

## **I. OVERVIEW OF RACIAL AND ETHNIC DISPARITY FOCUSED ON BY PROJECT**

Augusta-Richmond County is a mix of urban and rural development, with high poverty, low educational levels and other problematic demographics and poor birth outcomes. These issues/problems impact on the children and families in the community and thus the overall community.

With regards to

- Poverty, it was estimated in 1999, that 21.4% of the county's total population and 32.6% of children below age 17 lived below the poverty level (Georgia Department of Community Affairs). When broken down by race, an estimated 29.7% of African Americans and 9.7% of whites lived below the poverty level.
- Low education levels, in 1990, 9.3% of white adults (age 25 and older) had less than a 9<sup>th</sup> grade education, while 17% of African American adults had not finished ninth grade. The percentages of those adults not completing high school were 23.2% for whites and 38.8% for African Americans.
- Other problematic demographics, note that
  - the average income, based on 1990 census data, was \$23,497 for all families in the county.
  - a survey in 2000, estimated that 4,300 people were homeless and an additional 43% of the 44,639 people lived in substandard housing. In addition, there were 2,253 female-headed households and a total of 26% of the children under the age of 18 living in households with incomes below 185% of the federal poverty level.
- Poor birth outcomes, a review of local perinatal health indicators illustrated disparities in perinatal outcomes as well as in the access and utilization of perinatal health services. Vital statistics from the years 1995 through 1999 for Richmond County showed that 45% of the population in Richmond County was African American, and between 1996 to 1998, they accounted for: 52.5% of all live births, 73.5% of births to teens aged 17 and younger, 69.2% of infant deaths, 70.5% of neonatal deaths (28 days or less), 65.4% of post neonatal deaths (29 to 364 days), 69.2% of low birth weight infants, and 71.4% of very low birth weight infants. Over the five-year period 1995-1999, when compared to white babies, African American babies in Richmond County were: 1.6 times more likely to die during infancy than white babies; 1.5 times more likely to be preterm; and 1.9 times more likely to have low birth weight (source: Georgia Vital Statistics). Analysis of the data also showed that these disparities could be linked to race/ethnicity, family economic capacity, levels of formal education, level of awareness of community resources and fragmentation of the community perinatal service delivery system which research indicates are all considered major contributing factors in racial and ethnic disparities in health.

Via the Healthy Start Initiative, the Augusta-Richmond County Community Partnership for Children and Families, Inc sought to address many of these factors.

In addition, the ARCCP's Perinatal Health Education Focus Group, a group composed of consumers, community health educators for various agencies/organizations, hospital MCH personnel, social workers, and school board personnel, reassessed the status of perinatal health education in the community focusing on the appropriateness, availability, accessibility, and affordability services and found that there were persistent systemic issues that needed to be addressed, to include: lack of timely, affordable and reliable transportation; lack of short-notice,

short-term child care,; centralized geographic location of services; service hours that conflicted with work schedules; treatment by personnel which is often less than courteous and respectful; distrust/intimidation by people in the community of the large institutions which serve them; lack of understanding of the need for prenatal care, and perceived reluctance by physicians to accept new Medicaid patients.

As a result of the data and a review of evidence based strategies, the Augusta-Richmond County Community ARCCP for Children and Families, Inc developed an approach that focused on reducing infant mortality and improving perinatal outcomes through: the elimination of disparities in perinatal health related to adverse birth outcomes; enhancement of the community's perinatal service system; routine screening and intervention for depression during and around the time of pregnancy; and promotion of the full concept of interconceptional care (risk assessment, health promotion, and intervention). More specifically, the approach included collaborative development, system changes and family engagement activities.

## **II. PROJECT IMPLEMENTATION**

The Augusta-Richmond County Community ARCCP for Children and Families, Inc implemented five program service models – outreach/client recruitment, case management, health education and training, interconceptional care, and depression screening and referral- as well as four core systems-building efforts. These core systems-building efforts included development of a local health system action plan, consortium building, collaboration and coordination with State Title V and other agencies, and sustainability.

### *1. Core service models*

#### *a. Outreach/Client Recruitment*

The outreach component was designed to integrate client recruitment and retention efforts of outreach workers with case management services provided to program participants thus making them full members of the family services team. The ARCCP's approach to outreach was based on several factors:

- There was no formal system in place to link women and families with community medical and social services.
- Outreach programs that were in existence were program specific and generally targeted a select population or geographic area. In addition, most did not include neighborhood canvassing. None coordinated outreach efforts with other community agencies.
- Community awareness of perinatal health issues and associated disparities was low.

The original approach to outreach was neighborhood canvassing focusing on client recruitment supplemented by a public relations campaign to increase awareness of perinatal issues and the Healthy Start Initiative itself. These approaches were chosen as the most efficient and effective method to recruit clients, educate the public on perinatal health issues, and effect systems change as it allowed us to not only provide general information to the community-at-large but to also target specific messages to specific groups (i.e. women in the preconception phase, high-risk women, perinatal providers, etc).

In the first year of this phase, plans called for the utilization of one (1) Hospital Liaison, an Outreach Manager and four (4) outreach workers indigenous to the Augusta-Richmond County area. Outreach efforts were supplemented by the Public Relations Specialist and ARCCP partners working with women of childbearing age to include pregnant and parenting women. At the end of this phase, through a number of changes described below, outreach efforts were shared between three (3) Family Support Workers assigned to the case management team and the Outreach/Adolescent Program Manager with support from the Public Relations/Information Specialist and ARCCP partners.

The initial plan included a nurse hospital liaison to recruit clients from two of the major birthing hospitals. This plan was based on a series of meetings held during the planning phase for this grant with personnel from the two hospitals and the Enterprise Community Healthy Start Initiative, whose clients from the outlying counties utilize the Augusta hospitals for delivery. Shortly after funding was received, a second series of meetings were held with personnel from these two hospitals. At that time, due to personnel turnovers at these facilities, new staff were involved in the discussions and felt that the position, as developed, was not needed as they could perform the key elements of the position. As a result, that position was not utilized and converted to a case management position. Over the next three years, this arrangement worked well and in fact, the primary method of client recruitment shifted to hospital staff and provider practices as opposed to neighborhood canvassing. This enabled us to focus our efforts on high-risk women and high-risk infants, eliminate one outreach position and to further integrate the outreach workers into the case management function as required by HRSA/MCHB without adversely impacting client recruitment efforts.

As a result of the above, in Year 02, the outreach workers were moved to the supervision of the Social Services Program Manager and retitled as Outreach/Family Support Workers. This move not only further integrated the outreach workers into the case management team but also allowed us, through shared client responsibilities, to reduce the case managers' case load from an average of 72 clients to the Healthy Start recommended 35 clients for the High-Risk Nurses and 45 for other case managers and outreach workers. A side outcome of this move was less time for neighborhood canvassing. Note that while their primary focus was case management/client support, the Family Support Workers retained outreach responsibilities via staffing of the ARCCP's information and referral line and attendance at community events.

As a follow-on to transferring the outreach workers to the Social Services Program Manager, the Outreach/Client Recruitment Manager was retitled as the Outreach/Adolescent Program Manager with a change in primary focus from coordinating outreach activities to that of community health promotion activities, contract monitoring and youth consortium activities. This allowed us to enhance our community health awareness efforts and develop/coordinate programs to promote healthy behaviors and attitudes among youth in areas of high teen pregnancy.

There were no changes to this component in years 03 and 04. However, in 2004, a Spanish speaking Outreach/Family Support Worker was added to the staff. This individual, of Mexican descent, was not native to Augusta but was able to connect with the Hispanic community, which is predominantly Mexican, and assist the ARCCP in providing culturally appropriate services to this population.

Resources needed to implement this component included staff knowledgeable of the community and its resources, able to relate to community residents regardless of their race, ethnicity and/or socioeconomic status and unafraid to venture into a variety of neighborhoods. In addition, support from perinatal providers was a must. Resources and events facilitating client recruitment efforts included the willingness of the perinatal community to refer their patients to the Healthy Start Initiative and state budget cuts that impacted the health department's grants in aid program. These cuts lead to staff reductions in prevention programs related to smoking cessation, SIDS, and birth defects as well as in areas such as perinatal case management and teen clinics. Budget cuts to the regional perinatal hospital, led to staffing reductions in their perinatal case management program without a concurrent loss of service responsibility and the loss of the Regional Perinatal Coordinator position. The result was increased reliance on the ARCCP Healthy Start Initiative to provide services to pregnant and parenting women and coordinate community systems change efforts.

b. Case Management

The case management component provided coordinated, culturally sensitive services via home visiting and proactive partnerships between case management staff, families, service providers and the community. The ARCCP's approach to case management, which utilized case managers who had degrees and experience in the social services field to provide case management services in concert with other community and local perinatal and case managers, was based on the recognition by staff and partners that:

- Existing community programs did not address perinatal health care issues such as improving access to care, decreasing perinatal disparities, or decreasing infant mortality.
- Case management and social services programs in the community were fragmented and focused on agency specific areas (i.e. child abuse, juvenile delinquency, school failure, etc) and did not take into account the multiplicity of issues that impact families requiring that multiple community systems come together to address these various issues. It was also noted that these programs did not include home visiting and were not coordinated with other service agencies working with the family. Additionally, when the family satisfied the requirements of the agency providing case management to them, services to them were stopped even though there may have been needs in other areas.
- To be on equal footing with other community case managers, case managers assigned to the Healthy Start Initiative needed to have degrees and experiences closely related to those of the community agencies they would be working with.
- Home visiting has been shown, via research, to be effective in addressing a number of psychosocial issues in a family as well as improve child health and development.

Emphasis for this phase was placed on high-risk women and infants based on feedback from perinatal specialists at the Medical College of Georgia (MCG) and perinatal nurses who indicated that high-risk women and parents of high-risk infants had no where to go with questions about how to find needed services, specialized nutritional supplements, and how to access needed social services.

