

Detroit Healthy Start Project – Impact Report for Phase III
June 1, 2001 through May 31, 2005

Introduction

Detroit Healthy Start was one of the 15 original demonstration projects. During the 2001-2005 project period, we focused on improving the poor physical and mental health outcomes of the African American women and infants that were prevalent in the project area from the baseline years of 1996-1998. There have been three major areas of concentration for the project: improving pregnancy and birth outcomes, assisting women to access interconceptional care between pregnancies, and improving the identification and treatment of perinatal depression. These areas of concentration were selected on the basis of a low rate of early entry into prenatal care and high infant mortality rates. There was a large disparity in the infant mortality rates between white and black infants not only in the project area, but in the City as well. Finally, there were inadequate treatment resources for women experiencing perinatal depression.

The Detroit Healthy Start Project area encompassed approximately 40% of the City of Detroit, and included sixteen subcommittees. The area was characterized by high rates of infant mortality, poverty, unemployment, substance abuse, and poor housing. In 1990, the total population of the area was 398,526, and 28.8% (114,890) of the population were women of childbearing age (US Census Bureau, 1990). The majority of those women were African Americans (108,857/ 95%), with white women (4%/ 4,278) and women of Hispanic origin (0.5%/652) constituting small proportions of this group. At that time, over sixty per cent of the total population (61%) had an income below 185 % of the Federal Poverty Level (FPL) and 54% of children younger than 18 lived in families with incomes below the FPL. The project area's average percent of female-headed households with children was 66%. Since most residents in the area were African-American, most of our services were targeted to that population of women and infants.

Each core service focused on specific aspects of service to address our community's disparities in perinatal outcomes. Outreach focused on early identification of pregnant women and recruitment into prenatal care. Case management focused on risk assessment, risk reduction, assisting women to access health care and other resources for themselves and their infants, the provision of transportation, and encouraging women to seek preventive care. Interconceptional care focused on supporting high risk women to obtain preventive care between pregnancies, family planning, and addressing problems that negatively influenced their family's well being as ways to decrease infant mortality in the long term. Since health education was an integral part of each of these three core services, the focus of the health education core service was to support the educational activities of the other components. Perinatal depression focused on establishing screening as a routine component of care and increasing treatment capacity. The four core systems-building efforts focused on increasing access to care and improving coordination of services. The goal of the Local Health System Action Plan was to establish a single entity that would develop, implement, and evaluate a comprehensive, county wide plan to address infant mortality. The goal of the Consortium was to educate, empower, and engage consumers. The goal of Collaboration and Coordination was to assure maximum utilization of services. The goal of Sustainability was to identify resources to maintain Healthy Start services. To facilitate Healthy Start's ability to achieve its goals, the grantee agency provided an extensive array of in kind services. During the

project period, the grantee agency underwent a name change. The Detroit Health Department became the Detroit Department of Health and Wellness Promotion. The name change did not affect the department's commitment to maternal child health services, including Healthy Start.

Overview of Racial and Ethnic Disparity Focused on By Project

Perinatal outcomes and Interconceptional care.

The baseline needs assessment data underpinning the four core services of outreach, case management, health education and interconceptional care were drawn from census and vital statistics data bases. There were 17,484 births in the Healthy Start area over the three-year period, 1996-1998, with an average of 5,828 births per year, 90% of which were to African-American mothers. The 1996-1998 three year average infant mortality rate for the entire Healthy Start catchment area was 16.6/1000 live births, with a low of 14.6 in the Central region and a high of 17.9 in the East region. The black infant mortality rate was 17.1/1000 live births versus 5.0 for whites in the project area. The infant mortality rates were 16.7 for blacks and 6.2 for whites respectively city-wide.

Over half (64.7%) of the infant deaths in 1996-1998 occurred in the neonatal period (the first 28 days of life). The major contributors to neonatal infant mortality were low birth weight/short gestation (26.33%), congenital anomalies (9.33%) and respiratory distress syndrome (7%), which together, accounted for 42.66% of the infant deaths from 1996 through 1998. Sudden Infant Death Syndrome (SIDS) was the major cause of deaths in the post neonatal period, (between 28 days and one year) accounting for 20% of all infant deaths. It is especially noteworthy that all SIDS deaths in the Healthy Start area occurred to black infants. Another seven deaths for these three years were attributable to unintentional injuries and five were due to homicides. All except one of these deaths were to black infants.

In 1996-98, the three-year average for low birth weight births in the Healthy Start catchment area was 19%. This rate was 1 ½ times the City rate (12.9%) and 2 ½ times greater than that of the state and the nation. A disparity also existed for the overall percent of preterm births (deliveries occurring before 37 weeks of gestation). The preterm rate for the Healthy Start area was 26%, which was 1-2 times greater than the national and state rates. However, the city rate of 25% matched that of the target area.

A similar racial disparity existed in the incidence of preterm and low birth weight births. The three-year state average for preterm births for whites was 9.27% versus 16.63% for blacks. The disparity, in the Healthy Start area, for preterm births mirrored that of the state. Nineteen percent (19%) of births to whites were preterm while 26% births to blacks were preterm. Both the state and Healthy Start preterm birth rates exceeded the Healthy People 2010 Objective of 7.6 per 1000 live births.

Michigan's three year average for low birth weight births for blacks (13.6%) was two times greater than the average of 6.5% for whites. In the Healthy Start area low birth weight rates were high for all women, at 15%, for black women and 12% for white women. The Healthy People 2010 Objective is no more than 5% of all live births. These figures reflected large racial disparities in

preterm and low birth weight births in the area, and also indicated we were far from reaching the Healthy People 2010 goals for both black and white infants.

Lack of prenatal care is associated with increased rates of preterm and low birth weight births. Between 1996-98, an average of 57.8% of the women in the Healthy Start area received prenatal care in the first trimester of pregnancy, with more white women, on average, receiving first trimester care than black women (white: 63.9%; black: 57.8%). Overall, 4% of women in the Healthy Start area had no prenatal care during this time. While these figures represent some racial disparity, the rate of first trimester entry into care is low for all women, and the proportion of women with no prenatal care is high for all women. The Healthy People 2010 Objective is 90% for first trimester entry into care.

Based on the data presented here, between 1996-98, the perinatal care system in the Healthy Start area was not achieving the Healthy People 2010 goals for increasing prenatal care and decreasing infant mortality. Therefore the Detroit Healthy Start Project decided to focus on improving maternal and infant outcomes within its outreach, case management, health education and interconceptional care components, as well as the core-systems building efforts.

Perinatal Depression

Using data from Hutzel Hospital, the postpartum surveys, and birth certificates, we estimated that a significant number of women in the project area were at risk for postpartum depression. Between 1996 and 1998, there were 17,484 births in the Detroit Healthy Start Project service area, with a three-year average of 5,828 (Healthy Start Target Area and City-Wide Infant Mortality Data Table, 1996-1998, Detroit Health Department, Office of Health Policy, Planning and Grants Management, February 2001). Using the accepted estimate of a prevalence of 10%, we determined that approximately 580 women in the Detroit Healthy Start Project area would experience perinatal depression each year. Based on an assessment of existing resources, it was clear to us that the need for treatment far exceeded the service capacity of our local perinatal health system. Thus, we used the opportunity afforded to us by the Healthy Start request for proposals to address this important unmet need. Our data demonstrated that there was a serious lack of services available. Therefore, we decided to create our own screening and treatment program.

Women who resided in the Detroit Healthy Start Project service area and/or received services from the Detroit Healthy Start Project were primarily covered by Medicaid for their medical and mental health services. Since 1998, with the exception of the severely and persistently mentally ill, the State of Michigan mandated that mental health services for this population must be authorized and/or provided by managed care organizations. Women and children who were non-insured could receive mental health services through the Community Mental Health (CMH) system. Typically, referrals for women who were not severely or persistently mentally ill were made to outpatient clinics that provided treatment in an office setting with little attention to the fact that the woman was pregnant or had a young infant. Anecdotal comments from clinic, case management, and CMH staff indicated that depressed women tended not to follow-through with these referrals and did not keep their appointments. For this reason, Detroit Healthy Start Project chose to provide a home-based intervention that was culturally congruent and sensitive to the needs of the mother-infant dyad.

When we conducted our needs assessment, we looked at what services were available in the target area and how many women were likely to be at risk for perinatal depression. First, we assessed how many and what type of mental health services were available in the project area. To determine this, we conducted a survey of local CMH Centers. Six centers provided services to women and children with emotional disorders such as depression, but none focused exclusively on diagnosis and treatment of perinatal depression. Development Centers Inc. (DCI), one of the CMH centers, and the Merrill Palmer Institute at Wayne State University, had Infant Mental Health (IMH) programs which specialized in treatment of mother-infant dyads during pregnancy and infancy (birth to 3 years of age). The goal of these programs was to intervene with the family to promote emotional health in early childhood and prevent a variety of disorders in young children (Karr-Morse & Wiley, 1997; Osofsky & Fitzgerald, 2000; National Center for Clinical Infant Programs, 1997). Women with perinatal depression were an appropriate population for these programs. Although none of these IMH programs was specifically targeted only to women with perinatal depression, Development Centers Inc. had a day treatment program for mothers with serious mental illnesses that has been in place since 1987. In addition, all of the IMH programs in Detroit include women with clinical depression and their infants in their case loads. The total capacity of all the IMH home-based programs in Detroit combined was about 125 families, and the DCI day treatment program for mothers with serious emotional disorders had capacity for only 8 families at any given time. A major goal of Detroit Healthy Start Project was to increase the treatment capacity of the IMH programs.

The research and clinical literature on perinatal depression indicated that the percentage of women with depression during pregnancy ranges from 4 to 16% (Green & Murray, 1994), and postpartum depression ranges between 8 and 15%, with 10% the most common estimate in the general population (Cooper & Murray, 1995; Cox, Murray, & Chapman, 1993; O'Hara, 1997; O'Hara, Neunaber, & Zekoski, 1984; O'Hara, Zekoski, Philipps, & Wright, 1990). This body of literature also indicated that there are several factors which place a woman at risk for postpartum depression: a previous depression, an inadequate support system, especially lack of a confidant, living in conditions that are stressful, such as poverty or high crime (Cox, Holden, & Sagovsky, 1987; Holden, 1994; O'Hara, 1997), or a perinatal stressor such as having a premature infant (Singer, 1999).

Approximately 70% of the women in Detroit Healthy Start Project received their prenatal, postpartum, and family planning care through three clinics: the Grace-Ross Health Center (a clinic of the grantee agency whose prenatal services were partially supported by Healthy Start), the Hutzel Hospital clinic at University Health Center (UHC), and the Sinai-Grace Hospital clinic. All of these sites used a standard health assessment format that included questions about depression as part of their routine care, and this information was noted in their clinic record. In 2001, prenatal care clinic data at Hutzel Hospital was abstracted from clinic records and entered into a central data base. This data base included data related to perinatal depression. To obtain an estimate of depression during pregnancy or postpartum for women who delivered at Hutzel, the local evaluator requested data on women in Detroit Healthy Start Project zip codes who delivered an infant between 1996 and 2000. Specifically, the request was for information on women who had experienced depression during the current pregnancy or a previous pregnancy, or who were known to have risk factors associated with perinatal depression. Among 10,603 deliveries between 1996

and 2000 to Detroit Healthy Start Project area women, only 47 were identified as having depression during the current pregnancy, and 20 were known to have experienced postpartum depression in a previous pregnancy. Based on these figures, less than 1% of the women in the Detroit Healthy Start Project area were known to have experienced depression during or around pregnancy (Hutzel Hospital perinatal data base, 1996-2000). The evaluator then asked for data on women with risk factors for postpartum depression between 1996 and 1998. Among 6,274 total deliveries to women in the project area, 10.4% (650 women) reported a major emotional or psychiatric problem (Hutzel Hospital perinatal data base, 1996-1998). Overall, these data indicated that the percentage of women in the Detroit Healthy Start Project service area with a major emotional disorder (including depression), that was identified through routine prenatal care health assessment was consistent with the national average for postpartum depression. Additionally, among these same 6,274 deliveries, an average of 13.2% of the women ($n = 272$) reported having inadequate resources (range 13.9% - 23.8%), 15.9% ($n = 333$) reported past physical abuse, rape/sexual abuse or mental abuse (range 6.8% - 24.2%), and 2.7% ($n = 56$) reported recent physical, sexual or mental abuse (range 3.4% - 5.2%) (Hutzel Hospital perinatal data base, 1996-1998).

The final set of data we used to estimate the number and percent of women in the Detroit Healthy Start Project service area who experienced depression was the postpartum surveys conducted at Hutzel Hospital by the Healthy Start Project evaluation team. Women were interviewed within 24 hours of delivery. One of the questions in the interview asked: “In the past six months, was there a time lasting one continuous week or more when you felt sad, blue, or depressed most of the time, or when you lost all interest and pleasure in things you usually care about and enjoy?” (Detroit Healthy Start Project Postpartum Survey, 2000). Based on data from 496 women interviewed between 1997 and 2000, 40.9% ($n = 203$) reported feeling depressed during pregnancy. While these self-report data do not reflect diagnosed clinical depression, they do indicate that almost half of the women from the Detroit Healthy Start Project service area who completed an interview within 24 hours of delivery perceived themselves to be depressed at some point during their current pregnancy. This was important because women, like all people, interact with others based on their internal perception of their own affective states. The fact that such a high percentage of women would self-report depression has important implications for the health of the women and for the growth and development of their newborn infants.

II. Project Implementation

Core service - Outreach and Client Recruitment

- A. Detroit Healthy Start decided to utilize existing resources within the grantee agency to meet the requirements for outreach and client recruitment. The Detroit Department of Health and Wellness Promotion, the grantee agency, had an important asset, an existing outreach program that was operating within the context of the department’s community outreach plan. As the goals of that plan mirrored those of the Healthy Start project, it did not seem appropriate to create a new outreach entity within Healthy Start. While this was a cost effective way for the project to provide outreach services, the challenge was to provide a presence in the project area with staff who were serving the entire city. To address this challenge, we planned for the Maternal Child Health Advocates who

were assigned to the case management core service to work in the project area. Their activities were expected to augment the work of the outreach and client recruitment core intervention by assuring that there was a focus on women who resided in the project area.

- B. There were three main components of the outreach intervention, the Prenatal Advocacy and Outreach Program, the Medicaid Outreach and Advocacy Program, and Healthy Start case management. The Prenatal Advocacy and Outreach Program, funded by our state Title V agency, was intended to increase access to prenatal care for minority populations. Activities included collaboration with organizations serving specific minority populations, hosting community forums, participating in community events, and operating a telephone helpline. The Medicaid Outreach and Advocacy Program enrolled pregnant women, infants, and children into MICHild and Medicaid, the state and federal insurance programs for low income families. Maternal Child Health Advocates from the case management core service component regularly engaged in outreach and recruitment activities. They were out stationed at agencies within the project area that served high risk women such as shelters and food banks. They also participated in community events and distributed information.

