

**HEALTHY START IMPACT REPORT**  
Heart of Georgia Healthy Start Initiative  
6/1/2001-5/31/2005

**I. Overview of Racial and Ethnic Disparities Focused on by Project**

The Heart of Georgia Healthy Start Coalition (HGHC) identified a large perinatal outcome disparity in the 1990s, as well as several intermediate issues believed to lead to perinatal disparities, between all women and infants in the rural ten county South Central Health District (SCHD) and women and infants of most parts of Georgia, and the nation as a whole. The disparities were both racial (African American outcomes being worse than white outcomes) and geographic (outcomes for all women and infants were worse than in other areas). In a specific response to perinatal disparities in the SCHD, the target population for the Heart of Georgia Healthy Start Initiative (HGHSI) was set as all women of childbearing age (wcba) and their infants when the grant application was first made in 1997. Based on statistical evidence, that target population remained the same during the period covered by this impact report. By June 2001, the Heart of Georgia Healthy Start Initiative (HGHSI) had already developed some successful interventions that impacted, in conjunction with national trends and other local interventions, infant mortality and morbidity and other measures of perinatal health. However, both racial and geographic disparities continued to be present in the ten county rural area served by HGHSI. By 2005, statistics indicated that the geographic perinatal disparity for white women and infants for the SCHD had been eliminated, and a new target audience, African American wcba and their infants were chosen as the focus of HGHSI.

The needs assessment from the competitive grant application in 2001 indicated several areas of disparity both within the SCHD (racial disparities) and between the SCHD and other areas. Some of these statistics were perinatal and some were those that can be associated with increased perinatal risk for a population. The Infant Mortality Rate (IMR) for the SCHD is geographically disparate as indicated by a comparison of the SCHD IMR of 11.38 per thousand live births for 1996-1998, the time period HRSA required for the needs assessment in 2001, with the IMR of other areas. For that same time period, the IMR for the state of Georgia was 8.80, and the IMR for the United States as a whole was 7.38. The SCHD African American IMR was both geographically and racially disparate. The following table provides three-year averages for some key perinatal statistics used to determine the target population of HGHSI. Both racial and geographic differences are highlighted by providing statistical information from other areas. Where a cell is left blank, this indicates the information was not available to us or used by us for decision-making for that time period.

<b>Key Perinatal Statistics for HGHSI</b>				
	1996-1998	1996-1998	1996-1998	1989
	IMR	% LBW	% VLBW	% Children < 5 Living < FPL
<b>SCHD</b>				
Black	15.86	14.60	2.95	57.29
White	8.46	6.80	1.22	16.82
B:W Ratio	1.87	2.15	2.42	3.41
Total	11.38	10.02	1.94	33.59
<b>Georgia</b>				
Black	14.00	12.80	3.00	43.70
White	6.10	6.50	1.10	10.94
B:W Ratio	2.30	1.97	2.73	3.99
Total	8.80	8.60	1.80	22.13
<b>Atlanta Metro</b>				
Black	12.20	12.10	2.90	*
White	5.60	6.20	1.10	*
B:W Ratio	2.18	1.95	2.64	*
Total	8.80	8.30	1.70	*
<b>United States</b>				
Black	14.40	*	*	44.04
White	6.03	*	*	13.80
B:W Ratio	2.39	*	*	3.19
Total	7.23	*	*	18.82

Sources: SCHD: Vital Statistics, Linked Birth and Death Files. Georgia and Atlanta Metropolitan Area: Georgia Department of Human Resources, Oasis Website. United States: National Center for Health Statistics. Poverty: 1990 Census - 1989 data (2000 Census/1999 data had not yet been released when the competitive application for the reporting period was written). \* Data not available to HGHSI at the time of the competitive application for BY 01/02 or not used by HGHSI in making decisions about that application.

## **II. Project Implementation**

### **A. Core Service: Outreach and Client Recruitment**

#### **a. Outreach: Decision-Making about Approaches**

The Heart of Georgia Healthy Start Coalition, which serves as the perinatal advisory consortium to HGHSI, completes periodic community needs assessments. The decision to provide outreach and peer counseling to women in the community was made based on what women, families, employers, and health care providers told us in the mid-1990s. Needs assessments indicate that geographic isolation due to lack of transportation and the rural nature of the ten counties served by HGHSI are key issues to be addressed when making decisions about outreach. In response, HGHSI hired women as Healthy Start Advocates (HSAs) from several communities, then placed them in a variety of

locations frequented by higher risk women and infants (health departments, housing authorities, schools, and community service organizations). The HSAs are required to have their own personal transportation and reimbursement for mileage is planned into the budget so they can do home visits, canvas neighborhoods, and go where a woman is to assess her level of risk and enroll her. The need for outreach and the type of outreach that is most effective is periodically confirmed by additional needs assessments, perinatal care data from vital statistics, case studies of individual women and infants who were found early and late in the perinatal period through intensive outreach, and the experiences of outreach workers.

**b. Outreach: Identify the Components, Resources, and Changes Needed for Implementation**

The components of outreach at HGHSI consist of formal outreach opportunities (health fairs, community festival booths, etc.), informal community outreach including neighborhood and community awareness of women and infants at risk (best practiced by Healthy Start Advocates, peer counselors who have dual functions as case managers and outreach workers), and staff assignment to locations where highest risk women come for other services. The resources required for successful outreach have been: 1) staff who specialize in outreach in highest risk communities (Healthy Start Advocates/HSAs and their supervisor), 2) cross-training of all HGHSI staff in recognition and assessment of potential participants, and 3) collaborative partnerships with agencies and individuals who provide opportunities for HGHSI staff to be present in their facilities to provide outreach and who make direct referrals of women through a formal referral system that was in place prior to 2001.

There was a major change in outreach in terms of quantity in 2001 and 2002. During the first four years, intensive outreach in a number of places to establish participant caseloads and community presence were required. By 2001, caseloads were well established (and too large) and were reined in by common sense and a new HRSA policy. In 2001, policies were implemented to choose the highest risk women and infants within high risk groups for enrollment in case management.

**c. Outreach: Resources or Events that Facilitated or Detracted from Successful Initiation and Implementation**

HGHSI outreach was in place for four years prior to this reporting period. Implementation was a continuing issue, applicable to the current reporting period as well as the previous one. References to strategies that were initiated in the previous reporting period (1997-2001) and continued into the reporting period covered by this report (2001-2005) are identified along with newly implemented strategies.

Affiliation with public health and strong collaborative relationships with other organizations which have contact with wcbas in higher risk groups (Family Connections, schools, Housing Authorities, teen and parent resource centers such as Communities in Schools, domestic violence and sexual abuse programs, and substance abuse organizations) facilitated outreach. However, without staff specifically placed within communities to find the highest risk women, the level of outreach and the resultant positive outcomes would have been impossible to achieve in the SCHD. The other resources listed were insufficient for excellent perinatal outreach without the added component of HGHSI staff.

There has been no reimbursement by Medicaid, managed health care, or insurance programs for perinatal outreach in Georgia. Therefore funding is always dependent on specific grants and state programs, all of which are temporary in nature. HGHSI is dependent on federal funding for outreach. Similarly, other programs such as Family Connections are dependent on grants for outreach. There is no local public or political appreciation of the impact perinatal outreach can have among the highest risk mothers. Medicaid will soon become a function of HMOs in Georgia. HGHSI promotes the concept of perinatal outreach as part of early prenatal enrollment and risk reduction for HMOs.

A critical lack of transportation and communication resources for women of childbearing age (wcbas) in many parts of the SCHD complicate effective early perinatal outreach. Many women lack access to a personal vehicle, most women lack access to and resources to pay for taxis, and there is no public transportation in the SCHD (other than a Medicaid van which women told us in focus groups that they perceive as difficult to use). Many women are also isolated by low functional literacy and lack of access to women's magazines that encourage preconceptional care and early self-referral for prenatal care.

## **B. Core Service: Case Management**

### **a. Case Management: Decision-Making about Approaches**

The decisions about HGHSI's approach to case management were made prior to this reporting period during the first four years of the initiative. The success of the program meant that decisions about substantive changes in approach did not need to be made during the reporting period. Decisions about adjustments of content, emphasis, and caseload for case management were made during the reporting period based on the evolution of evidence-based care, HRSA requirements, consumer input, and feedback from staff members. For this reporting period, the model from 1997-2001 was largely used. HGHSI Case Management was designed in 1997 based on the premise that both nurses and paraprofessionals, with appropriate training, could provide effective perinatal case management to wcbas and infants. It was also HGHSI's belief that paraprofessionals could provide better case management if they had regular

input from Registered Nurses on some issues. HGHSI's concept of case management was that of a team effort, where Registered Nurse Care Coordinators (RNCCs) and Healthy Start Advocates (HSAs) carried caseloads that were both separate and, in the cases of some women and infants, overlapping. Divided geographically into four teams, the HSAs, RNCCs, HSA supervisor, lactation, and other program staff meet weekly to discuss the women and infants in each case management staff member's caseload. By 2001, the HSAs were providing quality case management for women who were considered at higher risk due to social and personal risk factors as well as sharing the care of women who were at higher risk due to identified medical and psychosocial risk factors with RNCCs when the woman clearly needed peer input in order to best utilize health interventions. The RNCCs carry their own separate caseload of women who have one or more medical or psychosocial risk factors, share a caseload of participants with the HSAs in their geographic area, provide nursing input on participants both at weekly meetings and by phone at any time, and evaluate positive results of screening tools for depression and domestic violence for HSA participants as well as their own.

**b. Case Management: Identify the Components, Resources, and Changes Needed for Implementation**

The components of Case Management which HGHSI found to be critical were 1) use of well trained and experienced Healthy Start Advocates as case managers for women who learn best from a peer and whose specific risk factors are appropriate for such care, 2) the availability of professional case management by Registered Nurses as the sole case manager or in a team with an HSA, 3) the ability to do home visits when indicated rather than only when the standard care plan schedules them as is the case with the public health programs Pregnancy Related Services (PRS) and Perinatal Case Management (PCM), and 4) good collaborative relationships with a variety of resources for health and social services, including the ability to be housed in facilities where higher risk women and infants receive other services. Case management was an area where affiliation with public health was a tremendous benefit. RNCCs received full public health nurse training with review of basic physical and psychosocial assessment skills, Pregnancy-Related Services (PRS) training, Perinatal Case Management (PCM) training, and a host of other training. These skills resulted in several "saves" during home visits to high risk women and infants as well as a high standard for assessment, intervention, participant education and anticipatory guidance, and referral in all situations. RNCCs were able to provide ongoing continuing education to HSAs and ask the right questions about HSA participants. HSAs in turn provided an ability to communicate, to respect without failing to tell a woman what she needed to hear, to be culturally appreciative, and to be known in their communities.

Evaluation is necessary component of case management. Consumer input about satisfaction and perception of effectiveness were part of an overall evaluation

package. Other aspects of the evaluation of case management were a statistical analysis of outcomes, especially between HGHSI case managed Program Participants and women with similar initial risk factors who were not enrolled in HGHSI.

The ability to budget for and provide basic and continuing education for all staff as an ongoing function of HGHSI is discussed more fully in the Health Education section below. However, it must be noted here that initial and ongoing staff education was a necessary component of effective case management.

