

SAGINAW “GREAT BEGINNINGS” HEALTHY START IMPACT REPORT NARRATIVE

I. Overview of Racial and Ethnic Disparity Focused on by Project

The Saginaw “Great Beginnings” Healthy Start project focused on the racial disparities seen between the African American and Caucasian infant mortality rate by focusing on a reduction in the African American infant mortality. “Great Beginnings” targeted reducing the African American low, and very low, birth weight pre-term deliveries and adequacy of prenatal care using the Kotelchuck Index, as another strategy to reduce/eliminate the racial disparity. Other goals were to reduce the African American infant death rate, due to positional asphyxia, and to reduce Chlamydia infections in African American females.

The Saginaw “Great Beginnings” project also developed objectives that were targeted toward Healthy Start participants. These objectives were to offer annual formal cultural competence training to community healthcare providers; comprehensive risk reduction and health education services were offered at two major prenatal care provider offices and health education/trainings were offered to Healthy Start staff, community residents, providers and the consortia members. To improve perinatal health outcomes, our project focused on reducing repeat pregnancies within a 24 month span, non-smoking for Healthy Start participants, and obtaining full required childhood immunizations per age at case closure. Services to men were provided in an effort to increase male involvement and support to the family unit. Finally, two mentoring Programs were to be developed to increase support and involvement from the targeted community members.

Saginaw’s initial community assessment focused on the three year span of 1996-1998 and 1990 Census data. The 1990 Census documented Saginaw’s population at 211,946, with 20,066 African American females, 16,858 African males, 85,918 Caucasian females, and 79,593 Caucasian males. There was a large disparity in per capita income and poverty, with the Caucasian per capita income at \$13,668 and a 10.3% poverty level compared to the African American per capita income of only \$7,377 and a poverty level of 43.6% (1990 U.S. Census).

Racial segregation was another significant issue in Saginaw County. With the exception of Wayne County in Detroit, Saginaw County was the most racially segregated county in Michigan. This was shown through the segregation index, where 0 is complete equality and 100 complete inequality. Saginaw scored an index rate of 82.7 (<http://vip.msu.edu/sass/data/dataright2.html>). Racial disparity is a definite problem within the Saginaw Community.

From 1996-1998, Saginaw County had an average of 2,954 live births, with 61.1% of the births occurring to residents of the City of Saginaw and 94% occurring in a Saginaw County hospital. The racial distribution of those births documented 59.0% were Caucasian, 26.4% African American, and 14.7% Other. According to electronic birth certificate data, 65.8% of Medicaid pregnant women were Caucasian and 79.4% African American. Disparities were seen between Saginaw’s African American and Caucasian pregnant women. Electronic birth certificate data showed that from 1996-1998, Saginaw African American pregnant women gained an average of 27.6 pounds, compared to 30.6 pounds in Caucasian pregnant women. The 1996-1998 African American prematurity rate was 24.4% and the Caucasian prematurity rate 16.9%. Low

birth weight deliveries in African American infants were at 16.2%, compared to 7.5% for Caucasian infants.

Entrance into prenatal care was another disparity issue in Saginaw County. From 1996-1998, Caucasian women showed that 89.1% entered prenatal care in the first trimester, compared to 70.2% of African American women. Adequacy of prenatal care was another issue. According to the Kessner Index, 84.6% of Caucasian women received adequate care, 11.3% intermediate care, and 4.1% inadequate prenatal care compared to 63.2% of African American women receiving adequate, 24.5% intermediate, and 12.3% inadequate prenatal care. It is significant because it is documented that adequacy of prenatal care is related to pregnancy outcomes. Low birth weight, prematurity, stillbirth, and infant mortality all have documented worse outcomes when there is a documented lower level of prenatal care. The prematurity rate is 2.1 times greater for women receiving intermediate prenatal care compared to those who received adequate prenatal care. The low birth weight rate is 2.8 times greater, stillbirth rate 17.5 times greater and an infant mortality rate of 4.6 times greater in women receiving intermediate prenatal care. Women with no prenatal care had a 6.5 times higher infant mortality rate than women who received any prenatal care and the stillbirth rate was 26 times higher for women with no prenatal care.

Domestic violence, substance abuse and smoking are issues in Saginaw County and can impact infant mortality. From 1996-1998, 24.6% of all women screened for domestic violence reported abuse within their lifetime. The racial breakdown documented 24% in Caucasian women and 25.4% for African American women. Fetal Infant Mortality Review (FIMR) findings documented that 57% of African American women reported being victims of violence compared to 27% of Caucasian women. Substance abuse per electronic birth abstracts revealed that from 1996-1998 only 2.3% of pregnant women admitted to alcohol use and cocaine use was admitted by only 0.6% of pregnant women. These numbers are felt to be underreported. Finally, 21.6% of pregnant women in Saginaw County reported smoking, per electronic birth abstract data, for the period of 1996-1998.

Within the State of Michigan, Saginaw County has documented one of the lowest Caucasian infant mortality rates and one of the highest African American infant mortality rates. This has led to a significant racial disparity ratio in the Caucasian and African American infant mortality rates for the Saginaw community. The 1996-1998 African American infant mortality rate was 17.6 per 1,000 live births compared to the Caucasian rate of only 5.7 per 1,000 live births. This demonstrates a 3.1:1 African American to Caucasian ratio during this time period.