The major outreach interventions were:

- Case Finding
- The Family and Parenting Helpline
- The Prenatal Health Assessment
- Health insurance enrollment
- Guarantee of Payment Letter
- Linkages to interdepartmental and community resources
- Healthy Start Project referral process

The Family and Parenting Helpline (an established central point of contact for Detroit residents seeking family and parenting related resources and information) was determined to be a logical vehicle for some of the outreach intervention to the perinatal population for the following reasons:

- The Helpline received in excess of 1,000 calls annually from pregnant women seeking advocacy services relative to pregnancy, i.e., prenatal care, health insurance, and parenting skills.
- The majority of women who accessed the Helpline did so within the 1st and 2nd trimesters of pregnancy.
- Helpline technicians who processed Helpline calls were trained advocates, capable of assessing and referring pregnant women to Healthy Start for case management services.

The Helpline technician administered a “Prenatal Health Assessment” tool to all pregnant women who called the Helpline as a method of case finding. The services of Healthy Start were described to the women and they were offered a referral. After providing women

with information on needed resources (health insurance, prenatal care, WIC), the Helpline technician forwarded the Prenatal Health Assessments to Healthy Start for ongoing case management services.

To assure access to care, when a pregnant woman presented for enrollment into health insurance, she was issued a “Guarantee of Payment Letter” which guaranteed payment to the provider for prenatal care (whether the client’s Medicaid was approved or not). Valid for 45 days, this letter allowed the client immediate access to care. The enrollment outreach worker also scheduled the client’s initial prenatal care and WIC appointments. Transportation with the Healthy Baby Services van was scheduled as needed.

The resources needed to implement the outreach intervention consisted of a telephone system for the Helpline, Helpline technicians, other program staff, supplies/materials, and a referral system between Outreach and Healthy Start.

- C. Decreases in state funding were the primary events that detracted from the successful implementation of Outreach and Client Recruitment. At the beginning of the project period the outreach program was primarily state funded. In 2003 there were major decreases in the state budget, and the outreach program was slated to be discontinued. However, the grantee agency decided to continue outreach services using other funds. Thus the outreach intervention processes remained consistent over the course of the project, but there were both structural and staff changes. Staffing and service capacity were reduced as a result of these cuts. Funding for Prenatal Advocacy and Outreach Program was eliminated in 2003. Also in 2003, state budget cuts resulted in a 50% reduction of Helpline technicians from 4 to 2 full time positions. In addition, these budget cuts resulted in the lay off of 16 maternal child health advocates who were part of the case management staff. Events that facilitated the successful implementation of outreach included organizational changes, ongoing training and a public information campaign. All outreach efforts, including the Family and Parenting Helpline, were consolidated into the Medicaid Outreach and Advocacy Program and placed under a single manager, late in 2003. This was intended to increase efficiency and coordination. All Medicaid Outreach and Advocacy Program staff received cross training, which enhanced the effectiveness of the outreach efforts. Lastly, a multimedia public information campaign, Love My Baby/Love My Family, began in 2001. This campaign was funded by a local foundation and was intended to increase awareness of available resources as well as to educate the community about the importance of early and regular prenatal care. Posters, pamphlets, and billboards, strategically placed throughout the city, advertised the campaign and reinforced the messages about prenatal care and health insurance.

Core service - Case Management

- A. To provide case management services to Healthy Start participants, Detroit Healthy Start decided to build on established practices and leverage the resources of the Detroit Department of Health and Wellness Promotion, the grantee agency. Healthy Start and the grantee agency had previously combined their home visiting staff to establish a multi-disciplinary team that included public health nurses, nutritionists, social workers, and maternal health advocates. Therefore, Healthy Start had as an asset, staff that were

experienced in both case management and team work. As both the community and the women had many risk factors, utilizing a case management team with a broader range of expertise helped to facilitate case assignment based on the identified need. For example, 650 women from the area received no prenatal care during the baseline period (1996-1998). As previously noted, there were high rates of poor pregnancy outcomes, infant mortality, and substance use. Again, the challenge in maximizing this asset was to provide targeted services to women living in the Healthy Start area while meeting the needs of the entire community. In addition, most case managers had to provide services for a variety of programs such as lead poisoning, immunizations, and the Medicaid Maternal Support Services program. To address these challenges, administrative staff worked to improve efficiency and minimize duplication of effort.

B. The components of the case management intervention were:

- Home visiting
- Case finding
- Assessments
- Health education
- Medical supervision
- Counseling

The resources needed to implement case management services included staff; educational resources such as modules, videos, and literature; supplies and materials; an intake process; and referral mechanisms to connect families to community resources. There were no major changes in Healthy Start case management services over the project period. There were organizational changes beyond the control of Healthy Start that influenced workload, procedures, and reporting responsibilities. For example, the project director had no direct line authority for the case management operations until the last year of the project. Thus, data collection issues that affected our reporting ability could not be effectively resolved during the life of the project.

C. Several events detracted from the successful implementation of the case management intervention. The major factor was the significant loss of staff. Decreases in state and local funding, inter-department transfers, promotions and resignations resulted in a 60% reduction in the number of case management staff that were in kind supports from the grantee agency. (This reduced the total staff from 42 at the beginning of the project period to 25 at the end of the project period.) Another factor that detracted from effective implementation was the Work First program. This required clients who received any public assistance to work a minimum of 30 hours a week, thus decreasing clients' availability for home visits. We addressed this challenge through a reiteration of the grantee agency's flexible schedule policy in order to accommodate clients' work schedules.

Core service – Health Education and Training

A. Detroit Healthy Start decided to focus its health education and training core intervention on two factors that directly contributed to excess African American infant mortality, cigarette smoking and unsafe sleep environments for infants. There were several reasons for this decision. First, these behaviors were amenable to educational intervention and tools for staff use were readily available. Second, with only one Healthy Start staff position specifically dedicated to health education, equipping all staff with educational tools would maximize this effort. Third, case managers had received training in the Smoke Free for Baby and Me program, a prenatal smoking cessation intervention. The training was sponsored by our state health department specifically to help the large percent of low income pregnant women stop smoking and minimize their risk of having low birth weight births. Fourth, unsafe sleep was identified as a leading cause of post neonatal mortality.

B. The components of this intervention were:

- Risk assessment
- Client education
- Community education

The resources required to implement the intervention included staff, training materials, and client/community educational materials. There was one change in the intervention during the project period. The client tools (logs, goal cards, etc.) for the Smoke Free for Baby and Me program that had been available from the state health department became unavailable midway through the project. Staff substituted other materials, but they did not mirror the intervention in the same way.

C. Two events detracted from the successful implementation of the health education and training intervention. First, the health educator position was never filled. Therefore, the newsletters were not created and distributed to the larger community. Second, as noted above, the client tools for the Smoke Free for Baby and Me program ceased to be available. This decreased the effectiveness of the intervention.

Core service - Interconceptional Care

A. For Interconceptional Care services, Detroit Healthy Start decided to focus on providing postpartum services to women who received little or no prenatal care. There were 3 reasons for this decision:

1. Women who receive little or no prenatal care often have poor pregnancy outcomes, putting their infants at increased risk for death and disability. In addition, these women may be socially isolated, may have untreated chronic health problems, and are more likely to have problems related to substance abuse or domestic violence.
2. The percentage of women who received inadequate prenatal care increased from 7.7% in 1998 to 8.4% in 2000.

3. Women who receive inadequate prenatal care but do not have major problems during pregnancy or at delivery often receive little or no follow up care after their hospital discharge.

Detroit had two primary assets that influenced our choice of approach to interconceptional services, experience in providing these services and a receptive partner.

First, our Healthy Start application team had the benefit of learning from the successful Inreach project, an intervention specifically designed to engage women who received little or no prenatal care, that was operational in Detroit from 1993-1997. Not only did the Detroit Healthy Start application team include the principal investigator who designed Inreach, but we had access to their data, assessment tools, implementation plan, and evaluation.

Inreach data, as reported in the 2001 Inreach Evaluation Report, illustrated that the women and their infants who participated in the original Inreach project had a very high level of risk compared to women who received adequate care:

- Women who received inadequate care had high rates of substance use, 48 % used tobacco and 31% used alcohol or drugs.
- The infants born to women who received inadequate care had an average gestational age of 36.7 weeks and an average birth weight of 2800 grams. Fifteen percent of these infants were admitted to NICU compared to the average NICU admission rate at our tertiary delivery hospital of 10%.
- The infant mortality rate for the entire group of women enrolled in Inreach was 29.17.

In spite of the high level of risk, the Inreach Project intervention was effective in identifying women who received inadequate prenatal care and retaining them in services after delivery. National Healthy Start subsequently incorporated interconceptional care into its core service requirements based in part on the success of the Inreach model.

Second, our tertiary delivery hospital, Hutzel Hospital, was a partner in the original Inreach Project. The hospital administration was familiar with the project's success and was receptive to participating in a similar program.

The major challenge to our approach to interconceptional services was the eligibility criteria of many community based programs. The original Inreach project operated on the assumption that high risk women would be more receptive to services if an early, strong connection was made to an engaging, individual provider. As previously mentioned, this was a successful intervention. Therefore, we needed community based service providers that could respond quickly to referrals, provide intense services, and assist women with complex problems. Changes in the health and human service systems that took place between 1997 and 2001 resulted in fewer comprehensive,

flexible, community based programs. Two important changes were reduced funding for health and human services and the change to mandated managed care. It should be noted that some changes in the substance abuse treatment system facilitated access. However, changes in the physical and mental health systems impeded access.

B. The components of the interconceptional care intervention (Interconceptional Care Inreach -ICCI) included:

- Identification of newly delivered women who had 5 or fewer prenatal visits prior to discharge from the hospital
- Explanation of ICCI and recruitment into services
- A comprehensive needs assessment
- Matching the women with a needs appropriate program
- Making a linkage to a community based program for ongoing care
- Follow up to assure women received the care
- Collecting long term outcome data
- Linkage to peer support
- Community education opportunities

The resources needed to implement this intervention included Healthy Start staff, materials, supplies, partnerships with the delivery hospitals and community based services, a peer support network, and community education activities.

There were several changes made throughout the project period. It was initially proposed that recruitment for ICCI would be conducted at two birth hospitals, Hutzel and Sinai-Grace. After the recruitment was initiated at Hutzel Hospital, it became apparent that working out of two hospitals would not be possible with only one staff person devoted to the activities of client recruitment, assessment, planning, and follow-up.

Bimonthly education activities were planned as another way to link the women to resources in their communities. These activities were conducted in partnership with community groups and agencies and were intended to provide information, tools, and supports for healthy behaviors. Incentives, child care, fun activities, and refreshments were provided. Topics included infant safety and women's health. All the women who enrolled in ICCI were invited to each activity. These activities were discontinued after two years as none of the women enrolled in ICCI attended. While there was good attendance from the community at large, the objective of providing information and resources to the ICCI clients was not achieved. At the end of 2003, ICCI mothers were invited to focus groups to discuss what other types of services they would be interested in, but again there was no participation. Therefore, staff concentrated on providing information and resources during the initial assessment and follow up contacts.

C. A major resource that facilitated the successful implementation of ICCI, our interconceptional care service component, was the positive response of the delivery hospital. Hutzel, the delivery hospital used for recruitment, is our tertiary care facility

and has over 6,000 deliveries each year. Discharge planning staff spend most of their energy assuring follow up care for the highest risk families and there are few referral resources for other lower risk families. As a result, the staff were very glad to have another referral option.

The limited capacity of the community based programs to whom ICCI staff would be making referrals detracted from the successful implementation. While these programs were receptive to the ICCI concept, most had relatively narrow criteria and generally could not accept those women who “just had problems with insurance, child care, transportation, stress, etc.” In addition, the few specialized programs for adolescents were at capacity and were unable to commit to accepting ICCI clients. Furthermore, several programs closed during the project period and the community mental health system underwent changes that further restricted eligibility.

Core service – Perinatal Depression

- A. For perinatal depression, Healthy Start decided to build an infrastructure that would create internal capacity for both screening and intervention. The main rationale for this decision was the lack of specialized mental health services for pregnant and postpartum women in the community. Although there were a few infant mental health programs, no home based services for women with mild to moderate depression existed. It was decided that it would be inappropriate to initiate screening for perinatal depression without assuring that there would be services designed to meet the identified needs.

Many of the women living in the Healthy Start area had Medicaid and were required to receive their health care, including mental health services, through a managed care provider. These plans typically offered mental health services only in an outpatient office setting with little attention to the fact that the women were pregnant or had young infants. Anecdotal information from staff suggested that depressed women were unlikely to keep appointments in these settings. Women without insurance were able to receive services at community mental health agencies. With the exception of limited capacity infant mental health programs, the majority of these services were also office based. Therefore, a home based intervention that was sensitive to the needs of pregnant women and mothers with infants was developed.

- B. The components of the perinatal depression intervention included:

- Training for all staff on perinatal depression
- Screening for depression using a standardized tool
- Clinical assessment of positive screens
- Recruitment of eligible women into the Healthy Start PD intervention
- A two tiered, home based intervention
- Consultation and supervision for staff

The resources needed for the intervention included Healthy Start staff, materials and supplies, partnerships with infant mental health and prenatal care providers, and referral

resources for women with severe mental health problems. The two-tiered intervention model included a short-term, 8-week cognitive behavioral intervention and a long-term, six-month infant mental health intervention.

There were several changes in the program design over the project period. Screening was to be conducted during prenatal clinic visits and case management home visits. Screening was successfully initiated in one health department prenatal clinic, but has not been sustained. The staff from the outpatient clinic of our major delivery hospital participated in the training, but screening was never initiated at that clinic. The Healthy Start nurses and social workers providing case management services were very resistant after their initial training. In addition to screening their clients, they were to provide the short term intervention for all clients with mild depression. They indicated that they could not realistically incorporate the short term intervention into their work load due to the visit intensity required. In addition, many felt they were not adequately prepared to provide the intervention. As a result the majority did not conduct the screening with their clients.

Given that the screening was not being conducted as planned and that there were few successes with engaging clients in the intervention, the intervention model was revised in the first year of the project. It was agreed that two case managers would be identified to provide the short term intervention, one would see clients living on the east side of town and one would see clients living on the west side. As a result, there was a total of four staff responsible for implementing the two-tiered home-based intervention. After this change, most case managers began screening clients during home visits.

- C. Our in house expertise in perinatal depression, the cooperation of local infant mental health providers, and the positive response of the clients facilitated implementation of this program. We were very fortunate to have a member of the application team, Dr. Judith McComish, who had considerable expertise in perinatal depression. Dr. McComish had the knowledge and vision that enabled her to assist us to develop a workable, home based intervention model. In addition, she had extensive contacts with the infant mental health community and was able to draw from their expertise. Furthermore, she engaged them as partners in the implementation plan to assist with the intervention, training, and consultation. That partnership has enhanced the capacity of all members of the Healthy Start team in the area of perinatal depression. Lastly, the women that Healthy Start serves have been very receptive to the screening and accepting of the intervention.

