration. Free lunch and child care are provided at the events.

Campaign Health Topics

- Eating healthy for less
- Family planning resources
- Effects of stress & depression on pregnancy
- Smoke-free homes & tobacco cessation
- Back-to-Sleep/SIDS Prevention
- Effects of substance use during pregnancy

Community Awareness Campaign

Campaign activities include a building-by-building campaign, circulation of a free bimonthly *Healthy Living Healthy Families* newsletter, community presentations, dissemination of printed health materials, and free community raffles. These efforts promote community awareness regarding maternal and child health issues, as well as increase program visibility.

Community Outreach & Information and Referral

Community outreach activities are conducted at health fairs, community events, public spaces, service agencies, and retail centers. Targeted community residents learn about various health topics and available community resources.

Peer Health Leadership & Provider Training

Community residents, teens, consumers, and providers are trained in various health topics including perinatal health, reproductive health, nutrition, and child health and safety. Additionally, participants are trained in helping skills and leadership to increase the community's capacity to help others. Training participants expand the reach of our services to those most in need, and have received awards and recognition for their dedication and leadership.

For More Information About IPOP

Case Management & Care Coordination Services	(510) 618-1967
Health Promotion & Community Education Services	(510) 618-2080
Fatherhood Services	(510) 618-2080

Improving Pregnancy Outcomes Program, Alameda County Public Health Department
1000 San Leandro Boulevard, Suite 100, San Leandro, California 94577

A Healthy Start Initiative

ALAMEDA COUNTY PUBLIC HEALTH DEPARTMENT

This publication is supported in part by Project number 5H49MC 00130-02, The Healthy Start Initiative, Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services (Printed March 2005)

VIII. Project Data

Please note regarding submission of forms and tables:
Certain forms and tables were not required until calendar year 2003 or calendar year 2004 although they are being requested for all four years of the project period. It is difficult to comply with this request since the information desired may not have been gathered at all or not gathered in the manner required as of calendar years 2003 or 2004.

In this Impact Report, we are submitting the forms and tables in the same format as previously submitted for calendar years 2001-2004.

List of Forms in Order of Appearance

MCH Budget Details (Form 1)

Variables Describing Healthy Start Participants (Form 5)

Common Performance Measures and Interventions Specific Performance Measures (Form 9)

Characteristic of Program Participants (Table A)

Risk Reduction/Prevention Services (Table B)

Major Service Table (Table C)

Project Period Objectives Table 2001-2005

2001-2002

1. MCHB GRANT AWARD AMOUNT			$1,998,013.00
2. UNOBLIGATED BALANCE			$1,693,684.93
3. MATCHING FUNDS (Required: Yes [ ] No [x] If yes, amount)			$0.00
A.	Local funds	$	
B.	State funds	$	
C.	Program Income	$	
D.	Applicant/Grantee Funds	$	
E.	Other funds	$	
4. OTHER PROJECT FUNDS (Not included in 3 above)			$20,796.10
A.	Local funds	$	
B.	State funds	$	
C.	Program Income(Clinical or Other)	$	
D.	Applicant/Grantee Funds(includes in-kind)	$20,796.10	
E.	Other funds (including private sector, e.g. Foundations)	$	
5. TOTAL PROJECT FUNDS (Total lines 1 through 4)			$2,018,809.10
6. FEDERAL COLLABORATIVE FUNDS			
	(Source(s) of additional Federal funds contributing to the project)		
A.	Other MCHB Funds (Do not repeat grant funds from Line 1)		
	1) SPRANS	$	
	2) CISS	$	
	3) SSDI	$	
	4) Abstinence Education	$	
	5) Healthy Start	$	
	6) EMSC	$	
	7) Traumatic Brain Injury	$	
	8) State Title V Block Grant	$	
	9) Other	$	
B.	Other HRSA Funds		
	1) HIV/AIDS	$	
	2) Primary Care	$	
	3) Health Professions	$	
	4) Other	$	
C.	Other Federal Funds		
	1) CMS	$	
	2) SSI	$	
	3) Agriculture (WIC/other)	$	
	4) ACF	$	
	5) CDC	$	
	6) SAMHSA	$	
	7) NIH	$	
	8) Education	$	
	9) Other:	$	
7. TOTAL COLLABORATIVE FEDERAL FUNDS			$0.00

FY 2002-2003

1. MCHB GRANT AWARD AMOUNT			$2,000,000.00
2. UNOBLIGATED BALANCE			$873,939.50
3. MATCHING FUNDS (Required: Yes [ ] No [x] If yes, amount)			$0.00
A.	Local funds	$	
B.	State funds	$	
C.	Program Income	$	
D.	Applicant/Grantee Funds	$	
E.	Other funds	$	
4. OTHER PROJECT FUNDS (Not included in 3 above)			$68,317.96
A.	Local funds	$	
B.	State funds	$	
C.	Program Income(Clinical or Other)	$	
D.	Applicant/Grantee Funds(includes in-kind)	$68,317.96	
E.	Other funds (including private sector, e.g. Foundations)	$	
5. TOTAL PROJECT FUNDS (Total lines 1 through 4)			$2,068,317.96
6. FEDERAL COLLABORATIVE FUNDS			
(Source(s) of additional Federal funds contributing to the project)			
A.	Other MCHB Funds (Do not repeat grant funds from Line 1)		
1)	SPRANS	$	
2)	CISS	$	
3)	SSDI	$	
4)	Abstinence Education	$	
5)	Healthy Start	$	
6)	EMSC	$	
7)	Traumatic Brain Injury	$	
8)	State Title V Block Grant	$	
9)	Other	$	
B.	Other HRSA Funds		
1)	HIV/AIDS	$	
2)	Primary Care	$	
3)	Health Professions	$	
4)	Other	$	
C.	Other Federal Funds		
1)	CMS	$	
2)	SSI	$	
3)	Agriculture (WIC/other)	$	
4)	ACF	$	
5)	CDC	$	
6)	SAMHSA	$	
7)	NIH	$	
8)	Education	$	
9)	Other:	$	
7. TOTAL COLLABORATIVE FEDERAL FUNDS			$0.00

FY 2003-2004

1. MCHB GRANT AWARD AMOUNT			$2,000,000.00
2. UNOBLIGATED BALANCE			$200,527.67
3. MATCHING FUNDS (Required: Yes [ ] No [x] If yes, amount)			$0.00
A.	Local funds	$	
B.	State funds	$	
C.	Program Income	$	
D.	Applicant/Grantee Funds	$	
E.	Other funds	$	
4. OTHER PROJECT FUNDS (Not included in 3 above)			$18,084.02
A.	Local funds	$	
B.	State funds	$	
C.	Program Income(Clinical or Other)	$	
D.	Applicant/Grantee Funds(includes in-kind)	$18,084.02	
E.	Other funds (including private sector, e.g. Foundations)	$	
5. TOTAL PROJECT FUNDS (Total lines 1 through 4)			$2,018,084.02
6. FEDERAL COLLABORATIVE FUNDS			
(Source(s) of additional Federal funds contributing to the project)			
A.	Other MCHB Funds (Do not repeat grant funds from Line 1)		
1)	SPRANS	$	
2)	CISS	$	
3)	SSDI	$	
4)	Abstinence Education	$	
5)	Healthy Start	$	
6)	EMSC	$	
7)	Traumatic Brain Injury	$	
8)	State Title V Block Grant	$	
9)	Other	$	
B.	Other HRSA Funds		
1)	HIV/AIDS	$	
2)	Primary Care	$	
3)	Health Professions	$	
4)	Other	$	
C.	Other Federal Funds		
1)	CMS	$	
2)	SSI	$	
3)	Agriculture (WIC/other)	$	
4)	ACF	$	
5)	CDC	$	
6)	SAMHSA	$	
7)	NIH	$	
8)	Education	$	
9)	Other:	$	
7. TOTAL COLLABORATIVE FEDERAL FUNDS			$0.00

FY 2004-2005

1. MCHB GRANT AWARD AMOUNT			$2,000,000.00
2. UNOBLIGATED BALANCE			$246,064.69
3. MATCHING FUNDS (Required: Yes [ ] No [x] If yes, amount)			$0.00
A.	Local funds	$	
B.	State funds	$	
C.	Program Income	$	
D.	Applicant/Grantee Funds	$	
E.	Other funds	$	
4. OTHER PROJECT FUNDS (Not included in 3 above)			$235,022.66
A.	Local funds	$	
B.	State funds	$	
C.	Program Income(Clinical or Other)	$	
D.	Applicant/Grantee Funds(includes in-kind)	$235,022.66	
E.	Other funds (including private sector, e.g. Foundations)	$	
5. TOTAL PROJECT FUNDS (Total lines 1 through 4)			$2,235,022.66

6. FEDERAL COLLABORATIVE FUNDS

(Source(s) of additional Federal funds contributing to the project)

