

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

For 17 years the Center for Black Women's Wellness (CBWW) has been committed to improving the health and well-being of Black women and their families. The Center for Black Women's Wellness (CBWW)/Atlanta Healthy Start Initiative (AHSI) has been in operation since 1998 and is a unique, culturally competent model that specifically addresses the factors associated with high infant mortality rates and high teen pregnancy rates within the Neighborhood Planning Unit V (NPU-V) community of Atlanta, Georgia. The NPU-V, located just south of downtown Atlanta, encompasses an approximately 3.5-square-mile area. NPU-V includes the neighborhoods of Mechanicsville, Pittsburgh, Summerhill, Peoplestown, and Adair Park. According to 2000 Census data, the total population of the NPU-V area is 15,825.

From 2001-2005 the racial/ethnic disparities addressed by the Atlanta Healthy Start Initiative were the disparities between Black and White perinatal health outcomes, particularly as they related to infant mortality, low birthweight and teen birth rates. The impact of poverty on perinatal health disparities was also addressed by the project. According to 2000 Census data, the demographic profile for NPU-V was 92% Black, with 88% female-headed households. Nearly 62% of the residents lived below 150% of the federal poverty level, more than double of the rate of the city of Atlanta, at 30.3%. Between 2001-2003, the three-year average infant mortality rate for NPU-V was 10.8 per 1,000 live births, with a rate of 12.6 for Blacks and 0.0 for Whites. Between 2001-2003, the three-year average low birth weight rate was 11.9 per 100 live births, with a rate of 12.3 for Blacks and 6.4 for Whites. Moreover, in a 1998 youth survey conducted by the Annie E. Casey Foundation in this community, 94% of 17-18 year-old female teens and 93% of 17-18 year-old male teens that were surveyed reported having had sexual intercourse. In addition, the average age that sexually active youth reported that they first engaged in sex was 13.

The obstacles which impact maternal and child health—including lack of insurance or underinsurance and poverty—result in poor health outcomes in NPU-V which mirror trends throughout the nation. Unfortunately, the cause of poor maternal and child health within the African-American community is multi-factorial with each factor having looming effects. For instance, according to HRSA's Women's Health 2004, only 75.2% of Black women got prenatal care compared to 88.6% of White women. Also, the AHRQ's 2004 National Healthcare Disparities Report showed that Black women were almost twice as likely than White women (17.9% vs. 9.8%) to be uninsured.

For this project period, the Atlanta Healthy Start Initiative built upon lessons learned and utilized the strengths and commitment of leaders in its neighborhoods, consortium members, and health care providers to assist mothers and their families to improve perinatal health outcomes and improve access to care. Efforts included extensive outreach to hard-to-reach eligible families; resource distribution through in-kind resources provided to participants; substantial assistance from the case management team in assisting participants with navigating the system of care; health education; and coordination through the consortium and key partnerships to address systems level barriers to care. As such, the objectives of the 2001-2005 AHSI were to: 1) identify and enroll 120 high risk women into case management and health education services

each year; 2) recruit 85% of participants into prenatal services during their first trimester of pregnancy; 3) decrease the percent of low birthweight infants born to participating women to 10%; 4) decrease the percent of very low birthweight babies born to participants to 2%; and 5) provide adolescent health education services to 280 at-risk adolescents each year.

This Impact Report provides our perspective of the lessons learned, accomplishments and challenges experienced as a result of implementing AHSI from June 1, 2001 through May 31, 2005 to address the perinatal health disparities experienced by African American families in our project area of NPU-V.

## **II. Project Implementation**

*Using as a framework the five Healthy Start Core Services (Outreach and Client Recruitment; Case Management; Health Education and Training; Interconceptional Care; and Depression Screening and Referral) and the four Core Systems-building Efforts (Local Health System Action Plan; Consortium; Collaboration and Coordination with State Title V and Other Agencies; and Sustainability) identify how your Healthy Start Project implemented each service and system intervention.*

### **A. Outreach & Client Recruitment**

#### **1. Approach to Service**

A number of health and social service providers are in close proximity to where NPU-V residents live, work, or go to school. However, needs assessment findings and dialogue among consortium members revealed that access and utilization of these services was a different issue, due to issues such as mistrust, lack of information, cost, and competing priorities.

The outreach core service was the entry point for all other core services. It was needed to identify and enroll clients most in need of Atlanta Healthy Start services, and to increase consumers' access to services as well as to increase their knowledge of available services and resources by raising awareness of perinatal health issues. Outreach services also provided a vehicle to broadly disseminate information regarding program services, educate the public, and create awareness about the program to women of childbearing age who may have one day needed AHSI services.

The approach to this model was to rely on the assets of a cadre of women from the community while creating economic opportunities by training them to provide culturally competent and linguistically appropriate outreach services to recruit pregnant and postpartum women into Healthy Start services. Prior to this project period, the AHSI was funded as a replication project and focused on the Adolescent Services model only. However, in 2000 AHSI began providing outreach and case management services to a small number of pregnant teens and women utilizing paraprofessionals, known as "Resource Mothers". Thus, the strategy developed in 2001 was to expand this pool of Resource Mothers to provide outreach and case management services. The AHSI objective, based on the population of women of child bearing age and the number of live births per year in the area, was to serve 120 pregnant and postpartum women each year.

## **2. Components of Intervention and Resources Needed to Implement Intervention**

The Atlanta Healthy Start Initiative utilized a full-time Community Organizer to assist in identifying Resource Mothers, organize outreach and recruitment activities, and interface with community groups on a regular basis. In September 2001 a full-time Outreach Specialist was hired to serve as supervisor of the Resource Mothers, adapt existing outreach and case management protocols, as necessary, and work jointly with a Nurse Consultant to address the client needs in obtaining medical and social services. The Outreach Specialist was also responsible for building relationships with hospitals, community health centers, and other points of entry for pregnant and postpartum women; building partnerships with untapped resources in the community (e.g., faith based organizations, court system, businesses); enhancing our referral network; assessing client satisfaction with existing referral agencies; and identifying and coordinating ongoing training needs.

The Healthy Start budget supported eight Resource Mother contractual positions. Resource Mothers were selected for their personal strengths, experience, and knowledge of the community. The Resource Mothers were identified through word-of-mouth and flyer distribution throughout the project area, referrals from partnering agencies, and referrals from civic and tenant associations that were contacted by project staff. Throughout 2001-2005, the number of Resource Mothers ranged from five to eight. In order to ensure the provision of outreach services despite Resource Mother vacancies, hours were increased over the project period from 20 hours per week to 30 hours per week. In addition, from 2004-2005, one Resource Mother assignment was modified to include the provision of administrative support to the project, which included the compiling of client files, providing phone coverage for the AHSI phone line, compiling materials for community events, and recording recruitment forms.

The outreach core service involved: 1) initial training, 2) outreach and recruitment activities, and 3) on-going training. For initial training, the project collaborated with the local health department (Fulton County Department of Health and Wellness) to provide training utilizing the training module used by the state Resource Mothers program—INMED Mothernet America's home visitors curriculum. This curriculum was specifically geared towards equipping paraprofessionals to conduct home visitation services programs with at-risk pregnant women. The curriculum included topics on recruitment, building rapport and trust, nutrition, breastfeeding, family planning, child growth and development. The training, which occurred in October 2001, occurred over a two- week period and was provided for an in-kind amount of approximately \$2,600. A total of five out of seven women (based on 34 applicants) completed this training.

In 2003, this training was repeated to fill open positions. In addition, the 2003 training was expanded to include a five-day home visitation training series developed and implemented by Family Nurturing Center of Georgia. This training, which was opened to other outreach worker staff from eight partnering organizations, focused on topics such as: basic home visiting techniques, building relationships, problem solving, listening skills, and communication styles. This training was conducted from December 1-5, 2003, and attended by 28 participants.

The utilization of Resource Mothers from the community proved extremely successful in providing outreach to traditionally hard-to-reach populations and linking women to needed health and social services. Resource Mother duties related to outreach services included client identification and recruitment and the broad dissemination of program information and other materials pertaining to maternal and infant health. The following outreach activities served as the primary medium by which the community gained information about AHSI and enrolled into program services.

**Community Canvassing:**

The Community Organizer planned group community canvassing efforts, in which the Resource Mothers concentrated on a particular neighborhood and went door-to-door to talk about program services, identify potential clients, distribute outreach materials and materials pertaining to specific events, and inform residents of the AHSI program. Each canvassing effort lasted approximately 2-3 hours, depending on climate. Individually, Resource Mothers also worked to maintain visibility in their assigned neighborhoods by distributing outreach literature, providing information about the program to neighborhood resources, and maintaining communication with tenant and civic associations and other formal or informal community networks.

**Community Events:**

Maintaining visibility in the community was essential to building trust, credibility, and broadening program awareness to reach women who were pregnant or were likely to become pregnant in the future. Typically, The Community Organizer worked with the Outreach Specialist to identify specific outreach events for staff to be visible to promote and recruit for program services. Outreach efforts included participation at community and church-sponsored health fairs, agency resource fairs, and school festivals.

**Enhancing Referral Sources through Partnerships with Service Providers:** While most clients were enrolled as the result of direct outreach efforts, another strategy for client recruitment was the continuous building of relationships with hospitals, community health centers, and other points of entry for pregnant and postpartum women; and increasing service providers' awareness of the program as well as enhancing the system of care for pregnant and postpartum women by establishing relationships for mutual referrals and resources. Site visits, which were typically scheduled by the Outreach Specialist, occurred with several agencies to share program information and to develop resources for clients. As a result, several new partnerships were developed with agencies including: Department of Family and Children Services (DFACS), Atlanta Medical Center, Task Force for the Homeless, Capitol Area Mosaic, Carver High School/Teen Parent Program, Jars of Clay Outreach Center, Romae Powell Juvenile Justice Center, The Bridge, Achor Transitional Housing Center, Grady Health Systems/First Steps to Healthy Families, Fulton County Juvenile Court, St. Jude's Recovery Center, Englewood Community, Mount Calvary Community, Fulton County Municipal Court/ Victim Witness Program, Cleveland Avenue Library, Milton Avenue Transitional Center, Crawford Long Hospital, West End Medical Center, and t Congregational Church.

Lastly, an on-going training plan was developed to provide opportunities for continued skills building and learning. The training plan included an average of one professional development activity per month, for a minimum of 24 hours per year, and attendance at the annual State Resource Mothers conference.

In February 2005, due to major demographic changes in our project area (described in the next section) which presented challenges to recruitment, and the challenge expressed by Resource Mothers of conducting outreach and case management services, the approach to outreach was modified. At that juncture, Resource Mother responsibilities were redistributed and four Resource Mothers continued to work in tandem with the Nurse Consultant to provide case management services. These Resource Mothers continued to be supervised by the Outreach Specialist.

Two additional women, who had a longstanding relationship with the CBWW and have assisted with other CBWW recruitment activities, were utilized as outreach workers to assist two Resource Mothers with outreach, for a total of four to assist with outreach services. The Community Organizer supervised the Resource Mother/outreach workers. Outreach worker training occurred from February 22-28, 2005 and was conducted in collaboration with Fulton County Department of Health and Wellness. Topics included: roles and responsibilities of outreach workers, overview of outreach worker notebook, overview of Medicaid Transportation, overview of Healthcheck services, overview of NPU-V resources, neighborhood tours, goals of AHSI and CBWW programs, policies and procedures, and outreach tools and forms. In addition, all Resource Mothers and outreach workers went on a site visit to Heart of Georgia Healthy Start to shadow workers and gain information on outreach strategies.

### **3. Resources or Events that Facilitated or Detracted from Successful Initiation**

The in-kind training resources provided by a key partner, Fulton County Department of Health and Wellness, contributed to the successful implementation of the Outreach model. As described above, this two-week initial training occurred in 2001 and 2003 and was valued at approximately \$2,600. In addition, in 2005 the health department conducted two days of the five-day outreach worker training.

Events that detracted from the implementation of outreach services included: 1) changing demographics of NPU-V; and 2) difficulty of Resource Mothers in conducting outreach and case management services. Beginning in 2002, the project area of NPU-V began changing rapidly, due to the redevelopment of three public housing complexes and the creation of mixed income housing. One public housing unit, Capitol Homes (486 units), was demolished in 2002; another public housing unit, Pittsburgh Civic League (120 units), was vacated in 2004, and residents of yet another public housing unit, McDaniel Glenn (314 units), relocated in 2005. With all of these relocation efforts, eligible residents were given Section 8 housing vouchers for subsidized housing. While some of this housing was available within NPU-V, many families were moved throughout Metropolitan Atlanta. Unfortunately, only time will tell the impact of these major housing redevelopment efforts on residents' social support, access and utilization of services and, ultimately, health outcomes.

As residents vacated public housing and faced stressors related to finding safe and affordable housing, outreach was hampered. In addition, Resource Mothers, who were stretched to provide even more intensive support to families, voiced that there was insufficient time to help clients address their myriad of needs while outreaching to new families. As a result of these realities, the Outreach model was modified to have four Resource Mothers conduct case management services with the Nurse Consultant and four Resource Mothers/outreach workers to conduct outreach services. As a result, our outreach goal of serving 120 women per year, while not met in 2003-2004, was met in 2004-2005.

## **B. Case Management**

### **1. Approach to Service**

While a number of health service organizations exist in our target community, often care is not coordinated nor is care continuity supported among agencies and organizations that offer health, social, educational, or employment services. Thus, the case management model was needed to facilitate interrelated services for clients most in need of Atlanta Healthy Start services. While outreach activities increased consumers' knowledge of available services and resources, case management helped to ensure that clients utilized these resources without encountering barriers. Case management activities included: home visits, assessments, assisting clients in making appointments, making and monitoring needed referrals, advocating for clients, and serving as a resource for the entire family unit as strategies and activities to improve birth outcomes are implemented.

### **2. Components of Intervention and Resources Needed to Implement Intervention**

The staffing required for the case management model included Resource Mothers, an Outreach Specialist, a Community Organizer, and a Nurse Consultant. The Resource Mothers, who were indigenous to the community and had a primary role in recruiting clients through Outreach services, were the logical extenders of the case management process, especially in the monitoring and follow-up to ensure that clients were enrolled and received services offered through the referral linkages. Each Resource Mother had the capacity to manage a caseload of a maximum of 15 clients at one period of time.