There were several changes made during the reporting period. Staff caseloads were returned to a manageable level of 32 mother/baby pairs being intensively case managed per FTE (full time equivalent) case manager as directed by HRSA. Case management was originally provided until the baby was one year old, and expectations about case management for interconceptional women who did not have an infant in the program were not absolutely clear. During the reporting period, the experience of HS sites which received additional funds for Interconceptional Care grants led to the HRSA decision to have all HS sites provide case management to infants to age two and offer case management for two years to interconceptional women who were enrolled prenatally or due to the birth of a fragile infant. This allowed HGHSI case managers to have a greater impact on women's knowledge and decision-making process about child spacing, control of chronic conditions, and parenting than previously. During the reporting period, additional guidance was provided by HRSA on Risk Factor Assessment, and by the end of the reporting period a much more effective system for assessing risks for the purpose of providing improved individual health education and other case management (as opposed to utilizing risk factors to assess for enrollment eligibility, which was already in place at the beginning of the reporting period) was in place. HGHSI chose to add a few risks to the list because, in the experience of the project and due to research evidence, these factors also impact outcomes and are amenable to being positively impacted by the types of intervention HGHSI staff and other medical and social resources available can offer. These additions include environmental tobacco smoke (ETS) exposure, stress, lack of adequate social supports, mother-baby attachment issues, risk of overweight/obesity in children nearing two years of age, lead exposure in infants and children up to age two, dental caries and/or periodontal disease in children up to age two, and not breastfeeding.

Perinatal depression screening and referral are discussed fully in Section II.E. However, the addition of that function within case management had a large impact. Awareness of mental health needs led to greater appreciation of the role stress and the mind play in perinatal health. Support groups and one-on-one contact have been initiated for individual Program and Community Participants and a campaign is underway to educate the community about the impact of stress and mental health.

**c. Case Management: Resources or Events that Facilitated or Detracted from Successful Initiation and Implementation**

HGHSI case management was in place for four years prior to this reporting period. Implementation was a continuing issue, applicable to the current reporting period as well as the previous one. References to strategies that were initiated in the previous reporting period (1997-2001) and continued into the reporting period covered by this report (2001-2005) are identified along with newly implemented strategies.

HSAs had already established themselves as capable and highly valued members of the case management team prior to 2001. Continuity of Healthy Start funding in order to establish this kind of competence and expectation of benefit was very important.

Public health providers are not uniform in their understanding of the work of grant-funded staff, and that issue was revisited several times over the reporting period. RNCCs and their supervisor periodically had to reestablish the parameters of their work and discuss the advantages to public health of their presence in order to maintain an environment where they could be most effective. HGHSI found that for this sort of collaborative partnership to work, there has to be clear communication of the client needs the RNCCs are meeting, the type of work they will be doing in order to meet those needs, and the necessity of focusing solely on that work. It is sometimes necessary to be firm that the expectation is that nurses paid with federal grant funds will perform only work that promotes the goals of that federal grant rather than general health department duties of state and locally-funded positions. For the sake of continued collaboration, the way in which the work of HGHSI staff benefits the health department and its staff as an incidental but welcome effect of their activities needs to be reiterated at intervals and any time there is a personnel change. During the previous reporting period, the HSAs established their abilities and roles in public health, and this issue was not evident during the 2001-2005 reporting period.

HGHSI continued to seek reimbursement for RNCC case management activities during the reporting period. Lack of reimbursement is a detriment to sustainability and will be discussed more fully in that section.

Perinatal nurses are in great demand in middle Georgia. Public health nurse salaries in Georgia have not kept pace with the salaries RNs working in hospitals can command. In addition, some RNs are prepared by temperament and training to provide care more independently, seeing clients at more than one health department, in their homes, in schools, and other locations. Other nurses do not adapt. For those reasons there was periodic turnover in RNCCs during the reporting period. Training a new public

health nurse requires several months. Therefore, lack of an RNCC in a geographic area for a period of time was a resource issue. HGHSI covered the care of participants using the available nurses, assistance from other public health nurses employed by the grantee, and the HSAs. The current group of RNCCs seems well supported within the program and enjoys the HS approach to care. Attention to professional growth, remaining aware of issues within the health departments relative to staff who are only present 2-3 days a week, and input from other HGHSI staff or collaborative partners when dealing with particularly challenging clients are among the steps taken to encourage staff continuity.

Interestingly, the HSAs have not had similar problems with leaving HGHSI. The current seven HSAs have been with HGHSI at least six years. HGHSI attributes their longevity as members of the staff to adequate pay for their educational level, the high status of the work they do in their own eyes and in the community's view, respect for their capabilities within the program, and attention to professional growth. The stability of the group has been a tremendous asset in the community and for the RNCCs.

### **C. Core Service: Health Education and Training**

#### **a. Health Education and Training: Decision-Making about Approaches**

Health education for participants and the community and professional continuing education and training were considered an important part of outreach and case management as HGHSI was being initiated in 1997 and 1998. By the beginning of this reporting period in 2001, experience had taught HGHSI that health and continuing education are critical to changing perinatal outcomes. For a community to come together and change SIDS risk factors for the vast majority of its infants (one change seen in 2001-2005), both consumers and professionals had to receive and implement the SIDS risk reduction message. The same need for health education in order to affect breastfeeding initiation rates and ETS exposure has been seen in the SCHD.

The specific topics and the style of providing health information were chosen based on evidence-based knowledge and audience characteristics. Much participant health education is accomplished one-on-one, an effective way to provide individually tailored messages and assess learning. Support groups and classes for consumers are often kept participatory to maintain interest. Topics are often chosen by the consumers themselves, and HGHSI staff "sell" topics or tailor them to expressed needs rather than just expecting participants to want to learn what seems important from the view of a health professional. Providers are a challenge to involve in continuing education. HGHSI varies their approach to providers, offering classes for their staff that change practice and filter up, offering topics and speakers that attract providers, and asking about how hours, costs, and incentives affect their willingness to attend.

HGHSI decided to add mental wellness, perinatal depression, and stress management topics to their classes and support groups in all ten counties. This was an evidence-based practice decision. HGHSI staff have attended several continuing education programs showing the relevance of psychoneuroimmunology to our participants' health and to the high rate of preterm birth in the SCHD, particularly among African American infants. The March of Dimes has provided other scientific evidence that immune function, relative to both inflammation and infection, is related to preterm labor. On the other hand, our participants have been largely unaware of this information or its impact on their babies. It was up to us to package it in a way that made sense to HGHSI participants. Similar decisions about topics, presentation formats, modes of advertisement, use of ongoing relationships to bring clients in, and incentives were made throughout the reporting period.

**b. Health Education and Training: Identify the Components, Resources, and Changes Needed for Implementation**

The necessary components of health education included: one-on-one health education for Program Participants; classes and support groups that utilized the strengths of the women and families to increase the impact of health education; community education in the form of presentations, newspaper articles, PSAs, TV appearances, billboards, handouts, flyers, and health fair and community festival booths; HGHSI staff continuing education to hone skills and develop new areas of perinatal health understanding; provider education about topics that could impact their practices and the overall perinatal health of the community; and evaluation of effectiveness.

The resources necessary for health education were HGHSI staff committed to health education as a major aspect of the plan for changing perinatal outcomes, a plan for what topics must be presented to every Program Participant, inclusion of health education in weekly team meetings about the care given to each participant, community members with expertise to share, funding for attending conferences for staff, other providers, and community members, written and audiovisual materials to support learning through different modalities, consortium provision of monthly continuing education opportunities, and social marketing skills. Adequate HGHSI staff time has to be devoted to honing communications skills and adding to each staff member's knowledge base. One successful technique was to allow each staff member to pick one or two health education topics from among those that HGHSI management, HGHSI members, and consumers believe are critical. The staff member then becomes expert in that area, attending conferences, reading, discussing needs with participants, sharing that knowledge with the rest of the staff and other providers, and serving as a consultant in that area to other staff members and at classes and support groups. Perinatal depression, stress management, psychoneuroimmunology, family planning, domestic violence, breastfeeding,

child abuse, infant brain development, SIDS risk reduction, and smoking cessation are among the topics that have been addressed this way. Staff team teach for group presentations, allowing one person to watch for body language indicating boredom, disbelief, or other feelings that might indicate that the message is missing its mark and is less likely to be incorporated by the participant. Adjustments can be made immediately. Participants also complete written evaluations for all group health and continuing education, and individual health education effectiveness is evaluated periodically by behavior change assessment and client report.

**c. Health Education and Training: Resources or Events that Facilitated or Detracted from Successful Initiation and Implementation**

HGHSI health education was in place for four years prior to this reporting period. Implementation was a continuing issue, applicable to the current reporting period as well as the previous one. References to strategies that were initiated in the previous reporting period (1997-2001) and continued into the reporting period covered by this report (2001-2005) are identified along with newly implemented strategies.

Necessary resources for a successful health education program were listed in Section II.C.b above. Among the resources HGHSI identifies as facilitating health education implementation include funding for local conferences and travel to conferences in other locations, a critical issue in a rural area hours away from population centers where there is a similar interest in cutting edge perinatal health information. HRSA's research and initial presentation of new information to be included in health education have several times stimulated intense interest and whole new avenues to impact perinatal health. Examples include perinatal depression and psychoneuroimmunology. The provision of convenient venues by various community organizations and providers (including schools, health departments, housing authorities, the Parenting Information and Resource Center, Communities in Schools, Community Mental Health, hospitals, and physicians' offices) for classes, support groups, provider workshops and conferences, and individual health education have been critical for implementation. Scattered over a ten county area with a high incidence of transportation difficulties, participants need to have health education brought as close to them as possible. The Family Health Branch's (FHB's) continued interest and assistance have increased the number of health education offerings in and near our communities.

There have been no major events that have negatively impacted health education. A chronic lack of transportation resources and geographic isolation have decreased the number of opportunities for health education for participants, staff, and other providers by experts in their fields. HGHSI and HGHSC, in concert with the other HS sites in Georgia, the FHB, and other providers and organizations have worked to maximize opportunities for the

sharing of vital health information with Program Participants, Community Participants, and providers.

**D. Core Service: Interconceptional Care**

**a. Interconceptional Care: Decision-Making about Approaches**

Interconceptional care is an integral part of perinatal case management and thus has been included in the HGHSI program since 1998 and continuing through this reporting period. Although HGHSI was not among the grantees that received additional funding in 2001 to provide interconceptional care (IC) to previously unenrolled women who delivered a preterm baby or had other major risk factors for a subsequent poor perinatal outcome, the project continued to provide interconceptional care to women enrolled during pregnancy and a smaller group of women with high risk infants who were enrolled after delivery. During the reporting period, HRSA requested that IC be extended for two years, and HGHSI happily complied since both HGHSI staff and participants found a one year cut-off allowed insufficient time to deal with ongoing medical and social problems among mothers, promote family planning to achieve a > 2 year birth interval, continue to monitor immunization status, and assess and intervene in developmental and parenting issues. Thus the decisions about IC were made based on current standards for the provision of quality case management, HGHSC and HGHSI assessments of the needs and preferences of families, HRSA requirements, and funding levels.

**b. Interconceptional Care: Identify the Components, Resources, and Changes Needed for Implementation**

The components needed for implementation of IC included: 1) trained and experienced perinatal case managers (4 RNCCs and 7 HSAs), 2) care plans that were flexible enough to reflect the participants' preferences and individual needs yet delineated the necessary health education, assessment, intervention, and referrals to be provided, 3) caseloads kept to a reasonable size (32 mother-baby pairs per FTE case manager), and 4) development of ongoing relationships with mothers (a reflection of the capabilities of case managers) so they continued to want to meet and talk with their case manager and attend classes and support groups as their babies moved out of early infancy.