A.	Other MCHB Funds (Do not repeat grant funds from Line 1)		
1)	SPRANS	$	
2)	CISS	$	
3)	SSDI	$	
4)	Abstinence Education	$	
5)	Healthy Start	$	
6)	EMSC	$	
7)	Traumatic Brain Injury	$	
8)	State Title V Block Grant	$	
9)	Other	$	
B.	Other HRSA Funds		
1)	HIV/AIDS	$	
2)	Primary Care	$	
3)	Health Professions	$	
4)	Other	$	
C.	Other Federal Funds		
1)	CMS	$	
2)	SSI	$	
3)	Agriculture (WIC/other)	$	
4)	ACF	$	
5)	CDC	$	
6)	SAMHSA	$	
7)	NIH	$	
8)	Education	$	
9)	Other:	$	

7. TOTAL COLLABORATIVE FEDERAL FUNDS	$0.00

FORM 5

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED)

Program Participants*

By Type of Individual and Source of Primary Insurance Coverage

For Projects Providing Direct Health Care, Enabling or Population-based Services

Calendar Year 2003

Table 1

Pregnant Women Served	(a) Number Served	(b) Total Served	(c) Title XIX %	(d) Title XXI %	(e) Private/ Other %	(f) None %
Pregnant Women (All Ages)*		168				
10-14	9					
15-19	21					
20-24	27					
25-34	29					
35-44	9					
45 +						

Table 2

Children Served	(a) Number Served	(b) Total Served	(c) Title XIX %	(d) Title XXI %	(e) Private/ Other %	(f) None %
Infants <1		45				
Children 1 to 22						
1-4						
5-9						
10-14						
15-21						
20-24						

Table 3

CSHCN Served	(a) Number Served	(b) Total Served	(c) Title XIX %	(d) Title XXI %	(e) Private/ Other %	(f) None %
Infants <1 yr		0				
Children 1 to 22						
1-4						
5-9						
10-14						

Table 4	(a)	(b)	(c)	(d)	(e)	(f)
Women Served	**Number Served**	**Total**	**Title XIX %**	**Title XXI %**	**Private/**	**None**
Women 22+		278				
22-24						
25-29						
30-34						
35-44						
45-54						
55-64						
65 +						

Table 5	(a)	(b)	(c)	(d)	(e)	(f)
Other	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/ Other %**	**None %**
Men/Unknown		409				

Table 6	(a)	(b)	(c)	(d)	(e)	(f)
TOTALS	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/ Other %**	**None %**
		900				

OMB #0915-0272 Expiration: January 31, 2006

* Unduplicated counts contain community education contacts for whom age breakdowns are only available as under 18 and over 18; therefore no age breakdowns are indicated.

FORM 5
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED)
Program Participants*
By Type of Individual and Source of Primary Insurance Coverage
For Projects Providing Direct Health Care,
Enabling or Population-based Services
Calendar Year 2004

Table 1	(a)	(b)	(c)	(d)	(e)	(f)
Pregnant Women Served	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/ Other %**	**None %**
Pregnant Women (All Ages)*		134	86.6		11.2	
10-14	3					
15-19	44					
20-24	43					
25-34	37					
35-44	7					
45 +						

Table 1 – 2.2 % Unknown

Table 2	(a)	(b)	(c)	(d)	(e)	(f)
Children Served	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/ Other %**	**None %**
Infants <1		100	82			
Children 1 to 24 yr		103	67		2	
12-24 months	59					
25 months-4 years	3					
5-9						
10-14						
15-19	20					
20-24	21					

Table 3

CSHCN Served	Number Served	Total Served	Title XIX %	Title XXI %	Private/ Other %	None %
Infants <1 yr		1	100.00%			
Children 1 to 24 yr		2	100.00%			
12-24 months	2					
25 months-5-9	0					
10-14	0					
15-19	0					

FORM 5
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED)
Program Participants*
By Type of Individual and Source of Primary Insurance Coverage
For Projects Providing Direct Health Care,
Enabling or Population-based Services
Calendar Year 2004

20-24	0					

FORM 5
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED)
Program Participants*
By Type of Individual and Source of Primary Insurance Coverage
For Projects Providing Direct Health Care,
Enabling or Population-based Services
Calendar Year 2004

Table 4	(a)	(b)	(c)	(d)	(e)	(f)
Women Served	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/ Other %**	**None %**
Women 24+		30	76.70%		6.70%	
24-29	10					
30-34	11					
35-44	9					
45-54						
55-64						
65+						

Table 4 – 16.6 % Unknown

Table 5	(a)	(b)	(c)	(d)	(e)	(f)
Other	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/ Other %**	**None %**
Men		6	16.7			

Table 6	(a)	(b)	(c)	(d)	(e)	(f)
TOTALS	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/ Other %**	**None %**
		376				

OMB #0915-0272 Expiration: January 31, 2006	

* Unduplicated counts contain community education contacts for whom age breakdowns are only available as under 18 and over 18; therefore no age breakdowns are indicated.

FORM 5
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED)
Program Participants*
By Type of Individual and Source of Primary Insurance Coverage
For Projects Providing Direct Health Care,
Enabling or Population-based Services
Calendar Year January 1, 2005 through May 31, 2005

Table 1	(a)	(b)	(c)	(d)	(e)	(f)
Pregnant Women Served	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/ Other %**	**None %**
Pregnant Women (All Ages)*		37	91.89 (34)	5.40 (2)	2.70 (1)	
10-14	1					
15-19	16					
20-24	12					
25-34	6					
35-44	2					
45 +	0					

Table 2	(a)	(b)	(c)	(d)	(e)	(f)
Children Served	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/ Other %**	**None %**
Infants <1		112	105	1.78 (2)	4.46 (5)	
Children 1 to 24 yr		173	93.64 (162)	3.46 (6)	3.46 (6)	
12-24 months	54					
25 months-4 years	20					
5-9	0					
10-14	2					
15-19	51					
20-24	46					

Table 3

CSHCN Served	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/ Other %**	**None %**
Infants <1 yr		0				
Children 1 to 24 yr		0				
12-24 months						
25 months-5-9						
10-14						
15-19						
20-24						

Table 4	(a)	(b)	(c)	(d)	(e)	(f)
Women Served	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/ Other %**	**None %**
Women 24+		82	91.46 (75)%	3.65 (3)	4.87 (4)%	
24-29	40					
30-34	30					
35-44	12					
45-54	0					
55-64	0					
65+	0					

Table 5	(a)	(b)	(c)	(d)	(e)	(f)
Other	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/ Other %**	**None %**
Men		18	**	**	**	

Table 6	(a)	(b)	(c)	(d)	(e)	(f)
TOTALS	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/ Other %**	**None %**
		482				

OMB #0915-0272 Expiration: January 31, 2006

* Unduplicated counts contain community education contacts for whom age breakdowns are only available as under 18 and over 18; therefore no age breakdowns are indicated.

** Did not track health insurance data

*** Contains data from fatherhood services, but no health insurance information was gathered

Form 9

Tracking Discretionary Grant and Title V Block Grant Performance Measures

Annual Objective and Performance Data

	Baseline____	CY 2001*	CY 2002*	CY 2003	CY 2004	CY 2005
PERFORMANCE MEASURE #07						
***Degree to which programs ensure family participation*.**		*	*			
Annual Performance Objective						
Annual Performance Indicator						
Numerator				10	11	11
Denominator				18	18	18
PERFORMANCE MEASURE #10						
Degree to which programs have incorporated cultural competence.		*	*			
Annual Performance Objective						
Annual Performance Indicator						
Numerator				41	46	46
Denominator				69	69	69
PERFORMANCE MEASURE #14						
Degree to which morbidity/mortality review processes are used.		*	*			
Annual Performance Indicator						
Numerator				N/A	6	6
Denominator				N/A	9	9
PERFORMANCE MEASURE #17						
Percent of children 0-2 years of age with a medical home.		**				
Annual Performance Objective						
Annual Performance Indicator				97.50%	88.20%	100.00%
Numerator				40	142	166
Denominator				41	161	166
PERFORMANCE MEASURE #20						
Percent of women participants who have an ongoing source of primary care.		**	**			
Annual Performance Objective				50%	50%	50%
Annual Performance Indicator				94.5	92.2	89.90%
Numerator				137	189	188
Denominator				145	205	209

Form 9

Tracking Discretionary Grant and Title V Block Grant Performance Measures

Annual Objective and Performance Data

	Baseline____	CY 2001*	CY 2002*	CY 2003	CY 2004	CY 2005
PERFORMANCE MEASURE #22						
Degree to which programs facilitate screening for risk factors.		*	*			
Annual Performance Objective						
Annual Performance Indicator						
Numerator				48	49	49
Denominator				72	64	64
PERFORMANCE MEASURE #35						
Percent of communities having comprehensive systems for women's health services.		*	*			
Annual Performance Objective						
Annual Performance Indicator						
Numerator				19	11	11
Denominator				42	28	28
PERFORMANCE MEASURE #36						
Percent of pregnant participants who have a prenatal visit in the first trimester of pregnancy.		**				
Annual Performance Objective						
Annual Performance Indicator			38%	63%	71%	73%
Numerator			10	63	95	27
Denominator			26	100	134	37
PERFORMANCE MEASURE #50						
Percent of very low birthweight (<1500 grams) infants among all live births.		**				
Annual Performance Objective						
Annual Performance Indicator			0%			
Numerator			0	0	0	0
Denominator			4	18	91	91
PERFORMANCE MEASURE #51						
Percent of live singleton births weighing less than 2,500 grams among all live births.		**				
Annual Performance Objective						
Annual Performance Indicator			0%	33.30%	5.50%	6.50%
Numerator	0		0	6	5	6
Denominator	4		4	18	91	91