There were several tensions that detracted from the successful implementation of the perinatal depression services. The first was coordinating implementation of the screening with the establishment of the intervention resources. It was not appropriate to begin screening clients until staff were hired, trained, and prepared to provide the intervention. The intervention was two tiered; short term for women with mild depression and long term was for women with moderate depression. Infant mental specialists were needed for the long term intervention. Several months elapsed before they were hired and trained. As soon as the intervention staff were in place, training for

the screening began. Thus there was a period when the long term intervention staff had little to do as no one was being screened. In addition, one long term staff member accepted another position just as screening was being initiated which left us with an inadequate intervention capacity.

The second tension was assuring there was sufficient intervention capacity to meet the needs as we moved to increase the number of screening sites. As mentioned above, the case managers as a group were initially very resistant to providing the short term intervention. After the implementation plan was modified and two designated staff were assigned to provide short term services, our intervention capacity was greatly decreased. Plans to increase the number of screening sites then were called into question. We had planned to conduct screening at three prenatal clinics and as well as during home visits. One of the three clinics was a health department clinic and the other two were hospital based. Training for the screening was conducted for two clinics and was successfully implemented at the health department clinic. However, screening was never implemented at the hospital clinic in spite of multiple attempts to develop a system that would be functional for all involved. One problem was related to the fact that Healthy Start only served a portion of Detroit, but the hospital clinic had patients from the entire metropolitan area which made the implementation a complicated issue at the clinic. The clinic staff did not think that screening all clients would be beneficial if services were not readily available. However, screening only those clients who lived in the Healthy Start area was seen as burdensome. There were also other internal barriers which Healthy Start could do little to address. Given the decreased intervention capacity and difficulty getting the screening established at the hospital clinic, it was decided to limit the screening to the health department clinic and home visits.

The third tension was adapting the depression intervention, both the short term cognitive behavioral therapy and long term infant mental health models, to the needs of the women. Many of the women Healthy Start serves are very poor and meeting basic needs is a constant struggle. It was often difficult to focus on the intervention work in the face of such overwhelming need. It appeared to many staff that the infant mental model often that overlooked the needs of the mother due to the emphasis on the needs of the infant.

Core Systems Building Efforts - Local Health System Action Plan

- A. The Detroit community decided to create a broad based coalition as the structure in which to frame our local health system action plan based on the effectiveness of a prior coalition. During the 1980s and early 1990s, Detroit had a county wide infant health promotion coalition that provided the leadership necessary to address the persistent problem of infant mortality. The coalition was instrumental in developing an action plan and mobilizing the community to implement the plan. The coalition had a number of notable successes including the establishment of a 24 hour telephone information and referral line as well as the establishment of a door to door transportation program, both of which remain operational. The coalition became inactive in the mid 1990s

- largely due to a lack of leadership. As a result, progress in reducing infant mortality throughout the county stalled and collaborative efforts decreased. After a decade without the coalition, there was a consensus among many providers and stakeholders that a similar entity was needed for the purposes of planning a comprehensive approach to perinatal care and providing an ongoing mechanism for collaboration across systems. Both the successful record of the coalition and the consensus that a concerted, collaborative effort was again needed were assets. There were also several challenges inherent in this approach. First, the establishment and maintenance of a county wide coalition required dedicated staff, time, and money, none of which were readily available. Second, it was necessary to gain the support of a group of leaders in the political and health arenas across the county who sometimes had conflicting agendas.
- B. The components of the intervention to establish a local health system action plan included securing start up funding, conducting a needs assessment, developing recommendations for establishing a new coalition, developing an implementation plan, and executing the plan. The resources needed included administrative support from the city and county health departments, dedicated staffing, and stakeholder participation. In 2003, a small workgroup was formed that proposed hiring staff, conducting a gap analysis, and establishing a coalition that would have the resources to address the gaps. Over time, it was agreed that we needed to step back and get more input to determine whether a new coalition was indeed was the most effective plan. An environmental scan was then conducted. The scan involved interviewing key stakeholders, completing an inventory of programs and services, and compiling data. After reviewing the report from the environmental scan, the workgroup and the leadership of the health departments agreed that a coalition was an appropriate mechanism to lead the development of the health systems action plan. The coalition would not only become the planning body, it would act as a clearinghouse to insure collaboration and coordination across the perinatal service providers. The work of establishing this coalition is ongoing.
- C. Healthy Start staff (project director, and the coordinators for quality assurance, ICCI, and Perinatal Depression) and were active members in the workgroup that developed the plan to re-establish the coalition and secured start up funding. Several things greatly facilitated the activities of the work group. They included the support of the directors of the city and county health departments, a grant from the Kellogg Foundation, a dynamic project consultant, and the inclusion of several key stakeholders. There were also factors that delayed the progress of the workgroup and thus delayed the establishment of the coalition. They included inconsistent participation and lack of stakeholders from two major health systems in the workgroup, difficulty hiring a project consultant, and difficulty making the necessary contacts to conduct the environmental scan. In late 2004, the workgroup presented final recommendations to the directors of the city and county health departments. The directors had some reservations about re-establishing a coalition and suggested that establishing a Community Action Team arm for the Fetal Infant Mortality Review (FIMR) might better serve our needs than a fully developed coalition. Early in 2005, a few months after the workgroup submitted their recommendations to the department

directors, the State of Michigan issued a call to the counties with the most African American infant deaths to establish broad based coalitions to deal with this pressing issue. With this call and the resources provided by the state, it was agreed to move forward with the establishment of a full coalition. A membership roster, organizational structure, goals, and implementation timeline were quickly developed. The kick off event for the coalition is scheduled for September 2005.

Core Systems Building Efforts – Consortium

- A. Detroit decided to use the Healthy Start Consortium that was in place at the time of the competitive application. As the Consortium was active, had good consumer participation, and was known to the community, building on our existing structure was the most effective approach. The consumers' knowledge about Healthy Start and their commitment to the project was a significant asset. The lack of provider participation in the Consortium was the primary challenge.
- B. The components of the Consortium included the Community Consortium, the Executive Committee, three Local Advisory Councils, and the Alumni Club. The resources needed to implement the Consortium included Healthy Start staff, materials and supplies, policies, consumers, and providers. There were changes in the Consortium that were made to enhance consumer participation in project decision making. At the beginning of the project period, the consumers who attended the Executive Committee meetings frequently did not take an active part in the discussions. The Executive Committee decided that a different mechanism for appointing the consumer members was needed. In addition, training and supports were provided. An application, interview, and selection process was developed to fill the consumer positions. In addition, mentoring was implemented and training was provided. The details of these changes are described below in Question 5.
- C. The resources that facilitated the implementation of the Consortium included a dedicated Consortium Coordinator who had effective relationships with the consumers, a dedicated core of consistent consumer participants, funding to support consumer involvement, and presenters who were able to engage the consumers and provide them with important information and resources. The events/resources that detracted from the implementation included a lack of provider participation in the Executive Committee and a delay in appointing a new Consortium chairperson following the resignation of the previous chairperson.
- D. Additional elements for the Consortium:
 - 1. The Detroit Healthy Start Project has had a Consortium since 1992. This body was established during the initial demonstration phase and has remained active throughout each of the funding cycles, including this project period. The Consortium has been a constant, but evolving component of Healthy Start. The Detroit Department of Health and Wellness Promotion (DHWP), the grantee agency, has been a critical part of the planning,

prioritization, and implementation of all Healthy Start policies. The Director (and Health Officer of DHWP) serves as the Consortium Vice Chair. In addition, both the Director and Deputy Director are members of the Executive Committee, which functions as the governance body and policy making arm of the project. Wayne State University Departments of Obstetrics & Gynecology and Community Medicine also had a dominant presence as did several community clinics.

Although the Consortium was established, barriers emerged which had to be addressed in order for the Consortium to move forward. The mechanisms for addressing the barriers included changing policies, increasing consumer training, and altering the structure of the meetings. See Question #5 for a more detailed discussion of these barriers.

2. The working structure of the Consortium was defined in the existing By-Laws. As previously mentioned, the Executive Committee was the policy making arm of the project. It consisted of twenty-five (25) members of which community and program participants constituted a majority (13). During this phase, eight (8) consumers were trained and are current members of the Executive Committee. It is intended to recruit and train the five (5) additional consumers to form a majority. Providers and agencies held the remaining twelve (12) seats. Ex-officio members included Healthy Start staff and grantee agency representatives.

There were three (3) Local Advisory Councils which were community based and functioned to bring together providers, agencies, community and program participants, and staff to collaborate on issues and events that affected families at the regional level. The Recruitment and Retention Subcommittee addressed challenges and barriers to active and ongoing consumer involvement. A peer support group, the Alumni Club, provided health education and promoted empowerment of both community and program participants.

Provider and agency members included representatives from the state Title V agency, staff from the local public health department (grantee agency), other health care providers, state social service agency staff, early intervention programs representatives, and members of religious organizations.

As consumer and client participation increased in the Consortium during the replication phase (1997-2001), the challenges of successful recruitment and retention involved a change in the Community Consortium structure. The Executive Committee made the decision to change the forum from a vehicle that conducted project business to one of consumer education and empowerment reflecting a consumer driven focus. The Executive Committee became the policy making arm of the project and the venue for

issues related to quality assurance, program monitoring, service utilization, and technical assistance.

In this project period, the majority of Consortium members were community participants, 95% of which were African-American females. Consistent membership was defined as those consumer/clients who attended at least three Community Consortium meetings in a budget year. For budget years spanning 2001 through 2005, the number of consistent community participants and the average number of persons attending each meeting is shown in the following table:

Budget Year	Consistent Members	Average Number of Attendees (6 meetings annually)
01/02	59	61.3
02/03	87	87.8
03/04	49	61
04/05	43	40.7

The Community Consortium reached its objective to assure consistent and active consumer participation in the community Consortium for this project period. Average membership meeting attendance, and consumer participation remained high. The decrease in consumer attendance for budget year, 2003/2004 and budget year 2004/2005 was the result of a decision made by the Executive Committee to discontinue client recruitment. This was due, in part, to the overwhelming response of members to recruitment efforts, but mostly to the challenges that arose with large numbers people at each meeting. Sidebar conversations and the presence of small children who needed the care and attention of their parents were distractions, increased the noise level of the meetings, and created a barrier to receiving the health information presented.

Although attendance at Community Consortium meetings was very high throughout the project period with an average attendance of 50.70 per meeting, percentages and averages are not a true indicators of active participation. This is better defined by those clients and consumers who engaged in direct and ongoing dialogue in the planning and development of project policies. In our project, consumer involvement in planning and development took place in the Executive Committee. According to Consortium Bylaws, 13 of the 25 Executive Committee members are slotted for consumers maintaining a consumer majority. At the end of this phase (2001-2005), eight (8) consumers were members. The project will recruit and train an additional five (5) consumers in the next phase.

3. The activities used by the Consortium to assess ongoing needs, identify resources, establish priorities for allocation of resources, and monitor implementation were initiated by the Executive Committee. As the policy making body for the project, all matters relevant to project planning, goals, objectives, and sustainability were discussed by that body.

Specific activities included:

- Attendance by 2 consumers and 3 staff members (project director, evaluator and consortium coordinator), and consortium chair at the 2004 National Healthy Start Association's Region V Conference in Chicago which facilitated discussion about the technical assistance needs of the project. This resulted in further discussion at subsequent Executive Committee meetings.
- Activities to assess ongoing needs included monthly meetings with the grantee agency, project director, and health center administrators; as well as monthly meetings with regional health center administrators and their staff. Annual tests are administered in the Community Consortium meetings to assess consumer educational needs.
- Local Advisory Councils identified resources and collaborated with providers and agencies to sponsor community events that included health education, parent recognition, and empowerment activities. Collaborative partners included correctional facilities, faith-based organizations, and community health agencies.

The Detroit Healthy Start Consortium has had ongoing relationships with other collaboratives. For example, Healthy Start has worked with other groups serving the target population such as the city wide clergy council. A critical activity in serving clients effectively has been the collaboration with other agencies to facilitate client centered, community events.

4. A variety of community strengths have enhanced Consortium development. One strength has been the consumers' familiarity with both the Department of Health and Wellness Promotion (DHWP) and our tertiary delivery hospital, Hutzel Hospital, where Community Consortium and Executive Committee meetings are held. The grantee agency, DHWP is recognized throughout the city as a provider of a wide variety of health care services. In addition, DHWP has partnered with the county health department on a variety of initiatives to enhance services. It is centrally located for those clients who require public health and support services. Also housed within the grantee agency are HIV/AIDS services, the 961-BABY Family and Parenting Helpline, social work resources, and birth and death records.

Hutzel Hospital has been the meeting location for the Healthy Start Consortium since its inception in 1992. There were brief experiments with

other venues, but Hutzel has retained its standing as the site of choice for community members.

As an established provider within the City of Detroit, Healthy Start has come to be recognized as a program concerned with the needs of its clients. Maternal child health programs such as the March of Dimes and advocacy organizations such as Westside Mothers have supported Healthy Start in addressing issues related to infant mortality. The longstanding presence of Healthy Start in the community and the comprehensiveness of the services it offers has fostered an image of credibility, caring, and continuity.

Traditionally, Detroit's Mayor has supported Healthy Start through his appointment of the Consortium chairperson based on recommendations from the City's public health director.

5. A key barrier which had to be addressed in order for the Consortium to move forward was the lack of critical stakeholders on the Executive Committee. While consumer participation improved greatly over the project period, provider membership decreased. This was an ongoing challenge. One explanation for the lack of provider participation may have been that organizations have had to function with reduced staff and funding. Increased demands on those who have experienced downsizing may have left little opportunity for activities outside their own program and contributed to the difficulty in engaging critical stakeholders as active participants.

Another barrier was a lack of leadership. The Consortium Chair position was vacant from October 2001 until August 2003. This was a substantial challenge to the effectiveness of the Consortium. Without a Chair, recommendations for and approval of numerous policies intended to facilitate consumer training, participation, and empowerment could not be acted upon.

Lack of an effective mechanism to update Community Consortium members about project progress was also a barrier. A one-page summary regarding project goals, objectives, and the relative progress was intended to inform both consumer and client members of the Community Consortium. It was hoped that it would encourage interest in project activities and foster new membership in the Executive Committee. However, this was not implemented. Emphasis on consumer participation halted the achievement of this goal as the implementation of training and other related activities for new consumer members of the Executive Committee took precedent. (See Question #6.)

Lastly, and most importantly, ongoing demands on consumers and clients have consistently been major impediments to the work of the Consortium.

These include: department of social services work requirements, healthcare appointments, parental and familial responsibilities, lack of available childcare, lack of transportation (e.g. inadequate mass transit system), and consumer uncertainty as to their role in effecting policy. These factors have frequently resulted in sporadic consumer participation.

6. A variety of activities and strategies were used to increase consumer and client participation in the Consortium. Some activities, reimbursement for childcare and transportation and the provision of nutritional supplements, have been ongoing since the Consortium was established. A newer strategy was the development of a consumer driven agenda for Community Consortium meetings. Activities for this strategy included presentations to educate consumers about perinatal health issues; availability of staff support at Community Consortium, Local Advisory Council, and Alumni Club meetings; Client Appreciation Day; Client Spotlight; the presence of a Consumer Vice Chair; and a majority consumer membership as required by project By-Laws.