The resources needed for implementation of IC were adequate funding for staff to provide services, health education staff and collaborative partners to provide referral resources, availability of space in a variety of facilities to provide contact points with participants, and funding of travel for home visits.

The major changes related to IC during the reporting period were decrease of caseloads to 32 women per FTE case manager (decreasing the total number of women in the target area who could be offered intensive IC) and extension of

the IC period to two years. HGHSI also made changes that included establishment of the clear expectation that Program Participants would be given IC for two years after the end of their pregnancies no matter what the outcome for the baby (live birth with living child, infant death, fetal demise, or miscarriage), documentation of the assessment of a number of additional risk factors and provision of related health education and referral, perinatal depression screening and referral, and domestic violence screening.

**c. Interconceptional Care: Resources or Events that Facilitated or Detracted from Successful Initiation and Implementation**

The presence of HRSA funding was crucial to implementation of IC. The presence of HGHSI and HGHSI in the community for four years prior to the onset of this reporting period provided significant collaborative partnerships and better communication with providers, allowing assessments, referrals, health education, and interventions related to risk factors to proceed more successfully. Continuity of HS in the SCHD has been a very positive factor in the provision of IC.

The continued rollbacks in Medicaid reimbursement and subsequent difficulty in getting approval for additional programs prevented HGHSI from being able to bill Medicaid for home visits, PCM by RNCCs, and PCM by HSAs. The failure of HGHSI to obtain separate HRSA funds for IC coupled with the mandated decrease in caseloads resulted in a decrease in the total number of women served and prevented HGHSI from enrolling all the high risk women in the SCHD who met the criteria.

Some of the same staffing issues discussed in Section II.B.c under Case Management also apply to Interconceptional Care. As discussed in Section II.D.a above, HGHSI applied for but did not receive additional HS funds for Interconceptional Care. All of these events affected the number of wcb who could be offered IC, but did not prevent the Interconceptional Care elements of the project from continuing. HGHSI's assessment is that the decreased caseload may have decreased the numbers of women served yet it had a positive effect on the intensity and quality of care given.

**E. Core Service: Depression Screening and Referral**

**a. Depression Screening and Referral: Decision-Making about Approaches**

HGHSI identified the presence of perinatal depression (PD) most often in the early years among its highly verbal, lower risk Community Participants in the Lactation Program. Gradually those specific cases coupled with perinatal depression information offered by HRSA and knowledge gleaned from other conferences attended by HGHSI staff led to a recognition of the pervasiveness of PD among all groups of participants. HGHSI staff were particularly

motivated by the impact of PD on the infant's growth and development, the potentially fatal nature of PD, and poor job and school performance among women with symptoms of PD, leading to economic and interpersonal difficulties. Members of the staff began to suspect that PD symptoms might explain the flat affect, poor communication, and apparent lack of interest exhibited by some women during perinatal health visits as well some of what has been traditionally called "non-compliance."

HRSA's presentations at conferences provided valuable information about the incidence and impact of PD, PD assessment, and PD resources. HGHSI did not wait until there was an absolute mandate for PD screening by HRSA, but moved quickly to put a system into place. By 2002, HGHSI screening policies and procedures were finished, and screening of all Program Participants was instituted. HGHSI continues to look for ways to make PD screening, referral, and treatment universal by all providers of health and social services to pregnant and interconceptional women.

**b. Depression Screening and Referral: Identify the Components, Resources, and Changes Needed for Implementation**

The components necessary for implementation were staff education, a culturally appropriate screening tool that can be administered in a written format or orally to women with low literacy skills, a policy about screening, and referral resources for emergent and non-emergent positive screens. Research into current standards and comparison of screening options were necessary because there was no single recommended approach to setting up professional and paraprofessional screening when diagnosis and treatment is not provided within the program. Decisions had to be made about which participants are to be screened, when they are to be screened, when it is not accurate to screen, who will score the screening tool, the score that will be considered a positive screen, how the need for referral will be communicated to the participant, referral protocol, and identification of which HGHSI staff member will be responsible for follow-up. Mentoring sites that received Perinatal Depression funding from Healthy Start offered options and guidelines but no firm protocols applicable to all HS sites.

A major change was the addition of what seemed to be a nursing or professional function (PD screening and scoring) to the duties of paraprofessional case managers. A compromise was reached to permit them to screen and score in order to maximize the number of participants who were screened on an optimal schedule. Positive screens and concerns about symptoms in the presence of a negative screen were referred to an RN and then, as appropriate, to a mental health professional or the participant's personal physician. The process was formalized into a policy so the lines of communication and referral were clear and did not vary. This was the first formal, routine mental health screening tool and policy (other than substance use) that was introduced into public health practice by local initiation in the SCHD.

**c. Depression Screening and Referral: Resources or Events that Facilitated or Detracted from Successful Initiation and Implementation**

The greatest impediment to successful initiation was the relative lack of referral resources for women with positive PD screens or other signs of PD or other mental illness. Community Mental Health (the publicly-funded mental health inpatient and outpatient program for the SCHD) received budget cuts around the time HGHSI instituted PD screening of all Program Participants. In spite of this setback for their program, Community Mental Health management staff met with HGHSI and HGHSC, established a collaborative partnership, took all emergent referrals, and worked in less critical referrals as appointments were available. In April 2005, as the reporting period was coming to a close, HGHSI was able to hire an MSW with experience in working with PD. The MSW began providing mental wellness and stress management classes and support groups during the reporting period, as well as teaching all HGHSI staff basic ways to promote mental wellness in participants. A cooperative venture of her seeing PD clients, specifically HGHSI Program Participants, at Community Mental Health's facility is being discussed, offering the safety net of the presence of a psychiatrist, other mental health colleagues, and medication prescription services when needed on site.

There have been no major events or resources that facilitated successful initiation and implementation other than HRSA's provision of continuing education about PD and a mandate to provide this service. Technical assistance in the form of site visits by experts (including affected women) to train staff and interested community members would have been helpful. However, the resources provided were adequate as evidenced by successful PD screening and referral initiation.

**F. Core Systems-Building Effort: Local Health System Action Plan**

**a. Local Health System Action Plan: Decision-Making about Approaches**

The Local Health System Action Plan (LHSAP) has been a flexible document, changing as goals are met, understanding of the concept of LHSAP increased, and community needs assessments indicated a change in focus. Needs expressed by participants, evidenced-based practice in perinatal care, and the perceived capabilities of HGHSI, HGHSC, and collaborative partners have had the greatest impact on the choices of LHSAP objectives and strategies.

The most recent strategic planning session of the coalition, held near the end of the reporting period, will, for instance, greatly affect the next LHSAP. During strategic planning, the coalition looked to its mission statement, current community perinatal health statistics, and the needs expressed by consumers before choosing objectives that required both individual and system-wide

change components for achievement. These were repeat teen pregnancy (requiring a community effort to help these women succeed as mothers and as students, acquire birth control they can consistently use, and focus on positive activities for themselves and their children after school is out for the day), increased breastfeeding (requiring physicians to promote and support breastfeeding, employers and schools to protect breastfeeding, families to appreciate the benefits of breastfeeding, and women to choose breastfeeding), decrease the number of children (broadly defined as pregnancy through age 18) exposed to Environmental Tobacco Smoke (requiring legal changes related to public smoking the consortium was involved in assisting as well as social marketing among teens to prevent initiation of smoking and families of children to decrease exposure in private homes and cars), and increase the number of licensed (and therefore trained) childcare providers so that infants and children whose parents work outside the home or attend school will have safe care that attends to their physical and developmental needs (a major change in this rural area) and so that participants and other consumers will have a job opportunity that allows them to be with their own children while utilizing the talents many of them have in caring for infants and children by providing a safe, nurturing, and enriched environment. Those were the decisions, but it took two days of sifting through focus group reports, needs assessments, reports by consumer advisory group facilitators, statistics, the expert opinions of a variety of health care and social service providers, previous successes and disappointments, and resources before the group of approximately 25 seasoned coalition members who know and appreciate each other were able to nail down elements that can be included in the next LHSAP. Such an LHSAP might be able to be created under less friendly and experienced conditions, but the difficulties in strategic planning mount and the likelihood of successful implementation may decrease.

**b. Local Health System Action Plan: Identify the Components, Resources, and Changes Needed for Implementation**

The LHSAP requires first and foremost an understanding of the concept by those who are designing it. Acquiring this understanding was an ongoing process and is still a challenge. The other components required were consortium input and control of the process, participant input, knowledge of the community, and specific resources related to each of the objectives in the plan. Adequate time and money had to be set aside for planning sessions, and this piece was better implemented as the grantee and its advisory coalition gained experience. Finally, the assistance of key stakeholders and consumers must be solicited in order to implement the specifics of the LHSAP. Social marketing, as appropriate, must be designed to sell the plan and sell the messages necessary to its success in changing perinatal systems and perinatal health. This is a complicated process. One useful approach has been for HGHSI and HGHSC to offer to do a lot of the legwork, then provide the key players with a manageable amount of action and change. If you want more mothers to breastfeed, you not only approach the mothers, you find a way to insert a breastfeeding

knowledgeable and friendly WIC clerk into all three birthing hospitals, provide her with a computer, have her explain the benefits of an exclusive breastfeeding package to low income mothers, complete their paperwork and get them their vouchers in the hospital, and have them going home without formula or formula coupons thinking of themselves as official breastfeeding mothers. Then you offer formal breastfeeding certification to the staff of obstetricians, pediatricians, and hospitals. Throw in special recognition in the newspaper (something that's free and possible in small towns). Get them together regularly to share ideas about breastfeeding promotion and support in their own areas. There is quickly a group of 25 professionals positively impacting breastfeeding in hospitals and doctors' offices. Add about a dozen other specific interventions such as grant-writing to double the number of peer counselors trained and placed in paying positions. These are systems changes that influence individual parental behavior and perinatal outcomes.

**c. Local Health System Action Plan: Resources or Events that Facilitated or Detracted from Successful Initiation and Implementation**

The ongoing needs assessments that GHSC had done over several years were excellent resources in the development of the LHSAP. The presence of a wide variety of individuals on the consortium increased the number of areas that could be considered for the LHSAP. Although cutting LHSAP objectives to two or three was difficult, the outcome was better with creative and open-ended initial discussion than if only a limited range of options had been considered. Development of trust in consumers and other coalition members to make good choices about the LHSAP that both the coalition and the project must implement was a revelation and a necessary step in establishing an effective LHSAP to guide perinatal decision-making.

HRSA definition of the LHSAP and continuing education in its design was needed, but the support was insufficient. HGHSI and GHSC still need technical assistance in this area, and it is probable that the other HS sites also need such assistance.

