

PROJECT IDENTIFICATION

Project Title: Twin Cities Healthy Start
Project Number: H49 MC 00073
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Project Period: July 1, 2001 – May 31, 2005
Total Amount of Grant Awarded: \$3,700,000

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

Twin Cities Healthy Start's mission is to reduce the disparities in infant morbidity and mortality among the Minneapolis and St. Paul African American and American Indian communities. *These two racial groups and the Twin Cities project area were selected for the following reasons: 1. Minneapolis and St. Paul are characterized by poor health status for women of childbearing age and their infants when compared to their cohort in the State of Minnesota. 2. American Indian and African American women and their infants are at greater risk for poor birth outcomes than White women and their infants living in the TCHS project area.*

American Indian and African American women and infants residing in the TCHS project area are disadvantaged compared to their White counterparts on a variety of health status measures. In general, American Indian and African American women are less likely to receive early or adequate prenatal care, and are more likely to give birth to a low birth weight (LBW) infant and /or premature infant than White women. Infants in these urban American Indian and African American communities are also more likely to die within the first year compared to their White peers. The infant mortality rate for infants born to African American women is over 2 times as high as that of Whites (3-year average ratio of 2.3:1), and American Indian infants have a rate that is 3 1/2 times that of Whites (3-year ratio of 3.4:1).

Data for our project area further demonstrates that American Indian infants are seven times more likely to die in the post neonatal period than White infants. African American infants are three times more likely to die in the post neonatal period. Additionally our needs assessment determined that both American Indian and African American infants are more likely to die in the neonatal period than White infants. The wide post neonatal disparity for American Indians indicated a need to improve the access, availability or acceptance of infant care to American Indian births in the project area as it may differ from that of White births. The higher death rates due to preterm birth and LBW in African American Infants indicates a need to focus on maternal health services. The following tables summarize the trends in disparity ratios for infant mortality and other contributing factors for the TCHS project area.

Trends in Racial Disparities in IMR over Time in Project Area: 1978-2001

| Race | 1978-1982 | 1989-1993 | 1994-1998 | 1999-2001 |
|------------------|------------------|------------------|------------------|------------------|
| White – NH | 9.9 | 7.7 | 6.5 | 5.23 |
| African American | 24.7 | 19.3 | 16.9 | 13.10 |
| American Indian | 18.5 | 17.8 | 23.9 | 11.52 |
| AA:W Ratio | 2.5:1 | 2.5:1 | 2.6:1 | 2.5:1 |
| AI:W Ratio | 1.9:1 | 2.3:1 | 3.7:1 | 2.2:1 |

American Indian: White Disparity Ratios for Key MCH Indicators: 1996 – 1998

| Indicator | TCHS Project Area | | Ratio |
|---|--------------------------|--------------|-------------------------------|
| | American Indian | White | American Indian: White |
| Health Status¹ | | | |
| Infant Mortality | 22.6 | 6.4 | 3.5:1 |
| Neonatal Mortality | 9.3 | 4.4 | 2.1:1 |
| Post neonatal Mortality | 13.4 | 1.9 | 7.1:1 |
| Determinants² | | | |
| VLBW (< 1,500 grams) | 1.4 | 1.2 | 1.2:1 |
| LBW (< 2,500 grams) | 9.2 | 6.4 | 1.4:1 |
| Contributing Factors² | | | |
| Low Prenatal Care | 14.8 | 4.4 | 3.4:1 |
| Births to Teens | 27.8 | 9.1 | 3.1:1 |
| Single Moms | 84.7 | 30.0 | 2.8:1 |

1. Rates per 1,000 live births.

2. Rates per 100 live births

Twin Cities Project Area:

African American: White Disparity Ratios for Key MCH Indicators: 1996 - 1998

| Indicator | TCHS Project Area | | Ratio |
|---|--------------------------|--------------|--------------------------------|
| | African American | White | African American: White |
| Health Status¹ | | | |
| Infant Mortality | 14.4 | 6.4 | 2.3:1 |
| Neonatal Mortality | 8.7 | 4.4 | 2.0:1 |
| Post neonatal Mortality | 5.7 | 1.9 | 3.0:1 |
| Determinants² | | | |
| VLBW (< 1,500 grams) | 2.7 | 1.2 | 2.3:1 |
| LBW (< 2,500 grams) | 11.9 | 6.4 | 1.9:1 |
| Contributing Factors² | | | |
| Low Prenatal Care | 10.5 | 4.4 | 2.4:1 |
| Births to Teens | 24.7 | 9.1 | 2.7:1 |
| Single Moms | 70.7 | 30.0 | 2.4:1 |

1. Rates per 1,000 live births.

2. Rates per 100 live births

II. Project Implementation

Describe approach, intervention and resources, barriers and activities.

The Twin Cities Healthy Start Initiative implemented the following core services in their target communities: Outreach and client recruitment; case management; health education and training; interconceptional care; and depression screening and referral. The Twin Cities Healthy Start consortium in collaboration with the State Title V and other health care agencies also developed a Local Health Systems Action Plan and strategy for sustainability.

Through contract and cooperative agreements TCHS developed five service networks: North Minneapolis African American Network; South Minneapolis African American Network; Minneapolis American Indian Network; St. Paul African American Network and St. Paul American Indian Network. Through these service networks, agencies directly contracted with the City of Minneapolis/TCHS for the responsibility of setting up and managing a Service Network in one of five racial/geographic areas, either as an individual agency or in partnership with another agency. The following is a description of the contracting for each Service Network.

North Minneapolis Healthy Start Service Network – North Point Health and Wellness Center, a Hennepin County community clinic, is the primary contractor for this network. It subcontracted with Fremont Community Health Center (until June 2004). African American families residing in North Minneapolis were the target population.

South Minneapolis Health Start Service Network – Minneapolis Way to Grow was the contractor for this Service network from July 1, 2001 – June 2003. Way to Grow is a city wide school readiness program. This agency provided Healthy Start services to African American families residing in South Minneapolis at its main office in South Minneapolis and a community agency site located in the Powderhorn neighborhood. At the conclusion of the contract in 2003, outreach to this geographic area was provided by TCHS central office staff. African American clients identified in South Minneapolis were referred to the North Point Health and Wellness or Minnesota Visiting Nurses Association which has a non healthy start contract with the City of Minneapolis.

Minneapolis American Indian Healthy Start Network – TCHS contracted with two agencies that worked closely together to provide the Healthy Start Core services to the Minneapolis American Indian community, the Division of Indian Work and the Minnesota Indian Women's Resource Center. DIW has a longstanding reputation of providing social and supportive services through their Teen Indian Parents Program (TIPPS). MIWRC provides outpatient chemical treatment, transitional housing, and other social services to American Indian women. As of June 2003 MIWRC was no longer a contractual partner with TCHS. TCHS however continued to accept and send referrals to MIWRC for services.

St. Paul African American Healthy Start Network – Open Cities Health Center, a St. Paul community health clinic, is the contractor for the St. Paul African American Service Network. It subcontracted with four agencies to provide the Healthy Start core services to St. Paul African American families; the North End Clinic, Face to Face clinic, and Eastside Family and Northwest Midway Family Centers, which are sites of the St. Paul/Ramsey County Children’s Initiative, a citywide school readiness program. This contract was terminated on December 2004. From February 2005 thru June 2005, TCHS contracted with Eastside Family Center to provide Outreach and Health Education Services to currently enrolled families. TCHS also continued to collaborate with Open Cities staff and sponsored prenatal education and breastfeeding support activities at the North End clinic.

St. Paul American Indian Healthy Start Service Network – The American Indian Family Center, a site of the St. Paul/Ramsey County Children’s Initiative, is the contractor for the St. Paul Indian Healthy Start Network. AIFC subcontracted with St. Paul Ramsey Public Health for public health nursing services on site. They also collaborated with the Turtle Women Program a Doula and prenatal education initiative and Healing Journey a mental health program co located in their facility.