The Community Organizer assisted with the identification and disbursement of resources (e.g., MARTA tokens) to facilitate accessing services and to meet some of the various immediate needs of clients. In September 2001 a full-time Outreach Specialist was hired to serve as supervisor of the Resource Mothers. Her responsibilities included: adapting existing outreach protocols, as necessary, and working in concert with the Nurse Consultant to address the client needs in obtaining medical and social services. The Outreach Specialist was also responsible for building relationships with hospitals, community health centers, and other points of entry for pregnant and postpartum women; building partnerships with untapped resources in the community (e.g., faith based organizations, court system, businesses); enhancing our referral network; assessing client satisfaction with existing referral agencies; and identifying and coordinating ongoing training needs. The Nurse Consultant conducted Perinatal Case Management (PCM) and Pregnancy Related Services (PRS), which included: prenatal,

postpartum and infant assessments and follow-up care; assisting participants in following prescribed plan of care and securing medical or other related services; and monitoring clients to ensure they receive health education and appropriate services. The Nurse Consultant also served as the clinician for the wellness program, providing preventive health care services to women and health workshops to the community.

While the emphasis during Year 1 was on staffing positions and the development and implementation of an initial and on-going training plan, subsequent years focused on enhancing processes needed for effective program implementation. Not only were case management procedures clarified, but staff increased their knowledge and ability to provide a standardized quality system of care—resulting from job experience and staff development—and added linkages were continuously made with service providers to identify resources for clients.

The following section describes the Case Management component of Atlanta Healthy Start. These services were provided by the Nurse Consultant and the Resource Mothers, who were supervised by the Outreach Specialist. Moreover, the Nurse Consultant provided feedback during case management meetings and assisted, as needed, in addressing any identified health needs of clients. The Nurse also worked with the Health Educator to assure that the health education needs of these and all clients were met.

<b>Administrative and Core Team Involved</b>	<b>Support Team Involved</b>	<b>Forms Needed</b>	<b>Reports Generated</b>
<ul style="list-style-type: none"> <li>▪ Resource Mothers</li> <li>▪ Outreach Specialist</li> <li>▪ Nurse Consultant</li> <li>▪ Community Organizer</li> </ul>	<ul style="list-style-type: none"> <li>▪ Information Specialist</li> <li>▪ Data Entry/Admin. Assistant</li> </ul>	<ul style="list-style-type: none"> <li>▪ RM Initial Contact Form</li> <li>▪ Client Information Form</li> <li>▪ Psychosocial Assessment</li> <li>▪ Consent to Receive Services</li> <li>▪ Authorization for Consent to Release Health Information</li> <li>▪ Home Visit/Follow-Up Form</li> <li>▪ Case Plan</li> <li>▪ Pregnancy Outcome</li> <li>▪ Progress Notes</li> <li>▪ Resource Distribution Form</li> <li>▪ Locate letter (retention)</li> <li>▪ RM Daily Activity Sheet</li> </ul>	<ul style="list-style-type: none"> <li>▪ RM Monthly Report</li> <li>▪ Resource Disbursement Report</li> <li>▪ Outreach Specialist Monthly Report</li> </ul>

Risk assessment was conducted at enrollment. The intent of the risk assessment was to identify the strengths and challenges of the client, and to determine the client’s medical, nutritional, and/or psychosocial needs. Eligibility for the Resource Mother case management component was determined by being: 1) a pregnant or postpartum teen or woman residing in NPU-V; and 2) being determined as having at least three risk factors—based on a health, psychosocial, and socioeconomic assessment. The Resource Mother and client worked together to develop a case plan based on the assessment. Enrolled women then received home visits throughout their pregnancy, until 24 months postpartum. The content of home visits was three fold: the review and joint monitoring of progress made towards attainment of the case plan; the coordination of health and social services, whereby Resource Mothers identified needed resources and worked to alleviate any client barriers to accessing care; and the review of core pregnancy related topics based on trimester of pregnancy. Once enrolled, Resource Mothers began to assist clients in making appointments, link them to facilitation services such as transportation and child care to

alleviate barriers to appointment compliance, conduct home visits, make and monitor needed referrals, advocate for clients, and serve as a resource for the entire family unit as strategies and activities to improve birth outcomes were implemented. Pregnant women that were identified as a result of outreach services were encouraged to enroll in Perinatal Case Management (PCM) services, where they received health-related case management services from the Nurse Consultant, in addition to the more frequent home visitation provided by the Resource Mother.

The number of visits provided was determined by the risk level of the client. However, on average, the Resource Mother was to provide two face-to-face home visits and one phone contact per month during pregnancy until the infant turned one year. Afterwards, the Resource Mother was to provide one face-to-face home visit and one phone contact per month from the time the infant was one-years-old until the infant turned two.

Pregnant clients enrolled in PCM received 6-8 nurse case management visits through their pregnancy to one year postpartum. There were four services covered under the PCM program: 1) the comprehensive new visit; 2) brief follow up visits; 3) extensive follow up visits; and 4) the postpartum visit. The Nurse Consultant conducted the comprehensive visit, extensive visits, and the postpartum visit. Brief visits, when necessary, could be conducted by Resource Mothers. The assigned Resource Mother usually accompanied the Nurse to her visits, as she may have established relationship with the participant prior to the first PCM visit. A summary of services provided to clients by the Nurse Consultant during the postpartum period is described in the Interconceptional section of this report.

Weekly team meetings provided a forum for the case management team to conduct planning, problem solve, and discuss program implementation. Monthly conferences provided individual time for the Outreach Specialist to review and reassess the Resource Mothers' strengths and needs, an opportunity for support and coaching, time to identify resources needed for growth and development, and an ongoing participatory evaluation process. Quality assurance was determined as a high priority for the program and the grantee organization. The quality assurance process monitored the accuracy, quality, and effectiveness of case management, in addition to the development of tools necessary for improvement and changes to produce and maintain a continuum of quality case management. In an effort to enhance the data collection system, our local evaluator began attending the meetings with the Outreach Specialists and Resource Mothers. As a result of the input from our local evaluator various case management forms and protocols were enhanced to ensure the appropriate documentation and reporting of all processes.

### **3. Resources or Events that Facilitated or Detracted from Successful Initiation**

Our Case Management model relied on trained paraprofessionals who were indigenous to the project area. None of these women possessed Case Management experience and, despite the intense level of initial and on-going training, the large quantity of documentation required for the project proved to be a challenge for some. To address this, when Resource Mother candidates were sought in 2003 the position description was amended to include the requirement of a high school diploma or GED. In addition, during the interview process an exercise was conducted to assess writing skills to ensure the ability to complete client documentation.

Also, policy and demographic changes and client barriers presented some challenges to the provision of Case Management services. The most common barrier for clients was the securing of safe and affordable housing. Also, policy changes required a six month work history for eligibility for public housing. This created a barrier for our many non working clients. To complicate existing housing issues, dramatic housing changes occurred in our existing area of NPU-V resulting in hundreds of families being relocated due to the closing of public housing developments that are being replaced by mixed-income units. These factors of a transient clientele and the multiple stressors faced by clients, has impacting the direction of case management services. In addition to the often more frequent support provided to vulnerable families, for the 2005-2009 project period AHSI has expanded its project area to include the adjoining community of NPU-L.

### **C. Health Education and Training**

#### **1. Approach to Service**

The Health Education Model was a multi-pronged approach with the purpose of increasing consumer knowledge of maternal and infant health issues and of risk factors associated with disparities in perinatal health. Health education was also used to promote behavior change to reduce risk factors associated with poor perinatal outcomes. Emphasis was placed on Health Education for at-risk youth, in response to the needs assessment data that determined teenage pregnancy to be a great challenge to the NPU-V community.

#### **2. Components of Intervention and Resources Needed to Implement Intervention**

The AHSI utilized a full-time Health Educator to oversee the day-to-day responsibilities of planning and implementing health education activities. A Nurse Consultant was utilized to provide various group health education sessions, and one-one-one health education to pregnant clients during home visits. Resource Mothers also provided health education during home visits. The full-time Community Organizer was chiefly responsible for coordinating all recruitment efforts for all workshops, forums, and education sessions. Other consultants were also utilized for the health education model, including Dr. Tonja Hampton, who was contracted to develop health promotion materials and other resources. On October 16, 2002, Dr. Hampton was hired as a permanent part-time employee to serve as the CBWW Wellness Coordinator. In this capacity, she continued to develop health education materials, while planning health promotion strategies for CBWW and enhancing operations of the clinic.

Health education activities were conducted to the following target groups:

- All pregnant and postpartum Healthy Start participants enrolled in outreach and case management services;
- Teens at-risk of becoming pregnant;

- Groups of individuals that may have an impact on participants' health behaviors (e.g., partners of pregnant and postpartum participants, parents, grandmothers, childcare providers); and
- The community-at-large, including women of childbearing age who may one day seek Healthy Start services.

The Health education activities are described in the following section.

### **Health Education for Pregnant and Postpartum Healthy Start Program and Community Participants**

- **Health Education during Home Visitation**

The Resource Mothers and Nurse Consultant provided one-on-one Health Education to pregnant and parenting participants during home visits. These visits, and the education provided through them, were provided by the Nurse until one year postpartum and by the Resource Mothers until two years postpartum. For Resource Mothers, the Resource Mothers handbook allowed them to provide instruction specific to the client based on the stage of pregnancy or age of the child. For the Nurse Consultant, a Postpartum Visit Teaching Guide was utilized to track the education covered. Topics included parent and infant nutrition, postpartum care for the parent and the child, safety, and child growth and development. At postpartum assessment, the nurse also discussed family planning options and received health education, social support, and encouragement in decision-making concerning future pregnancies and reproductive health behaviors (family planning and safer sex practices).

- **Group Health Education**

In 2002, a contract was entered into with Eluzai, Inc. to conduct childbirth education and support groups for participants. In March 2002, our first 10-series teen parent support group began at Alternative Life Paths, a nearby residential home for teenage girls. Eight teen parents participated in this workshop series, which they coined the "Young Mom's Club". The two-hour workshops were held once a week in the evenings, and topics covered included: types of listening, communicating with our children, bonding and attachment, growth and development, discipline, child abuse, and handling anger. A second group began in July 2002 at Southside Medical Center. This group had five participants, who benefited from the same content area. Due to barriers to recruitment, the creation of additional classes did not occur. However, all program and community participants desiring parent education were linked to and the PIIP (Parent Infant Intervention Program) program of the Fulton County Department of Health and Wellness. Also, when possible, pregnant clients were referred to Grady Hospital to receive group prenatal care through its Centering Pregnancy Program. This "group care" model provided health education on prenatal and postpartum care and parenting, in addition to risk assessment and opportunities for social support and interaction.

## **Health Education for At-Risk Adolescents:**

Plain Talk, the signature youth development program provided by CBWW, included the following four core activities to address adult and teenage sexual risk-taking for the reduction of teen pregnancy, STDs, and HIV/AIDS:

- Askable Adult Workshops
- LivingRoom Party Host Training
- LivingRoom Parties
- Summer Youth Leadership Training Program (SYLTP)
- After-school program

The major program components of this Adolescent Model are described in the following section:

### ▪ **Askable Adult Workshops**

The eight-session Askable Adult evening workshop series focused on educating parents and other adults on the critical issues of adolescence such as puberty, peer pressure, and relationships. The workshop was a strategy to help adults talk openly with youth and support them in making informed decisions. Participants were recruited through outreach efforts spearheaded by the Community Organizer. To alleviate barriers to attendance, for each cycle the project contracted with two people from the community to provide on-site child care during each workshop session and also provided nutritional supplements at workshops. From 2001 – 2005 the workshop series was held twice each year in the spring and fall. The exceptions were in the fall of 2003, when the Health Educator went on maternity leave, and the fall of 2004, when we were without a Health Educator. Despite this, each series was extremely successful, with approximately 25 participants per workshop series and evaluation results that demonstrated significant increases in knowledge related to content area for each cycle.

### ▪ **Livingroom Party Host Training & Living Room Parties**

After the completion of at least five of the eight Askable Adult workshops, participants then began Livingroom Party Host Training where they had the opportunity to share the information learned during home-based workshops (Livingroom Parties). Programs were held in the spring and fall of 2001 – 2005. Workshop participants who hosted Livingroom Parties were given priority to sponsor a youth into the Summer Youth Leadership Training Program. There were two cycles in which some who signed up to participate expressed a need for transportation. To address this, we contracted out with Parks and Recreation to provide van service to pick up participants who did not live within walking distance.

### ▪ **Summer Youth Leadership Training Program (SYLTP)**

The eight-week SYLTP program provided valuable life skills training and leadership development to male and female youth ages 10-15. The program used interactive activities facilitated by counselors and guest speakers to address the issues of teen pregnancy and the spread of sexually transmitted disease, including HIV. The youth participants gained a wealth of knowledge and skills from the trained counselors and a number of guest speakers. Participants were provided leadership development, information about sex, sexuality, and other skills to help them make informed decisions in order to reach their fullest potential.

The SYLTP was offered to approximately 35 youth each year from June to July in 2001- 2005. In 2001, 42 youth participated in the SYLTP. In 2002, 2003, and also in 2004 we had 39 participants.

The Health Educator was responsible for the planning of the SYLTP program from 2001 to 2004. Each year three counselors, two female and one male, were contracted to provide supervision and instruction to the youth.

Program participants were recruited through word-of-mouth and outreach to schools and after-school programs within the community. Priority was given to youth sponsored by a parent or adult who completed the Askable Adult workshop series, Livingroom Party Host Training and who hosted a workshop (Livingroom Party) in their home.

- **After-School Program**

In 2001 the Health Educator was responsible for conducting the After School program activities, which provided life skills training to male and female youth ages 10-16 for 13 weeks from February through May. Recruitment was conducted through flyers, word-of-mouth, mail-outs to participants of Askable Adult workshops, and contact with local schools. After school activities included a male and a female reproductive health program that included a curriculum that covered topics such as: peer relationships, career development, STDs, teen pregnancy, parenthood, sexuality, and growth and development. Peer Educators that were trained in the summer of 2002 also assisted in the facilitation of after-school program sessions in 2002 and 2003. Due to funding restraints, after-school activities did not recommence after the fall 2003 session.

### **Health Education for the Family and Kinship Network of Participants and the Community-at-large**

The development and/or dissemination of health education materials enabled us to broadly disseminate messages to families about health promotion or risk prevention topics. In December 2001, the Atlanta Healthy Start Initiative developed a 2002 baby calendar. Due to the tremendous success of the first calendar, we continued to develop calendars for 2003 through 2005. In order to produce the calendar, an annual baby photo contest was conducted, and photos of babies from the community were featured for each month of the calendar. The calendar provided information about program services, an immunization schedule, and a list of community services and resources. In addition, each month provided useful information on infant health and safety. Topics included: breastfeeding, immunizations, ways to keep baby safe, father's involvement, teething, SIDS, myths about fever, and infant growth and development. The consortium was instrumental in providing the various health education topics for the calendar each year. A total of 500-1000 calendars were distributed to clients, the community-at-large, service providers, and other stakeholders each year.