In Year 01 of this phase, staffing included a Case Coordinator Manager, four (4) family case managers, one (1) Nurse Case Manager, one (1) High Risk Care Coordination Case Manager, a consumer advocate, and a social service specialist. As a result of changes noted above, Year 04 staffing included a Social Services Program Manager (retitled from Case Coordinator Manager), the Senior Case Manager, two (2) High Risk Case Managers (both nurses), four (4) family case managers, a consumer advocate, and the three (3) Outreach/Family Support Workers previously listed under the outreach component. The use of Outreach/Family Support Workers to support case managers was based on HRSA/MCHB's promotion of the integration of outreach and case management activities. Locally, it was determined that outreach would provide services to low-risk interconceptional women and their families to allow case managers to see more pregnant women and high-risk infants. The use of nurses as case managers came as a result of increased numbers of high-risk clients being referred by local providers and the Medical College of Georgia, which, through budget cuts, ended up all but eliminating its perinatal case management program.

In Year 02, the Social Services Program Manager assumed supervisory responsibility for the outreach workers as well as the case managers. This change was made because direct recruitment efforts via hospitals and physician offices, precipitated in part by decreased funding to the Regional Perinatal Center and the local health department and the resultant elimination of their perinatal case management programs, were more effective for recruiting high-risk women. These decreases in funding did not change these agencies' mandate to provide perinatal case management services and as a result they turned to the ARCCP Healthy Start Initiative for support. This led to increased integration of outreach/family support workers and case management efforts to provide services to low-risk women and infants and the development of the Associate Social Services Program Manager position, which was later retitled to the Senior Case Manager, to provide administrative and program support to the Social Services Program Manager.

An additional change with regards to direct services was the contracting with and utilization of Resource Mothers within the local health department to provide case management services for 20 pregnant and parenting teens. This was later increased to 40 pregnant and parenting teens. Additional contracts were let with other community group, such as the Links and Good Hope Missionary Baptist Church, to provide case management support for young mothers and teens requiring intensive support that was best provided via mentoring coupled with the traditional case management services. ARCCP partners (i.e. Department of Family and Children Services, Community Mental Health, Salvation Army, etc) continued to provide support to the case management staff and program participants at no cost, incorporating services into their existing programs.

There were no additional changes in subsequent years. Resources needed to implement this intervention and resources/events facilitating the case management component are the same as those listed in the above section on outreach (reference page 4).

c. Health Education and Training

The health education and training component was designed to provide multi-faceted, culturally appropriate activities to increase knowledge and awareness of perinatal issues for the community, program participants, staff and providers. Additionally, through social marketing and health education, this component sought to change individual health behaviors. While the ARCCP had adopted a health education/public information strategy as part of its initial Healthy Start grant in 1997, emphasis during this phase was placed on targeted messages to providers, participants and the community-at-large. To accomplish this, partners were utilized to supplement the efforts of Healthy Start staff. While supportive funding was made available via contracts for these efforts, the majority of our partners (primarily large institutions, agencies, etc) did not seek supportive funding, but opted instead to integrate these efforts into their existing programs. As a result, while funding for health education decreased during this phase, the amount and scope of services were not adversely affected but rather became more coordinated and targeted to specific populations.

The provision of health education had as its basis a goal formulated by the community's Perinatal Health Education Focus Group in 2001 - to provide a multi-layered health education and training program for consumers and providers (perinatal and community) in Richmond County, covering topics that promote perinatal health, interconceptional health, mental health, and availability and accessibility of health services.

Meetings of the Perinatal Health Education Focus Groups and surveys of providers, program participants and the community-at-large revealed that:

- Perinatal health education services in the county were offered through local hospitals, community based clinics and community agencies and limited health education, generally one-on-one for patients, was provided by physicians and their office staff but was not structured and was limited by the time constraints inherent with office visits. In addition, it was revealed that for hospital and clinic based programs, accessibility issues were present associated with the hours they were offered, the cost, location of the training, and cultural and linguistic appropriateness.
- Health education provided one-on-one in providers' offices as well as that offered by hospitals focused more on specific point-in-time issues as opposed to a coordinated, holistic effort.
- Utilization of perinatal services had been affected by several factors: fewer economic resources to spend on healthcare/lack of insurance, welfare-to-work rules that require those receiving TANF to be employed and a lack of knowledge of available services, enabling services, and understanding of the importance of perinatal and interconceptional care.
- Training for providers was generally limited to that received at conferences they may have attended or via pharmaceutical representatives. In addition, it was also

noted that this type of training was limited to those that could afford to attend and, in the case of pharmaceutical representatives, to those involved in prescribing medications and their nurses. These trainings also did not provide opportunities for providers to learn about local issues and resources that could impact them and, ultimately, their patients and lead to an improved system of care.

- Training for non-health care providers of service was limited to that provided by their individual agencies. This training was not related to community issues such as infant mortality, teen pregnancy, perinatal issues, etc and as such these agencies, whose activities impacted on pregnant and parenting women were not involved in creating needed systems change.
- Community training on perinatal issues, to include disparities, was basically non-existent outside of the ARCCP's consortium.

In year 01 of this project phase, a community educator was budgeted for, however when that position became vacant, a decision was made to not fill that position and have the Project Coordinator and Social Services Program Manager, both of whom held degrees in health education, share this responsibility with support from the Outreach/Adolescent Program Manager and Public Relations/Information Specialist. Under this arrangement, the Project Coordinator provided oversight to the Outreach/Adolescent Program Manager, who was responsible for community health awareness activities, and the Social Services Program Manager, who was responsible for coordinating all program participant education activities. The Public Relations/Information Specialist, under the supervision of the Project Director, worked with the program staff and partners to develop a public relations/social marketing campaign to promote positive health behaviors and educate the public on perinatal health issues and to develop materials for use in client recruitment efforts and ARCCP sponsored health awareness activities. Additionally, the Project Coordinator was responsible for working with program staff in identifying and coordinating staff development sessions for program staff and arranging provider education opportunities.

Other changes during this period included:

- Changing the provider education component, which was originally designed to offer scholarships to providers (physicians, nurses, perinatal case managers, health educators, etc) to attend state and national conferences to gain information and knowledge that could be utilized in the community to support Healthy Start efforts to the provision of locally sponsored conferences/workshops and lunch and learn sessions carried out in their offices/ hospital settings that all of the staff could participate in. This change was based on the underutilization of the scholarship program, despite heavy promotion of available opportunities. As a result, the Healthy Start Initiative was able to reach more providers, target education to their needs, involve provider support staff and have on-going contact with the providers and their staff. This in-turn strengthened their involvement in the Healthy Start Initiative as we were able to work with them on their schedule and involve them more in the development of programs and program materials as well as integrate our efforts.

- Case management staff were charged with providing more in-home health education.

Resources needed to implement this component include community health educators, training for staff to enable them to effectively provide health awareness information to the community, health education materials for community awareness activities and program participants, and partners willing to provide/expand their services to underserved populations and areas. Events that facilitated growth in the health education program included the community's history of working together, to include assessments of and discussions about the state of perinatal health education in the community; the work and guidance of the ARCCP-led Perinatal Health Education Focus Group; and the provision of supportive funding via the Healthy Start Initiative to community agencies to expand their programs to underserved areas and populations.

d. Interconceptional Care

Interconceptional care, the provision of services to women from the end of one pregnancy to the beginning of the next pregnancy, or 24-month postpartum, was always a part of the ARCCP's Healthy Start Initiative provided by the case management staff. In phase III, emphasis was placed on high-risk women and their infants and provided by the High-Risk Nurse Case Managers. The ARCCP's approach to interconceptional care, which included risk assessment, health promotion and intervention, was based on the definition and elements of interconceptional care provided by HRSA/MCHB in its Request for Proposal and the *Recommended Guidelines for Perinatal Care in Georgia, 2<sup>nd</sup> Edition*. More specifically, the ARCCP chose to focus on addressing risky behaviors and psychosocial issues due to fragmentation in the current system of care, accessibility issues and decreasing case management program support for women of childbearing age (and their families) to address these issues. In addition, through community assessments and asset mapping, it was noted that:

- While the number of perinatal resources in the community is generally seen as adequate and appropriate, disparities in accessibility existed.
- Utilization of perinatal services has been affected by several factors: fewer economic resources to spend on healthcare/lack of insurance; welfare-to-work rules that require those receiving TANF to be employed; a lack of knowledge of available services; enabling services; and understanding of the importance of perinatal and interconceptional care.
- Hospitals (and two provider practices) provided limited perinatal case management/social services for their patients.
- Perinatal health education services in the county were offered through local hospitals, community based clinics and community agencies. Limited health education, generally one-on-one for patients, was provided by physicians and their office staff but was not structured and was limited by the time constraints inherent with office visits.
- There was a lack of services for the Hispanic population that is culturally and linguistically appropriate.

There were no additional changes in subsequent years. Resources needed to implement this intervention and resources/events facilitating the interconceptional component are the same as those listed in the above section on outreach (reference page 4).

e. Depression Screening and Referral

Depression screening involved the screening of all clients by case managers as part of the family assessment and referral to community agencies for those showing signs of depression or psychosis. The ARCCP's approach to depression screening of all program participants was dictated by HRSA/MCHB in response to events related to perinatal depression on the national level. Locally, the decision was made to use the Edinburgh screening tool for women prenatally and during the postpartum period based on research of perinatal depression via the Internet, a survey of local perinatal depression providers and technical assistance received from the State Title V agency. The decision to administer the screening tool prenatally was made in an effort to identify risk factors for depression and potential depression as well as to establish a baseline for comparison with the postpartum administration.

Changes to this component included moving from the use of general questions aimed at understanding how women felt to the implementation of the Edinburgh Screening Tool and working with local physician practices to implement depression screening within their practices. An additional part of this component included the identification of service providers (with annual update) who would work with women experiencing depression or psychosis and sharing of this information with community partners.

Resources needed to implement this component included an empathic staff knowledgeable of community resources, screening tools that are easy to administer and score, and services to refer those screening positive. The primary factors impacting the provision of depression support services were state and community level budget cuts that led to the two hospitals which provided depression support services to cut services; financial irregularities involving the local community mental health center which led them to cut staffing and hours; a lack of providers specializing in perinatal depression; and a lack of facilities to provide inpatient care/therapy. Resources that facilitated getting women into support programs/care included screenings by physicians and by Blue Cross Blue Shield.