Form 9

Tracking Discretionary Grant and Title V Block Grant Performance Measures

Annual Objective and Performance Data

	Baseline____	CY 2001*	CY 2002*	CY 2003	CY 2004	CY 2005
PERFORMANCE MEASURE #52						
The infant mortality rate per 1,000 live births.		**				
Annual Performance Objective						
Annual Performance Indicator						
Numerator			0	0	0	0
Denominator			4	4	91	91
PERFORMANCE MEASURE #53						
The neonatal mortality rate per 1,000 live births.		**				
Annual Performance Objective						
Annual Performance Indicator						
Numerator			0	0	0	0
Denominator			4	4	91	91
PERFORMANCE MEASURE #54						
The post-neonatal mortality rate per 1,000 live births.		**				
Annual Performance Objective						
Annual Performance Indicator						
Numerator			0	0	0	0
Denominator			4	4	91	91
PERFORMANCE MEASURE #55						
The perinatal mortality rate per 1,000 live births.		**				
Annual Performance Objective						
Annual Performance Indicator						
Numerator			0	0	0	0
Denominator			4	0	0	0

OMB #0915-0272 Expiration: January 31, 2006	

*** This information was not required prior to the 03 calendar year.**
**** No data available due to delay in initiation of services.**

Improving Pregnancy Outcomes Program
(IPOP Division)
Public Health Nursing
Monthly Report Form

Month: December **Year:** 2002

HEALTHY START PARTICIPANT DATA TABLE

	Section A - Characteristics of Active Clients Participating in IPOP/Healthy Start	Enrolled To Date For Fiscal Year	
		Pregnant	Postpartum
1.	**Number of Pregnant/Postpartum Participants During Reporting Period**	26	29
2.	**Number of Pregnant/Postpartum Women who are:**		
	a. Under age 15		
	b. Aged 15 - 17	4	1
	c. Aged 18 - 19	4	4
	d. 35+ or older	2	5
3.	**Number of Pregnant/Postpartum Women by Race:**		
	a: Black/African American	12	17
	b. White	2	6
	c. Asian	1	
	d. American Indian of Alaskan Native		
	e. Native Hawaiian or Other Pacific	1	1
	f. Other	8	5
	g. Unknown		
4.	**Number of Pregnant/Postpartum Women by Ethnicity:**		
	a: Hispanic or Latino	14	10
	b. Not Hispanic or Latino	10	19
	c. Unknown		
5.	**Number of Pregnant/Postpartum Women with Income:**		
	a. Below 100 Percent of the FPL	10	14
	b. Between 100 - 200 Percent of the FPL	21	2
6.	**Number of Pregnant/Postpartum Participants Who are Medicaid Recipients**		
	a. Unknown	25	23
7.	**Number of Pregnant/Postpartum Participants Showing Evidence of Substance Use:**		
	a. Illicit Drug Use	1	9
	b. Alcohol Use		5
	c. Smoking Use	1	7
	d. Prescription Drug Abuse	1	1
	e. Unduplicated Numbers of Pregnant/Postpartum Participants Showing Evidence of Substance Use	2	10
8.	**Number of Pregnant/Postpartum Participants Showing Evidence of HIV/STI's/STD's/Group B Strep or Bacterial Vaginosis:**		
	a. HIV/AIDS	1	3
	b. STI's/STD's		2
	c. Group B Strep or Bacterial Vaginosis		
	d. Unduplicated Numbers of Pregnant/Postpartum Participants Showing Evidence of HIV/STI's/STD's/group B Strep or Bacterial Vaginosis	1	5

Improving Pregnancy Outcomes Program
(IPOP Division)
Public Health Nursing
Monthly Report Form

Month: December **Year:** 2002

HEALTHY START PARTICIPANT DATA TABLE

	Section A - Characteristics of Active Clients Participating in IPOP/Healthy Start (continued)	Enrolled To Date For Fiscal Year	
		Pregnant	Postpartum
9.	**Number of Pregnant/Postpartum Participants showing Evidence of chronic Health/Nutrition Problems**		
	a. Diabetes	3	1
	b. Hypertension		2
	c. Obesity	1	2
	d. Anemia	3	5
	e. Other:_____	2	2
	f. Other:_____	2	
	g. Unduplicated Number of Women Showing Evidence of Chronic Hypertension/Nutrition Problems:	8	4
10.	**Number of Pregnant/Postpartum Women who entered Prenatal Care:**		
	a: During First Trimester	10	7
	b. During Second Trimester	3	3
	c. During Third Trimester	9	4
	d. Receiving No Prenatal Care		2
	e. Unknown	3	10
11.	**Number of Pregnant/Postpartum Participants Perceiving Adequate Prenatal Care (Kotelchuck[1], Kessner[2] or similar index)**		
	a: Known	10	9
	b. Unknown	10	8
	Section B - Characteristics of Active Clients Participating in IPOP/Healthy Start	**Enrolled To Date For Fiscal Year**	
		Pregnant	**Postpartum**
1.	**Number of Infant Participants During Reporting Period regardless of Whether Mother Entered During Prenatal or Postpartum**		16
2.	**Number of Infants ages 0-1 by Race:**		
	a: Black/African American	2	17
	b. White	1	5
	c. Asian	1	
	d. American Indian of Alaskan Native		
	e. Native Hawaiian or Other Pacific		
	f. Other	2	7
	g. Unknown		
3.	**Number of Infants ages 0-1 Enrolled During Reporting Period, by Ethnicity:**		
	a: Hispanic or Latino	1	4
	b. Not Hispanic or Latino	2	14
	c. Unknown		

1. Kotelchuck: Percent of women whose ratio of observed to expected prenatal visits is greater than or equal to 80%. 80 Percent defined in the Adequacy of Prenata Care Units (APNCU) as the lower of "adequate care" (expected visits for gestational age and month prenatal care began).

2. Kessner: This index takes into account three factors: month in which prenatal care began, number of prenatal care visits, and length of gestation "Not adequate" prenatal care includes intermediate, inadequate, and unknown adequacy of care.

(IPOP Division)

Public Health Nursing

Monthly Report Form

Month: December **Year:** 2002

HEALTHY START PARTICIPANT DATA TABLE

	Section C - Characteristics of Healthy Families Participating in IPOP/Healthy Start	Enrolled To Date For Fiscal Year	
		Pregnant	Postpartum
1.	**Number of Pregnant/Postpartum Women and their families who Show Evidence of Recorded at Assessment and Updated as Necessary:**	2	16
	a. Illicit Drug Use		5
	b. Alcohol Use		5
	c. Smoking Use	2	8
	d. Prescription Drug Abuse	1	2
	e. Inadequate Housing	3	1
	f. Problems with bonding with Infant		
	g. Domestic Violence		
	h. Lack of Family Support		
	Section D - Characteristics of IPOP/ Health	**To Date**	
	Start Outreach	**Pregnant**	**Postpartum**
	1. Number of Women Contacted through Outreach by IPOP/Healthy Start	2	1
	Section E - Characteristics of Active Postpartum Clients Participating in IPOP/Healthy Start		
	1. Postpartum		
	a. Total Number of Postpartum Women during this Reporting Period including Pregnancy clients That have Delivered	2	29
	Section F - Characteristics of Births to IPOP/Healthy Start Participants	**To Date**	
		Delivered to Pregnant Clients	**Postpartum**
1.	**Birth Outcomes**		
	a. Total Number of Deliveries/Births During the Reporting Period to Pregnant women that Were Cased Managed/Total Number of Infants to Postpartum Clients Not Enrolled During Pregnancy	4	29
2.	**Births Which Were:**		
	a. Preterm (<37 weeks Gestation)	1	2
	b. Moderate Low Birth Weight (1500 to 2499 Grams)		
	c. Very Low Birth Weight (1499 Grams or Less)		

Improving Pregnancy Outcomes Program
(IPOP Division)
Public Health Nursing
Monthly Report Form

Month: December **Year:** 2002

HEALTHY START PARTICIPANT DATA TABLE

	Section F - Characteristics of Births to IPOP/Healthy Start Participants (Continued)	To Date	
		Delivered to Pregnant Clients	Postpartum
3.	**Births with Evidence of Substance Use:**		
	a. Prenatal Exposure to Drug		6
	b. Prenatal Exposure to Alcohol		3
	c. Prenatal Exposure to Smoking		5
	d. Prenatal Exposure to Prescription Drug Abuse		
	e. Unduplicated Numbers for Clients with Prenatal Exposures		6
4.	**Births With Evidence of HIV/STD's/STI's/Group B Strep or Bacterial Vaginosis**		
	a. Prenatal Exposure to HIV/AIDS		
	b. Prenatal Exposure to STI's/STD's		
	c. Prenatal Exposure to Group B Strep or Bacterial Vaginosis		
	d. Unduplicate Numbers of Clients with Prenatal Exposure to HIV/STI's/STD's/Group B Strep or Bacterial Vaginosis with Prenatal Exposure		
	Section G - Characteristics of Infants of IPOP/Healthy Start Participants		
1.	**Total Number of Infants to Postpartum Participants Receiving:**		
	a. Well Child Visits 2-4 Weeks after Birth	4	34
	b. Number of Infants with Recommended Number of Well-Child Visits by Age One[3]		2
	c. Number of Infant Deaths During Reporting Period:		
	Within 28 Day of Birth		
	After 28 Days of Birth		
	d. Number of Deaths Determined to be Sudden Infant Dath Syndrome		
	e. Number of Fetal Deaths	1	

