

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

The Goal of the AMYSC Healthy Start Project is to improve access to quality maternal and child health services in order to reduce the high rate of infant mortality and impact the racial disparity that exists in the Project Area.

The Aunt Martha's (AMYSC) Healthy Start Project Area for this Project Period initially included *Ford Heights*, and *Chicago Heights* and are among the neediest communities in Illinois and the Nation. The Project Area covers ten (10) square miles and is located 30 miles south of downtown Chicago and 4 miles from the Indiana Border. Severe economic stress and its related social problems characterize the residents in the Project Area. According to Census Data, 38% of the total population was at or below 185% of the Federal Poverty Level. Eleven percent of the population was unemployed. The Project area suffers from insufficient affordable housing, high crime levels, homelessness, and substance abuse.

The Project Area is designated as a Medically Underserved Area (MUA), and drive by observations by AMYSC Staff and the Local Evaluator, confirm that the most basic services such as gas stations, grocery stores, and banks are extremely limited in much of the area (i.e., Ford Heights). This lack of basic services is a considerable barrier to low income pregnant women having easy access to fresh food and transportation. The risk factors for poor perinatal outcomes among women in the Project Area include mothers who smoke, drank, and/or used street drugs during their pregnancy; other behavioral factors; and teenage mothers.

### **1. Race/Ethnicity of the Target Population**

The racial/ethnic composition of the residents of the Healthy Start Project Area differs dramatically from the racial composition of residents of the State of Illinois. Based on data from birth certificates filed with the Illinois Department of Public Health between 1996-98 (the most recent data available at the time of the initial Community Needs Assessment) the Illinois birth cohort had a racial composition that was 76.6% white and 23.4% non-white with 18.0% being Hispanic. Among Project Area births, 48.1% were white and 51.9% were non-white. Approximately 23.6% of all births among Project Area residents are to Hispanics.

## 2. **Targeting “Hard to Reach High Risk” Women in AMYSC Project Area**

To better describe the “hard to reach, high risk” population served by the Project to legislators, advocates, providers, residents of the target area, other Agencies, and the Consortium, the Local Evaluator captured data from the Risk Assessments of the pregnant participants and created a *risk profile*.

The following *risk profile* of the “typical” Healthy Start *Pregnant Participant* was used to “put a face” on the “hard to reach, high risk” pregnant women served by the AMYSC Project:

*The “typical” AMYSC Healthy Start Pregnant Participant can be described as a minority female of low educational attainment, that is at high risk for a poor outcome of pregnancy. The “typical” AMYSC Pregnant Participant is likely to have a history of many pregnancies, be under 18, have a language barrier and have a history of substance abuse.*

## 3. **Results of Community Needs Assessment**

An examination of the Health Status Indicators for women in the Project Area finds that all of the indicators compare very unfavorably with Health Status Indicators for all women in the State of Illinois (see Table 1 below). A further comparison of these Health Status Indicators suggests that there is significant racial disparity in Perinatal Health Status among residents of the Project Area. The wide racial disparity exists among all Health Status Indicators, Determinants, and Contributing Factors that are known to impact on preventable infant deaths (See Table 2 below).

The comparisons made between rates already achieved by a subpopulation (read white births) in the Project Area to other subpopulations (read black births) that have not achieved these rates, does in fact, identify an “opportunity” to evaluate and reestablish priorities in preventing excess infant mortality and morbidity.

The initial Community Needs Assessment provided data that led the AMYSC Healthy Start Community to focus on identified racial disparities not only in *Health Status Indicators* (i.e., infant mortality), but also the *Determinants* (i.e., birth weight), and *Contributing Factors* (i.e., low prenatal care) that are known to impact health status. Table 2 below highlights the racial disparity that existed in the AMYSC Project Area.

A review of the black/white ratios for key MCH indicators finds wide disparity between black and white births in the Healthy Start Project Area for 1996-98 (baseline data). This data suggests that wide racial disparity existed for *Health Status Indicators*, *Determinants* and *Contributing Factors*. The following page provides empirical statements that best characterize findings that led the AMYSC Healthy Start Project to focus on impacting racial disparity:

**Mortality:**

**Infant Mortality Rates:** The *Infant Mortality Rate* (IMR) in the Project Area was 10.0 infant deaths per 1,000 live births. This IMR was 20.5% higher than the Statewide Infant Mortality Rate (8.3) for 1996 – 1998. The IMR for black births in the Project Area (14.3) was more than twice the IMR for white births (5.7). The black to white ratio of Infant Mortality was 2.5 to 1.

**Neonatal Morality:** The *Neonatal Mortality Rate* (NMR) in the Project Area was 5.8, which is approximately 7.4% higher than the Statewide Neonatal Mortality Rate (5.4) for 1996 – 1998. For that same period, the NMR among black births in the Project Area (7.5) was almost more than double the NMR among white births (4.1). The black to white ratio of Neonatal Mortality was 1.8 to 1.

**Post Neonatal Mortality:** The *Postneonatal Mortality Rate* (PMR) in the Project Area was 4.6, which is approximately 58.6% higher than the Statewide Postneonatal Mortality Rate (2.9) for 1996 – 1998. For that same period, the PMR among black births in the Project Area was 6.8 which is more than four (4) times the PMR among white births (1.6). The black to white ratio of Post Neonatal Mortality was 4.3 to 1.

**Determinants of Mortality:**

**Very Low Birth Weight:** The *Very Low Birth Weight* rate (VLBW) among live births in the Project Area was 2.0 for 1996 – 1998. This VLBW rate is 25.0% higher than the VLBW rate for live births in the State of Illinois (1.6). In the Project Area, the VLBW rate among black births was 2.7% compared to 1.3% for White births. The ratio of black to white VLBW births was 2.1 to 1.

**Low Birth Weight:** The *Low Birth Weight* rate (LBW) for live births in the Project Area was 10.3 for 1996 – 1998. This LBW rate is 28.7% higher than the LBW rate (8.0) for live births in Illinois. In the Project Area, the LBW rate among black births was 13.3% compared to 7.4% for White births. The black to white ratio for LBW births was 1.8 to 1.

**Contributing Factors:**

**Low Prenatal Care:** The rate of *Low Prenatal Care* (LPC) for live births in the Project Area was 8.4 for 1996 – 1998 and this LPC rate was more than twice the LPC rate for live births in the State of Illinois for the same period (4.0). In the Project Area, the LPC Rate among black births was 12.8% compared to 3.8% for White births. The ratio of black to white infant deaths is 3.4 to 1.

**Teen Births:** The *Rate of Teen Births* in the Project Area was 21.6 for 1996 – 1998. This rate is 71.4% higher than the rate in Illinois (12.6). In the Project Area, the rate among black births was 27.9% compared to 15.3% for White births. This is a racial disparity ratio of 1.8 black teen births for every 1 white teen birth (1.8 to 1).

#### **4. AMYSC Pursues Further Analysis of the Underlying Causes of Racial Disparity**

In order to better target AMYSC efforts to improve racial disparity, additional analysis to better understand and define its underlying causes is necessary. CDC has identified a useful tool for defining and examining the underlying causes of preventable mortality and racial disparity called the "Perinatal Periods of Risk Analysis" (PPOR). The PPOR Analysis has been recommended for implementation in Healthy Start Projects not only by CDC, but also by HRSA.

AMYSC is pursuing the use of Illinois Vital Records data to complete a *Perinatal Periods of Risk (PPOR)* analysis that is relevant to not only the AMYSC Healthy Start Project, but all Healthy Start Projects in Illinois. More specifically, PPOR will be used to map the fetal/infant mortality by age, birth weight and race in order to assist the AMYSC Project in prioritizing prevention efforts; mobilizing communities and key actors; establishing ongoing surveillance; and enhancing FIMR findings/recommendations.

(Note: The Local Evaluator has incorporated the PPOR Analysis into the Evaluation Plan for the Healthy Start Project and continues to participate in "Level II Training" sponsored by the Bureau of Maternal and Child Health related to implementation of the PPOR Analysis).

**Table 1**  
**Health Status Indicators for Project Area and State of Illinois: 1996-1998**

<b>Indicator</b>	<b>State of Illinois</b>	<b>Project Area</b>	<b>% Difference</b>
<b>Mortality</b>			
Infant	8.3	10.0	+20.5%
Neonatal	5.4	5.8	+7.4%
Post-Neonatal	2.9	4.6	+58.6%
<b>Determinants of Mortality</b>			
VLBW	1.6%	2.0%	+25.0%
LBW	8.0%	10.3%	+28.7%
<b>Factors Contributing to Mortality</b>			
<u>Low PrenatalCare:</u>	4.0%	8.4%	+110.0%
Birth to Teens	12.6%	21.6%	+71.4%

**Table 2****Racial Disparity in AMYSC Project Area:  
1996-1998**

Indicator	AMYSC Project Area Residents		% Difference
	White	Black	Black: White
<u>Mortality:</u> Infant	14.3	5.7	2.5:1
Neonatal	7.5	4.1	1.8:1
Post-Neonatal	6.8	1.6	4.3:1
<b>Determinants of Mortality</b>			
<u>Birth Weight:</u> VLBW	2.7%	1.3%	2.1:1
LBW	13.3%	7.4%	1.8:1
<b>Factors Contributing to Mortality</b>			
<u>Prenatal Care:</u> Low	12.8%	3.8%	3.4:1
Birth to Teens	27.9%	15.3%	1.8:1

**II. Project Implementation**

## **OUTREACH**

- A. In order to make an impact in the communities we serve it was necessary to target “high-risk” pregnant and interconceptional women whom are at risk for poor perinatal outcomes as well as infants and toddlers whom are at risk for developmental delay or special health care needs.

The “high-risk” women and children have to be located and empowered to enroll and participate in Healthy Start Services. The first goal was to educate the woman on the importance of care and the desired outcome. Many of these women have seen their mother, sisters and friends get by without a medical home. Health care, unfortunately, is not a priority on their list.

In CY04, the project exceeded their goal, enrolling 83% (126/153) of Healthy Start participants into prenatal care in their first trimester.

- B. The outreach model guidelines utilized volunteers from each of the three communities, the project served, to recruit clients. This approach would focus on a volunteer, typically a grandmother type figure, who would be the “go to” person in the area. This person would inform potential clients about Healthy Start services as well as other services Aunt Martha's could offer. The volunteers would recruit participants into the program and for each successful enrollment a stipend would be given to her.

After months of recruiting only one volunteer to the program the model was not meeting the needs of the program or communities. The communities the project services have multiple issues regarding trust. This model relied on volunteers depending on the agency to follow through and pay them after the service was provided.

The plan was evaluated and restructured. The newly devised plan consisted of hiring full time outreach workers as Aunt Martha's employees. The design of this plan required the outreach worker to live in one of the three communities the project services. Workers became full-time employees requiring accountability. An outreach plan was devised and policies and procedures put into place. After six months it was clear that there was not enough man power to make the impact the program desired. During this time it was also noted that it was difficult to maintain a responsible van driver. The demand for daily transportation services was causing a strain on the one funded position. The solution was to merge the two positions of outreach and van driver into one, resulting in a newly created position of Community Representative. Creating this position allowed enough time for staff to truly service the community by providing outreach as well as expand capabilities of transportation. Community Representatives are able to provide education to potential and existing clients on the services Healthy Start can offer. Clients' received transportation to their medical appointments, WIC appointments, public

aid office visits, and staff were able to market Healthy Start services and empower the women to enroll.

In order to meet the program goals four community representatives were hired to provide outreach and participate in the driving rotation.

Community Representatives have the responsibility of reaching the "*hard to reach-high risk*" women. This is accomplished by:

- ❖ Attending community events because gaining the trust in the community begins with visibility. During Community events is a chance to speak with potential clients who are in need of finding medical homes as well as case management and health education services.
  - ❖ Canvassing the neighborhoods and areas businesses with fliers to notify the community of the services that are available to them. Residents who receive the flier and establish a medical home are given an incentive.
  - ❖ Working with the Family Support Center, and health education team in sponsoring quarterly community baby showers. Distributing invitations throughout the community and to all the local health centers. This allows recognition in the community and a chance to reach out to pregnant women who may not be encountered otherwise.
  - ❖ Providing transportation to Healthy Start clients (i.e. medical appointments, WIC appointments, Public Aid office visits, pharmacies, food pantries). Community Representatives have the clients' attention while the client is riding in the van allowing the marketing of Healthy Start services with possible enrollment.
- C. Outreach is closely linked with The Family Support Center. The Family Support Center is designed to provide a safe, comfortable, neighborhood based setting for families with children, age 5 and younger. It is an entry point for families to access an array of support -- from parenting and communication classes, health education, job and education training. The Family Support Center is a place where parents can increase their competencies and reduce their sense of isolation. Parents can form life-long friendships and share in the joy of parenting which hosts quarterly baby showers for the community. The baby showers are offered in English and Spanish. This event comprises an education component (i.e. postpartum depression, immunizations), question and answer session, nutritional supplements, and marketing event. Clients have the opportunity to meet other women facing similar situations. Clients are drawn to one another, and enjoy sharing their experiences while developing a support network. In 2004, 88 Spanish speaking women attended and over 210 English speaking women attended the shower. This event is also geared to attract new clients who qualify into the program. It is a great marketing tool to reach clients who receive treatment in other south suburban area clinics.

Healthy Start services are limited by budget resources and therefore, require the program to screen potential clients to verify they met the qualifications. Difficulty occurs when someone does not live in the communities Healthy Start Services, but

meets the medical and social criteria. Referrals are made to the Family Case Management Program, but this program lacks the intensity of Healthy Start.

A challenge the program continues to encounter is identifying the "high-risk" women. It is not as easy as canvassing areas handing out fliers, the program must continue to be creative to empower these women. The high risk-hard to reach population has more complex issues. In order for these women to focus on their health or their baby's health they must deal with the issues at hand. Many women are dealing with issues of unstable housing, lack of employment, depression, substance abuse and/or domestic violence.

### **CASE MANAGEMENT**

- A. The Healthy Start needs assessment revealed that health and social service providers do not have adequate resources to meet the demand for services. Services are very often fragmented which has resulted in women and infants not receiving proper follow-up. This is especially critical for the high-risk populations in our service area. In addition to the medical needs of low-income, teen, and single pregnant and parenting females, many of these women need ongoing support and assistance in finding resources to help support themselves and their families. There is a high rate of smoking, drinking, and drug use in the area. There are few treatment options for young and pregnant women. Sexually transmitted diseases are occurring at a much higher rate in Chicago's south suburbs than in any other part of the metropolitan region. Domestic violence has become an increasing problem, especially with women in high-risk categories. Given these concerning situations, there is a need for a comprehensive program that addresses the holistic needs of women, children, and families in the service area.

It is a fundamental principle of Aunt Martha's that people should be in control of their own lives. As such, it is not our job to enforce services we think people need, rather it is our responsibility to develop a partnership with people in need of health and social services to help empower and educate them. Aunt Martha's employs several strategies to form that partnership. First, each participant is encouraged to be an active part of the service team and make her own decisions regarding the services she receives. While some may need extra support and education, each participant has the capability of making decisions for herself and her children. Second, we understand how important family involvement can be for a participant. Therefore, we make continued efforts to include family and other support systems in service planning and delivery. Third, by offering thorough, reliable care to each participant and advocating for them in the community, we can help them secure any needed services.

Aunt Martha's offers three case management options for perinatal clients – Family Case Management, Healthy Families Illinois, and Healthy Start.

Both Aunt Martha's and Cook County Department of Public Health provide Family Case Management services to pregnant and parenting women and their children

under age one. Aunt Martha's is the only agency in the South Suburbs with a contract from CCDPH to provide these services. This program does not serve children over the age of one no do they provide outreach services.

Aunt Martha's also operates a Healthy Families Illinois program in the South Suburbs. This program is primarily designed to teach parenting and other skills to prevent child abuse. The program has very focused eligibility criteria: teens 19 and younger, who are pregnant with or parenting their first child, identified as high-risk using the program's screening process, and who must initiate services during pregnancy or within two weeks of birth. The maximum capacity for this program is 56 clients per year.

In order to untangle the confusing web of services Aunt Martha's integrated its case management programs resulting in levels of case management. The bottom line is the participant does not care about the name or funding source of the program. They want to know what they qualify for and how to obtain it. Aunt Martha's has a central intake specialist who screens each client using a risk assessment tool. The intake Specialist determines which programs the client qualifies for and makes the connection. The Department of Human Services has recognized Aunt Martha's Youth Service Center as doing an outstanding job in the area of integration.

Due to the need to reduce infant mortality, low birth weight and racial disparities in perinatal outcomes, in 2001 Aunt Martha's Healthy Start restructured its program to identify "hard to reach – high risk" pregnant women early to enroll them in prenatal care, manage their ongoing, comprehensive medical and social service needs, and support them through the infants' first two years of life. The Case Management components are very similar to the successful adolescent model of education, prevention and intervention. The program had to be tailored to meet the needs of the "high risk".

The program provides a more intensive level of case management services are provided to Healthy Start Participants. These Participants include high risk prenatal, postpartum/interconceptional, infant, and toddlers. Aunt Martha's Healthy Start has gained the trust of residents in the Project Area. Aunt Martha's has been effective at enrolling and retaining its Healthy Start Participants by offering culturally sensitive case management services, Doula services, health education classes, the Family Support Center<sup>1</sup>, and transportation. Case managers develop an individualized Care Plan for all participants, and seek to assure that all referrals made are kept. The Case Managers facilitate linkage (assuring/providing transportation when necessary) of program participants to a comprehensive array of healthcare services as well as to education, housing, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program, and job training. By keeping medical appointments, attending classes, participating in home

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<sup>1</sup> The Family Support Center is a safe, comfortable, neighborhood-based setting for families and children where they can access an array of support from health education classes (parenting, prenatal, breastfeeding, etc.) to job skills.

visits, or working toward educational or employment goals participants earn incentives such as baby supplies, clothes, linens, etc.

- B. Our purpose is to prevent and reduce infant/maternal illness and death, which for several years have been excessively high in our communities. By enabling at-risk residents to access vital information, coordinate care, supportive health and social supportive services and assisting families to secure public health benefits and resources needed to maintain health. We have seen a significant reduction in infant death and improved maternal and child health status.

The program utilizes a risk assessment tool to assure that only high risk women qualify and are enrolled in the Healthy Start Program. The typical Aunt Martha's Healthy Start Pregnant Participant can be profiled as a female of low educational attainment, that is at high risk for a poor outcome of pregnancy. The Pregnant Participant is likely to have less than a high school education, a history of many pregnancies, have a language barrier, and a history of substance abuse.

The services case managers offer begins once a participant is recruited through outreach efforts or external referrals. The participants come in and have a risk assessment done by the Intake Specialist. Once the risk criteria and service area is met, the participant is assigned a case manager. The participant is assessed for needs such as benefits counseling, WIC, housing, and GED. In depth assessments including a depression and substance abuse screening are provided and together, the case manager and participant develop a care plan. The program has the capacity to refer participants to the counselor (LCPC), located on site, at the Women's Health Center. The counselor is not a Healthy Start funded position, but rather a partnership with a local mental health partner. The participants are connected to a medical home and referred for education classes. There is a protocol for the minimum amount of face to face and home visits the case manager will make, but the participants needs ultimately drive the amount.

Doula services are available. The Doula provides emotional and physical support to empower the participants during the prenatal, intra-partum, and post-partum periods. The Doula promotes health and fitness through education and advocacy. Education is provided on the labor and delivery process: breathing exercises comfort measures as well as development of a birthing plan. The birthing plan is discussed with the medical provider and a copy sent to labor and delivery at the appropriate hospital. The Doula discusses bonding with the unborn baby, educate on the development of the baby as well as breast and bottle feeding. The Doula encourages self advocacy.

The Doula is present during the labor and delivery process. She assists with comfort measures, relaxation techniques, and focusing. The Doula serves as the participant's labor coach or assist the partner and/or family in the process.

The Chicago Black Nurses Association provided the Doula training to the case management team. The Aunt Martha's Doula's have seen first hand the benefits a

Doula can provide. The client feed-back has been positive as well as the medical staff response. The Healthy Start project has seen the breast-feeding rate jump from 36 percent to 54 percent.

The postpartum and interconceptional care period begins with a visit from the case manager at the hospital. This is the perfect time to educate, answer questions and assist with scheduling follow-up visits with medical providers and/or behavioral health providers. A home visit is scheduled between the participant and case manager. At this time necessary assessments including depression, enrollment in WIC, education on family planning methods, referral to parenting classes, review and/or redevelopment of care plan is provided.

The infant/toddler case management activities coincide with the mothers. Initially a complete infant risk assessment is provided. The case manager screens the infant/toddler utilizing the Ages and Stages Developmental Screening Tool. This assists the case manager in making early intervention referrals that are needed. The family is assisted with enrollment in WIC, connection to a medical home, develop and review of care plan, as well as health education. The family is encouraged to participate in parenting classes.