Implementation of each successive LHSAP has been both a challenge and a learning experience. Sometimes the LHSAP lacked sufficiently detailed action steps. Sometimes the LHSAP did not truly represent the needs of the consumers and the best thinking of the consortium. Sometimes the LHSAP was too vague. An example from the 2001/2002 HGHSI grant application: "Increased mutual referral among physicians and other providers." An increase in such referrals was important to improve perinatal services for participants, and based on HGHSI's experiences it can be stated that it certainly happened, but GHSC did not have real benchmarks for comparison to see if the amount and types of referrals had improved. The most recent LHSAP has more specific objectives. Sometimes portions of the LHSAP were way beyond the capability and clout of the consortium and its collaborative partners at the time. Fetal Infant Mortality

Review (FIMR) is an example from several LHSAPs. Desperately wanting the information FIMR can provide and strongly encouraged by HRSA, HGHSC and HGHSI placed FIMR at the top of its LHSAP. However, the political power of physicians, hospitals, and other mortality review boards, fear of lawsuits, lack of funding, lack of a mandate from the state Department of Human Resources and the Legislature, and the sheer number of jurisdictions involved in this ten county project made establishing FIMR a task that would have required using major time and energy resources without a significant chance of success. HGHSC's response has been to table it as a part of the LHSAP while at the same time continuing the promotion of the concept and its applicability to community perinatal health. (HGHSC members repeat in appropriate company statements such as: "We can't know what to do to decrease fetal and infant mortality and morbidity until we know what is killing our babies both before and after they are born.") Other steps HGHSC has taken included HGHSC's Co-Chair making the necessary connections to be placed on the Child Fatality Review in the largest county, commissioning a PPOR (Perinatal Periods of Risk) analysis for the SCHD, and the Medical Director of HGHSI's grantee calling a meeting of key stakeholders to present the PPOR analysis and educate them about the need for more information.

## **G. Core Systems-Building Effort: Consortium**

### **a. Consortium: Decision-Making about Approaches**

When discussing the consortium, this question can have two meanings: decisions that are made about the consortium's configuration and functions and how the consortium makes decisions in its advisory capacity to the HS project. The initial decision to form the Heart of Georgia Healthy Start Coalition was made in 1993 by one perinatal health nurse because it was required by her funding (WIC/Department of Agriculture). In 1997, the group of about 30 that had developed chose to expand the coalition and its scope by designing a Healthy Start initiative that would qualify for HRSA funding in order to provide the services identified by a community needs assessment including specifically perinatal peer counselors, a workplace lactation program, and measures to decrease infant mortality. Those decisions were made a self-selected few who asked and listened to a number of other members of the community including consumers.

By the beginning of the reporting period, HGHSC was a 501(c)3 non-profit organization with an elected Board of Directors, by-laws, strong committees, and periodic strategic planning. By the end of the reporting period, committees had even greater responsibility for designing interventions and making collaborative partnerships that further the objectives of HGHSI, the LHSAP, and the goals of the consortium. All HGHSC members are invited to join formal strategic planning meetings. The impact of those meetings on future actions of both the coalition and HS project are stressed. Consumers are specifically

invited to share in the decision-making. Where work or school precludes a consumer from sitting in, HGHSC solicits her views actively prior to planning sessions. The most recent one was a two day session in April 2005 which also required follow-up meetings to fine tune the strategic plan and define how it relates to the newest LHSAP, additional needs assessments, and committee meetings to begin implementation. When time is of the essence, the Executive Board makes decisions about pursuing grant applications and collaborative partnerships that further the goals of the coalition and meet the needs identified by consumers.

**b. Consortium: Identify the Components, Resources, and Changes Needed for Implementation**

The components and resources necessary for coalition implementation overlap significantly. Those items that belong on both a list of components and a list of resources include a community need or concern around which people from the community can coalesce. “Our babies are dying unnecessarily” is an excellent rallying point. A group of committed citizens willing to give significant time must be identified. A subgroup who are willing to take on leadership roles for a period of time, limited or long term, must also be identified. A place and time of meeting that allows consumers and key stakeholders an opportunity to attend and that generally promotes participation in the consortium is critical. HGHSI chose to meet in a geographically central location in the ten county area near two pediatricians who wished to be active members and closer to consumers with the greatest transportation limitations rather than the largest town.

Consortium structure tends to evolve along fairly predictable lines. At each step along the way, HGHSC members believed they were just taking the next step to make the coalition more effective. With hindsight, after reading books about coalition development, HGHSC leadership recognized that the coalition is following a predictable pattern of increasing effectiveness by changing and adding functions as the evolution of the consortium demanded. At the current state of development, HGHSC finds it very helpful to have strong, semi-autonomous committees designing and implementing specifics that address the strategic plan. There is a culture of expectation that members will pick one or more areas of personal and/or professional interest and serve on those committees. This maintains a strong buy-in and prevents stagnation of the consortium or the individuals in it.

**c. Consortium: Resources or Events that Facilitated or Detracted from Successful Initiation and Implementation**

Among the major events that facilitated coalition development was the increasingly common requirement of the existence of coalitions serving as advisory boards to a variety of grant and government funded social and health service programs in the project area. Many organizations must have

an advisory consortium or must participate in a consortium, so their appreciation of HGHSC and collaborative efforts have increased. The availability of relatively small but critical funding of consortium activities has allowed an aura of professionalism to surround HGHSC. This atmosphere, in conjunction with our reputation for meeting deliverables, set the stage for better collaboration with other organizations and attracted individuals. This professional aura included holding annual meetings, offering professional and consumer conferences, and having accounting and auditing practices that meet current standards for best practices.

Transportation for consumers spread over a ten county area has been a resource we have lacked. Overcoming that challenge has required the use of the Healthy Start van and private vehicles of HGHSC members who are not state employees as well as providing meeting opportunities for consumer advisory boards held in all ten counties. Loss of the Regional Perinatal Coordinator near the end of the reporting period due to statewide elimination of those positions brought a major social marketing project to a temporary standstill. The impact of budget cuts for a collaborative partner often has a ripple effect.

**d. Consortium: Additional Elements**

**1. Establishment of the Consortium**

HGHSC was founded in 1993 prior to its first application for a Healthy Start grant in 1997. It underwent a name change and expansion in the scope of its focus on perinatal health issues at that time. The coalition moved from a simple grass-roots organization to a more formalized format with an Executive Board, by-laws, conflict of interest statement, 501(c)3 status, and semi-autonomous committees (Advocacy/Publicity, Breastfeeding, Collaborative Development/Membership, Community Resources, Consumer Recruitment, Executive, Men to Men, SIDS/Infant Safety, Sustainability, Teen/Youth Issues, Tobacco Use Prevention/Smoking Cessation, and Women's Health Issues). HGHSC has been the recipient of the Perinatal Health Care Delivery Award from the Medical Center of Central Georgia. HGHSC celebrated its 10<sup>th</sup> anniversary with an educational conference attended by consumers, health care and social service providers, community activists, the aide to our Congressman, and the Governor's floor leader in the Georgia General Assembly.

**2. Consortium: Working Structure, Composition, and Active Membership:**

HGHSC has an Executive Board consisting of four officers elected every two years by the entire coalition membership (Chair, Co-Chair, Secretary, and Treasurer) and the chairs of each committee (elected by the members of the committee). The Executive Director is appointed by the Executive

Board. For most of the reporting period there have been 12 committees. During the reporting period, the Men to Men Committee was added, and near the end of the reporting period the Membership functions were transferred from the Advocacy/Publicity Committee to the Collaborative Development Committee creating the new title Collaborative Development/Membership Committee. This was a result of strategic planning in April 2005.

At the end of the reporting period, there were 96 members of the consortium (variation over the reporting period = 92-108). The percentage of HGHSC members who are currently active (attending at least 50% of meetings of the full consortium) averaged 54 %, although many other members are active through committee and advisory group work.

The Calendar Year 2004 (CY 04) percentages of consortium members representing the categories listed in the guidance are typical of the reporting period and are as follows:

The CY 04 gender breakdown of HGHSC is:

Female: 89.4%

Male: 10.6%

The CY 04 racial/ethnic breakdown of HGHSC is:

White: 67.7 % (65.0% of SCHD population)

African American: 31.2 % (32.9% of SCHD population)

Asian: 1.1 % (0.4% of SCHD population)

American Indian or Alaskan Native: 0 % (0.1% of SCHD population)

Native Hawaiian or Pacific Islander: 0 % (0% of SCHD population)

Hispanic or Latino: 1.1 % (1.5% of SCHD population)

The CY 04 breakdown of HGHSC by types of representation is:

State or local government (G)

(includes public health, schools, and public officials): 51.1 %

Program Participants (PP): 4.3 %

Community Participants (CP): 6.5 %

Community-based organizations (CBO) (includes faith-based): 20.7 %

Private agencies or organizations (PAO): 3.3 %

Providers contracting with the Healthy Start program (PC): 0 %

Other providers (OP) (private physicians and hospitals): 13.0 %

Other: 0 %

### **3. Consortium: Activities Utilized to Assess Ongoing Needs, Establish Policies for Allocation Resources, and Monitor Implementation:**

HGHSC conducts formal and informal community needs assessments including focus groups led by trained facilitators from the community,

written surveys and evaluations, meetings specifically called to identify needs, the outcomes of needs assessments by collaborative partners, both individual consumer recommendations and the consensus of consumer advisory groups, analysis of local perinatal data, and current evidenced-based practice. The Executive Committee maintains regular, near-daily contact with HGHSI management. The Executive and Sustainability Committees have had the continuing responsibility of monitoring implementation in general, and other committees have monitored specific aspects of implementation related to their areas of focus. An example is oversight of and involvement in community and Program Participant health education about SIDS risk reduction by the SIDS/Infant Well-being Committee.

#### **4. Consortium: Community Strengths Which Enhanced Consortium Development**

Rural areas often have many health-related weaknesses, but a strength of this (and many other) rural areas is a disproportionate degree of caring for each other and pride in the community. When perinatal health disparities are pointed out, a number of people indicate that they care and are willing to assist. In less rural areas, hospitals often are concerned about politics and profits to the exclusion of collaborative efforts. In the SCHD, all three hospitals signed on with active participation from the outset. Not just one or two of the relevant Family Connections joined; all seven Family Connections saw the overlap of interests and enhanced effectiveness of collaboration. Ministers, school officials, programs for young people, and our local United Way are excellent members and partners.

A second strength is that at the same time HGHSC was developing as a consortium, a number of other community service organizations were created. There was a growth of formal projects to attend to health and human service areas such as child abuse, domestic violence, advocates for children, teen court alternatives to help first-time non-violent offenders get back on track, Family Connections projects to improve education readiness, and community after-school activities. That kind of atmosphere feeds on itself, making all such projects intended to improve the well-being of members of the community more acceptable.

#### **5. Consortium: Describe Any Weaknesses and/or Barriers Which Had to Be Addressed in Order for the Consortium to Move Forward**

It is always very difficult to involve enough consumers and key stakeholders in a health consortium. Consumers state that a lack of time and transportation hinder their attendance. Consumers are mostly mothers who are away from their children for hours every day for work or school and want time for their children, themselves, and the basic acts of keeping up a

home and family. They do not generally work at jobs where absence for a consortium meeting is tolerated. Holding meetings at another time (evenings or weekends) does not change their opinion about using critical time in this fashion.

The key stakeholders HGHSC would most like to include are hospital and insurance executives, physicians, dentists, state public health, members of the business community, heads of related health and social service agencies, and policy makers. HGHSC has one pediatrician and one dentist who attend regularly. In general, the groups of individuals named are busy with their own projects. They are aware of HGHSC, they appreciate the work the coalition does, they often respond favorably to requests for specific actions, they may attend an occasional called meeting specifically designed for key stakeholders only, and many will send representatives to meetings regularly. Examples include representatives of hospital management (a Director of Nursing and a Nurse Manager for Perinatal Health), a liaison for state Title V and public health who drives 3 hours from Atlanta for almost every monthly meeting, the legislative aid for our Congressman who regularly attends meetings, and the State Representative for the area who attends some annual meetings, has been present for a HRSA site visit, and is willing to make appointments with HGHSC members and HGHSI staff to discuss issues. In general, key stakeholders expect the coalition to take care of the daily business of planning for perinatal health for the community, involving them as needed.