3. As Determined by nation standards, i.e., Bright Futures, AAP, EPSDT, etc

*** This information was not require prior to the 03 calendar year.**

Healthy Strat Participant Data Table A 2003

Project Name:	Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP)	**City:**	San Leandro
Project Grant #:		**State:**	CA

2003

DIVISION OF PERINATAL SYSTEMS AND WOMEN'S HEALTH DATA SHEET

Section A. Characteristics of Program Participants Page 1

Characteristics of Program Participants Page 1 of 3	Race (Indicate all that apply)						ETHNICITY		
	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	Caucasian	Unknown	Hispanic or Latino	Not Hispanic or Latino	Unknown
a. Number of Pregnant Women									
Under age 15		1	3		4	1			
Aged 15-17			5	1	3	2			
Aged 18-19			7		3				
Aged 20-24			18		8	1			
Aged 25-34		3	13	2	10	1			
Aged 35-44		1	4	1	2	1			
45+									
Number of Pregnant Women with Incomes:									
Below 100 Percent of the FPL		9	37	1	20	4	11		
Between 100-185 Percent of the FPL			19		14	1	5		

DIVISION OF PERINATAL SYSTEMS AND WOMEN'S HEALTH DATA SHEET

Section A. Characteristics of Program Participants Page 1

Characteristics of Program Participants Page 1 of 3	Race (Indicate all that apply)						ETHNICITY		
	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	Caucasian	Unknown	Hispanic or Latino	Not Hispanic or Latino	Unknown
Number of Pregnant Participants who Enter Prenatal Care:									
During First Trimester		7	34	1	21	1	13		
During Second Trimester		1	16		13	2	12		
During Third Trimester	1		1						
Receiving No Prenatal Care									
Unknown			1		1		1		
Number Pregnant Participants Receiving Adequate Prenatal Care (Kotelchuck[1],or similar index)					1		1		

Healthy Strat Participant Data Table A 2003

	DIVISION OF PERINATAL SYSTEMS AND WOMEN'S HEALTH DATA SHEET Section A. Characteristics of Program Participants Page 2								
	Race (Indicate all that apply)						ETHNICITY		
Characteristics of Program Participants Page 2 of 3	**American Indian or Alaska Native**	**Asian**	**Black or African American**	**Native Hawaiian or Other Pacific Islander**	**Caucasian**	**Unknown**	**Hispanic or Latino**	**Not Hispanic or Latino**	**Unknown**
Number of live births to participants		6	8		4		3		
Number of live births between 2499 grams and 1500 grams to participants			1		2	2	1		
Number of live births less than 1499 grams to participants			1						
Number of Participating Women in Interconceptional Care/Women's Health Activities During Reporting Period									
Under age 15									
Aged 15-17									
Aged 18-19			2		2	1			
Aged 20-24		1	9	1	3	2			
Aged 25-34			6		4				
Aged 35-44			3		2				
Aged 45-54									
Aged 55-64									
Aged 65 and older									

	DIVISION OF PERINATAL SYSTEMS AND WOMEN'S HEALTH DATA SHEET Section A. Characteristics of Program Participants Page 2								
	Race (Indicate all that apply)						ETHNICITY		
Characteristics of Program Participants Page 3 of 3	**American Indian or Alaska Native**	**Asian**	**Black or African American**	**Native Hawaiian or Other Pacific Islander**	**Caucasian**	**Unknown**	**Hispanic or Latino**	**Not Hispanic or Latino**	**Unknown**
Number of Infant Participants Aged 0 to 12 months		2	15		8	3	8		
Number of Child Participants aged 13 to 24 months									
Number of Male Participants 17 years and under									
Number of Male Participants 18 years and older									

Project Name: Alameda County Healthy Start, Improving Pregnancy Outcomes Program (IPOP) **City:** San Leandro
Project Grant #: **State:** CA
Total: 2004

DIVISION OF PERINATAL SYSTEMS AND WOMEN'S HEALTH DATA SHEET

Section A. Characteristics of Program Participants Page 1

Characteristics of Program Participants Page 1 of 3	Race (Indicate all that apply)							ETHNICITY			
	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	Caucasian	Unknown	Total	Hispanic or Latino	Not Hispanic or Latino	Unknown	Total
a. Number of Pregnant Women											
Under age 15			2		1		3	1	2		3
Aged 15-17			15	1	9		25	9	16		25
Aged 18-19			13		5		18	5	13		18
Aged 20-23			23		14		37	9	28		37
Aged 24-34		2	23	1	19		45	17	28		45
Aged 35-44		1	1		4		6	4	2		6
45+											0
Total # of Pregnant		3	77	2	52		134	45	89		134
b. Number of Pregnant Women with Incomes:											
Below 100 Percent of the FPL		2	59	2	45	1	109	39	70		109
			17				0				0
Between 100-185 Percent		1			7		25	7	18		25
Between 200 Percent of the FPL							0				0
During First Trimester		1	55	1	38		95	32	63		95
During Second Trimester		2	16		11		29	10	19		29
During Third Trimester			5		3		8	3	5		8
Receiving No Prenatal Care							0				0
Unknown			1	1			2		2		2
Total		3	77	2	52	0	134	45	89	0	134

Project Name: Alameda County Healthy Start, Improving Pregnancy Outcomes Program (IPOP) **City:** San Leandro
Project Grant #: 5H 49 MC 00130-02 **State:** CA

DIVISION OF PERINATAL SYSTEMS AND WOMEN'S HEALTH DATA SHEET

Section A. Characteristics of Program Participants Page 2

Characteristics of Program Participants Page 2 of 3	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	Caucasian	Unknown	Total	Hispanic or Latino	Not Hispanic or Latino	Unknown	Total
d. Adequate Prenatal Care											
Number Pregnant		1	54	2	34		91	31	60		91
Participants Receiving											0
Level of Adequate Prenatal Care Unknown		1	54	2	34		91				0
e. Live Singleton Births to Participants							0				
Number of live births to participants		5	48		38		91	34	57		91
Number of live singleton births between 2499grams and 1500 grams to program participants			4				4		4		4
Number of live singleton births less than 1499 grams to program participants					1		1	1			1

Project Name: Alameda County Healthy Start, Improving Pregnancy Outcomes Program (IPOP) **City:** San Leandro
Project Grant #: 5H 49 MC 00130-02 **State:** CA

DIVISION OF PERINATAL SYSTEMS AND WOMEN'S HEALTH DATA SHEET

Section A. Characteristics of Program Participants Page 3

Characteristics of Program Participants Page 3 of 3	Race (Indicate all that apply)							ETHNICITY			
	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	Caucasian	Unknown	Total	Hispanic or Latino	Not Hispanic or Latino	Unknown	Total
f. Number of Program Participats in Interconceptional Care/Women's Health Activities											
Under age 15											0
Aged 15-17			7		2		9	2	7		9
Aged 18-19		1	5	1	5		12	5	7		12
Aged 20-23			11		5		16	5	11		16
Aged 24-34			18		6	1	25	6	18	1	25
Aged 35-44		3	5		1		9	1	8		9
Aged 45 +											0
Total		4	46	1	19	1	71	19	51	1	71
g. Infant/Child Health Participants											
Number of Infant Participants Aged 0 to 11 months		2	54		44	1	101	23	77	1	101
Number of Child Participants aged 12 to 23 months		5	38	1	16		60	7	53	1	60
Total		7	92	1	60	1	161	30	130	1	161
h. Male Support Services Participants											
Number of Male Participants 17 years and under											
Number of Male Participants 18 years and older			6				6		6		
Total		0	6	0	0	0	6	0	6	0	6

Project Name:	Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP)	**City:**	San Leandro
Project Grant #:		**State:**	CA

Total: January 1, 2005 through May 31, 2005

DIVISION OF PERINATAL SYSTEMS AND WOMEN'S HEALTH DATA SHEET

Section A. Characteristics of Program Participants Page 1

Characteristics of Program Participants Page 1 of 3	Race (Indicate all that apply)							ETHNICITY			
	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	Caucasian	Unknown	Total	Hispanic or Latino	Not Hispanic or Latino	Unknown	Total
a. Number of Pregnant Women											
Under age 15					1		1	1			1
Aged 15-17		1	4	1	3		9	3			9
Aged 18-19			5		2		7	2			7
Aged 20-23			8		1		9	1			9
Aged 24-34			4		5		9	5			9
Aged 35-44			1		1		2	1			2
45+											
Total # of Pregnant Women		1	22	1	13		37	13			37
b. Number of Pregnant Women with Incomes:											
Below 100 Percent of the FPL		1	18	1	12		32	12			32
Between 100-185 Percent			3		1		4	1			4
Between 200 Percent of the FPL			1				1				1
During First Trimester			16	1	10		27	10			27
During Second Trimester		1	6		3		10	3			10
During Third Trimester											
Receiving No Prenatal Care											
Unknown											
Total		1	22	1	13		37	13			37