Each network was responsible for assuring seamless unduplicated medical, behavioral and social services from multiple service providers to meet each pregnant woman and their infant’s needs.

A. Outreach and Client Recruitment –In year one TCHS had on staff 8.55 (11 people) FTEs responsible for outreach and client recruitment. In addition to their role as client recruiters, TCHS Outreach staff played a major role in providing community health education; group facilitation, peer support and one on one education.

Outreach activities included the following strategies: 1) community education about perinatal care, infant mortality, and Healthy Start, 2) identifying, determining the eligibility of, and enrolling families into TCHS, 3) cultivating relationships with community resources such as medical providers, schools, childcare, transportation, MFIP, etc., and linking clients with these resources and facilitating their access to them, 4) home visiting, and 5) tracking failed or missed appointments to key medical behavioral and social resources. Client recruitment methods used by the Service Networks included contacts with and referrals from other agencies and programs such as WIC, schools, clinics, and hospitals; hosting of community gatherings, baby showers, health fairs or women health forums; participation in community health fairs, family oriented community events, community/cultural celebrations such as pow-wows; and screening and referrals from within Network agencies and programs. Clients were also recruited as they transition out of the justice system or emergency shelters.

In years 3 and 4 the number of Outreach staff employed through TCHS decreased. This was primarily the result of high turnover and level funding for the Healthy Start

project. By project end TCHS had 2.75 FTE Outreach Workers. As the Twin Cities community became more aware of TCHS and the number of enrollees increased, the program began to focus more on case management, depression screening, health education, and interconceptional care.

TCHS elicited the assistance of the African American and American Indian advisory committees with outreach and recruitment. Consumer members of the Consortium were trained to do presentations about the program to community groups, clinics and agencies. Consumers were also hired to staff community events and health fairs. As incentives for participating, TCHS provided cash, gas and/or food vouchers as compensation for their work.

The African American committee had a recruitment activity at least three times per year. Each member had to identify community groups or agencies that they frequented. Members volunteered to take flyers and brochures to these establishments to distribute. Even though the number of staff assigned to perform Outreach activities decreased, this grass roots approach was very effective in identifying high risk women to enroll in the project. It also provided consumers with an opportunity to be actively involved with the implementation of the project.

B. Case Management – Each network staffs a professional case manager with experience in nursing, social or behavioral services. Additional nursing staff funded through the TANF home visiting program also provided case management services to TCHS enrollees. The TCHS case managers functioned as the primary care coordinators for each TCHS client. These individual's responsibilities included: 1) risk assessment, 2) developing a care plan for each enrolled client, and 3) care coordination and advocacy. Each TCHS site had a lead Case Manager and RN nurse who was responsible for doing risk assessments and developing a care plan. Outreach Workers also assume some responsibility for care plan implementation, advocacy, social support, and tracking and follow up.

Each network was responsible for developing a multidisciplinary team. Members of the team included the Case Manager, RN, Outreach Worker and TANF Public Health Nurse from Minnesota Visiting Nursing Association or St. Paul Ramsey Public Health Department. Because of level funding TCHS experienced decreases in the number of Healthy Start Sites between 2001-2005. In the first year TCHS had staff located in 8-10 locations within Minneapolis and St. Paul. The majority of the sites provided outreach however CORWs were also assigned some case management responsibilities. By project end we had phased out seven sites.

In 2001 TCHS had 1.5 RN case managers and 3.3 SW case managers. By 2005 we had 1.45 RN case managers and 5.6 SW case managers. In order to maintain the staffing level of Case Managers the number of Outreach Workers funded through TCHS decreased between 2001 – 2005. The other great benefit during this period was the home visiting services being provided to our populations through TANF funded programs. TCHS was able to use its leverage to negotiate administrative/outreach time from public nursing to co locate staff at Fremont, North

Point, and Division of Indian Work in Minneapolis. The public health nurses assigned to these sites were responsible for participating in care plan development and providing TCHS with status updates on all families referred to Minnesota Visiting Nurse Association for home visiting services. In order to build rapport with the Healthy Start families these nurses also assisted with site health education activities providing one on one and group information on child birth preparation and infant development.

In St. Paul, the St. Paul Ramsey County Public Health department co located a public health nurse at the Healthy Start site at American Indian Family Center. In 2004 this position was threaten to be phased out due to a decrease in State funding for local public health. TCHS consortium members provided testimony to the State Health Commissioner in June 2004 at an Executive Committee meeting held at Open Cities Health Center one of the TCHS contract sites. This public forum resulted in SPRCPH reconsidering their plans and finding funding to secure the position through 2005.

B. Health Education and Training – TCHS conducted three Health Education strategies: 1) the use of Case Managers and Outreach Workers to provide one on one education to project participants, 2) the staffing of a Health Educator at our Central Healthy Start office who was responsible for working with sites on creating a culturally specific curricula and training staff and or community persons to provide group education, and 3) training for TCHS contract staff and community providers on selected perinatal topics.

In most Service Networks, health education is provided by the CORW... The TCHS one to one health education strategy utilizes "pregnancy diaries," which are books that are provided to each pregnant Client and are used as an aid to educate women about how to have a healthy pregnancy. To facilitate active learning with the Health Educator, the books' topics progress through each stage of the pregnancy, and include places for written fill-in. There are two pregnancy diaries, one for African American families and one for American Indian families. The diary for the African American Families, "Guidance for the Journey" was developed by Face to Face, a TCHS partner. The American Indian diary was edited and organized by members of the American Indian Advisory Committee of the consortium. A consultant and the TCHS Health Educator developed reference materials that were used by TCHS staff as background information for assisting parents with interpreting material included in the diaries. Topics covered in the diaries included: Prenatal Care, Body Changes, Substance Abuse, Nutrition, Sex During Pregnancy, including HIV and STI prevention, Labor and Delivery, Breastfeeding and Baby Care.

On September 20, 2001, TCHS received a two year award from the Office of Minority Health, department of Health and Human Services. TCHS used these dollars to implement the Health Education Plus program. The purpose of the grant was to enhance the health education services already being provided through TCHS. The result of this activity was the development of a quality, culturally specific health

education program that included prenatal care/birthing, infant development/parenting education for African American and American Indian Women. An American Indian public health nurse was hired as a Health Educator to implement this program. Stephanie Graves, PHN had previous experience as a prenatal nurse and program coordinator for a chemical dependency program for American Indian pregnant women. Rather than to reinvent the wheel, our program strategy was to review and collect existing curriculum for prenatal/childbirth and parenting/infant development and adapt to meet the needs of African American and American Indian women. Through this project course outlines for African American and American Indian prenatal/childbirth education classes were developed using materials from the March of Dimes and International Childbirth Education (ICEA) curricula. American Indian and African American parenting/infant development education classes were developed using Sacred Gifts, Effective Black Parenting and Positive Indian parenting curricula. In addition to the Health Educator, 11 African American and American Indian women were recruited and trained to facilitate the classes.

TCHS programs were also supplemented by State funding from the Office of Minority and Multicultural Health. Two of our sites, Division of Indian Work and American Indian Family Services received money to train and support women from the community to be Doulas to pregnant women who wanted them. These Doulas supplemented the work being performed by Healthy Start staff by providing childbirth education to moms, labor support during delivery, postpartum follow up as well as breast feeding education. TCHS occasionally paid for Doulas to work with some of our African American women. In addition we contracted with Doulas to facilitate childbirth education classes at North point and Northend; and to facilitate breastfeeding support groups at North point, Northend, Division of Indian Work and Open Cities Health Center.

Through this grant initiative we were able to implement group prenatal and parenting education classes at all sites. When the funding ended in September 2003, TCHS sites assumed responsibility for maintaining group education at their sites. All TCHS sites continued to offer at least twice per year through 2005. The Health Educator continued to assist as needed at the sites and facilitated a prenatal education class at Division of Indian Work and Baby's Space a non TCHS contract site which provides child development services in Minneapolis.