#### **6. Consortium: Activities and Strategies Employed to Increase Resident and Consumer Participation**

Consumer participation, if examined in terms of attending regular monthly meetings of the coalition, has been much less than HGHSC needs. One way to increase that specific type of participation has been to provide training and personal interaction that makes them feel welcome, useful, and respected. The best way has been to identify consumers who have talents and skills to share with their community, find them positions with HGHSC's projects or collaborative partners, and make sure attendance at coalition meetings is allowed on the clock and mileage or transportation is provided. The final way HGHSC has increased consumer participation is to expand the definition of consumer participation. While perhaps most active HGHSC members think attending a noon luncheon meeting about child abuse and what the women of a community can do to decrease it is the ideal way to make contacts and share that information, consumers may prefer a Saturday "house party" with the same topic. When a discussion is facilitated by a peer counselor with formal facilitation training, information about what consumers identify as needs and best approaches can be elicited. Often those same women are asked to participate in focus groups (offered during the reporting period in the SCHD with the assistance of HGHSI by HGHSC, the

Family Health Branch of the Division of Public Health, and the Mercer School of Medicine), providing additional information to HGHSC about their view of current health problems and the types of responses our community should put in place.

**7. Consortium: Consumer Input in the Decision-Making Process**

This was discussed in Section II.G.d.6 above and in Section II.I.a below.

**8. Consortium: How Did HGHSC Utilize the Suggestions Made by Consumers**

Consumers asked for several changes in order to improve their health and general well-being. They specifically asked for greater community respect for their condition when they are pregnant in order to decrease stress. HGHSC responded by arranging for several businesses to reserve convenient parking spaces labeled for pregnant women and mothers of infants. The intent was as much to let women know they were valued as to let them park closer. HGHSC's Sustainability Committee wrote two March of Dimes grants to obtain funds for perinatal stress reduction health education and activities. Community education was provided in a 100 Acts of Kindness toward Pregnant Women Campaign (based on research done in Atlanta and Los Angeles and modified by focus group comments of women from the SCHD). Care packages were also provided to pregnant women including lotion and shampoo and other self-care products. Consumers stated that their male partners needed parenting support and health education. In addition to the ongoing childbirth preparation and breastfeeding classes HGHSC provides, the coalition's Men to Men and Sustainability Committees wrote a successful grant to the Georgia Children's Trust Fund to establish a Meld for Young Dads program which operated for 18 months. Consumers said that setting aside time and arranging transportation and child care for health education classes and support groups was a challenge, so HGHSC asked for funds to be set aside out of the HGHSC budget for a non-monetary Incentive Program to provide participants with diapers to make classes and support groups seem less like a drain on resources and more like a source of help with the basics. Male and female participants said that men needed something tangible for the mother of their baby and the baby to smooth communication and increase frequency of positive contacts, so enrolled Meld for Young Dads participants were also included in the Incentive Program. Consumers stated that affordable, quality childcare was an ongoing issue for families in the SCHD. HGHSC invited the Director of Child Care Resource and Referral to become a member of the coalition. The Director has been active, and HGHSC's Strategic Planning Team included increasing the number of trained childcare providers offering safe, affordable, and quality care as part of the Strategic Plan in April 2005. By the end of the reporting period, steps were being

taken to implement that plan, including encouraging capable HGHSI participants to become regulated Family Day Care providers. Consumers described a problem with taking their babies out for WIC certification 1-2 days after discharge from the hospital in order to ensure access to formula. (Breastfeeding mothers generally felt comfortable waiting until their baby was a week or two old to sign up for the breastfeeding package, although the change to WIC certification prior to discharge was positive for them as well.) HGHSC and HGHSI negotiated with all three birthing hospitals and local WIC to place computers and trained personnel in the hospitals to do WIC certifications and issue vouchers prior to discharge. Consumers repeatedly identified transportation, Medicaid limitations, and PeachCare (Georgia SCHIP) limitations as problems. HGHSC was unable to solve these issues, although all three were communicated often to other organizations, agencies, and policy makers. HGHSC maintains a resource book for all ten counties used by members and collaborative partners to help women identify alternatives as health care and transportation situations arise.

#### **H. Core Systems-Building Effort: Collaboration and Coordination with State Title V and Other Agencies**

##### **a. Collaboration and Coordination: Decision-Making about Approaches**

Decision-making about which collaborative partnerships to pursue and how to approach collaboration largely lay in the hands of the Project Coordinator of HGHSI, the Executive Committee of HGHSC, and the Collaborative Development Committee, although the coalition as a whole, the Executive Director, the Medical Director of the grantee, and HGHSI had significant input as well. Final decisions about the types of collaboration rested with the Project Coordinator and the Executive Committee. Decisions about collaborative partnerships were based on the degree to which a partnership or collaborative activity could further the mission and goals of the HGHSC or the objectives of the HGHSI. For established programs, the potential collaborative partner's history of meeting deliverables was also considered before significant staff time or funds were invested.

Commitments of coalition funds for collaborative activities are placed before the coalition membership for a vote. Commitments of HGHSI funds are in the hands of HGHSI management with the knowledge and approval of the Executive Committee of the coalition.

##### **b. Collaboration and Coordination: Identify the Components, Resources, and Changes Needed for Implementation**

Collaboration and coordination with State and local Title V and other agencies and organizations has several components. They include an analysis of where

the goals and objectives of the two organizations overlap, whether the collaboration and coordination is required or optional, and the types of activities that will be most beneficial and realistic. Mutual positive relationships must be developed both among organizations and between the individuals in each organization who plan and implement projects. These positive relationships involve regular contact, a reputation for meeting deliverables in shared projects, and responsiveness to small requests such as letters of support and information about resources. Cultivation of an atmosphere of collaboration rather than competition is a critical component.

Collaboration and coordination with other organizations and agencies always involve a mutual exchange of some combination of goods, services, ideas, and encouragement. Resources for these exchanges must be available. It was necessary that HGHSI have adequate staff time set aside for collaborative projects and additional assistance was obtained from coalition members and non-HS staff from the grantee to meet obligations to collaborative partners. Personnel most in demand for collaborative projects were the Project Coordinator and the Outreach and Education Supervisor. All HGHSI staff and active HGHSI members participated in collaborative efforts in order to maximize the number and types of collaboration that occurred and prevent any one person from spending too much time away from other duties. For example, the Project Coordinator serves on the Governor's M&I Council, an HSA serves as Family Advisor to the largest Family Connection, other staff serve on all the other Family Connections Boards, and the Project Coordinator and the HGHSI Chairperson and membership meet regularly with State Title V. HGHSI serves as a major collaborative conduit, involving all seven Family Connections, the Level III NICU for this Region (not located in the SCHD), Medicaid, State and local Title V, and a number of other organizations and agencies. Monetary resources must also be ear-marked for mutual projects. All four Georgia HS sites and the Family Health Branch (State Title V) contribute to projects they design together that would not be feasible alone. During the reporting period these included three regional perinatal health conferences, two regional perinatal depression training workshops for providers, and the production of a web-interactive CD that provides data, summaries, and resources for perinatal health for policy makers, libraries, organizations, agencies, and community members. A copy of the CD, "Maternal and Child Health in Georgia: Birth through Age 5: 2004," is included with this report. It highlights each of the main contributors, the four HS sites and the FHB, as well as a number of other resources for perinatal health.

**c. Collaboration and Coordination: Resources or Events that Facilitated or Detracted from Successful Initiation and Implementation**

There were a number of events that facilitated collaboration and coordination. The assignment of an energetic FHB (State Title V) liaison to the HS sites in Georgia was a positive event that facilitated even better

coordination and collaboration than we had previously enjoyed. The continued funding of four of the five Georgia HS sites permitted long-term relationships to develop, and the small and large collaborative acts among the four were enhanced. HGHSC becoming and maintaining its position as a United Way agency opened some additional collaborative opportunities locally. The increasing demand by funders that organizations be connected with a community consortium promoted membership in HGHSC since it was already in place, functioning well, and willing to serve in an advisory capacity to organizations and agencies with compatible goals.

There is no place in the Impact Report Guidance asking for a list of collaborative partners and the results of those collaborations. In the case of HGHSI and HGHSC, that list would be extensive including all three birthing hospitals in the SCHD, the Level III NICU hospital for the region (not located within the project area), Healthy Mothers/Healthy Babies of Georgia, the Family Health Branch of the Georgia Division of Public Health, the Governor's M&I Council, the Rollins School of Public Health at Emory University, March of Dimes, the National Healthy Start Association, La Leche League International, the Georgia Public Health Association, the Georgia Perinatal Association, the Georgia Chapter of the American Academy of Pediatrics, the Centers for Disease Control, several local pediatricians, several local obstetricians, eleven schools, the Parenting Information and Resource Center, Communities in Schools, ten county health departments, several Healthy Start sites, Mercer University School of Medicine, local Title V and Women's Health, the Tobacco Free Dublin/Laurens County, the Georgia SIDS Alliance, state and local WIC, Stepping Stone (the local Child Advocacy Center), Teen Court, the Georgia Children's Trust Fund, MELD, all seven Family Connections in the project area, local United Way, several churches, TV 35, the Courier Herald, Medicaid, DFACS, the local Salvation Army, and the Child Care Resource and Referral.

There are finite limits on time and funds that allow HGHSI to collaborate with other agencies and organizations. Those limits can be stretched by smart planning and mutuality of collaborative commitments, but they cannot be exceeded.

## **I. Core Systems-Building Effort: Sustainability**

### **a. Sustainability: Decision-Making about Approaches**

Decisions about what aspects of HGHSI and HGHSC to seek sustainability for are in the hands of the coalition, particularly the Executive Committee, Executive Director, and the Sustainability Committee, with input by consumers, the rest of the coalition, and HGHSI staff. Community needs assessments, assessment of what other organizations, agencies, and providers are already

doing well, assessment of perinatal statistics, current evidence-based practice, and assessment of the capabilities of HGHSI and its collaborative partners under various funding scenarios are used to make those decisions. Consumers often base their recommendations on the ease or difficulty they have in obtaining various services and resources they know are critical to their family's well-being, the success of their family and their community in responding to situations involving preventive and problem-related health and social services, and major issues in their family and community, such as the death, illness, or developmental difficulty of a baby they know. Many consumers have strong and valuable opinions about what will improve the health of infants and families, and HGHSI and HGHSC include those opinions in planning for sustainability as well as program planning.

Choosing the course of sustainability requires an active approach and cultivation of contacts who will share information about possible resources. HGHSC remained active in promotion of HS at the national level (through annual educational visits to Capitol Hill, approximately monthly contact with our Congressman's staff, and letters as needed) and components of HS at the state level (through statewide organizations such as Healthy Mothers/Healthy Babies and directly through contacts with legislators and our liaison with the Family Health Branch, Division of Public Health, Department of Human Resources). HGHSI and HGHSC continued throughout the funding period to be alert to opportunities to fund the project in the future through Medicaid reimbursement for services rendered to improve the health of infants and families. Statistics about the decrease in significant and costly health events among HGHSI Program Participants compared to unenrolled women and infants have been analyzed and presented. Collaborative partners have helped attach dollar amounts of savings to these improved outcomes.