Project Name:	Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP)	**City:**	San Leandro
Project Grant #:	5H 49 MC 00130-02	**State:**	CA

DIVISION OF PERINATAL SYSTEMS AND WOMEN'S HEALTH DATA SHEET

Section A. Characteristics of Program Participants Page 2

Characteristics of Program Participants Page 2 of 3	**American Indian or Alaska Native**	**Asian**	**Black or African American**	**Native Hawaiian or Other Pacific Islander**	**Caucasian**	**Unknown**	**Total**	**Hispanic or Latino**	**Not Hispanic or Latino**	**Unknown**	**Total**
d. Adequate Prenatal Care											
Number Pregnant Participants Receiving Adequate Prenatal Care (Kotelchuck[1],or similar index)		1	22	1	13		37	13	0	0	37
Level of Adequate Prenatal Care Unknown											
e. Live Singleton Births to Participants											
Number of live births to participants		1	43		47		91	47			91
Number of live singleton births between 2499grams and 1500 grams to program participants			3		3		6	3			6
Number of live singleton births less than 1499 grams to program participants											

Project Name:	Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP)	**City:**	San Leandro
Project Grant #:	5H 49 MC 00130-02	**State:**	CA

DIVISION OF PERINATAL SYSTEMS AND WOMEN'S HEALTH DATA SHEET

Section A. Characteristics of Program Participants Page 3

Characteristics of Program Participants Page 3 of 3	**Race (Indicate all that apply)**							**ETHNICITY**			
	American Indian or Alaska Native	**Asian**	**Black or African American**	**Native Hawaiian or Other Pacific Islander**	**Caucasian**	**Unknown**	**Total**	**Hispanic or Latino**	**Not Hispanic or Latino**	**Unknown**	**Total**
f. Number of Program Participats in Interconceptional Care/Women's Health Activities											
Under age 15			1		1		2	1			2
Aged 15-17			17		10		27	10			27
Aged 18-19			12		11		23	11			23
Aged 20-23			20		17		37	15	3		37
Aged 24-34		5	38	1	25	1	70	25		1	70
Aged 35-44		2	5		6		13	5	1		13
Aged 45 +											
Total		7	93	1	70	1	172	67	4	1	172
g. Infant/Child Health Participants											
Number of Infant Participants Aged 0 to 11 months		4	61	1	46		112	46	1		112
Number of Child Participants aged 12 to 23 months		2	30		21	1	54	13		1	54
Total		6	91	1	67	1	166	59	1	1	166
h. Male Support Services Participants											
Number of Male Participants 17 years and under											
Number of Male Participants 18 years and older			16		2			2			18
Total											

Project Name:	Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP)
Project Grant #:	
City:	San Leandro
State:	California

Year 2003

B. RISK REDUCTION/PREVENTION SERVICES Page 1
(For Program Participants)

RISK FACTORS **Page 1 of 3**	**Number Screened**	**Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling**	**Number whose Treatment is Supported by Grant**	**Number Referred for Further Assessment and/or Treatment**
a. PRENATAL PROGRAM PARTICIPANTS				
Group B Strep or Bacterial Vaginosis	32	0	0	0
HIV/AIDS	41	0	0	0
Other STDs	46	0	0	0
Smoking	50	6	1	1
Alcohol	49	1	0	0
Illicit Drugs	47	2	0	1
Depression	52	6	1	4
Other Mental Health Problem	10	1	0	1
Domestic Violence	22	1	0	1
Homelessness	19	1	1	1
Overweight & Obesity	20	2	0	1
Underweight	7	1	0	0
Hypertension	24	2	0	10
Gestational Diabetes	42	2	0	1
Peridontal Infection	2	0	0	0
Asthma	39	0	0	0

Project Name:	Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP)
Project Grant #:	
City:	San Leandro
State:	California

Year 2003

B. RISK REDUCTION/PREVENTION SERVICES Page 2 (For Program Participants)

RISK FACTORS **Page 2 of 3**	**Number Screened**	**Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling**	**Number whose Treatment is Supported by Grant**	**Number Referred for Further Assessment and/or Treatment**
b. INTERCONCEPTIONAL WOMEN PARTICIPANTS				
Group B Strep or Bacterial Vaginosis	13	1	0	0
HIV/AIDS	9	0	0	0
Other STDs	19	1	0	0
Smoking	24	8	0	1
Alcohol	15	3	0	1
Illicit Drugs	16	6	0	1
Depression	15	2	0	1
Other Mental Health Problem	5	0	0	7
Domestic Violence	5	0	0	0
Homelessness	9	2	0	2
Overweight & Obesity	7	0	0	0
Underweight	1	0	0	0
Lack of Physical Activity	2	0	0	0
Hypertension	13	2	0	5
Cholesterol	1	0	0	0
Diabetes	4	2	0	5
Family History of Breast Cancer	2	0	0	0
Fecal occult blood test	13	0	0	0
Asthma	2	3	0	0
Peridontal Infection	0	0	0	0

Project Name:	Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP)
Project Grant #:	
City:	San Leandro
State:	California

Year 2003

B. RISK REDUCTION/PREVENTION SERVICES Page 3 (For Program Participants)

RISK FACTORS **Page 3 of 3**	**Number Screened**	**Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling**	**Number whose Treatment is Supported by Grant**	**Number Referred for Further Assessment and/or Treatment**
c. INFANT CHILD (0-23 mths)				
Prenatal Drug Exposure				
Prenatal Alcohol Exposure				
Mental Health Problems				
Family Violence Intentional Injury				
Homelessness				
Not Attaining Appropriate Growth				
Developmental Delays				
Asthma				
HIV/AIDS				
Other Special Health Care Needs				

OMB 0915-0272 Expiration: January 31, 2006

Project Name:	Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP)
Project Grant #:	
City:	San Leandro
State:	California

Year 2004

B. RISK REDUCTION/PREVENTION SERVICES Page 1
(For Program Participants)

RISK FACTORS **Page 1 of 3**	**Number Screened**	**Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling**	**Number whose Treatment is Supported by Grant**	**Number Referred for Further Assessment and/or Treatment**
a. PRENATAL PROGRAM PARTICIPANTS				
Group B Strep or Bacterial Vaginosis	48	24	0	0
HIV/AIDS	64	38	0	0
Other STDs	65	41	0	0
Smoking	70	45	0	1
Alcohol	71	46	0	1
Illicit Drugs	70	42	0	2
Depression	61	38	3	0
Other Mental Health Problem	53	27	0	2
Domestic Violence	67	33	0	1
Homelessness	50	26	0	0
Overweight & Obesity	47	29	0	0
Underweight	48	26	0	1
Hypertension	67	37	0	0
Gestational Diabetes	75	33	0	1
Peridontal Infection	59	31	0	0
Asthma	64	3	0	1

Project Name:	Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP)
Project Grant #:	Alameda County Health Care Services Agency - Improving Pregnancy Outcomes Program
City:	San Leandro
State:	California

Year 2004

	B. RISK REDUCTION/PREVENTION SERVICES Page 2 (For Program Participants)			
RISK FACTORS Page 2 of 3	**Number Screened**	**Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling**	**Number whose Treatment is Supported by Grant**	**Number Referred for Further Assessment and/or Treatment**
b. INTERCONCEPTIONAL WOMEN PARTICIPANTS				
Group B Strep or Bacterial Vaginosis	38	14	0	0
HIV/AIDS	123	18	0	0
Other STDs	43	16	0	0
Smoking	42	18	0	0
Alcohol	42	20	0	1
Illicit Drugs	42	20	0	1
Depression	41	19	1	0
Other Mental Health Problem	35	9	1	0
Domestic Violence	41	17	0	1
Homelessness	36	12	0	0
Overweight & Obesity	37	14	0	0
Underweight	33	9	0	0
Lack of Physical Activity	38	18	0	0
Hypertension	43	14	0	0
Cholesterol	42	13	0	0
Diabetes	42	14	0	1
Family History of Breast Cancer	34	10	0	0
Fecal occult blood test	25	7	0	0
Asthma	40	18	0	0
Peridontal Infection	29	11	0	0

RISK FACTORS Page 3 of 3	B. RISK REDUCTION/PREVENTION SERVICES Page 3 (For Program Participants) Number Screened	Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling	Number whose Treatment is Supported by Grant	Number Referred for Further Assessment and/or Treatment
c. INFANT CHILD (0-23 mths)				
Prenatal Drug Exposure	61	32	0	0
Prenatal Alcohol Exposure	61	32	0	0
Mental Health Problems	52	22	0	0
Family Violence Intentional Injury	63	34	0	0
Homelessness	52	22	0	0
Not Attaining Appropriate Growth	59	35	0	0
Developmental Delays	60	34	0	0
Asthma	61	38	0	0
HIV/AIDS	55	24	0	0
Other Special Health Care Needs	43	18	0	0

Year 2004

OMB 0915-0272 Expiration: January 31, 2006

Project Name:	Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP)
Project Grant #:	
City:	San Leandro
State:	California