The case manager's schedule of appointments for each of the following types of clients:

**Prenatal**

- ✓ Face to face every trimester
- ✓ 7<sup>th</sup> and 8<sup>th</sup> month bi-monthly
- ✓ 9<sup>th</sup> month weekly
- ✓ after past due date and have not delivered every other day
- ✓ a minimum of one home visit

**Postpartum/interconceptional**

- ✓ face to face contact every 2, 4, 6, 9, 12, 18, 24 month
- ✓ a minimum of one home visit

**Infant**

- ✓ face to face contact every 2, 4, 6, 9, 12, 18, 24 month
- ✓ a minimum of one home visit

Training is a key component to the projects success. The case managers received individualized training, as they began the healthy start program by the Coordinator of Case Management as well as the DHS Nurse Consultant.

Case Managers attended three day training on how to operate and utilize the Corner Stone system which is the preferred computerized case management system operated by the Department of Human Services in Illinois. A DHS Nurse Consultant provides technical assistance training quarterly as well as a regional representative assists with the Corner Stone Data System.

The Illinois Healthy Start Partnership hosted trainings throughout the course of the program. The trainings were geared towards staff and included, SIDS, Developmental delay, perinatal disparities, postpartum depression and consumer empowerment.

Each Case Manger completed the Aunt Martha's core training. The training consists of Reality Therapy (40 hours), cultural awareness (12 hours), Universal Precautions (8 hours), Program Specific Orientation (2 hours), Safety Site training (4 hours), annual CPR certification (8 hours), as well as annual updates on domestic violence, substance abuse and HIV/AIDS.

- C. While continuing to meet the growing needs of the clients, the department continued to evaluate the effectiveness of the program. Over the last few years there were many challenges that the program had to endure. Those challenges included: staffing, training, screenings, risk assessment tool, and integration with other programs.

At the beginning of our grant cycle the clients and staff were predominately English speaking. As the program progressed it stayed determined to reach the high risk population. The client racial mix began to change rapidly. The cities the program serve had an increase in Latino population coming in from Mexico. Many were working as migrant workers with little or no education or understanding of the English language. In order to meet the need of this growing population, additional bi-lingual staff was hired.

In an effort to meet the on-going challenges of the program the social needs component on the initial risk assessment tool was changed. This strengthened the screening tool as well as raised the intensity of clients entering the program.

The agency has dedicated itself to utilization review in which 30% of charts are reviewed by trained staff. This allows the program manager to see areas of weakness and research how to strengthen it. A satisfaction survey is done annually as well to monitor the program. These tools have prompted the coordinator to incorporate performance improvement projects to better meet the needs of the program, clients and staff.

Data collection has been a challenge over the course of the program. The agency made a commitment to incorporate the Cornerstone computer system which is an Illinois Department of Human Services program. This incorporated not only Healthy Start but other case management programs in Illinois along with WIC. Anytime a new system is put in place there are bumps in the road. At this time the program is continuing to evaluate the systems. There has been a comparison done, between Cornerstone and Aunt Martha's Internal Data, showing many improvements. The goal is to stop using the excel spreadsheets and rely solely on the Cornerstone Data System.

With the level of high-risk participants are presenting with it became critical to provide access to the best and most appropriate care available, Aunt Martha's has established a direct referral relationships with Rush Presbyterian-St. Luke's Hospital, which is a Level III Perinatal Center in Downtown Chicago. Pregnant Participants found to be at highest risk are referred to the Rush Perinatal Center for the balance of their prenatal care and delivery. However, Aunt Martha's continues to case manage these very high risk participants and provide all coordinates all necessary services and transportation during their pregnancy.

Through the course of the project the case management program serviced 1,162 high-risk women and 809 infants and children under the age of two. The Case Management Program exceeded 7 out of the 10 case management objectives the program set for 05/31/05. The Aunt Martha's Healthy Start program allows participants to gain power and control over their lives, by playing an active role in establishing and maintaining a healthy and prominent life style.

### **HEALTH EDUCATION**

- A. Before an education plan was developed the education needs of the communities was assessed. This was done in a variety of ways including contacting key service organizations, churches and neighborhood action groups, as well as former and current participants to participate in surveys and focus groups.

There are three local community groups that represent the key organizations within the service area. These community groups include: The Crossroads Coalition, which focuses on ensuring that a comprehensive network of social and medical services are available in the community; the Ford Heights Youth and Family Coalition, which focuses on developing strategies to address problems in the Ford Heights Community; and the Eastside Renewal Foundation of Chicago Heights, which focuses on reviving a section of Chicago Heights that is experiencing particularly serious disparities in variety of medical and social indicators. We used both formal surveys and verbal feedback to obtain input on community health needs, and prevention of risk behaviors such as engaging in unprotected sex, neglecting childhood immunizations, transmitting communicable diseases, drug or alcohol abuse and delaying prenatal care.

In addition to obtaining input from formal community groups, the program also solicited feedback from churches and neighborhood action groups. This was done through one-on-one conversation and informal focus groups, as the formal process can be intimidating in these settings. This provided valuable insight into what community members believed to be most critical in their neighborhoods.

Gathering information from Healthy Start participants was another method utilized to conduct an assessment of the education needs. This was a three prong approach. First, information was gathered about various circumstances faced by past and present Healthy Start participants (e.g. number of unplanned recurrent pregnancies

while in the program, and type and frequency of preventable childhood illnesses). In doing so, we were able to identify health education needs that have possibly gone unaddressed, as well as able to identify potential prevention opportunities. Second, we solicited direct input from the participants. This was done using consumer surveys designed to solicit feedback on educational topics they believe would be beneficial. This was so successful that the process has been repeated annually.

All of this information from the various needs assessments was analyzed by the Coordinator of Outreach and the Project Director and utilized to modify and develop health education campaigns.

- B. Aunt Martha's Healthy Start education services began with what we call our "core curriculum". These are training packages that participants attend as they address needs that are nearly universal to the population being served. They include childbirth education, prenatal information, breastfeeding, and parenting, and family planning classes. For those participants who need it, smoking cessation is considered core training. All core trainings are offered in English and Spanish.

The Prenatal Training curriculum includes a series of eight weekly sessions, three of which address childbirth. The purpose of Prenatal Training is to educate the participant on the medical, emotional and physical aspects of pregnancy. Topics covered include: nutrition and exercise, preparing for the baby to come home, developing a good support system, physical changes that occur throughout pregnancy, emotions they may experience, the importance of on-going prenatal medical care and what happens at a medical appointments, labor and delivery, and bringing the baby home.

Childbirth Education is presented as a subsection of Prenatal Training. The purpose of Childbirth classes is to prepare each participant for labor and delivery by providing them with the basic information they need to understand what is happening to them physically and mentally. Childbirth Education includes three weekly sessions that address all of the following: stages of labor, specifics of delivery, the medical terms and medication used during labor and delivery, postpartum care, the importance of breastfeeding, the possibility of postpartum depression and information on birth control after delivery. This curriculum also addresses immediate care the baby will need such as medical appointments and immunizations.

Aunt Martha's has two parenting curriculums- one that addresses the special challenges faced by teen parents, and one that is geared more for our adult participants. While both curriculums follow the same format, the curriculum for teen parents covers issues that are specific to being a parent while still being an adolescent. The goal of the training is to teach good parenting skills and techniques. This is done by taking a holistic approach to teaching parenting that includes information such as caring for yourself, accessing community resources and thinking creatively, in addition to covering more traditional topics such as discipline and child development

Smoking cessation is a five-week course offered for the purpose of giving people the tools they need to stop smoking. Participants are educated on the dangers of smoking, encouraged to examine the reasons why they smoke and are provided action steps they can use to help them stop smoking. Participants maintain journals throughout the course and an ongoing videotape is shown weekly as the course builds on a process that can help participants stop smoking for good. Over the course of the project the percentage of pregnant participants who self-reported reduction in smoking during pregnancy has been on the rise. This objective benefited from being part of a CQI activity. In CY04 74% (24/32) of the pregnant women reported a decrease or cessation of smoking compared to 55% (20/36) in CY02.

In addition to the core curriculum, Aunt Martha's Healthy Start program currently offers all of the training listed below:

- ❖ STD's and Birth Control
- ❖ Personal Hygiene
- ❖ Dental
- ❖ Self-esteem
- ❖ Hygiene
- ❖ Employment Skills
- ❖ Anger Management/Conflict Resolution

Some Healthy Start participants require special one-on-one educational care. This type of education often occurs in the participant's home and at a pace that matches the participant's ability to learn. Reasons for the need for one-on-one services include circumstances such as a low level of literacy, complicated or special medical conditions, special emotional or cognitive circumstances, or the need to focus on areas the participant did not fully learn in training, as demonstrated by post-testing. These education services are provided by a variety of staff including health educators, case managers, and outreach workers.

The health education team includes one Nurse who provides education. She prepares educational packets for each trimester of pregnancy to prepare our clients for the healthy birth of their child. For our inter-conceptual clients, she provides educational materials on family planning and pediatric concerns that a parent may have. Our nurse educator also offers asthma workshops and support groups to our clients because asthma has been a growing concern in our service area.

The Nurse Educator position has changed from contract provider to a part-time employee. Our decision to make this change occurred to ensure accountability of service provision and continuity of care. All of the information she provides is uniform with all of our healthy start materials.

The Nurse Health Educator not only provides classes, but spends time in the clinic/waiting room at the Community Health Centers bringing education to the participants. For those participants who chose not to attend classes, this is an ideal

opportunity. This is also a way to promote classes. A monthly schedule is distributed in English and Spanish and the educator can enroll them on-site.

When we were funded in 2001 we had one part-time bilingual health educator and the Health Education Coordinator. Our Latino population continued to grow and the demand for bilingual services increased. In 2002 we hired our bilingual health educator full time and began to offer all of our classes in both languages.

The program also has two full time Health Educators who educate the community by attending community groups, school based programs, and working with our Family Support Center. The clients are enrolled in the Healthy Start Program through the Intake worker and a referral is made at that time for educational sessions on prenatal and parenting classes. The health education team then assists the clients with other life skill classes as needed.

The Coordinator of Health Education has worked with the Healthy Start Program since its inception. She has played a critical role in the community assessment and development of the health education components.

There is a great need in the community for prevention and intervention in the areas of prenatal care, breastfeeding, parenting, and family planning. The schedule includes eight classes on a monthly basis geared toward these areas to ensure members of the communities we serve have access. Breastfeeding is on the rise and the health educators are able to provide not only a class, but one-on-one breastfeeding in homes of new mothers who need more instruction with the comforts of her natural setting. Health education is offered inside the community health center to the clients during waiting time as well as one on one in the exam rooms. Education folders have been developed for pregnant women, and are given out during each trimester. The folder not only includes educational material but, a class schedule and how to sign up. A referral system is in place with case management to ensure that the clients that are case managed are also enrolled in health education classes. We closely work with outreach to supply health education calendars to the hard to reach client and they are informed of our services. The health education department works with the family support center to provide education during the quarterly baby showers. This is a great way to share health information in a fun environment. During the baby showers we also talk about our classes and calendars are given. A partnership has been formed with our county housing authority to provide eight-week sessions of education workshops, which is geared to reach the high-risk population.

- C. In 2002 the teams of outreach and health education were combined. This was done in order to better integrate our service delivery. Outreach and education have combined activities such as our quarterly community baby showers, and our Mommy & me and parenting class. Both these services are provided in the comfortable setting of our Family Support Center. This puts our clients at ease because they have the familiar faces of the outreach team introducing them to our educational environment. Having outreach and education working in tandem has

lead to better marketing of our health education classes. Outreach markets our health education classes as well as other Healthy Start materials.

Empowering clients to participate in an education class has had challenges. This is achieved by getting the support and reinforcement of the medical staff at the local community health centers; distributing set monthly calendars in English and Spanish; and providing needed education in a creative and fun way. The educators work with case managers to utilize an incentive card for classes the client attends. The client receives a laminated Healthy Start "Card" which is punched at each medical appointment as well as each education session they attend. Once the card has been punched ten times, the client can redeem it for necessary infant goods at the Healthy Start Store.

In the four year project period over 4,000 program and community participants received health education services.

### **INTERCONCEPTIONAL CARE**

- A. Interconceptional care is key to improving the health of women. Benefits include improving pregnancy outcomes and promoting positive parenting skills to assure the best physical, intellectual, and emotionally developed infants.

When a pregnancy is spaced less than two years apart, it places increased risk for delivery of a premature infant, delivery of an infant with low birth weight, delivery of an infant with mental and physical disabilities and chronic disease. In 2001, in the Healthy Start service area, there were 995 live births. Out of 995 live births, 116 were low birth weight (LBW) and 32 were very low birth weight (VLBW). There were 5 infant deaths. Among the 126 pregnant participants in the year 2002, 12 tested positive for sexually transmitted disease (STD), 9 tested positive for Group B Strep or Bacterial Vaginosis. 36 clients admitted to smoking while they were pregnant, 4 substance abusers and 3 suffered domestic violence. 100% of these clients are on Medicaid.

A case manager works one on one with the client to ensure the client and infant has a medical home. In 2004, 98% (355/365) of Healthy Start women and 87% (240/248) of infants were enrolled in a medical home exceeding their goal. A referral for WIC is given if not already receiving services. Transportation is available through our van service.

Aunt Martha's Healthy Start project is committed to increasing the percentage of postpartum women with more than eighteen months between pregnancies. In the 2004 calendar year 126 out of 153 women (82%) had reached this goal. The project is confident it can meet its goal of 85% by 2005. In order to accomplish this each client receives case management services, educational services and referrals as needed.

Aunt Martha's Women's Health Center provides the only Title X funded Family Planning Program within the project service area. This program served 2,898 clients in FY02, compared to 2,540 clients in FY01. Each family planning client goes through a detailed history and is required to attend an extensive education session. The client and the medical provider develop a plan of care.

- B. The goal of the program is not only to focus on identifying women with medical illness or unhealthy behaviors during the interconceptional period, but impacting them. This has been done by offering education and counseling during the client's medical visit at the health centers as well as reducing barriers to attending classes. Classes have been scheduled throughout the community and transportation provided.

The program has also strived to work closer with providers and medical staff to increase awareness of the importance of the interconceptional period. This has been done through staff meetings, trainings and supervisions.

The Healthy Start program conducts interconceptional services through an array of staff including the case managers, medical providers, health educators, and outreach workers.

The Case Manager performs an assessment and provides education during routine contacts with the participant. After the birth of their child, contact is made with the woman and infant at each of the following intervals: within 48 hours after delivery, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months. The case manager visits the mother and newborn in the hospital. She brings a congratulatory gift and reviews their plan of care. An appointment is made for the newborn check-up at the community health center. At this time education topics are reviewed which includes, but is not limited to, importance of postpartum visit, family planning, birth control, STDs, substance abuse, postpartum depression, and breast feeding. The case manager also takes time to discuss "baby basics" and other questions the participant may have. Home visits enable the case manager to assess the living environment and give the worker clues to areas where she may be of assistance. Referrals are made for WIC, family planning counseling at the community health center, education classes or support groups, counseling, etc. The goal is to promote an overall healthy lifestyle.

The medical staff is able to provide interconceptional counseling during routine medical appointments, including well baby visits. All medical staff are part of the interdisciplinary team.

The health educators promote healthy lifestyles through a wide array of classes. Clients are encouraged to attend classes on nutrition, family planning, STDs, parenting, and smoking cessation (if necessary).

The Outreach Workers educate the community on positive behaviors by attending health fairs, community events and canvassing of the community. They provide referrals as necessary to the healthy start program as well as other available resources if it is beyond their scope of service.

In CY04 the Healthy Start program serviced 219 women and 248 infants during the interconceptional period.

The Healthy Start program tracks whether an infant has a newborn visit within four weeks of hospital discharge as well as immunizations. The case manager contacts the participant when her infant reaches 2, 4, 6, 9, 12, 15, 18, and 24 months of age to assess if the infant has received the age appropriate well baby visit and proper immunizations.

- C. Aunt Martha's Community Health Center provides the only Title X funded Family Planning Program within the project service area. Each family planning client goes through a detailed history and is required to attend an extensive education session. The client and the medical provider develop a plan of care. If a client is choosing a form of birth control, she must be given detailed instructions and sign a consent form. The client receives an exit interview, which allows time not only to educate, but encourage positive behavior.

Educating the client on methods of birth control and dismissing all the myths they have either heard or been told is important. The case manager, health educator and medical staff work with the client to develop a plan of care appropriate for her and her family.

Due to issues of religion, the community hospital cannot encourage the use of birth control or provide the much needed education. To ensure referrals, Aunt Martha's has built relationships with many providers on staff at the community hospital. Upon delivery at the hospital, many clients request birth control, especially the Depo-Provera injection. The local medical providers, even labor and delivery nurses, encourage the client to contact the Community Health Center. The Community Health Center is conveniently located one block from the community hospital.

Word of mouth is a powerful tool. The team has been amazed by the women who come in and say my friend told me she received a service how do I take advantage of that too? A satisfied client can be your best marketing tool.

### **DEPRESSION**

- A. According to the National Institute of Mental Health (NIMH), it is estimated that 7.9% of U.S. women experience a major depression during their lifetimes. Many others experience dysthymia, a milder and more chronic form of depression. Between 70% and 80% of women experience some type of postpartum depression that tends to start 2-3 days following birth. Of these women, about 10% will have a

more severe postpartum depression, marked by intense feelings of sadness, anxiety, or despair that impair the new mother's ability to function.

As any new parent knows, the days following the birth of a baby are both magical and stressful. Now add in factors such as housing, substance abuse, domestic violence and lack of emotional support. This is the reality our clients in Aunt Martha's Healthy Start face.

In January of 2002, the Illinois Healthy Start Partnership provided training for all the direct line staff. The goals of the presentation were to introduce participants to mood disorders related to childbirth, identify risk indicators and symptoms for the mood disorders, and provide general guidelines for treatment and prevention.

To ensure successful integration, additional training was also provided for the case managers and medical staff prior to the implementation of the Edinburgh Tool. Aunt Martha's was also able to link with Grand Prairie Mental Health Center, which is the largest mental health provider in the south suburban area. A full-time Licensed Clinical Professional Counselor is now located at the Vincennes Community Health Center, providing a seamless transfer to mental health services for our prenatal clients.

Aunt Martha's Healthy Start began screening prenatal clients for depression in July 2002. The tool being used at that time was the Edinburgh Postnatal Depression Scale (EPDS). The screening was a self-administered tool given to the client by the case manager at intake to the program (ideally during pregnancy), seven days after delivery and six weeks post-partum. The case manager scored the tool and makes referrals to counseling and/or psychiatry. 14 of 57 clients (25%) screened positive and required a referral for further assessment.

As the Community Access Program developed, Aunt Martha's has been able to locate a case manager at the community hospital emergency room, where many prenatal clients go for care if they do not have a medical home. The case manager links the pregnant client to Aunt Martha's, and schedules an appointment at the Community Health Center. The Healthy Start Case Manager is notified and begins immediate intervention, including a depression screening.

Aunt Martha's participates in the HRSA, Bureau of Primary Health Care, Health Disparities Collaborative on Adult and Adolescent Depression. This collaborative incorporates a patient centered care model and is designed to develop best practices for treating depression in a primary health care setting.

In January 2004, all Healthy Start clients began being screened using the Patient Health Questionnaire (PHQ), which has shown to be a reliable and valid measure of depression severity. The PHQ is available in English and Spanish. The PHQ is a brief, 9-item self-report depression assessment tool that was derived from the

interview-based PRIME-MD.<sup>2</sup> Research indicates that the instrument takes patients about 5 minutes to complete and can be scored in less than 30 seconds. The PHQ has been shown to be a useful tool for the diagnosis of major depression in primary care, with acceptable reliability, validity, sensitivity, and specificity. The 9 items of the PHQ target the 9 DSM-IV signs and symptoms of major depression.

In addition to its use as a diagnostic instrument, the PHQ can also be used as a severity tool. With possible scores ranging from 0-27, higher scores on the PHQ are highly correlated with other measures of depression severity. Many clinicians and organizations are currently tracking PHQ severity over time (e.g. as a result of treatment). Because the items on the PHQ are so similar to items on other validated depression outcome measures, the face validity for using PHQ in this way is quite high.<sup>3</sup>

- B. The initial depression screening is administered by the Intake Coordinator. The Intake Coordinator is a case manager employed in the Healthy Start program providing .80 FTE's. Additional perinatal depression screenings take place in the participants third trimester and within 6 weeks after delivery.