In addition to promoting the continuation of adequate federal funding of HS, constantly working to provide and document an excellent perinatal health care program that is worthy of continued HRSA funds, seeking stable funding through Medicaid reimbursement, and promoting components and the whole HGHSI program in the state, the HGHSC Sustainability Committee chose specific projects needed to meet community perinatal health needs, such as a father support and education group, additional SIDS risk reduction education for the African American community and day care providers, a workplace parenting education and support program, stress reduction for pregnant and interconceptional women, and training for health care providers about current topics in perinatal care. Funds from state and local organizations such as March of Dimes, Children's Trust Fund, United Way, the Department of Agriculture WIC Program, and the Family Health Branch were obtained to maximize the impact of HGHSI.

**b. Sustainability: Identify the Components, Resources, and Changes Needed for Implementation**

The components of sustainability necessary for implementation included clearly delineated responsibility for sustainability (HGHSI Project Coordinator, HGHSC Executive Committee, and HGHSC Sustainability Committee), a plan for sustainability, and a team able to respond to opportunities and requirements as they arose. The resources necessary were assistance from HRSA and collaborative partners in identifying funding sources, maintenance of local and project statistics to support applications, and the assistance of state legislators and Members of Congress. Obtaining grant funding and in-kind assistance, the sources of income for HGHSI, require the willingness to make any changes needed to offer the services and meet other deliverables required by the funding source. These have included major changes in data collection and evaluation during the reporting period as well as the addition of responsibilities for all staff.

**c. Sustainability: Resources or Events that Facilitated or Detracted from Successful Initiation and Implementation**

Medicaid reimbursement has been raised with the Department of Medical Assistance (DMA) at the state level, the Division of Public Health, state legislators, and our Congressman. HGHSI and HGHSC sought guidance from experienced state personnel, attended national conferences to learn more about how to approach the issue, and discussed the issue with other Georgia HS sites and organizations. The failing economy during the reporting period (which may be correcting itself as the reporting period ends), the rising costs of Medicaid and the resultant public demand for reining in those expenditures, the difficulty of getting a Medicaid provider number for a federally funded HS program in Georgia because no one in DMA can clearly state whether the funding stream of Medicaid is such that this would constitute “double-dipping,” and lack of legislative mandate for reimbursement of services peer counselors have been major impediments to sustainability based on fees for services rendered or contracts for reimbursement for rendering services to groups of eligible women and infants.

The continued funding of Healthy Start by Congress has been the event that has most positively impacted HGHSI sustainability. The availability of smaller but significant funds from other agencies through grants has also been important. Expressed interest in HGHSI and its results at the state level offer possibilities that extend beyond the reporting period.

**d. Sustainability: Additional Elements**

**1. Sustainability: Managed Care Organizations and Third Party Billing**

This issue was also discussed in Sections II.H.a, II.H.b, II.H.c, and II.H.d above. HGHSI continued to seek opportunities to bill for services

covered by Medicaid such as case management. So far every attempt has been blocked, and additional requests for discussions were tabled due to the dismal status of all Medicaid reimbursement in Georgia in the last three years and the eminent change to HMO Medicaid coverage in the SCHD. After the HMO Medicaid change occurs, talks can be reopened. Based on HGHSI's track record with fewer LBW/VLBW babies among the highest risk Medicaid recipients, there is a financial incentive for the HMOs to discuss including HGHSI in care plans for those women. Managed care for Medicaid, which provides coverage for the majority of our participants, is slated to be instituted in the SCHD after the reporting period. Therefore, it was not an issue relative to sustainability during the reporting period. HGHSI made a few small contracts for health education with businesses, but there were never any arrangements made with managed care for privately insured participants for any HGHSI services due to the multiplicity of coverage and the small numbers of participants who would have been covered. Third party billing for insured participants was not instituted because of the small numbers and the lack of coverage by private insurance companies in this area for perinatal outreach, case management, health education, or depression screening and referral. HGHSI does not provide interconceptional care services such as family planning that are covered by Medicaid and private health insurance companies.

HGHSI has worked and will continue to work with the FHB and the other Georgia Healthy Start sites to determine how to obtain 3<sup>rd</sup> party reimbursement for services by nurses. (Reimbursement for peer counselors is not currently available by law in Georgia.) The Project Coordinator of HGHSI has written a four-page report on the process and future expectations. This has already been provided to HRSA. The Georgia Division of Medical Assistance has not been able to provide clarification during previous contacts. Plans for a meeting between the state Medicaid Director and the Healthy Start sites have been postponed due to the current state budget cuts. The coalition discussed the issue with three aides to our congressman, Rep. Jim Marshall, and provided them with information about other states where such reimbursement to federally funded programs is allowed. The HGHSI Project Coordinator has attended previous HRSA-sponsored 3<sup>rd</sup> party reimbursement conferences. HGHSI is prepared to begin billing as soon as the state permits us to have a provider number. However, financial data related to services and charges by other public health nurses in this area indicate that a program of this intensity cannot be supported fully on the reimbursement that is anticipated. Private insurance coverage is uncommon among HGHSI Program Participants, so such reimbursement is not expected. Mentoring/training reimbursements for non-Healthy Start program funded recipients are not expected to be available.

**2. Sustainability: Resources to Continue Key Components of HGHSI Interventions without HS Funding**

This issue was also addressed in Sections II.H.b and II.H.c above. HGHSI and HGHSI approached sustainability from several directions: excellence of implementation of the project in order to continue Healthy Start funding, additional grants to provide activities that cannot be included in the budget allotted by HRSA, attention to 3<sup>rd</sup> party reimbursement opportunities, demonstration of successful perinatal health strategies to the State Division of Public Health, small money-earning projects (such as the Baby Registry for baby showers and health promotion jewelry sales) that increase community awareness of perinatal health while generating some funds, and sliding scale fees for some aspects of the program such as breastfeeding accessories. The applicant agency and other providers and entities in the SCHD will be able to continue some elements of the project when HRSA funding of HGHSI ends. The health departments will continue to provide Perinatal Case Management (PCM) and Pregnancy Related Services (PRS) in the same format as HGHSI nurses but to a smaller number of women and with a decrease in home visits. Family Connections in some counties will continue to provide Targeted Case Management (TCM), which has some elements of Healthy Start case management but lacks the health assessment and education components. Breastfeeding promotion and assistance will continue in the WIC clinics (including the 6 new breastfeeding peer counselors funded by WIC and currently supervised by HGHSI lactation nurses), by La Leche League, and by hospital and physician staff trained as Certified Lactation Counselors (CLCs) during Healthy Start's tenure here. Parenting education will continue to be provided by Stepping Stone (the Child Advocacy Center), some Family Connections, and some DFCS agencies, although the content and approach differs from that of HGHSI parenting education. Childbirth education classes will continue at one hospital, several doctors' offices, and one health department. Perinatal depression screening and Fresh Start Family smoking cessation interventions will continue by health departments and by private providers, but the level is expected to fall off due to lack of constant encouragement. Some committees of the consortium will dissolve, while several (Women's Health, SIDS/Infant Safety, Breastfeeding, and Tobacco Use Prevention/Smoking Cessation) can be expected to continue in some form, though not necessarily within one perinatal consortium.

Both the project and the consortium strongly believe that in the absence of an economic turn-around resulting in better funding of Title V in Georgia with an opportunity for the FHB to fund Healthy Start sites in several communities in Georgia, loss of HRSA Healthy Start funds would eliminate some of the best parts of the program, such as the HSAs, and adversely impact provision of all services, particularly home visits, health education, and lactation services.

Previous grant funding successes were noted in Section II.H.b above. HGHSI and HGHSC have continued to search for and pursue other grant opportunities. Most recently HGHSI and HGHSC successfully applied for a state Loving Support breastfeeding peer counselor program. The coalition is also exploring grant opportunities with local charities and organizations for the program for young fathers.

### **3. Sustainability: Ability to Overcome Barriers or Decrease Their Negative Impact**

Sustainability is a difficult issue. Healthy Start (HS) at the national level exists because there was previously no other federal funding available to decrease infant mortality and eliminate perinatal health disparities through community-driven approaches that work well in high-risk groups. Elimination of the federally-funded HS initiative, absent a mandate for states to continue funding of such projects through Title V, HMOs, SCHIP, and/or traditional Medicaid, would likely result in loss of most of the functions of the program and loss of ground in perinatal health parameters.

The major barriers HGHSI and its advisory coalition, HGHSC, identified during the reporting period to sustaining HGHSI functions without HS funds are 1) lack of state funds ear-marked for that purpose (including lack of Medicaid funding throughout the reporting period and significant uncertainty about the effect of HMO Medicaid on such reimbursement possibilities after it is instituted later this year), 2) lack of time, reimbursement, and commitment by health care providers, and 3) continued insufficient understanding by policy-makers and the community of the effectiveness of preventive health measures in addition to traditional prenatal medical care and well baby visits, especially among higher risk populations.

HGHSI and HGHSC have been chipping away at the last issue (policy-maker and community awareness of the broader meaning and effectiveness of perinatal health care and education for self-care). Private providers have been the recipients of both formal and informal training in adding certain perinatal health care and education topics into their usual care model. Reimbursement for private providers to be able to offer more extensive health education and other services is similar to the issue HGHSI faces about Medicaid reimbursement. Contraction rather than expansion of covered services has been the trend throughout the reporting period. HGHSC has continued to educate state policy-makers about the need for community-based perinatal health programs, but money has been very tight during the reporting period. Specifically, HGHSI was unable to solve the problem of Medicaid reimbursement for

services during the reporting period. HGHSI and the other Georgia Healthy Start sites have an excellent relationship with the Family Health Branch (FHB), but the FHB does not have funding allocated to support even the four current Healthy Start sites, let alone increase that number to provide such interventions in all the communities who demonstrate a need.

HGHSI and HGHSC are working toward making perinatal depression (PD) screening and referral universal in the SCHD. If the private physicians and the HMOs buy in, this piece of HGHSI's services could be preserved. The PD, mental wellness, and stress management classes and support groups HGHSI's MSW offers would likely not be duplicated for low income, higher risk mothers because the connections among stress, depression, preterm delivery, infant well-being, and increased health care and social costs seem to be largely unrecognized in the insurance/HMO and medical communities.

If HS funds were eliminated in the SCHD, we can only hypothesize what will happen, particularly since Medicaid changes are coming soon but are not yet defined. Depending on the upcoming design of HMO Medicaid care for woba, pregnant women, and infants and the contracts that are made, public health nurses may continue doing Perinatal Case Management (PCM) and Pregnancy Related Services (PRS) which would allow some women and infants to be served by nurses in a manner similar to HGHSI case management. HMOs might also hire their own nurses to provide PCM/PRS-type services. From HGHSI's point of view, that would be a smart, cost-effective move on their part. Family Connections can be expected to continue to offer, as grant funds permit, a more education and social service type of case management (as opposed to the health assessment, education, intervention, and referral case management offered to HGHSI participants) for some sub-groups of the HGHSI target population. Health education will be spotty without HGHSI. Parenting education will be offered by some county DFACS, PIRC (Parenting Information Resource Center), and some Family Connections. Perinatal outreach has never been funded well in Georgia. Most programs have been dependent on self-referrals by women and referrals to health and social services by family and friends of woba.

Use of individual additional grants and specific funding assistance for mutual projects by the Georgia Family Health Branch (state Title V) increases the impact of HGHSI on perinatal health in the community but does not address sustaining the level of outreach, paraprofessional peer and professional case management, health education, interconceptional care, and depression screening and referral that HGHSI currently provides. HGHSI alone does not have the political muscle or resources to overcome the barriers discussed.