TCHS sought additional funding to provide health education around specific areas. A recommendation from our community consortium was that more supportive services were needed for mothers with alcohol problems and who had children diagnosed with fetal alcohol spectrum disorder (FASD). In spring of 2001 TCHS was able to get Dr. Ira Chasnoff from the Children's Research Triangle to talk to us about screening for substance abuse in pregnant women. We also received funding from the Walker Foundation and Minnesota Department of Health to train staff on effective screening and motivational interviewing. In addition a Support Sisters group was developed and implemented for both the African American and American Indian populations. Chemical Dependency counselors were hired as consultants and facilitated these

groups two times per week beginning in June of 2004. This initiative is funded through December 2005. Plans are currently underway to identify ways that we can continue to provide support group activities in the American Indian community as this group was well attended and effective in modifying drinking behavior.

What we have learned is that health education material for population of color should be multifaceted. The curricula and supporting materials should address language, visuals, and cultural factors that are unique to each ethnic group. Currently these types of products are practically non-existent. In addition information and dialogue about cultural behaviors or health remedies that are counterproductive to the women's or child health must be approached in a manner that is sensitive, respectful and educational; not accusatory, shaming and blaming. What we also learned is that there is a need for more persons of color to be trained to provide health education services to our target population of African American and American Indian women in Minneapolis and St. Paul. In April 2005 TCHS sponsored a two day basic teach training for Childbirth education. The trainers were from the International Childbirth Education Association. Of the 39 persons who completed the training 10(26%) were persons of color.

Group Health Education Received During Pregnancy (717 women)

| Topic | # receiving | Percent |
|-----------------------------|-------------|---------|
| Prenatal/Childbirth | 253 | 35 |
| Parenting/Child development | 54 | 8 |
| Parenting Support groups | 75 | 10 |
| Smoking Cessation | 21 | 3 |
| Nutrition | 55 | 8 |
| Other | 117 | 16 |

The TCHS Program Coordinator developed an annual orientation and training program for all staff. The majority of the training focused on preparing the paraprofessional staff employed through TCHS. Because of the varying skill levels and experience of the CORW Staff information was provided on topics such as medical terminology, prenatal care, SIDs, as well as setting boundaries, interviewing skills and home visiting. Several of our contracting agencies also provided training and invited staff from partnering TCHS agencies to participate. Many of the TCHS CORW staff received certificates of completion for parent education, car seat safety training and Doula training.

A program goal identified in our Local Health Systems Action plan is to Increase the number of African American and American Indian health care workers serving TCHS populations. In September 2003 the State Title V coordinator arranged a meeting with TCHS, representatives from Minnesota State Colleges and Universities (MNSCU), and the Blue Cross Foundation. TCHS staff was invited to participate on a workgroup which developed a Community Health Worker curriculum. This workgroup received financial funding from Robert Wood Johnson and the Blue Cross Foundation and in 2005 piloted a Community Health Worker certification program at

several junior colleges located throughout the state of Minnesota. TCHS provided financial assistance to two TCHS Outreach Workers and 3 Consortium members to complete this program in the Spring of 2005. The TCHS Project Director is the Co chair of the Policy committee overseeing the implementation of the project. In addition the TCHS Program Coordinator serves as a consultant to the grant and is very instrumental in curriculum development, as well as student and faculty recruitment.

This group has been very effective in bringing third party payors to the table and has developed a business case which justifies the financial benefit (e.g. savings in ER costs) of using CHWs in health care delivery. It is our hope that this collaboration will result in reimbursement for the services being provided by the Outreach Workers hired through TCHS.

Community Provider Training. TCHS planned at least one community wide training annually. With the assistance of our Project Director Janice Berger, the project was able to get technical assistance from HRSA to bring in some nationally renowned speakers and agencies to provide training to TCHS contract staff. TCHS used these opportunities to collaborate with local experts and agencies. All of TCHS trainings were open to the public. The table below outlines the various large provider trainings we sponsored from 2001 – 2005.

| Date | Topic | Presenter | # of attendees |
|-------------|---|------------------------------------|-----------------------|
| August 2001 | Cultural Perspectives on Breastfeeding Promotion | Healthy Children 2000 Project | 101 |
| June 2002 | Cultural Health Practices and Spiritual Healing | DIW | 30 |
| Jan 2003 | FASD & Tobacco | Dr. Lydia Caros Jennifer Irving | 48 |
| July 2004 | Improving your Agencies Response to Family Violence | EndAbuse Rebecca Whiteman | 43 |
| April 2005 | ICEA Childbirth Educator | ICEA | 36 |
| May 2005 | Promoting Maternal Mental Health in Pregnancy | NCAST-U of Washington | 28 |

C. Interconceptional Care – TCHS did not receive special funding from HRSA to develop an interconceptional care program. Our project enrolled women during their pregnancy. Our strategies included the following services:

- Notification by Mom to Case Manager that they have delivered
- Hospital visit by Case Manager or Outreach Worker before discharge. Some sites (Open Cities and North Point) developed a gift basket which they provided to parents.
- Home visit within two weeks of discharge

- Postcard and telephone reminder for an office appointment within six weeks of discharge, with follow-up if this appointment is not made
- Contraceptive education and information on family spacing; documentation of contraceptive use at various intervals post partum
- Breast feeding education and distribution of breastfeeding kits to moms who elect to breast feed
- SIDs education and referral to family support services as needed
- Offer parenting groups
- Postpartum depression screening and referrals for positive screens
- Risk assessment for a change in health status and to identify and needs for infant
- Monitoring behavioral change related to alcohol, tobacco or illicit drug use

Infants who remained enrolled in TCHS until they were two years of age received the following services:

- Assessment of the medical status of the infant, including for special needs
- Monitoring infant growth and development
- Scheduling or following-up with well-child checks and immunizations
- Family safety and injury prevention
- Accessing other needed appointments according to the family's care plan
- Infant massage

Two important community resources for the TCHS families with infants are Minneapolis Way to Grow and Early Childhood Family Education. Minneapolis Way to Grow is a neighborhood based school readiness program. Early Childhood Family Education is an infant development and school readiness program funded by public school systems. A TCHS contractor, American Indian Family Center, is an Early Childhood Family Education site.

E. Depression Screening and Referral – TCHS perinatal depression screening is conducted by its service network subcontractors, and is the responsibility of the subcontractors under the guidance of their case managers. The service networks used a variety of perinatal depression tools and protocols. In Spring 2003 TCHS provided training to all staff on the use of the Edinburgh depression scale. LaVonne Moore, RN, CNM also developed a resource guide specifically for TCHS staff to use when counseling women identified with signs of depression. Each site was responsible for developing protocols on how to handle TCHS participants positive for depression. Fortunately all four of the Healthy Start Networks had mental health resources available for participants either on site or through contractual arrangements. Depression screenings were conducted during intake, during office appointments, or during home visits by case managers, social workers or PHNs.

TCHS recommended that the subcontractors screen for depression any time during pregnancy and required a postpartum screen no later than eight weeks following delivery. Following is a list of the various screening tools used by contract sites:

- North Point Health and Wellness: PHQ9 and the Edinburgh Postnatal Depression Scale for postpartum clients.

- Fremont Community Health Services: BECK Depression Inventory for all clients
- Division of Indian Work: Edinburgh Postnatal Depression Scale
- Open Cities Health Center: PHQ9
- American Indian Family Center: Edinburgh Postnatal Depression Scale

Clients also received health education about perinatal depression one to one through service network staff, such as case managers, outreach workers and doulas. The project provided staff with a tip sheet on depression to use during this health education. It also distributes an “Understanding Postpartum Depression” tear sheet for its clients. At Open Cities Health Center, depression is discussed at intake, and there is discussion about the screening if it is administered, and possible helping resources. At American Indian Family Center, education about depression is conducted during home visits, childbirth education classes, Mothers’ Circle groups, and Early Childhood Family Education. In 2004 North Point TCHS staff worked with the mental health clinic located on their site to develop a fast track program for TCHS referrals. They also implemented a Moms support group for clients with depression and other mood disorders.