After a positive screen for depression, the participant's medical provider is given a copy of the results and that provider will determine whether the client should be seen by the licensed counselor and/or the community health center's psychiatrist. The communities the program serves are fortunate to have a mental health agency that collaborates with the community health centers. The mental health agency has bi-lingual capabilities and accepts many insurance plans, public aid as well a sliding fee scale for residents with no insurance.

Due to the health disparities collaborative the screening results are tracked in the Patient Electronic Care System (PECS). This allows staff to track follow-up appointments, medications, and measure outcomes. If the participant is diagnosed with clinically significant depression (CSD) as indicated by their PHQ score, an interdisciplinary staffing will be held with case management, medical staff, and counselor/psychiatrist.

If the woman does not follow through with the mental health referral the case manager, health educator and medical staff will educate and reinforce the importance at each proceeding visit and assist with rescheduling.

Beyond the screening the program continues to educate clients about the signs and symptoms of perinatal depression during the initial interview with the case manager, as well as at required visits with the client (during pregnancy and after).

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<sup>2</sup> Spitzer RL, Kroenke, K, Williams JB. Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. Primary Care Evaluation of Mental Disorders. Patient Health Questionnaire. JAMA 1999;282:1737-44.

<sup>3</sup> Kroenke K, Spitzer RL. The PHQ-9: A new depression and diagnostic severity measure. Psychiatric Annals 2002; 32:509-521.

Signs and symptoms of perinatal depression are also reiterated during prenatal class and during each trimester when the client receives a prenatal packet.

- C. Anytime a screening tool is being utilized it takes training to administer it. Clients are quick to build up a wall and feel threatened. If the questions are asked in a certain way it can come across as non-threatening. The team has invested time in training to be able to meet this task.

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To ensure successful integration, additional trainings were provided for the case managers and medical staff prior to the implementation of the Edinburgh Tool. Aunt Martha's was also able to link with Grand Prairie Mental Health Center, which is the largest mental health provider in the south suburban area. A full-time Licensed Clinical Professional Counselor was located at the Vincennes Community Health Center, providing a seamless transfer to mental health services for our prenatal clients.

It is crucial to have all the team players at the table. It is not possible to screen for depression and not have anywhere to refer your client. The program has committed to form the relationships necessary to give the client the care they need and deserve. This has brought us to the table with the local mental health provider, local physicians and hospitals. The depression collaborative has only strengthened these bonds as we work with national experts in this area.

Participating in the depression collaborative has already proven successful. Over half of the CSD (clinically significantly depressed) patients in the depression collaborative have had a 50% or more reduction in their PHQ score upon reassessment 4-8 weeks after initial screening took place. The successful team consists of the medical director, RN, case manager, counselor, primary care physician, and program assistant. This project has assisted the healthy start program in making a strong commitment to educate, screen and treat depression as well as collect data that is entered into an extensive data base which can be compared with other communities nationwide.

The changes made in depression screening and prevention and treatment has allowed the Healthy Start Project to be on the cutting edge working closely with National experts whom provide training and consultation to our implementation team.

### **LOCAL HEALTH SYSTEM ACTION PLAN**

- A. Several needs assessments in the target area were utilized to identify key community partners and gaps in the service area. These assessments include:

- ❖ Healthy Start Local Evaluation (ongoing):
- ❖ Uncompensated Care Task Force of St. James Hospital
- ❖ Community Needs Assessment of Suburban Cook County
- ❖ Community Needs Assessment, Resident Council Cook County
- ❖ Public Housing Project in Chicago Heights.
- ❖ Focus Groups

Summary of Needs Assessments: The Aunt Martha's service area suffers from high levels of poverty and unemployment, low levels of education, and social problems such as crime and substance abuse. There is a lack of sufficient capacity for low income uninsured and underinsured patients to have a regular source for primary health care. The mainstream health care delivery system in the south suburbs is oriented toward serving a commercially insured marketplace.

St. James Hospital's ER is an anchor among safety-net providers. As a percentage of total revenue, St. James provided twice as much care to self-pay ER patients, than four other local hospitals in the south suburbs. St. James' emergency room experienced steady growth in the number of uninsured outpatients per year for the period 1997 to 2000. The number of uninsured outpatients declined somewhat from a high of 6,155 in 2000 to 5,641 in 2001. The decline can be attributed in part to SCHIP (KidCare) eligibility, and increase reliance on the safety net providers.

While there are several programs available for pregnant and parenting women and their children, there are still gaps and insufficient resources in the local perinatal service delivery system. Many programs have very strict eligibility guidelines; others do not have the capacity to serve those in need. In general, there is a lack of timely, affordable services available for Medicaid, uninsured, and underinsured women. Illinois Department of Public Health data showed that from 1997-1999; one third of women (31.9%) did not receive first trimester care. This is nearly double the state rate. Also, 4.3% of women received no prenatal care, which is triple the state rate.

Health and social service providers do not have adequate resources to meet the demand for services. Services are very often fragmented which has resulted in women and infants not receiving proper follow-up. This is especially critical for the high-risk populations in our service area. In addition to the medical needs of low-income, teen, and single pregnant and parenting females, many of these women need ongoing support and assistance in finding resources to help support themselves and their families.

A total of 47 prenatal clients participated in two focus groups in December 2002, and the findings indicated that many of the services, which are needed, are currently provided in the community. Needs identified included: parenting classes, breastfeeding classes, Lamaze, childcare, housing, Dentist, birth control, and children supplies.

### **Priority Needs**

The Local Health Action Plan, which is linked with the State Title V Action Plan, has identified three variables to improve the perinatal system within the Healthy Start service area:

- *Early and Continuous Access to Prenatal Care*
- *Health education and outreach that communicates effectively how to access health care.*
- *Continuum of care between primary health care and behavioral health care services.*

- B. The first step was to develop a community wide-resource manual. This manual was distributed by the outreach team into the community and is available at the community hospital and city hall.

HRSA funding was obtained from the Maternal Child Health Bureau for a one year Community Access Program (CAP) which encompasses the Healthy Start service area. These Healthy Start Consortium members are: ACCESS Health Network, St. James Hospital, Cook County Department of Public Health and Aunt Martha's Youth Service Center. This program changed how safety-net providers operated and related to each other – CAP Lay Advocates and Case Managers set up a computerized referral system from the emergency room to community health centers.

This program was instrumental in getting the community health centers to evaluate their scheduling processes resulting in increasing available capacity for the uninsured and underinsured. Together the two community health centers in the healthy start service area had 24,000 encounters from 7/02 – 7/03.

The CAP Community Workers enrolled 2,845 area residents into primary care at the local community health centers in only one year. Through the programs benefits counselors, 2134 residents applied and received some form of public benefits.

In 2004, almost 72% of Aunt Martha's Community Health Center clients entered prenatal care in the first trimester as compared with approximately 55% in 2001. Of the Healthy Start participants, over 82% entered prenatal care in the first trimester in 2004 as compared with 52% in 2001.

Behavioral health services were connected to primary health care. Governors State University and Aunt Martha's received an evaluation grant to evaluate the effectiveness of screening instruments for adolescent depression at the Aunt Martha's Community Health Center in Chicago Heights, IL.

A partnership agreement with Grand Prairie Mental Health was developed providing increased behavioral health treatment. Grand Prairie placed a licensed counselor full-time at the Aunt Martha's Community Health Center.

- C. The Local health System Action Plan has been used to provide community and political attention on system changes needed in the perinatal network in the South Suburban area.

The Crossroads Coalition has had great success in getting the necessary groups to collaborate, but it has been difficult to get the different communities to come together and unite on an ongoing basis. The Cook County South Suburban Area is comprised of over 20 towns, villages, and townships each with their own political climate.

It has been challenging to recruit and involve Healthy Start clients and community residents in the development of the Local health Systems Action Plan. These participants are not comfortable in participation at meetings with key community partners. Two focus groups were held for Healthy Start clients and community residents to solicit input and support.

In July 2001, Aunt Martha's integrated its case management services to ensure comprehensive quality care. DHS, Illinois' Title V agency, has noted Aunt Martha's innovation, commitment, and quality in the provision of these services. The Teen Parenting Services Program, which provides case management services to expectant teen mothers and their newborns, became part of our case management services in January 2002. These changes have allowed Aunt Martha's to better identify high risk prenatal clients who are eligible for Healthy Start services.

In October 2001, Healthy Start case managers began visiting all clients within 24 hours after delivery. A gift was provided that included an immunization calendar, and case managers offered to help them schedule their child's first well-baby visit and their post partum visit.

The Chicago Heights Community Health Center continues to strive to be a one-stop shop for health and related services. Other community agencies are co-located in our clinic. The Women, Infants and Children (WIC) program operated by the Community Economic Development Association (CEDA) has an office in our clinic, and increased their days of operation from two to five days a week starting in April 2001. .

In June 2001, the Aunt Martha's Vincennes-Community Health Center recruited a dentist to practice at the Vincennes-Community Health Center using the new dental suites, which includes 3 operatories. The Healthy Start Program has been able to refer clients on-site for oral health services.

### **CONSORTIUM**

- A. The Crossroads Coalition, which currently serves as the Healthy Start Consortium, was formed in 1998 as a collaboration of community agencies and healthcare providers, in the South Suburbs of Chicago, addressing maternal and child health care needs of low-income residents and to insure access to quality, convenient and affordable care.

Aunt Martha's Healthy Start Consortium provides the leadership and coordination necessary to improve the integration of all perinatal services and increase access for uninsured and underinsured in our Healthy Start service area.

The Mission of Crossroads Coalition, the Aunt Martha's Healthy Start Consortium, is to build a collaboration of organizations and individuals who share a common vision for improving the health status of the diverse residents of the South Suburbs through:

- Implementing effective outreach strategies;
- Facilitation/coordination of services;
- Empowering people to gain access to quality healthcare;
- Advocating for effective policy programs and equitable distribution of resources

The membership is comprised of a diverse group of service providers and consumers and includes: prenatal mothers, Healthy Start clients, hospitals, community health centers, Cook County Department of Public Health, mental health, social services, and community services and programs.

- B. The Crossroads coalition meets on a monthly basis, with opposing months reserved for the board of directors. Shannon King, Coordinator of Outreach for the Healthy Start Program, sits on the Board of Directors. Ms. King currently holds the role of Treasurer. This role assists, Ms. King and the coalition in keeping on task with the goals of the Healthy Start program. At each meeting Healthy Start is placed as an agenda item. This allows time to be allotted specifically for Healthy Start activities. Meeting on a regular basis allows for planning to take place in order to meet the Healthy Start objectives. This is a time to discuss where we are at in our overall plan of action. This includes dealing with programmatic issues, strategic planning, communication/media efforts, developing the scope of services, personnel recruiting/hiring, data collection and sustainability of program activities.

Including the consumer is a critical piece in this relationship. Consumers are encouraged to play an active role in the consortium. The consumers will be educated and trained on what a consortium is, how it works, and the role they can play. Consumers will be encouraged to vote on budget/financing of the consortium funds. Focus groups will also be used with consumers, in part, to recruit members for the consortium. The consumer perspective will be critical to know what services the communities need.

The Healthy Start Consortium has a Community Liaison that is responsible for coordinating the activities between the consortium and the Crossroads Coalition. The duties include assisting in the recruitment of members to the consortium, coordinate and attend committee and executive meetings, record minutes and distribute, provide presentations to neighborhood and community groups regarding the activities of the consortium. This position also develops and maintains linkages with community and health service organizations. The Community Liaison reports to the Executive Board.

- C. Crossroads Coalition was extremely successful in mobilizing community efforts and assisting in securing funding to address the needs of the perinatal system. In the last funding cycle the coalition has:
- ❖ Formed a committee to address problems public aide recipients are having accessing Medicaid HMO providers in their community. Three community meetings were held between August 2003 and January 2004 with the Department of Public Aide, private physicians, community health centers, hospitals, and legislators. Funding was obtained in March 2004 to conduct focus groups with public aide HMO recipients.
  - ❖ Helped Governor's State University and Aunt Martha's received funding to evaluate the effectiveness of behavioral health screening instruments at the Aunt Martha's Vincennes Health Center.
  - ❖ Played a major part in bringing the South Suburban colleges and universities that provide allied health care education which led to a Department of Labor grant to expand health care education and increase access to minority groups in January 2004.
  - ❖ Funding to Crossroads members was received from HRSA for years two and three for the Community Access Program which is integrating safety-net services and expanding access to primary health care in the South Suburbs
  - ❖ Brought the IL Department of Children and Family Services together with the medical providers involved in CAP to enable abused and neglected children in the South Suburbs to receive comprehensive physicals within 21 days after being placed in foster care.
  - ❖ First Annual Pioneer Awards Celebration held during African American History Month, February 26, 2004, to recognize and celebrate the long history of the pioneering advances of African Americans in the field of science and medicine

There are challenges to the effectiveness of the consortium. The barriers include insufficient staff time, lack of healthy start resources, attendance by key members; political environment; resources in the state or communities are insufficient to support the goals of the consortium.

#### Additional Elements Regarding Consortium:

1. Aunt Martha's Consortium was established in 1997 as an adjunct of the preexisting Aunt Martha's Health Services Advisory board. The composition was 95% consumer based. The majority of the members being pregnant and parenting females. Non-consumers represented a local church, CEDA, and a student.

In 2001, the Aunt Martha's Healthy Start Consortium merged with the Crossroads Coalition. This allowed greater representation from service providers, community organizations, health centers, health departments and hospitals in the project area. The change enhanced our collaboration by expanding our linkages and providing us with valuable input on maternal and child health needs in our target area.

Barriers that were faced included fears of losing identity and retention of consumers. The fear of losing identity was overcome by structuring the agenda to include Healthy Start as an agenda item at each meeting. The Consortium revised its by-laws and elected an executive board and officers. The Healthy Start Program representative currently serves as Treasurer.

New strategies involving consumers was initiated. The Consortium held community meetings encouraging consumers to voice their concerns and identify gaps in services in their community. Aunt Martha's continues to offer transportation, incentive items and refreshments to encourage community participation. Village Trustees, Consortium members and Outreach workers encourage participation and distribute fliers to ensure knowledge of the meetings.

As consumers became more involved in Consortium activities, they received training from Healthy Start staff and were encouraged to attend workshops and conferences. Consumers were encouraged to participate in the activities of the Illinois Healthy Start Partnership. This gave them an opportunity to meet consumers from other programs and learn how other Healthy Start Programs are organized and provide services.

Community service providers who are members of the Consortium have reached out to their clients and invited their participation.

2. The working structure of the Consortium (see organizational chart Appendix C)

The Crossroads coalition meets on a monthly basis, with opposing months reserved for the board of directors. Shannon King, Coordinator of Outreach for the Healthy Start Program, sits on the Board of Directors. Ms. King currently holds the role of Treasurer. This role assists, Ms. King and the coalition in keeping on task with the goals of the Healthy Start program. At each meeting Healthy Start is placed as an agenda item. This allows time to be allotted specifically for Healthy Start activities. Meeting on a regular basis allows for planning to take place in order to meet the Healthy Start objectives. This is a time to discuss where we are at in our overall plan of action. This includes dealing with programmatic issues, strategic planning, communication/media efforts, developing the scope of services, personnel recruiting/hiring, data collection and sustainability of program activities.

Including the consumer is a critical piece in this relationship. Consumers are encouraged to play an active role in the consortium. The consumers are educated and trained on what a consortium is, how it works, and the role they can play. Consumers are encouraged to vote on budget/financing of the consortium funds. Focus groups are used with consumers, in part, to recruit members for the consortium. The consumer perspective is a critical to know what services the communities need.

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The number of members serving on the consortium is 25. The members of the consortium represent the following categories:

- State or local government (G) 15%
- Program Participant (PP) 15%
- Community participant (CP) 10%
- Community-based organizations (CBO) 35%
- Private agencies or organizations (not community based)(PAO) 20%
- Providers contracting with the Healthy Start program (PC) 0%
- Other providers (OP) 5%

The racial/ethnic breakdown of consortium by percentage is:

- African American 52%
- Hispanic 13%
- White 31%
- Other 1%

The percentage of the consortium that are currently active is 75% (active is defined as attending at least 50 percent of meetings of the full consortium).

3. Crossroads Coalition was extremely successful in mobilizing community efforts and assisting in securing funding to address the needs of the perinatal system. (See C above)
4. The communities’ major strengths include the willingness to work toward common goals and coordinate efforts. This has been evident with the Crossroads Coalition embracing the Healthy Start Goals and becoming the Consortium in 2001. The consortium includes social service agencies, health centers, hospitals, universities, churches and local business representatives. This allows for sharing of resources. The willingness of the community health centers to work together and address the needs of the residents.
5. There are challenges to the effectiveness of the consortium. The barriers that were faced and overcome include insufficient staff time, lack of healthy start resources, membership lacks critical stakeholders, attendance by key members, no history of

collaborative efforts; political environment; resources in the state or community are insufficient to support the goals of the consortium.

A Community Liaison was contracted allowing sufficient time to be allocated to consortium efforts.

The healthy start program works with existing resources in the communities it serves. The Crossroads Coalition (healthy start consortium) allows for collaboration amongst its members and provides additional resources.

It is crucial to have critical stakeholders as members. The Crossroads Coalition (healthy start consortium) is an established coalition with key members of the community. This includes members representing government, universities, social service agencies and health care. The members participate in this coalition because they benefit by not only being a voice in their community, but by having a means of collaboration and support.

Competing agendas of member organizations create barriers, but successful demonstrations of collaborations, especially in regards to getting funding will successfully impact this.

The political environment and lack of resources in the state and community is important in regard to sustaining fundamental system changes in the perinatal system. Aunt Martha's continues to aggressively pursue revenue through sources such as cost-based reimbursement, Illinois' SCHIP program and Kidcare, 330 funding, and fundraising from individuals, community groups, local businesses and churches for unrestricted funding which can be applied to the provision of healthy start services.

6. Consumer participation was an initial barrier, but new strategies for involving consumers was initiated. The Consortium held community meetings encouraging consumers to voice their concerns and identify gaps in services in their community. Aunt Martha's continues to offer transportation, incentive items and refreshments to encourage community participation. Village Trustees, Consortium members and Outreach workers encourage participation and distribute fliers to ensure knowledge of the meetings.

As consumers became more involved in Consortium activities, they received training from Healthy Start staff and were encouraged to attend workshops and conferences. Consumers were encouraged to participate in the activities of the Illinois Healthy Start Partnership. This gave them an opportunity to meet consumers from other programs and learn how other Healthy Start Programs are organized and provide services.

Community service providers who are members of the Consortium have reached out to their clients and invited their participation.

7. Consumer input was obtained through focus groups and surveys.
8. The suggestions by the consumers were taken seriously and reviewed by the Healthy Start Staff and the Consortium. This allowed for a discussion to take place along with a plan of action. Once a plan was put into action it was monitored and re-evaluated in thirty days.

### **COLLABORATION AND COORDINATION WITH STATE TITLE V AND OTHER AGENCIES**

- A. Aunt Martha's has a long history of collaboration and coordination with our State Title V agency – the Illinois Department of Human Services (DHS). Aunt Martha's delivers services through a number of DHS programs. DHS has been impressed with the way that Aunt Martha's can integrate several small state-funded programs to provide a comprehensive service system, serving the maximum number of people with combined resources. DHS has noted Aunt Martha's innovation, commitment, and quality in the provision of our services. This year, with strong support from DHS, Aunt Martha's has integrated its case management services to ensure comprehensive quality care. The Teen Parenting Services Program (TPS), which provides case management services to expectant teen mothers and their newborns, became part of our case management services in January 2002. The integration of case management services and the addition of TPS has increased Aunt Martha's ability to identify high risk prenatal clients who are eligible for Healthy Start services.

Another level of cooperation with DHS is through the Illinois Healthy Start Partnership. This collaboration of the DHS Bureau of Maternal and Infant Health and the six Illinois Healthy Start programs has resulted in the sharing of best practices, an increased understanding of maternal and child health issues across various regions, and an enhanced commitment by all participants to improving maternal and child health outcomes in our respective service areas.

The Partnership has been effective at providing technical assistance to the six Illinois Healthy Start programs. Aunt Martha's has shared its successes in collaboration, data management, local coalition building, and integrating services for pregnant and parenting clients of other Healthy Start initiatives. These dialogues have helped Healthy Start projects understand each other, the State's priorities, and the perinatal system at large.

- B. The Illinois Healthy Start Partnership administers several programs jointly with the state's Title V Maternal and Child Health Program:
- ❖ *Family Case Management.* All six Healthy Start grantees in Illinois participate in the state's Family Case Management Program which provides low income pregnant women with linkage to public benefits and basic human services with the goal of promoting a stable beginning for each newborn.