2. *Core Systems-building efforts*

a. Local Health Systems Action Plan

To address the issues/gaps in services and complement the community-based activities that were already occurring through local organizations in the project area, the ARCCP facilitated a services development planning process that included consumers, maternal and child health service providers, substance abuse treatment providers, perinatal health education providers, advocates and advocacy organizations, and State/local Title V officials, which resulted in the development of a Five Year Strategic plan and an annual operating plan, which communicated our goals, objectives, strategies, evaluation measures, etc, and described ongoing collaborative mechanisms and efforts toward an integrated system for perinatal care for our target population. The Local Health Action

plan, was a small section of the community's Five Year Strategic Plan, and focused on coordination of perinatal health education and services and improving mental health services in Richmond County. This procedure was not changed throughout the project period.

Resources needed to implement this plan are shown in the section above on health education (reference page 8) and depression screening (reference page 9) as well as consortium members willing to work collaboratively to address community issues. The major events that continued to facilitate this process, was the consortium's history (since 1985) of working collaboratively and the continually escalating emphasis funders placed on community collaboration as a prerequisite for receiving funding.

b. Consortium

1) Approach – While a consortium was in place prior to the receipt of Healthy Start funding, consideration was given to the establishment of a new consortium. However, because the consortium (section 3) which was in place had

- as its rationale for establishment the purposes of addressing community needs such as infant mortality, low birthweight, child abuse and neglect, racial disparities, etc., a fragmented service delivery system and the possibility of combining resources.
- a governance structure in place with by-laws, was a 501(c)(3) entity, etc.
- representation from all sectors of the community (education, health, government, housing, faith, community, non-profits, for profits, businesses, civic groups, individual citizens, and most importantly consumers of services) actively involved in governance – thus decision-making – and in the planning, implementing, and evaluating processes – it was determined that we would not establish a new consortium but rather build on that in place.

Additionally, the consortium had longevity, problem-solving and planning processes in place.

2) Components of our intervention (Consortium) were

- A governance structure to ensure policies and procedures - including decision-making processes- were in place and to ensure that all members of the consortium participated in this process.
- A recruitment process to identify new individuals (with emphasis being on consumers of services) and agencies.
- A planning process to develop the community's comprehensive strategic and annual operating plans which serve as road maps to address infant mortality and racial disparities.
- Maintenance to ensure that existing members remained actively involved.
- An evaluation process to determine the effectiveness of its efforts.

Resources needed to implement and maintain the consortium included:

- Active governance team members on the Board of Trustees as well as active members of the Membership Council, Consumer Council, and Youth Council, Child Health Committee, School Success Committee, Family Functioning

Committee, Family Economic Capacity Committee and Child Development Committee.

- Core staff to support and facilitate the efforts of the consortium and sustain its forward motion.
- Skilled facilitators and mediators to guide the consortium in its work and to help it over the rough spots (i.e, conflicts, turf guarding)
- Skilled facilitators and mediators to guide the consortium in organizational development
- Ongoing training to keep consortium members abreast of trends related to issues being addressed as well as of evidence based strategies and activities to successfully address the issues.

3) Resources or events that facilitated successful initiation and implementation of the consortium included the governance structure, core staff, skilled facilitators, ongoing training, continuous commitment and involvement of consortium members, and utilization of Memoranda of Agreement which delineate roles and responsibilities of the ARCCP and partners. Resources or events that detracted to some extent the successful initiation and implementation were the ongoing turf guarding and continuity of representation from some agencies/organizations.

c. Collaboration and Coordination with State Title V and Other Agencies

1) The approach to collaborating and coordinating efforts with the State Title V and other agencies such as the Richmond County Departments of Public Health, Family and Children Services, Community Mental Health Center, etc. was based on the following:

- A fragmented delivery system.
- Duplication of services.
- Needs not being met.
- Reduction in or elimination of resources.
- Implementation of initiatives without input of community agencies/organizations whose programs could be negatively impacted. An example was the implementation of a regional perinatal coordinator position by the State Title V program which led to the local health department employing and supervising a regional perinatal coordinator whose roles and responsibilities were not clearly defined – thus leading to a duplication of services and some confusion.
- Relationship building and maintenance.

2) Components of the Collaborating and Coordinating Intervention

a) Components of the intervention included meeting on a regular scheduled basis, information sharing, training, technical assistance, strategic planning, co-sponsoring events/activities, monitoring efforts, evaluating or assessing progress and integration of state and local efforts.

b) Resources needed to implement the intervention included human resources (personnel from each agency sharing their data, information regarding their programming, offering their technical assistance to all partners as appropriate).

Resources or events that facilitated successful initiation and implementation of collaboration and coordination included the State's Title V agency

- hiring Family and Community Involvement Coordinators and designating them to work with Healthy Start sites and sending them to Healthy Start trainings and coming to sites to gain an understanding of them.
- increasing willingness to secure resources from other departments within the Georgia Department of Public Health, such as the Epidemiology Branch, Vital Records Branch, and Office of Health Information and Policy, to support Healthy Start sites.

The major detraction from successful initiation and implementation of collaboration and coordination was the implementation of a regional perinatal coordinator position by the State Title V program which lead to the local health department employing and supervising a regional perinatal coordinator whose roles and responsibilities were not clearly defined – thus leading to a duplication of services and some confusion.

d. Sustainability

1) Approach – In making a decision regarding the approach to address to sustainability, we revisited the sustainability plan in place and determined that for this phase of the Healthy Start Initiative we would focus on specific strategies and activities outlined in the plan – not take a totally different approach. This decision was based on strategies either employed in the past that did not work, those that had not been pursued and those where we had originally met some degree of success.

2) Components of Intervention (Sustainability)

The components of our intervention included

- The development of proposals which had been, to some extent, successful in the past.
- Medicaid reimbursements.
- Services for Managed Care Organizations.
- Partners' integration of Healthy Start strategies, programs, and activities into theirs as appropriate.
- Membership fees.
- Fundraising.
- Resource sharing.

Resources needed to implement this component included:

- Technical assistance and consultant services in developing the plan.
- Partners committed to integrating Healthy Start strategies into their work.
- Seed dollars to assist agencies in developing/expanding programs which would be sustained by them in future years.
- Willingness of partners to pay a membership fee.

Resources or events that facilitated the successful initiation of the intervention (sustainability) were the existence of a Resource Development Committee which pursued various avenues for funding, core staff and partners who jointly prepared proposals and the receipt of funding, Medicaid reimbursement for one service (Targeted Case Management), partners willingness to work toward integration of strategies, programs, and activities. Resources or events that detracted from successful initiation and

implementation were the lack of support from managed care organizations, the governing board's inability to reach a decision regarding a membership fee and fundraising activities, and the reluctance of the ARCCP to compete for the same dollars its partners were pursuing.

### 3. Consortium

#### 1) Consortium establishment

The consortium in place during the second and third phases (1997-2005) of the Healthy Start Initiative was established in 1991. At that time there were nine participating partners whose efforts were coordinated, facilitated, etc. by the current Healthy Start Project Director and who served – on a volunteer basis – as the Executive Director. The organization, and thus its consortium, which was called the Family Connection, was the “brainchild” of our then Governor who worked with local community organization/agency representatives and families to address the needs of children and families.

In 1996, the Family Connection consortium merged with the Augusta Coalition for Children and Youth (an advocacy group formed in 1985 to address child abuse and neglect) to form the Augusta-Richmond County Community Partnership for Children and Families, Inc. (ARCCP).

During the formation of the original consortium (1991), the major barriers that emerged included:

- The lack of paid staff to facilitate the consortium's establishment which was addressed by the current Executive Director committing to the process in a voluntary position and the employment of three staff members.
- The lack of clarity in terms of roles and responsibilities, which was addressed via Memoranda of Agreements (MOA) and job descriptions.
- The non-existence of bylaws, policies, and procedures which was addressed minimally in the early years by the MOAs and later through the development of these documents.
- The attitude that this was a passing initiative which was addressed by staff's continued commitment to the process, to partners and the community in addressing their needs and focusing on the “big picture.”
- The lack of realization that consumers of services needed to be at the table in the beginning stages. This was addressed by initiating a consumer recruitment effort.

#### 2) Consortium structure

The consortium was two pronged – a Board of Trustees, which set policy and thus served as the governing body, and the advisory councils (Membership, Youth and Consumer). The Membership Council, through its subcommittees, assumed responsibility for the development and implementation of the community's strategic and annual operating plans. Note that these plans addressed many issues including those related to infant mortality and racial disparities. The Youth and Consumer Councils provided input into this process through focus groups and participation on subcommittees. This structure allowed members to: serve in leadership positions; participate in the planning,

implementation, and evaluation of activities; and participate in appropriate and agreed upon training/staff development. During Phase III of the Healthy Start Initiative, the consortium included 127 agencies and approximately 393 individuals representing the business, faith, medical/health, education, social services, youth serving, and government sectors of the community as well as media organizations and consumers of services. At the end of Phase III, 85% of the consortium was active. The composition of the consortium was as follows:

- One hundred consumers (25%).
- Seventy-eight community based organizations (20%).
- Sixty-five providers (17%).
- One hundred fifty other organizations/agencies (38%).

Of this group, there were an average of 94 males and 299 females. Racial breakdown showed an average of 59.4% Blacks, 32.1% Whites, 6.9% Hispanic, .58% Asian/Pacific Islander, and .87% other.

During this phase, the major areas of expansion were in the areas of business, youth serving agencies and consumer involvement.

### *3) Community assessments*

During phase III of the Healthy Start Initiative, methodology used to assess needs included:

- the collection, analysis and utilization of the results feedback from
  - surveys conducted by individuals representing partnering agencies/organizations including the ARCCP.
  - community mapping activities.
  - information sharing by partners.
  - public hearings.
  - forums and focus groups.
  - individual interviews.
- the analysis and utilization of available current national, state and local data related to perinatal health.