Women who have a positive screen were referred to a service network mental health service or a psychologist. It is the responsibility of case managers and the referring staff to follow-up with all mental health referrals. Tracking is done through client files, charts, the TCHS database, and updates with the client’s therapists.

F. Local Health Systems Action Plan - The TCHS LHSAP for 2001-2005 was developed in spring of 2001 and approved at a joint meeting of the African American and American Indian Advisory Committees. It was reviewed and revised by the Executive Committee of the Consortium in Fall 2001, December 2002 and 2003. The LHSAP has three goals:

1. Improve provider and health plan awareness of TCHS services for at risk pregnant women and infants.
2. Increase the number of African American and American Indian health care workers serving TCHS populations.
3. Address perinatal substance use/abuse (ATOD) and mental health (MH) issues.

The Healthy Start Collaborative, a subcommittee of the Consortium has overall responsibility for implementing the LHSAP. This group developed an annual work plan with specific activities for the Collaborative, TCHS staff and contractors and the African American and American Indian advisory committees. Some of the activities that were initiated through this Collaborative were as follows:

1. Improved Communications – Local Public Health for both Ramsey and Hennepin Counties, MCH programs administered through the State Department of Health, TANF and Medicaid provided periodic updates to the TCHS consortium regarding legislative changes or new programs effecting women and children.
2. TCHS consortium members were invited to participate in the State Title V five year planning process

3. The Council of Health Plans developed a two page explanation of health plan services (PMAP) available to TCHS women and children enrolled in their health plans
4. The Maternal Case Management Excellence Project was developed. This project conducted three pilot projects aimed at refining the case management model being implemented through TCHS. Some of the areas evaluated were depression screening, multidisciplinary care teams, and psychosocial risk assessments. MDHFS secured funding in 2004/5 from Medica Foundation to study and enhance the TCHS case management program being implemented at North Point Health and Wellness Center.
5. Created a Perinatal Provider Network group which meets two times a year. The purpose of the group was to bring together case managers from TCHS sites with persons from WIC, Child and teen Check up, school readiness programs, health plans and community clinics to talk about services at their sites and to promote service integration.
6. Hosted two Health career fairs and periodically invited health professionals of color to present to TCHS parents about career options in the health care industry.
7. Partnered with Minnesota Colleges and Universities (MNSCU) to develop and implement a community health worker certification program in Minnesota.
8. Access to resources from the State Department of Health (MDH) for staff training.

The biggest barriers in implementing the LHSAP were the state budget deficits in 2003/2004. The deficits resulted in cuts to health and social service programs for low-income families and in severe cuts for local public health and local government aid.

G. Coordination with State Title V and other Agencies – Minnesota’s Title V MCH agency is within the Minnesota Department of Health (MDH), in the Division of Family Health, which includes three sections: Maternal and Child Health, Minnesota Children with Special Health Care Needs (MCSHCN), and Women, Infants, and Children Nutrition Program (WIC). The division is responsible for the administration of programs carried out by allotments under Title V. The division director is the State’s Title V Director. Within the Maternal and Child Health Section is the State’s Infant Mortality Consultant, who has been designated to provide technical assistance and act as liaison between Twin Cities Health Start and the Title V agency.

The State’s Title V Infant Mortality Consultant has continued active involvement with TCHS throughout 2005. She is an ex officio member of the Executive Committee of the Consortium, participates in Consortium activities, and co-chairs the Healthy Start Collaborative. She attended the annual grantees meeting in Washington, DC in 2002 and 2003. She has instrumental in getting state WIC staff and the state’s Family Home Visiting program involved with the collaborative in an effort to facilitate communication and improve system coordination and support for TCHS. The following is a summary of some of the key activities that have resulted from MDH/TCHS collaboration.

Infant Sleep Safety Education Project. In 2002, the MDH provided portable cribs and sheets to TCHS along with Infant Sleep Safety Education folders that address such issues as crib safety, Back to Sleep, soft bedding, and the hazards of bed sharing. Although the MDH no longer provides portable cribs to Minnesota families due to state budget cuts in 2003, TCHS identified a need for cribs and continues to provide them to their families HRSA dollars and other funding. MDH continues to provide the Infant Sleep Safety Education folders, which are produced in collaboration with the Director of the Minnesota Sudden Infant Death Center, Kathleen Fernbach.

Smoking Cessation for Women of Childbearing Age. The infant mortality consultant continues to make available to TCHS best practice materials and tools for smoking cessation during pregnancy. These include the “Let’s Not Smoke!” video from the American Legacy Foundation’s Great Start Program, “You Can Quit Smoking” tear sheets from the Agency for Healthcare Research and Quality, a fact sheet on Tobacco and Pregnancy and a tool for using the 5 A’s-Ask, Advise, Assess, Assist, Arrange-as recommended by the American College of Obstetrics and Gynecologists (ACOG).

Maternal and Child Health 5 Year Needs Assessment. MDH’s Maternal and Child Health Section began its 5-Year Needs Assessment process in December 2003. Several TCHS contractors and parents participated in a stake holders’ retreat in 2004 which identified the MCH priorities for the State.

Save 10 Committee. In 2002, the CDC reported on Infant Mortality Rates in the 60 largest cities for the years 1995-1998. St. Paul was 4th highest for African American infants among these 60 cities. The local media reported this and St. Paul’s Mayor Randy Kelly publicly expressed his concern and willingness to address the issue in partnership with the African American community.

Gloria Lewis, Director of the Office of Minority and Multicultural Health at the MDH, brought together a multi-agency group which has become known as the Save Ten Committee. TCHS, MDH, Minneapolis Department of Health and Family Support (MDHFS), St. Paul/Ramsey County Department of Public Health, the Minnesota Department of Human Services are represented on this committee. The “Save Ten” name came from the MDH Center for Health Statistics staff who determined that if each population could just save ten babies each year, they could eliminate the disparities in infant mortality experienced by each population. The group has held two planning conferences: one in February 2003, and the other in January 2004. In April 2005 TCHS cosponsored a media campaign to raise awareness in the African American communities about infant mortality.

TCHS presents annually to the Healthy Start Collaborative, the Minnesota Department of Health, Department of Human Services, and Minneapolis City Council about the number of people served and key accomplishments.

H. Consortium –TCHS consortium was established in 1999 under the first Eliminating Racial/Ethnic Disparities in Perinatal Health grant in which we received from HRSA. TCHS bylaws were developed and approved by the Consortium in August 2000. Currently there are 104 members on our Consortium. The Consortium has the following committees:

- Executive committee – responsible for monitoring the implementation of the program and providing TCHS staff and the City of Minneapolis with input on staffing, contracts, collaboration and sustainability. There are two Co Chairs that are elected for two year terms to preside over this committee. Requirements are that the two chairs are also representative of both target populations served, African American and American Indian. Persons should also not be employed by agency that receives funding from TCHS. The Executive committee met monthly. The Co Chairs of the Executive committee also preside over the full Consortium when convened.
- African American and American Indian Advisory committees – responsible for assuring that TCHS services of Outreach, Case Management, Health Education, Depression and Interconceptional meet the needs of the African American and American Indian families in Minneapolis and St. Paul. Provide input on program development, assist with community awareness and identifying ways in which our program can be culturally appropriate for the populations we serve. Each committee has two Co Chairs, one agency person and a TCHS parent. Each committee has to develop an annual work plan which includes planning one full Consortium meeting. These committees met bi monthly.
- Data and Evaluation Committee- This committee worked closely with the Project Evaluation team to assist in promoting, among consortium members, data collection, dissemination and review of TCHS success/short comings in achieving program outcomes. Membership includes researchers, epidemiologist and program evaluators from hospitals, University of Minnesota, local public health, and March of Dimes. TCHS parents were also members of this committee. A parent served as convener of this group. This committee met quarterly
- Collaborative – This committee was TCHS primary link to state Title V and Title XIX management. The committee membership included representatives from Title V, WIC, TANF-home visiting, local public health, health plans and Title XIX, TCHS contract agencies as well as community members. This group developed and implemented the Local Health System’s Action Plan and was an expert source on project matters of federal and state policy and program. This committee was Co Chaired by the TCHS Project Director and MDH Infant Mortality Consultant (TCHS Title V liaison)