- ❖ *High Risk Care Management.* All high risk infants born in Illinois, including those with low birth weight, and those who are substance exposed, receive public health nursing follow up care through this state program.
- ❖ *Information Systems.* The Illinois Department of Public Health administers several tracking and registry programs that are critical resources for Healthy Start grantees. The Adverse Pregnancy Outcomes Reporting System (APORS) data base helps track neonatal risk, and represents a critical resource for assuring service linkages for infants at risk. The state's "Cornerstone" database system generates an annual statewide portrait of psychosocial issues affecting pregnant women and services levels afforded through case management.

The collaboration with perhaps the most dramatic impact on the visibility of the Illinois Healthy Start grantees and their effectiveness within their respective communities has been the sponsorship of three consumer conferences. These conferences, planned and organized by consortium members from across the state, brought together hundreds of Healthy Start patients and family members to focus their attention on resources valued by patients (for example, stress management techniques), their families (for example, male involvement practices), and their communities (for example, keynote by Congressman Jesse Jackson, Jr). A widely distributed summary of the second conference offers a replicable model of the structure of the conference, discussing the impact of the conference on future community level activity.<sup>4</sup>

The Illinois Healthy Start Partnership continues to meet quarterly to pursue an agenda in line with the Title V State Plan. The Partnership effort includes the following joint activities:

- ❖ *Depression screening.* In response to the work of the six grantees, the state has convened an Illinois Perinatal Depression Task Force and has initiated an effort to promote provider education on anticipated morbidity rates, screening tools and intervention mechanisms. Drawing on our expertise in depression screening and on the data that we have compiled on maternal depression, the Illinois Healthy Start Partnership will continue to be an advocate for mental health resources for pregnant women and for parents of infants.
- ❖ *Sustainability.* All of the delivery sites within the Partnership are either Federally Qualified Health Centers (FQHCs) or public health department clinics. This grantee structure in turn provides a set of agency and voluntary advocacy association contacts for the Partnership which are critical for program sustainability. For example, the original Healthy Start "clinical model" which allowed grantees to build high risk obstetrics and gynecology resources for high risk women in underserved areas has resulted in sustainable provider practices, which are now enhanced by Healthy Start enabling services. In turn, the funders that support these health centers and clinics view the collaboration with Healthy Start as a key model for building programs for the underserved given limited funds for primary health care and enabling services.

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<sup>4</sup> Illinois Healthy Start Partnership, Knox, Melanie, "Building Healthy Families." Report on the Illinois Healthy Start Consumer Conference. Chicago, 2001.

- ❖ *National association.* The Illinois Healthy Start Partnership is a founding member of the National Healthy Start Association. Currently, Illinois has sent a consumer/lay advocate representative to their governing board and two senior staff participate on their sustainability committee.<sup>5</sup> This Association provides a robust network for education regarding best practices and a forum for promoting Healthy Start program sustainability.

In addition to working closely with many programs and bureaus of the State Title V agency, Aunt Martha's works with a number of local public and private agencies at varying levels in the delivery of perinatal health care. These collaborations include:

#### ***WOMEN'S HEALTH CENTER***

As a result of the comprehensive and integrated care, including Healthy Start services, patients received at Vincennes Health Center the number of prenatal patients saw a dramatic growth. In FY'04 the prenatal clinic was providing over 230 prenatal visits per month. A new Women's Health Center was created, within two miles of the Vincennes Health Center in January 2004. This health center provides prenatal, family planning, and other medical care to women. The Family support center is located at the Women's Health Center along with the health educators, Community Representatives (Outreach Workers), and Case Managers. Case managers are able to provide face to face visits during their clinic time.

#### ***HARVEY COMMUNITY HEALTH CENTER***

The Harvey Community Health Center is a Federally Qualified Health Center. The health center opened in 2002. The health center has approximately 400 visits a month. Due to the increase need for prenatal care in this community the health center will be expanding to include prenatal services in the Spring of 2005. The health center will work closely to refer participants into the healthy start program in order to provide them with the most comprehensive services.

#### ***CHICAGO HEIGHTS COMMUNITY HEALTH CENTER***

The Chicago Heights Community Health Center is a Federally Qualified Health Center that recently expanded its capacity by adding a full-time Pediatrician and Internal Medicine providers as well as doubled their space. The health center has approximately 1000 visits a month. Healthy Start has a case manager on-site to provide services.

#### ***CEDA WIC***

The CEDA WIC program is a nutrition supplement program for Women, Infants and Children. This service is offered on-site at the Women's Health Center. They have been involved with the community health center since September 1998. The CEDA WIC program offers not only assistance with nutritional supplements, but breast feeding education and breast pumps for those enrolled. WIC has been a primary source of referrals for the Healthy Program.

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<sup>5</sup> Membership dues paid to associations are NOT derived from federal Healthy Start funds by any of the Illinois grantees.

***Kid Care***

Kid Care is the state's child health insurance program (SHIP) designed to assist pregnant women, parenting women and infants. This program has been a part of Aunt Martha's scope of services since the agency's inception. The majority of participants and clients seen at the Chicago Heights Community Health Center, Harvey Health Center and the Women's Health Center are Medicaid recipients or Medicaid-eligible. A full time patient benefits associate ensures that all eligible clients are enrolled. In CY 03 a total of 640 Kid Care applications were submitted to the state.

***Family Planning Title X Grant***

Aunt Martha's has been a Title X Family Planning Grantee through the Department of Human Services Family Planning Program since 1977. This program provides family planning services on a sliding fee scale to childbearing-aged women.

***Behavioral Health***

Aunt Martha's has integrated behavioral health care within their Community Health Centers. Grand Prairie Mental Health Center has located a full time Licensed Certified Professional Clinician (LCPC) on site to see clients referred from the health center. This will include prenatal clients with a positive score on the depression screening. A psychiatrist is also available for the patients requiring medication management or further clinical assessment. In addition Aunt Martha's is part of the Bureau of Primary Health, Health Disparity Collaborative – on Adult and adolescent depression.

Substance abuse assessment, counseling, and referrals are made internally to Aunt Martha's Substance Abuse Treatment Program.

***South Suburban Health Collaborative***

A HRSA Community Access Project was funded in September 2002, to extend the safety net for the underserved and expand access to uninsured and underinsured residents. The Healthy Start service area is targeted and Aunt Martha's is one of the four collaborative partners. Other collaborators include: Access Community Health Network, St. James Hospital, and Cook County Department of Public Health.

***Administration for Children, Youth and Families***

Aunt Martha's Youth Service Center is funded through the Administration for Children, Youth and Families to provide Basic Center, Street Outreach and Transitional Living Service for runaway and homeless youth. The Women's Health Center provides medical services for youth that are pregnant and need services. The Chicago Heights Community Health Center is able to provide other primary and preventative care as needed by these youth and adolescents. The shelters and location of these youth may fall within Aunt Martha's target area and, therefore, can be provided services through the Healthy Start program.

***Dental***

Oral health services have been provided at the Chicago Heights Health Center since March 1, 2003. Prenatal participants are referred for an oral health screening during their second trimester.

***Education***

Aunt Martha's also has a GED program located in Park Forest, IL, located just west of our service area. This GED program refers their students that meet the requirement of Healthy Start, for education, case management or medical services. Another educational service offered by Aunt Martha's includes our Healthy Families Illinois program. Healthy Start refers participants to this program for support services.

- C. The Illinois Healthy Start Partnership is strengthened by having the Illinois Department of Human Services at the table at every meeting in an organizing role; not only is this agency the state's original Healthy Start grantee, but also, it develops and administers the state's Title V Maternal and Child Health State Plan.<sup>6</sup> As a result, all of Illinois Healthy Start grantees enjoy a high degree of integration of their infant mortality and low birth weight initiatives with the Maternal and Child Health State Plan and have access to related state services that support women, infants and families.

In turn, the six Illinois Healthy Start projects contribute to the effectiveness of the State Plan which is built around both national and also statewide performance measures, several of which match closely with Healthy Start objectives.<sup>7</sup>

Our six funded programs provide our state with the opportunity to benefit in ways that outstrip the capacity of any one grantee acting alone. No single grantee alone could have the impact on the state of the state Title V Maternal and Child Health Plan as compared with the effect of the six programs together. Further, no grantee alone will be able to mobilize the types of education, consumer involvement through conferences, expertise, and advertising capacity that the grantees can launch together. Each grantee has an important role at our table, each contributing complementary strengths, and sustaining working relationships built through years of Healthy Start experience. The promise of six collaborative grantees in Illinois, all focused on the infant mortality and low birth weight components of the state's Maternal and Child Health Plan, remains highly important for the state as whole as well as for each grantee community.

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<sup>6</sup> Illinois Department of Human Services. "Maternal and Child Health Block Grant Annual Report for FY03 and Application for FY05." Springfield, Illinois, July 15, 2004.

<sup>7</sup> National Performance Measures include: #7 fully immunized two-year-olds, #11 breastfeeding at hospital discharge, #15 very low birthweight, #18 first trimester prenatal care. State Performance Measures include: #1 adequate prenatal care, and #2 interpartum interval.

## SUSTAINABILITY

- A. As a Federally Qualified Health Center, Aunt Martha's is able to bill for cost-based reimbursement for services provided to Medicaid-eligible clients at Chicago Heights Community Health Center, and the Women's Health Center. The resulting Public Aid revenue is used to fund a significant portion of our providers and their support staff as part of our Healthy Start Program.

Aunt Martha's continues to aggressively pursue revenue made available through Illinois' SCHIP program KidCare. The Community Health Center remains an Outstation Provider Site, which allows us to receive payment for each application submitted which results in a successful enrollment. Additionally, our case managers and nursing staff have been trained to enroll patients into KidCare.

Aunt Martha's contracts with the Illinois Department of Human Services to provide family planning, and with the Cook County Department of Public Health to provide family case management services at the Community Health Center.

Aunt Martha's continues to sub-lease office space to local Women, Infants, and Children (WIC) programs and Community Health Partnership, which provides health services to migrant farm workers. This allows our clients to do "one-stop-shopping" and helps to offset some fixed building costs for the agency.

Aunt Martha's experience maximizing revenue and operating efficiently during the program period includes:

- ❖ Billing for cost-based reimbursement
- ❖ Received Section 330 Community Health Center funding
- ❖ Family case management contract
- ❖ Syphilis Grant – medical and education services Title X family planning grant
- ❖ Client fees from sliding fee scale
- ❖ Rent office space to CEDA/WIC and Community Health Partnership
- ❖ Subcontracts with CCDPH to provide outreach services and HIV/AIDS education, testing, and referral

The agency also conducts fundraising from individuals, community groups, local businesses and churches for unrestricted funding which can be applied to the provision of Healthy Start services.

- B. The Division Manager and the development department at Aunt Martha's have major responsibilities for sustainability. Other Healthy Start staff assists in identifying funding opportunities, as well as grant writing. In 2002, the Suburban Service League of Flossmoor, IL adopted Aunt Martha's Healthy Start Family Support Center and provided \$1,500 to purchase child care and other educational supplies. The Service League has agreed to continue to help meet the needs of the Family Support Center.

Aunt Martha's is one of the six Healthy Start projects which collaborate as the Illinois Healthy Start Partnership to share resources, exchange best practices, and join efforts on sustainability strategies. The Illinois Department of Human Services, one of the Healthy Start Partnership members, is responsible for developing and administering the state's Title V Maternal and Child Health State Plan. As a result, Aunt Martha's enjoys a high degree of integration in the states infant mortality and low birth weight initiatives with the Maternal and Child Health State Plan and have access to related state services that support women, infants and families.

All of the delivery sites within the Partnership are either Federally Qualified Health Centers (FQHCs) or public health department clinics. This grantee structure in turn provides a set of agency and voluntary advocacy association contacts for the Partnership which are critical for program sustainability. For example, the original Healthy Start "clinical model" which allowed grantees to build high risk obstetrics and gynecology resources for high risk women in underserved areas has resulted in sustainable provider practices, which are now enhanced by Healthy Start enabling services. In turn, the funders that support these health centers and clinics view the collaboration with Healthy Start as a key model for building programs for the underserved given limited funds for primary health care and enabling services.

- C. As a Federally Qualified Health Center, Aunt Martha's is able to bill Medicaid for cost-based reimbursement for medical services provided to pregnant Healthy Start clients and their children. The leveraging of Healthy Start services and funding has allowed Aunt Martha's to add two FQHC health centers in the targeted community area. The Women Health's Center, which opened in January 2004, currently is providing prenatal care to 300 patients. The Harvey Community Health Center, which opened in February 2004, provides adult and pediatric care. OB/GYN services are to be initiated in 2005. Healthy Start services will be integrated on site at both of these health centers in addition to the Chicago Heights Community Health Center. The resulting Public Aid revenue is used to fund a significant portion of our providers and their support staff as part of our Healthy Start Program.

Crossroads Coalition, the consortium, has assumed more responsibility for sustainability by becoming a 501-C-3 not-for-profit organization. Crossroads has successfully obtained a POET grant to increase access to care for women and an Export grant that is developing behavioral health care services.

***Additional Elements for Sustainability:***

- 1) As a Federally Qualified Health Center, Aunt Martha's is able to bill Medicaid for cost-based reimbursement for medical services provided to pregnant Healthy Start clients and their children. The leveraging of Healthy Start services and funding has allowed Aunt Martha's to add two FQHC health centers in the targeted community area. The Women Health's Center, which opened in January 2004, currently is providing prenatal care to 300 patients. The Harvey Community Health Center, which opened in February 2004, provides adult and pediatric care. OB/GYN services are to be initiated in 2005. Healthy Start services will be integrated on site

at both of these health centers in addition to the Chicago Heights Community Health Center. The resulting Public Aid revenue is used to fund a significant portion of our providers and their support staff as part of our Healthy Start Program.

The agency also conducts fundraising from individuals, community groups, local businesses and churches for unrestricted funding which can be applied to the provision of Healthy Start services.

In addition to Medicaid reimbursements Aunt Martha's continually seeks funding from local, state, and other federal grants. Currently Aunt Martha's receives funding as part of the Health Community Access Program (HCAP) working to increase access to care and eliminate health disparities. Aunt Martha's also is receiving funding from the county for syphilis out reach prevention program. Aunt Martha's also sub-leases office space to the local Women, Infants, and Children (WIC) program at the Women's Health Center, which allows our clients to do "one-stop—shopping" and helps to offset some fixed building costs.

- 2) Aunt Martha's has developed a long range strategy in order to sustain Healthy Start's work. This includes Healthy Start as an integral part of our Federally Qualified Health Centers. This not only allows integration of services but allows the agency to leverage funding sources.

The Women's Health Center, which opened in January 2004, is currently providing prenatal care to over 300 women. The Harvey Community Health Center, which opened in February 2004, provides adult and pediatric care. OB/GYN services were initiated in June 2005.

- 3) The project has overcome barriers in order to continue interventions without Healthy Start funding by integrating with the Federally Qualified Health Centers. The program could sustain, although interventions would be limited.

### **III. Project Management and Governance**

- A. All services and programs provided by Aunt Martha's operate under the authority of the agency's Board of Directors, the President/CEO, and key management staff. The President/CEO, a full-time employee of Aunt Martha's, is an agent of the Board of Directors, is hired, evaluated, and dismissed by the Board, and remains accountable to the Board at all times. He maintains full responsibility for the Community Health Centers, including oversight of the health center's operations.

Aunt Martha's organizational structure is designed to ensure quality services and accountability to our clients, our funder, and the community. The organization is divided into five units based on geographic area and program services. Division Managers are responsible for program development, fiscal accountability and operational effectiveness within each unit. Division Managers report to the General Manager, who reports to the President/CEO. Division Managers work with the General Manager and Medical Director to ensure proper oversight of Health

operations. The Community Health Center and the Healthy Start program are part of the Health Division Unit.

- B. To improve integration and coordination between financial management and program services, in November 2002, Raul Garza, the Business Manager, became the General Manager; and Jerry Garvey, the General Manager, became the Business Manager. The Business Manager serves as the agency's finance director and is responsible for all financial management, contract management, safety, human resources, facilities, and risk management functions. The General Manager is responsible for the day to day operation of all programs and services within the agency.
- C. Three new administrative positions have been added directly to the Healthy Start budget which allows more direct management of resources and services within the Healthy Start Program. The Project Manager (new position, formerly Business Manager) reports directly to the Division Manager. Specific duties include new project implementation, oversight of day-to-day business operations (including Healthy Start); insure compliance with funder contracts, allocation of expenses per budget, and oversight of accounts payable/receivable. An Administrative Assistant (new position) reports directly to the Division Manager. Specific duties include develop data bases and prepare reports for measurement of Healthy Start goals, maintain records and files, and track assignments of staff. Community Relations Director (new position) reports directly to the Division Manager. Specific duties include the marketing of all Health Division programs and services including Healthy Start outreach flyers, brochures, and informational packets, and press releases.
- D. It was necessary for the Director of Health Finance to take on a more active role in Healthy Start. She developed policies and procedures in order to monitor the proper distribution on funds.
- E. Fiscal and program monitoring is an ongoing process. The Director of Health Finance along with the Program Director review expenditures on a monthly basis. Payments to contractors or sub-contractors are not made until evidence of quality performance is verified and an invoice submitted.

A budget analysis is done, by the Director of Finance, on a quarterly basis. This assists the Program Director in monitoring the budget by revenue versus expenditures. The variance is discussed and corrections can be made.

Utilization review is performed on a monthly basis to assist in program monitoring. This review calls for 30% of all charts to be reviewed. A progress report is compiled and distributed to the Program Director. This type of monitoring allows for continuous quality improvement to take place. Areas requiring improvement will be depicted and a plan of action will be developed. That Continuous Quality Improvement Plan (CQI) is then monitored each month for progress.

- F. Language and culture have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse

populations, Aunt Martha's Youth Service Center uses a culturally and linguistically approach to meet the needs of their clients. This includes interpreter staff, translated written materials including consents, rights and responsibilities, and education materials.

The Agency has developed and implemented a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that represents the racial and ethnic communities being served.

Administration, clinical, and support staff are required to participate in education and training in culturally and linguistically competent service delivery. This is a training offered through the Aunt Martha's Training Department. An 8 hour training that helps Aunt Martha's employees explore aspects of their own culture, determine some general characteristics of other cultures, identify cultural biases and their effect on intercultural relationships.

Participants learn to:

- ❖ Identify their own cultural beliefs and values
- ❖ A working definition for "culture"
- ❖ Understand the reason behind cultural bias, prejudice and discrimination
- ❖ To access resources to learn about diverse cultures and value systems and how to effectively provide service to people whose culture is different from ones' own.
- ❖ About gay/lesbian/bisexual and transgender populations
- ❖ About Hispanic cultures, the variety and different issues with serving this population

It is policy for all staff, including medical providers and volunteers, to complete this training within one year of employment.

The Agency promotes and supports the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment. Ongoing organizational self-assessments of cultural and linguistic competence, and integrates measures of access, satisfaction, quality, and outcomes for culturally and linguistically appropriate services through internal audits and performance improvement programs. Patient satisfaction surveys are used as a means of evaluating satisfaction with services.

Aunt Martha's Youth Service Center has developed policy and procedures to address cultural ethical and legal conflicts in their health care delivery system and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services. The provision of these services offers the potential to improve patient outcomes and the efficiency and cost-effectiveness of health care delivery.

#### **IV: Project Accomplishments – Appendix A**

#### **V. Project Impact**

A. Systems of Care: The Healthy Start Program has enhanced collaborative interaction among community organizations and services involved in promoting maternal and infant health and social support services in a positive way.

1. Aunt Martha's Healthy Start Consortium provides the leadership and coordination necessary to improve the integration of all perinatal services and increase access for uninsured and underinsured in our Healthy Start service area.

The membership is comprised of a diverse group of service providers and consumers and includes: prenatal mothers, Healthy Start clients, hospitals, community health centers, Cook County Department of Public Health, mental health, social services, and community services and programs.

Crossroads Coalition is the nucleus for advocacy, resources, identifying future funding and policy change. The Coalition has:

- ❖ Formed a committee to address problems public aid recipients are having accessing Medicaid HMO providers in their community. Three community meetings were held between August 2003 and January 2004 with the Department of Public Aid, private physicians, community health centers, hospitals, and legislators. Funding was obtained in March 2004 to conduct focus groups with public aid HMO recipients.
  - ❖ Helped Governor's State University and Aunt Martha's received funding to evaluate the effectiveness of behavioral health screening instruments at the Aunt Martha's Vincennes Health Center.
  - ❖ Played a major part in bringing the South Suburban colleges and universities that provide allied health care education which led to a Department of Labor grant to expand health care education and increase access to minority groups in January 2004.
  - ❖ Funding to Crossroads members was received from HRSA for years two and three for the Community Access Program which is integrating safety-net services and expanding access to primary health care in the South Suburbs
  - ❖ Brought the IL Department of Children and Family Services together with the medical providers involved in CAP to enable abused and neglected children in the South Suburbs to receive comprehensive physicals within 21 days after being placed in foster care.
2. In 2001, the Aunt Martha's Healthy Start Consortium merged with the Crossroads Coalition, a collaboration of community agencies and healthcare providers. This allowed greater representation from service providers, community organizations, health centers, health departments and hospitals in the project area. The change enhanced our collaboration by expanding our linkages and providing us with valuable input on maternal and child health needs in our target area.