Resource identification was addressed via ARCCP outreach and consortium development activities, partners identifying community resources not already known to the ARCCP and presentations to community groups and agencies. Priorities for allocation of resources were established through the results of the community needs assessment, the availability of resources to address those needs, and the potential impact that could be made by the allocation of the resources. Implementation was monitored by the Project Director with support from the Board of Trustees and its evaluation committee through evaluation of the community's strategic and annual operating plan of which Healthy Start is a part.

The CSRA Partnership for Community Health was the only other consortium operating in this community serving much of the same population. Their goal, however, was the development and implementation of the neighborhood based clinics to increase/improve access to care for the indigent population. As a partner of the ARCCP, the CSRA

Partnership shared needs assessment and community demographic data with the ARCCP, participated in the strategic planning process, and provided medical, social and health education services to the target population (women and their families living in Richmond County). In addition, their Executive Director participated in the Augusta-Richmond County Community Partnership's consortium and served on its Board of Trustees as a member representative.

#### *4) Community strengths*

The major strengths which enhanced consortium development included: the ARCCP's stability and history (20 years) of working collaboratively with the community to address the needs of children and families; our shared decision-making and planning process; and the community based approach taken to develop and implement a community plan that addressed community needs. Other strengths included a sustainable infrastructure based on community ownership and empowerment, commitment of partners to address community issues and clearly defined roles and relationships.

#### *5) Weakness/barriers inhibiting consortium progress*

In order for the consortium to move forward, the following issues had to be addressed:

- Consistent consumer representation.
- Turf guarding.
- Availability of current local and state data.
- Turnover of agency representatives (not the agencies themselves).
- Roles of other collaboratives, coalitions, and groups.
- Lack of awareness of MCH issues by non-perinatal health related partners.
- Lack of partner awareness about community resources.
- Buy-in from collaborative members to complete a fiscal inventory.
- Buy-in from the collaborative to develop comprehensive tools for community assessment and evaluation to address the data and evaluation needs of our partners.

#### *6) Increasing resident and consumer participation*

Activities and strategies utilized to increase consumer and resident involvement included:

- Direct communication - asked them/extended personal invitations to meetings and activities.
- Provision of enabling services such as childcare, transportation, translation, and access to a clothes bank.
- Recognition and celebration of their participation.
- Building on and utilizing their strengths and skills.
- Working with consumers new to the consortium to familiarize them with the consortium activity, what had happened in the past (if appropriate), what to expect and what their role was to be.
- Provision of leadership opportunities for leadership and for consumers and residents to share their experiences with the partners.
- Administration of surveys and provision of input/feedback via surveys and to determine needs and interest.
- Outreach to local parent, support, and church groups.

- Meaningful activities with increasing responsibilities.

In the early stages of the Healthy Start Initiative, only transportation and childcare were provided. As we progressed, we began to implement other mechanisms to increase involvement such as incentives, consumer participation in local, state, and national conferences, leadership opportunities, training opportunities, employment of bilingual Family Support Workers, provision of bilingual materials, identification of translators, establishment of relationships with Spanish speaking groups or churches, provision of Spanish language education for staff, implementation of the Family of the Year Award, training based on participant feedback/interest, increased opportunities for involvement.

#### *7) Consumer involvement in the decision-making process*

Consumers played a critical role in the development, implementation and evaluation of all Healthy Start activities. Their input into the decision-making process was obtained via their participation in the Parent Support Group, Consumer Advisory Group, Perinatal Health Education Focus Group, Membership Council, Board of Trustees, the strategic planning meetings, and via committees and the administration of surveys. Consumers also worked with project staff one-on-one on how to address the barriers faced by Healthy Start clients in accessing health and social services. For example, consumers worked with our Parent Advocate in the planning of the Parent Resource Room to include types of furniture and materials to be included. Consumers were also involved in decision-making activities through community forums, such as Georgians for Children, and the Georgia Family Connection Partnership Community Dialogue.

#### *8) Utilization of consumer input*

Consumer input was utilized in developing the community's strategic and annual operating plans, funding proposals, program and evaluation design, implementation and revision, identifying areas for consumer involvement, designing consumer training and in setting up the Parent Resource Room. In addition, input provided through the advisory councils was used by the Board of Trustees in their decision-making processes. In addition, information was shared with partners in an effort to improve their services. Consumer input was critical to the success of the project and is evidenced by the program modifications made and implemented in Phase III of the Healthy Start Initiative.

### *4. Sustainability*

ARCCP's Healthy Start Consortium, from its inception, realized that securing, managing and maintaining its resources would be critical to sustaining its efforts. To this end, a sustainability plan which included specific strategies, activities, etc., and outlined roles and responsibilities of consortium members was developed. Within this plan, the major strategy emphasized a reliance on building collaborations, partnerships, and other innovative relationships at the local level. This strategy was and is critical to sustainability because due to a convergence of factors – government and foundation dollars for human service programs have shrunk or become limited/non-existent.

1) While we made a concerted effort through one of our partners, Integrated Health Resources, to get “our foot” inside the door to provide outreach and case management

services for one or more managed care organizations, we were unsuccessful. This was due to the fact that the non-Medicaid population had experienced financial difficulties and began eliminating services and thus were not interested in taking on another service.

With regards to third party billing, we continued in our efforts to push for a waiver through the state to make this a reality. However, in the state of Georgia, personnel paid with federal funds are not authorized to bill Medicaid for services provided. As such, personnel paid using Healthy Start funds were not authorized to bill for services. This then precluded the Augusta-Richmond County Community Partnership for Children and Families, Inc. Healthy Start initiative from billing for services by Healthy Start funded case managers and outreach workers.

2. Major factors associated with the identification and development of resources included:

- Knowledge about available resources (monetary and programmatic).
- Our ability to leverage dollars and match funds.
- Conducting a community fiscal inventory beginning with partners to determine the amount and source of funding coming to the community to address specific issues.
- Desire to eliminate competition (i.e. if a partner was applying for a grant, the ARCCP would not submit an application for that same grant) for shrinking dollars.
- Inability to assign a full-time staff person to resource development.
- Local and state foundations funding buildings and the arts.
- Lack of understanding of infant mortality and low birthweight babies and their link with teen pregnancy.
- More funding going towards school sponsored programs as a result of No Child Left Behind and less funding allocated to out of school programs.
- State public health initiating projects without coordinating with local Healthy Start sites.

3. Barriers to overcome included:

- turf guarding,
- shrinking funds,
- lack of state coordination with communities (the state giving money to agencies without knowing how it relates/supports other community efforts),
- inability to bill Medicaid for services rendered if Project is funded by Federal Government
- financial difficulties of managed care organizations, and
- difficulty in developing a message that 'sells' the ARCCP as an agency as opposed to selling a program.

Barriers were addressed by working with:

- partners (established and new) to ensure they understand the ARCCP role in the community.
- partners in joint grant writing activities, soliciting of in-kind services and materials and matching dollars, blending/pooling funds and sharing resources.

- the state Family Connection, which serves as an umbrella for all Georgia Family Connection sites including the ARCCP, to have them advocate for local Family Connection sites to serve as a clearinghouse of community programs.
- a local PR consultant to develop a message to sell the ARCCP as an agency as opposed to its programs.

Because of their efforts, we were able to decrease their negative impact.

### **III. PROJECT MANAGEMENT AND GOVERNANCE**

A. The project, over the course of Phase III, included a management team led by the Project Director who provided oversight and management of the ARCCP and its Healthy Start Initiative and performed all activities involving consortium development and sustainability. The Project Director, received guidance and oversight from the Board of Trustees. Additional management team members included the:

- Project Coordinator, who also served as the ARCCP Deputy Director, was responsible for management of all ARCCP programs;
- Fiscal Manager who managed the day-to-day fiscal operations;
- Data Management Specialist, who designed and managed all ARCCP databases, provided data analysis and worked with the external evaluator and project staff to carry out the Healthy Start evaluation;
- Public Relations/Information Specialist, who was responsible for all public relations and social marketing activities to include planning the same with staff, partners, and consumers;
- Human Resources/Operations Manager, who was responsible for all human resource functions and activities related to the Board of Trustees;
- Social Services Program Manager, who under the supervision of the Project Coordinator, provided supervision and oversight to the case management team and assisted in implementation of the health education component;
- Outreach/Adolescent Program Manager, who under the supervision of the Project Coordinator, was responsible for all community health awareness activities.

B. Resources which were essential to financial and program management included the:

- Richmond County Health Department, which served as the ARCCP's fiscal agent during Phase II, provided on-going assistance to the ARCCP as needed. In addition, the health department worked with the ARCCP to enhance its program efforts in maternal and child health - via its programs such as Resource Mothers and early intervention - as well as teen pregnancy by providing programming (forums, adolescent pregnancy prevention activities) and services (family planning, WIC, breastfeeding, etc) to program participants. In addition, the Richmond County Health Department provided training for program participants, community residents, staff and partners to include those on HIV/AIDS, STDs, Immunizations, SIDS, etc.
- Medical College of Georgia Information Systems Division, which managed the case management database, FACTORS, and whose director served as a liaison to coordinate data collection and sharing efforts between the ARCCP, CSRA ARCCP for Community Health and United Way.
- Local hospital perinatal staff, physicians, and other perinatal providers, who were key resources in developing and modifying programs to address their needs as well as those