For the project period 2001 – 2005 TCHS goal was to have 51% of the Consortium members be consumers. TCHS was able to maintain the same level of consumers (42%) on the committee through May 2005. The breakdown of the membership composition of the Consortium is as follows:

| Representation | Percentage |
|-----------------------|-------------------|
| Program Participants | 42% |
| Community Members | 23% |

| | |
|-----------------------------------|-----|
| Providers | 18% |
| State/local Governmental agencies | 16% |

The current racial ethnic representation is:

| Racial/Ethnic Population | Percentage |
|-----------------------------------|-------------------|
| African American | 39% |
| American Indian or Alaskan Native | 40% |
| White | 19% |
| Other | 2% |

There was an ongoing campaign to recruit members for the Consortium. Some agencies such as the March of Dimes and the Minnesota Sudden Infant Death Center became members of our consortium because of our shared interest in preventing infant mortality. There were also designated slots on our Executive committee for local public health, and contract agencies. TCHS also had designated slots for community partners such as Way to Grow a school readiness program who was a former contractor. The Executive committee of the Consortium voted to retain the agency on the committee because of the work that they do with African American and American Indian infants and their families. As consumers became more familiar with the Consortium they also invited other agencies that they utilize for services to join our Consortium. Southside Family Clinic which has a Men’s health program and Father’s group, and Minnesota Organization on Fetal Alcohol Syndrome (MOFAS) are examples of agencies that have joined our Consortium as a result of consumer invitation.

TCHS consumer representatives have membership on all Consortium committees. All TCHS consumers are asked if they are interested in participating in the Consortium upon their enrollment in the project. The outreach worker or case manager enrolling the client provides the client with an overview of the Consortium, why it is important to participate, and presents the client with a one-page application form. To become a member, the client must show an interest by submitting the application form.

Since its inception, TCHS has enabled consumer participation on its Consortium by providing supportive services that allow consumers to attend Consortium meetings and events, such as child care, transportation, and meals at meetings. The project also provides food vouchers, redeemable at local grocery stores, as an incentive for participants.

Description of the communities and challenges – TCHS had to deal with two very different and very vocal communities. The challenge within Healthy Start has been to develop a trusting relationship between these communities and the City of Minneapolis Health Department (MDHFS) and St. Paul Ramsey County Public Health (SPRCPH). This was very difficult because of the bureaucratic structure in which TCHS has to operate. For example, there were some individuals and smaller community agencies that competed for contracts with TCHS that were not accepted because of their capacity and governance. The City of Minneapolis has stringent contract requirements that even some

of our larger agencies could not adhere. Because of the limited selection of minority own agencies in Minneapolis and St. Paul as well as the small number of African American and American Indian health care professionals, finding culturally diverse staff was an ongoing challenge. This often frustrated community members because they did not feel that some of the agencies we contracted with had the community's best interest as a priority.

Another challenge has been membership turnover. One reason for this is the Project's success stories: program participants who were members, but left the consortium after expiring their eligibility of two-year postpartum, or gaining economic and social self sufficiency, such as finding permanent employment or going back to school, limiting the time they can contribute to TCHS activities. Housing instability and mobility, such as homelessness, leaving to return to a rural reservation home, and instability because of drug and alcohol addictions, are other reasons for unsteady participation in the Consortium.

Because the communities of the target populations we served were small it was easy for us to identify community leaders to act as ambassadors for our program. TCHS staff also had a good relationship with the Office of Minority and Multicultural Health at the State. This connection allowed us to partner with agencies who were recipients of the Eliminating Health Disparities grants. These partnerships further enhanced the visibility and credibility of our program.

Creating the Consortium Planning committee really increased consumer participation in the decision making process. Giving the committees a tangible project to plan and work on put the parents at ease and gave them a sense of accomplishment. Working with the parents in small groups created an atmosphere where parents felt comfortable asking questions about program operations and program goals. TCHS staff also used these opportunities to teach parents how to plan an agenda and conduct a meeting. This group was responsible for planning the community forums hosted by the full Consortium. From September 2004 – April 2005, this group met monthly to plan and organize the 2005 Annual Awards banquet. Parents had responsibility for managing the budget, selecting the topics, selecting and contacting a speaker, securing a meeting place, planning the meal and selecting a cater, sending out the meeting announcements and making follow up reminder calls to Consortium members.

Some key activities that were planned were:

Key recent accomplishments of the African American and American Indian committees have been:

- Planned and implemented a July, 2003 Cultural Diversity retreat.
- Developed Advisory Committee Job Descriptions for both committees.
- Reviewed and revised the TCHS orientation manual.
- Conducted a series of informational sessions on health careers.
- Held a series of discussions on Fathers' involvement in TCHS. Both groups are trying to create more opportunities for Fathers to be involved in the Consortium.

- 2005 Annual Awards banquet held at the Midway Sheraton Hotel

In addition to the above TCHS Consortium developments, recent accomplishments of our Consortium and participants include:

- Developed skills in leading meetings with the assistance of the TCHS staff. As mentioned above, the Full Consortium and Executive Committee co-chairs, Ms. Marilyn Jones and Ms. Theresa Fountain, are community members.
- Leading the African American and American Indian Advisory Committees, and the Data and Evaluation Committee. Ms. Ludella Casey (a former consumer) and Ms. Cleora Brown co-chair the African American Advisory committee, Ms. Autumn Swanson, a program participant, co-chairs the American Indian Advisory Committee (other co-chair is currently vacant). Ms. Doris Lane, a community member, chairs the Data and Evaluation Committee.
- Provided ideas for the content of grant proposals. Ms. Dawn LaRoque, a program participant, provided the peer support intervention idea for the Support Sisters project.
- Reviewed Project budgets and expenditures at committee meetings.
- Interviewed candidates for Project positions.
- Review Project media, such as the TCHS brochure. This year, the Consortium helped the Central staff design a new brochure.
- Coordinated a culturally specific health education/career fair, held at the Minneapolis Urban League in October, 2004.
- Continued the Consortium Planning Committee.
- Distributed voter registration cards at Consortium and committee meetings during October, 2004.
- Coordinated a Project meeting with the Minnesota Department of Health Commissioner, hosted by the Project contractor Open Cities Health Center, held in June, 2004.
- Coordinated a Project program participant initiative to recruit new members to the African American and American Indian Advisory Committees in 2004.
- Attended the regional Healthy Start Association meeting in Chicago, May 2004.
- Attended the National Healthy Start Association meeting in Washington, March 2005.

The Executive Committee also experienced an expansion of participant leadership, and now has majority representation of nine consumer representatives compared to five agency representatives on the committee.

The key activities completed by the Data and Evaluation Committee have been:

- Assisted staff with the development of a contract management tool looking examining key outcomes.
- Assisted staff with the development of a patient satisfaction survey.

Consumer participation in the National Healthy Start activities was new experiences for our moms. None of them had ever been on an airplane before. While some had traveled to Chicago, none of our parents had ever traveled to Washington DC. The TCHS parents were anxious to attend the National Healthy Start Association Meetings in Washington and present their stories to our Congressional delegation in Washington, D.C. Our parents were always well received. Their first hand testimony brings reality to the work being done through Healthy Start. Last year the Consortium Co Chair and consumer Chairs of the African American and American Indian advisory committees attended a regional meeting in Chicago. This event allowed our parents to network with other healthy start consumer leaders in our region. Sharing their personal experiences and learning more about Healthy Start motivated these moms to come back to the Twin Cities and use some of the ideas and resources they learned about at the meeting with our local TCHS Consortium. These trips have also motivated other parent to get involved with the hope that they will have the opportunity to represent TCHS.