Aunt Martha's has integrated its case management services to ensure comprehensive quality care. The Teen Parenting Services Program (TPS), which provides case management services to expectant teen mothers and their newborns, became part of our case management services in January 2002. The integration of case management services and the addition of TPS have increased Aunt Martha's ability to identify high risk prenatal clients who are eligible for Healthy Start services.

3. Key relationships that have developed as a result of Healthy Start efforts:
- a. Health service agencies, social service agencies and community-based organizations:  
(See Project Implementation: Collaboration and Coordination with State Title V and Other Agencies)

- b. Consumer and/or Community Leader Involvement:  
New strategies for involving consumers were initiated. The Consortium held community meetings encouraging consumers to voice their concerns and identify gaps in services in their community. Aunt Martha's continues to offer transportation, incentive items and refreshments to encourage community participation. Village Trustees, Consortium members and Outreach workers encourage participation and distribute fliers to ensure knowledge of the meetings.

As consumers became more involved in Consortium activities, they received training from Healthy Start staff and were encouraged to attend workshops and conferences. Consumers were encouraged to participate in the activities giving them an opportunity to broaden their knowledge base and meet consumers from other programs.

Consumers participated in many events sponsored by the Crossroads Coalition including:

- ❖ Southland Ministerial Networks Men's Forum
- ❖ Celebrating Women of Wonder which focused on breast cancer and obesity
- ❖ World Asthma Day Forum
- ❖ Senior Provider Network forum discussing prescription drugs
- ❖ New Faith Breast Cancer Walk
- ❖ Hepatitis C Forum

4. The impact Healthy Start has had on the comprehensiveness of services.
- a. Eligibility and/or intake requirements for health or social services (see 3a).
- b. There were initial barriers to access and service utilization and community awareness of services that were overcome. This is due to the amount of community outreach and marketing that was done. It took work to develop that trust in the community. This was accelerated by working closely with the churches, schools and hospitals.

The Consortium has assisted a great deal with the organizations. The Community Organizations have seen the success that health start can bring and have come aboard.

- c. Care coordination to assure continuity of care, quality improvement and follow-up system for client referrals revolves around the case manager role. The Cornerstone DHS

Computer System assists in this area. The case managers monitor their clients closely and track their number of visits, referrals, and completed referrals. If a client does not keep an appointment it is documented in the progress notes, the client is contacted and assistance and encouragement are given to the client and the appointment is rescheduled.

The agency is committed to utilization review and 30% of the programs charts are reviewed using a standard review tool once a month. The results are shared with the Coordinator and Case Managers.

Interdisciplinary staffing occurs a minimum of once a month with additional meetings as necessary. This meeting consists of the entire care team including the RN (Community Health Center), Counselor, Assistant Administrator (RN), Case Managers, and any other applicable service provider (ex. Health educator, outreach, substance abuse counselor, etc...). This is the time to discuss all the participants' needs or issues with pertinent staff at the table allowing all staff to be aware of plan of care.

- d. The Cornerstone data system allows access to all DHS funded programs, including WIC, Public Aid information, family size, screenings, home visits and referrals.

The Case Managers have access to the Aunt Martha's Agency Computer System which tracks Aunt Martha's Health Center clients. The information available includes insurance information, appointments, screening, and diagnosis. The Case Managers send a copy of the depression screening and substance abuse screening to the client's provider after receiving consent.

5. The impact on enhancing client participation in evaluation of service provision.
- a. Language and culture have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, Aunt Martha's Youth Service Center uses a culturally and linguistically approach to meet the needs of their clients. This includes interpreter staff, translated written materials including consents, rights and responsibilities, and education materials.

The Agency has developed and implemented a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that represents the racial and ethnic communities being served.

Administration, clinical, and support staff are required to participate in education and training in culturally and linguistically competent service delivery. This is a training offered through the Aunt Martha's Training Department. An 8 hour training that helps Aunt Martha's employees explore aspects of their own culture, determine some general characteristics of other cultures, identify cultural biases and their effect on intercultural relationships.

Participants learn to:

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- ❖ About gay/lesbian/bisexual and transgender populations
- ❖ About Hispanic cultures, the variety and different issues with serving this population

It is policy for all staff, including medical providers and volunteers, to complete this training within one year of employment.

Aunt Martha's promotes and supports the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.

Aunt Martha's Youth Service Center has ongoing organizational self-assessments of cultural and linguistic competence, and integrates measures of access, satisfaction, quality, and outcomes for culturally and linguistically appropriate services through internal audits and performance improvement programs. Patient satisfaction surveys are used as a means of evaluating satisfaction with services.

Aunt Martha's Youth Service Center has developed policy and procedures to address cultural ethical and legal conflicts in their health care delivery system and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services.

- b. The Consortium held community meetings encouraging consumers to voice their concerns and identify gaps in services in their community. Aunt Martha's continues to offer transportation, incentive items and refreshments to encourage community participation. Village Trustees, Consortium members and Outreach workers encourage participation and distribute fliers to ensure knowledge of the meetings.

As consumers became more involved in Consortium activities, they received training from Healthy Start staff and were encouraged to attend workshops and conferences. Consumers were encouraged to participate in the activities of the Illinois Healthy Start Partnership. This gave them an opportunity to meet consumers from other programs and learn how other Healthy Start Programs are organized and provide services.

Community service providers who are members of the Consortium have reached out to their clients and invited their participation.

## B. Impact to the Community:

1. A community wide-resource manual was developed. This manual was distributed by the outreach team into the community and is available at the community hospital, library and city hall. This was an excellent use of resources. It required the team to research all available resources in the community. The feed-back from the community has been extremely positive.

2. Consumer participation was an initial barrier, but new strategies for involving consumers was initiated. The Consortium held community meetings encouraging consumers to voice their concerns and identify gaps in services in their community. Aunt Martha's continues to offer transportation, incentive items and refreshments to encourage community participation. Village Trustees, Consortium members and Outreach workers encourage participation and distribute fliers to ensure knowledge of the meetings.

As consumers became more involved, they received training from Healthy Start staff and were encouraged to attend workshops and conferences. Consumers were encouraged to participate in the activities of the Illinois Healthy Start Partnership. This gave them an opportunity to meet consumers from other programs and learn how other Healthy Start Programs are organized and provide services.

Community service providers who are members of the Consortium have reached out to their clients and invited their participation.

With the assistance of key Consortium Members HRSA funding was obtained from the Maternal Child Health Bureau for a Community Access Program (CAP) which encompasses the Healthy Start service area. These Healthy Start Consortium members are: ACCESS Health Network, St. James Hospital, Cook County Department of Public Health and Aunt Martha's Youth Service Center. Consumers were an important piece in understanding the needs and direction the program needed to head. This program changed how safety-net providers operated and related to each other – CAP Lay Advocates and Case Managers set up a computerized referral system from the emergency room to community health centers.

This program was instrumental in getting the community health centers to evaluate their scheduling processes resulting in increasing available capacity for the uninsured and underinsured. Together the two community health centers in the healthy start service area had 24,000 encounters from 7/02 – 7/03.

The CAP Community Workers enrolled 2,845 area residents into primary care at the local community health centers in only one year. Through the programs benefits counselors, 2134 residents applied and received some form of public benefits. Behavioral health services were connected to primary health care.

3. When the Aunt Martha's Healthy Start Consortium merged with the Crossroads Coalition, presented some challenges. Challenges included resolving the fears the members had regarding losing their identity and retention of consumers. The fear of losing identity was overcome by structuring the agenda to include Healthy Start as an agenda item at each meeting. The Consortium also revised its by-laws and elected an executive board and officers. A plan was developed on how to integrate consumers into the new consortium which included training on what a consortium is and how they can make a difference.
4. The consortium played a role in developing the Southland Health Careers Program. This program is supported by funds from DOL (Congressman Jackson) and POET, targeting community residents with CNA's and helps them get into and stay in nursing programs to

fill critical shortages in our South Suburban Hospitals. In providing services to community residents, more than 35 students are currently enrolled in LPN and RN programs in local colleges and are receiving tuition, fees and books, transportation, childcare, and academic and life support. The program recently received funding from the Governor's Office Initiative to address critical skills shortages. Health Care Professionals will be able to explore career laddering options, increased educational opportunities and onsite (community hospital) counseling and classes to fill upper management vacancies. The program is becoming a model for the region, state, and nation.

- C. Impact on the State: Aunt Martha's has a long history of collaboration and coordination with our State Title V agency – the Illinois Department of Human Services (DHS). Aunt Martha's delivers services through a number of DHS programs including Family Planning Title X, Family Case Management, and Teen Parent Services. In July 2001, Aunt Martha's integrated its case management services to ensure comprehensive quality care. DHS, Illinois' Title V agency, has noted Aunt Martha's innovation, commitment, and quality in the provision of these services. The Teen Parenting Services Program, which provides case management services to expectant teen mothers and their newborns, became part of our case management services in January 2002. These changes have allowed Aunt Martha's to better identify high risk prenatal clients who are eligible for Healthy Start services.

The Healthy Start program utilizes DHS Cornerstone Software System to record and track all data, increasing the integration of Healthy Start with Illinois' Title V agency and providing the state with data on the clients served by Aunt Martha's. Aunt Martha's participates in forums and discussions on DHS needs assessments.

Aunt Martha's also continues to play an active role in the Illinois Healthy Start Partnership. This collaboration of the DHS Bureau of Maternal and Infant Health and the six Illinois Healthy Start Programs has resulted in the sharing of best practices, an increased understanding of maternal and child health issues across various regions, and an enhanced commitment by all participants to improve maternal and child health outcomes in our respective service areas.

Kid Care is the state's child health insurance program (SHIP) designed to assist pregnant women, parenting women and infants. This program has been a part of Aunt Martha's scope of services since the agency's inception. The majority of participants and clients seen at the Vincennes Health Center and the Women's Health Center are Medicaid recipients or Medicaid-eligible. A full time patient benefits associate ensures that all eligible clients are enrolled. In CY 03 a total of 640 Kid Care applications were submitted to the state.

- D. Local Government Role: It is crucial to have critical stakeholders as members. The Crossroads Coalition (healthy start consortium) is an established coalition with key members of the community. This includes members representing government, universities, social service agencies and health care. The members participate in this coalition because they benefit by not only being a voice in their community, but by having a means of collaboration and support.

Competing agendas of member organizations create barriers, but successful demonstrations of collaborations, especially in regards to getting funding will successfully impact this.

The political environment and lack of resources in the state and community is important in regard to sustaining fundamental system changes in the perinatal system. Aunt Martha's continues to aggressively pursue revenue through sources such as cost-based reimbursement, Illinois' SCHIP program and Kidcare, 330 funding, and fundraising from individuals, community groups, local businesses and churches for unrestricted funding which can be applied to the provision of healthy start services.

The consortium formed a committee to address problems public aide recipients are having assessing Medicaid HMO providers in their community. Three community meetings were held between August 2003 and January 2004 with the Department of Public Aide, private physicians, community health centers, hospitals, and legislators. Funding was obtained in March 2004 to conduct focus groups with public aide HMO recipients. The results will assist in the development of a plan of action.

## **VI Local Evaluation**

### **Section I. INTRODUCTION**

#### *Local Evaluation Component*

##### *A. The impetus for the Local Evaluation was twofold:*

1. HRSA strongly encouraged funded Healthy Start Projects to conduct a Local Evaluation that was independent but compatible with the National Efforts to evaluate the Performance and Effectiveness of Healthy Start Projects. According to Federal Guidance, a Healthy Start Project lacking a complete and well conceived Evaluation Protocol may not be funded.
2. AMYSC valued an independent review of the Healthy Start Project and the development of a well designed and scientifically sound Evaluation Plan. The Plan had to be capable of demonstrating and documenting measurable progress toward achieving stated objectives and include a Continuous Quality Improvement Process.

AMYSC held that the Evaluation Plan and the measurement of progress should be focused through empirically defined, outcome-oriented objectives designed to monitor the "performance" and "effectiveness" of the AMYSC Healthy Start Project in implementation of the "required components" of the Project and their impact on the health status of the target population. The Evaluation Plan was based on a clear rationale tied to meeting the identified needs of the target population.

The Project's local evaluation was designed to be a combined Outcome and Process Evaluation intended to assess both the impact of the Healthy Start interventions on natality and mortality among program participants and racial disparity in the targeted communities.

The plan was developed by Hamilton•Bell Associates, a Chicago management and health care consulting firm with extensive experience in maternal and child health.

As local evaluator for the AMYSC Healthy Start Project, Hamilton•Bell Associates (HBA) facilitated a process to develop an Evaluation Plan that met AMYSC expectations, and was in compliance with HRSA Guidance. This Evaluation Plan was developed under the leadership of the Local Evaluator (HBA), with input from AMYSC Leadership, AMYSC Healthy Start Project Staff, and members of the Consortium. The Evaluation Plan has a four part focus:

- Project/Agency Performance in Implementing Core Services;
- Project Effectiveness in Improving the Health Status of mothers and infants;
- Health System Interface/Integration (i.e., screening and intervention for depression); and
- Racial Disparity in the Project Area.

B. The Evaluation Plan was developed and implemented in collaboration with AMYSC Leadership, Healthy Start staff, other Agencies, and the Consortium. The Plan has the following three components:

- *Project Performance in Implementation of Core Services;*
- *Project Performance in Implementation of Core Systems*
- *Project Effectiveness in Improving Health Status and Racial Disparities*

The performance and accomplishments of the AMYSC Healthy Start Program was measured both quantitatively and qualitatively. At the *client level* the impact is measured in incremental improvements in birth outcomes, health behavior and client knowledge and perceptions. At the *service delivery level*, impact is measured by the Project's performance in the implementation of efficient and effective approaches to deliver the five (5) Core Services and the four (4) Core Systems. At the *community level* a longitudinal comparison is used to measure changes in the Healthy Start target population residing in the three (3) Communities in Cook County that comprise the AMYSC Project Area. Changes in Health Status among to Project Area residents will be compared to changes among residents in two reference areas (City of Chicago and State of Illinois) over time.

The evaluation of the AMYSC Healthy Start Project focused on achievement of a defined set of objectives for the project period and calendar year. The Performance Objectives were organized and linked to monitoring progress in Agency implementation of the *Core Services* and *Core Systems* and the overall Project Effectiveness in improving Low Birth Weight and Infant Mortality among participants.

Most project objectives were measured at the client level through the AMYSC Healthy Start Information System. At the community level, Illinois Vital Records were used to measure changes in perinatal health status indicators. Special surveys and other primary data collection methods will be used to examine client satisfaction.

Qualitative measures used in the evaluation included a Healthy Start Participant Satisfaction Survey designed to help AMYSC and the Consortium determine the level of satisfaction that participants have with the delivery of services through the Healthy Start Project. The survey was conducted annually.

The AMYSC Healthy Start Project institutionalized a Continuous Quality Improvement Program. Routine monitoring of Performance Measures that finds that “expectations” are not being met, will result in a more focused review to identify and resolve issues/barriers to meeting stated objectives. The CQI program involved all stakeholders.

A Healthy Start CQI Committee consisting of the Local Evaluator, AMYSC Administration, the Project Director, AMYSC Healthy Start Staff representing all Core Services, and as needed, Line Staff (i.e., Outreach Workers and Case Managers) serving the Target Areas, met on a quarterly basis to review HBA findings and recommendations for seeking improvement and conducting more “Focused Review.” These Focused Reviews subsequently led to changes in policies and/or implementation processes or procedures. The “Focused Reviews” that were approved by the CQI Committee would be carried out by the contingent of staff that was most accountable or involved in impacting on the specific performance measures under review. These Focused Reviews provided the context and resources necessary to complete an “Evaluation Study” (See Appendix 2-4).

As part of the “Outreach” Evaluation, the Local Evaluator used Cornerstone Data on participants to develop statistical profiles that provide a *Demographic Profile* of all AMYSC Healthy Start participants and a *Risk Profile* of pregnant participants.

C. HBA's Plan for the Local Evaluation calls for a three-phase implementation process. The three phases of the evaluation are the Formative Phase, the Process Phase and the Outcome Phase. The tasks accomplished in each of these phases to date are briefly described below.

Formative Phase: Upon engagement as the independent “Local Evaluator,” for the AMYSC Healthy Start Project, HBA initiated the “*Formative Phase*” of the Local Evaluation. During the *Formative Phase*, HBA played a leadership role in designing and implementing a process to bring AMYSC administration, Healthy Start staff, and the Consortium together in the collaborative development of an Evaluation Plan for the Project. This Plan was ultimately reviewed and accepted by AMYSC and submitted to DHHS for approval.

During this phase, HBA also assisted AMYSC efforts to redesign the “Core Interventions” to comply with revised HRSA Guidance. HBA facilitated a process of Agency and Evaluator feedback that helped AMYSC confirm that policies and procedures were in place to implement the *Core Services* and *Core Interventions* in compliance with Federal Guidance. The Formative Evaluation identified the AMYSC policies and implementation processes that needed to be “synchronized” in order to be effective.

During the *Formative Phase*, HBA and AMYSC leadership worked with Healthy Start staff to examine, design, and implement modifications to “implementation processes” that included:

- Outreach Activities;
- Risk Assessments;
- Use of Incentives;
- Staffing Patterns and Retention;
- Interface with Family Case Management;
- Data Collection Procedures; and
- Communication between/among Administrative Staff, Healthy Start Staff, Providers and the Consortium

*Process Phase*: The *Process Phase* began when AMYSC “signed-off” on the Healthy Start Evaluation Plan. The Evaluation Plan included an empirically based set of Project Period Objectives and 24 performance measures used to monitor Agency Performance in implementing each of the Core Services and Core Systems required by HRSA. The *Process Phase* was designed to monitor how the program was being implemented. During the *Process Phase*, the evaluation was primarily focused on monitoring performance and progress toward meeting objectives as defined in the Evaluation Plan.

During the *Process Phase*, HBA designed, developed and distributed a series of Standard Reports (based on AMYSC Cornerstone Data) that were used to monitor Agency performance and progress toward meeting objectives for each of the Core Services. As AMYSC is committed to transitioning from its internal data system to the DHS Cornerstone System, benchmark comparisons of performance data from these two systems were routinely performed. The Standard Reports were generated and distributed on a quarterly and year-to-date basis. Progress toward meeting objectives was measured at the Project, Agency, and Clinic levels.

Additionally, HBA prepared and presented quarterly analyses by Project and Agency that summarized and updated:

1. The Demographic Profiles of *Pregnant and Interconceptional Participants*;
2. Risk Profiles of newly enrolled *Pregnant Participants*; and
3. Current Status of Agency Performance in implementing Core Services for all *Pregnant, Interconceptional and Child Participants*.

These quarterly analyses also highlighted the specific performance measures that were not being met. This information became the basis of CQI activity leading to changes in policy and/or implementation processes and ultimately improvement in the performance measure.

During this Phase, HBA played a leadership role in the design and institutionalization of the methodology for ongoing review and evaluation of key implementation processes. HBA designed and institutionalized a Continuous Quality Improvement Program (CQI). A CQI Committee provided the structure for review and modification of Agency activities. The CQI Committee included the Local Evaluator, AMYSC Administration, the Project

Director, AMYSC Healthy Start Staff representing all Core Services, and as needed, Line Staff (i.e., Outreach Workers and Case Managers) serving the Target Areas.

The Healthy Start CQI Committee met on a quarterly basis to review HBA findings and recommendations for seeking improvement and conducting more "Focused Review" which subsequently led to changes in policies and/or implementation processes or procedures. The "Focused Reviews" that were approved by the CQI Committee would be carried out by the contingent of staff that was most accountable or involved in impacting on the specific performance measures under review.

In summary, the CQI program has been effective in identifying and resolving barriers to Agency performance in implementing the Core Services and meeting other AMYSC expectations (i.e., appropriate documentation of events and data entry into Cornerstone).

Outcome Phase: The AMYSC Healthy Start Project is now entering the *Outcome Phase* of the evaluation. The *Outcome Phase* is designed to look at longer-term outcomes, however, the *Outcome Phase* of the evaluation cannot be finalized until vital records data used to track health status indicators for not only the *Target Population* but also *Project Participants* is available through at least 2004.

The *Outcome Phase* will determine if the Healthy Start Project had an "impact" on the health status of the population served. The Evaluation Plan identified a select set of health status and racial disparity indicators which will ultimately be used to determine the "Effectiveness" of the Project.