These strategies and activities were key to increasing resident and consumer participation during the project period. As consumer participation increased, there was more focus on enhancing consumers' ability to become active in the Executive Committee, especially in the decision making process. (See Question #7 for further details.)

To enhance the role of consumers in program planning, evaluation, and communication, strategies to mentor consumers were added in 2003. These consisted of a one-hour conference the day prior to Executive Committee meetings and an additional half-hour session before the start of the meeting to allow consumers to discuss meeting minutes, terminology, and other barriers to participation. In 2004, two trainings were offered. These sessions were facilitated by the local chapter of Women in Community Service (WICS) and included six leadership sessions for eight consumers who now sit on the Executive Committee. The topics covered included "Effective Communication," "Attitudes are Not Forever," and "Value Systems." It was anticipated that the training would help facilitate consumer participation in the Executive Committee. Three Executive Committee meetings were held after the completion of the training. While the consumers were still becoming acclimated to their new environment, they were more comfortable and started to engage more in the discussions.

Consumers have been a key component in all of the conferences that the Detroit Healthy Start Project attended. Two consumers were chosen from the consistent membership of the Community Consortium to attend the National Healthy Start Annual Grantee meetings as well as the National Healthy Start Association's Spring Education conferences. During these meetings, consumers have benefited from the consumer and consortia

workshops as well as interaction with their federal legislators which increased their knowledge relating to program objectives and political advocacy. In addition, consumers attended the National Healthy Start Association's Region V Conference in Chicago in 2004. Consumers took an active part during the technical assistance workshops that were offered at the conference, and later took part in the follow through sessions in Detroit as members of the Executive Committee.

Another training activity for consumers was their involvement in workshops at the state capitol. A "Legislative Advocacy Day" has been a longstanding activity of the Alumni Club and Community Consortium that facilitated consumer awareness and involvement in the political decision making process. Previous trips to the state capitol were one-day sessions which included both a workshop and visits to legislators.

In 2005, the Executive Committee changed the format and facilitated a two-day consumer legislative advocacy effort which included a presentation at the April Community Consortium by a representative from the Michigan Council for Maternal Child Health to educate consumers about the political process. The second part of the workshop was held in early May and consisted of the traditional trip to the capitol. Several scheduled appointments were made with legislators. Because the primary workshop had already taken place, more time was allocated for consumers to speak with their own representatives during their visit. "Leave behinds" (consisting of project mission, services, and goals) were presented to all of the consumers' legislators in addition to a listing by constituent zip code of various consumer concerns that were communicated at the April Community Consortium meeting. The "leave behinds" were also distributed to the legislative leadership of both parties.

An annual HIV/AIDS screening at the Community Consortium meetings started in 2004. Representatives from the HIV/AIDS division of the grantee agency facilitated both a health education presentation and the screening. After the meeting, over half of the attendees received services. Twenty two members were tested for HIV/AIDS while 32 members received information from the HIV/AIDS outreach staff (information/condom packets given). In addition 10 members were separately tested for syphilis. The grantee agency began offering testing for syphilis at the Community Consortium in 2003.

Consumer input was particularly critical with their participation in a focus group concerning perinatal depression in June 2002. In addition to the concern that Healthy Start women were more depressed (16%) than the general population (10%), the fact that women were not accepting treatment prompted the creation of the focus group.

The Local Evaluator facilitated the meeting which garnered important information about the attitudes and feelings of women who are depressed, signs and symptoms of depression, and possible activities to recruit more women into treatment. One particular finding was that women and their families were unaware of the symptoms of depression. Recommendations to the Executive Committee included the need for extensive health education using videos, the media, and other means available.

A corollary activity associated with this event was the creation of a poster that was presented at the World Infant Mental Health Association Conference in Amsterdam in July 16-20, 2002 by the Local Evaluator that described the implementation of perinatal depression screening and treatment in an urban setting.

7. The Consortium obtained consumer input in the decision-making process by offering training, support, and a safe environment. Many of these activities and strategies were discussed in question 6. Obtaining consumer input has long been the focus of the project and as such Detroit Healthy Start has supported extensive training for new Executive Committee members as well as their inclusion in all areas of project governance.

The distinction between the Community Consortium as a vehicle for consumer education and empowerment, and the Executive Committee as the policy making arm of the project, however, must be made. Issues such as strategic planning, budget/finance, communication/media efforts, data collection/evaluation, and sustainability fall within the scope of the Executive Committee. Staff developed plans, presented them for review, and received feedback. In general, consumers participated in the review process and discussion of project issues. More effective consumer participation resulted from the completion of the consumer training in October 2004. Five additional consumers are expected to be selected for the Executive Committee in 2005 which will bring the total number of consumer participants to thirteen (See Question #2 for additional details).

Thirteen Healthy Start consumers also took an active role in the decision making process related to the establishment of our local health system action plan. They were one of the groups interviewed for the environmental scan. Their comments and suggestions were incorporated into the recommendations presented to stakeholders by the consultant.

8. Suggestions made by the consumers have been used in a variety of ways. For example, the consumer input at the Local Advisory Councils level have been instrumental in planning of baby showers, client holiday events, and Month of the Young Child Celebrations that are meaningful to the community. Other events such as focus groups (see Question #6) and the Recruitment and Retention Subcommittee (created in a previous project

period) have been vehicles for consumer input into the decision making process. This subcommittee always had consumer membership. Their suggestions and comments were extremely constructive in a previous project phase with the design of the survey that was key in recruiting clients to the Community Consortium.

Core Systems Building Efforts - Collaboration and Coordination with State Title V and Other Agencies

- A. Collaboration and coordination with our State Title V agency, the Michigan Department of Community Health, was driven primarily by its relationship to our grantee agency, the Detroit Department of Health and Wellness Promotion (DHWP). The Detroit Department of Health and Wellness Promotion collaborates with our state Title V agency on a host of programs and initiatives. DHWP implements many programs including WIC, Medicaid outreach and enrollment, SCHIP, and immunizations. The Detroit Healthy Start Project is a program of the city health department. Therefore, Healthy Start activities were designed to maximize DHWP's ability to provide these services to individuals at greatest risk, just as DHWP's in kind contributions enhanced Healthy Start's efforts. In addition, Healthy Start participated in the statewide Healthy Start network convened by MDCH.
- B. The components of this intervention included administrative structures; mechanisms for communication and coordination; as well as staff training. There were no significant changes in the approach over the project period.
- C. Although Healthy Start received a significant amount of in kind funding from the city health department, there were significant cuts in state funding that resulted in the layoff of outreach staff. These changes detracted from our ability to identify the highest risk women and get them into services

Core Systems Building Efforts – Sustainability

- A. Detroit Healthy Start's primary approach to sustainability was to leverage the resources of the grantee agency, the local health department. One asset was the grantee agency's willingness to combine and coordinate all available resources to achieve our mutual objectives to improve perinatal outcomes. This approach was taken to avoid duplication of efforts as well as to enhance the efficiency and effectiveness of the efforts put forth to improve the health of the women, infants, and families of Detroit. The primary challenge for Healthy Start was to secure Medicaid reimbursement for its case management services. After the state implemented mandated managed care for all Medicaid recipients, we were unable to directly invoice the state's Medicaid agency for reimbursable services.
- B. The major component of Detroit Healthy Start's sustainability efforts consisted of leveraging in kind services. This was largely due to the Medicaid environment and cuts in state funding for maternal child health services. Early in the transition to Medicaid

managed care, the grantee agency was unable to enter into contracts with the managed care providers, presumably because the capitation rate they had agreed to with the state was below their operating costs. Therefore, the plans did not contract with other agencies such as the local health department for services such as outreach and case management that were required by their state contracts.

- C. The willingness of the grantee agency to support Healthy Start and the availability of new revenue streams facilitated our sustainability plans. However, restrictions on the use of state funds and the change to mandated managed care for Medicaid recipients detracted from our ability to independently sustain the project.

The grantee agency supported Healthy Start with a significant amount of in kind funding. This funding provided the majority of the core services of Outreach and Client Recruitment as well as supporting a significant portion of case management. The resources of the Healthy Baby Services transportation program were also leveraged. In addition to being funded through a collaborative that included the grantee agency, the Wayne County Health Department and the Oakland County Health Department, Healthy Baby Services received supports from the local March of Dimes for a portion of the project period.

During 2001-2002, a source of revenue became available through a contract between the Family Independence Agency and the grantee agency. The Family Independence Agency (the state department of social services) instituted a Child Well Being Program. This program was intended to assure that the health and safety of children were not jeopardized by sanctions that were put in place for non compliance with new agency requirements. Social workers and nurses were authorized to make a maximum of 2 home visits to assess the safety of the children and ascertain whether referrals were needed for insurance, food, clothing and housing. These visits were reimbursable. Families that were eligible for Healthy Start case management were enrolled in our program, but ongoing Healthy Start services were not reimbursable.

The grantee agency received funding from the state's Title V MCH, Title X Family Planning, and Title XXI SCHIP programs. Therefore, these were not available as grant funding options for the Detroit Healthy Start Project.

The advent of mandated Medicaid managed care was a major detraction to our sustainability efforts. As described above, Michigan made the transition to managed care beginning in 1998. There was a great deal of change and many problems establishing contractual relationships between the managed care organizations and other providers. By 2001, we expected that these difficulties would be resolved and the grantee agency would be reimbursed for supportive services such as case management. However, the difficulties with the contracts persisted and reimbursement remained a problem. After the contracts were signed, managed care organizations referred very few clients to other providers. This was due in part to continued low reimbursement rates to the managed care providers from the state. The lack of increase in

reimbursement rates was driven by the shortfalls in the state budget that persisted throughout this project period.

D. Additional elements for sustainability:

1. All of Detroit Healthy Start's sustainability efforts with managed care organizations and third party billing have been through the grantee agency, the Detroit Department of Health and Wellness Promotion. The grantee agency did establish contracts with the managed care organizations that served Medicaid recipients in Detroit. These contracts contained language relative to reimbursement for the state's Maternal Support Services program. As of 2005, reimbursement for those case management visits made to women who were eligible for Maternal Support Services improved. While this is a source of revenue, it goes to the grantee agency's general fund and not directly to Healthy Start.

2. The major factors associated with the identification and development of resources to continue our interventions without Healthy Start funding included the availability of resources within the grantee agency, declines in state funding, the availability of opportunities to diversify funding, and changes in the state Medicaid program.

Michigan's state revenue sharing contribution to cities declined over the project period. This decreased the funding available to the local governments and thus hampered the grantee agency's ability to provide maternal child health services.

Although unsuccessful, with the sanction of the grantee agency, Healthy Start submitted an application to receive earmark funds from two US Congress members who represented the project area. The grantee agency planned to pursue this avenue in the future.

A collaborative effort was undertaken to obtain funding through a Small Business Innovation Research Contract Proposal. However, this National Institutes of Mental Health proposal to develop Postpartum Depression training materials for primary care providers was not funded. The collaborative partners included Wayne State University College of Nursing and the OB/GYN Department of the School of Medicine, a Detroit small business web-based development company, and Healthy Start. The Healthy Start staff involved in the proposal development included the project director, the evaluator, and the perinatal depression core services coordinator. We believed this opportunity was well suited to the expertise we had developed in this area. This proposal addressed two issues that were identified as barriers to treating postpartum depression in the primary care system, provider training and engaging women in treatment. Healthy Start had dealt with both issues in the implementation of our perinatal depression core intervention and so was able to offer practical strategies to address the issues highlighted in the request for proposals.

3. Healthy Start, in conjunction with the grantee agency, was able to overcome some of the barriers to sustainability. The grantee agency was able to finalize contracts with six of the managed care providers that provided services in Detroit and was then able to bill

and receive reimbursement for Maternal Support Services visits. To address decreases in state funding, the grantee agency continued to support outreach services with other revenue sources.

III. Project Management and Governance

- A. The administrative management of the Detroit Healthy Start Project rested solely with the grantee agency, the Detroit Department of Health and Wellness Promotion. The project director was a Health Department employee occupying a civil service position. A grantee agency senior accountant was responsible for the overall fiscal management of the project and functioned as the chief fiscal officer.

Healthy Start utilized the resources of a fiduciary, Southeastern Michigan Health Association, for some staff hiring. This was done through a contractual arrangement with the grantee agency via the City's contracting process.

The grantee agency actively communicated with the Consortium and contractors regarding all aspects of the project. Detroit's Public Health Director was one of two vice-chairs of the Consortium. The other vice chair position was held by the Wayne County Public Health Director. Management of the project rested with the grantee agency per the By-laws. The chief administrative officer assumed the position of project director in year two of the project period.

The grantee's relationship with the Consortium was strengthened as a result of the extensive in kind support provided to the project. Grantee agency administrative staff participated in Community Consortium meetings and gave regular reports to the Executive Committee. As the Consortium and Executive Committee meetings occurred on opposite months, governance activity occurred monthly. Representatives from the various agencies that contracted with the project also participated in the Community Consortium and Executive Committee meetings. All project operation issues that required Consortium approval were placed on the next Executive Committee meeting agenda or a special meeting was called.

Mechanisms were established to assure staff/contractor compliance with deliverables and/or scope of work. Supervisors reviewed client records on an ongoing basis and made recommendations to the administrators about staff/contractor compliance based on data collection and analysis. Recommendations were discussed with the project director.

- B. The resources available to the project which proved to be essential for fiscal and program management were the full time project director and a grantee agency senior accountant. The senior accountant, funded by Healthy Start at 25%, was responsible for the overall fiscal management and functioned as the chief fiscal officer.
- C. There were several changes in management and governance that occurred during the project period that included changes in key personnel. The Healthy Start Consortium

chair became vacant in October 2001 and remained vacant until August 2003. The grantee agency's Public Health Director position was vacant for the majority of calendar year 2002 and a new Public Health Director was not appointed until February 2003. The Executive Committee made a recommendation for a new chairperson, which was submitted to the grantee agency and subsequently the Mayor for appointment. In August 2003, a chairperson was appointed. According to the By-laws, the Public Health Director served as one of two Consortium vice chair. However, the director relinquished his position to a consumer. The consumer was then mentored as the vice chair during 2004.

The change in the project director position was submitted with our March 2003 Continuation Application. The former Chief Administrative Officer was reassigned to the project director position and retained her previous duties and responsibilities. The change in the project director was the result of an overall reorganization within the grantee agency.

Despite the Public Health Director and chairperson vacancies, the Community Consortium and the Executive Committee continued to meet with the chief administrative officer chairing the meetings. Though not voted on, issues were identified, discussed, and recommendations were formulated.

Other challenges were due to the national, state and local budget deficits that contributed to staff reductions. The loss of maternal child advocates placed an additional burden on the remaining staff of Outreach and Client Recruitment and case management core services.