J. Sustainability - The Consortium delegates all decision making to the Executive Committee to work with MDHFS in developing a sustainability plan for TCHS. The Executive Committee reviews and approves any funding announcements presented as possible funding sources for TCHS. Community members and community agency staff from the Consortium work with TCHS to develop program ideas for proposals being developed for the project. The Minneapolis Department of Health and Family Support has had mixed results in securing grants to augment and amplify TCHS' work. Over the life of the Project we have received the following grant support:

- Archie D. & Bertha H. Walker Foundation: For Fetal Alcohol Syndrome staff training and consumer education --funded for \$5,000.
- Boston Scientific Foundation, Inc.: For health education activities -- funded for \$2,500.
- Minnesota Department of Health, Maternal Alcohol Use and Prenatal Alcohol Exposure Prevention/Intervention Initiative: For staff training in Motivational Interviewing and the development of a peer support system -- funded for \$68,618 for two years.
- Medica Foundation (an organization of one of Minnesota's major health plans, Medica) to fund the Maternity Case Management Excellence project – funded for \$104,000 for one year.
- MDHFS has been granted a CDC Prevention Specialist assigned to work with the Maternity Case Management Excellence project, working with TCHS, other MDHFS staff, and project partners. The term of the assignment is September 2004 through August 2006.

In 2003 the Executive had a series of discussions about the future direction and sustainability of TCHS. Using information from the National Evaluation presentation at the annual Healthy Start meeting in Washington D.C. the Consortium Chair and Project Director challenged the committee to identify, the strengths, weaknesses and gaps in our current program. The second part of the exercise was to determine the role of the City of

Minneapolis in supporting the Consortium and providing sustainability for the Healthy Start project in the Twin Cities. The recommendations were as follows:

- Provide a venue for the community to advocate for reducing infant mortality.
- Continue to develop grant applications for core Healthy Start funding.
- Provide technical assistance on data collection, evaluation, and other support for community based agencies.
- Provide leadership development for participants and staff.
- Seek resources and improve coordination of services in the areas of domestic violence, substance abuse, mental health, and interconceptional care.

Because TCHS is a program of the City of Minneapolis, it does not qualify for grant funds provided through most private grant makers, nor is it able to fundraise from individual donors. In 2003 the Executive Committee requested a letter from the MDHFS endorsing the idea of the Consortium looking at alternative organizational structures for Healthy Start. The letter was accepted at the August, 2003 Executive Committee meeting. Informal dialog regarding establishing TCHS as a 501(c) 3 or subcontracting the entire operations of the project to a local non profit agency were discussed over the next six months. In 2004 the Project Director sought input from her Project Officer regarding the process to transfer the TCHS project to a non profit entity. Upon input from HRSA, Division of Perinatal Systems and Women's Health, decisions regarding reorganization were delayed. In addition the economic downturn and the struggles facing some of the non profits who were members of the Consortium slowed the momentum of the Consortium to aggressively move ahead. The Executive committee agreed that any reorganization of TCHS will be contingent upon the project being funded beyond 2005.

The major strategy for TCHS sustainability is for more service network perinatal health services to become eligible for third-party reimbursement. Some key activities were:

- Health Education Plus, TCHS' health education project funded by the U.S. Office of Minority Health, was instrumental in two TCHS service network agencies – Division of Indian Work and American Indian Family Center -- becoming credentialed and eligible to receive third-party reimbursement from UCare, a local managed care organization, for their culturally specific childbirth preparation classes. TCHS is currently working with Pilot City Health Center to have their childbirth education classes credentialed for third-party reimbursement. TCHS' goal is for all the local major health plans to credential its childbirth education classes.
- The community health worker certification program under which Twin Cities Healthy Start Outreach Workers would earn certification as community health workers, enabling more of their services to become eligible for third-party reimbursement, especially managed care plans, allowing more cash flow from third-party payers into Twin Cities Healthy Start agencies.

- Assisting TCHS outreach workers and other service network staff to become certified child birth educators, enabling their service to be eligible for third-party reimbursement.
- Continuing the Twin Cities Healthy Start Collaborative, which maintains a relationship between TCHS, State Title V, State Title XIX agencies, and local managed care organizations, through which these entities will continue to discuss reimbursement for and systems barriers affecting TCHS and community perinatal activities?
- An objective of the Maternal Case Management Excellence project is to address systemic third-party reimbursement barriers affecting perinatal health services. Successfully addressing these barriers through the project could lead to sustainable third-party reimbursement for the TCHS service networks.

The Healthy Start Collaborative, which is comprised of representatives of local and state public health agencies, the State Medicaid agency, health plan representatives and TCHS lead agencies and consumers is one of the structures within TCHS where work on system level change is focused. In addition to the Collaborative, TCHS staff under the leadership of the TCHS Executive Committee worked with Project contracted agencies to improve the uniformity of their practices and to secure available third-party reimbursement.

In September 2004, MDHFS received a grant from the Medica Foundation. This grant supports the Maternity Case Management Excellence project, which documents levels of social risk and appropriate corresponding levels of intervention to address that risk. One goal of the initiative is to use the information to seek reimbursement changes to expand payment for social risk case management.

TCHS and MDHFS are working with a community clinic, North Point Health and Wellness Center, that contract with TCHS to provide outreach, case management and health education to evaluate untapped funding opportunities and develop internal system changes to take advantage of those opportunities. The primary funding opportunity is to bill for services already being performed. Currently none of the TCHS sites are seeking Medicaid reimbursements for any services performed. Based on the Case Managers' current credentials, one Case Manager could already be billing for care coordination, and we are determining how the other could bill for care coordination. In addition to billing for care coordination, we are looking for all staff to receive a specific certification to receive reimbursement for one-on-one and group education. Other opportunities we plan to explore include postpartum visit reimbursement and reimbursement for child welfare work when case management is addressing child protection issues. Lessons from this community clinic will be expanded to other contract agencies and community based providers.

Through our Medica Foundation grant, we have been able to work with one TCHS community clinic to address standardization of screening, assessment, case management,

and accessing third-party reimbursement for support services for TCHS program participants. This experience has convinced us that there is significant potential for improving financial support of many of the services that TCHS program participants need. With continued funding, we plan to reassign staff to work intensively with contracted community agencies to apply what has been learned through the Medica Foundation grant and Maternity Case Management Excellence project to all TCHS contracted agencies. Our experience demonstrates that this will require intensive and ongoing intervention with the agencies, but if successful will provide sustainable long-term support for the services needed by Healthy Start participants. These changes will have an impact beyond the TCHS program and should require minimal maintenance.

Standardizing the educational preparation of Community Health Workers, who are responsible for TCHS outreach, is a step toward securing third-party reimbursement for their services. Doris Williams, Program Coordinator for TCHS and several TCHS contract staff participated in a Robert Wood Johnson funded initiative evaluating the work currently being performed by paraprofessionals (Community Health Workers) in the State of Minnesota. These persons were a part of a workgroup which developed a curriculum for a training and certification program that was piloted at two Minnesota community colleges this past Spring. TCHS project staff has been working with Minnesota Colleges and University Staff (MNSCU), health plans, hospitals and other health care agencies to develop a business case for the use of Community Health Workers in systems navigations, perinatal health education and chronic disease management. Some smaller successes to date have been the acceptance and recognition of work being performed by Doulas. Currently three health plans in the Metro area will provide reimbursement for one on one health education that is provided by a DONA certified Doulas.

The Healthy Start Collaborative is a group that promotes conversations among funders, regulators, consumers, and providers that lead to identification of system level issues that impact the care and services available to TCHS participants. Past activities include health plan representatives working to streamline their authorization and referral process for home visiting and health promotion counseling, as well as the development of a quick reference guide to perinatal services and incentives offered by all the major public health plans.