#### Key Questions/Hypotheses

The AMYSC Healthy Start Project Evaluation was designed to answer a well-defined set of general and specific questions. The general questions the AMYSC Healthy Start Evaluation will seek to answer over the life of the project are:

1. To what extent did the AMYSC Healthy Start project achieve its process (i.e., performance) and outcome (i.e., health status) objectives?
2. Is there an association between receiving Healthy Start services (i.e., the five Core Services related to prenatal, infant and interconceptional care) and an improvement in birth outcomes, perinatal, and infant mortality?
3. To what extent did the Healthy Start Project act as a catalyst for policy changes and systems interface/integration with the larger Perinatal System?
4. To what extent has the racial disparity in the AMYSC Healthy Start Project Area been addressed among key MCH Indicators?

A more detailed set of questions to be answered include but are not limited to:

- Has the rate of infant, neonatal, or postneonatal mortality decreased in the Healthy Start Project area? Has there been a reduction in racial disparity?

- How have the infant, neonatal and postneonatal mortality rates for the Project Areas changed (increase or decrease) in relation to the State of Illinois and the City of Chicago? Has there been a reduction in racial disparity?
- How much has the change in neonatal versus postneonatal mortality contributed to the change in infant mortality that occurred in the Project Areas?
- Has the change (increase or decrease) in infant mortality varied in the targeted community areas?
- Has the rate of VLBW (under 1500 grams) or LBW (under 2500 grams) decreased in the Healthy Start Project Areas? Has there been a reduction in racial disparity?
- How have the VLBW and LBW rates for the Project Areas changed (increase or decrease) in relation to the State of Illinois and the City of Chicago?
- Has the change (increase or decrease) in VLBW or LBW varied by race within the targeted community areas?
- Has the rate of low prenatal care, birth to teens and births to single moms decreased in the Healthy Start Project Areas? Has there been a reduction in racial disparity?

## Section II. PROCESS

### A.

#### 1. Framework for Local Evaluation:

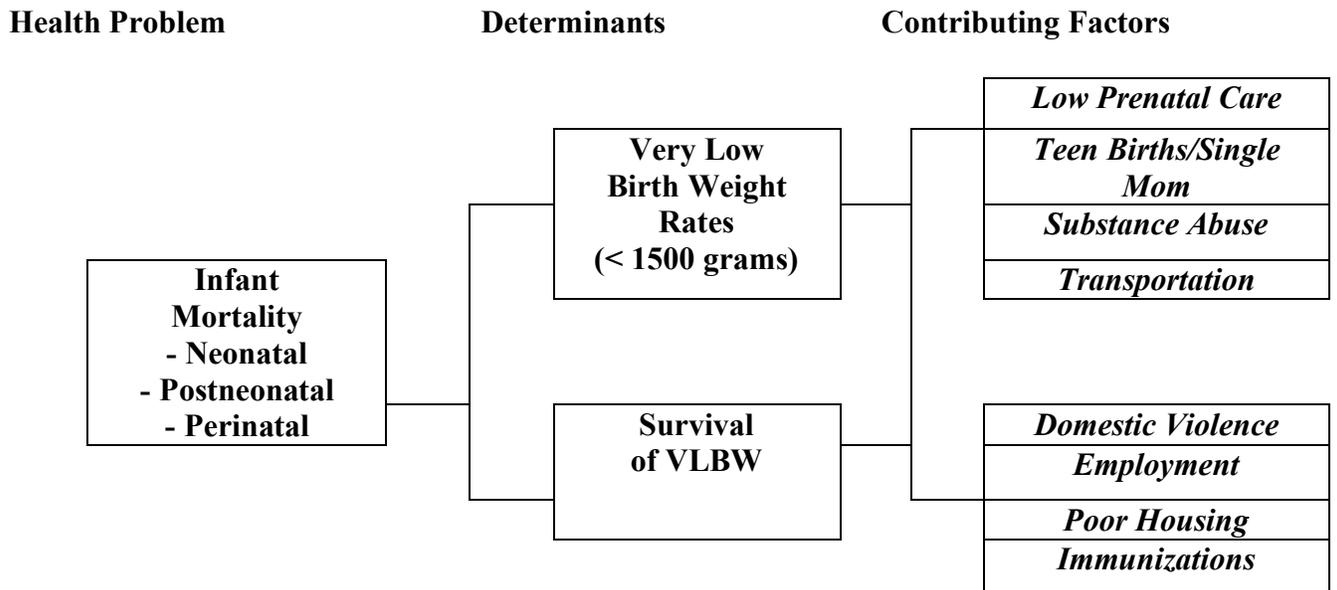
The framework for the Healthy Start Local Evaluation was based on a model that was developed by CDC and has proven to be “user friendly” in that it encourages participation of all key actors (e.g., health professionals, health care providers and health care consumers) in the evaluation. CDC’s Public Health Practice Office originally developed the *Health Problem Analysis Model*. HBA, as Local Evaluator for the Healthy Start Project, facilitated the introduction and use of the Health Problem Analysis as a framework for evaluation. This framework will be used as a structure for sharing information with the Consortium and other consumers while soliciting input on local contributing factors that impact on the access and availability of services needed to improve perinatal outcomes and reduce infant mortality. The Project utilized this framework to facilitate an understanding and involvement of all key actors (e.g., Consortium), in the design of the evaluation.

The following chart illustrates the *Health Problem Analysis Model* used for the Healthy Start Evaluation. The model identifies three levels of assessment: *health problem*, *determinants* and *contributing factors*. Outcomes relate to the level of health problems and are specified in terms of measures of health status, such as mortality, morbidity and disability rates. Each health problem has one or more determinants which can be defined as direct causes or risk factors which, based on scientific evidence or theory, are thought to directly influence the level of a specific health problem. Low birth weight is a prime example of a determinant for the health problem of neonatal mortality.

The ability to analyze health problems (e.g., infant mortality) hinges on the identification of risk factors and pathways of causation. This type of analysis is necessary in order to make appropriate programmatic decisions and identify

specific actions that can address factors that directly relate to the health problem under review. First, however, it is necessary to define the *health problem* itself. In this analysis, preventable infant mortality is the problem and can be measured by a number of *health status indicators*. These indicators include infant, neonatal, post-neonatal, perinatal, and fetal mortality rates.

**HEALTH PROBLEM ANALYSIS  
(Simplified Example)**



The Health Problem Analysis requires that health problems be clearly specified and that all pertinent determinants and their contributing factors be identified. With health problems as complex as perinatal health outcomes, this can be an extensive undertaking. This component of the evaluation will provide information on health status indicators and its determinants. The analytic and data gathering process to be utilized should yield a priority list of contributing factors (direct and indirect) as identified by the Consortium, professional staff, and consumers.

**2. Methodology for Evaluation:**

Using information obtained from the Illinois Department of Public Health and the Illinois Department of Human Services, an analysis of key indicators of maternal and child health was completed by Hamilton•Bell Associates. The poor health status of mothers and infants in the Chicago Healthy Start Project Area was empirically defined. Data/information extracted from vital records (birth and death certificates) filed with the State Registrar was used:

1. To compare MCH health status indicators, their determinants and contributing factors for residents in the Project Area to residents of the State of Illinois and City of Chicago (external reference).
2. To define and compare the racial disparity that exists in MCH health status indicators, as well as their determinants and contributing factors for residents in the Project Area (internal reference).

For this component of the evaluation, a set of “questions to be answered” were developed. The answers to these questions required a review and comparison of the changes in selected indicators over the study period and a comparison between the Healthy Start Project Area, the City of Chicago, and the State of Illinois. The source of information used to address these questions was vital records filed with the Illinois Department of Public Health for the Project Period.

A longitudinal comparison was used to measure and observe changes in selected mortality and natality indicators over time within the six community areas in Chicago that comprise the Project Area. The changes in the Healthy Start Project Area were also compared to those changes that occurred in the City of Chicago and the State of Illinois during the same time period. The Illinois Department of Public Health performs quality assurance activities on Vital Records. The Department uses edits to measure, monitor and seek to improve the accuracy, completeness and reliability of the information captured on live birth, death and stillbirth records. The reliability and validity of the fields of information available from these vital records vary widely according to both IDPH experience and the research literature. Based on discussions with key staff at IDPH and AMYSC and their knowledge of the relevant research, the specific fields of information used in this analysis are considered to be among those that are substantially valid and reliable.

Due to the rarity of events being measured (e.g., infant mortality) and the resulting small numbers involved in rate calculations at the Community Area level, three year moving averages were used rather than single year rates. This methodology provides greater stability to the rates and limits the spurious variability introduced by small number calculations for individual years. All rates based on less than ten (10) events in the numerator or one hundred (100) events in the denominator are often suppressed in this type of analysis. However, since three-year moving averages were used to calculate rates, the rates have been provided but caution was used in the interpretation and findings.

For tests of significant difference in rates over time within the Project Area, a binomial approximation to the normal distribution was used. For comparison of rates within areas over time, the difference between the probability at base line and at the end of the study period was measured and a confidence interval was calculated. The confidence interval was the used to determine whether the difference in rates was statistically significant given the sample size, the magnitude of the difference and a 95% level of confidence.

*B.*

- The AMYSC Healthy Start Data System and the DHS Cornerstone System together provided the data on Healthy Start Participants and was used to

monitor, evaluate and improve Agency Performance in implementing the Core Services.

- Vital Records Data was used to evaluate the “Effectiveness” of the Healthy Start Project in improving the Health Status of Healthy Start Participants as well as the Health Status of the Target Population.

C. Below is a list of the Measures that were used in the Evaluation of *Project Performance* in implementing *Core Services* and *Core Systems* and the overall *Effectiveness of the Project*:

### **Project Performance in Implementing Core Services**

#### 1. Outreach and Recruitment

- Number of high risk pregnant women identified from target area
- Percent high risk pregnant women who initiate prenatal care in 1<sup>st</sup> trimester

#### 2. Case Management

- Percent of eligible high-risk pregnant/postpartum women/infants enrolled
- Percent with adequate prenatal care (Kessner Index)
- Percent of high-risk pregnant women linked to a “medical home”
- Percent of high-risk pregnant women enrolled in WIC
- Percent of children (0 - 2) linked with a “medical home”
- Percent of referrals made and kept for Pregnant, Child, Interconceptional Participants
- Percent of participants who complete initial postpartum visit
- Children (0 - 2) up-to-date with immunizations
- Children (0 - 2) up-to-date with EPSDT exams

#### 3. Health Education

- Pregnant participants self-reporting reduction/cessation in smoking during pregnancy
- Pregnant participants self-reporting reduction/cessation of substance abuse during pregnancy
- Interconceptional participants that self-report breast feeding of infants
- Interconceptional participants that self-report use of Family Planning services
- Interconceptional participants with more than 18 months between pregnancies

#### 4. High Risk Interconceptional Care

- Percent of Pregnant participants who completed a post partum visit.
- Percentage of high risk participating women who receive interconceptional services
- Percentage of Interconceptional women linked with a medical home
- Reduce the proportion of pregnancies occurring within 24 months of a previous birth

- Increase the percentage of women receiving family planning services in the post-partum period.
5. Perinatal Depression
- Number and percent of Healthy Start participants who deliver and are screened for depression
  - Number and percent of Healthy Start Participants who are screened for depression (EPDS) and are referred for diagnosis/treatment.
  - Number and percent of Healthy Start participants who were referred for and received treatment/consultation for depression.

**Project Performance in Implementing Core Systems**

1. Local Health Systems Action Plan
  - Extent to which objectives of the local health action plans are accomplished.
  - Extent to which Healthy Start Core Services/Systems are integrated/interfaced with the local MCH Health Service Delivery System.
2. Collaboration with Title V
  - Participation in Title V Needs Assessment
  - Interface with Title V Programs and Services
  - Exchange of Data and Information
3. Consortium
  - Percent of consumers participating in Consortium activities
  - Increase in capacity of Consortium members (training efforts)
4. Sustainability/Administration/Management
  - Efficient use of resources (i.e., staff and dollars)
  - Modification/Improvement in Interventions based on Lessons Learned
  - Development of Sustainability Plan
  - Dissemination of Evaluation Findings and Conclusions

**Project Effectiveness Toward Improving Health Status and Racial Disparity**

To measure Program Effectiveness in improving “Health Status” among residents of the target population, a longitudinal comparison will be used to measure and observe changes in selected MCH Indicators within each of the targeted Communities and compare to changes that occurred in 2 reference areas (City of Chicago and State of Illinois).

The set of indicators that will be used to monitor **Project Effectiveness** included:

- Infant, neonatal and postneonatal mortality rate in the Project Area
- Impact on racial disparity for perinatal outcomes in the Project Area
- Percent of low birth weight (LBW) and very low birth weight infants (VLBW)

**Section III. FINDINGS/DISCUSSION**

*Present the **findings** of your local evaluation including a discussion of any methodological **limitations** of the evaluation (e.g., completeness and quality of data, and response rates to survey instruments).*

1. Current Status of AMYSC Healthy Start Project Period Objectives

Below is a table that is intended to succinctly identify the findings and limitations of the Local Evaluation. The table organizes the findings and limitations by Project Period Objectives.

<b>Project Period Objective (to be achieved by 5/31/05)</b>	<b>Core Service</b>	<b>Findings and Limitations</b>
<b>Pregnant Participants</b>		
Increase the number of “at risk” women to 250 whom are annually enrolled in Healthy Start.	Outreach	<p><b>Findings:</b> <u>In CY 04, AMYSC exceeded the Target Level for this objective.</u> Aunt Martha’s Healthy Start project enrolled a total of 472 at risk women. This included 153 hard to reach high risk Pregnant Women and 219 at risk Interconceptional Women.</p> <p><b>Limitations:</b> None</p>
75% of Pregnant Participants Initiate Prenatal Care in the First Trimester	Outreach	<p><b>Findings:</b> <u>In CY04, AMYSC exceeded the Target Level for this objective.</u> AMYSC enrolled 75% of Pregnant Participants in the first trimester of pregnancy. The project exceeded the goal as 82% of the hard to reach, high risk pregnant women enrolled in Healthy Start in their first trimester of Prenatal Care.</p> <p><b>Limitations:</b> None</p>

<p>90% Pregnant/Parenting Participants linked to Medical Home</p>	<p>Case Management</p>	<p><b>Findings:</b> In CY04, AMYSC exceeded the Target Level for this objective. AMYSC linked 98% of pregnant and/or parenting participants to a medical home for primary health care.</p> <p><b>Limitations:</b> None</p>
<p>75% Pregnant Participants with Adequate Prenatal Care</p>	<p>Case Management</p>	<p><b>Findings:</b> In CY04, AMYSC exceeded the Target Level for this objective of 75% of Pregnant Participants receiving Adequate Prenatal Care.</p> <p>In CY 04, 82.4% women received adequate prenatal care according to the Kessner Index.</p> <p><b>Limitations:</b> None</p>
<p>Increase the percentage of Pregnant Participants who self report reduction/cessation in smoking during pregnancy to 90%.</p>	<p>Health Education</p>	<p><b>Findings:</b> Over the course of the project the percentage of pregnant participants who self-reported reduction/cessation in smoking during pregnancy has increased significantly. This objective benefited from being part of a CQI activity.</p> <p>In CY 02, 55% of the pregnant women reported a decrease or cessation of smoking. In CY04, 74% of the pregnant women reported a decrease or cessation in smoking.</p> <p><b>Limitations:</b> None</p>
<p>70% of Pregnant Participants self report lowered frequency or elimination of substance abuse</p>	<p>Health Education</p>	<p><b>Findings:</b> In Calendar year 04, AMYSC exceeded the Target Level for this objective. The 70% goal was exceeded since 75% of pregnant participants self reported lowered frequency or elimination of substance abuse.</p> <p><b>Limitations:</b> None</p>
<p><b>Interconceptional Participants</b></p>		
<p>75% of Interconceptional Participants will complete initial post partum visit.</p>	<p>Case Management</p>	<p><b>Findings:</b> In 2002, 59% of Healthy Start women completed their postpartum exams and in 2003 the number reached 67%. In 2004, the numbers continued to rise reaching 72%. The data suggests the goal will be achieved in 2005.</p> <p><b>Limitations:</b> None</p>

<p>60% of Interconceptional Participants self report breast feeding their newborn infants</p>	<p>Health Education</p>	<p><b>Findings:</b> Over the course of the project the percentage of participants who self-reported breast-feeding has increased significantly. This objective benefited from being part of a CQI activity. In CY 02, 36% of the women reported breastfeeding and in CY04 the project reached 54%.</p> <p><b>Limitations:</b> None</p>
<p>90% of Interconceptional Participants use Family Planning</p>	<p>Health Education</p>	<p><b>Findings:</b> Over the course of the project the percentage of participants who self-reported family planning has increased significantly. This objective benefited from being part of a CQI activity. In CY 02, 73% of the pregnant women reported breastfeeding and in CY04 the project reached 78%.</p> <p><b>Limitations:</b> None</p>
<p><b>Child Participants</b></p>		
<p>75% Participating Children (0-2) Current with Well-Child Visits (i.e., EPSDT)</p>	<p>Case Management</p>	<p><b>Findings:</b> Over the course of the project the proportion of children whom are compliant with age-appropriate EPSDT exams has increased significantly. This objective benefited from being part of a CQI activity. In CY 02, 57% of the infants were up to date and in CY04, the project reached 66% of infants were up to date with EPSDT exams.</p> <p><b>Limitations:</b> None</p>
<p>75% Participating Children Current with Immunizations</p>	<p>Case Management</p>	<p><b>Findings:</b> Over the course of the project the proportion of children whom are up to date with immunizations has increased significantly. This objective benefited from being part of a CQI activity. In CY 02, 60% of the infants were up to date and in CY04 the project reached 69% of infants were up to date.</p> <p><b>Limitations:</b> None</p>

Overall Project Effectiveness		
<p>Reduce the rate of low birth weight babies born to pregnant females who access Healthy Start services to 7.5%, very low birth weight to 1.7% and preterm babies to 10%.</p>	<p>All <i>Core Services</i> and <i>Core Systems</i></p>	<p><b>Findings:</b> <u>In CY2004, the program exceeded the target levels for low birth weight, very low birth weight and preterm infants. See CY 2004 data below:</u>                  2.6% for low birth weight (target = 7.5%)                  1.3% for very low birth weight (target = 1.7%)                  5.1% for preterm babies (target = 10%)  <b>Limitations:</b> None</p>

**2. Findings of Local Evaluator**

The independent Local Evaluator for the Healthy Start Project found that:

1. The AMYSC Healthy Start Project is “effective.” By the last year of the Project Period, AMYSC exceeded its target level for low birth weight, very low birth weight, and preterm infants born to the hard to reach, high risk pregnant participants.
2. The AMYSC Healthy Start Project is “efficient.” The Project was designed and implemented to successfully interface and complement other Title V programs. Using Family Case Management outreach workers to provide “Outreach” avoids duplication of services and a more effective interface of the Healthy Start Project with the existing Perinatal Service Delivery System.
3. The AMYSC Healthy Start Project finds and enrolls the “hard to reach, high risk” pregnant population in the Targeted Communities. This can be documented by the *risk profile* of the 2003 and 2004 “hard to reach, high risk” *Pregnant Participants* that have been served by the Project.
4. The AMYSC Healthy Start Project has a CQI Program that has been effective in identifying and resolving barriers to improving Agency performance in implementing the Core Services and meeting other AMYSC expectations (i.e., data entry).
5. The AMYSC Healthy Start Project has made progress toward achieving its stated Project Period Objectives. Most of the Target Levels for the Project Period Objectives have been exceeded in CY 2004. Significant progress has been documented on all of the other Project Period Objectives (see findings above.)

6. AMYSC Administration, Healthy Start Staff, and the Local Evaluator have successfully collaborated in the identification of areas needing improvement in 2005.

#### Section IV. RECOMMENDATIONS

- A. Recommendation # 1: During FY 05 the Local Evaluator and the COI Committee recommended that AMYSC expand Focused Reviews and COI activity beyond program issues related to implementation of the core services. The COI Committee and the Local Evaluator would like to expand COI into the following areas which are targeted for improvement.

A. Data Access Issues:

- Timely access to accurate birth data for residents of the Project Areas
- Timely access to accurate mortality data for Project Area residents

B. Data Reliability/Validity Issues:

- Birth Weight and Mortality of Participants\*
- Ethnicity of Participants,
- Performance Data for the Evaluation of Health Education Activities

C. Programmatic Issues:

- Adequacy of Prenatal Care
- Well-Child Exams
- Completed Post-Partum Visits

- B. Further Evaluation: Apply PPOR Analysis to Healthy Start Project Area.