- D. The grantee agency has a history of receiving and appropriately disbursing federal funds. Consequently, various processes were in place throughout the Project Period and did not require any changes. This also applied to the subcontract with its fiduciary. The Healthy Start project director, chief administrative officer and the project fiscal officer provided fiscal management oversight.
- E. Grantee agency resources were included in our plan to support quality assurance activities. However the use of these resources could not be sustained throughout the project period. The quality assurance coordinator was an in kind support from the grantee agency. She worked in conjunction with the Healthy Start Project Evaluator to monitor the quality of project services based on client records, client satisfaction questionnaires, and client, staff. Record audits were a major tool for assessing the quality of Healthy Start services. A randomly selected sample of case management records was reviewed semiannually by the Quality Assurance Coordinator who compiled the results and distributed them to committee members, supervisors, and administrative staff. However, early in the project she was assigned additional duties and conducting this semi-annual review was no longer possible. case management supervisors continued to conduct record reviews throughout the project period. Supervisors' audit results were discussed one-on-one with staff, at monthly staff and team meetings. Audit results are used to plan staff education activities, review/revise

protocols and evaluate progress toward the model's goals and objectives. Client satisfaction was an overall project objective and was measured and reported annually. The project director carried out the project plan for monitoring the contracts.

- F. There was no evidence that contractors or project staff were not providing services in a culturally competent manner. Therefore, this was not an issue for the project.

IV. Project Accomplishments

Detroit Healthy Start used a variety of strategies to achieve the project goals. All project objectives with the related strategies, activities, and status, as well as the accomplishments for each are detailed in Attachment A. A discussion of the effectiveness of the strategies employed by each core service follows.

A. Outreach and Client Recruitment used three related strategies to achieve their objectives. Those strategies were aggressive case finding, use of diverse methods to engage pregnant women and enroll them in care, and aggressive public information and outreach.

- 1. The first strategy, aggressive case finding of pregnant women in the first trimester, was not successful in overcoming the barriers to early care.*

Objective 1: The percentage of women residing in the Healthy Start area who enrolled in prenatal care in the first trimester decreased from the baseline of 72% to 45.3% in 2005.

The average percentage of women residing in the Healthy Start area who enrolled in prenatal care in the first trimester for entire project period was 51%.

Healthy Start outreach workers reached out to high-risk women by visiting shelters, food pantries, and other community service sites on a weekly basis. The women using these services were often transient and follow up was difficult. However, they were generally appreciative of the information, resources, and supports provided. Domestic violence shelters were engaged in referring pregnant women not receiving prenatal care. These women were in crisis and were at increased risk for poor pregnancy outcomes. Contacts with these shelters raised the awareness of the importance of prenatal care for this group of women.

All staff that participated in health fairs and other community events used the opportunity to inform the public about sources for prenatal care, health insurance, and other pregnancy related services. They also recruited pregnant women into Healthy Start.

As a part of the Love My Baby/Love My Family campaign, outreach workers distributed pamphlets about the 961-BABY information and referral phone service as well as information about presumptive eligibility to decrease delays in seeking prenatal care (961-BABY is now the "Family and Parenting Helpline"). Outreach workers also began enrolling pregnant women into "Maternity Outpatient Medical Services" (MOMS), a State funded insurance program that was implemented to encourage women to seek early prenatal care. At the time

of enrollment into MOMS, the outreach worker:

- Issued a “Guarantee of Payment Letter” to the client.
- Scheduled the client’s first prenatal care appointment
- Scheduled client’s transportation with Healthy Baby Services as needed
- Scheduled the client’s first WIC appointment

Valid for 45 days, the guarantee letter was presented to providers to ensure that pregnant women received prenatal and outpatient services and that providers would be paid for services rendered during that time period while Medicaid was being approved. A major barrier to accessing early prenatal care was providers’ lack of familiarity with the state’s efforts to assure providers received payment and the unwillingness of some to accept the guarantee of payment letter.

2. The second strategy, use of diverse methods to engage pregnant women and enroll them in care, was somewhat successful.

Objective 2: The percentage of women residing in the Healthy Start area who delivered with no prenatal care remained relatively constant over the project period. It increased slightly to 4.4%, for 2003 from the baseline of 4%.

Outreach staff used traditional methods to engage women such as distributing information and participating in community events. They were also out stationed at clinics and other community sites where they were able to complete enrollment into insurance programs onsite. They regularly visited shelters and other community facilities to identify and recruit pregnant women into care. As previously mentioned, outreach staff also are responsible for the Family and Parenting Helpline, a resource that women can access any time that is convenient for them.

A unique opportunity to diversify outreach methods was the Love My Baby/Love My Family campaign. The campaign featured media messages on topics such as WIC/nutrition, prenatal health insurance, and well baby care. Women had the opportunity to receive incentive gifts, such as car seats and layettes, when they enrolled in prenatal care. In addition, they became eligible to participate in the final campaign event, a community baby shower. The baby shower featured speakers, information, gifts, and activities. Women were also awarded prizes for keeping their prenatal care appointments throughout the campaign.

Lastly, outreach staff were able to issue a guarantee of payment letter at the time a woman completed an insurance application. In addition, staff could make an initial prenatal care appointment with a provider, make a WIC appointment, and schedule transportation as needed. Clients left the encounter with everything they needed to begin care.

3. *The third strategy, aggressive public information and outreach, was somewhat successful.*

Objective 3: The percentage of pregnant women receiving case management services who were identified via case finding and outreach decreased from the baseline of 32% to 19.3% by 2005, and did not meet the project period objective of 50%.

The percentage of pregnant women receiving case management services who were identified via case finding and outreach varied throughout the project period. By 2003, the percentage had increased to 35.8. However, two events in 2003 led to the downward trend that took place in 2004 and 2005. There was the lay off of 16 Maternal Child Health Advocates in case management and an existing outreach campaign, the Infant Mortality Initiative, was discontinued.

The Love My Baby/Love My Family public information campaign began in 2001. This multimedia campaign was instrumental in increasing public awareness about resources for prenatal care, health insurance, and related services. Posters, pamphlets, and billboards, strategically placed throughout the city, advertised the campaign and reinforced the messages about prenatal care and health insurance. The effort was effective and resulted in a 55% - 60% increase in calls to the Family and Parenting Helpline during the campaign which continued for several weeks after the campaign ended. This illustrated both the impact of a public information campaign and the short term nature of such an impact.

The Family and Parenting Helpline has been a major source of referrals to Healthy Start. Every pregnant woman who called the Helpline was assessed and referred to Healthy Start case management if appropriate. Outreach workers also conducted daily outreach, again referring pregnant women who needed case management services to Healthy Start.

Coordination has increased between Healthy Start and Medicaid Outreach and Advocacy program managers, resulting in a closer collaboration between programs to intensify outreach and referrals for case management. In 2004 the Medicaid Outreach and Advocacy Program became a component of Healthy Start, with enhanced participation in Healthy Start planning and activities.

The major barriers were the loss of state funding and the decrease in staff. These barriers were addressed by seeking alternative sources of funding, consolidating programs, and decreasing participation in community events.

Lessons learned

1. Educating the public about prenatal health is an ongoing effort that requires significant resources.
2. A variety of outreach methods are needed to reach the range of women at risk for poor outcomes. For example, both women over 35 and young teens are at increased risk. The methods that engage a 15 year old are unlikely to engage a 40 year old.
3. Providing “one stop shopping” facilitates women’s use of prenatal care.

4. Regular engagement with the community enhances the effectiveness of case finding.

B. Case Management used five strategies to achieve their objectives. Those strategies were identification and intervention with women at risk for preterm/low birth weight births, outreach to pregnant women at risk for late or no prenatal care, assuring clients received needed services, assuring clients were knowledgeable about risks and resources, and the provision of services in partnership with clients to improve satisfaction.

1. The first strategy, identification and intervention with women at risk for preterm/low birth weight births, was successful as the targets for the two related objectives showed improvement.

Objective 1: The percentage of low birth weight births to Healthy Start clients was reduced from the baseline of 15% to 11.4% by 2003 (birth certificate data not available for 2004 and 2005). The project goal was 10%.

Objective 2: The percentage of pre-term births was reduced from the baseline of 26% to 16% by 2003 (birth certificate data not available for 2004 and 2005). This exceeded the project goal of 20%.

Risks were identified through the assessment process and interventions were developed in concert with the client. Staff received training from the state health department in the smoking cessation program, Smoke Free for Baby and Me. This enabled them to more effectively address smoking, a major contributor to low birth. However, support materials were not available from the state throughout the entire project period.

2. The second strategy, outreach to pregnant women at risk for late or no prenatal care, was not successful in assisting pregnant women to overcome the barriers to early access to care.

Objective 3: The percentage of women residing in the Healthy Start area who enrolled in prenatal care in the first trimester decreased from the baseline of 72% to 45.3% in 2005. This is also significantly less than the project goal of 81%.

This objective was not achieved in spite of increased coordination between outreach and case management. Case management staff actively participated in case finding activities at community events as well as conducting case finding during home visits. Maternal Child Health Advocates dedicated 1½ days weekly to outreach activities. However, the advocates were laid off in 2003.

Assuring women enrolled in case management services had access to care was a priority. All pregnant women were assessed for prenatal care at the initial visit. A structured service plan to meet the client's needs was then developed. Those clients not enrolled in prenatal care were assisted in finding a resource for care. Information on insurance and transportation as well as assistance with child care arrangements was provided as needed.

Follow-up contact via phone calls, home visits, letters helped identify additional barriers to care. However, high caseloads and the transient nature of much of the target population made timely and consistent follow up difficult.

3. The third strategy, assuring clients receive needed care and services, had mixed success as evidenced by the variation in the outcomes for the objectives this strategy was intended to achieve.

Assure clients obtain postpartum care:

Objective 4: the percentage of Healthy Start postnatal clients who received a postpartum check up increased from the baseline of 55% to 64% by 2005, but remained below the project goal of 75%.

Case managers educated pregnant women in their 3rd trimester and newly delivered clients on the importance of postpartum check-ups. Transportation and lack of insurance were the major barriers to postpartum care. Postpartum women who lacked insurance were referred to clinics that provided low cost or free services. Clients enrolled in HMOs were referred back to their HMO for assistance with transportation. Clients were also referred to the Health Baby Services transportation program, given bus tickets, or provided with emergency cab vouchers if needed.

Intensive follow-up to assure infants receive recommended immunizations:

Objective 6: the percentage of Healthy Start infants up to two years of age who had up to date immunizations increased from the baseline 32% to 37% by 2005 and did not meet the project goal of 75%.

Immunizations have been a priority for the case management staff. In addition to working with individual families to address barriers to care, case management staff educated families about the Michigan Immunization Childhood Registry (MICR) and encouraged parents to obtain a copy of their children's records from the registry. Case managers were able to request immunization records from our Detroit Immunization Program to provide effective follow-up for children whose immunizations were delayed. In turn, Healthy Start helped to populate the registry by providing immunization information that was entered into MICR. The grantee agency, the Department of Health and Wellness Promotion, offered evening immunization clinics twice a month and walk in clinics three days a week. Copies of the monthly immunization schedule were given to parents.

Assure all of very low birth weight (VLBW) infants are enrolled in appropriate specialized care programs.

Objective 7: the percentage of very low birth weight (VLBW) infants who receive specialized care increased from the baseline 62.9% to 90% by 2005 and met the project goal of 90%.

The progress on this objective was due to a focus on assessing the health and development of all VLBW infants at the initial visit. Families were referred to Children Special Health Care Services for evaluation as needed. Supervisors also reviewed records to assure VLBW infants were receiving services according to the established policies.

Assure clients receive needed services:

Objective 8A: The percentage of clients who received needed transportation for prenatal appointments decreased from the baseline of 17.2% to 11.9% in 05/31/05 and fell short of the project goal of 21%.

Objective 8B: The percentage of clients who received needed nutritional services increased from the baseline of 66.8% to 89.7% by 05/31/05 and exceeded the project goal of 85%.

At the initial home visit, all pregnant clients are assessed for transportation and nutritional needs. If the family lacked transportation, they were referred to their managed care provider or Healthy Baby Services transportation program as appropriate. If the family needed assistance with food, they were referred to WIC or Focus: HOPE (our local USDA commodities program). Supervisors also reviewed all records to assure clients needing services received the appropriate referrals and follow up. The lack of success related to transportation is most likely due to the decrease in funding for the Healthy Baby Services transportation program which resulted in fewer staff and reduced hours of service.

4. The fourth strategy, assuring clients were knowledgeable about risks and resources, had mixed success based on the achievement of the related objectives.

Assure all pregnant women and families with infant under on (1) year of age are knowledgeable about ways to reduce the risk of sudden infant death:

Objective 5: the SIDS death rate in the Healthy Start catchment area decreased from the baseline rate of 228.35/100,000 to 41.13/100,000 live births in 2003 and exceeded the project goal of 150 per 100,000 live births.

While vital statistics data demonstrated a dramatic decline in SIDS deaths, the use of the diagnosis of SIDS on the death certificates changed over the project period. More sudden infant deaths were attributed to positional asphyxia and overlay. Therefore, even though we had fewer deaths attributed to SIDS, the overall post neonatal infant mortality death rate did not decline appreciably.

Case management staff emphasized risk reduction by educating families about the major contributors to post neonatal infant deaths, unsafe sleep practices and environmental smoke. In collaboration with Tomorrow's Child, Healthy Start distributed Safe Sleep brochures door to door, at local churches and at doctors' offices in the community. Back to Sleep campaign video tapes were also provided to WIC offices and community organizations. Clients who did not have a crib were referred to a community resource. The

importance of a smoke-free environment was also emphasized. The Smoke Free for Baby and Me as well as the Safe Sleep materials provided powerful messages about the risks to the baby of parental smoking.

Assure pregnant women are knowledgeable about and utilize available transportation resources:

Objective 9: the percentage of pregnant women in the project area who missed prenatal appointment due to lack of transportation increased from the baseline of 18.4% to 51.7% over the project period.

All pregnant clients were educated on the importance of keeping prenatal appointments and assessed for transportation needs. Case managers assisted clients with exploring transportation options and if none were available referrals to their managed care providers or the Healthy Baby Services transportation program were made. Clients were also educated about the policies and procedures for receiving transportation services. For example, clients must call 72 hours in advance of their appointment to schedule transportation. In the Healthy Baby Services transportation program, if a client has two “no shows” they are dropped from the program rolls. A “no show” is defined as the client not responding to a scheduled van pick up. In spite of these efforts, there was no progress in reducing this barrier to care. As noted elsewhere, the Healthy Baby Services transportation program has decreased its service capacity with a negative effect on access to prenatal care.

5. The fifth strategy, provision of services in partnership with clients to improve satisfaction was moderately successful in that over 90% of the clients were satisfied throughout the project period:

Objective 10: the percentage of participating clients who report they were satisfied with services changed little from the baseline of 93%. It was 91.4% as of May 2005 but did not meet the project goal of 97%.

Efforts to improve satisfaction focused on assuring client input into the service plan. Case managers and clients developed a service plan based on the needs identified by the clients during the initial home visit and were updated as necessary.