III. Project Management and Governance – The Minneapolis Department of Health and Family Support (MDHFS) is the applicant agency for TCHS. It has served as TCHS’ administrative, management and sponsoring entity since the Project began in 1999. TCHS is a high Department priority, meeting the Department’s strategic directions of eliminating health disparities and improving community health. These strategic directions call for the MDHFS to work with community partners to support and develop programs and policies that address public health and social conditions of Minneapolis residents. TCHS has been the Department’s largest project funded by a discretionary grant, with a budget for the first two-year first project period (1999-2001) of \$2 million, and for the second four-year project period (2001-2005) of \$3.7 million.

The MDHFS is a local public health department of the City of Minneapolis, and a charter department of the City. Through the Minnesota Department of Health, the Department is the Title V contractor and agency for the City of Minneapolis. In a reorganization of the Department in 1996, the focus of the Department's activities shifted from direct services to core functions of public health model, in which Department activities are provided in the areas of research and evaluation, policy and assurance. An impact of these changes is that the MDHFS now delivers the majority of its MCH services through contracts with community-based agencies and Hennepin County.

The City uses an automated grant accounting system for the accounting of individuals grants, including TCHS. The City's software is the American Management System, a local government version of this package. This system has the capacity to perform detailed financial reports of TCHS. TCHS funds were incorporated into the system upon execution of the Health Start contract between the City and the Health Resources Services Administration. The City is audited annually by the State of Minnesota.

TCHS services are decentralized. As mentioned previously, TCHS contracts with community base agencies to provide the core services of Outreach, Case Management, Health Education, Interconceptional Care and Depression screening. TCHS uses the City of Minneapolis Request for Proposal process for identifying potential vendors. TCHS staff, City of Minneapolis staff and Consortium members review and rank all proposals received and make recommendations for contracts. MDHFS communicates with finalist and do an Administrative review. All contracts over \$50,000 must be approved by the City Council of Minneapolis before being executed.

Contract budgets, scope of services, and programmatic deliverables are established in contract negotiations. The TCHS Program Coordinator assisted the Project Director in developing program deliverables and managing the contracts. Contract sites participated in periodic Contractor meetings and were responsible for providing TCHS with quarterly reports. These reports were submitted to the program Evaluator then reviewed by Central office staff and the Data and Evaluation committee of the Consortium. TCHS contract sites received summary reports of their data and comparison data with other networks on areas such as caseload, client retention, care plan completion rates and depression screening completion rates. Sites also received a quality control report which identified inconsistencies in their data. The Program Coordinator would review this information with sites during her periodic site monitoring visits. At least twice a year the Program Coordinator and the Health Educator would conduct chart audits and review client files with TCHS staff. The purpose of this activity was to get an idea of the types of services that were being provided to TCHS clients.

The Twin Cities Healthy Start Bylaws, which were adopted by the project's Executive Committee on January 6, 2000 and revised in August 2000, describe in detail the duties of the grantee agency and project management. These duties include: financial accountability and reporting, submission of all reports, contract monitoring and compliance, data collection, coordination of the evaluation, coordination of the public

information campaign, committee coordination, and coordination of project development activities.

Key program and evaluation staff of TCHS are employees of the MDHFS. This group works as a team to manage and lead project activities, which is facilitated by their co-location in the MDHFS office. They also held regular staff meetings every other week, and met with the MDHFS Director of Public Health Initiatives once per month. The Project Director also meets with the Project Evaluator and City finance staff on an as needed basis. The staff included:

- Coral Garner, TCHS Director (1.0 FTE): Plans, implements, and monitors TCHS in coordination with the TCHS Consortium. Ms. Garner also develops and advocates for maternal child health policy initiatives resulting from TCHS, ensures the project's evaluation, oversees the project's budget, writes and submits reports, develops project contracts, and supervises all central staff. She also leads or participates in other grant initiatives or committees associated with TCHS, such as the Maternity Case Management project and the Healthy Start Collaborative.
- Doris Williams, Healthy Start Program Coordinator (1.0 FTE): Managed the administrative and programmatic implementation of the healthy start core services. Coordinated ongoing training for contract staff. Managed the TCHS central referral line. Conducted periodic site visits to monitor contract sites and their progress toward meeting the goals of outreach, case management, health education, interconceptional care, and depression screening and referral.
- Stephanie Graves, Health Education Coordinator (.80 FTE): Provided technical assistance to the TCHS Service Networks on health education activities. Project manager for the Health Education Plus grant and the FASD prevention grant. Facilitated Prenatal and child birth preparation classes at various Healthy Start sites in Minneapolis and St. Paul.
- Shada Buyobe-Hammond, Office Support Specialist II (1.00 FTE): Provided Consortium leadership development, planning and administrative support, as well as general Project administrative support.
- Abbey Sidebottom, TCHS Evaluator (.30 FTE): Lead and conducted the TCHS evaluation plan, including monitoring performance measures and the local evaluation plan, works with the project contractors on data quality, and submits performance measures to the Health Resources Services Administration.
- Ann Mathews (.25 FTE), an accountant with the City of Minneapolis Finance Department, is responsible for financial management with the TCHS Project Director.

Cultural Competency of Contractors – TCHS has been somewhat successful in having a diverse staff. In 2004/2005 there were 26 full and part time staff designated to provide Healthy Start services. The racial breakdown of the staff was as follows: African American 43% American Indian 46% and White 11%

Management Changes - In March 2005 the Director of Public Health Initiatives, Gretchen Musicant was appointed Commission of Health for the City of Minneapolis. This resulted in a reorganization of the MDHFS as her previous position was eliminated.

TCHS was reassigned to the Research and Assessment Department and currently reports to Patricia Harrison, PhD, Director of Research. Other changes in the program were with the Contracting agencies. Two contractors Minneapolis Way to Grow and Open Cities Health Center were discontinued as a result of high staff turnover and contract management issues. Fremont and Minnesota Indian Women's Resource Center decided not to continue to be a part of TCHS because of management and staff changes at the two sites.

IV. Project Accomplishments – See attachment A.

V. Project Impact

Systems of Care: TCHS developed service networks that were geographically and racially designated. Each TCHS contractor had to identify medical, social and behavioral services that they would be a part of their service network. This process forced contractors to evaluate their partnerships and also how well their clients were accessing services. Some agencies decided to use TCHS dollars to subcontract for some services, while others used letters of agreement outlining expectations of these formal relationships. Concerns over duplications of services and turf issues regarding clients prevented some Networks from fully integrating services. However, the positive outcomes outweighed these issues of turf and competition. Some of the major outcomes were:

- Identification of community based agencies that provide services to women and children
- Co location of Public health nursing staff from MVNA and SPRCPH at TCHS contract sites as well as other community based clinics and agencies.
- Developed working relationships with Child and Teen Check up (EPSDT), Hennepin County Follow Along (Newborn Screening), and WIC
- Work accomplished on LHSAP and the Collaborative

TCHS has had limited success with impact on the comprehensiveness of services, however we have been able to advocate for consumers to get eligibility regulations overturned. In October 2003 the Department of Human Services had a policy change which required that mothers had to make arrangements to enroll their newborn into a health plan with their MFIP financial worker. No case worker such as a TCHS case manager, PHN etc. were allowed to make these arrangements for the mother. If arrangements were not made the Newborns would be on fee for service for their first month. DHS made this policy change to prevent hospitals from double billing (capitated payment made to a Health Plan was supposed to include care of baby in hospital however; the hospitals were also billing DHS for baby's care). This policy created a burden to some mothers and TCHS staff provided examples to DHS as to how it impacted parents and created a barrier to health care access. DHS took our input under consideration and effective January 2005 newborn infants are automatically enrolled in their mother's health plan.

In 2004 the reductions in the State Family Planning Special Projects funding negatively impacted the implementation of TCHS programs in the St. Paul African American Network. In our St. Paul American Indian Network, TCHS was impacted by the level funding being provided through the Indian Health Service dollars distributed through the MDH. SPRCPH was considering pulling the PHN co located at American Indian Family Center. The Co Chairs of the TCHS Executive committee wrote a letter to the Commissioner of Health outlining their concerns. The Commissioner responded to the letter and agreed to meet with the Consortium in June 2004. At this meeting TCHS parents provided testimony regarding the need for subsidized family planning services in the African American community. With the funding decisions that were made the primary clinic serving this population was forced to reduce their services and also lay off staff that had historically worked with TCHS. Members from the American Indian community expressed their concerns about the needs of urban Indians being different than Indians who live on the reservations yet are often overlooked or forced to compete with tribal agencies for funding.