In order to better target AMYSC efforts to improve racial disparity, additional analysis to better understand and define its underlying causes is necessary. CDC has identified a useful tool for defining and examining the underlying causes of preventable mortality and racial disparity called the "Perinatal Periods of Risk Analysis" (PPOR). The PPOR Analysis has been recommended for implementation in Healthy Start Projects not only by CDC, but also by HRSA.

AMYSC is pursuing the use of Illinois Vital Records data to complete a *Perinatal Periods of Risk (PPOR)* analysis that is relevant to not only the AMYSC Healthy Start Project, but all Healthy Start Projects in Illinois. More specifically, PPOR will be used to map the fetal/infant mortality by age, birth weight and race in order to assist the AMYSC Project in prioritizing prevention efforts; mobilizing communities and key actors; establishing ongoing surveillance; and enhancing FIMR findings/recommendations.

(Note: The Local Evaluator has incorporated the PPOR Analysis into the Evaluation Plan for the Healthy Start Project and continues to participate in "Level II Training" sponsored by the Bureau of Maternal and Child Health related to implementation of the PPOR Analysis).

Section V. IMPACT BASED UPON THE RECOMMENDATIONS /RESULTS OF THE LOCAL EVALUATION

- A. At this time, the AMYSC Healthy Start Project cannot document that the Project has been effective in improving the “Health Status” of residents in the Project Area. This can only be measured by an examination of “changes in the health status and racial disparity indicators in the *Target Population*” and “changes in health status of the *Healthy Start Participants*.” Until vital records data for 2003 and 2004 is available, HBA will not be able to assist AMYSC in defining the full impact of the Healthy Start Project on the health status of participants and Target Area residents.
- B. During the *Formative Phase* of the Local Evaluation, HBA and AMYSC leadership worked with Healthy Start staff to examine, design, and implement modifications to “implementation processes” that included:
- Outreach Activities;
  - Risk Assessments;
  - Use of Incentives;
  - Staffing Patterns and Retention;
  - Interface with Family Case Management;
  - Cornerstone Data Collection Procedures; and
  - Communication between/among all key actors

During the *Process Phase* of the Evaluation, CQI activities led to conclusions, Focused Reviews, and ultimately changes in Project implementation and/or management and/or administration of the Project. These changes are highlighted below.

- AMYSC concluded that data entry on total number of prenatal visits, EPSDT or Well Child Visits, and post partum visits was incomplete and an issue that needed to be addressed. AMYSC reviewed their data entry procedures and provided in service training that emphasized diligence in correct completion of the appropriate fields for capturing information on prenatal visits, EPSDT or Well Child Visits, and post partum visits.
- AMYSC provided in-service training on the use of the Kessner Index when measuring “Adequacy of Prenatal Care.”
- AMYSC reviewed and refreshed their protocols and procedures related to “**reminding**” participants of their scheduled post partum visit and subsequently “**recalling**” participants who miss their appointments for post partum visit.
- AMYSC completed a review that determined the “primary reasons” that these Healthy Start participants miss a scheduled appointment and enhanced their enabling services related to transportation as a result of the review. The enhanced services were primarily focused on:
  1. Pregnant Participants who miss a prenatal visit;
  2. Child Participants who miss a Well-Child Visit and;
  3. Pregnant Participants that miss their initial post partum visit.

**HEALTHY START LOCAL EVALUATION REPORT # 1****PROJECT NAME:** AMYSC Healthy Start Project**TITLE OF REPORT:** Infant Mortality Rates-*Partial Data***AUTHORS:** Hamilton•Bell Associates**Section I: Introduction**

HRSA's Office of Professional Review (OPR) has recently (June 2004) started conducting *Performance Reviews* of several HRSA funded Projects. These Reviews are performed by a number of Review Teams that operate out of Regional Offices. The Chicago Region has three (3) Reviewers that operate as a team in conducting *Performance Reviews*. Based on the Project team consisting of OPR staff, AMYSC Administrative staff, and AMYSC Healthy Start staff, the *infant mortality rates among pregnant participants* was identified as an area for "Focused Review" and a Local Evaluation was completed.

**Section II: Process**

The Project Team was charged with reviewing the identified performance measure (*i.e.*, *Infant Mortality Rates*). The OPR *Performance Review* is required to review all HRSA funded Projects that are provided by an Agency. For AMYSC, the *Performance Review* included the Healthy Start Project and the FQHC. The steps in the process were as follows:

1. AMYSC receives notification of upcoming *Performance Review*.
2. A package of written materials were forwarded to AMYSC prior to *Performance Review*.
3. Five (5) conference calls were scheduled and conducted that result in the final consensus on the Performance Measures to be used in the *Performance Review*.
4. AMYSC was expected to provide data for a number of years for each of the Performance Indicators selected. This data was provided for Participants as well as the Target Area and one or more Reference Areas (*i.e.*, County, State).
5. The HRSA Project Team prepared graphs of the Performance Measures over time as well as an initial draft of the Final Report prior to site visit.
6. Performance Review Teams conducted a 3 day Site Visit.
7. A Summary of the Findings/Results of the Review was presented "informally" on the last day of the Site Visit.
8. A Final Report was prepared the Performance Review Team and submitted to AMYSC.
9. AMYSC subsequently developed and submitted an Action Plan that details actions to be taken in response to the Final Report.

**Section III: Findings/Discussion**

1. **Healthy People 2010 Objective 16-1c:** Reduce all infant deaths (within 1 year) to 4.5 per 1,000 live births. Baseline (1997): White = 6.0 and Black = 13.7.
2. **Population Served:** Aunt Martha's Healthy Start program targets single, Black, Spanish-speaking, and/or teenaged women and their children in the contiguous communities of Chicago Heights, Ford Heights, and Sauk Village. In 2003, 374 prenatal and interconceptional women and 298 children received services.
3. **Services Provided:** A more intensive level of outreach and case management services are provided to Healthy Start Participants. These Participants include high risk prenatal, postpartum/interconceptional, infant, and toddlers. AMYSC has gained the trust of residents in the Project Area. Aunt Martha's has been effective at enrolling and retaining its Healthy Start Participants by offering culturally sensitive outreach and case management services, doula services, health education classes, the Family Support Center<sup>8</sup>, and transportation. Case managers develop an Individualized Care Plan for all participants, and seek to assure that all referrals made are kept. The Case Managers facilitate linkage (assuring/providing transportation when necessary) of program participants to a comprehensive array of healthcare services as well as to education, housing, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program, and job training. By keeping medical appointments, attending classes, participating in home visits, or working toward educational or employment goals participants earn incentives such as baby supplies, clothes, linens, etc.

To assure that Pregnant Participants assessed to be at the highest risk of a poor perinatal outcome are provided access to the best and most appropriate care available, AMYSC has established a direct referral relationships with Rush Presbyterian-St. Luke's Hospital, which is a Level III Perinatal Center in Downtown Chicago. Pregnant Participants found to be at highest risk are referred to the Rush Perinatal Center for the balance of their prenatal care and delivery. However, AMYSC continues to case manage these very high risk participants and provide all requisite transportation during their pregnancy.

4. **Impact:** All countries of the world measure the infant mortality rate as an indicator of general health status. The infant mortality rate is made up of two components: neonatal mortality (death in the first 28 days of life) and postneonatal mortality (death from the infant's 29th day but within the first year). The leading causes of neonatal death include birth defects, disorders related to short gestation and low birth weight, and pregnancy complications. Of these, the most likely to be preventable are those related to preterm birth and low birth weight, which represent approximately 20% of neonatal deaths. Postneonatal death reflects events

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<sup>8</sup> The Family Support Center is a safe, comfortable, neighborhood-based setting for families and children where they can access an array of support from health education classes (parenting, prenatal, breastfeeding, etc.) to job skills.

experienced in infancy, including Sudden Infant Death Syndrome (SIDS), birth defects, injuries, and homicide. Birth defects, many of which are unlikely to be preventable given current scientific knowledge, account for approximately 17% of postneonatal deaths; the remainder are likely to stem from preventable causes.<sup>9</sup> The United States has made progress in reducing the infant mortality rate, but the rate of decline has slowed in the last ten years. There is still significant racial disparity, as noted in the Healthy People 2000 Mid-course Review.<sup>10</sup> Rates are much higher in the lower social class and in the lowest income groups across all populations. The disparity (ratio) for black infant mortality is over twice the white rate. Black women are twice as likely as white women to experience prematurity, low birth weight, and fetal death.<sup>11</sup>

**Table 4**  
**Infant Mortality Rates for Illinois, Project Area and Healthy Start Participants: 1993-2004**

	1993-1995 <sup>a</sup>	1994-1996 <sup>a</sup>	1995-1997 <sup>b</sup>	1996-1998	1997-1999	1998-2000	1999-2001 <sup>c</sup>	2000-2002	2001-2003	2002-2004
<b>INFANT MORTALITY</b>										
<b>Illinois</b>	9.3	9.1	8.6	8.3	8.2	8.2	8.0	7.7	N/A	N/A
<b>AMYSO Project Area<sup>d</sup></b>	15.1	14.9	11.5	10.0	8.5	10.1	8.8	9.1	N/A	N/A
<b>Healthy Start Participants</b>			0.0	0.0	0.0	0.0	3.6	8.9	6.5	4.3

Data Source: Grantee's internal database; Illinois Department of Public Health

Explanatory Notes: (Data in Table 4 excludes Sauk Village)

- a. Baseline data used to establish Healthy Start eligibility for the Healthy Start project area.
- b. AMYSO Healthy Start model was targeted to reach adolescents and prevent unintended pregnancies from 1997 through 2000.
- c. AMYSO Healthy Start model was targeted to reach and serve high risk pregnant women from 2000 through 2004.

<sup>9</sup> [http://healthypeople.gov/document/html/volume2/16mich.htm#\\_edn59](http://healthypeople.gov/document/html/volume2/16mich.htm#_edn59)

<sup>10</sup> <http://www.healthypeople.gov/data/2010prog/focus16/>

<sup>11</sup> MCH Title V Block Grant outcome measures;  
<https://performance.hrsa.gov/mchb/tvisapp/Guidance/DetailSheets/OM02.html>

d. Infant Deaths Data as reported through the Illinois Project for Local Assessment of Needs (IPLAN)<sup>12</sup> for Chicago Heights in 1999 and 2000 was either a statistical aberration or incorrect. The Group planning the Performance Review and selecting the Performance Measures to be reviewed and requested use of adjusted/corrected data to better reflect historical trends in infant mortality rates in AMYSC Project Area.

5. **Findings:** The State of Illinois infant mortality rate<sup>13</sup> has declined from a high three-year average of 9.3 deaths per 1,000 live births for 1993 – 1995 to a three-year average of 7.7 for 2000 – 2002. The three-year average for the AMYSC Project Area has been reduced from a high three-year average for 1993 – 1995 of 15.1 deaths per 1,000 live births to 9.1 for 2000 – 2002. (Data for 2003 and 2004 are not available from the state.) The three year average infant mortality rates has varied for Aunt Martha's Healthy Start participants from a low three-year average of 0.0 for six of the eight years of the Project- to a high of 8.9 for 2000 – 2002 (Note: The wide variance in the three year infant mortality rates for Healthy Start Participants is spurious and misleading. This variance is due to the small numbers involved in the calculation of the rates and the multiple counting of the same infant death in order to calculate a three year moving average). The infant mortality rate for Healthy Start participants over the life of the project (1997-2004) is 3.9 infant deaths per 1,000 live births. The grantee's performance exceeds the Healthy People 2010 objective of 4.5 infant deaths per 1,000 live births. Over the life of the Healthy Start Project, there were a total of three deaths, and for six of the eight years of the AMYSC Healthy Start Project there were no infant deaths among Healthy Start Participants. While there was one infant death in 2001 and two infant deaths in 2002, a review of these three deaths found that they were "non-preventable." The infant death in 2001 was related to multiple anomalies. The client received genetic counseling and declined the option of an abortion. The two infant deaths in 2002 were a SIDS death and an infant <500 grams (non-viable).

#### **Section IV: Recommendations**

As a result of the *Performance Review*, the following AMYSC recommendations were translated into action:

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<sup>12</sup> The Illinois Project for Local Assessment of Needs (IPLAN) is a community health assessment and planning process that is conducted every five years by local health jurisdictions in Illinois. Based on the *Assessment Protocol for Excellence in Public Health* (APEX-PH) model, IPLAN is grounded in the core functions of public health and addresses public health practice standards. The completion of IPLAN fulfills most of the requirements for Local Health Department certification under Illinois Administrative Code Section 600.400: Certified Local Health Department Code Public Health Practice Standards. The essential elements of IPLAN are: an organizational capacity assessment; a community health needs assessment; and a community health plan, focusing on a minimum of three priority health problems.

<sup>13</sup> The number of infant deaths (children less than one year old) in a three-year period was divided by the total number of live births in the same three-year period and converted to thousands. The infant mortality rate reflects the number of infants who died per thousand live births. Using three-year averages reduces but does not eliminate the likelihood of statistical aberrations when working with small numbers or incidences.

1. AMYSC should enhance their Health Education Core Service by developing a module that focuses on the elements of a "healthy pregnancy" and this module should be incorporated into the Health Education Program at the AMYSC Federally Qualified Health Center.
2. AMYSC should provide monthly prenatal classes in both English and Spanish at the AMYSC Federally Qualified Health Center.
3. AMYSC should routinely provide Health Education while the hard to reach, high risk pregnant participants are waiting to be seen for their prenatal visit.
4. AMYSC should develop and distribute educational packets to every prenatal client at the women's health center. These packets should be developed with relevant information for each of the three trimesters of pregnancy.
5. AMYSC should conduct two focus groups with Ford Heights residents (the Target Area with the worst Health Status Indicators in the AMYSC Project Area in order to identify and address barriers to accessing prenatal care.

**HEALTHY START LOCAL EVALUATION REPORT # 2****PROJECT NAME:** AMYSC Healthy Start Project**TITLE OF REPORT:** First Trimester Prenatal Care**AUTHORS:** Hamilton•Bell Associates**Section I: Introduction**

HRSA's Office of Professional Review (OPR) has recently (June 2004) started conducting *Performance Reviews* of several HRSA funded Projects. These Reviews are performed by a number of review teams that operate out of HRSA Regional Offices. The Chicago Region has three (3) reviewers that operate as a team in conducting *Performance Reviews*. The Project Team consisting of OPR staff, AMYSC Administrative staff, and AMYSC Healthy Start staff identified *the percentage of pregnant participants who receive their prenatal care in the first trimester* as an area for "Focused Review" and a Local Evaluation was completed.

**Section II: Process**

The Project Team was charged with reviewing the identified performance measure (*i.e., First Trimester Prenatal Care*). The OPR *Performance Review* is required to review all HRSA funded Projects that are provided by an Agency. For AMYSC, the *Performance Review* included the Healthy Start Project and the FQHC. The steps in the process were as follows:

1. AMYSC receives notification of upcoming *Performance Review*.
2. A package of written materials were forwarded to AMYSC prior to *Performance Review*.
3. Five (5) conference calls were scheduled and conducted that result in the final consensus on the Performance Measures to be used in the *Performance Review*.
4. AMYSC was expected to provide data for a number of years for each of the Performance Indicators selected. This data was provided for Participants as well as the Target Area and one or more Reference Areas (*i.e., County, State*).
5. The HRSA Project Team prepared graphs of the Performance Measures over time as well as an initial draft of the Final Report prior to site visit.
6. Performance Review Teams conducted a 3 day Site Visit.
7. A Summary of the Findings/Results of the Review was presented "informally" on the last day of the Site Visit.
8. A Final Report was prepared the Performance Review Team and submitted to AMYSC.

9. AMYSC subsequently developed and submitted an Action Plan that details actions to be taken in response to the Final Report.

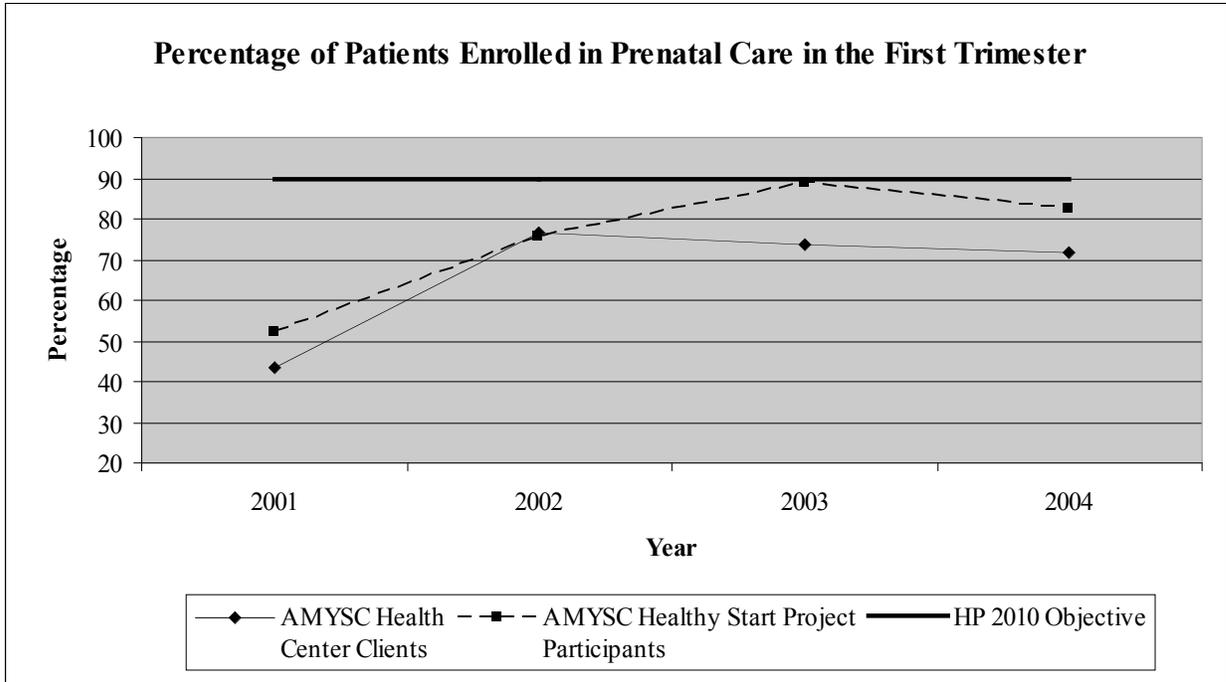
### **Section III: Findings/Discussion**

1. **Population Served:** In addition to serving the low income uninsured/underinsured health center population identified in this Performance Measure, Aunt Martha's Healthy Start Program seeks to find and enroll hard- to-reach, high risk pregnant women from a defined target area (Chicago Heights, Ford Heights, and Sauk Village). AMYSC uses a Risk Assessment to assure that only high risk women are enrolled in the Healthy Start Program, based on data from these Risk Assessments. The typical AMYSC Healthy Start Pregnant Participant can be profiled as a female of low educational attainment, that is at high risk for a poor outcome of pregnancy. The AMYSC Pregnant Participant is likely to have less than a high school education, a history of many pregnancies, have a language barrier, and a history of substance abuse. In 2004, 739 pregnant women received prenatal care through the health center program and 153 hard- to-reach, high risk pregnant women received prenatal care through the Healthy Start program.
2. **Services Provided:** In addition to the comprehensive health center services identified in this Performance Measure, Aunt Martha's Healthy Start program provides the core required services of outreach, case management, health education, interconceptional care, depression screening, and consortium development. Obstetric care is provided to Healthy Start program participants at the Chicago Heights Community Health Center and at the Women's Health Center, also in Chicago Heights.
3. **Impact:** Prenatal care includes three major components: risk assessment, treatment for medical conditions or risk reduction, and education. Each component can contribute to reductions in perinatal illness, disability, and death by identifying and mitigating potential risks and helping women to address behavioral factors, such as smoking and alcohol use that contribute to poor outcomes. Prenatal care is more likely to be effective if women begin receiving care early in pregnancy.<sup>14</sup> Early and adequate prenatal care provides a means to identify mothers at risk of delivering a preterm or growth-retarded infant and to provide an array of available medical, nutritional, and educational interventions.<sup>15</sup> Many poor pregnancy outcomes are costly, some of which are considered preventable with early intervention as a result of comprehensive prenatal care.

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<sup>14</sup> <http://www.healthypeople.gov/document/html/volume2/16mich.htm>

<sup>15</sup> Alexander GR and Kornbrot CC. The Role of Prenatal Care in Preventing Low Birth Weight. The Future of Children 1995;5(1):103-20.