All Case management sites had weekly case conferences which served as a communication forum, a learning experience for staff, and an opportunity to enhance and improve services for the clients. Team conferences involved case management staff and supervisors.

Supervisors focused on quality assurance using individual case conferences with staff, record reviews, and tracking mechanism. All records were reviewed for substance, accuracy, continuity of care, and need for referrals. An accountability log and the Supervisor’s Documentation Tracking Log were used for tracking services. In addition, it is policy to respond promptly to all questions and complaints from clients and the community.

Several barriers affected the overall progress of this core intervention. They included a lack of resources which made accessing care difficult, lack of knowledge, provider attitudes, and internal program difficulties.

Lack of transportation is a significant problem in accessing care. Detroit only has a bus system for public transportation and many clients are not aware of the transportation benefit available through their managed care providers. In addition, lack of child care resources was a barrier to access. Clients were often lost to follow up as they were cohabitating with other family members or friends and often became transient.

Clients often reported a lack of sensitivity from their prenatal care providers and little attachment as they often saw different doctors at each visit. These barriers were addressed by educating clients about the services they were entitled to, educating them about appropriate health care practices and how to prepare for provider visits, assisting with problem solving, and providing resources.

Healthy Baby Services transportation program was affected by budget. To address this barrier, services were limited to prenatal and postpartum visits, well-baby visits, and WIC appointments. In addition, service hours were curtailed in 2005. The latest appointment time for pick up was 1:00 PM and the latest pick-up time for return home was 4:00 PM.

The use of manual tracking systems and a lack of information technology support were also barriers to accomplishing program goals. The data requested was manually counted and extracted from record reviews to compile most reports. Manual systems involved counting multiple forms. Changes in programs forms, such as the discontinuation of the Healthy Start intake and closure forms, added to the complexity.

Some program needs were not met largely due to internal changes. There were many changes in policies and procedures that were intended to enhance the health of the community. However, there was little follow-up to assess the effects of these changes. With changes in staff, training of new supervisors, and administrative changes, we were unable to complete some of the activities planned to help meet our objectives. The training on risks for preterm births was not scheduled. We addressed this lack of training by offering some staff the opportunity to attend the annual Healthy Mother, Healthy Baby Conference or the Smoke Free for Baby and Me training. We were unable to meet with the Food & Nutrition Extension Program, but Healthy Start staff were able to use this resource. Finally, the administrative staff had little opportunity to become formally involved in advocacy activities related to client services until late in the project period. In 2004, there were changes in the organizational structure of the grantee agency. As a result, Case management came under the direct supervision of the project director and the case management administrators became involved in meetings where they had the opportunity to participate in advocacy on behalf of clients.

Lessons learned

1. When staff receives timely, accurate information and was allowed to give input on the proposed services changes; they were more likely to embrace the program changes.
2. A manual count of data increased errors and did not yield clear information.
3. When record forms are discontinued before appropriate plans are made to replace them, the result is a lack of an effective mechanism for obtaining and recording information.

C. Health education used two strategies to achieve their objectives. Those strategies were active promotion of a smoke free environment for pregnant women and infants and assuring clients were knowledgeable about ways to reduce the risk of sudden infant death.

1. The strategy of actively promoting a smoke free environment for pregnant women and infants was moderately successful.

Objective 1: From 2001 to 2005, 2,307 pregnant women who smoked received Smoke Free for Baby and Me cessation interventions from the case management staff.

Pregnant women who smoked received the Smoke Free for Baby and Me intervention per Healthy Start protocol. In addition, families were educated on the importance of a smoke-free environment using a variety of tools such as literature, videos, and smoking cessation literature in order the pregnant woman's efforts to quit smoking or cut down their use.

2. The strategy of assuring clients were knowledgeable about ways to reduce the risk of sudden infant death was moderately successful.

Objective 2: The incidence of SIDS deaths in the Healthy Start catchment area was 41.13/100,000 live births in 2003, a decrease from the baseline and exceeding the project goal of 150 per 100,000 live births.

As noted in case management, the use of SIDS on death certificates changed during the project period and influenced the reported rates. However, Healthy Start distributed Safe Sleep brochures and Back to Sleep campaign videos to clients, providers, and organizations. The importance of a smoke-free environment and safe sleep was emphasized with both pregnant clients and those with infants.

The major barriers to accomplishing the goals of health education were the lack of a health educator and retaining clients in service. The health educator position was advertised repeatedly and several candidates did apply. However, those that met the qualifications chose not to accept the job for various reasons. As a result, there was a lack of leadership related to overall health education efforts. To overcome this barrier, case management and outreach staff distributed educational materials to individual clients as well as the larger community. In addition, information was made available at the Community Consortium meetings. Educational interventions require regular and repeated contact. Efforts to retain clients in service to receive those interventions included meeting clients at a location of their choice (school, work, relative's home, clinic) and adjusting visit times to meet their

schedules. Finally, due to budget cuts in state health department funding to the grantee agency, new staff did not have the opportunity to attend *Smoke Free Baby and Me* training and the client education materials were not available throughout the project period.

Lessons learned

1. Multiple venues should be used for health education to assure the community and clients receive consistent messages.
2. Changing behavior requires ongoing intervention and support as well as assessing readiness to change.
3. The literacy level of the audience is an important consideration in planning educational interventions.
4. Reinforcing health education information with tools such as pre and post tests enhances learning.

D. Interconceptional Care Inreach (ICCI) used three strategies for achieving their objectives which included recruiting women in the hospital after delivery, linking them to community based services, and providing the support, information, and resources that would facilitate utilization of health care resources to meet their own health care needs as well as those of their infants. We were somewhat successful in achieving the overall program goal of linking women who received inadequate prenatal care and their infants to a regular source of care.

1. The strategy of actively recruiting women in the hospital after delivery was somewhat successful.

Objective 1: By 2005, 78% of high risk walk-ins who delivered at Hutzel Hospital between Monday and Friday were being identified and offered ICCI services. While this was short of the project goal of 90%, it was a significant increase from the baseline of 40%.

ICCI services were implemented at only 1 of 2 targeted delivery hospitals. Only 1 full time staff equivalent was devoted to recruitment and follow-up of eligible clients. After establishing ICCI at the first delivery hospital, Hutzel Hospital, we hoped to minimize the time spent in identification and recruitment by working more closely with discharge planning staff. However, Hutzel underwent significant changes during the project period, physically moving into a new facility late in 2002. Staffing changes and reorganization also took place. The workload of the discharge planning staff increased, thus they were unable to assist with identifying or referring clients to ICCI. Given the limited ICCI staff, adding another delivery hospital was not feasible.

Throughout the project period, ICCI staff visited the postpartum units at Hutzel. They identified eligible clients from the records and then visited each client in person to confirm eligibility. All eligible clients were offered ICCI services.

Almost 800 women were identified as potentially eligible for ICCI. About half (462/48%) were confirmed to be eligible during an initial interview and were invited to enroll in the ICCI program. The most common reason women were not eligible was that they reported

they had more than 5 prenatal visits. Of the women whose eligibility was confirmed, 38%, or 175 women accepted the services. There were a number of barriers to actually making contact with the women after they were identified through the record review. Those barriers included the short postpartum hospital stay, the many demands on the women's time, and the amount of information they received. ICCI staff addressed those barriers in several ways. If a woman was not in her room when staff made the initial contact attempt, they would revisit the room before they left the unit and again the following day. An important step was trying to find a time with relatively little activity on the postpartum unit to meet with the women. It took several months, but late afternoon was determined to be the best time to conduct ICCI recruitment. The ICCI information packet was visually appealing and unique. Although it contained a great deal of information, staff reviewed only a few critical pieces in detail during the assessment interview. The information on safe sleep, the importance of well baby care, and postpartum care was emphasized.

2. The strategy of linking women to long term community based services was unsuccessful.

Objective 2: As of May 2005, 32% of the walk-ins who accepted ICCI long term case management (linkage with a community based program) received ongoing services from that program through the 12 week postpartum period. This was significantly less than the baseline of 69.8% as well as the project goal of 90%.

The majority of the 175 women who enrolled in ICCI opted for the least intense service levels. Most, 45%, chose the information only option and another 40% accepted short term case management. Only 15% accepted long term case management which included a referral to a community based program. However, throughout the 12 weeks of ICCI contact, some women who chose the lower intensity service levels did request a referral for community based services. In total, 19% of the women were referred for long term case management services. ICCI was able to maintain direct contact for 12 weeks with only 40% of the women who were referred to community based services. Of the women we retained contact with, the majority were still receiving services at the end of the 12 week monitoring period. However, there was evidence that many of the women were connected with the health care system over time. Half of the women enrolled in ICCI (88) responded to at least one of the semi-annual mail surveys. Over 85% of these 88 reported that they had a regular source of health care for both themselves and their babies. In addition, most indicated they were receiving regular check-ups.

3. The third strategy, providing support, information, and resources to facilitate utilization of health care resources to meet their health care needs as well as those of their infants, had mixed success as evidenced by the varying degree to which the related ICCI objectives were met.

Objective 3: By 5/31/05, 65% of walk-ins who accepted ICCI services reported receiving a postpartum check up within 8 weeks of delivery, an increase from the baseline of 53% and short of the project goal of 80%.

Women received information on the importance of postpartum care and available resources which were reviewed during the initial assessment. They also received reminder phone

calls and postcards. The multiple demands on their time and resources were often identified as barriers to receiving postpartum care.

Objective 4: By 5/31/05, 76% of walk-ins who accepted ICCI services reported that their infants had a well baby check by 2 months of age, an increase from the baseline of 55% but far short of the project goal of 90%.

Women received information on the importance of well baby care as well as phone and mail reminders when their baby's check-up was due. Those who had problems were assisted as needed (e.g. those without insurance were given information about free/low cost sources of care). Follow-up calls were also made to determine if the women were able to keep the appointments. On the semi-annual mail surveys, 76% of the women who returned them indicated their babies had a well baby check-up in the previous 6 months. This indicated the infants were receiving well baby care on a regular basis.

Objective 5: By 5/31/05, 68% of walk-ins who accepted ICCI services reported that they received a yearly pap smear. This was short of the project goal of 80% but was an increase from the baseline of 59%.

The semi-annual surveys provided a reminder about the need for regular check ups and annual PAP smears. Although several community education sessions that focused on women's health were held, none of the women who enrolled in ICCI attended. As previously noted, it appears that the women with whom we had ongoing contact were able to meet their health care needs.

Objective 6: As of 5/31/05, 72% of walk-ins who accepted any level of ICCI services reported that they used birth control, an increase from the baseline of 57% but short of the project goal of 80%.

The women received information on birth control options and they were reminded about the importance of using birth control if they did not wish to become pregnant again during the initial assessment. Many women received Depo-Provera before discharge and would be using birth control if they received their first survey within 3 months of delivery. This may account for the relatively high number of women who reported using birth control on their initial survey (72%) and the smaller number using birth control on subsequent surveys (50 to 60%). Over the project period, 24% of those who responded to the semi-annual surveys indicated they had a subsequent pregnancy or birth. Given that less than 25% of the women indicated they were using birth control prior to becoming pregnant, it appears that ICCI was successful in helping some of them have more control of their reproductive lives.

Objective 7: By 5/31/05, 74% of walk-ins who accepted ICCI services reported that their infants' immunizations were up to date at age 6 months, an increase from the baseline of 57% but well short of the project goal of 85%.

Each woman received an infant immunization schedule at enrollment. Phone calls and postcards were used to remind the women when their baby's initial immunizations were

due. There was also evidence from the semi-annual surveys that infant immunizations remained up to date. One question on those follow up surveys asked if the baby's immunizations were up to date. The majority of women who responded (85%) consistently reported that immunizations were current.

There were several barriers that affected the accomplishments of ICCI. First, there was only 1 staff person devoted to client recruitment and follow up. This limited the number of women enrolled and the extent of the follow up. This barrier was addressed by restricting ICCI to a single delivery hospital. Second, there was limited availability of community based services, especially for postpartum women who did not have a specific problem such as alcohol abuse. Throughout the project period several programs closed including a long standing residential substance abuse treatment facility. This barrier was addressed by referring women to available resources and sharing updated information with them as it became available. Third, none of the ICCI enrollees participated in the group and community based educational activities. These activities were not only intended to provide information, but to help women develop coping skills and change risky behaviors. This barrier was addressed by planning focus groups to get feedback from the women on what services would best meet their needs. Invitations were mailed to all ICCI clients. Incentives to attend included a meal, child care, and a gift card. Although several women responded to the invitation, no one actually attended and so this attempt was unsuccessfully. Therefore, information and support were provided via the less effective measures of phone contact, semi-annual surveys, and periodic mailings.

Lessons learned

1. Follow up contact to inquire how the women were doing was appreciated.
2. Women who received inadequate prenatal care were not a homogenous group.
3. Most of the women did not intend to become pregnant, but few used birth control.

A profound lesson was how much the women appreciated the ongoing contact. This was reflected in the comments they made on the surveys including "thank you for checking up on us" or "I appreciate your concern". A second lesson was the great variability in the situations of the women. Clearly, one size interventions do not fit all. Women often updated us on their situation on the surveys. Many indicated they were doing well (finished school, got a job, got a new house) but many others asked for help (needed substance abuse treatment, needed housing, did not have the resources to provide for their children). Follow up phone calls or mailings were made in response to all requests for help. A third lesson was the rather profound disconnect between pregnancy intention and use of birth control. Only 24% of the women enrolled in ICCI reported that they were using birth control when they became pregnant, yet only 5% reported they were trying to get pregnant. In addition, the majority 60% had mixed feelings or a negative response to learning that they were pregnant. This highlights the need for interconceptional services and for assuring women get regular preventive care.

In April of 2005, a final mother's day survey was sent to the majority of the women who had enrolled in ICCI (120 surveys were mailed, surveys were not sent to the women for whom we did not have a good address). There was a 40% response rate, 52 women sent

back the survey or participated in a final interview. Of those 52 women, 77% had a regular doctor, 71% had health insurance for themselves, and 65% had not had another baby since their ICCI delivery. In addition 81% had a regular doctor for their children while 85% reported their children had health insurance. Overall, ICCI seemed to have positively impacted this small group of women and most expressed appreciation for the information and support that the program provided.

E. Perinatal Depression used four strategies to achieve the overall goals of integrating screening for depression into routine perinatal care and creating a treatment infrastructure. Those strategies included developing a standardized screening and referral protocol, developing and two-tiered intervention protocol, implementing the screening protocol, and implementing the intervention protocol. We were moderately successful in achieving these goals.

1. Developing a standardized screening and referral protocol has been moderately successful in that the protocols were developed and screening was implemented within Healthy Start and the Detroit Department of Health and Wellness Promotion, the grantee agency.

Objective 1: By 5/31/05, screening was routinely conducted at the 3 Healthy Start case management sites. Although there was improvement from the baseline, it was far from the project goal of increasing the number of perinatal health care clinics where women are screened for perinatal depression to 6.