Other health education materials were identified and utilized to address the health needs of clients and the community-at-large. The Center for Black Women's Wellness, through its Wellness Program, focused on identifying culturally relevant materials to support all programs and segments of our population. Materials were selected that addressed health disparities and the

specific health concerns of the black community; supported program objectives; and provided basic health information that might have been difficult for clients to access. The Center had available 45 videotapes and 130 pamphlets/brochures to address a variety of topics and the individualized needs of clients. During PCM visits, clients were given general material on preventive health care and nutrition and any identified health issues. Materials were also provided to reinforce topics discussed during health workshops. Health education materials are available on the following topics:

Exercise	Breast Cancer	Breastfeeding
Depression (including postpartum)	Diabetes	Drug Abuse
Heart Disease and Hypertension	HIV/AIDS	Infant/Child Care
Mammography	Menopause	Nutrition/Diet Obesity/Weight Loss
Older Adult Issues	Pap Test	Preconception/Prenatal Care
Pregnancy	STDs	Smoking Cessation
Stroke	SIDS	Cancer screening and prevention
Teen Issues	Women's Health	

Several health education activities were implemented with success. In March 2002, during a site visit with Achor Transition Center—a transitional housing facility for women with children located in NPU-V—a need was expressed by the facility to provide health workshops to residents to improve their knowledge and behaviors around risk reduction. As a result of several meetings between the Outreach Specialist, nurse case manager and the facility's Volunteer Resource Coordinator, a health education plan was developed to outline the scheduling and content of workshops. As a result, two-hour, evening health education workshops were provided to Achor residents in June, July, August, October and November 2002. The workshops were conducted by the Nurse Consultant, who received support from one Resource Mother each month. On average, there were 14 participants at each workshop. While this collaboration provided a benefit to these community residents, the relationship developed also provides a benefit to Atlanta Healthy Start. Through an informal agreement, Atlanta Healthy Start clients that fit their profile receive preference at this facility.

Nine youth were trained during the summer of 2002 to serve as peer educators and assist with our efforts to penetrate the community and spread messages to youth on risk behavior prevention. Peer educators facilitated a teen summit on HIV, in which they planned and presented to community youth information on HIV transmission and prevention. A total of 25 youths participated in the event. Peer Educators also participated in various community activities, including a youth conference held at a local elementary school, where they facilitated focus groups to obtain feedback on neighborhood concerns.

In 2001 we conducted a SIDS education forum with 22 women from our WIC clientele (a community health center provides WIC voucher pick up and re-certification for WIC on a monthly basis on-site at our agency), and provided workshops on Improving Health Behaviors/Interconceptional Care at two local daycare centers, reaching a combined total of 38 participants.

### **3. Resources or Events that Facilitated or Detracted from Successful Initiation**

The CBWW operated without a full-time Health Educator from August 30, 2004 through the end of the project period. As a result, Plain Talk activities scheduled to take place in the fall of 2004 (Askable Adult workshop series and Livingroom Party Host Training) did not occur. In the spring of 2005, a consultant was utilized to conduct the spring Askable Adult workshop series. Fortunately, AHSI was able to meet its recruitment objectives for the Adolescent Model for the 2004-2005 budget year.

#### **D. Interconceptional Care**

##### **1. Approach to Service**

Interconceptional care helped to reduce the number of poor pregnancy outcomes by ensuring that women were healthy prior to beginning a pregnancy. Realizing the importance of adequate information to ensure informed reproductive decisions, the scope of project services covered the pregnancy and interconceptional phases for women and infants residing in the NPU-V. Since clients could be case managed until an infant turned the age of two years, most clients were enrolled in AHSI services during the interconceptional period and many entered the program during the interconceptional period. The program soon discovered that regardless of whether or not a client was pregnant or postpartum, case management services did not lessen. Interconceptional clients continued to face numerous barriers to care, including unstable and inadequate housing, lack of quality child care, and lack of employment. Moreover, clients did not live in isolation: the case management team was involved in the life of her family and in trying to alleviate challenges to family stability.

##### **2. Components of Intervention and Resources Needed to Implement Intervention**

Case management services were conducted by the Nurse Consultant and the Resource Mothers, who were supervised by the Outreach Specialist. Based on Resource Mother protocols, interconceptional clients received two home visits and one phone contact per month until 24 months postpartum for much of the project period. Protocols were ultimately amended to require less frequent visits (one home visit and one phone contact) from 12-24 months postpartum, however, the level of case management services varied depending on the needs of the client and her family.

Interconceptional clients received case management services to address the array of health and social issues that impacted the well-being of the mother, infant and her family. This care was provided based on a clients' risk assessment and goals written in the case plan. During home visits, the client and her Resource Mother reviewed an 18-item check list on the Home Visit/Follow-Up Form. The Resource Mother noted the provision of counseling, information, or a referral for each identified issues, if the client was using a family planning method, if the baby

had his/her first doctor's visit, and if immunizations were up-to-date. Detailed information on content of the home visit was documented on progress notes.

For nurse case management services, postpartum services began within 14 days post delivery. The first two visits from the Nurse Consultant were to provide services to both mother and child by conducting a postpartum health assessment of the mother, home/environmental assessment, nutritional counseling and newborn assessment. Subsequent visits, which occurred until the child was 12 months old, were for the purpose of addressing the needs of the child by weighing the baby during each visit, providing a physical or nursing assessment, and providing a nutritional and behavioral assessment. The Nurse Consultant provided instruction and guidance based on the completed assessment. Though the visits from the Nurse Consultant were discontinued after 12 months, the Resource Mothers, by conducting one home visit and making one phone contact per month, continued to assist clients with identifying and obtaining the myriad of resources needed to meet their health and social service needs until 24 months postpartum. The following chart depicts the schedule and content of home visits during the interconceptional period.

**Visitation with Nurse Consultant:**

*Visitation took place in the client's home and discontinued after child was 12 months.*

<p><b>Two Postpartum Visits</b></p> <ul style="list-style-type: none"><li>▪ Visit one is to be completed before the 14<sup>th</sup> day after delivery.</li><li>▪ The second visit is to be completed before the 28<sup>th</sup> day after delivery.</li></ul>	<p><b>Two Health Check-Related Interperiodic Visits</b></p> <ul style="list-style-type: none"><li>▪ Visit one is to be completed within six to seven months after delivery</li><li>▪ Visit two is to be completed during the eleventh and twelfth month after delivery after which visitations from Nurse Consultant discontinues.</li></ul>
--	--

**Visitation with Resource Mother:**

*Visitations took place in the client's home and discontinued after child was 24 months.*

<p><b>Two Home Visits per month (0-12 months postpartum)</b></p> <p><b>One Home Visit per month (13-24 months postpartum)</b></p>	<p><b>One Phone Contact per month</b></p>
---	---

Health education during the interconceptional period occurred during home visits by the Nurse Consultant and Resource Mothers. The content of health education was manual-directed and based on the stage of the postpartum period and age of the infant. Various group health education efforts, (e.g., SIDS workshops) were geared towards both pregnant and postpartum clients.

Lastly, if the mother did not have a medical home, interconceptional care served as a means for the Center for Black Women's Wellness to either become the medical home or to make referrals to other providers. The Center's Wellness Program provided preventive health services to women in a holistic, comprehensive manner and in a community-based setting, which alleviated barriers to access and care.

### **3. Resources or Events that Facilitated or Detracted from Successful Initiation**

A number of staffing changes took place during the project period. Deborah Adams, Nurse Consultant, became a permanent part-time employee on October 16, 2002 and was then included as key personnel rather than a contractual position. In April 2004 the position of Nurse Consultant became vacant. During that same month Beverly Roseberry assumed the role, which resulted in no interruption of services.

#### **E. Depression Screening & Referral**

##### **1. Approach to Service**

Women experience depression at roughly twice the rate of men. Depression is the major contributor to suicide, which is one of the leading causes of death among women of childbearing age. With appropriate treatment, most people will recover from depression.

Since the charge was set forth by HRSA and communicated to Healthy Start grantees during the annual meeting in November 2002, Atlanta Healthy Start has approached the need to screen and refer clients for depression in two ways: by collaborating with the other Georgia Healthy Start projects and the state Title V office to address the need for depression screening and to identify potential screening instruments; and by working to identify additional resources by which to refer clients screened and identified as exhibiting risk factors for depression. Based on the review of existing resources, and feedback from other Healthy Start sites during the Healthy Start grantee meeting in October 2003, depression screening services were implemented in 2004.

##### **2. Components of Intervention and Resources Needed to Implement Intervention**

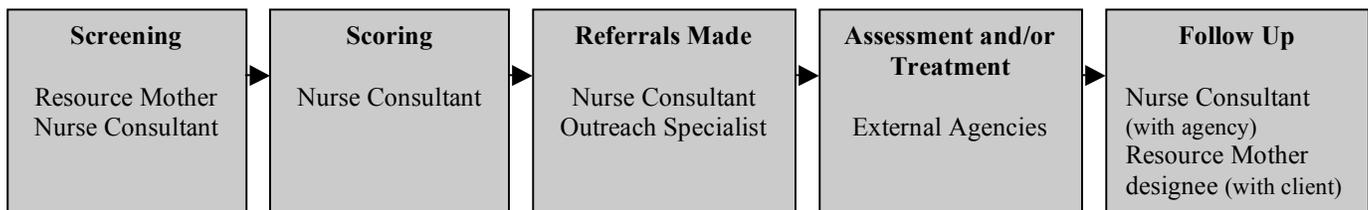
Beginning in November, 2004 all clients who received services from the Nurse Consultant (pregnant, postpartum and interconceptional women) also received a depression screening using the Edinburgh Depression Screening Assessment Tool. The Edinburgh Postnatal Depression Scale (EPDS) was used to screen pregnant and interconceptional women. This 10-item scale has been validated and widely used. The scale provided brevity for participants, who already provide a large amount of risk assessment information to case managers.

According to existing AHSI protocols, Resource Mothers screened clients for depression at the initial home visit, or at a subsequent time based on the agreement of the participant. If the client was an interconceptional woman, she was screened once per year. If the client was pregnant, she was screened during her initial PCM or PRS visit, a postpartum visit with the Nurse Consultant, which occurs within 30 days of delivery, and then annually. Wellness Program participants received a depression screening during their annual wellness screening and, if an AHSI participant received women's wellness care at CBWW, screening was only conducted through one source. If a participant scored above a 12, a follow up screening was conducted within 60 days.

Realizing that with postpartum depression, the time after delivery is very critical to identifying depression symptoms, perinatal depression screening was conducted by the Resource Mother designee at or soon after the initial home visit, and by the Nurse Consultant during the PRS visits. In order to provide a holistic and comprehensive approach to women’s health, the Nurse Consultant also conducted depression screening on all women who received a wellness screening at the Center for Black Women’s Wellness.

All completed screening instruments were submitted to the Nurse Consultant for scoring. Based on scoring, appropriate referrals were made for further assessment and, where necessary, treatment by external agencies. Referrals were made by the Nurse Consultant and/or the Outreach Specialist. The completed screening instrument and any documentation of action taken were maintained in participant files.

All referrals were maintained on a referral log. Referrals were faxed to the agency or given to the client to take to the referring agency. A copy of the referral form along with the Authorization to Release Information form was kept in the client’s records. Documentation of completed referrals for mental health services was followed up by the Resource Mothers. The Resource Mother, who has the most frequent contact with the participant, communicated with the woman to determine if the referral source was accessed, quality of services was received, and if any barriers to services were encountered. The following chart illustrates the depression screening process and the individuals responsible for administering the services.



In addition, several health education materials on depression were made available for program and community participants, including the brochure, *“Depression and African Americans: Not Just the Blues”*, developed by the National Mental Health Association, and *“Are You Feeling Blue?”* by Pfizer Women’s Health. Brochures from referral sources were also available. Written health education materials were provided to clients, and distributed at health fairs and other community events, as appropriate.

Lastly, on a broader level, the AHSI has addressed perinatal depression in the following ways: First, the Georgia Infant Health Report—the collaborative effort between AHSI, the three other Georgia Health Start projects, and State Title V—incorporated on its interactive CD-Rom a section on perinatal depression. This CD-Rom and executive summary was a significant vehicle that was distributed across the state to educate stakeholders—including agencies, legislators, and advocates—on issues pertaining to perinatal health in Georgia. Second, in 2005, our collaboration with the Georgia Healthy Start sites and the State Title V office included the co-sponsoring of a Postpartum Support Group training. Conducted by Licia Freeman, MA, Med, of Postpartum Support International, this training was attended by 60 providers across the State.

### **C. Resources or Events that Facilitated or Detracted from Successful Initiation and Implementation of Intervention**

The African American Mental Health Provider Directory, sponsored by a local alumnae chapter of Delta Sigma Theta Sorority, was a key resource in identifying qualified, culturally appropriate mental health treatment. The AHSI also developed several viable referral sources for clients and the community for culturally competent mental health services. These sources included: Vanessa Jackson, LSSW; the Behavioral Health Link – single point of entry (formerly Fulton County Department of Mental Health, Mental Retardation & Substance Abuse); the National Association of Mental Health, Georgia (NAMI); Grady Hospital Mental Health Services; the Family Outreach Resource and Empowerment Services; and National Mental Health of Georgia.

Vanessa Jackson, LSSW, who has a private practice and a longstanding relationship with the CBWW, conducted an in-service for staff in 2004 on depression in the African American community, and provided reduced rate services for clients who desired counseling services. The Behavioral Health Link had a 24-hour crisis hotline, accepted Medicaid, provided substance abuse services, and offered day treatment, peer support, day support programs, supportive living services, and case management services. This agency had an emergency hotline, and provided information on facilities for screening, assessment and treatment based on the location of the client. The NAMI provided resources, training and education to those suffering with mental illnesses and the individuals in their lives. The Family Outreach Resource and Empowerment Services is located approximately 10 miles from this service area and provided individual, group and family counseling, psychotherapy, assessment and treatment for depression. A relationship was developed with its therapist, Elizabeth J. Henry, PhD, LCSW, who accepts Medicaid. Lastly, Grady Hospital had a psych/ob department with expertise in the management of pregnant women receiving psychological treatment.