**Table 3**  
**First Trimester Entry into Prenatal Care for**  
**Health Center Clients and Healthy Start Participants: 2001 – 2004**

	2001	2002	2003	2004
<b>FIRST TRIMESTER ENTRY</b>				
<b>AMYSC Health Center Clients</b>	164 / 299 (54.8%)	398 / 631 (63.1%)	589 / 797 (73.9%)	531 / 739 (71.9%)
<b>AMYSC Healthy Start Participants</b>	78 / 150 (52.0%)	95 / 126 (75.4%)	184 / 207 (88.9%)	126 / 153 (82.4%)

Data Source: Grantee’s internal database

- Findings:** In 2004, almost 72% of Aunt Martha’s health center clients entered prenatal care in the first trimester as compared with approximately 55% in 2001. Of the Healthy Start participants, over 82% entered prenatal care in the first trimester in 2004 as compared with 52% in 2001. (Both programs have experienced a slight decline in performance between 2003 and 2004).

#### **Section IV: Recommendations**

##### *Policy, program, practice and other recommendations*

As a result of the *Performance Review*, the following AMYSC recommendations were translated into action:

1. AMYSC should create new forms that capture participant cell phone numbers to facilitate contact for reminding patients about upcoming prenatal care visits.
2. AMYSC should solicit a Hispanic based media outlet for communicating information about the AMYSC Healthy Start Project and the comprehensive services offered by AMYSC.
3. AMYSC should develop and present information to at least 50% of the schools in Harvey (a newly added Community to the AMYSC Healthy Start Target Area).

#### **Section V: Impact**

Prenatal Care is more likely to be effective if women begin receiving care early in pregnancy. Many poor pregnancy outcomes are costly and some of this is avoidable with Early Prenatal Care.

The Project Period Objective for AMYSC was to have at least 75% of their hard to reach, high risk pregnant participants enroll in Healthy Start in their First Trimester. A review of the AMYSC data finds that in CY04, the project exceeded the goal of enrolling 75% of Pregnant Participants in the first trimester of pregnancy. The project exceeded the goal as 82% of the hard to reach, high risk pregnant women enrolled in Healthy Start in their first trimester of Prenatal Care.

**HEALTHY START LOCAL EVALUATION REPORT # 3**

**PROJECT NAME:** AMYSC  
**TITLE OF REPORT:** Adequacy of Prenatal Care  
**AUTHORS:** Hamilton•Bell Associates

**Section I: Introduction**

The Evaluation Plan for the AMYSC Healthy Start Project calls for the establishment of a CQI Committee to routinely review data from an internal Healthy Start Data System, DHS Cornerstone, and Vital Records to monitor the Performance of all Grantees in the implementation of the five (5) required Core Services. Based on a review of all Performance Measures, the CQI Committee selected *% of Pregnant Participants with Adequate Prenatal Care* as an area for “Focused Review” by AMYSC Administration, Healthy Start Staff, and the Project Evaluator.

A Local Evaluation or “Focused Review” was completed for this area in 2004.

**Section II: Process**

During the *Process Phase*, HBA played a leadership role in the design and institutionalization of a methodology for ongoing review and evaluation of key implementation processes. HBA designed and institutionalized a Continuous Quality Improvement Program (CQI). A CQI Committee was formed in order to provide the “structure” for review of data and make recommendations for modification of Agency activities.

The CQI Committee was comprised of the Local Evaluator, AMYSC Administration, the Project Director, AMYSC Healthy Start Staff representing all Core Services, and as needed, Outreach Workers and Case Managers serving the Target Areas.

The CQI Committee met every two or three months during 2005. Typically, the agenda for these CQI meetings was to review and discuss HBA findings and recommendations based on the latest data in the quarterly Standard Reports from Cornerstone and/or the AMYSC Healthy Start data system. These Standard Reports were always provided to the Agencies prior to the CQI meetings. Secondly, time was taken to review “administrative issues” that may have surfaced since the last meeting. This may include updates on AMYSC policies, Federal Guidance, interactions with Consortium and DHS, Federal reporting, Quality Assurance, and billing.

In general, the CQI meetings conclude with a consensus on the areas needing “improvement” and plans for conducting more “Focused Reviews” (a.k.a., Local Evaluation). The “Focused Reviews” that were approved by the CQI Committee were

usually carried out by the contingent of staff that was most accountable or involved in impacting on the specific performance measures under review. These Reviews often led to changes in policies and/or implementation processes or procedures.

In summary, the CQI program has been effective in identifying and resolving barriers to Agency performance in implementing the Core Services and meeting other AMYSC expectations (i.e., appropriate documentation of events and data entry).

### **Section III: Findings/Discussion**

#### 1. Discussion

To Assure Improvement in Agency/System Performance, a CQI Structure and Process was put in place that included the following elements:

- Use of Valid and Reliable Data
- Capacity to Convert “Data to Information”
- Regular Review and Discussion among Key Actors
- Identification of Areas for Improvement
- Ability to Implement Change
- Monitoring Impact of Change

In the AMYSC Healthy Start Project, Continuous Quality Improvement (CQI) became an ongoing function where “strengths” were extrapolated and “weaknesses” addressed. During 2004, HBA and the CQI Committee identified *Adequacy of Prenatal Care* as an area for more focused review and improvement:

#### 2. Findings:

The Focused Reviews resulted in the following findings related to “*Adequacy of Prenatal Care:*”

1. AMYSC must reinforce the importance of Case Managers inputting the number of prenatal visits into the correct Cornerstone screens and the AMYSC Case Management Coordinator must continue to reinforce the importance of accurate and timely data entry during regularly scheduled meetings with staff.
2. AMYSC must develop a Semi-Annual Audit Report that identifies missing data.
3. AMYSC must develop a correction procedure for routinely updating Adequacy of Prenatal Care data when found to be incorrect.
4. AMYSC must provide in-service training on the appropriate use of the Kessner Index when measuring Adequacy of Prenatal Care.
5. AMYSC must enhance its Reminder/Recall System so that there is more timely contact with pregnant, interconceptional, and child participants relative to prenatal, post partum, and well child visits.

6. AMYSC must include prenatal visits in its "Utilization Review Process." This process reviews 30% of client files from the Case Management Program and is performed on a monthly basis.
3. Results:
    - AMYSC concluded that the incomplete data entry related to "total number of prenatal medical visits" was an issue to be addressed. AMYSC reviewed current data entry procedures and emphasize diligence in completing this field for all Healthy Start pregnant participants.
    - AMYSC concluded that they would review their current practice regarding "**reminding**" participants of their scheduled post partum visit and subsequently "**recalling**" participants who miss their appointments for post partum visit.

#### **Section IV: Recommendations**

- AMYSC should routinely monitor data entry for Cornerstone Screen PA10, related to "Adequacy of Prenatal Care" for Pregnant Participants.
- AMYSC should establish ongoing procedures to capture data on the "primary reasons" that these Healthy Start participants miss a scheduled appointment. Special emphasis should be placed on Pregnant Participants who miss a prenatal visit.

#### **Section V: Impact**

Prenatal care includes three major components: risk assessment, treatment for medical conditions or risk reduction, and education. Each component can contribute to reductions in perinatal illness, disability, and death by identifying and mitigating potential risks and helping women to address behavioral factors, such as smoking and alcohol use that contribute to poor outcomes. Prenatal care is more likely to be effective if women begin receiving care early in pregnancy.<sup>16</sup> Early and adequate prenatal care provides a means to identify mothers at risk of delivering a preterm or growth-retarded infant and to provide an array of available medical, nutritional, and educational interventions.<sup>17</sup> Many poor pregnancy outcomes are costly, some of which are considered preventable with early intervention as a result of comprehensive prenatal care.

*The Project Period Objective is to have 75% of the "high risk" Pregnant Participants receive "Adequate Prenatal Care" (Kessner Index) by 5/31/2005.* In summary, the Focused Reviews and CQI activity has been effective in identifying and resolving barriers to improving Agency performance in implementing the Core Services (i.e., data entry). As a result of the efforts of the CQI Committee, Aunt Martha's Healthy Start Project exceeded their goal of 75% of Pregnant Participants receiving Adequate Prenatal Care. In CY 04, 82.4% received adequate prenatal care according to the Kessner Index.

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<sup>16</sup> <http://www.healthypeople.gov/document/html/volume2/16mich.htm>

<sup>17</sup> Alexander GR and Kornbrot CC. The Role of Prenatal Care in Preventing Low Birth Weight. *The Future of Children* 1995;5(1):103-20.

**HEALTHY START LOCAL EVALUATION REPORT # 4**

**PROJECT NAME:** AMYSC Healthy Start Project

**TITLE OF REPORT:** Well-Child Visits

**AUTHORS:** Hamilton•Bell Associates

**Section I: Introduction**

The Evaluation Plan for the AMYSC Healthy Start Project calls for the establishment of a CQI Committee to routinely review data from an internal Healthy Start Data System, DHS Cornerstone, and Vital Records to monitor the Performance of all Grantees in the implementation of the five (5) required Core Services. Based on a review of all Performance Measures, the CQI Committee selected *% of Child Participants Current with Well-Child Exams* as an area for “Focused Review” by AMYSC Administration, Healthy Start Staff, and the Project Evaluator.

A Local Evaluation or “Focused Review” was completed for this area in 2004.

**Section II: Process**

During the *Process Phase*, HBA played a leadership role in the design and institutionalization of a methodology for ongoing review and evaluation of key implementation processes. HBA designed and institutionalized a Continuous Quality Improvement Program (CQI). A CQI Committee was formed in order to provide the “structure” for review of data and make recommendations for modification of Agency activities.

The CQI Committee was comprised of the Local Evaluator, AMYSC Administration, the Project Director, AMYSC Healthy Start Staff representing all Core Services, and as needed, Outreach Workers and Case Managers serving the Target Areas.

The CQI Committee met every two or three months during 2005. Typically, the agenda for these CQI meetings was to review and discuss HBA findings and recommendations based on the latest data in the quarterly Standard Reports from Cornerstone and/or the AMYSC Healthy Start data system. These Standard Reports were always provided to the Agencies prior to the CQI meetings. Secondly, time was taken to review “administrative issues” that may have surfaced since the last meeting. This may include updates on AMYSC policies, Federal Guidance, interactions with Consortium and DHS, Federal reporting, Quality Assurance, and billing.

In general, the CQI meetings conclude with a consensus on the areas needing “improvement” and plans for conducting more “Focused Reviews” (a.k.a., Local Evaluation). The “Focused Reviews” that were approved by the CQI Committee were

usually carried out by the contingent of staff that was most accountable or involved in impacting on the specific performance measures under review. These Reviews often led to changes in policies and/or implementation processes or procedures.

In summary, the CQI program has been effective in identifying and resolving barriers to Agency performance in implementing the Core Services and meeting other AMYSC expectations (i.e., appropriate documentation of events and data entry).

### **Section III: Findings/Discussion**

#### 1. Discussion

To Assure Improvement in Agency/System Performance, a CQI Structure and Process was put in place that included the following elements:

- Use of Valid and Reliable Data
- Capacity to Convert "Data to Information"
- Regular Review and Discussion among Key Actors
- Identification of Areas for Improvement
- Ability to Implement Change
- Monitoring Impact of Change

In the AMYSC Healthy Start Project, Continuous Quality Improvement (CQI) became an ongoing function where "strengths" were extrapolated and "weaknesses" addressed. During 2004, HBA and the CQI Committee identified *Well-Child Visits* as an area for more focused review and improvement:

#### 2. Findings:

The Focused Reviews resulted in the following findings related to "*Well Child Visits:*"

1. AMYSC must reinforce the importance of Case Managers inputting the number of Well-Child Visits into the correct Cornerstone screens and the AMYSC Case Management Coordinator must continue to reinforce the importance of accurate and timely data entry during regularly scheduled meetings with staff.
2. AMYSC must develop a Semi-Annual Audit Report that identifies missing data.
3. AMYSC must develop a correction procedure for routinely updating Well-Child Visit data (i.e., EPSDT) when found to be incorrect.
4. AMYSC must enhance its Reminder/Recall System so that there is more timely contact with pregnant, interconceptional, and child participants relative to prenatal, post partum, and well child visits.
5. AMYSC must include Well-Child Visits in its "Utilization Review Process." This process reviews 30% of client files from the Case Management Program and is performed on a monthly basis.

### 3. Results:

- AMYSC concluded that data entry on EPSDT or Well-Child Exams has been and may continue to be a problem. AMYSC reviewed current data entry procedures, and codes and to emphasize diligence in completing this field for all Healthy Start active children.
- AMYSC concluded that they would review their current practice regarding “**reminding**” participants of their scheduled Well-Child Exam and subsequently “**recalling**” participants who miss their appointments for the Well-Child Exam.

### **Section IV: Recommendations**

- AMYSC should establish ongoing procedures to capture data on the “primary reasons” that these Healthy Start participants miss a scheduled appointment. Special emphasis should be placed on Child Participants who miss a Well-Child Visit.
- AMYSC should take aggressive action to assure that information captured on SV01 related to EPDST or Well-Child Visits will be captured for all Child Participants.

### **Section V: Impact**

*The Project Period Objective is to have 75% of participating children (age 0-2) current with Well-Child Exams by 5/31/2005. In summary, the Focused Reviews and CQI activity has been effective in identifying and resolving barriers to improving Agency performance in implementing the Core Services and meeting other AMYSC expectations (i.e., data entry). As a result of the efforts of the CQI Committee, the proportion of children whom are compliant with age-appropriate EPSDT exams has been on the rise. This objective benefited from being part of a CQI activity. In CY 02, 57% of the infants were up to date and in CY04, the project reached 66% of infants up to date with EPSDT exams.*

The ultimate impact that this documented improvement in “Well Child Visits” has on the health status of participating children is difficult to assess. However, the Literature suggests that there is a link between compliance with Well Child Exam (i.e., EPSDT requirements that include immunizations, age appropriate screenings, and education) and the health status of children.

**HEALTHY START LOCAL EVALUATION REPORT # 5**

**PROJECT NAME: AMYSC Healthy Start Project**

**TITLE OF REPORT: Interconceptional Participants Completing Initial Post Partum Visit**

**AUTHORS: Hamilton•Bell Associates**

**Section I: Introduction**

The Evaluation Plan for the AMYSC Healthy Start Project calls for the establishment of a CQI Committee to routinely review data from an internal Healthy Start Data System, DHS Cornerstone, and Vital Records to monitor the Performance of all Grantees in the implementation of the five (5) required Core Services. Based on a review of all Performance Measures, the CQI Committee selected % of *Interconceptional Participants Completing Initial Post Partum Visit* as an area for "Focused Review" by AMYSC Administration, Healthy Start Staff, and the Project Evaluator.

A Local Evaluation or "Focused Review" was completed for this area in 2004.

**Section II: Process**

During the *Process Phase*, HBA played a leadership role in the design and institutionalization of a methodology for ongoing review and evaluation of key implementation processes. HBA designed and institutionalized a Continuous Quality Improvement Program (CQI). A CQI Committee was formed in order to provide the "structure" for review of data and make recommendations for modification of Agency activities.

The CQI Committee was comprised of the Local Evaluator, AMYSC Administration, the Project Director, AMYSC Healthy Start Staff representing all Core Services, and as needed, Outreach Workers and Case Managers serving the Target Areas.

The CQI Committee met every two or three months during 2005. Typically, the agenda for these CQI meetings was to review and discuss HBA findings and recommendations based on the latest data in the quarterly Standard Reports from Cornerstone and/or the AMYSC Healthy Start data system. These Standard Reports were always provided to the Agencies prior to the CQI meetings. Secondly, time was taken to review "administrative issues" that may have surfaced since the last meeting. This may include updates on AMYSC policies, Federal Guidance, interactions with Consortium and DHS, Federal reporting, Quality Assurance, and billing.

In general, the CQI meetings conclude with a consensus on the areas needing "improvement" and plans for conducting more "Focused Reviews" (a.k.a., Local Evaluation). The "Focused Reviews" that were approved by the CQI Committee were usually carried out by the contingent of staff that was most accountable or involved in impacting on the specific performance measures under review. These Reviews often led to changes in policies and/or implementation processes or procedures.

In summary, the CQI program has been effective in identifying and resolving barriers to Agency performance in implementing the Core Services and meeting other AMYSC expectations (i.e., appropriate documentation of events and data entry).

### **Section III: Findings/Discussion**

#### 1. Discussion

To Assure Improvement in Agency/System Performance, a CQI Structure and Process was put in place that included the following elements:

- Use of Valid and Reliable Data
- Capacity to Convert "Data to Information"
- Regular Review and Discussion among Key Actors
- Identification of Areas for Improvement
- Ability to Implement Change
- Monitoring Impact of Change

In the AMYSC Healthy Start Project, Continuous Quality Improvement (CQI) became an ongoing function where "strengths" were extrapolated and "weaknesses" addressed. During 2004, HBA and the CQI Committee identified *% of Interconceptional Participants Completing Initial Post Partum Visit* as an area for more focused review and improvement:

#### 2. Findings:

The Focused Reviews resulted in the following findings related to *"% of Interconceptional Participants Completing Initial Post Partum Visit."*

1. AMYSC must reinforce the importance of Case Managers inputting the number of *Initial Post Partum Visits* into the correct Cornerstone screens and the AMYSC Case Management Coordinator must continue to reinforce the importance of accurate and timely data entry during regularly scheduled meetings with staff.
2. AMYSC must develop a Semi-Annual Audit Report that identifies missing data.
3. AMYSC must develop a correction procedure for routinely updating *Initial Post-Partum Visit* data when found to be incorrect.
4. AMYSC must enhance its Reminder/Recall System so that there is more timely contact with pregnant, interconceptional, and child participants relative to prenatal, post partum, and well child visits.

5. AMYSC must include *Initial Post Partum Visits* in its "Utilization Review Process." This process reviews 30% of client files from the Case Management Program and is performed on a monthly basis.
3. Results:
    - AMYSC concluded that capturing the date of the initial post partum visit appears to be a "Data Entry Issue" in the Cornerstone System. AMYSC found that the use of the Cornerstone PA 10 Screen to capture the *post partum visit data* was compromised as this field was being completed by WIC staff prior to the post partum exam. Until this was resolved by the Illinois Department of Human Services, AMYSC utilized its internal Healthy Start Data System to track completion of *initial post partum visits*.
    - DHS subsequently developed a procedure that provided correct guidance for capturing information relative to *Initial Post Partum Visits*. AMYSC agreed to discontinue using the PA 10 screen and use only the Cornerstone SV01 screen to capture information on the *Initial Post Partum Visit*.
    - AMYSC concluded that they would review their current practice regarding "**reminding**" participants of their scheduled post partum visit and subsequently "**recalling**" participants who miss their appointments for their post partum visit.

#### **Section IV: Recommendations**

- In order to successfully transition to the DHS Cornerstone System, AMYSC should establish procedures to routinely monitor data entry for Cornerstone Screen SV 01 related to Initial Post Partum Visits.
- AMYSC should establish ongoing procedures to capture data on the "primary reasons" that these Healthy Start participants miss a scheduled appointment for an Initial Post Partum Exam.

#### **Section V: Impact**

*The Project Period Objective is to have 75% of Interconceptional Women complete their Initial Post Partum Visit by 5/31/2005.* In summary, the Focused Reviews and CQI activity has been effective in identifying and resolving barriers to improving Agency performance in implementing the Core Services and meeting other AMYSC expectations (i.e., data entry). As a result of the efforts of the CQI Committee, the percentage of *Interconceptional Participants Completing the Initial Post Partum Visit* increased from 59% in 2002, to 72% in 2004. It is anticipated that the 75% target level will be achieved in 2005.

The ultimate impact that improvement in the percentage of pregnant participants who "*Complete their Initial Post Partum Visit*" has on the health status of Interconceptional Women is difficult to assess. However, these women are hard to reach, high risk pregnant

women when initially enrolled in the AMYSC Healthy Start Project, and they must return for their Post Partum Visit to receive the benefit of the Interconceptional Care component of this Project. Interconceptional Care allows for continuity of health care from one pregnancy to the next. Women who had a poor pregnancy outcome are at substantial risk for having another poor pregnancy outcome. Many risk factors are carried from one pregnancy to the next. The Interconceptional Period offers an important window of opportunity for addressing these risk factors and optimizing women's health prior to their next pregnancy. The Interconceptional Care component of AMYSC's Healthy Start Project served women with prior adverse pregnancy outcomes and maybe an important step toward closing the racial disparity gap in key MCH Indicators.

Those pregnant participants who do not return for a Post Partum Visit and are "lost to follow up" are likely to remain high risk for a poor outcome of pregnancy. The AMYSC Healthy Start Project has targeted *completion of the initial post partum visit* by pregnant participants as an area for further improvement in 2005.

**VII. Fetal and Infant Mortality Review (FIMR):** Currently the communities the project serves is not participating in a FIMR process.

**VIII. Products (See Appendix A)**

**IX. Project Data (See Appendix B)**