The Edinburgh Perinatal Depression Screening Scale (EPDS) was selected as the screening tool. One question on the EPDS was modified for use with our population with the permission of the author. The change was based on feedback from the staff that the original wording was not commonly used in our community. Staff were trained on the screening protocols to assure pregnant and postpartum women who received care from Healthy Start and one Detroit Department of Health and Wellness Promotion clinic were screened for perinatal depression.

Screening had been established at one of the grantee agency prenatal clinics, but was not maintained as a routine practice. Training was conducted with staff from Hutzel Hospital's outpatient prenatal clinic in early 2003. Screening was to be implemented at that site by June 2003, but staffing and budgetary issues prevented the implementation from moving forward. No other sites were approached to implement the screening. Efforts were concentrated on improving screening within Healthy Start and the grantee agency prenatal clinic

2. The strategy of developing a two-tiered intervention protocol was relatively successful as evidenced by the increase in service capacity.

Objective 2: By 5/31/05, the capacity of the community health and mental health system to intervene with women with perinatal depression increased by 150, more than doubling the treatment capacity from the baseline of 133. This brought the total treatment capacity to 283, short of the goal of 500.

A two-tiered home based intervention for women with mild to moderate depression was developed and implemented. The first tier intervention for mild depression, an 8 week cognitive behavioral therapy (CBT) model, was provided by Healthy Start social workers. The second tier intervention for moderate depression, a 6-month infant mental health model with CBT elements, was provided by infant mental health specialists or other master's prepared professionals.

The original plan for increasing service capacity was based on the assumption that all Healthy Start nurses and social workers would provide the short term intervention. As previously discussed in section II Project Implementation, Perinatal Depression, the intervention plan was changed in 2003 due to staff resistance. The new plan had only 2 Healthy Start social workers assigned to provide the short term intervention. With only 4 staff providing all the depression intervention, the ability to expand service capacity was limited.

3. The strategy of implementing the screening protocol was partially successful.

Objective 3: the project period goal of increasing to 90% the eligible women screened for perinatal depression during routine clinic/home visits using a standardized instrument by 05/31/05, was not achieved. However, almost 900 women were screened within the project period, a significant increase from the baseline of zero.

Of all the women screened, 336 were identified as depressed. Approximately 50% were mildly depressed, 40% were moderately depressed, and 10% were severely depressed. The majority of the women who screened positive (64%) were pregnant.

As noted above, screening was successfully integrated into Healthy Start case management services. While it was implemented in one prenatal clinic, that change was not sustained.

4. The final strategy, implementing the intervention protocol, has been successful.

Objective 4: By 05/31/05, 18 women had a lowered depression score as assessed on a standardized instrument within three months of completion of the intervention. Their average EPDS score at screening was 14.39 and their average EPDS score at the follow up visit was 5.61.

Most women who screened positive for depression accepted a referral for some level of service at the time of screening; only 6% refused all referrals. Those who were severely depressed were referred to a community mental health provider and/or crisis center as the Healthy Start Perinatal Depression program was not designed for women with severe depression or significant mental health problems.

Intervention services were initiated with 65% of the women referred for the Healthy Start Perinatal Depression program. Approximately 15% of those referred could not be contacted by the intervention staff and another 10% refused to start the intervention. Only

32 women have completed the intervention to date. About 25% of those who started the intervention were lost to service and another 6% refused ongoing services.

The evaluation data suggest the intervention was effective. The EPDS has a maximum score of 30. The mean score at screening was 15.82 (N = 272) and the mean score after completing the Healthy Start intervention was 5.92 (N = 26). Based on a comparison of the EPDS scores at screening and evaluation there was significant, long term improvement.

Objective 5: By 5/31/05, 79% of infants of moderately depressed women exhibited a decrease of withdrawn behavior as assessed by the Alarm Distress Baby Scale 3 months after completion of the long term depression intervention. This exceeded the project goal of 70%.

The development of infants who mothers' are depressed can be compromised. Therefore, as part of the evaluation infant development and level of withdrawal were assessed. Of the 11 infants assessed at the 3 month evaluation visit, only one infant did not score within range on the developmental assessment and none were highly withdrawn.

There were multiple barriers to accomplishing the goals of perinatal depression. Initially, the biggest barrier was staff resistance to screening. Comments on the evaluations from the first training indicated that staff felt unprepared to address the issues that might be identified as a result of the screening, such as suicidal ideation. In spite of providing training, consultation, specific protocols, and emergency plans, the majority of the case managers did not screen their clients at the beginning of the project. While similar concerns were expressed by clinic staff, their biggest issue was adding another task and more paperwork. These barriers were addressed with ongoing training and consultation. As a result, attitudes within Healthy Start did change. Staff began to understand the value of the screening and indicated that this was a good program. However, we were unsuccessful in implementing screening in the hospital clinic.

Most Healthy Start case managers remained resistant to providing the short term intervention. Not only did they feel unprepared to implement the intervention, the need to see clients weekly or every other week for 8 sessions was problematic given their workload and schedules. Assigning specific staff to provide the intervention largely overcame this barrier.

Another barrier to screening was retaining women in care. Women were generally not to be screened at opening. Having an established relationship was identified as important in overcoming the stigma associated with depression. In addition, the literature suggested that the most appropriate time to screen was in the late second or early third trimester. How many women did not remain in care long enough to be screened is unknown.

Lastly, initiating services and retaining women in care to complete the intervention has been a barrier. As noted above, depression services were initiated with 65% of the women who accepted services when they were screened. In addition, a third of the women who initiated services did not complete them. One fourth were lost to service and another 6%

refused ongoing services. Plans for asking other providers to institute the program were delayed as we had limited success in retaining clients in care.

Lessons learned

1. Extensive training and support are needed to prepare staff to screen for depression.
2. The intervention for perinatal depression is most effectively implemented if it is the primary workload of designated staff.
3. Perinatal depression is a significant problem.
4. Depression during pregnancy is more common than during the postpartum period.
5. Women are generally receptive to screening.
6. Expanded services for all levels of depression and other mental health problems are needed.

F. Consortium had two major strategies for this project period. The first was to assure Community Consortium members were well informed about factors related to perinatal health and the second was to assure consistent and active consumer participation in the Consortium.

1. The first strategy, assuring Consortium members were well informed about factors related to perinatal health was moderately successful.

Objective 1: By 12/2004, Community Consortium members' knowledge of factors related to perinatal health increased to a mean of 77%, exceeding the baseline of 67.42%, but not meeting the project goal of 80%.

To assess member knowledge, annual surveys were administered each December. Average scores were low for the first two years (67% in 2001), (65.44% in 2002), but improved over the next two years (78.34% in 2003), (77% in 2004).

To address the low scores, the Executive Committee recommended that each survey question be read to assure members understood of the intent of the question. In addition, pre- and post tests for each health care presentation were instituted so that gaps in understanding could be addressed in a timely manner.

2. The second strategy, assuring consistent and active consumer participation in Consortium activities was successful.

Objective 2: By 5/31/05, consumer participation in the Community Consortium was maintained at 100%, meeting the project goal.

A major accomplishment was the increased willingness of consumers to participate in project governance, training, and discussion. This was evidenced by the number of consumers who submitted applications to become members of the Executive Committee. In 2002, 43 consumers responded to the first request for volunteers for the Executive Committee. In 2004, 14 consumers responded to a second request. A total of eight (8)

consumers were selected to receive training and filled vacancies on the Executive Committee. In addition, 13 consumers were interested in the position of Consumer Vice Chair for the Consortium. Consumer involvement in the environmental scan used to help establish our local health system action plan solidifies the belief that consumers are willing to become active participants if given opportunity and the necessary support. These examples testify to their growth and to their willingness to engage in leadership activities. The growth and development of consumers within the Consortium can be attributed not only to the strategies and activities, but also to their trust in staff and their increased comfort level that empowers them to take on new challenges.

Major barriers have been consumers' lack of familiarity with the procedures of business meetings as well as with the roles and responsibilities of the many staff that participate in project meetings. In addition, the lexicon of community health, grant funding, and the medical field is a challenge for many consumers. These barriers have been addressed by providing mentoring and training for consumers. Mentoring was ongoing, while training was time limited. In addition, staff worked to create a support environment that facilitated the active and ongoing participation of the consumers.

Lessons learned

1. Consumer input in all areas of project governance added value and significantly moved the Consortium forward.
 2. Training for consumers facilitated their participation in the Executive Committee.
 3. Enhancing consumers' understanding of project objectives and their role in achieving those objectives helps to maintain their engagement in project governance.
- B. During the project period, the Detroit Healthy Start Project did not request mentoring or technical assistance from another site, but did request technical assistance relative to the use of Perinatal Periods of Risk (PPOR) and also provided mentoring and technical assistance to other programs.

Detroit Healthy Start requested technical assistance on the use of the Perinatal Periods of Risk Approach. City/MatCH in coordination with its National partners including the March of Dimes, CDC, and HRSA/MCHB advanced the dissemination, utilization, and integration by offering two levels of technical assistance. Detroit applied for and was selected for Level 2. The activities included participating in monthly phone seminars as well as the required conferences. The process is ongoing and Detroit plans to incorporate the PPOR process into both its Local Health System Action Plan and its FIMR. In addition, this information will be used to enhance the decision making of the Healthy Start Executive Committee.

Detroit Healthy Start facilitated a two-day conference in July 2001 with Beverly Watkins, Tennessee Healthy Start Project Director, and Morrstein Holman, Deputy Administrator Memphis-Shelby County Health Department. Ms. Watkins and Ms. Holman gathered information regarding case management service protocols and client/consumer recruitment and retention strategies. Although Mentoring Contact Log forms were provided, no feedback information was forwarded to DHSC.

In October 2001, Mindy Hersey, Saginaw Healthy Start, attended the Client Appreciation meeting to observe the dynamics of the Detroit Healthy Start Consortium. Later in the month, Ms. Hersey attended a one-day session to discuss recruitment strategies and lessons learned with the Consortium Coordinator. Saginaw Healthy Start has participated in mentoring activities since October 1999. Ms. Hersey had several successive email communiqués with the Consortium Coordinator throughout 2001 and early 2002 to discuss the possibility of a visit by the Consortium Coordinator to Saginaw to address consumer participation in their Consortium. This was not implemented due to the resignation of Ms. Hersey in the summer of 2001.

In 2002 Stephanie Smith, Community Coalition Coordinator, with Saginaw Healthy Start meet with the Consortium Coordinator to discuss recruitment strategies and consumer participation. Although Mentoring Contact Log forms were provided, no feedback information was forwarded to DHSC.

In December 2003, Sheree Holmes, Kalamazoo Consortium Coordinator, contacted DHSC and requested mentoring. Her intent was to attend a Community Consortium meeting and later meet with the Detroit Consortium Coordinator to discuss recruitment concerns and strategies. Arrangements were made for Ms. Holmes to attend first the December meeting, and later the February 2004, she was prohibited from doing so. No further contact was made.

Lessons learned

A lack of ongoing communication with mentoring sites may result in missed opportunities for further mentoring.

V. Project Impact

Overall, Healthy Start had a positive impact on both the project area and the larger community. While many challenges persist, there have been changes within the care systems and the community. Healthy Start has helped strengthen the efforts of our State Title V program. Lastly, relationships with both our state and local governments have heightened awareness of maternal and child health issues.

A. Systems of Care: Detroit Healthy Start has enhanced collaborative interactions within the grantee agency as well as among the community organizations and services working to promote maternal and infant health through the activities of its core services and core systems building efforts.

1. The approaches Detroit Healthy Start utilized to enhance collaboration included the establishment of partnerships across systems, the development of direct referral processes, maintaining and enhancing communication mechanisms, conducting joint trainings and participation in the development of a broad based

coalition designed to act as the entity through which to address maternal child health issues.

2. Healthy Start had a role in the significant procedural changes within the grantee agency that have enhanced service system integration. A prime example is the development of a direct referral process between the Medicaid Outreach and Advocacy Program (MOA) and Healthy Start. This process has streamlined enrollment into case management. Every pregnant woman who calls the Helpline is screened for eligibility for Healthy Start via a questionnaire. As eligibility has been established before a referral is sent to Healthy Start, the need for case management supervisors to screen these referrals is minimized. In addition, referrals are now sent to Healthy Start on a daily basis which has decreased the response time to calls for service. Healthy Start created a partnership between the public health and mental health systems with the development of the intervention for perinatal depression. The perinatal depression referral procedure that has been developed has facilitated the integration of the public health and mental health systems. Clients who receive public health services are screened for depression and those who require long term intervention are directly referred to a provider. They do not have to go through a mental health system intake process. The referral process and communication mechanism that was established between Healthy Start and the infant mental health providers has enhanced the integration of mental services and social support services.

3. Several key relationships have developed as a result of Healthy Start efforts. Project staff, local advisory councils, the Executive Committee, and the Consortium have been instrumental in this process:

a. Healthy Start and its grantee agency have maintained referral relationships with each of the major health systems serving Detroit. In addition, contractual relationships between the grantee agency and the HMOs serving the Medicaid population have been strengthened to assure families can readily access public health services. As a result of these relationships, families enrolled in an HMO can receive immunizations, lead testing, and other basic public health services from the grantee agency without a referral from the HMO. In turn, the grantee agency is reimbursed for those services. Healthy Start has directly helped to enhance relationships across systems by maintaining contractual relationships with medical and mental health providers for the purpose of expanding access to prenatal care and treatment of depression.

Healthy Start also maintained referral relationships with the major social service agencies and community-based organizations to facilitate clients' access to resources and services. Detroit Healthy Start had on-going relationships with health providers such as the Visiting Nurses Association, Children's Hospital of Michigan and St John's Health System. These providers referred clients who were discharged from their care to assure

continuity from hospital to home or from acute care to health maintenance. Interactions with social service organizations such as the Family Independence Agency (our state TANF agency) and Westside Mothers permitted resource identification and awareness of entitlements. Finally, the associations established with community-based organizations such as St. Vincent DePaul, Capuchin Center, Pregnancy Aide, Mound Road/Ryan Correctional Facility, St. Paul Lutheran Church, and Peace Lutheran Church resulted in a wealth of resource assistance for clients. Catherine Blackwell and Our Lady Star of the Sea schools provided economic, clothing and food supplements. Christ Child Society provided infant supplies and layettes. Within the grantee agency, Healthy Start collaborated with the clinics, the immunization program, WIC, and Healthy Baby Services. All collaborations were intended to promote maternal infant health through augmenting the support services provided by case management. Healthy Start was also part of the Urban MCH Data Use Institute. This City/MatCH and CDC collaborative offered training to enhance the effective use of data for urban maternal and child health effort. Healthy Start staff have participated in two trainings, one that focused on perinatal HIV/AIDS and another that focused on the development of maternal child health risk profile.