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

#### **A. Structure of Project Management**

HGHSI management was the same throughout the reporting period. The Executive Director of HGHSI was Jannell Knight, MSA; the Project Coordinator (responsible for daily management for HGHSI) was Margaret Turner; the Administrator was Wanda Brantley; and the Outreach and Education Coordinator was Priscilla Adams, MEd. The Medical Director for the grantee, the Laurens County Board of Health/South Central Health District, was Lawton Davis, MD. These positions have continued into the new grant cycle, giving HGHSI significant stability and increased credibility when establishing collaborative partnerships.

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

A major was the close relationship between public health (the grantee) and HGHSI (the project). Public health nurse training and other initial and continuing education offerings for HGHSI staff have increased their knowledge base, improving care for case managed clients. The placement of staff in all ten county health departments for portions of each week have increased access to potential participants, allowing staff the opportunity to meet and assess large numbers of women who have self-referred for WIC, Medicaid assistance, family planning, and other services for low income families. The SCHD was able to provide sound fiscal management with many years of experience with large grants and the use of good policies. A community-based initiative such as HGHSI requires flexibility and community input that is not always present in established state and local public health systems. In order to have the flexibility and community involvement necessary to succeed, HGHSI depended on a combination of the input of HRSA (requirements for grantees carry a lot of clout), the willingness of individuals in positions of authority to listen well and be persuaded, and the changing thinking nationally about what works in perinatal health and community health in general. HGHSI has worked with Healthy Start sites with ties to smaller or to non-governmental entities that have also succeeded well in their management, but this strong and direct relationship with public health has been highly effective for HGHSI.

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

There was no significant change in management and governance during the project period. Key personnel remained the same. Basic duties remained the same, although details shifted as the needs of the clients and community were further refined. The general assessment is that the management and other staff began the four year period at a capable and knowledgeable level and matured even further over the four years in their ability to manage and implement the project, a natural and welcome effect of additional experience with the unique abilities and requirements of a community-based initiative.

#### **D. Process of Appropriate Distribution of Funds**

HGHSI was first funded in October 1997. At that time, fund distribution was made a function of the experienced SCHD Administrator and her staff. This dependence on solid policy and accurate accounting with multiple checks continues into the 2001-2005 funding period. All the rules set in place by the State of Georgia to govern distribution and record keeping related to grant funding were utilized. External audits, clear records related to contracts and receipt of deliverables, and other standard mechanisms were important to demonstrating on-going sound fiscal policy. Additionally, HGHSI implemented careful hand checking by knowledgeable members of the management staff of hours, travel, and expenditures in each budget area compared to the submitted budget.

#### **E. Additional Non-HS Resources Obtained for Management and Governance Functions**

HGHSI utilizes in-kind management and governance assistance from the grantee, the Laurens County Board of Health, South Central Health District (LCBH/SCHD). The Medical Director for the grantee and the Executive Director of HGHSI are fully paid by non-HS resources. Members of HGHSI offer advisory and oversight functions as volunteers and/or as in-kind contributions of their employers.

### **IV. Project Accomplishments**

#### **A. Major Strategies, Goals, and Accomplishments**

The major strategies, goals, objectives, and accomplishments for this period are detailed in Appendix A as per the format provided by HRSA.

#### **B. Mentoring and Technical Accomplishments**

HGHSI did not receive any formal mentoring or technical assistance from another HS site during this four-year period. The project also did not give any formal mentoring or technical assistance to another site. Informal mentoring and technical assistance are a frequent and highly effective mode of interaction for HS sites. The Georgia sites in particular stay in contact and mentor and support each other, sharing information and resources.

### **V. Project Impact**

#### **A. Systems of Care**

##### **1. Approaches Utilized to Enhance Collaboration**

Approaches to enhance collaboration are also discussed in Section II.H.

The development of a strong perinatal consortium (Heart of Georgia Healthy Start Coalition) was the primary tool for enhancing collaboration. Several other approaches were highly effective. The use of Memoranda of Agreement (MOAs) allowed for the clear definition of deliverables collaborative activities. Developing professional relationships with both directors and staff members of collaborative agencies increased communication and more opportunities to work together effectively appeared. Many collaborative projects were built on the foundation of previous successful collaborative activities. The extra effort it takes to exceed expectations and develop a reputation for responsiveness and meeting deliverables pays off later. HGHSI and HGHSC give all proposed collaborative perinatal projects careful consideration and the answer to requests for project or coalition participation, with modifications suggested as necessary, is often affirmative. HGHSI staff serve on interagency councils such as the Governor's Maternal and Infant Council, the Babies Can't Wait Local Interagency Coordinating Council (Children with Special Needs), and the Child Abuse Council.

## **2. Structured Changes for the Purpose of System Integration**

As noted in Section V.A.3.a.paragraph 4 below, mutual referral forms between HGHSI and other providers, agencies, and organizations have been in place for several years. There has been a structured change in the relationship of HGHSI/HGHSC and state Title V due to the assignment of a liaison from the Family Health Branch who serves on HGHSC and maintains two-way communication and collaborative projects between state Title V and HGHSI/HGHSC. HGHSC members assisted substantially with the most recent Needs Assessment for the Maternal Child Health Block Grant. Prior to HGHSC's involvement, most input came out of Atlanta or other population centers. The systematic inclusion of rural input led to consumer focus groups in very rural areas of HGHSI's project area. HGHSC recruited participants and FHB conducted the focus groups in order to better reflect the MCH needs of the whole state.

Another example of system change is the relationship of the Level III NICU serving the Region and HGHSI. The Neonatal Outreach Coordinator and the Maternal Outreach Coordinator for the Region Level III hospital and NICU are members of HGHSC. This allows better coordination of perinatal health provider education in the area as well as more seamless care of high-risk infants (HGHSI in the community before birth and after NICU discharge).

HGHSI staff have cross-trained with Children with Special Needs staff so that HGHSI staff perform Children's First Assessments on their own Program Participants, smoothing the path into care for children who may have Special Needs. The Outreach and Education Supervisor of HGHSI sits on the Babies Can't Wait Interagency Council for staffing of babies and their families each

week. This assures that HGHSI babies receive needed Special Needs services and that HGHSI serves as the case management team as appropriate for babies (and their families) who have been screened for Special Needs.

Parenting classes in several counties have become more integrated among agencies, with one agency (Healthy Start or a collaborative partner such as Family Connections, DFACS, or Parenting Information and Resource Center) acting as the lead agency and the others contributing speakers, meeting locations, transportation, outreach, etc. Family Connections/Healthy Start partnerships have contributed to this community education cooperative effort as well as a number of other projects that promote perinatal health and social service integration in the SCHD.

Breastfeeding policies and procedures are more standardized across the project area in a variety of provider types. HGHSI and state WIC funded training of twenty-five providers as CLCs, including physician's office staff, hospital staff, health department staff, and HGHSI staff. These Certified Lactation Counselors took standards for care of pregnant women and breastfeeding women and infants back to their respective practices, agencies, and organizations.

### **3. Key Relationships that Developed as a Result of HGHSI**

#### **a. Relationships among Health Service Agencies, Health and Social Service Agencies, and with Community-Based Organizations**

These relationships are also discussed in Sections II.G and II.H above.

HGHSI's grantee organization is local public health, so there are written policies and procedures for provision of HS services within the health departments and in collaboration with local Title V, WIC, and Title X. HGHSI maintains close contact with both management and individual staff members in the health district and at all ten health departments, allowing for informal communication and coordination in addition to the formal lines of communication. It has developed into an excellent system.

An example of the positive working relationships among health service agencies is the WIC Peer Counselor Program instituted during the reporting period and currently ongoing. HGHSI prepared the grant application in collaboration with local WIC for five new WIC Peer Counselors provided through the Family Health Branch of the Georgia Division of Public Health (State Title V and State WIC). The WIC Peer Counselors are based in health departments, are supervised by HGHSI staff, and work with WIC Clerks and Nutritionists. This type of smooth coordination is the result of 8 years of collaborative efforts.

There is a formal system of referral between HGHSI and other providers, agencies, and organizations including clearly delineated responsibility for assuring that referrals both to and from HGHSI are received and acted upon. The written referral format was designed during a previous reporting period and continues to be utilized.

HGHSI shared personnel with the largest Family Connection (community-based organization) in the area for a portion of the reporting period, and Family Connection continued to provide office space for an HGHSI staff member. HGHSI and the Teen Youth Issues Committee of HGHSC collaborate with Communities in Schools (community-based organization) and local schools to provide teen programming that promotes life goals for family, education, and career. Another example is TeenAge Mothers Succeeding (TAMS). The lead agency for this support group for teen moms is the HGHSC Teen Youth Issues Committee which worked with Stepping Stone (community-based child advocacy center), Family Connection, and the Laurens County Health Department. “I’m A Mom, I’m a Dad” is a project of the Laurens County Family Connection with a number of collaborative partners including HGHSI and HGHSC. “I’m a Mom, I’m a Dad” has created a resource matrix defining what resources teen parents need within the community to parent successfully and have a safety net for themselves and their children. Agencies and organizations have identified which of these resources they provide. Empty cells in the matrix are tagged for community response to design a way to provide those services.

**b. Relationships that Focus on Involvement of Consumers and/or Community Leaders**

These relationships are also discussed in Sections II.G.d.6, II.G.d.8, and II.I.a.

The valuable role of consumers has been strongly promoted by HGHSC among the members of the coalition and between HGHSI and other organizations. Significant support for involving consumers was found among the Family Connections, all seven of whom are members of HGHSC now. HGHSC has requested and received the support of both the State Representative and the U.S. Congressman for the project area. One of the Congressman’s aids attends most HGHSC meetings.

**4. Impact of HGHSI on Comprehensiveness of Services**

**a. Eligibility and/or Intake Requirements for Health or Social Services**

As described in Section V.A.2, HGHSI staff have been trained by Children with Special Needs to complete Children’s First Assessments on infants enrolled in HGHSI or being assessed for eligibility to be enrolled in HGHSI.

Because an HGHSI staff member attends weekly staffing for Babies Can't Wait, mutual referral is rapid and requires no additional appointments for the mother and baby.

The presence of HGHSI has meant that there were four additional public health nurses doing PRS and PCM for women and infants in the SCHD. HGHSI limited themselves to women who met the eligibility requirements for HS, but providing this service for all the women in the caseload freed other public health nurses to offer PRS and PCM to women and infants not enrolled in HGHSI, thus increasing the total numbers served and decreasing the number of women and infants who failed to receive these services.

**b. Barriers to Access, Service Utilization, and Community Awareness of Services**

Major barriers to access to health care for woba and their infants in the project area included lack of outreach, transportation, and failure of woba to recognize the need for services or identify resources to meet perinatal health care needs. HGHSI has impacted each of these areas.

Woba at high risk for poor outcomes may fail to self-refer for perinatal health care for a variety of reasons, including family and peer dynamics, lack of knowledge about their bodies, lack of knowledge about the impact of health care and self care, drug abuse, mental health issues, domestic violence, a history of child abuse, lack of transportation, lack of a phone, and fear of the unknown. Outreach to women who are isolated by lack of transportation or modern communication, abuse, youth, and all the other reasons cited requires trained and experienced outreach workers who know the teens and the trailer parks and the housing projects and the back roads in their area. An understanding of who holds the power in a family and how to assess which approaches will work is vital. HGHSI staff have been honing these abilities for several years.