- of their patients. In addition, they provided valuable input into strategic planning efforts.
  - Consortium members, who served as key resources in providing and coordinating services for program participants such as health education, breastfeeding support, etc (most at no cost to the ARCCP). In addition, they provided valuable input into strategic planning efforts.
  - Consumers, who were key resources in developing and modifying programs to address their needs and provided valuable input into strategic planning efforts.
  - External evaluator, who provided data and data analyses to the ARCCP which was used to gauge program progress, direct program efforts and to carry out strategic planning.
- C. Changes in the management structure during this phase included staff turnover in the positions of fiscal manager, public relations specialist and data manager due to resignations. Changes in the governance structure were as a result of Board turnover due to term limitations as specified in ARCCP's by-laws.
- D. To assure appropriate distribution of funds, the ARCCP utilized procedures and guidelines for fiscal management, contracting, program monitoring, etc that were established during the last program phase with the exception of changes in contracts where expectations for outcomes as well as a culturally sensitive approach to services were requested.
- E. Additional non-Healthy Start resources obtained for quality assurance, program monitoring, service utilization, and technical assistance which became important as contractors were funded and/or staff members hired included:
- Local hospitals and perinatal providers whose role became more important as they became the primary outreach source for client recruitment activities for the ARCCP as a part of their on-going services.
  - The Medical College of Georgia, which provided technical assistance in the area of perinatal health and database management.
  - Richmond County Health Department, which provided technical assistance in the area of finances and recruitment of program participants.
  - State Family Connection ARCCP, which provided technical assistance in the development, implementation and evaluation of the strategic plan, of which infant mortality was a part.
  - State Title V agency, which provided technical assistance in maternal and child health issues.
- F. Cultural competency was an issue in that many partners were slow to recognize that the Hispanic population was growing and becoming a more visible population. In addition, many did not realize that a large number of them were in an illegal immigration status and thus had additional concerns around sharing information, having "official" identification, etc. To address this, the ARCCP highlighted community statistics, teamed up with informal leaders in the Hispanic community and hired a Hispanic outreach worker to work with program participants as well as serve as advisors to partners as needed. Noticeable benefits included increased access to services for our Hispanic clients, increased numbers of partners providing Spanish language materials and forms, and partners, following the ARCCP's lead, providing Spanish language classes for their staff, to hire translators as needed to provide language appropriate services and include cultural competency in their staff development programs.

#### **IV. PROJECT ACCOMPLISHMENTS/LESSONS LEARNED/BARRIERS**

*A. Project Accomplishments*

Project accomplishments can be documented in each of the core services and core systems-building efforts and are shown in the chart found at attachment 1.

*B. Barriers and Lessons Learned*

Barriers encountered included the following, by service area:

Outreach

- Inadequate information provided to potential program participants by community agencies resulting in women not always remembering signing up and therefore, declining services when contacted as some partners were simply providing names to Healthy Start outreach workers without informing the client/patient of the referral and discussing it with them. To address this, brochures with information on the program were provided to partners for them to utilize to provide more comprehensive information to their clients/patients. Additionally, they were asked to secure the patient's signature acknowledging the referral.

Case Management

- Inadequate number of in-patient substance use/abuse treatment programs for Medicaid clients locally due to state budget cuts and other financial considerations. The mental health community has taken this issue to local legislators. To help support local providers, Healthy Start outreach staff conducted, on an annual basis, an inventory/assessment of local substance use/abuse programs who serve Medicaid clients and their capacity. This information was posted to the ARCCP's database and shared with providers and clients.
- Lack of individuals who speak Spanish in the majority of our partnering agencies as well as not having forms and materials in the Spanish language and lack of cultural sensitivity. Via the HSI, translation services were provided for program participants seeking services from partnering agencies and many forms and materials were translated into Spanish. In addition, via the consortium, information on the numbers of Hispanic families was provided as well as information regarding their needs and cultural considerations.
- Changes in Georgia's Medicaid program (cuts in provider reimbursements each year and the move to place Medicaid families and PeachCare (the state SCHIP) children into pre-paid care management organizations similar to HMOs which impacts participants' access to care and their ability to maintain a medical home). The ARCCP and its partners advocated for maintaining/increasing funding to Medicaid and PeachCare with local legislators.
- Poor transportation services in the community. To address this, the HSI provided transportation via taxi or bus tokens for clients to prenatal care and well baby visits. In addition, several key agencies that serve populations that rely on public transportation formed a focus group to develop strategies to address the issue for presentation to local, state and federal legislators.
- Large number of women requiring social service support which outweighed the ability of the Healthy Start Initiative to provide services to them. These women (and their families) were referred to other ARCCP and community programs for services as necessary. Those referred to community programs were those with one-time/short term needs while those

referred to other ARCCP case management programs required long term support or support for which there was no referral agency available.

- Lack of insurance coverage for Hispanic clients without legal immigration status. HSI staff worked with:
  - Local providers to encourage them to develop a bundled services package that included needed ancillary services and that could be paid in installments.
  - DFCS and Hispanic client providers to increase understanding and appropriate use of emergency Medicaid for pregnant women without legal immigration status as many providers were unaware of the scope of medical episodes that were covered under emergency Medicaid or populations it could serve.
  - Local pediatrician and neighborhood clinics to identify those that provided free vaccine to those unable to get them via the local health department or other sources due to their inability to pay.
  - Staff from the local health department to provide information on the Babies Born Healthy program to ARCCP case management staff and partners. ARCCP staff also worked with the Health Department and Medical College of Georgia to enroll pregnant women who were without legal immigration status into the program.
- Lack of coordinated/comprehensive case management in the community. To address this, ARCCP staff worked with social services providers such as perinatal case managers, hospital social workers, and Department of Family and Children Services staff to identify joint clients and establish information sharing and feedback loops to reduce duplication of efforts and ensure wrap around services for program participants.

#### Health Education and Training

- Strict guidelines by the local Board of Education on what could and could not be taught in the schools resulted in family planning not being addressed during the community partner run in-school program for pregnant and parenting teens. Additionally, school nurses and staff were not able to provide information to pregnant girls unless the girl disclosed she was pregnant –even when the pregnancy was showing. To address this, the partners working with pregnant and parenting teens as well as the teens themselves encouraged other girls to enroll in the Healthy Start case management program and provided Healthy Start brochures to them. ARCCP staff also established relationships with individual school nurses and other staff members and encourage them to refer girls to Healthy Start when they disclosed their pregnancy. On-going dialogue was begun with Board of Education members who recognized the issue of pregnant teens and supported Healthy Start efforts to identify strategies to address the teen pregnancy (and repeat teen pregnancy) issue.
- Lack of a coordinated perinatal health education programs which were appropriate, accessible and affordable for women of reproductive age. To address this, the ARCCP continued to work with the Perinatal Health Education Focus group, formed in Phase II of the Initiative, to keep the health education topic chart and selected curriculum current, identify underserved areas of the community and identify resources to provide the needed education. In addition, the ARCCP provided supportive funding to those partners with a need to provide needed courses in these underserved areas.
- Lack of funds to institute evidenced based out-of-school programs that could address teen pregnancy and other risky behaviors. Through collaborative efforts with partners who

provide services to teens, we have addressed issues such as teen pregnancy and other risky behaviors via health education sessions and teen forums within community settings for teens and their parents with an emphasis on sharing resources and pooling/blending funds. Note that funding for out-of-school programs was one of the top issues presented to legislators at the annual legislative breakfast 2001-2004.

- Lack of funding to develop a comprehensive social marketing campaign to increase awareness of disparities in health care, promote healthy behaviors and positive perinatal outcomes. Through outreach efforts, flyers, pamphlets, newsletters, etc. information about health disparities were addressed. Community forums were conducted to increase awareness of disparities in health care and perinatal outcomes and actions steps were developed.

#### Interconceptional Care

- Limited availability of funding for family planning services. Family planning services were under funded with funds being depleted prior to the end of the state fiscal year. To address this, the health department, and other agencies with alternate funding sources, continued funding services utilizing an alternate funding source. ARCCP staff and the consortium took this issue to the legislators with data supporting a recommendation to maintain/increase funding for family planning.
- Changes in funding sources (state dollars to federal dollars) for family planning which in effect further decreased funding by eliminating the ability to match state dollars with federal dollars. ARCCP staff and the consortium took this issue to the legislators with data supporting a recommendation to maintain/increase funding for family planning. This barrier emerged late in Phase III.

#### Depression Screening and Referral

- No standardized tool for depression screening utilized by providers (some had their own tools and others relied on what Blue Cross/Blue Shield provided). ARCCP staff conducted lunch and learn sessions with local physicians and their staff to share information on perinatal depression, the need for screening and the Edinburgh Depression Screening Tool as a means for conducting screenings. Most physicians agreed to incorporate the forms into their charting procedures. For those physicians that had a perinatal case manager on staff, their patients were referred to them for linkages with community support services. Other providers made referrals to the Healthy Start Initiative. In addition, outreach staff conducted an annual inventory/assessment of local programs and their capacity. This information, and any changes, were posted to the ARCCP's database and shared with perinatal providers.

#### Local Health Systems Action Plan

Our local health systems action plan covered enhanced mental health and substance use program services and creation of a coordinated perinatal health education system. Barriers related to these include:

- Lack of local comprehensive mental health and substance abuse intervention services for adolescents and pregnant and parenting women. The mental health community, to include the regional Division of Mental Health/Developmental Disabilities/Addictive Disease,

worked with the state to create a new office for Children and Adolescent Mental Health to build appropriate local systems of care.

Barriers related to perinatal health education are addressed in the health education section above.

### Consortium

- Lack of commitment/involvement by businesses, faith community, and local government. To address this issue, the Project Director called upon the Board members who represented these sectors of the communities to accompany her on presentations to businesses, churches and civic organizations such as the Rotary Club, Optimist Club, Lions Club, etc and to identify potential consortium members.
- Redistricting for congressional and state representatives and turnover of the majority of the local commissioners resulting in the need to establish new relationships. Relationships were developed via one-on-one meetings with new legislators and their key staff, presentations to the local commission, and inviting both local commissioners and legislators to key consortium activities (i.e. Membership Council meetings, Legislative Breakfast, Annual Meeting, conferences, etc).
- Assessing capacity of system level resources and programs. Meetings were held with key staffers from the various agencies to explain the rationale for gathering the information and how it would positively impact their efforts.
- Partners not understanding the need for and/or accepting consumers as partners. The need for consumers to be at the table was presented and encouraged via Membership Council meetings, agency meetings and one-on-one meetings with key staffers. In addition, consumers were continually invited to participate in meetings with partner agencies so that agencies had an opportunity to work with consumers and see for themselves the value of having them at the table.
- Low consumer involvement, which was addressed by:
  - Extension of personal invitations to meetings from case management staff with follow-up calls and enabling services to encourage involvement.
  - Provision of enabling services (childcare, transportation, translation, and advocacy).
  - Administration of surveys and execution of focus groups to determine needs and interests.
  - Outreach activities targeted to local parent, support, and church groups.
  - Awarding of incentives (based on the earning of points).
  - Provision of meaningful activities with increasing responsibilities (i.e. attend meetings, go on trips, be on the Board, etc)
  - Offering of leadership and training opportunities (attendance at local, state, and national conferences) as well as opportunities for them to work, as partners, with community agencies that impacted them and for them to be a part of news interviews and public service announcements related to Healthy Start.
  - Employment of a bilingual Family Support Worker and use of bilingual materials in outreach, case management, and health education programs. In addition, ARCCP staff developed a list of translators in the community for its own programs (as needed) and use by partners as needed.
  - Establishment of relationships with Spanish speaking groups or churches that provide support and activities to the Hispanic community.
  - Provision of Spanish language education for staff.