Year 2005

B. RISK REDUCTION/ PREVENTION SERVICES Page 1 (For Program Participants)

RISK FACTORS Page 1 of 3	**Number Screened**	**Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling**	**Number whose Treatment is Supported by Grant**	**Number Referred for Further Assessment and/or Treatment**
a. PRENATAL PROGRAM PARTICIPANTS				
Group B Strep or Bacterial Vaginosis	29	20	0	0
HIV/AIDS	30	22	0	0
Other STDs	31	23	0	0
Smoking	32	24	0	0
Alcohol	31	24	0	0
Illicit Drugs	31	24	1	0
Depression	30	24	2	3
Other Mental Health Problem	24	16	0	0
Domestic Violence	26	16	0	0
Homelessness	25	16	0	0
Overweight & Obesity	28	20	0	0
Underweight	27	16	0	0
Hypertension	28	17	0	0
Gestational Diabetes	29	19	0	0
Peridontal Infection	28	16	0	1
Asthma	29	18	0	0

Project Name:	Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP)	**Year 2005**
Project Grant #:		
City:	San Leandro	
State:	California	

	B. RISK (For Program Participants)			
RISK FACTORS Page 2 of 3	**Number Screened**	**Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling**	**Number whose Treatment is Supported by Grant**	**Number Referred for Further Assessment and/or Treatment**
b. INTERCONCEPTIONAL WOMEN PARTICIPANTS				
Group B Strep or Bacterial Vaginosis	92	48	0	0
HIV/AIDS	114	59	0	0
Other STDs	112	61	0	0
Smoking	120	66	0	4
Alcohol	121	62	0	2
Illicit Drugs	122	65	3	2
Depression	118	81	2	4
Other Mental Health Problem	92	44	1	0
Domestic Violence	116	56	0	3
Homelessness	94	44	0	1
Overweight & Obesity	107	60	0	0
Underweight	97	45	0	0
Lack of Physical Activity	102	66	0	0
Hypertension	112	52	0	1
Cholesterol	102	37	0	0
Diabetes	101	38	0	0
Family History of Breast Cancer	78	34	0	0
Fecal occult blood test	61	27	0	0
Asthma	101	53	0	0
Peridontal Infection	85	46	0	1

Project Name:	Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP)	**Year 2005**
Project Grant #:		
City:	San Leandro	
State:	California	

	B. RISK (For Program Participants)			
RISK FACTORS Page 3 of 3	**Number Screened**	**Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling**	**Number whose Treatment is Supported by Grant**	**Number Referred for Further Assessment and/or Treatment**
c. INFANT CHILD (0-23 mths)				
Prenatal Drug Exposure	123	57	1	1
Prenatal Alcohol Exposure	124	56	0	0
Mental Health Problems	110	45	2	0
Family Violence Intentional Injury	119	58	0	0
Homelessness	102	43	0	0
Not Attaining Appropriate Growth	115	59	0	0
Developmental Delays	112	55	0	0
Asthma	122	70	1	0
HIV/AIDS	109	44	0	0
Other Special Health Care Needs	98	38	1	0

OMB 0915-0272 Expiration: January 31, 2006

Improving Pregnancy Outcomes Program
(IPOP Division)
Public Health Nursing
Monthly Report Form

Month: December **Year:** 2002

HEALTHY START MAJOR SERVICE DATA TABLE

	Medical Services	To Date for the Fiscal Year	
		Pregnant	Postpartum
1.	**Prenatal Clinic Visits:**	109	
	a. Number of Medical visits by all Prenatal Participants		
2.	**Well Baby/Pediatric Clinic Visits:**		
	a. Number of any Provider visits by all Infant Participants as Appropriate		42
3.	**Immunizations:**		
	a. Number of Age Appropriate Immunizations Received by Infants		27
4.	**Family Planning:**		28
	a. Number of Participants Receiving family Planning Services		
5.	**POSTPARTUM CARE**		
	a. Number of Women Enrolled When Pregnant who Received Postpartum Care with 6 weeks After the Birth of Their Infants	3	21
6.	**CASE MANAGEMENT & OUTREACH:**		
	a. Number of Families Assisted by Case Management	35	50
	b. Number of Families Assisted by Outreach	2	
	c. Number of Families Assisted by Care Coordination		
	d. Number of Families Assisted through Home Visiting	30	51
7.	**FACILITATING SERVICES**		
	a. Number of Families Assisted Referred Who Received Transportation Services Includes Tokens, Taxis, and Vans		
	b. 1. Number of Families Who Received Translation Services	22	12
	b. 2. Number of Families Who HS Funded Received Translation Services		
	c. Number of Families Receiving Child Care Services Arranged by PHN Staff		
8.	**PSYCHOSOCIAL SERVICES:**		
	8a. Substance Abuse Treatment and Counseling		
	a. 1. Number of Participants Referred		
	b. 2. Number of Participants Referred and Received Services (not paid by IPOP Healthy Start)		
	a. Illicit Drug Use	a. _____	a. _____
	b. Alcohol Use	b. _____	b. _____
	c. Smoking Cessation	c. _____	c. _____
	8b. HIV/AIDS Counseling and Treatment		
	1. Number of Participants Referred	1. _____	1. _____
	2. Number of Participants Referred and Received Services (not paid by IPOP Healthy Start)	2. _____	2. _____

Improving Pregnancy Outcomes Program
(IPOP Division)
Public Health Nursing
Monthly Report Form

Month: December **Year:** 2002

HEALTHY START PARTICIPANT DATA TABLE

	Medical Services (Continued)	To Date for the Fiscal Year	
		Pregnant	Postpartum
	PSYCHOSOCIAL SERVICES: (continued)		
8.	c. Domestic Violence		
	1. Number of Participants Referred	1. _____	1. _____
	2. Number of Participants Referred and Received Services (not paid by IPOP Healthy Start)	2. _____	2. _____
	d. Health Education Services:		
	1. Number of Participants Referred		
	a. Nutrition Education and Counseling	24	25
	b. Referred to WIC	14	8
	c. HIV/AIDS education only	9	2
	d. Parenting Education	13	25
	e. Childbirth Education	24	
	f. Smoking Cessation Education	4	2
	g. Illicit Drugs Use Cessation Education	1	
	h. Alcohol Cessation Education	1	
	i. Domestic Violence	7	2
9.	**Chronic Health/Nutrition Conditions:**		
	a. Number of Participants Screened; Counseled and Monitored		
	1. Diabetes	1. ___3___	1. ___2___
	2. Hypertension	2. _____	2. ___1___
	3. Obesity	3. _____	3. _____
	4. Anemia	4. ___2___	4. ___7___
	5. Other: _____	5. _____	5. _____
	6. Other: _____	6. _____	6. _____
10.	**Male Support Services**		
	a. Total Number of males Referred to IPOP Male Services Program	8	
11.	**Housing Assistance Referrals:**		
	a. Number of Participants Referred	1	1
12.			
	a. Total Number of Participants Referred		
	b. Total Number of Participants Served		
13.	**MENTAL HEALTH SERVICES**		
	a. Number of Participants Screened	8	3
	b. Number of Participants Who Screened Positive	2	
	c. Number of Participants Referred to IPOP Mental Health Services		
	d. Number of Participants Referred to Other Mental Health Services	1	

Project Name: Alameda Healthy Start Improving Pregnancy Putcomes Program (IPOP) 2003	
Project Grant #:	
City: San Leandro	
State: CA	

C. HEALTHY START MAJOR SERVICE TABLE*

*** When data is collected on both program participant and community participants, please report data separately for each category of participant.**

PP=Program Participant

CP= Community Participant

a. DIRECT HEALTH CARE SERVICES

Prenatal Clinic Visits: Number of Medical Visits by All Prenatal Participants	529
Postpartum Clinic Visits Number of Medical Visits by All Postpartum Participants	60
Well Baby/ Pediatric Clinic Visits Number of Any Provider Visits by All Infant/Child Participants	265
Adolescent Health Services Number of any Provider Visits by Participants age 17 and under	19
Family Planning Number of Participants Receiving Family Planning Services	60
Women's Health Number of Participants Receiving Women's Health Services	20
	142

Total Number of Families Served	
Number of Families in the Prenatal Period Assisted by **Case Management**	96
ber of Families in the Interconceptional	56
nber of Families in the Prenatal Period Assisted by **Outreach**	38

Project Name: Alameda Healthy Start Improving Pregnancy Putcomes Program (IPOP)	
Project Grant #: 5H 49 MC 00130-02	
City: San Leandro	
State: CA	

C. HEALTHY START MAJOR SERVICE TABLE*

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PP=Program Participant
CP= Community Participant

Number of Families in the Interconceptional Period Assisted by	33
nber of Families in the Prenatal Period Receiving **Home Visiting**	110
ber of Families in the Interconceptional Period Receiving **Home Visiting**	101
Number of Participants Age 17 and	17

Under who participated in **Adolescent**	
umber of Families who participated in **ncy/Childbirth Education Activities**	65
umber of Families who participated in **Parenting Skill Building/Education**	102
Number of Participants in **outh Empowerment/Peer Education/ Self-Esteem/Mentor Programs**	0
Number of Families who Received **Transportation Services** Includes Tokens, Taxis, and Vans	6
Number of Families Who Receive **Translations Services**	37
Number of Families Receiving **Child Care Services**	733
Number of Participants Who Received **Education, Counseling and Support**	63