Since the implementation of this screening instrument, the project has noted that 35% of the Healthy Start clients screened have scored above 10, which is the score that is used to refer a client for further assessment. This raised issues about the sensitivity of the instrument on this population, and how to distinguish between symptoms of depression, situational occurrences, and the common stressors faced by low-income, African American women. While we referred all participants who scored above 10 to appropriate, culturally competent referral sources, we recognized that many do not want to access these services. Therefore, other interventions will need to be considered in the future. The project will explore options to provide interventions to alleviate stressors for program and community participants, which may include peer support groups, stress management techniques, and faith-based counseling

### **F. Local Health System Action Plan (LHSAP)**

#### **1. Approach to Service**

For AHSI, the approach to the local health systems action plan was to engage various segments (e.g., consumers, service providers) for the identification of strategies to coordinate care and to address broader systems issues. The approach to accomplishing this, however, changed throughout the course of the project period. First, in 2001-2003, the intent was to conduct on-

going needs assessment activities in order to prioritize and address 1-2 needs/deficiencies of the current local perinatal system and enhance the system for the MCH population, and then to conduct community health forums and an on-going public relations campaign to shape locally-developed health promotion messages based on the needs identified to be addressed. Then, in 2003-2004, our approach was to convene meetings with service providers and consumers beyond the consortium for input on local health priorities and on strategies for improving the system of maternal and child health care. Lastly, in 2004-2005, when Georgia was selected to participate in an AMCHP Action Learning Lab, the strategy was modified again to utilize the State plan, developed through this Action Learning Lab process, as a model for our local health system action plan.

## **2. Component of Intervention and Resources Needed to Implement Intervention**

The Program Coordinator was responsible for working with the consortium on the development and implementation of the LHSAP. In 2003-2004, a consultant (Jackie Williams, PhD) was utilized to assist in the facilitation of meetings with service providers for input on local health priorities and on strategies for improving care coordination.

Early in the project period, the consortium provided input on the conditions of the service area as well as its strengths and assets in order to thoughtfully provide input on project activities that would address these conditions and address desired maternal and infant health outcomes. As a result, a project logic model was created and various health education materials were identified or developed (e.g., health education baby calendar).

On January 23, 2003, AHSI convened a meeting with 23 local service providers—representing hospitals, community health centers, community based organizations, and other providers providing care or advocacy for mothers and babies—to engage participants in a discussion around identifying gaps in care and approaches to enhancing the system of care. This meeting was the result of numerous planning meetings of the LHSAP committee (an ad hoc committee of the consortium) to develop goals and objectives for the meeting, establish agenda items, identify potential speakers, and determine meeting logistics. The consultant worked with the seven-member committee, which included the Project Director and Project Coordinator, to plan and convene the meeting. The emphasis of this Local Health System Action Plan meeting was on engaging service providers, particularly birthing hospitals, with who we had yet to establish, or desired to strengthen, a relationship.

The goals of the meeting were to: 1) share the goals of Healthy Start; 2) provide a context for the issue of infant mortality and perinatal health and share emerging research; 3) share the goals of State Title V for enhancing perinatal health on local and state levels; 4) facilitate a discussion on the existing perinatal health system; and 5) facilitate discussions on solutions to enhancing the perinatal health system. As part of the agenda, the Project Coordinator gave an overview of AHSI services and the need for meeting participants' support in developing and implementing a local health system action plan. Carol Massey, Director of the State Title V Women's Health Office, provided an overview of the components of and progress towards the development of the State Perinatal Plan. Dr. Diane Rowley served as guest speaker and gave a presentation on preterm delivery, low birthweight, psychological stress, and differences in culture and social

determinants among women. The meeting attendees then participated in small group discussions to identify strengths, weaknesses, opportunities and threats of the perinatal system. Lastly, a general discussion was facilitated to obtain feedback on next steps. Attendees also had opportunities to share written materials about their programs and services. The evaluation findings were very positive. Among the feedback provided at the meeting was the strength of the numerous groups committed to enhancing the coordination of care. Challenges included the lack of formal communication channels and the lack of private providers engaged in the process. Evaluation forms and notes from the meeting were compiled and reviewed by the committee.

While the LHSAP committee continued to work on its priorities, the Program Coordinator was asked to work with the State Title V office and others across the state to complete an application for the Association of Maternal and Child Health Programs (AMCHP) Disparities Action Learning Lab (ALL). Participation in the ALL provided states with technical assistance to develop effective strategies for incorporating specific guidelines for standards of care aimed at reducing racial and ethnic perinatal disparities at the state level. For Georgia, it was anticipated that this technical assistance would result in the full development and execution of its State Perinatal Plan. Technical assistance was awarded, and the AHSI Project Coordinator began serving on the Travel Team, which met with MCH leaders and researchers to receive specific guidance.

Due to the similarity in goals between the proposed strategies of the LHSAP and the State Perinatal Plan—which include strategies to communicate messages to providers, consumers and businesses about MCH issues and disparities— AHSI decided that to complement State efforts, rather than replicate them, was a more sustainable strategy. Also, several individuals on the AHSI consortium served on the State's committee to develop the State Perinatal Plan and it was felt that the wealth of information and resources that could be gained from participation in the ALL process could assist AHSI with its LHSAP.

### **3. Resources or Events that Facilitated or Detracted from Successful Initiation**

The challenge to fully developing the LHSAP was the time commitment needed from a desired broad representation of providers and consumers to develop, implement, and monitor the plan. While there was momentum from the initial LHAP meeting in January 2003, and there continued to be momentum among the consortium for coordinating services and integrating care, there was less momentum for developing a written plan. Moreover, in building consensus and desiring input from a broad cross-section of individuals, it was important to recognize the other work of coalitions and groups to enhance the perinatal system, particularly the network which drafted the State Perinatal Plan. We felt that to complement efforts, rather than duplicate, was a more sustainable strategy.

Lastly, a major event that occurred was the withdrawal of the State of Georgia from the AMCHP Action Learning Lab process. When the Director of the Women's Health Office resigned from the State, there was no other leadership provided to lead the effort. As a result, this process was abandoned, the development of the State Perinatal Plan stalled, and the LHSAP affected.

## **G. Consortium**

### **1. Approach to Service**

The Center for Black Women's Wellness, Inc. has had an advisory body since the inception of the organization. This advisory body, while changing in health issues addressed, has always been comprised of local service providers and residents to jointly plan and monitor activities aimed at impacting the community served. In 1997, this body evolved into the Atlanta Healthy Start consortium and representation was expanded from agencies which addressed teen pregnancy prevention to include agencies which addressed other perinatal health issues.

During 2001-2004, the approach to implementing the Consortium core systems-building effort was not to directly add numbers to the consortium but, rather, to ensure that participation on the consortium resulted in meaningful impact on the community served and for the agencies represented. In sum, the approach was to:

1. Build on existing relationships and ensure diverse, yet culturally competent, representation on the consortium;
2. Maintain on-going methods of communication and provide a vehicle for joint planning and training to effectively coordinate services for mothers and infants; and
3. Evaluate the impact of consortium participation on consortium agencies.

### **2. Component of Intervention and Resources Needed to Implement Intervention**

While all staff/consultants that provided direct services (e.g., Resource Mothers, Outreach Specialist, Community Organizer) were represented on the consortium, the personnel needed to implement this core systems-building effort was the Project Director, Project Coordinator and the Office Administrator. The Project Director and Project Coordinator worked on relationship building and partnership development; the Project Coordinator served as the point of contact for the consortium chair and committees and maintained regular contact to disseminate consortium and program-related information via e-mail, phone, and mail; and the Office Administrator recorded and maintained consortium minutes, agendas, attendance and consortium rosters, made meeting reminder calls, and ensured the provision of supplies at meetings.

Additional resources provided to implement the Consortium core service included local travel and non local travel for up to two consortium members to attend local meetings and conferences related to Maternal and Child Health activities and National Healthy Start meetings, for an average cost over the four-year period of \$5,900 annually. In addition, resources were available for board and other meeting supplies for monthly meetings, which had an average cost over the four-year period of \$4,000 annually.

The components of the consortium were identified and included in bylaws, developed by the bylaws committee, which provided guidelines on the structure and role of the consortium. The bylaws called for a consortium chairperson, co-chairperson, a recorder, and for established committees. (Please refer to section II.G.5. for details).

### **3. Resources or Events that Facilitated or Detracted from Successful Initiation**

Overall, the consortium core service was successfully initiated and was very effective. Because the fiscal agency of AHSI is a community-based non-profit organization, there were little perceived issues of “turfism”, which contributed to the consortium’s ability to work collaboratively. However, there were three challenges related to resources or events which impacted the consortium:

1. Limited resources dedicated to consortium development;
2. Lack of defined objectives for consortium development; and
3. Changes among agency staff designated to serve on the consortium.

**Limited Resources:** While the consortium meetings provided an opportunity for training of members, and resources were allocated for some local and non-local travel of consortium members, overall, there were few dollars allocated specifically to consortium development. Most resources were allocated to the major core services—outreach, case management, and health education—and, based on the small size of this project, no program staff had sole responsibility for consortium development.

**Lack of Defined Objectives:** All AHSI objectives were related to the core service areas. While consortium development was addressed in the evaluation plan, and evaluation of the consortium occurred annually, there were no specific measurable objectives by which the project attempted to track progress and develop strategies to increase progress towards specific outcomes.

**Consortium Agency Changes:** While changes among staff within consortium agencies did not impact the commitment of individuals and agencies to the consortium, it did impact the progress of committee work. For example, in 2003, four agencies had major funding and staff changes, which limited or prohibited their involvement. Two of these agencies no longer have a representative on the consortium: the March of Dimes, which is experiencing a shortage of staff; and the Atlanta Project, a community based organization forced to close its office in NPU-V due to lack of funds. It is important to note that two agencies that continued to remain represented on the consortium throughout the duration of the project were the state Title V agency (Georgia Division of Public Health/Family Health Branch) and the local Title V agency (Fulton County Department of Health and Wellness).

### **4. Establishment of Consortium**

The Atlanta Healthy Start consortium was formally established in 1997, and was birthed from an existing advisory council that served to work with CBWW on planning and implementing services. The Center for Black Women's Wellness, Inc. began working with an extensive network of collaborators in the late 1980s to accomplish its work around women's health and empowerment and teen pregnancy prevention. With the receipt of Plain Talk, a teen pregnancy prevention initiative spearheaded by the Annie E. Casey Foundation in 1993, CBWW formalized

a consortium of organizations and community residents charged with the governance of the initiative. This coalition was named Partners in the Mechanicsville Community Coalition for Plain Talk, (MCCPT) and, in 1998, the coalition was comprised of 14 core members including five community residents and nine members representing health and social service agencies, city, county, and state government, advocates, and the faith community.

It was the efforts of one MCCPT member to apply for Healthy Start funding and broaden the coalition's focus to address adolescent and women's health during and beyond pregnancy as a strategy to reduce infant mortality. As a result of the commitment to addressing the issue of infant mortality, and application and receipt of a Healthy Start planning grant, the MCCPT transformed into the Atlanta Healthy Start Consortium. With the broadened vision for maternal and infant health and with the expanded target area—from the one neighborhood of Mechanicsville to the six-neighborhood area called Neighborhood Planning Unit-V—a plan was developed to expand the consortium membership accordingly. In 1997, during the planning year for the project, the consortium was expanded to include more organizations with a concern for infant mortality and child and adolescent health. These organizations, along with others, continue to play an active role in planning, implementing, and coordinating services for women and children in NPU-V.

## 5. Structure of Consortium

**Membership:** The Consortium had established bylaws, which called for the consortium to include individuals and organizations from private, public and nonprofit sectors, community leadership, neighborhood associations, and individual and family participants. While diversity among these identified groups was desired, there was no identified number of individuals to represent each of these groups that was required. This allowed for great flexibility when inviting individuals to become a part of the consortium.

From 2001-2005, the AHSI consortium ranged in number of members from 21 to 29, with an average number of members in attendance at each consortium meeting of 16. These individuals included consumers and representatives from health and social service agencies located in or serving residents of NPU-V and the greater Atlanta area. Agencies represented included the state Title V agency, the health department, county hospital, a community health center, social service agencies, and other service providers equipped with the expertise to provide advice on addressing the conditions of this community and the needs of clients in this area. Overall, the consortium included the following representation during 2001-2005:

### **Consortium Membership Representation (average from 2001-2005)**

Membership Categories	Percent
Public agencies or organizations	24%
Community-based organizations	24%
Private agencies or organizations (not community based)	10%
Providers contracting with the Healthy Start program	3%
Other providers	0%
Consumers*	34%

Membership Categories	Percent
Other	3%
Total	100%

\* While the Community Organizer is from the community, she is represented as “community based organization”. The Resource Mothers, who are from the community as well, are listed as “consumers”

**Attendance Levels:** Due to staffing changes among several core agencies on the consortium (described in section II.G.3.), on average, 55% of consortium members attended at least 50% of the meetings. Additionally, it is important to note that two members that were unable to make most of the general consortium meetings were highly active on the evaluation committee, which typically met monthly.

**Consortium Activity Level – 2001-2005**

Consumer Activity Level (based on percent of meetings attended)	Percent of meetings attended (based on average of 11 meetings per year)
Attended 0-24% of meetings	17%
Attended 25-49% of meetings	28%
Attended 50-74% of meetings	24%
Attended 75-100% of meetings	31%
Total	100%

**Racial/Ethnic Composition:** Overall, the racial/ethnic composition of the consortium was 86% Black/African American and 14% White. This racial/ethnic breakdown was fairly reflective of the racial/ethnic composition of target population.

**Consortium Structure:** Official business was conducted at the monthly, 2-hour general consortium meetings. These meetings provided members with an update on project activities and any joint-planning efforts, an opportunity for agency and community information sharing, and, at times, training on maternal and infant health areas. The evaluator was present at all general consortium meetings to provide a report on the status of evaluation efforts.

The bylaws called for a consortium chairperson, co-chairperson, and a recorder as well as committees. The role of the chairperson was to facilitate collaboration and equal participation at meetings, and the co-chair conducted these responsibilities in his/her absence. The role of the recorder was to record and maintain meeting minutes and provide general assistance to the consortium (e.g., notification of meetings, general mailings). During 2001-2005, three individuals served as chairperson, and two as co-chair. A Resource Mother was selected as the recorder, however, due to the ongoing communication and information-exchange required the Office Administrator assumed this role among her existing administrative duties for the consortium. The project found that having the Office Administrator as the recorder helped to ensure accountability. Also, the Project Coordinator worked closely with the various

chairpersons to set meeting agendas and to guide the work of the consortium. In sum, strong staff support was needed to ensure momentum.

The bylaws called for seven (7) Consortium Committees: Administration and Finance; Community Advisory; Evaluation; Human Resources and Bylaws; Media and Public Relations; Program; and Training and Public Education. These committees met as needed, either in person or via other forms of communication (e.g., conference calls, e-mail), as determined by program priorities. The Evaluation committee met most frequently, typically monthly, due to the changes in required HRSA data reporting and forms and the continuous modifications needed to the project's database to capture needed information and the resulting training needs of staff/consultants which needed to be addressed. In order to make the work of the consortium more manageable, in 2004, the consortium narrowed down the number of committees to four: Evaluation, Relationship Building, Marketing, and Recruitment and Retention. These committees were formed to directly address the program's challenge of a declining population due to major housing relocation efforts occurring in its project area and the need to develop relationships with private providers to coordinate care.