At this meeting the Commissioner acknowledged that she is committed to work on disparities and that she would be working with her staff on language that would address disparities in the next two year funding cycle. It was also acknowledged that we need to look at some of the emerging and promising practices such as TCHS that connect clinical and others supportive needs.

Impact to the Community: TCHS has been able to successfully reach approximately 30% of the American Indian births on an annual basis, and has definitely had a positive impact on Infant Mortality Rates in this community. In 2003 and 2004 there were no American Indian infant deaths in Minneapolis. TCHS services are located in agencies that have a good reputation of providing services to Indian women and infants. In addition TCHS has had some well known community leaders participate on our Consortium. Elona Street Stewart was instrumental in planning and implementing the TCHS initiative and served on the Consortium for five years. When she ran for public office Ms. Stewart used her work with TCHS as an example of her commitment to the health and well being of the children in our community. Ms. Stewart is currently the Chair of the St. Paul Board of Education. Her visibility on the Consortium resulted in the African American and American Indian communities doing a voter registration drive to assure that TCHS parents were registered to vote. Ms. Stewart is currently unable to regularly participate on our Consortium because of her position with the School Board. However she still attends community events and is available to assist with any special projects. These community relationships help to heighten the visibility of the TCHS program in the American Indian community.

In the African American community we struggle with visibility in certain neighborhoods because this population is larger and it is more widely disperse throughout the Twin Cities. TCHS relied on its African American consumers to publicize the program through word of mouth. In 2004 the African American advisory committee developed a marketing strategy focuses on recruiting pregnant women for services, increasing membership on the consortium and making community agencies more aware of our

program. Parents volunteered to assist with program presentations for the Hennepin County Health Disparities conference and the March of Dimes Prematurity Conference that year. Parents revised our program brochure to clearly state some of the reasons why babies are dying e.g. who's at risk, and to specifically outline what services are available through TCHS. TCHS participants also distributed flyers and brochures at the agencies that they frequented so that other professionals would be familiar with our program.

Impact on State – We get tremendous support from the Minnesota Department of Health (MDH) through their Title V program. The State's Title V Infant Mortality Consultant is actively involved with TCHS and keeps the Project Director up to date on new initiatives at the State. She is an ex officio member of the Executive Committee of the Consortium, participates in Consortium activities, and co-chairs the Healthy Start Collaborative. In 2003 the TCHS Project Director was appointed to the State MCH advisory committee. This opportunity has created a venue for the Project Director to talk at a statewide level about some of the work being done through TCHS and to advocate for the needs of women and children in the African American and American Indian communities.

As mentioned previously, the MDH's Maternal and Child Health Section conducted its 5-Year Needs Assessment process in December, 2003. MDH staff presented the Needs Assessment process, its history, and its significance to the Healthy Start Collaborative during the December, 2003 meeting and invited TCHS to participate. TCHS staff and program participants participated in three stakeholders' retreats, conducted by State Title V staff, from 7/04 through 10/04 to select Minnesota's Maternal and Child Health priority needs/measures for the next five years. For the population of pregnant women, mothers, and infants, the following three priority areas were selected for the final list of ten state priorities:

1. (reduce) Health disparities in mothers and infants
2. (increase) Early and adequate prenatal care
3. (increase) Planned pregnancies and child spacing

As the final needs assessment and MCH block grant application was completed and submitted to the MCHB, members of the Maternal and Child Health Advisory Task Force as well as community members had an opportunity to comment on the final documents. The TCHS Project Director and the Director of the TCHS service network lead agency Division of Indian Work, Noya Woodrich, are members of the Task Force.

Currently, the primary perinatal initiative funded by the state is the Save 10 Community Task Force, funded by the Eliminating Health Disparities Initiative, which is part of the Minnesota Department of Health's Office of Minority and Multicultural Health. Title V funding does not directly support TCHS activities but does support Title V staff who work with TCHS.

Linkages to Medicaid were attempted on an annual basis with TCHS. TCHS staff met with the Medicaid Director in 2001 and again in 2002. Staff was assigned to participate on the Healthy Start Collaborative however their participation has been sporadic. Title

XIX has been resistant to doing any type of formal collaboration with TCHS. TCHS invites Title XIX representatives to TCHS events and has had staff to come and update us on changes in coverage or allowable services. This process did result in our having the newborn enrollment policy being revised in January 2005.

Local Government Role – TCHS is governed by the City of Minneapolis, Minneapolis Department of Health and Family Support. MDHFS provides the program with a grant writer which assists with the Healthy Start grant application and with working with the Consortium in putting together funding request for program enhancements or new program development. MDHFS manages the evaluation of TCHS. The Research staff works with the TCHS team in developing data collection tools and resources for program monitoring. TCHS works closely with the local MCH coordinators at MDHFS, Hennepin County, and SPRCPH. Meetings were conducted throughout the life of the project orienting MCH staff about the TCHS program. Representatives from local government participate on the Consortium. These staff liaison work with the TCHS Project Director in facilitating staff and client access to TANF services, Child and Teen Check Up, Follow Along, PHN home visiting and WIC. Attempts have been made to identify ways in which we could share data. With the exception of Medicaid, TCHS data can't be shared with any other program without signed patient consent.

Lessons Learned – It has been extremely challenging to design and implement an evaluation process that effectively measures outcomes from a decentralized program model. Problems with high staff turnover, agency capacity, and the variations in training and educational backgrounds of staff at individual agencies resulted in differences in the services received by TCHS parents at each site. Even though our performance measures indicated that we achieved most of our objectives it is difficult to determine what activities or services most contributed to the success. Our Medicaid funded project at North point heighten our awareness for the need for ongoing technical assistance from our contractors to assure that agency protocols and program implementation are consistent with the HRSA and TCHS expected outcomes. TCHS has revised the job requirements of the Contract Manager and the Health Educator that were funded in our previous grant. These persons are now considered Site Coordinators will each be assigned three program sites. They will assist these sites with program development, service delivery, quality assurance, community linkages and training.

A retrospective review of Healthy Start's evaluation component indicated that of all the services being offered through TCHS, case management services clearly had the most impact on improving birth outcomes and decreasing infant mortality in our community. The evaluation also revealed that our contractors that were clinic based reached women earlier in their pregnancy and identified more social and behavioral risk factors within the populations that they served. The disconnect between Healthy Start services and the medical providers often resulted in client's being referred late in their pregnancy and some high risk clients not being referred at all because they would not return to the clinic after receiving a positive pregnancy test. TCHS goal over the next four years is to reach women as soon as they are aware that they are pregnant, educating them about TCHS as

close to pregnancy testing as possible. To achieve this goal TCHS is contracting primarily with community based clinics with the 2001-2009 initiative.

Also identified was the need for a standardized approach to screening women before enrolling them in TCHS to assure that we are reaching pregnant women most in need. In our current structure the only requirement that a participant had to meet was being African American or American Indian, pregnant and a resident of Minneapolis and St. Paul. Clients were identified either through CORWs, our referral line or direct referral from a medical provider or agency. The intake was based on residential eligibility only. The risk assessment was completed after enrollment by the Social Worker or RN. This resulted in large caseloads.

In the Spring of 2005 TCHS began work on a multifaceted psychosocial screening tool which all sites will use to identify high risk pregnant and post partum women. This system will also recommend and monitor minimum service interventions for each woman identified as being moderate or high risk on various social and behavioral risks. TCHS contract clinic sites will be responsible for using the TCHS web-based screening tool on all pregnant women presenting for services at their site. Women who score moderate or high risk on certain domains will be recommended for enrollment in TCHS. Also women considered medically high risk because of their medical history; literacy or cognitive ability or age will also be eligible for enrollment.