## Augusta-Richmond County Community Partnership for Children and Families, Inc

- Implementation of a Family of the Year Award that was presented annually at the ARCCP's Annual Meeting.
- Development, implementation and evaluation of health education and life skills training based on participant feedback/interest.
- Utilized of their suggestions in the planning/modifying/evaluation of programs and services.

### Collaboration and Coordination with State Title V and Other Agencies

- Obtaining current data due to lag time between the calendar year end and the time that vital statistics are available. This on-going lag is due in part to the time it takes community health agencies to report the data to the state, time needed to clean the data and analyze it. Through meetings with the various groups within the Division of Public Health, concerns were expressed. As a result, the time lag has decreased. In addition, the state created a data website to facilitate access to a variety of data. To address the issue for reporting purposes, the ARCCP used unofficial data from partners and self-reported data.

### Sustainability

- Lack of recognition and awareness of the ARCCP and its mission, vision and initiatives by churches and groups in the furthest areas of the county (i.e. Hephzibah, Blythe, West Augusta). As a result a public awareness campaign was targeted to these areas via participation in community events, outreach to community leaders and businesses, and presentations to local groups based in those areas, etc.
- Inability to bill Medicaid for services provided under the Healthy Start Initiative umbrella due to the federal source of funding. This avenue was explored at several levels, however at this time, the Medicaid program in Georgia is moving toward use of managed care organizations (MCOs) to provide Medicaid and PeachCare services and is planning changes in the services they provide. Additional information regarding these changes and their impact on the ARCCP is forthcoming.
- Difficulty in selling ARCCP as an agency that facilitates community collaborative efforts to funders, who are more often interested in funding programs.

### **Lessons Learned**

#### Outreach

We have learned that we must:

- Provide information and tools staff need on a continuous basis to do their job (to include goals, objectives, expectations, training, and materials).
- Research the target area and identify key areas, locations, and groups.
- Keep the group focused on objectives and expectations. These can be reinforced in various ways (meetings, individual conferences, posted updates on progress such as numbers recruited, etc.).
- Always obtain input from staff--this results in ideas, a better product, and buy-in.
- Encourage and praise at every opportunity (staff or consumer).
- Develop an understanding of how other individuals, agencies, etc. conduct business.

## Augusta-Richmond County Community Partnership for Children and Families, Inc

- Identify habits of residents in various housing areas to maximize canvassing activities (for instance, in some areas it may be better to go door to door in the afternoon due to late sleepers).
- Plan in advance for the weather, especially the extreme heat in the summer time (and schedule canvassing activities accordingly)!
- “Talk the talk (to get results)! Talking in a “professional manner”, utilizing big words, acronyms, etc is a turn off. Outreach staff must be able to relate to each individual on his/her level.
- Communicate, communicate, communicate. Do not assume that everyone is on the same page.
- Have the support of community agencies (including providers) in referring potential program participants and providing training opportunities for staff, consortium members and program participants.

### Public Relations

We have learned that we must:

- Have all needed resources (equipment, software and staff) to develop effective public relations programs and activities.
- Be very specific with instructions when communicating with printing companies. One unspecified detail could cost you.
- Have two or more people review and edit publishing materials. Even the best writers can make typos and/or convey the wrong information. Involve the target audience in the development of materials to enhance its effectiveness.
- Never say “I guess” during an interview or when speaking to the public/individual. Be certain of what you are saying, or admit you don’t know the answer and tell the public/individual you will research the question.
- Avoid having too much information on a flyer, handout, brochure, etc.
- When dealing with the media, create a scenario for them and explain how they can benefit from the story.
- Be patient, but persistent with the media. Many times their interest in your issue will depend on what they need. Tie in stories to their health segments and “health issue of the month” activities.
- Not jeopardize the privacy of the consumer or the integrity of your organization, no matter how demanding a reporter can be.
- Not waste the time of TV reporters, radio personalities, and newspaper writers/reporters who are very busy and always on a deadline. When calling them, be straight to the point. Develop a relationship with them. Greet them when they attend events and have information packets available for them and people already identified for them to talk to, including consumers.
- Develop relationships with consumers so that they may feel more comfortable when you take their picture and ask them to sign a release form, as well as being more willing to let you interview them.
- When writing an article on a consumer or partners, always let them read and approve the article before publishing to make sure there is no misinterpretation of information.

### Case Management/Interconceptional Care

We have learned that we must:

- Coordinate services across multiple providers as this increases available resources to families.
- Work within multidisciplinary teams increases collaboration, eliminates duplication of services and allow for better outcomes.
- Intensify delivery of services based on the needs of individual families to produce more effective outcomes.
- Engage families in the planning and implementation process- to include their case plans, consortium activities, etc- as this ensures that their voice is heard and their perspective represented as well as secures their buy-in.
- Accept that even when a free, client-centered service is offered, it may be refused.
- Maintain contact with partner agencies must occur to maintain their support and channeling of referrals. The quality of service and dissemination of accurate and adequate information plays a key role in maintaining satisfied customers. This increases the cooperation and enthusiasm of key collaborators.
- Conduct follow-up with clients gives a personal touch and makes people feel important. It also shows, we are truly interested not just passing through their lives.
- Conduct home visits, as it is the optimum method for providing case management services.
- Have the support of community agencies (including providers) in referring potential program participants and coordinating services.

### Health Awareness/Education

We have learned that we must:

- Develop/negotiate contracts which define responsibilities of each partner, costs for services and reporting procedures with due dates set.
- Target health promotion and health education activities to teens. Services/agencies need to be “teen friendly”. To this end, trainings have been provided to the consortium regarding this concept.
- Have the support of community agencies (including providers) in referring potential program participants and providing services to staff, program participants and the community.

### Consortium/Systems Change

We have learned that we must:

- Utilize a multi-disciplinary approach to addressing issues. Also, we have learned that systems change strategies and activities are more of a challenge to plan and implement. It takes more time, skill and patience to get input “buy-in” from all agencies/organizations.
- Acknowledge that bureaucracies exist in all institutions, but they too can be overcome if vested partners are committed and willing to put in the time and effort necessary to achieve their common goal.
- Network with other agencies and groups.
- When building new coalitions with traditional groups, be prepared for an occasionally “rocky” but very rewarding experience.

Augusta-Richmond County Community Partnership for Children and Families, Inc

- Have buy-in from key community leaders.
- Build capacity within the community to resolve a lot of the issues consumers are faced with and offer encouragement, technical assistance and tangible resources to assist them.
- Build the team from the start because it pays off with better inter-agency understanding and cooperation.
- Have a coordinated community response based on common vision, goals, and objectives with partners who are able and willing to commit resources to secure the vision is a key component to the success of a collaborative ARCCP.
- Work with youth towards a definitive product is invaluable. Close guidance and lots of flexibility is required.
- Utilize outreach and case management efforts together to address this populations' lack of access to basic screening services.
- Be open to working with private and for profit groups to have long-term community health benefits.
- Seek the advice and consultation of model programs in other communities and then tailor them to our community.
- Seek the broadest possible community involvement.
- Build and document the case for additional programs.
- Allow time for collaboration to happen and remain committed.
- Have policies, procedures and written directions and utilize them consistently.
- Not assume that the availability of funding and a network of providers in the community will guarantee the expected outcomes. Commitment of all the key players in the community and a tremendous amount of education of the targeted population are needed.
- Have a vision, leadership and consistency of purpose to accomplish the goals and objectives that will benefit the community. It is worth all the work.
- Not "direct" a community or assume that we "know what's best". It is often slower to bring a community along in planning and decision-making, but the benefits outweigh the problems because, after all – our job is "to teach them how to fish".
- Advocate for the state to allow communities to make their own decisions about how local investments are made and allow them to develop local strategies to address local issues.
- Research and implement "best practices" from other successfully evaluated programs.
- Ask consumers to identify barriers to services, as they perceive them.
- Bring consumers to the table early on and through out the program so their voices and needs are heard.
- Utilize community liaisons, as they are extremely valuable in outreach recruitment. The trust and acceptance factors should be utilized.
- Establish sound data reporting systems at the onset of the program to support, assess and provide objectives evaluation of the programs.
- Keep everyone informed and updated at regular intervals.
- Ensure that the role of convener is not seen as threatening by not providing services that already exist within the community.
- Ensure that planned improvements in the delivery of quality care are coordinated with multiple staff at varying staff levels with support from both administrative and front line staff. Initiation of monthly meetings with appropriate "grass root" managers for implementation of new or revised protocols/policies along with input of those same

members in the development and evaluation of materials and forms has been beneficial and well received by all. Coordinated team efforts build team spirit.

- Communicate, communicate, communicate.
- Document everything, as it is essential in the delivery of quality services and in receiving prompt reimbursement for services rendered.
- Partner with diverse community organizations to create more synergy to effectively address community issues.
- Provide feedback on a regular basis to the community on the status of activities and their effects on the issue. Acknowledge their role in successes and needed efforts.
- Collaborate with other agencies/organizations.
- Involve the community and consumers in all planning, implementation and evaluation efforts.
- Empower the community to begin looking within their own agencies/organizations for ways to collaboratively address community issues.
- Maintain consumer involvement/“buy in” as they put their interest, effort and time into creating a successful initiative/ARCCP.