**6. Activities Utilized to Assess Ongoing Needs, Identify Resources, Establish Priorities for Allocation of Resources, and Monitor Implementation. Describe relationships with other consortia serving same population**

The consortium meeting served as the vehicle by which members identified needs and resources. Also, standing meeting agenda items ensured that the consortium was provided information on program status, for monitoring purposes. During meetings, members also had scheduled time to share information from agencies and the community on joint-planning opportunities. In addition, the Project Coordinator served as the point of contact for consortium members desiring to share information (e.g., available funding sources, opportunities for collaboration) and feedback via e-mail to the group.

Two instruments were used during this project period to evaluate the consortium, which aided in assessing and monitoring implementation of the Consortium model. The first was a structured half-hour interview developed by EMSTAR Research. This interview asked consortium members their opinion regarding the relationship between their respective organizations and AHSI, information and resource sharing, coordination of services and referrals, and ways in which their agency benefits from participating on the consortium. The interview also asked members to reflect on the functioning of the consortium as to whether it is well balanced, well-organized, able to attract new members, and adequately represented all members of the community. The second instrument used to evaluate the consortium was the consortium environment survey, which was administered twice a year to attendants at the consortium meetings. The survey consisted of fifty-two items divided into six subscales that measure the members' perception of the organizational "environment". The subscales were as follows: decision making/problem solving; organization; communication, including conflict management; cohesion; commitment; and effectiveness/task orientation. In sum, consortium members reported that as a result of their participation on the consortium members increased opportunities to share resources and to coordinate services based on the needs of the project area.

## **H. Collaboration with State and Local Title V**

### **1. Approach to Service**

Often, care is not coordinated nor is care continuity supported among agencies and organizations that offer health, social, educational, or employment services in our target community. Close linkages and coordination with State Title V and other agencies, however, was a priority of the Atlanta Healthy Start Initiative and the project worked closely with agencies to promote mutual goals of improving maternal and child health outcomes. Overall, it was the key relationships developed prior to this project period which aided in the successful collaboration between AHSI and State Title V agencies and other agencies.

The CBWW began its collaboration with the local health department when it was a program of the National Black Women's Health Project and the health department was among one of the service providers on the CBWW's advisory council. The health department then became a key partner when the CBWW was among one of five sites selected to implement Plain Talk in 1993, a community based teen pregnancy prevention strategy funded by the Annie E. Casey Foundation. As a result of the health department's involvement with the advisory council and Plain Talk, and based on needs expressed by the community for teen health services, when an opportunity arose it open a non-traditional teen clinic (the Dunbar Teen Center) on site in our offices in 1997. During this same year, which was the planning phase of AHSI, the health department played a critical role in providing local perinatal health data to the consortium to provide a context and framework for AHSI proposed strategies.

Prior to the 2001-2005 project period, the CBWW collaborated with the State Title V's Family Health Branch to conduct research on families who had experienced an infant loss, to provide lessons learned for use in future program interventions. The State Title V office remained a vital partner and partnered with AHSI in the following ways: data sharing through the State's Epidemiology Branch to assist AHSI in collecting needs assessment data and data on the project area and participants; the provision of joint training to agencies across the state through collaboration with Georgia Healthy Start sites; the provision of State representation on the consortium; and sharing of resources to initiate and support statewide initiatives (e.g., folic acid campaign) to improve perinatal health outcomes.

### **2. Component of Intervention and Resources Needed to Implement Intervention**

The major collaborative efforts between the Atlanta Healthy Start Initiative and State and local Title V agencies were as follows:

#### **Teen Clinical Services—The Dunbar Teen Center**

Collaboration was strong with the health department's Dunbar Teen Center, which served female and male youths, ages 10 to 19 year old, five days a week. Comprehensive teen clinical services included: physicals, immunizations, family planning, STD screening and treatment, HIV testing, nutritional counseling, hearing and vision screenings, nutritional counseling, and teen rap sessions. Primarily, collaboration included ensuring that clients and the broader

community were made aware of existing teen clinical services, and making referrals between AHSI and the Dunbar Teen Center. Dunbar Teen Center staff also made presentations during health education activities, including Askable Adult workshop series and the Summer Youth Leadership Training Program. The Dunbar Teen Center had an average of 800 client visits per year.

### **The Infant Vitality Initiative**

The Fulton County Department of Health and Wellness/Infant Vitality Initiative provides case management services to pregnant teenagers throughout the county, until the infant reaches age one. This program provided initial training to our Resource Mothers in 2001 and 2003, and, in 2003, we partnered with this project to co-sponsor one domestic violence training event for 150 nurses at the health department. Additionally, we referred teens that did not fall into our area into this program.

### **The Doula Project**

A program of the health department from 2003-2005, this project trained paraprofessionals to become "Doulas" and provide childbirth assistance and case management services to teenagers from 26 weeks gestation to 12 weeks postpartum. Our collaboration included participation on the advisory board, assistance with the Doula selection process, and in making and receiving referrals from the project. The Doulas and AHSI Resource Mothers worked together closely in the case management of approximately five clients in 2004-2005.

### **SIDS Outreach and Health Education**

Atlanta Healthy Start had a contract with the state MCH office in 2002-2003 and 2003-2004 to develop culturally appropriate SIDS health education materials and to provide outreach and SIDS health education services. The Project identified and disseminated various culturally relevant SIDS risk reduction health education materials throughout the target area, including materials developed for African American audiences produced by the Back-to-Sleep campaign of Bethesda, Maryland. Additionally, the Atlanta Healthy Start Initiative was integrally involved in the state's efforts to conduct a SIDS "kitchen table discussion" in October 2003. This event, conducted at Morris Brown College, was conducted in partnership with the Office of Minority Health and the Georgia SIDS Alliance to conduct small group sessions with service providers, students, and community members to discuss the impact of SIDS in the African-American community, heighten awareness and understanding of the risk factors of SIDS, and to gather feedback and report back on suggested interventions. The Atlanta Healthy Start Project Director served as one of the facilitators of this event.

### **Infant Health Report**

The four Healthy Start sites in Georgia (Atlanta, Augusta, Augusta Enterprise, and Heart of Georgia) collaborated with the state Title V agency to leverage resources and develop and disseminate an informative, creative, graphically pleasing, user friendly, and thought provoking infant health report for the state of Georgia. The purpose of the report—which included an executive summary with an accompanying multi-media CD—was to identify and discuss the leading causes of infant morbidity and mortality; provide data on maternal and child health outcomes for all Georgia counties; provide information on data trends and racial disparities in maternal and child health outcomes; identify and describe current and promising practices in

Georgia and nationally that would address infant morbidity and mortality; and present recommendations for improving birth outcomes. This CD and executive summary were submitted to stakeholders across the State of Georgia.

### **Depression Screening**

The Georgia Healthy Start sites met twice with representatives from the state Title V office to identify valid and reliable depression screening tools and to explore the feasibility of all Georgia Healthy Start sites utilizing the same instrument and the same protocols for depression screening. The state's involvement in these discussions with Healthy Start projects complemented their own efforts to conduct an assessment of substance abuse and mental health services (referral, treatment, residential, and support groups) for pregnant and postpartum women throughout the state and to identify gaps in services. Discussions with the state Title V office and Georgia Healthy Start projects resulted in the sharing of resource information on postpartum depression and other mental health services throughout the state; the extensive search and review of literature on depression screening instruments; and a review of depression screening instruments developed by Edinburgh and Cheryl Beck. In 2005, our collaboration included the co-sponsoring of a Postpartum Support Group training. Conducted by Licia Freeman, MA, Med, of Postpartum Support International, this training was attended by 60 providers across the State.

### **3. Resources or Events that Facilitated or Detracted from Successful Initiation**

During each budget period of the grant, each of the four Georgia Healthy Start sites agreed to include resources in their Healthy Start budgets for collaboration activities. The amount that AHSI committed to was \$10,000 in 2001-2002, \$9,000 in 2002-2003, \$5,000 in 2003-2004, and \$1,500 in 2004-2005. These resources were used to plan and develop the Georgia Infant Health Report and conduct joint trainings, which contributed to our successful collaboration.

#### **I. Sustainability**

##### **1. Approach to Service**

The Center for Black Women's Wellness' approach to sustainability was to utilize the resources (e.g., time, expertise) of staff, the consortium, the Board of Directors, and technical assistance consultants to develop strategies to maximize and leverage grant funds. As a result, the strategies that the CBWW employed to address sustainability were:

1. To increase agency and program visibility to secure new donors and other resources;
2. To enhance fiscal and data management procedures and reporting;
3. To cultivate relationships with potential and existing funders and partners;
4. To explore opportunities for third party billing; and
5. To develop a strategic plan, which included priorities for fundraising involving the organization and its Board.

The rationale for the aforementioned strategies evolved over the project period, and several strategies were implemented not with direct foresight into their impact on sustainability but with connections made afterwards on the long-term impact made on the organization as a result of

their undertaking. For example, while seeking additional funding has always been a priority of the CBWW, it became clear that a team approach was needed for grantsmanship and other fundraising efforts to build staff capacity and understanding of the importance of sustainability. As a result, specific actions were taken to engage the staff and Board members in the broad realm of fund development. Moreover, while enhancing fiscal and data management became a need early on for the project, particularly as HRSA data reporting guidelines changed, the project did not fully estimate how this process would prepare the organization for collecting and reporting on information that could help "tell the story" to other potential stakeholders and funders.

## **2. Components of Intervention and Resources Needed to Implement Intervention**

The components of the Sustainability core-systems building effort (as listed in section II.I.1.) were to: 1) increase agency and program visibility; 2) enhance fiscal and data management procedures and reporting; 3) cultivate relationships; 4) explore opportunities for third party billing; and 5) develop a strategic plan, which included priorities for fundraising.

**Increasing Visibility:** Various strategies were utilized to increase visibility and interest in the program and organization. In 2003, we entered into a contract with a web design firm to redesign our web site. One of the objectives of website enhancement was to encourage interest from the press, promote awareness of AHSI and other CBWW programs, and increase donations (both corporate and individual) and sponsorships by providing a variety of ways for supporters to engage with and contribute to AHSI and CBWW.

**Fiscal and Data Management:** As previously discussed, the organization enhanced fiscal policies and procedures, implemented a new accounting software (GMS), received technical assistance on its data system and ultimately implemented a web-based and user friendly database software (ETO).

**Cultivate Relationships with New and Potential Funders:** Proposal development continued to be a priority, specifically as it related to identifying funding that supported or complemented core program components. Due to a strong relationship with the State Title V office, and a demonstrated capacity to manage and monitor state contracts, we received several contracts to conduct activities which helped leverage Healthy Start funds and provide more outreach and health education services. The following details some of the results related to cultivating relationships during the project period:

### **Key AHSI Relationship Building Efforts and Impact on Sustainability**

Activity	Agency Involved	Sustainability Result
Proposal Development	State Title V (2003-2004)	Received funding for SIDS education and outreach (\$35,000)
	State Title V (2003-2004 and 2004-2005)	Received funding for health education for teen pregnancy prevention (e.g., Askable Adult workshop series) (\$77,000 per year)
	State Title V-Prevention Services	Received funding for HIV outreach

Activity	Agency Involved	Sustainability Result
	Branch/HIV Section (2003-2004)	and testing (\$42,729)
	Georgia Department of Family and Children Services (2003-2004, and 2004-2005)	Received funding for short term case management services (\$8,000 in funds of total grant of \$55,380 per year)
	Junior League of Atlanta (2003-2004)	Received funding for health education for teen pregnancy prevention (\$9,000)
Relationship Building	State Title V (2001-2005)	Increased visibility across state and resulted in shared resources to address mutual MCH goals (e.g., perinatal depression, SIDS outreach and health education)
	Fulton County Department of Health and Wellness (2001-2005)	Received in-kind training for Resource Mothers, resulting in increased pool of potential candidates if health department assumed responsibility for outreach services
	Consortium (2001-2005)	Received in-kind training of Resource Mothers, community and consortium

**Third Party Billing:** During the project period, the CBWW became a Medicaid provider and did begin billing for certain healthcare services. However, the goal of billing for Perinatal Case Management (PCM) and Pregnancy Related Services (PRS) was never realized. This process of building capacity for Medicaid billing is detailed in Section II.I.4.

**Strategic Plan/Fundraising Plan:** In 2003, the staff and Board participated in strategic planning meetings, which resulted in the development of a 2004-2006 strategic plan. The priorities set forth in the strategic plan included: Fundraising/Resource Development; Organizational Administration; Capacity and Development; Information Technology; Board Strengthening; Marketing/Public Relations; Programs/Services; and Stakeholder Development. The goals included in each of these areas addressed the sustainability of the organization and its programs. The Board also developed a Board fundraising plan, one of the goals of the Fundraising/Resource Development priority, which detailed Board-led fundraising events to raise a projected \$55,000 for the first year of the plan, with additional funds raised incrementally throughout the three-year plan.

**Needed Resources for Sustainability**

The personnel most directly responsible for sustainability was the Project Director. The Project Director, who also served as the Chief Executive Officer of the lead agency, was responsible for relationship building to explore available resources, marketing program benefits, and aggressively seeking other funding through a variety of resources. The Board of Directors, who have fiduciary responsibility for the organization, assist the CEO with fundraising through its fund development committee. Moreover, the Project Coordinator worked extensively on fund

development through exploring grant opportunities and preparing grants. During the 2004-2005 budget period, the Wellness Coordinator also played an integral role in conducting research to seek other contracts and grants that coincided with programs offered at the CBWW and prepared responses to Requests for Proposals and letters of inquiry. This expansion of number of persons involved in sustainability activities during the latter part of the project period greatly aided in building staff capacity, distributing responsibility for sustainability, and developing a more defined process for grantsmanship.

Technical assistance was also needed to develop the 2004-2006 strategic plan, which included a priority area for fundraising. The process for developing this plan included a two-day planning session with staff and a one-day planning session with the Board of Directors. Technical assistance for this process was provided by Leslie Patton and Associates in 2003.

### **3. Resources or Events that Facilitated or Detracted from Successful Initiation**

Resources which supported several technical assistance activities, as described earlier, influenced the successful initiation of numerous sustainability activities. Moreover, while the consortium bylaws did not indicate consortium responsibility for program sustainability, the consortium model—by its very nature of being an arena for joint planning, information sharing, and collaboration—did provide opportunities for certain program elements to be sustained. The strong partnerships with consortium members and other area providers have enabled AHSI to leverage support from an array of collaborating agencies which can potentially lead to the provision of new in-kind services and new funding. Lastly, a history of strong collaboration and mutual priorities with the State Title V and other maternal and child health programs aided in the continuance of meaningful collaborations and the identification of additional resources.