Healthy Start also facilitated relationships among providers and agencies through their involvement with the local advisory councils and Consortium. To illustrate, throughout the project period the local advisory councils have sponsored a variety of community events such as baby showers and educational forums. A host of providers and agencies worked collaboratively to plan and implement these events. They included churches, the Parish Nurses, the Infant Mortality Project, Wayne State University, Hutzel Hospital's Family Road, the Empowerment Zone Coalition, and Wayne County Community College.

b. Healthy Start facilitated the involvement of consumers and community leaders with our health and social service agencies. Communication between members of the faith community and health providers has increased. For example, the pastor of a local church, Tried Stone Baptist, opened his doors to Healthy Start several years ago. He and members of an auxiliary group became active partners in addressing infant mortality. They served on the local advisory councils, participated in the planning of community events, and met with legislators. The church "adopted" Healthy Start's peer support group, the Alumni Club, which provided an opportunity for clients to obtain their GED through an outreach program of our local community college. This relationship has enhanced the involvement of consumers with community agencies. The founder and director of our social welfare advocacy group, Westside Mothers, was a long standing member of the Consortium and now serves as the chairperson. In that position, she directly interacts with the health and social service

agencies that sit on the Executive Committee.

4. Healthy Start has influenced the comprehensiveness of services to our families as described below:

a. To facilitate intake into Healthy Start case management, the Family and Parenting Helpline began utilizing a “Prenatal Health Assessment” to determine if a woman’s health status indicated a need for case management services. Helpline Technicians participated in Healthy Start orientation to facilitate their ability to explain the program to clients and answer questions. This process helped to identify both the women who were likely to need services as well as the women who were not likely to need services, assuring a more effective use of staff time.

The grantee agency has developed a streamlined intake process for pregnant women. In the single intake visit, women are assisted in completing an insurance application, receive a provider guarantee of payment letter, have an initial prenatal appointment scheduled, are registered with Healthy Baby Services if transportation is needed, have a WIC appointment scheduled, and are referred to Healthy Start for home based case management services.

As noted above, women who need treatment for perinatal depression do not have to go through the community mental health intake process but are directly referred to an infant mental health specialist.

b. Transportation was a major barrier to accessing care and services. To address this barrier, Healthy Start, in partnership with the grantee agency and two adjacent county health departments, funded Healthy Baby Services throughout the project period. Healthy Baby Services provided door to door transportation for pregnant women, postpartum women and families with infants. Women were referred to Healthy Baby Service by both outreach and case management staff. To facilitate utilization of preventive health care, case managers assisted clients who did not have a primary provider in identifying a medical home and accessing care. To enhance awareness of services, case managers routinely informed clients about the availability of community resources, such as food banks, Head Start programs and support services available from their HMOs (transportation and classes). All Healthy Start clients received a community resource guide at the initial visit with the case manager.

Healthy Start also worked to increase awareness of resources in the larger community. As mentioned previously, Healthy Start sponsored a variety of community events. Other agencies and providers regularly participated in these events so that participants had the opportunity to directly learn about their services and could often register on site. In addition, written

information about services and resources was available at every project meeting and event.

c. Several mechanisms have been implemented by Detroit Healthy Start to insure continuity of care, quality improvement and follow-up of services.

Coordination of care was greatly enhanced with the implementation of a full service intake model whereby a pregnant woman:

- Was enrolled in a health insurance program
- Received a guarantee of payment letter to immediately begin prenatal care
- Had the first prenatal care and WIC appointment scheduled
- Had transportation scheduled via Healthy Baby Services as needed
- Was referred to Healthy Start case management as needed
- Received reminder calls for any prenatal care, WIC or Healthy Baby Services appointments that were scheduled for her.

Coordination of care between referring agencies and case management was facilitated through the use of return agency reports which describe the outcome of the home visits made to date and plans for ongoing service. Phone contact with referring agencies was also made as needed. Coordination of care and follow up for women receiving perinatal depression services was facilitated through the use of return reports and monthly case conferences.

Within Healthy Start, service and recording procedures were established to assure that there was follow up on client referrals. Supervisors were charged with responsibility of monitoring adherence to those procedures. However, lack of documentation of follow up on referrals remains a problem.

Healthy Start's quality improvement efforts were coordinated with the grantee agency's established policies for accreditation, which included guidelines for review of family service records. For a portion of the project period, Healthy Start had a Quality Assurance Coordinator as part of the grantee agency's in kind support of the project. In addition, all core components regularly reported their progress and problems to the Executive Committee.

d. Detroit Healthy Start shared data with other providers in the context of established referral and reporting procedures. There has been little change in the procedures during the project period. Within the grantee agency, the Family and Parenting Helpline intake process was adjusted to reduce the need for repetition. As previously indicated, MOA/Family and

Parenting Helpline utilized a “Prenatal Health Assessment” which provided essential client information. The intake process for the Helpline was as follows:

- Caller was interviewed relative to the reason for their call.
 - Demographic information was obtained.
 - If caller was pregnant, the Helpline Technician or Outreach Workers explained the Healthy Start Program.
 - The Prenatal Health Assessment questionnaire was administered.
 - Written referral was forwarded to Healthy Start with client’s consent.
5. The majority of health and human service providers had existing mechanisms for client participation in the evaluation of their service provision. Healthy Start offered clients the opportunity to participate through satisfaction surveys and membership in the Consortium, but had little impact on other systems.

a. Healthy Start attempted to maintain client participation by providing meaningful, culturally sensitive services, meeting clients at a location of their choice, and adjusting service hours to coincide with client schedules. Male partners were also encouraged to become a part of the home visits and participate in project activities. Several male clients became members of the local advisory councils. They focused their efforts on male responsibility and the male role in parenting.

While ninety-five percent of our clients were African-America who spoke English, staff had access to the AT&T Language Line to provide interpretation for non-English speaking clients. Resources to assist non-English speaking clients and clients from other cultures were also available through the Detroit Department of Health and Wellness Promotion’s Medical Social Work Division Refugee Advocate as well as the International Institute.

b. Consumers participated in developing assessment and intervention mechanisms through their participation in the Consortium. Consumers provided general feedback on the overall Healthy Start plan including the core service interventions throughout the project period. However, Healthy Start did attempt to increase consumer participation in critically examining and recommending revisions in its services. Two consumers participated in the National Healthy Start Association’s Region V conference and attended the technical workshops. They then were able to help lead the Executive Committee’s discussion about the difficulty that perinatal depression was having in retaining women in the intervention. Staff were then given the responsibility to implement the recommendations and establish a timetable for reporting back to the Executive Committee. This process was not completed

before the end of the project period, but Healthy Start plans to examine all services in this manner in the next phase of the project.

B. Impact to the Community. Detroit Healthy Start and the grantee agency have contributed to the development and empowerment of the community in the following ways:

1. Healthy Start has contributed to community residents' knowledge of available resources and how to access those resources by making information sharing a part of all project services and activities. As previously noted, all clients receive a community resource guide when they enroll in Healthy Start. The guides are updated regularly. The introduction to Healthy Start services included a review of the guide so clients knew what information it contained and how to use it. Information on key support services such as WIC, Healthy Baby Services, and Medicaid was also included in a new client packet. When clients were referred to other agencies, the referral process included informing them about the location, hours, intake procedures, and services available at the referral resource.

The Family and Parenting Helpline is an established central point of contact for Detroit residents seeking resources and information. Information about the helpline was distributed throughout the community on a regular basis. Helpline Technicians provided callers with information about community-based resources, expanding and enhancing the public's access to parenting education and support services.

Presentations by community agencies have been a regular agenda item at Community Consortium and Alumni Club meetings. Finally, all Healthy Start sponsored community events include representatives from a variety of agencies who share information about their resources and services.

2. Detroit Healthy Start facilitated consumer participation in establishing or changing standards and/or policies that affected the health or welfare of the community by educating consumers about the political process, providing information on legislation, hosting community forums, and encouraging the community to vote. As noted in the Consortium narrative, Healthy Start hosted an annual trip to the state capitol. Clients received information on the legislative and budget processes as well as updates on the health and human service issues of the day. A time for clients to meet with their representatives and share their concerns was included in the agenda each year. Information about state and federal legislation that had the potential to affect our community's health and welfare was also shared with consumers at Community Consortium and Executive meetings. Healthy Start also hosted several community forums where clients and consumers had the opportunity to interact with legislators and policy makers. For example, Michigan has been faced with significant budget shortfalls throughout the project period. When a number of health programs were slated for funding cuts, Healthy Start invited the state legislators to a forum to discuss the problems and to hear ideas on addressing the shortfalls from their constituents. Every legislator that represented the Detroit community attended. Last, consumers are always reminded about deadlines for registering to vote, election dates, and what positions, questions, or initiatives will be on the ballot.

3. Detroit Healthy Start contributed to our community's experience in working with divergent opinions and resolving conflicts by hosting community forums, inviting knowledgeable speakers to address controversial issues, and being inclusive. As previously discussed, Healthy Start facilitated community dialogue about the difficult issues, such as those that arise when government resources are insufficient to meet identified needs. Healthy Start encouraged discussion about controversial issues, such as how to control the spread of HIV/AIDS among young African American women. Healthy Start attempted to be inclusive of the entire community. All educational meetings and events are open to the public and information on upcoming activities is widely distributed. In addition, Detroit Healthy Start provided leadership training for the consumers that are members of the Executive Committee which included conflict resolution.
4. New jobs were not created within the community as a result of this Healthy Start funding cycle. However, the majority of Healthy Start funded staff lived in the community and Detroit was able to retain these jobs. Healthy Start jobs included clerical and professional positions. Healthy Start participated in helping clients and community residents prepare for employment by facilitating their access to educational opportunities and conducting workshops on interviewing, resume preparation, and dressing for success. Lastly, when information on employment opportunities became available, it was shared with clients and consumers.
- C. Impact on the State: Over the past four years Detroit Healthy Start has been a part of activities that have strengthened its relationship with the State Title V program. Detroit Healthy Start actively participated in the state wide Healthy Start network meetings convened by our Title V agency, the Michigan Department of Community Health. All projects shared information about their accomplishments and problems, which enhanced learning for everyone. While these meetings were helpful, they did not appreciably affect our relationship with other state programs such as SCHIP or Early Intervention. Our grantee agency, the Detroit Department of Health and Wellness Promotion has continued its extensive relationships with the state health department and implements the majority of the Title V programs in Detroit. As Healthy Start was a program of the city health department, the project's relationships with these services were well established prior to the establishment of the state Healthy Start network.
- D. Local Government Role: The grantee agency's relationships at the state and local level facilitated project development. Both the state and city governments were supportive of Detroit Healthy Start's application and provided help and information as requested. As Healthy Start is a program of the city health department, the health director was well acquainted with the success of the project, the ongoing need, and importance of maintaining services within the project area. The primary barrier was the ongoing budgetary problems of the city and the state. The grantee agency designated both city and state funded personnel as in kind supports to Healthy Start. With each round of budget cuts, staffing was affected. In addition, state budget cuts had an affect on the other community resources, decreasing the capacity of programs that Healthy Start relied on as referral resources. Lastly, as programs lost capacity, the city health

department and in turn Healthy Start, received more requests for services. Decreases in staffing were dealt with by shifting the workload. For example, when state budget cuts resulted in the lay off of the maternal child health advocates, the remaining case management staff were no longer out stationed to conduct case finding and their caseloads were increased. While these were not optimum solutions, there were few other options.

E. Lessons Learned: Several overall lessons were relearned.

1. Everything takes longer than expected, it is important to have realistic time frames.
2. It is important to set achievable goals and objectives.
3. It is important to understand what factors your project can affect and the degree to which those factors can be changed.

VI. Local Evaluation

Four local evaluations were conducted: Case Management, Outreach, Health Education; Interconceptional Care Inreach; Perinatal Depression; and Consortium. These Local Evaluation Reports are in the Appendices.

VII. Fetal and Infant Mortality Review (FIMR)

Healthy Start did not develop a FIMR, but has been a part of the existing FIMR at the Detroit Department of Health and Wellness Promotion which began in 2001. The focus has been on sudden or unexplained infant deaths. In addition, reviews in 2004 focused on the 57 infant deaths seen at the Wayne County Medical Examiner's Office and included Detroit as well as out Wayne County infants. Case Review Team meetings are typically held monthly. Since December 2004 we have also had quarterly FIMR/Fetal Alcohol Syndrome (FAS) meetings where the focus has been on deaths that occurred when alcohol was being used and alcohol use while pregnant was acknowledged, observed, or strongly suspected. With the hiring of a full-time FIMR abstractor and home interviewer who started on June 7, 2005, we are planning to offer services to all families in Detroit who have suffered an infant death. In addition to a FIMR home interview, bereavement services and a grief support group are being offered to all families who suffer an infant loss. Funding for the Detroit FIMR comes to the grantee agency from the state's Maternal Child Health Block Grant. Funding for FIMR/FAS through September 2006 is the result of an Agreement with the National FIMR as a subcontract under their grant from CDC. Detroit and Baltimore were the cities selected for the FIMR/FAS.

The FIMR Case Review Team has long been aware of the need to have a Community Action Team. There was an increased emphasis on this component starting in 2003 with the plan to re-establish a broad based community collaborative, the Infant Health Promotion Coalition. With funding from the Kellogg Foundation, the hiring of a coalition coordinator in the fall of 2004, and approval by the Healthy Start Executive Committee that the IHPC act as the FIMR Community Action Team (CAT), it became a reality when it was announced at a Stakeholders Meeting on June 3, 2005. With infant mortality funding to

eleven communities, including Detroit, from the Michigan Department of Community Health, the Coalition will serve as the CAT for Detroit and Wayne County. Wayne County, of which Detroit is its largest city, will hire their own Coordinator and the two will work together to take recommendations to action by the Coalition. Wayne County also received start-up monies to start their own FIMR Case Review Team.

Interface and partnering of Healthy Start with FIMR using the Perinatal Periods of Risk (PPOR) data is helping us to identify where the majority of our infant deaths are occurring: maternal health/ prematurity and the area of infant health. Findings and recommendations which come out of Healthy Start and Fetal and Infant Mortality Review will assist the Infant Health Promotion Coalition in directing efforts that will not only be effective but which will also have a long lasting impact on Detroit's infant mortality.

Recommendations have included the need to decrease the number of unplanned pregnancies and an emphasis on preconceptional as well as interconceptional planning. Back to Sleep education was expanded to include a host of messages about creating a safe sleep environment for infants. There is also a need for adherence to protocol that calls for a death scene investigation by the Police Department in conjunction with the Medical Examiner's Office. There has been a dramatic decrease in the number of deaths attributed to SIDS where the manner of death is more accurately given as, for example, positional asphyxia.

VIII. Products

The products produced during this project period were for program participants. The Perinatal Depression Brochure and Self Help insert were designed to acquaint participants with the perinatal depression intervention. The project was also the focus of a feature article entitled "Perinatal Depression Program" in *CityMatCH Urban Women's Health* (April 2005). The article highlighted best practices in perinatal depression including strategies, evaluation, and screening. Copies of these items are in the Appendices.

IX. Project Data

Healthy Start Data Reporting Requirements (HSDRR) forms for each year of the four year project period were submitted electronically. Included were the following forms: MCH Budget Details (Form 1), Variables Describing Healthy Start Participants (Form 5), Common Performance Measures and Intervention Specific Performance Measures (Form 9), Characteristic of Program Participant (Table A) Risk Reduction/Prevention Services (Table B), and Major Service Table (Table C).