Once pregnant or interconceptional woman is identified and convinced that health care is needed, the process of identifying her personal barriers to understanding which perinatal health and social services she needs, accessing them, and effectively utilizing the services offered to achieve a positive perinatal outcome. Appointments are made, but instruction on how to choose a provider of a service, make the call, negotiate time off from work or school or childcare duties, and actually get there are taught. A great deal of HGHSI staff time is spent in these activities with participants.

HGHSI and HGHSC have not been able to solve the transportation issue for participants, but HGHSI staff have become more adept at helping women access the few transportation services available, be creative in finding rides,

and remain convinced that perinatal health care and social services are worth the effort. HGHSI staff also intervene when health care providers fail to understand the reasons for failure to show on time or at all for an appointment. HGHSI serves as a reality check on this issue for providers of health and human services as well as educating families so they are more motivated to meet providers' expectations.

Access to mental health services deserves specific mention. Services are slim in this rural area, but an even greater issue has been failure on the part of everyone (including, initially, HGHSI) to realize the scope and impact of mental health issues among woba. HGHSI has always accepted very high-risk mentally ill women for case management, but the onset of routine PD screening and exploration of the relationship issue of stress and perinatal morbidity and mortality has revealed an unseen world. The confounding factor is that not only have we providers failed to appreciate the realities of mental wellness and illness, but women themselves often do not identify a treatable problem. "Stress-out" is just a phrase with no real self-assessment and usually no effective self-care or self-referral for professional assistance. "I don't feel like myself," "if I could just sleep," and other phrases fall from women's lips like rain, but no one has been saying to the disadvantaged population who hear about Andrea Yates on TV but don't read Brook Shield's book: "There's help. There are things you can do." After instituting PD screening of all Program Participants and initiating programs to help pregnant women identify, change, and rethink the stressors in their lives, HGHSI has found a new critical piece to health service access and utilization.

**c. Care Coordination including Mechanisms to Assure Continuity of Care, Quality Improvement, and Follow-Up Systems for Client Referrals**

HGHSI has focused on this area throughout the reporting period. The basics for continuity of care, quality improvement, and follow-up for referrals have been in place, but these are critical issues, so HGHSI continues to plan and implement improvement. HGHSI Program Participants have one staff person who is responsible for coordinating their care. This staff person deals with issues related to lack of continuity by other providers and agencies. Within HGHSI, there is a plan for each participant's care in the event that an HGHSI staff person resigns. Quality improvement is an internal HGHSI issue (discussed in a number of sections) as well as a systems issue and an individual issue for each participant relative to her other providers. The rural nature of the area facilitates the simple expedient of contacting the provider when a necessary element of care is missing. Education of participants helps them ask questions and request services. Follow-up for referrals is not just a simple question of whether the participant actually received an appointment and went to it. The case manager also wants to know what was done for the

participant, were her questions answered or does she still have questions, when should she call for the results of any tests, and did she understand what was said to her about how she should care for herself, the decisions she needs to make, or the next step in her care. This is real follow-up.

**d. Efficiency of Agency Records Systems and Sharing of Data across Providers**

HGHSI case managers have complete has access to health department and WIC records on their Program Participants. Because the grantee is public health, there is no violation of HIPPA, although participants are notified. HGHSI staff have access to a summary of prenatal care records, labor and delivery records, and nursery and postpartum records at each of the three birthing hospitals during the participant's hospital stay. During the reporting period, no other data sharing was available without a specific release from the participant.

**5. Impact on Enhancing Client Participation in Evaluation of Service Provision**

**a. Provider Responsibility for Maintaining Client Participation and Provider Sensitivity to Cultural, Linguistic, and Gender Needs of the Community**

HGHSI has raised the issue of provider and client/patient responsibility for maintaining client/patient participation by designing policies that both place a responsibility for follow-up with the case manager and promote a desire to maintain contact in the client and the family. The HGHSI case manager's responsibility more resembles that seen in some social services than the traditional medical model of patients being wholly responsible for seeking initial and follow-up care for themselves and their children. Close relationships involving frequent planned contact initiated by the case manager, two-way communication, active listening, and client assistance in designing care plus a non-cash Incentive Program increase the willingness of Program Participants to stay in contact, although case managers note that not all participants maintain contact even with these incentives in place. However, few physicians or hospitals offer any provider-initiated contact, and HGHSI's approach has not spread. The exception is the Outpatient Surgery Department at one of the hospitals which initiates contact with patients, but this affects only a few HGHSI Program Participants. The Targeted Case Managers at Family Connections, collaborative partners, also take responsibility for follow-up.

HGHSI, HGHSC, and the grantee, LCBH/SCHD take sensitivity to the individual cultural, linguistic, and gender needs of the community seriously. The grantee instituted a program called Language Links to serve the Latino

and Latina population in the SCHD. HGHSI provided funding to train an instructor for professional medical interpreters. HGHSI employs staff from the community, meeting needs for cultural appreciation and understanding not only on racial line but by SES, Southern or other regional heritage, and individual differences within groups. HGHSC's Men to Men Committee was initiated to assure that attention is paid to men's perinatal issues.

**b. Consumer Participation in Development of Assessment and Intervention Mechanisms and Tools**

The major participation by consumers in the development of assessment and intervention mechanisms has been by the HSAs, once consumers themselves and consulted on all assessment and intervention tools. Some additional consumers had input through their participation in HGHSC on the PD Screening and Referral tools and policies, which were developed in the Women's Health Committee.

**B. Impact on the Community**

**1. Residents Knowledge of Resources and Services**

Both formal Program Participant surveys and informal information from consumer advisory groups and Healthy Start Advocates indicate that consumers and their families and friends have a greater knowledge of resources and services available and a greater sense of competency about accessing those them. For 2001-2004, 98.2% of Program Participants indicated in an exit survey that after participating in HGHSI, they know more about programs in the community available to help them.

**2. Consumer Participation in Establishing or Changing Standards and/or Policies**

Healthy Start Advocates and a few other consumers intensely involved with the consortium were the only consumers who participated directly in changing standards and/or policies. These included perinatal depression screening and referral policies, breastfeeding policies at hospitals, and a policy allowing WIC certification in the hospital prior to discharge.

**3. Community Experience in Working with Divergent Opinions, Resolving Conflicts, and Team Building Activities**

HGHSC and HGHSI did not directly address this issue during the reporting period. An upcoming Community Forum is intended to incorporate aspects of this. Consumers employed due to HGHSI participate in formal team-building activities twice a year and are mentored on dealing with divergent opinions

and conflict resolution on an ongoing basis. Consumers who attend HGHSC meetings also receive ongoing training in these areas.

#### **4. Creation of Jobs within the Community**

HGHSI created 14 paraprofessional positions for members of the community. Seven of those positions were created in a prior funding cycle and continued throughout the reporting cycle. Seven were newly created during this reporting period. Six of the seven new positions continued through the end of the reporting period, while one that was funded by a separate grant which has since ceased funding positions for all grant locations.

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

HGHSI's innovative approaches to perinatal health have come to the attention of management in the Department of Human Resources, Division of Public Health. The Needs Assessment for the Title V block grant for Georgia looks different because of input from HGHSI, HGHSC, and SCHD consumers. The FHB has collaborated with local HS sites to provide regional perinatal health conferences around the state, The Governor's M&I Council, due to the Project Coordinator serving on it, has had the benefit of both the rural perspective and astute observations about how HGHSI's successes actually apply to urban and suburban perinatal health.

The Family Health Branch successfully applied for an Obesity Grant from the Center for Disease Control (CDC). HGHSI's Project Coordinator serves on the Planning Committee, providing both technical expertise in topic areas and a perspective on how to implement obesity prevention programs in less densely populated areas. This is an example of how the state has been enriched by additional views and assistance due to the presence of HGHSI and the other three HS sites.

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

The local State Representative has been interested and available to HGHSC to discuss issues and policy. He has been present for site visits and spoken at annual meetings. His greatest interest as a legislator has been education, and he sees the connection of healthy babies to curious, capable children and an educated citizenry.

The mayors of every town in the ten county project area signed a proclamation for Georgia Breastfeeding Month in May 2005. The ability to place an item on the city council agenda with the word breast in it has been a learned skill among these Southern men (currently all male mayors), and it is a reflection of the education they have received from HGHSC members and HGHSI staff about perinatal issues and their impact on their constituents.

Members of the Tobacco Use Prevention Committee of HGHSI lobbied hard for a law in the City of Dublin protecting women and fetuses from ETS in the workplace and women, infants, children, and fetuses from ETS in public places. They also were part of a successful statewide effort to protect the public from ETS, decreasing the amount of exposure of pregnant women and their fetuses to second-hand smoke and thus decreasing the risk of preterm labor.

#### **E. Lessons Learned**

Limiting this section to a few carefully distilled areas is a challenge. There has been a lot to learn.

Continuity of presence and services is important to the whole community. Consumers are accustomed to private organizations and public agencies that have funding now and not next month or with the next baby. Private physicians and hospitals count on a few long-term programs like Medicaid and WIC. Almost everyone else seems hardly worth the effort to get to know. HGHSI has been in this community for eight years (1997-2005) after four years of ground-laying work by the consortium (1993-1997). Twelve years of meeting or exceeding expectations, avoiding wholly dropping a program or service, expansion of services, and steady presence by staff and coalition members, there is some expectation that HGHSI is here for the long haul for families and providers. This kind of continuity is a must.

Collaboration is absolutely critical. It requires some amount of labor or resources with which to assist one another in achieving similar or identical goals. It also requires astute negotiation for a win-win situation. Not every offer of collaboration can be used because the goals are dissimilar or the activities would drain too many resources needed elsewhere, but adjustments are often possible to allow even small collaborations to be successful for improving the health of women, infants, and families.

Developing a reputation for caring, capability, and responsibility requires hard work and consistent effort. There must be a willingness to be honest with consumers, providers, and collaborative partners about what the mission is and what piece of the world's work your organization has taken on. An ability to honestly assess assets and available resources of time, money, and human talent is necessary in order to avoid breaking promises.

Intensive one-on-one relationships with knowledgeable, caring, culturally-appreciative case managers and health educators impacts outcomes for women and families. Group support is also important to many but not all women.

Not all perinatal health problems are amenable to solving with the resources available to community-based organizations. However, the corollary is that not all

perinatal health problems are amenable to being to being solved by large governmental or private entities. One size cannot fit all communities. Providing funding for a Healthy Start site or providing a user-friendly transportation system might be projects for state or federal government. Determining what user-friendly transportation looks like in a specific community is better handled by a community-based consortium.

Data collection is an ongoing challenge. HGHSI recommends getting professional assistance and asking other similar programs for copies of their data collection tools before designing a version that fits HRSA requirements and the individual project's needs. Prepare staff for changes in what must be collected, then use data collection and analysis as a springboard to better service provision.

## **VI. Local Evaluation**

The Local Evaluation was prepared by the Local Evaluators of HGHSI from the Rollins School of Public Health at Emory University in Atlanta, Georgia, John Carter, PhD, and Jill Andrews Davis, MPH. It has been placed in Appendix B.

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

There is no FIMR in the SCHD. FIMR is discussed in Section II.F.c.

## **VIII. Products**

Copies of materials produced are included in the box containing the paper and disk copies of this Final Impact Report.

## **IX. Project Data**

Forms 1, 5, and 9 and Tables A, B, and C have been included in Appendix C. They include data from all four years except for those years when a specific data element was not identified by HRSA as being required during that year.