### **4. Describe Efforts with Managed Care Organizations and Third Party Billing**

Third party reimbursement and, particularly, Medicaid reimbursement, was a strategy that was explored to assist with program sustainability. In 2002, the CBWW went through the process of applying to become a Medicaid provider and, in 2003, received a Medicaid provider number and began the process of building the capacity to bill for such services. In March 2003, three staff members attended Medicaid training, provided through the Georgia Health Partnership. The CBWW then began billing Medicaid-enrolled Wellness clients for reimbursable health services, such as full wellness screenings and family planning. Our wellness screening includes blood pressure evaluation, Pap smear, total blood chemistry profile, breast exam and instruction, screening for STDs, HIV pre- and post-counseling, cardiovascular disease risk assessment, and nutritional counseling.

In order to promote our expanded ability to serve Medicaid-eligible clients, a neighborhood canvassing strategy was initiated, which included the distribution of flyers within the communities announcing that the clinic had begun accepting Medicaid. While it was important to advertise the acceptance of Medicaid, another challenge was the limited capacity of our clinic to accommodate an influx of clients, as the Wellness clinic operated only two days a week. The

impact of the limited hours of the clinic was exacerbated by the fact that the clinic was without a Clinical Assistant. In 2003, a Clinical Assistant came on board to assist the Clinical Coordinator during clinical days and, for the 2004-2005 budget period, a small percentage of time was included in the Healthy Start budget for this position. As a result, we were able to service clients previously unable to be served and work to ensure that women had a medical home and received preventive health services prior to, or subsequently after, pregnancy.

While the CBWW's wellness clinic services were not directly supported through Healthy Start funding, the AHSI was optimistic that it would soon be able to bill Medicaid for the allowable number of reimbursable Perinatal Case Management (PCM) and Pregnancy Related Services (PRS) visits. This, unfortunately, never occurred during this project period.

**5. Describe Major Factors Associated with Identification and Development of Resources to Continue Key Components of Intervention without Healthy Start Funding**

The strong partnership with consortium members gave Atlanta Healthy Start opportunities to leverage support from an array of collaborating agencies which included the provision of new in-kind services and new funding.

**6. Describe Whether or Not you Were Able to Overcome any Barriers or to Decrease Their Negative Impact**

As a small project with a small staff, one challenge was focusing on sustainability efforts while focusing on planning and implementing the project core services. Also, limited resources, including time, at times made monitoring progress towards action steps in the strategic plan a lesser priority. Lastly, the process by which we have attempted to get authorization to bill Medicaid for eligible PCM and PRS visits has been long and arduous. In April of 2004, we completed the initial steps of having necessary staff complete an updated State PCM and PRS training. Then, we applied for a provider number. However, CBWW was denied as the payee on the original application. The Nurse Consultant, Beverly Roseberry, was later approved to bill for PCM visits, however this did not occur until July 2005.

**III. Project Management and Governance**

**A. Structure**

Overall, the structure of AHSI management and governance remained the same over the 2001-2005 project period. Management and administrative personnel included: the Project Director, Project Coordinator, Accounting Manager (formerly called Comptroller), and the Office Administrator (formerly called Administrative Assistant). Other key personnel included: Outreach Specialist, Community Organizer and Health Educator. Changes were made to some position titles, and the positions of Administrative Assistant and Secretary/Receptionist, used in Year 1, were later changed to be titled Office Administrator and Data Entry/Administrative Assistant. Lastly, in Year 2 an Information Specialist was included in the budget, in Year 3 the Clinical Coordinator (Nurse Consultant) was included in the budget, and in Year 4 a Wellness

Coordinator and Clinical Assistant were included as part of the structure. Previously the Clinical Coordinator (Nurse Consultant) was a contractual position. The following chart details the staff composition during the 2001-2005 project period.

Atlanta Healthy Start Initiative Staff Composition and Percent of Time on Project

Year 1: 2001-2002	Year 2: 2002-2003	Year 3: 2003-2004	Year 4: 2004-2005
Project Director .25 FTE	Project Director .25 FTE	Project Director .25 FTE	Project Director .20 FTE
Project Coordinator 1.0 FTE	Project Coordinator 1.0 FTE	Project Coordinator 1.0 FTE	Project Coordinator 1.0 FTE
Comptroller .30 FTE	Comptroller .25 FTE	Accounting Manager .25 FTE	Accounting Manager .30 FTE
Health Educator .80 FTE	Health Educator .60 FTE	Health Educator .65 FTE	Health Educator .50 FTE
Outreach Specialist 1.0 FTE	Outreach Specialist 1.0 FTE	Outreach Specialist 1.0 FTE	Outreach Specialist 1.0 FTE
Community Organizer .75 FTE	Community Organizer .69 FTE	Community Organizer .60 FTE	Community Organizer .50 FTE
Administrative Asst. .75 FTE	Office Administrator .50 FTE	Office Administrator .15 FTE	Office Administrator .15 FTE
Secretary/Receptionist .75 FTE	Secretary/Receptionist .38 FTE	Administrative Asst. .20 FTE	Data Entry/ Administrative Asst. .10 FTE
	Information Specialist .75 FTE	Information Specialist .75 FTE	Information Specialist .30 FTE
		Clinical Coordinator (Nurse Consultant) .50 FTE	Clinical Coordinator (Nurse Consultant) .50 FTE
			Wellness Coordinator .15 FTE
			Clinical Assistant .25 FTE

The position descriptions of all key personnel, utilized throughout a portion or the entirety of the project period, are described below:

**Project Director:** had all programmatic and fiscal accountability for the grant implementation. Responsible for maintaining contact with other organizations for

available resources, marketing the benefits and services of the organization, and aggressively seeking other funding through a variety of governmental and non-governmental resources. This position reported directly to the governing board.

**Project Coordinator:** directed the overall operation of the project, oversaw the implementation of project activities, coordinated with partner organizations, served as liaison with federal and state agencies, planned and provided training to staff, conducted meetings and coordinated with other agencies that are involved with infant mortality reduction and teen pregnancy prevention activities, gathered and interpreted collected data, conducted staff and program evaluations, and coordinated quality assurance activities to assure that the project maintained a high level of compliance within the agency's operations, contracts, and community activities. This position reported to the Project Director.

**Community Organizer:** responsible for promoting the mission of the program by conducting presentations, disseminating program material and meeting with community residents. Organized outreach and recruitment efforts to enroll program participants. This position reported to the Project Coordinator.

**Accounting Manager:** worked closely with grants management and the agency Finance Committee to insure quality internal controls were adhered to in the entire program operations. The Accounting Manager reported to the Project Director.

**Health Educator:** duties included facilitation of after school and life skills classes and workshop series, facilitation of parent/adult workshop series, assisting with the development of community health forums and meeting with case management team to identify other educational needs of clients. This position reported to the Project Coordinator.

**Data Entry/Administrative Assistant:** provided administrative and data entry support to the Atlanta Healthy Start Initiative (AHSI) and the Consortia. Prepared minutes for board and committee meetings, provided administrative and data entry support to staff, maintained client files, and did consortium reports and distribution of materials and health education packet preparation. This position reported to the Office Administrator.

**Office Administrator:** managed day-to-day communications incoming/outgoing, maintained schedules of staff, coordinated service calls for office equipment, monitored office supply status and requested needed supplies for staff, and assisted with typing and filing as needed. This position reported to the Project Director.

**Information Specialist:** had day-to-day responsibility for MIS coordination, data management, tracking objectives, and collection and data entry of project data for

analysis. This position also provided computer technical support for staff. This position reported to the Project Director.

**Nurse Consultant:** served as clinician for the wellness program, providing preventive health care services to clients and health workshops to the community. She also served as perinatal case manager for pregnant Healthy Start clients, and assisted in the area of assessing health needs of participants, closely monitoring clients to ensure they received health education and appropriate services, met with case management team, and provided necessary record keeping. This position reported to the Project Director.

**Wellness Coordinator:** assisted with the overall day-to-day operations of the Wellness program. Enhanced forms, protocols, and developed an operations manual for the clinic. This position was also responsible for conducting research to seek other contracts and grants that coincide with programs offered at the CBWW and prepare responses to RFP's and letters of inquiry. This position reported to the Project Director.

**Clinical Assistant:** managed day-to-day incoming/outgoing communications, track in-house and external referrals, assisted with typing and filing as needed, assisted the Clinical Coordinator with wellness screenings and the monitoring of client referrals. This position also assisted with providing data entry for Medicaid billing and was responsible for filing Medicaid claims, maintaining promissory note contracts, and assisting in the collection of outstanding payments. This position reported to the Clinical Coordinator.

## **B. Essential Resources for Fiscal and Program Management**

Apart from the necessary resources for personnel, technical assistance throughout the project period proved essential in enhancing fiscal and program management. Most notably, technical assistance provided by Leslie Patton and Associates (LPA) in 2001-2005 was critical to organizational and capacity development. For fiscal management, in 2002 LPA assisted the organization with revising its fiscal policies and procedures manual to be reflective and inclusive of its vast funders, with the federal guidelines language being principal over other funders due to more stringent federal laws. A Fiscal Consultant monitored the effectiveness and the use of the revised and newly implemented policies. Training was provided to the Accounting Manager, Project Director and Project Coordinator to ensure facilitate understanding and adherence to policies and procedures. In 2002, the CBWW also implemented new accounting software. The software selected was GMS (Grants Management Software). This software was assessed to be more accommodating to the organization's versatile needs due to having multiple funders and allowed the organization to enhance its overall reporting requirements to the multiple funders and to the management to continue to make well-informed financial decisions.

For program management and other organizational capacity building efforts, LPA facilitated annual staff planning retreats which served to assess program direction and identify solutions to challenges. As the result of on-going staff planning retreats, in 2004 a Quality Assurance

manual was created to develop and document organizational and program policies and procedures.

In-kind and other resources were used to update our technology systems, which had a direct impact on data reporting and program management. Due to the ongoing challenges with retrieving data from our Microsoft Access system, in 2005 the organization began using ETO Software, developed by Social Solutions, to support the management of all organizational, program, and client level data. ETO Software is web-based, is customizable by authorized users, and provides real-time reports with graphically advanced format through Crystal Reports. Capabilities of the system include tracking of demographics, with standard and user-created fields; participant records; participant outcomes; and case management notes and efforts. Services include data back up, software maintenance, and user support.

The Annie E. Casey Foundation (a 2004 funder) purchased an enterprise license package, which allowed the distribution of ETO Software licenses among partner organizations and included the cost of training for the use of the. We estimate that the value of this product, including provided training, was an in-kind value of approximately \$5,120.00 to AHSI. The Center for Black Women's Wellness also worked independently with Social Solutions to create custom reports and queries designed to meet HRSA requirements and other specific needs. An amount of \$2,700 was included in the 2004-2005 budget to support these efforts, based on projections of additional training needed.

### **C. Changes in Management and Governance**

There were no significant changes to the structure of management and governance and, overall, staff retention remained strong and the same key personnel remained in place throughout the duration of the project period. (Please refer to section A for details on key personnel).

There were three staff changes within key personnel. Adetola Adu, Comptroller, left the position in November 2002. Odelia Parsell, Accounting Manager, assumed this role in March 2003. Prior to the departure of the Accounting Manager, the Project Director and Project Coordinator were cross-trained to provide fiscal duties in the absence of a Comptroller and to ensure that fiscal operations remained in tact and the organization fully functional. Fiscal consultant, Kerri Pruitt, of LPA Management Consulting Firm, provided this training and fiscal technical assistance and provided initial training to Ms. Parsell. Ms. Parsell also received training from Grants Management Systems (GMS), our accounting software during her initial months with the CBWW.

The second staff change was that of the Clinical Coordinator/Nurse Consultant position. Deborah Adams, PA-C, filled this position until April 2003 at which point Beverly Roseberry, assumed the position. Lastly, the Health Educator, Roxanne Francis, resigned in August 2004. From that point, consultants were utilized to provide required health education services until the end of the project period, May 31, 2005. In all instances where position were filled with new candidates, the CBWW posted job notices in the local paper and other sources in order to recruit staff and ensured that positions were filled with qualified staff that were competent in the culture and values reflective of the community that we served. Qualified candidates were initially

screening through Administrastaff, our payroll and benefits manager, which also completes all necessary background checks.

**D. Process Developed to Assure Appropriate Distribution of Funds and What Happened with Process over Time**

The Atlanta Healthy Start Initiative was awarded \$575,000 for each budget period. Overall, there were several budget constraints and limited resources to redistribute funds. There were, however, two major factors that impacted the distribution of funds: changes in grant requirements and assessed program needs by staff and the consortium. First, in 2003-2004 changes in HRSA data requirements resulted in a needed redistribution of funds to ensure technology enhancements for the efficient reporting of all variables. Fortunately, some in-kind support was available to purchase and receive training on a new software system, ETO software. Other funds, however, were shifted from other budget categories to respond to the needed change to be in adherence with federal funding requirements.

Second, when challenges in program implementation arose, decisions were made to distribute funds to respond to program needs. For instance, due to hardships expressed by Resource Mothers in conducting outreach and case management services and in light of the more intense outreach efforts needed to identify pregnant women in our fast-changing project area, in 2005 Resource Mother’s roles were redistributed so that they were assigned to either outreach duties or case management duties. While this change did not change the amount of funds allocated for Resource Mothers, it did change the amount of funds allocated for each core service. In all decisions related to the distribution of funds, the Project Director, Project Coordinator and Accounting Manager interfaced to determine feasible options.

**E. Additional Resources Obtained for Quality Assurance, Program Monitoring, Service Utilization, and Technical Assistance**

There were some non Healthy Start resources that were obtained for technical assistance throughout the project period. The following chart illustrates some of the providers of these resources, as it relates to resources obtained for quality assurance, program monitoring, service utilization and technical assistance.

**Non Healthy Start Resources Obtained for Quality Assurance, Program Monitoring, Service Utilization, and Technical Assistance**

Source of Resource(s)	Type of Resource	Amount of Resources
Fulton County Department of Health and Wellness (2001 and 2003)	Initial training of Resource Mothers in 2001 and 2003 and increase service utilization	\$5,248 (\$2,624 per year)
Community Foundation of Greater Atlanta (2003)	6-month technical assistance grant which enabled a database developer, Professional Software Solutions, to add enhancements and increase our current database capability.	\$3,500
Annie E. Casey Foundation	Purchase of license for ETO	\$5,120

Source of Resource(s)	Type of Resource	Amount of Resources
(2004)	software and initial training	

## F. Cultural Competency

Throughout the duration of the 2001-2005 AHSI funding period, cultural competency of contractors and project staff remained an advantage in the provision of services. All staff positions were filled with qualified staff that were competent in the culture and values reflective of the community that we served. In addition, all Resource Mothers were identified based on their history and/or knowledge of the community served and their ability to relate to the cultural and linguistical norms of NPU-V.

