# Narrative Progress Report
# September 2003


| | |
|---|---|
| Project Title: | Prince William Health Collaborative |
| Project Number: | 1 H25 MC 00191-01 |
| Project Director: | Barbara DeChene |
| Grantee Organization: | Northern Virginia Family Service |
| Contact Person: | Sarah Donovan |
| Address: | 2200 Opitz Blvd<br>Suite 100<br>Woodbridge, VA 22191 |
| Phone Number: | (703) 490-1498 |
| E-mail Address: | sdonovan@nvfs.org |
| Home Page: | www.nvfs.org |
| Project Period: | 01/31/02-01/31/03 |
| Total Amount of Grant Awarded: | $150,000 |

# NARRATIVE PROGRESS REPORT

## I. PURPOSE OF THE PROJECT:

In 1999, pregnant women, infants, and toddlers living in Prince William's rural, urban, and federal land areas were not as healthy as the community desired. A tremendously overburdened health care system and health system problems presented barriers to the adequate health outcomes of this population. A coordinated preventive health service system did not exist in the community; neither did a one single place for pregnant women or parents of infants and toddlers to find out about available services, determine what complement of services would best meet their needs, and become connected with these services. Services that did exist were fragmented and often unaware of other programs offered. The county's rapid expansion from a rural to a more urban area, and the rapidly-growing population of non-English speaking clients formed another barrier to these women and children receiving the services they needed.

A small group of agency and county representatives who served this population met to discuss the problem. They included representatives from Potomac Hospital, Northern Virginia Family Service, PW Department of Health, and the PW Department of Social Services. They formed the Prince William Health Collaborative and together applied for the CISS grant with the objective of obtaining staff support and to begin the work of solving some of the problems listed above. The following goals were set as guidelines to focus the project.

## II. GOALS AND OBJECTIVES:

GOAL #1: *Coordinate and integrate existing preventive health services for pregnant women, infants, and toddlers.* To address the lack of a coordinated preventive health

service system in the Prince William Area, the project spent Year 1 looking at what services were currently available. Each program was considered in terms of enrollment criteria, enrollment capacity, outreach methods, confidentiality requirements, etc. The Collaborative condensed this material into service grids, which were then shared with other community services interested in service to women and children, both for their information and input. As these grids were shared, previously unknown program were discovered; as other services were made known to the Collaborative these services were added to the grid.

As information regarding available services became known, the Collaborative expanded to include representatives from the majority of all service providers to women and children in the Area. Membership for the collaborative increased to include representatives from other preventive health service programs in the community (see appendix for membership list), such as Pediatric Primary Care, Prince William Free Clinic, Potomac Prenatal Clinic, ICC & Early Intervention Services, Head Start, Healthlink, Child Specialty Services, Virginia Cooperative Extension, Mom's Project, Resource Mothers, the Community Services Board, Nurturing Parents, and the Marine New Parent Support Program. The Collaborative meets once a month; networking and sharing information so as not to duplicate agency efforts is an outcome of these meetings.

GOAL #2: *Utilize and expand the current **Healthy Families** New Parent Consultation process to identify pregnant women and new parents who are at risk for poor health outcomes and connect them with appropriate preventive services.* To address the lack of a single point of entry for preventive health care services, the Collaborative enhanced and expanded the ***Healthy Families*** New Parent Consultation (NPC) process.

The process included taking a systematic look at pregnant or new parents to ascertain if they might benefit from ***Healthy Families*** or ***Early Head Start*** services. Systematic screening, using a 15 item Screening Checklist occurred at three primary locations: Potomac Hospital labor/delivery, Prince William Hospital labor/delivery and Medicaid Intake. In addition, community partners, pediatricians, OB/GYNs, shelters, childcare centers, and Early Intervention agencies also made referrals using the screening process. Families are introduced to the programs and if they are interested in more information, give their permission for staff to complete screenings using information from their medical records and/or Medicaid applications. If the family screens positive, they are referred to the Prince William Health Department for a New Parent Consultation.

Two full-time, in-kind Public Health Nurses and one part-time Family Assessment Worker conduct these New Parent Consultations that include in-home assessments, prenatal health checks, and newborn checkups. Families are assessed using the Kempe Family Stress Checklist, to determine whether home visiting will be helpful to them. Preliminary income information is also gathered. The score on the checklist determines eligibility for ***Healthy Families*** services with a 25 or more being considered a positive assessment. If a family is assessed positive and is interested in receiving home visiting services, they are referred to ***Healthy Families*** or Early Head Start for assignment to a home visitor (depending on vacancies). Negative assessments are referred to other community resources.