### Management

We have learned that we must:

- Spend time with the front line staff acknowledge their contributions. These are critical to the success of the program and the agency.
- Seek out staff development opportunities as they are necessary and can lead to increased collaboration.
- Initiate sustainability efforts early in the project.

## **V. PROJECT IMPACT**

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

#### **1. Approaches used to enhance collaboration:**

- Expanded consortium to include more community agencies that work with adolescents on deterring their engagement in risky behaviors as well as faith based organizations, most of who have out-of school programs and ministries that are increasingly addressing community needs in the area of health, social services and housing.
- Utilized planning grants from other federal agencies that brought partners together to focus on specific risky behaviors of youth that lead to teen pregnancy as well as on teen pregnancy itself. These groups, were tasked with identifying the scope of the problem as well as evidenced based strategies and potential curricula/programs to address these issues and developing a county specific implementation plan that called for collaborative implementation efforts.
- Increased emphasis on the multisystemic nature of community issues and the fact that multisystemic solutions that involve all partners must be developed and implemented.
- Introduced strategy level evaluation concept for other programs beyond Healthy Start.
- Strengthened memoranda of understanding that clearly delineates the role of the ARCCP and the expectations of partners.
- Established informal mentoring of newly established organizations by the Project Director and appropriate partners.

## Augusta-Richmond County Community Partnership for Children and Families, Inc

- Changed existing by-laws to strengthen governance structure.
  - Increased publicity of partners' as a community resource and of their contribution to the Healthy Start Initiative via the ARCCP's newsletters and *the Augusta-Richmond County Community ARCCP for Children and Families, Inc Partner Report*, a document that lists partners, their mission, top accomplishments, etc.
  - Increased mechanisms for family members to be involved in collaborative partners' decision-making by involving them in their focus groups run by local and state representatives and in completing needs assessment surveys.
  - Increased involvement of consumers in the consortium.
  - Recognized the growing Hispanic population that is no longer invisible, and bringing key groups that provide services to this population to the collaborative table.
  - Introduced innovative models of care to the community (Centering Pregnancy Model of Care).
2. Structured changes established to facilitate systems integration included:
- The development of procedures to manage perinatal patients for the regional perinatal center to help them fulfill their mandate from the state.
  - Implementation of use of a child development screening tool currently utilized by the local health department. This included procedures for the health department to score the tool and work with the assigned Healthy Start case manager to develop a family plan.
  - Implementation of United Way's 211 information and referral line which draws upon the ARCCP's resource database as well as that of other partners. As the ARCCP had its WarmLine, which had grown from a being a recruitment tool/case management support to a community information and referral line for residents and agencies, ARCCP staff met with staff from the United Way prior to the line going into operation, to clarify which line would handle which type of calls, what types of calls would be referred to the ARCCP and data collection that would meet the reporting requirements of both agencies.
  - Sharing of community resource data with partners and the community via a server and website managed by a partner agency, the Medical College of Georgia.
  - Incorporation of the Health Department's Babies Born Healthy enrollment form into the Healthy Start family assessment packet to save women (and their families) from having to go to their birthing hospital of choice to complete it. The forms were then sent to the Health Department, which provided feedback on the enrollment to the participant's ARCCP Healthy Start case manager, which had the effect of eliminating the middle person (as far as Healthy Start program participants were concerned) allowing direct contact between the Health Department's Babies Born Health Coordinator and ARCCP case managers.
  - Facilitation by the ARCCP of implementation of the Centering Pregnancy Model of group prenatal care to the local community by coordinating orientation sessions with the national Centering Pregnancy and Parenting Association for providers (physicians, midwives, nurse practitioners, nurses, social workers, etc), and later training for those interested, to be held locally. Upon completion of the training, ARCCP staff facilitated meetings between the local catholic hospital and two

provider practices that had agreed to work together to implement it in order to bring the program to fruition.

3. Key relationships were developed with the:
  - a. Medical College of Georgia Health Disparities Research Workgroup whose mission was to promote mutual understanding and cooperation in working toward improved research and improved health for community members. The Community Advisory Group, of which the ARCCP was a member, was tasked to identify health issues (from a community perspective), promote communication between community leaders and researchers, identify and share resources, and bring together community leader and researchers for the purpose of designing, implementing and evaluating culturally sensitive research projects.
  - b. Interfaith Health ARCCP and its Institute for Public Health and Faith Collaborations which is aimed at fostering the capacity of public health systems and communities to improve the complex and enduring behavioral and social conditions under girding health disparities.
  - c. Integrated Health Resources, LLC which provides planning and management services to health and human service organizations and operates a comprehensive call center used for providing access and care management for specific consumer populations on behalf of public and private sector clients.
  - d. CSRA Community Voice Mail program, which provides support to Healthy Start participants and other community agency consumers who do not have access to regular telephone service. Through this program, participants have access to individual voice mailboxes where they can receive messages by calling an 800 number and entering their password. For Healthy Start participants, this allows providers and case managers to leave messages about appointments, referrals and general information that can be retrieved at any time. This service was especially important for women who were victims of domestic/family violence as it gives them a secure way to get information.
  - e. Housing and Neighborhood Development (HND) agency that became active in the consortium and provided funding to support programs that are a part of the community's strategic and annual operating plans. Efforts continue on ways to integrate the needs assessment each agency conducts (both of which have different focus areas) into a comprehensive plan.
  - f. CSRA Breastfeeding Coalition, which was reactivated in recent years by the nutrition staff at the local health department. ARCCP staff have attended health department funded trainings on breastfeeding, to include lactation consultant training and the national breastfeeding awareness campaign, and assisted them in developing their strategic plan and integration of that plan into the ARCCP facilitated community strategic and annual operating plans.
  - g. Georgia Psychological Services and Bradford Health Services, both of which provide substance use prevention and intervention programs in the community. Both are referral agencies for Healthy Start program participants.

Other key relationships established included those with Planned Parenthood (which has also been represented on the Board of Trustees), Children Unique (a local day care

center), The Medicine Shoppe (pharmacy), new community health service programs in the 30901, 30904, and 30906 zip code areas, Kids Restart (which works with parents suspected/confirmed for child neglect/abuse), the Hispanic Clinic initiated by the St. Vincent de Paul Clinic, and two new organizations (Claudine's House and Teens in Mind) whose ultimate goal is to establish homes for homeless pregnant teens.

In addition, discussion was initiated (and continues today) with the CSRA ARCCP for Community Health, the Richmond County Health Department, Richmond County Board of Education, the local Economic Opportunity Authority and United Way on development of a comprehensive needs assessment that would address each agency's needs and reduce the number of assessments given to the same groups (i.e. students).

4. The impact of the Healthy Start Initiative on the comprehensiveness of services is described below.
  - a. Eligibility/intake requirements –
    1. *Health services* – Eligibility/intake requirements for health services was not an issue for the majority of the population, even prior to the start of this phase of the Healthy Start Initiative. The exception to this rule was non-U.S. citizens in an illegal immigration status. ARCCP staff was able to work with the local health department and regional perinatal center to arrange for this population to receive services through special programs such as Babies Born Healthy and the development of special payment plans. In fact, the ARCCP incorporated completion of the Babies Born Health enrollment form into its assessment packet to save women (and their families) from having to go to their birthing hospital of choice to complete it. The forms were then sent to the Health Department, which provided feedback on the enrollment to the participant's ARCCP Healthy Start case manager. This, coupled with targeted outreach efforts increased their access to services.
    2. *Social Services* - Via the Healthy Start Initiative, access to social services was broadened to encompass populations that either would not have otherwise received them or would have had difficulty accessing them because they did not know where to go for services. By combining neighborhood canvassing with information distribution at health fairs, community events, community presentations, and direct referral from perinatal providers, ARCCP staff was able to increase awareness of the link between psychosocial factors with access to care and perinatal outcomes, offer its WarmLine and staff as an information and referral resource for the community, and work collaboratively with other agencies, as well as providers and hospitals, to ensure women and their infants received needed health and social services.

To facilitate entry into the Healthy Start Initiative, ARCCP staff developed a referral form that allowed the referring agencies to provide basic demographic information and utilize their own forms as an attachment to provide more detailed information about the patient.

- b. Barriers to access and service utilization and community awareness of services, such as lack of insurance and enabling services, are listed in section IV-A of this report.

- c. Care Coordination included home visiting and case staffing with the referring agency. Upon receipt of a potential client referral, from whatever source, a case manager was assigned (based on triaged risk status) to conduct a home visit and complete an assessment with the referred woman and her family. Utilizing this assessment and the referring agency's assessment information, a family case plan was developed. Feedback information to the referring agency was provided based on preestablished protocols between the ARCCP and the referring agency. For example, certain physician offices only want to be notified after the initial patient contact to know that the patient was enrolled in the program/received the service referred for, while quarterly meetings are held with the regional perinatal center.

To ensure continuity of care, a section of the family case plan included a schedule of doctor's visits (based on the Kotchelchuk index) and immunizations for the infant. At each client contact, case management staff checked to see if appointments were kept and if not why. Any barriers disclosed were handled at that time. Physician offices notified the Social Services Program Manager of clients not keeping appointments and asked for assistance in locating them and getting them back on schedule. This facilitated participants keeping their appointments and improved their probability of receiving adequate prenatal care.

Quality improvement and follow-up on client referrals were done based on the needs and desires of the referring agency as described above. In addition, the referral process, general needs, changes to the feedback process, patient trends, etc were discussed quarterly with physicians and their staffs as a means to ensure the participant's medical and social needs were being met and also allowed the provider to know what was happening with his/her client from a psychosocial perspective which in turn allowed for the provision of more holistic care.

- d. Sharing of agency information – Information shared between the referring agency and the ARCCP is based on HIPPA, client consent, and agency protocols. As a result of HIPPA, each agency, including the ARCCP has their patients/clients sign a HIPPA Consent Form that addresses the sharing of information between agencies. All clients have the option to opt out of, in writing, any portion of the HIPPA agreement to include the sharing of information across agencies. In addition, the local hospitals have their patients sign a consent form to acknowledge that they are being referred to the program and know what it is about. This form was implemented to address the problem ARCCP case management staff were having with the referred patients not knowing (or remembering) that they were being referred.