## IV. Project Accomplishments

### A. Implemented Strategies, Goals, Objectives, and Accomplishments

For the original 2001-2005 Healthy Start application, the project developed 11 objectives. However, ultimately, the project narrowed down its scope and measured progress towards five (5) objectives. This was in part for three reasons: 1) some proposed objectives did not have reliable data sources or external data could not be obtained in a timely fashion; 2) some proposed objectives did not effectively measure the program’s most important outcomes and efforts; and 3) the program redirected its efforts to focus on measuring fewer efforts and more outcomes.

Thus, the following objectives **were not** measured throughout the entirety of the 2001-2005: 1) to increase the percent of two year olds who receive the full age-appropriate immunizations; 2) to decrease the percent of preterm infants born to participating women; 3) to provide health education services to pregnant and postpartum clients; 4) to provide childbirth education and support groups for pregnant and postpartum participants; 5) to provide health education services to the community-at-large; and 6) to increase the percent of clients receiving Healthy Start funded health education that report lowered frequency or elimination of smoking and alcohol risk behaviors. It is important to note that data for many of the aforementioned objectives (e.g., immunizations, health education services, childbirth education) **was** collected and was reported on HRSA required data forms/tables.

The following section provides detail on the five calendar and budget period objectives, and progress and accomplishments made toward each objective. A table summarizing strategies and activities related to each objective is included as Attachment A.

### Objectives and Indicators (for all Core Services)

#### Outreach

<b><i>Objective 1: To identify and enroll high risk women into the Healthy Start Initiative</i></b>
Project Period Objective 1: By 6/01/05, identify and enroll 480 high-risk women into the Healthy Start initiative.
Calendar Year 1 Objective: By 12/31/2001, identify and enroll 60 high-risk women into the Healthy Start initiative.
Calendar Year 2 Objective: By 12/31/2002, identify and enroll 180 high-risk women into the

<p>Healthy Start initiative.          Calendar Year 3 Objective: By 12/31/2003, identify and enroll 300 high-risk women into the Healthy Start initiative.          Calendar Year 4 Objective: By 12/31/2004, identify and enroll 420 high-risk women into the Healthy Start initiative.</p>
<p>Baseline: In March 2001, there were 30 high-risk pregnant women enrolled in Atlanta Healthy Start services. (Source: Atlanta Healthy Start Resource Mothers Activity Report)</p>
<p>Project Performance Indicator: Number of participating pregnant and postpartum women</p>
<p>Progress/Accomplishments (Quantitative): By 5/31/05, 452 women were served          (Note: challenges to outreach, included changes in demographic area, described earlier)</p>
<p>Progress/Accomplishments (Qualitative)</p> <ul style="list-style-type: none"> <li>▪ Hiring of Outreach Specialist in September 2001</li> <li>▪ Identification of Resource Mothers</li> <li>▪ Collaboration with health department for the training of Resource Mothers in 2001 and 2003</li> <li>▪ Training of two additional outreach workers in February 2005 to address changes in demographics</li> <li>▪ Strengthened/developed relationships with service providers as a source of recruitment (e.g., Juvenile Justice Center, Department of Family and Children Services)</li> <li>▪ Conducted outreach strategies, including community canvassing, and distributed outreach materials, per outreach plan</li> </ul>

**Case Management**

<p><b><i>Objective 1: To identify and enroll high risk women into the Healthy Start Initiative</i></b></p>
<p>Project Period Objective 1: By 6/01/05, identify and enroll 480 high-risk women into the Healthy Start initiative.</p>
<p>Calendar Year 1 Objective: By 12/31/2001, identify and enroll 60 high-risk women into the Healthy Start initiative.          Calendar Year 2 Objective: By 12/31/2002, identify and enroll 180 high-risk women into the Healthy Start initiative.          Calendar Year 3 Objective: By 12/31/2003, identify and enroll 300 high-risk women into the Healthy Start initiative.          Calendar Year 4 Objective: By 12/31/2004, identify and enroll 420 high-risk women into the Healthy Start initiative.</p>
<p>Baseline: In March 2001, there were 30 high-risk pregnant women enrolled in Atlanta Healthy Start services. (Source: Atlanta Healthy Start Resource Mothers Activity Report)</p>
<p>Project Performance Indicator: Number of participating pregnant and postpartum women</p>
<p>Progress/Accomplishments (Quantitative): By 5/31/05, 452 women were served</p>
<p>Progress/Accomplishments (Qualitative)</p> <ul style="list-style-type: none"> <li>▪ See above progress detailed in outreach section.</li> </ul>

<p><b><i>Objective 2: To increase the percent of participants who initiate prenatal care in the first trimester of pregnancy</i></b></p>
<p>Project Period Objective 2: By 6/ 01/05, 85% of participants enrolled in program will have received prenatal care services during first trimester of pregnancy.</p>

Calendar Year 1 Objective: By 12/31/2001, 75% of participants enrolled in program will have received prenatal care services during first trimester of pregnancy
Calendar Year 2 Objective: By 12/31/2002, 78% of participants enrolled in program will have received prenatal care services during first trimester of pregnancy
Calendar Year 3 Objective: By 12/31/2003, 80% of participants enrolled in program will have received prenatal care services during first trimester of pregnancy
Calendar Year 4 Objective: By 12/31/2004, 83% of participants enrolled in program will have received prenatal care services during first trimester of pregnancy
Baseline: During 1996-98, 75% of pregnant women in NPU-V received prenatal care during first trimester. (Fulton County Office of Planning and Evaluation)
Project Performance Indicator: Percent of pregnant women who have been recruited and receiving services during the first trimester of pregnancy.
Progress/Accomplishments (Quantitative): By 5/31/05, 52% (73 of 141) of women received prenatal care in first trimester
Progress/Accomplishments (Qualitative) <ul style="list-style-type: none"> <li>▪ Case management protocols developed</li> <li>▪ Relationship developed with State's Epidemiology unit, which facilitated collection of birth certificate data</li> <li>▪ Home visitation services provided, which aided in monitoring prenatal care visits</li> <li>▪ More outreach conducted to recruit pregnant women in 2004-2005</li> </ul>

<b><i>Objective 3: To decrease the percent of low birthweight infants born to Healthy Start participants</i></b>
Project Period Objective 3: Project Period Objective 4: By 6/ 1/ 05, there will be a decrease in low birthweight infants (LBW) born to participating women to 10%
Calendar Year 1 Objective: By 12/31/2001, there will be a decrease in low birthweight infants (LBW) born to participating women to 15%
Calendar Year 2 Objective: By 12/31/2002, there will be a decrease in low birthweight infants (LBW) born to participating women to 13.5%
Calendar Year 3 Objective: By 12/31/2003, there will be a decrease in low birthweight infants (LBW) born to participating women to 12%
Calendar Year 4 Objective: By 12/31/2004, there will be a decrease in low birthweight infants (LBW) born to participating women to 10%
Baseline: In 1996-1998, 15% of babies born to women in target community were low birthweight infants. (Source: Fulton County Office of Planning and Evaluation)
Project Performance Indicator: Number of pregnant participants delivering an infant weighing less than 2500 grams.
Progress/Accomplishments (Quantitative): By 5/31/05, 9.4% (8 of 85) of infants were born low birth weight among program participants
Progress/Accomplishments (Qualitative) <ul style="list-style-type: none"> <li>▪ Case management protocols developed</li> <li>▪ Relationship developed with State's Epidemiology unit, which facilitated collection of birth certificate data</li> <li>▪ Home visitation services provided, which aided in monitoring prenatal care visits</li> <li>▪ More outreach conducted to recruit pregnant women in 2004-2005</li> </ul>

<b><i>Objective 4: To decrease the percentage of very low birthweight infants</i></b>
Project Period Objective 5: By 06/01/05, decrease the percent of very low birthweight infants (VLBW) born to participating women to 2%
Calendar Year 1 Objective: By 12/31/2001, decrease the percent of very low birthweight infants (VLBW) born to participating women to 3%. Calendar Year 2 Objective: By 12/31/2002, decrease the percent of very low birthweight infants (VLBW) born to participating women to 2.6%. Calendar Year 3 Objective: By 12/31/2003, decrease the percent of very low birthweight infants (VLBW) born to participating women to 2.3%. Calendar Year 4 Objective: By 12/31/2004, decrease the percent of very low birthweight infants (VLBW) born to participating women to 2%.
Baseline: During 1996-98 the rate of very low birthweight (VLBW) babies born to women in target area was 3%. (Source: Fulton County Office of Planning and Evaluation)
Project Performance Indicator: Number of participants delivering infants weighing less than 1500 grams.
Progress/Accomplishments (Quantitative): By 5/31/05, 1.2% (1 of 85) of infants were born very low birth weight among program participants
Progress/Accomplishments (Qualitative) ■ See Objective 3

## Health Education

<b><i>Objective 1: To provide Adolescent Services including adolescent pregnancy prevention, services specific to pregnant or parenting teens, and youth empowerment/mentoring programs.</i></b>
Project Period Objective 7: BY 6/1/05, provide Adolescent Services to 280 adolescents including adolescent pregnancy prevention, services specific to pregnant or parenting teens, and youth empowerment/, mentoring programs, each year (1120 total)
Calendar Year 1 Objective: By 12/31/2001, provide Adolescent Services to 280 adolescents including adolescent pregnancy prevention, services specific to pregnant or parenting teens, and youth Calendar Year 2 Objective: By 12/31/2002, provide Adolescent Services to 280 adolescents including adolescent pregnancy prevention, services specific to pregnant or parenting teens, and youth Calendar Year 3 Objective: By 12/31/2003, provide Adolescent Services to 280 adolescents including adolescent pregnancy prevention, services specific to pregnant or parenting teens, and youth Calendar Year 4 Objective: By 12/31/2004, provide Adolescent Services to 280 adolescents including adolescent pregnancy prevention, services specific to pregnant or parenting teens, and youth
Baseline: In 1990, there were 2,901 youth ages 10-19 in target community. (Source: City of Atlanta, Bureau of Planning.)
Project Performance Indicator: Number of youth receiving adolescent services, including adolescent pregnancy prevention, youth empowerment/mentoring programs, and male support services.
Progress/Accomplishments (Quantitative): As of 5/31/05 1,219 at-risk teens and their parents

were served through health education core service

Progress/Accomplishments (Qualitative)

- Pre and post surveys each year demonstrated significant changes in knowledge and skills for Summer Youth Leadership Training Program and Askable Adult workshops
- Successful recruitment efforts conducted to meet participation goals, despite staff changes which resulted in two cycles of workshops not conducted

**B. Activities/Lessons Learned from Other Sites**

In February 2005, the Resource Mothers, the Outreach Specialist, and the Community Organizer attended a site visit with the Heart of Georgia Healthy Start program in Dublin, Georgia. During this site visit, AHSI staff shadowed workers from this site to gain understanding of the case management process and various outreach methods. In addition, enrollment and case management forms were reviewed for consideration for AHSI. Moreover, through the National Healthy Start Association, the AHSI benefited from the sharing of expertise from other projects. Most notably, the Downstate Healthy Start project (Brooklyn, New York) shared its outreach and case management forms. Based on a review of the forms from these two projects, several AHSI forms were modified for the 2005-2006 budget period, to facilitate the collection of required data.

**V. Project Impact**

**A. Systems of Care**

**1. Approaches Utilized to Enhance Collaboration**

A main strategy that has been implemented to enhance collaborations has been the AHSI consortium. Through monthly meetings the consortium members were able to share information and provide support on a regular basis. The members of the consortium have been instrumental in assisting in our strategic planning and identifying potentially new partners for the referral of clients for health-related and other services.

In addition, by establishing ourselves as a center of health and social service provision, we have increased the exposure of these organizations to one another. The Fulton County Department of Health and Wellness and Southside Medical Center both have staff which provide services within our office space. By extending our space to these organizations we have the opportunity to bring more resources to our clients and to attract partnership programs. Beyond this, the CBWW has been very visible in the community through its participation in a number of task forces and advisory councils. Through events such as health fairs, the CBWW has catalyzed the development of relationships among health and service organizations. The CBWW has also been instrumental in the development of materials surrounding post partum depression that were distributed to several agencies throughout Georgia.

**2. Identify the extent to which structured changes, such as procedures and policies have been established for the purpose of system integration.**

The four main program areas of the Center for Black Women's Wellness are: maternal and child health, women's wellness, economic self-sufficiency and adolescent health and youth development. Understanding that the needs of our clients were often complex and diversified, we encouraged client participation in all eligible and appropriate of services. Wellness clients who were found to be pregnant were enrolled into our AHSI Case Management Services. The children of parents who completed parent communication workshops (Askable Adults) were invited to participate in the Summer Youth Leadership Training Program. Pregnant clients who received Perinatal Case Management services until 12 months post delivery were then eligible to continue receiving services from Resource Mothers. Currently, we are in the process of consolidating our client contact/information systems into one main system for all programs within the CBWW in hopes to reduce replication of services and more appropriately surrender needed services.

Through our consortium, we have made great improvements with our relationships with other health organizations. A prime example is our relationship with Grady Health System. It is now a standard procedure to communicate with Grady, Southside Medical Center, and any other health agency utilized by the client in order to coordinate care and reduce duplication of services.

**3. Describe key relationships that have developed as a result of Healthy Start efforts covering the following areas**

**a. Relationships among health service agencies; between health and social service agencies; and with community-based organizations**

Health and social agencies within the consortium have developed long lasting relationships. The Fulton County Department of Health and Wellness, by membership in the consortium, was afforded the opportunity to partner with the Georgia Campaign for Adolescent Pregnancy Prevention (G-CAPP) to provide funding for the Doula program. The Doula program provided assistance to pregnant mothers by aiding them in preparation for child birth. The CBWW also connected the Fulton County Department of Health and Wellness with the Dunbar Elementary school and facilitated and nurtured the ever developing relationship to identify children in need of receiving a Health Check and other needed health services.

In addition, the production of media materials in the form of an interactive CD in collaboration with the other Georgia Healthy Start initiatives and the State Title V office has been a great tool in introducing agencies to one another for support. Along with health and statistical information, the Georgia Infant Health report and its CD provided a list of organizations that were resources in the area of perinatal health. Lastly, the sharing of office space with the Fulton County Department of Health and Wellness and Southside Medical Center has fostered a mutually beneficial relationship.

**b. Relationships that focus on involvement of consumers and/or community leaders (who are not employed by the health or**

**social service agency) with any of the agencies/organizations listed above or any additional agencies**

The consortium inherently created opportunities for agencies and consumers to meet and develop relationships. Through the consortium, community leaders, Resource Mothers, and health, government and service agencies were brought together to share resources and discuss strategies in rendering services.