Project Name: Alameda Healthy Start Improving Pregnancy Putcomes Program (IPOP)	
Project Grant #: 5H 49 MC 00130-02	
City: San Leandro	
State: CA	

C. HEALTHY START MAJOR SERVICE TABLE*

*** When data is collected on both program participant and community participants, please report data separately for each category of participant.**

PP=Program Participant
CP= Community Participant

Number of Participants Who Receive	70
Number of Participants in **Male Support Services:**	3
Number of Participants Referred for **Housing Assistance**	12
Total Participants assisted with **Jobs/Jobs Training**	5
Total Participants served in **Prison/Jail Initiatives**	0

POPULATION

Number of Immunization Provided	0
Public Information/Education Number of Individuals Reached	1426

d. INFRASTRUCTURE BUILDING

Consortia Training umber of Individual Members Trained	12

Provider Training	
umber of Individual Providers Trained	174

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Project Name: Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP) 2004	
Project Grant #:	
City: San Leandro	
State: CA	

C. HEALTHY START MAJOR SERVICE TABLE*

*** When data is collected on both program participant and community participants, please report data separately for each category of participant.**

PP=Program Participant	X
CP= Community Participant	

a. DIRECT HEALTH CARE SERVICES	
Prenatal Clinic Visits: Number of Medical Visits	1249
Postpartum Clinic Visits Number of Medical Visits	211
Well Baby/ Pediatric Clinic Visits Number of Any Provider Visits by All Infant/Child Participants	636
Adolescent Health Services Number of any Provider Visits by Participants age 17 and under	0
Family Planning Number of Participants Receiving Family Planning Services	0
Women's Health Number of Participants Receiving Women's Health Services	154

b. ENABLING SERVICES	
Total Number of Families Served	205
Number of Families in the Prenatal Period Assisted by **Case Management**	134

Number of Families in the Interconceptional Period Assisted by **Case Management**	71
Number of Families in the Prenatal Period Assisted by **Outreach**	
Number of Families in the Interconceptional Period Assisted by **Outreach**	

Number of Families in the Prenatal Period Receiving **Home Visiting**	134
Number of Families in the Interconceptional Period Receiving **Home Visiting**	71
Number of Participants Age 17 and Under who participated in **Adolescent Pregnancy Prevention Activities**	
Number of Families who participated in **Pregnancy/Childbirth Education Activities**	130
Number of Families who participated in **Parenting Skill Building/Education**	80
Number of Participants in **Youth Empowerment/Peer Education/ Self-Esteem/Mentor Programs**	
Number of Families Who Received **Transportation Services** Includes Tokens, Taxis and Vans	30
Number of Families Who Receive **Translation Services**	13
Number of Families Receiving **Child Care Services**	
Number of Participants Who Received **Breastfeeding Education, Counseling and Suppo**rt	196
Number of Participants Who Received **Nutrition Education and Counseling Services,** including WIC Services	196

Number of Participants in **Male Support Services:**	6
Number of Participants Referred for **Housing Assistance**	102
Total Participants assisted with **Jobs/Jobs Training**	
Total Participants served in **Prison/Jail Initiatives**	

c. POPULATION

Number Of **Immunizations** Provided	
Public Information/Education: Number of Individuals Reached	

d. INFRASTRUCTURE BUILDING

Consortia Training Number of Individual Members Trained	
Provider Training Number of Individual Providers Trained	

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Project Name: Alameda Healthy Start, Improving Pregnancy Outcomes Program (IPOP) 2005	
Project Grant #:	
City: San Leandro	
State: CA	

C. HEALTHY START MAJOR SERVICE TABLE*

*** When data is collected on both program participant and community participants, please report data separately for each category of participant.**

PP=Program Participant **X - January 1, 2005 through May 31, 2005**

CP= Community Participant

a. DIRECT HEALTH CARE SERVICES	
Prenatal Clinic Visits: Number of Medical Visits	313
Postpartum Clinic Visits Number of Medical Visits	246
Well Baby/ Pediatric Clinic Visits Number of Any Provider Visits by All Infant/Child Participants	830
Adolescent Health Services Number of any Provider Visits by Participants age 17 and under	0
Family Planning Number of Participants Receiving Family Planning Services	0
Women's Health Number of Participants Receiving Women's Health Services	279

b. ENABLING SERVICES	

Total Number of Families Served	209
Number of Families in the Prenatal Period Assisted by **Case Management**	37
f Families in the Interconceptional Period Assisted by **Case Management**	172
nber of Families in the Prenatal Period Assisted by **Outreach**	37
ber of Families in the Interconceptional Period Assisted by **Outreach**	172
nber of Families in the Prenatal Period Receiving **Home Visiting**	37
er of Families in the Interconceptional Period Receiving **Home Visiting**	172
nts Age 17 and Under who participated **cent Pregnancy Prevention Activities**	0
umber of Families who participated in **ancy/Childbirth Education Activities**	209
umber of Families who participated in **Parenting Skill Building/Education**	172
Number of Participants in	0

outh Empowerment/Peer Education/ Self-Esteem/Mentor Programs	
Number of Families Who Received **Transportation Services** Includes Tokens, Taxis and Vans	20
Number of Families Who Receive **Translation Services**	12
Number of Families Receiving **Child Care Services**	10
Number of Participants Who Received **Education, Counseling and Suppo**rt	209
Number of Participants Who Received **Education and Counseling Services,** including WIC Services	209
Number of Participants in **Male Support Services:**	31
Number of Participants Referred for **Housing Assistance**	
Total Participants assisted with **Jobs/Jobs Training**	0
Total Participants served in **Prison/Jail Initiatives**	0

c. POPULATION

Number Of **Immunizations** Provided	0
Public Information/Education: Number of Individuals Reached	1928

d. INFRASTRUCTURE BUILDING

Consortia Training Number of Individual Members Trained	0
Provider Training Number of Individual Providers Trained	12

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City:	San Leandro
State:	CA

C. HEALTHY START MAJOR SERVICE TABLE*

*** When data is collected on both program participant and community participants, please report data separately for**

PP=Program Participant
CP= Community Participant - 2004

a. DIRECT HEALTH CARE SERVICES

Prenatal Clinic Visits: Number of Medical Visits by All Prenatal Participants	N/A
Postpartum Clinic Visits Number of Medical Visits by All Postpartum Participants	N/A
Well Baby/ Pediatric Clinic Visits Number of Any Provider Visits by All Infant/Child Participants	N/A
Adolescent Health Services Number of any Provider Visits by Participants age 17 and under	N/A
Family Planning Number of Participants Receiving Family Planning Services	N/A
Women's Health Number of Participants Receiving Women's Health Services	N/A

b. ENABLING SERVICES

Total Number of Families Served	1700
Number of Families in the Prenatal Period Assisted by **Case Management**	N/A

Number of Families in the Interconceptional Period Assisted by **Case Management**	N/A
Number of Families in the Prenatal Period Assisted by **Outreach**	N/A
Number of Families in the Interconceptional Period Assisted by **Outreach**	N/A
Number of Families in the Prenatal Period Receiving **Home Visiting**	N/A
Number of Families in the Interconceptional Period Receiving **Home Visiting**	N/A
Number of Participants Age 17 and Under who participated in **Adolescent Pregnancy Prevention Activities**	N/A
Number of Families who participated in **Pregnancy/Childbirth Education Activities**	24
Number of Families who participated in **Parenting Skill Building/Education**	72
Number of Participants in **Youth Empowerment/Peer Education/ Self-Esteem/Mentor Programs**	38
Number of Families Who Received **Transportation Services** Includes Tokens, Taxis and Vans	78
Number of Families Who Receive **Translation Services**	8

Number of Families Receiving **Child Care Services**	86
Number of Participants Who Received **Breastfeeding Education , Counseling and Suppo**rt	96
Number of Participants Who Received **Nutrition Education and Counseling Services** including WIC Services	96
Number of Participants in **Male Support Services:**	313
Number of Participants Referred for **Housing Assistance**	148
Total Participants assisted with **Jobs/Jobs Training**	N/A
Total Participants served in **Prison/Jail Initiatives**	N/A

c. POPULATION

Number Of **Immunizations** Provided	N/A
Public Information/Education: Number of Individuals Reached	741

d. INFRASTRUCTURE BUILDING

Consortia Training Number of Individual Members Trained	55
Provider Training Number of Individual Providers Trained	0

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Project Name:	**Alameda County Healthy Start, Improving Pregnancy Outcomes Program**
Project Grant #:	
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State:	CA

C. HEALTHY START MAJOR SERVICE TABLE*

*** When data is collected on both program participant and community participants, please report data**

PP=Program Participant

CP= Community Participant - January 1, 2005 through May 31, 2005

a. DIRECT HEALTH CARE SERVICES

Prenatal Clinic Visits: Number of Medical Visits by All Prenatal Participants	N/A
Postpartum Clinic Visits Number of Medical Visits by All Postpartum Participants	N/A
Well Baby/ Pediatric Clinic Visits Number of Any Provider Visits by All Infant/Child Participants	N/A
Adolescent Health Services Number of any Provider Visits by Participants age 17 and under	N/A
Family Planning Number of Participants Receiving Family Planning Services	N/A
Women's Health Number of Participants Receiving Women's Health Services	N/A

b. ENABLING SERVICES

Total Number of Families Served	616
Number of Families in the Prenatal Period Assisted by **Case Management**	N/A