In Year 2 of the project, the Collaborative enhanced this process by developing an expanded assessment process that included assessment and referral to all available programs in the county that served this population. Programs discovered through goal

one were added as referral sources with the guidelines for each program being considered in the screening process. Representatives from these programs met to agree upon a referral process to specific programs, and memorandums of understanding were made. The screening process now determines if a family is at risk for poor health outcomes, and which of the programs, from all those available in the county, will best meet the family's needs.

The Collaborative also realized that a significant number of Prince William citizens receive their prenatal care and deliver at hospitals outside of the area, and thus miss the screening process in place. Members of the Collaborative have joined with other agencies in the Northern Virginia Area to develop the same screening system used here in Prince William in the INOVA hospitals in Fairfax, Alexandria, and Arlington, which include as their patients women who live in Prince William. This added service will then broaden the pool of potential clients who will then be screened for available services in Prince William.

GOAL #3: *Identify and address gaps in services for pregnant women, infants and toddlers.* Using the information gathered in Goal 1 and the input of the new program representatives invited to join the project, the Collaborative began discussing the gaps in services for pregnant women, infants, and toddlers. Through brainstorming and using a method taught to the group by a meeting with the Technical Assistance team, the Collaborative decided to divide into two distinct committees to focus on service gaps in those areas. The two committees are *Children's Mental Health* and *Access to Prenatal Care*. Work was done with both committees to brainstorm ways of filling these service gaps by expanding existing services or by bringing new services to the Prince William

Area. Once the Collaborative defined and/or selected their desired program models, funding was sought from private and public partners to develop and implement (or expand if related to existing services) these programs.

The Collaborative utilized the Technical Assistance provided through the CISS grant twice during the grant period- once in the very beginning to help focus the mission of the group, and then once again after the two committees were chosen. Members of the Collaborative never participated in the yearly meetings of CISS grantees in DC because the Collaborative was not aware of these meetings happening.

*Resource Mothers*

As work was done to expand the existing screening tool for HF/ EHS, the Collaborative realized the need for a program targeted to pregnant teens. These teens often did not need the intensive services offered by Healthy Families/ Early Head Start, but were in need of more support than is available from the support groups and services through the busy DSS Bridges program for pregnant teens. In collaboration with both HF/EHS and the Bridges program, Resource Mothers, a mentoring program designed to link volunteers and teens that need a knowledgeable friend to support them through their pregnancy and first year, was developed and implemented with success to fill this gap in services. Resource Mothers volunteers mentor pregnant teens until the baby's first birthday, and the program is being expanded to include a paid caseworker, who will handle more intensive cases. This program has helped offer another service to those unable to get into HF/EHS.

Funding was obtained through a grant from Freddie Mac to hire a coordinator, who is currently applying to other foundations and sources for follow-on funding. This

program has been another example of the successful partnershipping through the CISS grant in Prince William. The board of Resource Mothers is composed of a wide variety of agencies who work with the current population, the coordinator is employed by the Department of Health; the volunteers are trained through training a community NPO provides, while the referrals come from a collaborative screening through the hospitals, the DOH, and another local NPO.

*Access to Prenatal Care*

As the collaborative discussed the types of prenatal care that we hope to be able to offer in the Prince William Area, many references were made to Mary's Center for Maternal and Child Health, a clinic for women in Washington, DC that has had much success in providing prenatal care to women from different cultures. As well as cultural sensitivity, this clinic also specializes in providing a one-stop option of all available services for women's, children's, and family health. Members of the Collaborative have met with members of the board of Mary's Center as well as the Executive Director. They have agreed to provide the clinical staff to support a satellite branch here in Prince William County. Space has been offered on both ends of the county from Potomac Hospital and the Department of Health. A small amount of funding has been obtained from a grant through the March of Dimes; other funding streams are currently being sought. Further plans are waiting concrete funding.

In addition, a small grant was written and approved to provide a Hispanic outreach worker to help many of the Hispanic women in our community access the prenatal care options that are available; at this time funding has not yet been received nor the program implemented.