Beyond the consortium, there were several other efforts to link consumers of resources with service providers. During the third year of our Healthy Start grant we assisted the Enterprise Foundation's Mechanicsville Community Learning Collaborative (MCLC) in connecting with parents to get feedback on barriers and challenges to early childhood services. In addition, as Fulton County Department of Health and Wellness expressed a need to hear from individuals who live and work with the population they serve to become members of a Parent Advisory Board, the CBWW assisted them in finding interested participants from NPU-V. Two Resource Mothers/outreach workers, who are also community residents, also began participating on the advisory board. As a result, the Resource Mothers and other community residents were able to articulate the health realities within NPU-V in a very real and sobering way.

Consumers also played a role in influencing program direction, as feedback was obtained from program participants through guided discussions and customer satisfaction surveys. For example, feedback from the participants of our SIDS health forum indicated that training on infant CPR would be of interest to them. In addition, from 2001-2003, youth peer educators met monthly with the Health Educator to plan upcoming activities to address the reduction of youth risk behaviors. Their input, and unique perspective on best approaches to deliver risk reduction messages, was invaluable.

Lastly, we realized that needed to expand our existing consortium to more adequately meet the needs of the increased numbers of pregnant and postpartum clients who will need coordinated care and health education services. While our Resource Mothers, who were all community members, participated on the consortium, we needed to address the additional recruitment of recipients of Healthy Start services. Currently, eight percent of our consortium members are consumers. An objective to increase consumer participation on the consortium was included in our 2005-2009 plan.

- 4. Describe the impact your HS project has had on the comprehensiveness of services particularly in the following areas**
  - a. Eligibility and/or intake requirements for health and social services**

One of the greatest resources within the Healthy Start Initiative was our staff. Our Outreach Specialist had a great deal of experience and insight in the rendering of social services. She imparted much of this information to our Resource Mothers. When participants were in need of services, because of knowledgeable Resource Mothers, we were able to connect them with appropriate resources.

As government assistance programs change, the maze of services became even more challenging to maneuver. A major obstacle was that the requirements for applying and the time-tables needed to be adhered to in order to receive services were far more stringent. We played a very large role in assisting our clients to navigate these obstacles. We have developed relationships with WIC through Southside Medical Center, Peachcare, and Medicaid. WIC uses the CBWW as a satellite office giving our clients the opportunity to apply for Medicaid at the CBWW with their applications being processed the next day. At the CBWW, we have found that we must be flexible because our clients can't be. Through our intervention we have provided flexibility to very rigid systems of care and have thereby created more comprehensive services for our clients.

In addition, we recognized that poverty was a very real obstacle that provided for a strong competing priority. In the words of our Outreach Specialist, "many of our clients cannot hear what we have to say about maternal and child health until we meet their immediate financial and basic needs." Due to relationship building, AHSI has worked within state systems to establish client eligibility and to give clients priority in receiving the appropriate services, including housing. An example of this is our relationship with the Department of Family and Children Services (DFACS) in which we have worked closely with case workers to alleviate barriers to accessing care for eligible services.

**b. Barriers to access and services utilization and community awareness or services**

Due to the overwhelming poverty issues affecting the residents of the NPU-V, the primary concerns of the participants were accessing resources to meet those needs. Healthcare issues were not a priority. However, once a woman desires services, we realize that the most basic but poignant barrier to access is lack of awareness. Our Resource Mothers were trained to be knowledgeable of available resources. After we identified services needed, clients were informed of the resources and assisted in accessing these resources. In educating our clients about resources, we aimed to educate them enough so that they could continue to have access to these resources in our absence and were able to inform others about the presence of such resources.

The AHSI also pursued resources that may not have been available to clients under other circumstances. There are many organizations outside of NPU-V that were willing to serve our clients, but our clients were often not knowledgeable about the available services, and often did not have the means to access them. We were vigilant in identifying these resources and providing the appropriate support to our clients such as informing clients, making appointments, and/or providing transportation.

In addition, we worked to insure that clients fully utilized resources. For services such as rent assistance, follow-through was almost 100%. However, more follow-up was needed for services that did not meet basic or immediate needs, such as prenatal medical services.

**c. Care coordination including descriptions of mechanisms implemented to assure continuity of care, quality improvement and follow up system(s) for client referrals**

During the initial contact with clients, Resource Mothers were able to identify needed resources. Resource Mothers not only identified and connected clients with the appropriate resources, but also ensured access and proper follow-through. Before each appointment with a service provider the clients were given a "friendly reminder." During follow-up home visits, clients were asked about the appointment, any issues that arose, and additional services that may be needed. If appointments were missed, Resource Mothers made a new appointment for the client and followed-up accordingly. An ongoing challenge for prenatal visits was the decrease of the compliance level with the number of births. Clients believed that because they had undergone multiple births prenatal care was no longer necessary. A major part of ensuring continuity of care was changing the ideology and culture through education and persistence.

To improve the quality of care rendered through the AHSI and through our service providers, we surveyed clients to assess services rendered. These surveys were given either face-to-face or via phone. In addition, through our contracted evaluator and the support of our Outreach Specialist, we conducted a number of focus groups.

One of the models for service improvement and continuous and systematic rendering of care was the Family Team Model. When clients developed challenges that were difficult to manage by one organization, all of the providers associated with that client came together to coordinate services. When needed, the CBWW provided facilitation of family team meetings to coordinate care.

**d. Efficiency of agency records systems and sharing of data across providers (within the confines of confidentiality rules) to reduce the need for repetition**

As Resource Mothers/outreach workers made contact with new clients, the clients were asked to submit Authorization for Release of Health Information forms, which met Health Insurance Portability & Accountability Act (HIPAA) standards. This allowed us to monitor the health provisions made to our clients. A common occurrence was the loss of information by clients regarding medical procedures such as immunization. We have developed strong relationships with a number of providers such as Southside Medical Center and the Grady Health System. Because of this, we were able to more quickly and completely access health care records as needed. As a result, we were able to identify needed services in most service areas, coordinate complete care, and reduce the replication of services.

**5. Describe the impact on enhancing client participation in evaluation of service provision in the following areas**

**a. Provider responsibility in maintaining client participation in the system and provider sensitivity to the cultural, linguistic and gender (especially male) needs of the community**

Since its conception, the CBWW has viewed residents as community assets and has valued their input in the planning and implementation of services in the community. Resource Mothers have

served as the primary means to ensure culturally and linguistically appropriate services. Per the policy of the Center, participants were probed for insights as to how we could enhance our program and the services that we provided.

The CBWW has worked with other agencies to build bridges and liaisons to promote community input. In 2002, Grady Memorial Hospital, the major health provider for most of our clients, developed an advisory committee for the purposes of modifying the delivery of services. Delores Ellison, Resource Mother and long time community resident of the NPU-V, served on this advisory committee. In addition, by collaborating with the Fulton County Department of Health and Wellness' Fatherhood Program in 2002, we had the opportunity to address the needs of males in service provision. Along with providing meeting space, we also connected the Fulton County Department of Health and Wellness with NPU-V resident Jerome Wallace to serve as one of the co-facilitators. Mr. Wallace galvanized other men within the community to work towards the resolution of male-related issues with special attention to parenthood, and attended many state Resource Mother conferences to give a much needed male perspective. Unfortunately, this health department program was not sustained throughout the project period, however, Mr. Wallace continues to serve as a resource to the health department. In addition, the CBWW serviced two male clients who are the primary care givers for their children through the Healthy Start Program. Non-parenting young men were also encountered and served through our summer youth program and our after-school program, where we taught life skills and conducted ongoing evaluation to assess needs and modify programs.

**b. Consumer participation in developing assessment and intervention mechanisms and tools to serve perinatal women and /or infants, and the extent of implementation and utilization of these tools or mechanisms**

Meetings between the Local Evaluator and Resource Mothers gave the Resource Mothers the opportunity to enhance evaluation tools. Also, a significant opportunity the AHSI had to enhance consumer participation in developing assessment and intervention tools was through the connection of the Enterprise Foundation/MCLC with community residents. During these focus and advisory group efforts, the service community was able to give feedback about the challenges and barriers that parents faced in accessing early childhood services.

**B. Impact to the Community**

**1. Residents' knowledge of resource/service availability, location and how to access these resources**

A main component of outreach was education. By working with the Resource Mothers, the residents of the NPU-V who participated in AHSI gained a great deal of knowledge of the availability and location of resources, as well as how to access available resources. When clients were enrolled and their needs assessed, Resource Mothers began by identifying appropriate support services. Not only did Resource Mothers connect participants to the available resources of need, but also appointments were arranged and the Resource Mothers followed up with clients to ensure that appropriate services were rendered. If clients did not have the resources to get to

appointment, they were provided with tokens so that they could take public transportation or a Resource Mother may personally accompany participants to appointments. Resource Mothers also showed participants how to continue to use the resources even without the assistance of the Resource Mother. This process empowered the participants to take charge of their own well-being.

Community residents who completed the Askable Adult workshops also received information on available resources during the workshops. In addition, because of our location within a multi-service center, we consistently got walk-ins from residents who were seeking information or referral services. Our Data Entry/Administrative Assistant was well versed in many community resources and how to identify others. The CBWW also had a resource manual, which was continually updated and served as a reference source for needed services. Also, the Healthy Start Baby Calendar listed key resources and health information and through several health fairs, we consistently took advantage of opportunities to inform clients of resources and give health information.

**2. Consumer participation in establishing or changing standards and/or policies or participating service providers and local governments, that affect the health or welfare of the community, and have an impact on infant mortality reduction**

A hallmark of the CBWW has been to give cultural and linguistically appropriate services through the use of clients and consumers of services as staff or consultants. In this way, our Resource Mothers were from the community we served. We also consistently looked for feedback from clients and consultants to modify our service strategies.

In addition, the Community Organizer was a long time resident of the community and was an active member of the consortium, the Mechanicville Civic Association, Summech Development Board and the Planning committee for NPU-V, and therefore had direct access to strategic planning and those who created policy for the organizations within.

**3. Community experience in working with divergent opinions, resolving conflicts, and team building activities**

Empowering communities and consensus building has long been a component of the CBWW's mission. Founded from the empowering concept of self-help and community led services, our programs were largely the result of community input. The CBWW has long worked with individuals, organizations and government agencies to bring them to one table to embark on a united strategy to attack health issues.

The Community Organizer and the Resource Mothers attended workshops and trainings that were sponsored by the Enterprise Foundation and the Annie E. Casey Foundation. Exercises on team building and conflict resolution taught our staff members relevant skills for teamwork (i.e. working with team members to come to an agreement). The staff also had the opportunity to understand why individuals feel discomfort in certain settings (i.e. some individuals may feel uncomfortable voicing their opinions while at meetings).

#### **4. Creation of jobs within the community**

As mentioned earlier, the CBWW has a long history of employing consumers of services. The CBWW has employed or contracted community residents for positions of Community Organizer and Data Entry/Administrative Assistant and Resource Mother. In addition, the project utilized the services of residents for on-site childcare during Askable Adult workshop series and other group health education sessions.

For clients, through our linkage with the Department of Labor, the Outreach Specialist and Resource Mothers provided AHSI participants information on employment assistance resources and linked participants to appropriate employment sources, GED programs, and job readiness courses.

#### **C. Impact on the State**

There are four Healthy Start sites in Georgia—Atlanta, Augusta, Augusta Enterprise Community, and Dublin (Heart of Georgia). Coordination between these sites and the State Title V office was extensive and meaningful throughout the four-year project period. The State Title V office committed a staff contact, Eddie Towson, to serve as the liaison between the Georgia Healthy Start sites and the State Title V office. Mr. Towson served on all of the Georgia Healthy Start consortia and attended all annual national Healthy Start grantee meetings.

While the benefit of this collaboration for Atlanta Healthy Start was increased visibility and access to resources, data, and information, this relationship had impact for the State of Georgia as well in the following ways: 1) community access and partnership, and 2) broad dissemination of MCH information.

First, the State's participation on the consortium provided entry into local communities and a broader perspective of maternal and infant health issues impacting these areas and specific demographic groups. One of the most recent examples of this was when the State Title V office relied on the Georgia Healthy Start sites to recruit users of MCH services for participation in various focus groups for the 2005 MCH Needs Assessment. Second, the state was impacted by Healthy Start through an increased ability to broadly disseminate MCH information. Examples of this were in our collaborations to develop and promote statewide maternal and infant health campaigns (i.e., SIDS risk reduction, folic acid awareness). Culturally competent information was disseminated on a local level through Healthy Start outreach methods—ways in which were not accessible by the State MCH office. Also, the sponsorship of joint trainings (e.g., Postpartum Support Training in 2005) and the development of materials and products (e.g., the Georgia Infant Health Report) allowed for greater State MCH impact through the sharing and leveraging of resources.

#### **D. Local Government Role**

Relationships with the local health department facilitated program development, due to committed in-kind resources for initial Resource Mother training. In addition, the State

Resource Mother program was initially used as a model for protocol and form development for case management services. The AHSI Resource Mothers, Outreach Specialist and Community Organizer participated in State Resource Mother conferences throughout the project period for collaboration. Input from several meetings with the State Title V office and Georgia Healthy Start sites impacted our decision on how to implement depression screening for clients. Lastly, the support of the Adolescent Model services, through funding from the State, aided in the development and implementation of the Askable Adult and SYLTP workshops.

## **VI. Local Evaluation**

Evaluation was of primary importance to quality improvement and assessment of the impact of Atlanta Healthy Start. Since there were several core services to monitor (Outreach and Client Recruitment, Case Management, Health Education and Training, Interconceptional Care, and Depression Screening) at several levels (program and community level) the evaluation was designed to monitor the development and progress of each service and provide timely feedback. EMSTAR Research, Inc. was the local evaluator for AHSI during the 2001-2005 project period. The AHSI Local Evaluation Reports are included as Attachment B.

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

The Atlanta Healthy Start Initiative did not participate in a FIMR project. There is no FIMR project in the city of Atlanta nor in Fulton County.

## **VIII. Products**

The Atlanta Healthy Start Policy and Procedures manual (which includes the forms used for case management services), the baby calendars for \*2002-2005, and the Georgia Infant Health Report interactive CD-Rom report are all attached to this report.

\* Due to the overwhelming response from the community, we have a limited quantity of calendars remaining. One complete set (2002-2005) will be given to the Program Officer, while the Grants Management Specialist will be given the remaining calendars for 2003 and 2005.

## **IX. Project Data**

The Healthy Start Data Reporting Requirements consisted of variables that described Healthy Start participants, major services provided by AHSI, and common program-specific performance measures. The following forms are attached to this Impact Report for the 2001-2005 project period:

- MCH Budget Details (Form 1)
- Variables Describing Healthy Start Participants (Form 5)
- Common Performance Measures / Intervention Specific Performance Measures (Form 9)
- Characteristics of Program Participants (Table A)
- Risk Reduction/Prevention Services (Table B)
- Major Service Table (Table C)