Number of Families in the Interconceptional Period Assisted by **Case Management**	N/A
Number of Families in the Prenatal Period Assisted by **Outreach**	N/A
umber of Families in the Interconceptional Period Assisted by **Outreach**	N/A
Number of Families in the Prenatal Period Receiving **Home Visiting**	N/A
Number of Families in the Interconceptional Period Receiving **Home Visiting**	N/A
Number of Participants Age 17 and Under who participated in **Adolescent Pregnancy Prevention Activities**	N/A
Number of Families who participated in **egnancy/Childbirth Education Activities**	9
Number of Families who participated in **Parenting Skill Building/Education**	106
Number of Participants in **Youth Empowerment/Peer Education/ Self-Esteem/Mentor Programs**	
Number of Families Who Received **Transportation Services** Includes Tokens, Taxis and Vans	50
Number of Families Who Receive **Translation Services**	28

Number of Families Receiving **Child Care Services**	146
Number of Participants Who Received **Breastfeeding Education , Counseling and Suppo**rt	9
Number of Participants Who Received **Nutrition Education and Counseling Services** including WIC Services	106
Number of Participants in **Male Support Services:**	
Number of Participants Referred for **Housing Assistance**	
Total Participants assisted with **Jobs/Jobs Training**	N/A
Total Participants served in **Prison/Jail Initiatives**	N/A

c. POPULATION

Number Of **Immunizations** Provided	N/A
Public Information/Education: Number of Individuals Reached	172

d. INFRASTRUCTURE BUILDING

Consortia Training Number of Individual Members Trained	26
Provider Training Number of Individual Providers Trained	15

OMB 0915-0272 Expiration: January 31, 2006

Project Period Objectives June 1, 2001--May 31, 2005	Strategies and Activities	Accomplishment
1) By May 31, 2005, at least 348 high-risk pregnant and parenting women (155 medically high risk and 193 socially at risk) who were enrolled during the prenatal period will receive case management/carecoordination services according to IPOP policies & procedures.	Strategy:Aggressively outreach to find high-risk pregnant women Activities (with Implementation): Alameda County Public Health Nursing will work with medical providers, community-based organizations to identify and recruit high-risk women. Alameda County public health nurses will provide case management services and CHOWs will provide care coordination services to high-risk pregnant and parenting women.	As of May 31, 2005, 309 high-risk pregnant and parenting women were enrolled during the prenatal period have received case management/care coordianiton services according to IPOP policies and procedures. Completed Completed
2) By May 31, 2005, at least 50 new medically high-risk women and their high-risk infants will be enrolled during the interconceptional period and will receive case management services according to IPOP policies & procedures.	Strategy:Aggressively outreach to find medically high-risk women and their infants during the interconceptional period. Activities (with Implementation): Alameda County Public Health Nursing will work with hospitals medical providers, and other organizations to identify and recruit high risk women and their infants for case management services. Alameda County public health nurses will provide case management services to high-risk women and their infants.	As of May 31, 2005, 155 high-risk women and their high-risk infants were enrolled during the interconceptional period have received case management/care coordianiton services according to IPOP policies and procedures. Completed Completed
3) By May 31, 2005, at least 170 new fathers or male partners with children 0-2 years of age will receive care coordination services.	Strategy:Care Coordination and Outreach Activities (with Implementation): Schedule, publicize services, and conduct outreach. Do street outreach, participate in health fairs, etc. to contact fathers. Provide care coordination services.	As of May 31, 2005, 64 new fathers or male partnets with children aged 0-2 years of age have received care coordinaton services. Completed Completed Completed

Project Period Objectives	Strategies and Activities	Accomplishment
June 1, 2001--May 31, 2005		
4) By May 31, 2005, at least 400 new fathers or male partners with new fathers or male partners with children 0-2 years of age in the target area will be contacted annually.	Strategy: Outreach Activities (with Implementation): Schedule, publicize, and conduct outreach. Work with public health nursing, community organizations, other agencies, and other male programs to recruit fathers or male partners for the program. Do street outreach, participate in health fairs, etc. to contact men who might be interested in the program.	As of May 31, 2005, 911 new fathers or male partners with children aged 0-2 years of age in the taret area have been contacted for the service years. Completed Completed Completed
5) By May 31, 2005, at least 208 new fathers or male partners will participate in health education programs.	Strategy:Targeted Health Education Activities (with Implementation): The Fatherhood Services Coordinator will identify and purchase health education materials related to fatherhood. Assure that staff are trained in providing culturally sensitive health education related to fatherhood. Provide health education services to fathers/ male partners.	As of May 31, 2005, 214 new fathers or male partners have participated in IPOP health education programs. Completed Completed Completed
6) By May 31, 2005, no more than 33% of pregnant women receiving care coordination and case management services will enter care during the third trimester. Baseline: 34.6% (9 of 26) of IPOP clients entered prenatal care in the third trimester during calendar year 2002	Strategy:Aggressive outreach to find pregnant women in third trimester Activities (with Implementation): Public health nurses and CHOWs will work with medical providers, and social service agencies to recruit pregnant women. CHOWs will do street outreach, participate in health fairs, etc., to contact pregnant women.	As of May 31, 2005, no more than 10% (31/309) high-risk pregnant and parenting women will be enrolled in their third trmester of their prenatal period have received case management/care coordinaton services according to IPOP policies and procedures. Completed Completed

Project Period Objectives June 1, 2001--May 31, 2005	Strategies and Activities	Accomplishment
7) By May 31, 2005, at least 50.0% of the women receiving case management/care coordination services will have an ongoing source of primary and preventive services.	Strategy:Case management/care coordination and health education Activities (with Implementation): Public health nurses and CHOWs will support clients in obtaining an ongoing source of primary and prevention services.	As of May 31, 2005, 83% (386/464) high-risk pregnant and parenting women enrolled during the prenatal period have an ongoing source of primary and preventive services. Completed
8) By May 31, 2005, at least 90% of children up to two years of age receiving case management/care coordination services will have a medical home.	Strategy:Care coordination/case management and health education to stress the importance of ongoing access to health care for children up to two years. Activities (with Implementation): Provide health education and outreach efforts to IPOP clients on the importance of well-baby check-ups and care in the health and growth of infants and young children. CHOWs and nurses will support clients in obtaining a medical home.	As of May 31, 2005, 96% (462/481) of the children of pregnant and interconceptional women enrolled in the program receiving case management/care coordination services have a medical home. Completed Completed
9) By May 31, 2005, at least 50% of women receiving case management/care coordination services requiring a prenatal, have a completed referral.	Strategy: Provide need referrals to women receiving care coordination/case management services. Activities (with Implementation): PHNs and CHOWs will identify clients who need referrals and will make needed referrals. CHOWs/PHNs will follow-up to facilitate completion of referrals.	As of May 31, 2005, 92.1% (223/242) high-risk pregnant and parenting women enrolled during the prenatal period have completed referrals. Completed Completed

Project Period Objectives June 1, 2001--May 31, 2005	Strategies and Activities	Accomplishment
10) By May 31, 2005, there will be an increase of at least 3% above baseline of the women in the program who are screened for depression.	Strategy:Conduct Edinburgh perinatal depression screening Activities (with Implementation): Public health nurses and CHOWs will utilize the Edinburg Depression Screening Scale to identify women at risk for depression Clients with positive screens will be referred to the IPOP mental health counselor for further assessment or, if appropriate, to Alameda County's Behavioral Care Services for treatment services. Clients assessed by the IPOP mental health counselor will either be referred to Alameda County Behavioral Health Care Services for treatment services or will be provided short-term therapy.	As of May 31, 2005, 53.8% (250/464) high-risk pregnant and parenting women were screened for perinatal depression. Completed Completed Completed
11) By May 31, 2005, at least 300 preconception, prenatal, postpartum, and/ or interconceptional women will participate in community education services and/or receive information on health and mental health topics.	Strategy:Provide a variety of mental health and health education/support groups: Activities (with Implementation): The IPOP community education team will provide a variety of community education groups: topics may include, but are not limited to: nutrition and weight loss, stress/depression, parenting, smoking cessation, and STDs/STIs. Health/Mental Health groups will be initiated on at least a quarterly basis.	As of May 31, 2005, 1,212 contacts of preconceptional, prenatal, postpartum and/interconceptional women participated in community education services and/or received information on health and mental health topics. Completed Completed
12) By May 31, 2005, a public education and information campaign will be conducted to reach at least 1,500 preconceptional, prenatal, postpartum and/or interconceptional women.	Strategy:Use mass media methofds such as public education and an information campaign to provide information to pregnant and parenting women Activities (with Implementation): Utilize the most appropriate methods to reach a large number of women in the target area (I.e. bus benches, billboards, bus cards, etc.)	As of May 31, 2005, 5,201 preconceptional, prenatal, postpartum and/interconceptional women were reached by a public education and information campaign. Completed