*Children's Mental Health*

For the past year and a half the Collaborative has been investigating different models of improving the mental health options for small children and their families. Representatives and others knowledgeable about programs designed to improve children's mental health have come to meetings as guest speakers. A grant was written and applied for which would begin a program of providing intensive counseling to some of the most vulnerable families, as well as send licensed mental health counselors into daycare centers to work with the staff, parents, and specific children on mental health issues. A decision on that funding source should be made within the next few weeks.

In the past few years, children's mental health has emerged as a concern in many different arenas and groups in the area. Members of the Collaborative who sit on other committees in the community have reported the interest, and the Collaborative has been involved in different initiatives to fill this gap that have taken place in the community.

In September, an intensive training is being offered to childcare providers and other direct service workers on appropriate discipline techniques and emotionally nurturing interactions with children. A committee was formed to direct the use of a large sum of money received as reimbursement for Title IV E activities; members of the Collaborative also sat on this committee. The money will be used to fund two programs which both relate to the CISS goals- one to encourage parent-child interactions and bonding through a literacy program provided through the library, and the other training for community workers on a comprehensive system for case management and mental health with families in the community.

In addition to the programs developed that related directly to the two main areas of Children's Mental Health and Access to Prenatal Care, members of the Collaborative also worked to support other groups that shared the stated mission of serving the target population of pregnant women and children 0-5. The Collaborative worked closely with United Way's Success by Six Initiative to fund a mobile Primary Car Van to service children and families without insurance on the west end of the county. This van will be up and running by January. Members of the Collaborative also worked with regional groups to find a distribution plan for our Area of the new Governor's Toolkits for New Parents, which will begin distribution shortly.

## III. PUBLICATIONS/PRODUCTS:

Publications written by this grant include the system matrixes and grids developed showing the available services in the Prince William Area. Brochures were also developed for the Resource Mothers program. Both of these publications are included in the appendix.

## IV. FUTURE PLANS/ FOLLOW-UP:

The biggest success of the CISS grant was to organize and unite the Prince William around the idea that pregnant women and children 0-5 in the community have needs that were going unmet and that need to be addressed. Although the Collaborative will not longer be meeting under the guidance of the CISS grant, the players who have been involved in this work are still committed. The many collaborations and partnerships that have come out of this effort have helped to assure the continuation of the goals of the CISS project: to meet the needs of pregnant women and children 0-5 in Prince William.

The mission of the Prince William Health Collaborative closely matches the mission of Success By Six, a United Way initiative that began last summer and has been working closely with the Collaborative. The grants written by the Collaborative, for children's mental health, Hispanic outreach worker, have been transferred to the Success by Six coordinator, and the members of the Collaborative not already involved with Success by Six have been invited to join. Separate committees under Success by Six will be formed to continue with the committee work being done in the two areas by the Collaborative.

The Prince William Health Collaborative sees the termination of the CISS grant as a means to an end, rather than an end in itself. Under the Success by Six umbrella, the Collaborative will continue to work with and support other groups in our community whose goals impact our goal, of improving services to pregnant women and children 0-5 in the Prince William Area.

# APPENDIX

# Narrative Progress Report Abstract
# September 2003

| | |
|---|---|
| Project Title: | Prince William Health Collaborative |
| Project Number: | 1 H25 MC 00191-01 |
| Project Director: | Barbara DeChene |
| Grantee Organization: | Northern Virginia Family Service |
| Contact Person: | Sarah Donovan |
| Address: | 2200 Opitz Blvd<br>Suite 100<br>Woodbridge, VA 22191 |
| Phone Number: | (703) 490-1498 |
| E-mail Address: | sdonovan@nvfs.org |
| Home Page: | www.nvfs.org |
| Project Period: | 01/31/02-01/31/03 |
| Total Amount of Grant Awarded: | $150,000 |

## ABSTRACT

### I. PURPOSE OF THE PROJECT:

In 1999, pregnant women, infants, and toddlers living in Prince William's rural, urban, and federal land areas were not as healthy as the community desired. A tremendously overburdened health care system and health system problems presented barriers to the adequate health outcomes of this population. A small group of agency and county representatives who served this population met to discuss the problem. They formed the Prince William Health Collaborative and together applied for the CISS grant with the objective of obtaining staff support and to begin the work of solving some of the problems listed above. The following goals were set as guidelines to focus the project.