To facilitate referrals, each referring agency utilized their own forms to provide detailed information related to the referral. These forms were faxed to the ARCCP Social Service Program Manager (utilizing a secured fax). Feedback information was provided either via phone or fax for most referring agencies, per their request. For the regional perinatal center, because of requirements levied on them by the state, feedback information was provided via a form designed by the hospital in conjunction with case management staff. This process not only facilitated referrals to the program

but also established feedback loops with providers to keep them abreast of other services their patients received and of psychosocial issues that may impact the pregnancy.

An additional sharing of information occurred in the area of community resources. The ARCCP, CSRA ARCCP for Community Health, Department of Family and Children Services and Task Force for the Homeless each maintained a database of information that was integrated and shared among the agencies and with others in the community via a server managed by a partner, the Medical College of Georgia. This database became the foundation for United Way's 211 information and referral line recently implemented in this community.

#### 5. Impact of Enhancing Client Participation in Evaluation

- a. Client participation in the annual evaluation of services enabled us to modify our client satisfaction surveys that not only measure satisfaction with services provided by the ARCCP but with services provided by referral sources. In addition, client feedback on community provider service indicated a need for enabling services such as transportation, translation services, and childcare. The ARCCP staff was able to provide transportation support for its clients as was the local health department for its Resource Mother's program clients. To address transportation issues, at the end of this phase a community task force was developed to look at transportation issues as a whole for this community. The Project Director will work with this group, and involve consumers, to ensure their concerns are addressed. With regard to translation services, the ARCCP hired a Hispanic Outreach/Family Support worker and provided translation services for its clients. This individual also accompanied our clients to partner agencies/referral agencies to provide translation services for them. In addition, the ARCCP worked with local provider, the regional perinatal center and other partners to look at the organizational barriers that the Hispanic and other non-English speaking groups face when coming to their facilities and how to address them. As a result, many agencies have identified one or more individuals that speak at least one other language to work with non-English speaking people and some have begun providing Spanish language classes for their staff as the ARCCP did. Additionally, culture sensitivity issues were addressed through one-on-one "conversations" with partners and classes sponsored by the various partners.
- b. Consumer participation in developing assessment and intervention mechanisms and tools was achieved through focus groups, parent support group meetings, one-on-one meetings, and annual evaluations. Their input was used to develop and revise case management protocols, screening tools, community surveys, develop health awareness and education materials, etc.

#### B. Impact to the Community

The impact of the Healthy Start Initiative has been documented in the following areas.

1. Residents of the community are more knowledgeable about resources in the community through outreach efforts, case management services and the WarmLine (the ARCCP's information and referral line). This increased knowledge was measured through community surveys and client satisfaction surveys.

2. Consumer participation in establishing or changing standards and/or policies of participating service providers was accomplished via focus groups sponsored by ARCCP and by its partners, consumer participation with service providers in the ARCCP facilitated strategic planning process, and involvement of consumers in state level focus groups carried out by the Georgia Family Connection ARCCP and the Family Health Planning Branch (state Title V agency).

Consumer involvement in the community's strategic planning process included working with partners/providers of service to look at data related to issues such as infant mortality, low birthweight, teen pregnancy, substance use, poverty, child abuse, etc, setting 3 year goals for each of these areas, developing strategies to address these issues, identifying activities and services to address the issues and current providers of those activities and services, and identifying gaps in services/activities. This information was put into a three-year strategic plan that was submitted to the state. From this three year plan, an annual operating plan, which served as a blueprint to guide the consortium's activities, was developed and distributed to the state as well as to partners in the local community. In addition, consumers were invited to attend the quarterly Membership Council meetings and had the opportunity to speak on the services they received in the community. Consumers also attended the community's annual meeting, facilitated by the ARCCP, to develop the Children's (and Families') Agenda, which outlined concerns for the community that they wanted legislators to address in the coming year. This agenda, which listed concerns and recommendations for actions, was presented to state and local legislators annually at the ARCCP's Legislative Breakfast. Consumers were involved in presenting the issues to the legislators and subsequent dialogue. This allowed consumers to become more aware of community issues, to provide the consumer perspective to the planning process, to network with community agencies. In addition, it allowed partnering agencies to experience consumer power first hand, to learn how their services are perceived in the community and receive kudos and suggestions for improvements.

Via the Peer-to-Peer Network, consumers were given the opportunity to be a part of a state wide network that serves in an advisory capacity at the state level to the Georgia Family Connection ARCCP, a state agency with state level partners addressing children and family issues, and to their local/county level Family Connection site (of which the ARCCP is one).

3. Community experience in collaboration, which had been in place since 1985, was enhanced by the Healthy Start Initiative through increased membership and a resultant increased coordination of services among community agencies. Protocols for managing divergent opinions and resolving conflicts had been in place since the formalization of the agency in 1991. Utilizing funding provided via the Healthy Start Initiative, the ARCCP was able to provide additional substantive team building activities that included joint trainings that included interagency discussions, interagency focus groups, involvement by partners in presenting at state and national level conferences where ARCCP staff spoke on Healthy Start, developing/designing public service announcements, etc.

4. While the Healthy Start Initiative did not lead to creation of jobs in the community, by working with clients to find jobs and improve their job seeking skills and providing on-going support to them, the initiative helped lower the jobless index and move clients from welfare to work.

### C. Impact on the State

The ARCCP worked with the State Title V agency by:

- Developing and distributing the Georgia Infant and Child Health report. Note that all Georgia Healthy Start sites participated in the development of the report but each handled distribution for their respective community.
- Improving data collection efforts by sharing the impact of state actions on local community efforts.
- Developing and implementing statewide campaigns around maternal and child health issues
- Addressing perinatal health disparities, infant mortality and teen pregnancy.
- Securing training for consortium members and the community.
- Supporting state efforts in ARCCP development.
- Developing the state Title V plan.
- Supporting training for local state Title V liaisons that enhanced the efforts of the consortium in planning, implementing and evaluating programs to address the factors related to infant mortality.
- Securing consumer and consortium attendance and input at state Title V sponsored focus groups.

With regards to coordination among other Healthy Start sites in the state, note that Georgia had a total of four (4) projects – two of which covered contiguous areas and shared community resources. Joint meetings were held to discuss mutual issues, brainstorm ideas and share successes and lessons learned. In addition, the ARCCP – which covered Richmond County, and the Enterprise Healthy Start Initiative, which provided services to the six surrounding counties, shared information and training opportunities with each other as well as information regarding the status of shared community resources and coordinated efforts to distribute the Georgia Infant and Child Health report in order to reduce duplication. Additionally, the two Healthy Start sites jointly:

- Planned two community conferences – one on perinatal health issues and one on perinatal mood disorders – for consortium members, providers of services, and consumers representing the seven counties covered by the two sites.
- Coordinated tours of the neonatal intensive care unit at two birthing hospitals for legislators, county commissioners, consumers, consortium members and staff.
- Presented information on the Healthy Start Initiative to pediatricians at the Medical College of Georgia.

In addition, through training of staff, consumers and local Title V liaisons, this community was better able to support the state Title V staff in their efforts to reduce teen pregnancy and infant mortality. An additional benefit was that Title V staff began to host meetings to coordinate efforts and provide technical assistance to Healthy Start sites.

The ARCCP provided indirect support to the SCHIP program via the local Covering Kids Initiative, a coalition that developed and implemented strategies such as using medical students to provide information and assist families in enrolling in both Medicaid and PeachCare for Kids.

#### D. Local Government Role

On the local level, the county commission has designated the ARCCP as the single point of accountability for results related to children and families, which facilitated the process of convening agencies/organizations and maintaining their involvement, all the while expanding the consortium as new agencies/groups addressing related issues are formed and/or identified. In addition, securing county support for grant funds was made easier because of this designation.

During this phase, the local government took a more active role in the consortium with the county commissioner assigned to the Board of Trustees attending meetings of both the Board of Trustees and the Membership Council. He was also instrumental in securing resources to support ARCCP activities. In addition, several commissioners attended a local Healthy Start conference where information and data was presented on perinatal issues followed by a tour of the NICUs at two local hospitals. This increased their awareness of the scope of infant mortality and low birthweight babies in this community as well as increased their awareness of ARCCP activities.

Barriers include:

- Lack of consideration of the impact of social issues on the community and thus lack of priority given to addressing these issues. This has impacted the ability of the Augusta-Richmond County Housing and Economic Development, whose mission was to create positive change by promoting self-sufficiency through ARCCP in economic development, quality housing and neighborhood reinvestment, to work with the ARCCP in developing a comprehensive community plan that addresses psychosocial, recreation, and economic issues. This is a major barrier because many of the issues addressed by each agency are contributing factors to each other.
- Emphasis, particularly in the area of funds, placed on infrastructure and 'bricks and mortar' projects.
- Turfguarding by the commissioners (relative to the district they represent).
- Inability by the commission to reach consensus on many community issues.

#### E. Lessons Learned

Lessons learned are found in section IV-A.

## **VI. LOCAL EVALUATION**

The local evaluation report is at attachment 2.

## **VII. FETAL AND INFANT MORTALITY REVIEW (FIMR)**

The FIMR process that was in place during Phase II of the Healthy Start Initiative ceased with the retirement of the physician assigned by the Health District Director during the first year of

Phase III. ARCCP staff began exploring the feasibility of reestablishing the FIMR with the Health District Director. Action steps taken included:

- Identifying procedures already in place at local hospitals and through the Child Fatality Review (CFR) process related to fetal and infant deaths.
- Identifying individuals to serve on the Community Review Team and the Community Action Team.
- Determining how the FIMR, CFR and Perinatal Periods of Risk (PPOR) could be integrated with each other and with fetal/infant review procedures already in place at local birthing hospitals.

## **VIII. PRODUCTS**

A chart showing materials produced under the Healthy Start Initiative is at attachment 3.

## **IX. PROJECT DATA**

Project data is at attachment 4.