### II. GOALS AND OBJECTIVES:

GOAL #1: *Coordinate and integrate existing preventive health services for pregnant women, infants, and toddlers.*

GOAL #2: *Utilize and expand the current* ***Healthy Families*** *New Parent Consultation process to identify pregnant women and new parents who are at risk for poor health outcomes and connect them with appropriate preventive services.*

GOAL #3: *Identify and address gaps in services for pregnant women, infants and toddlers.* Using the information gathered in Goal 1 and the input of the new program representatives invited to join the project, the Collaborative began discussing the gaps in services for pregnant women, infants, and toddlers. The Collaborative decided to divide into two distinct committees to focus on service gaps in those areas. The two committees are *Children's Mental Health* and *Access to Prenatal Care*.

*Resource Mothers*

As work was done to expand the existing screening tool for HF/ EHS, the Collaborative realized the need for a program targeted to pregnant teens. In collaboration with both HF/EHS and the Bridges program, Resource Mothers, a mentoring program designed to link volunteers and teens that need a knowledgeable friend to support them through their pregnancy and first year, was developed and implemented with success to fill this gap in services.

*Access to Prenatal Care*

Members of the Collaborative have met with members of the board of Mary's Center for Maternal and Child Health as well as the Executive Director. They have agreed to provide the clinical staff to support a satellite branch to provide culturally sensitive prenatal care to women in Prince William County. A small amount of funding has been obtained from a grant through the March of Dimes; other funding streams are currently being sought. Further plans are waiting concrete funding.

In addition, a small grant was written and approved to provide a Hispanic outreach worker to help many of the Hispanic women in our community access the prenatal care options that are available.

*Children's Mental Health*

For the past year and a half the Collaborative has been investigating different models of improving the mental health options for small children and their families. A grant was written and applied for which would begin a program of providing intensive counseling to some of the most vulnerable families, as well as send licensed mental health counselors into daycare centers to work with the staff, parents, and specific

children on mental health issues. A decision on that funding source should be made within the next few weeks.

In the past few years, children's mental health has emerged as a concern in many different arenas and groups in the area. Members of the Collaborative have been involved in different initiatives to fill this gap that have taken place in the community.

In September, an intensive training is being offered to childcare providers and other direct service workers on appropriate discipline techniques and emotionally nurturing interactions with children. A committee was formed to direct the use of a large sum of money received as reimbursement for Title IV E activities; the money will be used to fund two programs which both relate to the CISS goals- one to encourage parent-child interactions and bonding through a literacy program provided through the library, and the other training for community workers on a comprehensive system for case management and mental health with families in the community.

## III. PUBLICATIONS/PRODUCTS:

Publications written by this grant include the system matrixes and grids developed showing the available services in the Prince William Area. Brochures were also developed for the Resource Mothers program. Both of these publications are included in the appendix.

## IV. FUTURE PLANS/ FOLLOW-UP:

The biggest success of the CISS grant was to organize and unite the Prince William around the idea that pregnant women and children 0-5 in the community have needs that were going unmet and that need to be addressed. Although the Collaborative

will not longer be meeting under the guidance of the CISS grant, the players who have been involved in this work are still committed

The mission of the Prince William Health Collaborative closely matches the mission of Success By Six, a United Way initiative that began last summer and has been working closely with the Collaborative. The grants written by the Collaborative, for children's mental health, Hispanic outreach worker, have been transferred to the Success by Six coordinator, and the members of the Collaborative not already involved with Success by Six have been invited to join. Separate committees under Success by Six will be formed to continue with the committee work being done in the two areas by the Collaborative.

The Prince William Health Collaborative sees the termination of the CISS grant as a means to an end, rather than an end in itself. Under the Success by Six umbrella, the Collaborative will continue to work with and support other groups in our community whose goals impact our goal, of improving services to pregnant women and children 0-5 in the Prince William Area.

**ANNOTATION**

The Prince William Health Collaborative was formed to address the needs of pregnant women and children 0-5, who were not as healthy as the community desired. The CISS project provided staff funding and guidance to the Collaborative. The current system of referral to programs was expanded to include more potential clients, matrixes were developed of the current resources available, a Resource Mothers mentoring program for pregnant teens was began, and numerous other projects and community collaborative to support this population were brainstormed and work began.

**KEY WORDS**

Collaborative, children, infants, toddlers, children's mental health, preventative services, prenatal care, community partnerships