While much attention is given to the overall infant mortality rate, disparities also exist in the stillborn, neonatal, and post-neonatal mortality rates. From the African American stillbirth rate was 11.1 compared to a Caucasian rate of 5.0. This is a 2.2:1 disparity ratio. The African American neonatal mortality rate was 13.6 and the post-neonatal rate was 3.9 compared to the Caucasian neonatal rate of 3.9 and a post-neonatal rate of 1.5. These discrepancies demonstrate a 3.5:1 neonatal ratio and a 2.6:1 post-neonatal ratio. African American infant mortality in Saginaw County exceeds the Caucasian infant mortality rates in all categories: stillbirth rate, infant mortality rate, neonatal rate, and post-neonatal rate.

When examining the causes of infant deaths, racial disparities were shown. Over 64% of African American infant deaths were associated with prematurity/low birth weight compared to only 25% for Caucasian infant deaths. Another major factor in African American infant deaths was 17.4% of post-neonatal deaths were associated with positional asphyxia/bed-sharing.

Sexually transmitted infections were, and continue to be, a concern in Saginaw County. Saginaw County ranked 5th in Michigan for the number of gonorrhea and Chlamydia cases from 1997-1999 (MDCH Michigan Sexually Transmitted Diseases Databases). The distribution on cases was higher among women than men and the cases were more prevalent in African Americans than Caucasians. Gonorrhea was four times more prevalent in African Americans than Caucasians and Chlamydia was almost double. The cases of both gonorrhea and Chlamydia increased from 1996-1998 and are known contributors to preterm labor, infections, HIV/AIDS, and other perinatal complications.

Immunization rates in Saginaw County can be improved. For children between 19-35 months who received 4 DTP, 3 IPV, 3 HIB, 1 MMR, and 3 Hepatitis B, the Saginaw County Department of Public Health (SCDPH) had a 65% coverage rate on December 31, 1996, 88% on December 31, 1997 and 86% on December 31, 1998. For the years 1999 and 2000, immunization coverage levels for the same doses and antigens documented a 1999 SCDPH coverage rate of 86% and a community coverage rate of 28%. In 2000, the SCDPH immunization coverage rate was 86%, with a community coverage rate of 35% (SCDPH Quarterly Immunization Reports).

II. Project Implementation

- A. "Great Beginnings" developed and implemented many of the chosen strategies based on The National Standards for Cultural Competence Guidelines published by the Office of Minority Health in the December 22, 2000 issue of the Federal Register, Volume 65, Number 247, pages 80865-80879, and the 1996 New Jersey Blue Ribbon Panel's published report on findings and recommendations to improve pregnancy outcomes for black women and their families (<http://www.state.nj.us/health/fhs/bim.htm>). The outreach and client recruitment core service was developed through the hiring of staff members, considered peers, who lived in the target community and who had been on or who were on public assistance. Workers are racially representative of the target population to be served. This strategy was based on the National Standards for Cultural Competence Guidelines to implement strategies to recruit, retain, and promote, at all levels, a diverse staff and leadership representative of the demographic characteristics of the service area.

Outreach workers canvas neighborhoods to provide information on Healthy Start services. Information was disseminated through flyers, brochures, and one-on-one interaction. This strategy was chosen as it has been and continues to be an effective recruitment mechanism in the Saginaw Community. Outreach workers attend and participate in the monthly consortia meetings as a means of role modeling and networking. The use of outreach workers was a need in the Saginaw Community, as there were only two State of Michigan MIHAS outreach workers for the entire county.

Another outreach strategy developed and implemented was the use of a toll free number, promoted with brochures and on billboards throughout the community. The need for a place for women to call if they needed information and/or resources prompted development of this system. The need to get correct information with follow-up was crucial. The Community Resource nurse serves a large number of pregnant women annually, assisting with access to prenatal care and health insurance, as well as providing general health education. All of these outreach strategies have proven to be successful and offer one-stop shopping, which is a strategy recommended by the New Jersey Blue Ribbon Panel Report.

Saginaw Healthy Start initiated community outreach with the City Police Department and the Family Independence Agency. The City Police Department was to offer outreach to high-risk families living in Saginaw through the Parent and Police Partnering Program (PPP). This Program was developed based on an identified need by the City Police Department to establish a non-threatening presence within the community, as well as to promote safe sleep practices and other safety practices.

Another community outreach strategy was to be provided by the Saginaw Black Nurses Association (SBNA) through a subcontract with Healthy Start. The SBNA was to provide outreach to the faith-based community. This strategy was chosen as engagement with the faith-based community was felt to be important in promoting health education messages and prevention strategies. The SBNA was chosen because they were a known presence in the Saginaw African American community.

The Healthy Start consumer consortia provided outreach services through “word of mouth”. This strategy is effective in reaching the most hard-to-reach pregnant women. The use of the PPP, consortia and peer outreach workers met the Blue Ribbon Panel Report on Black Infant Mortality Reduction’s recommendation that outreach Programs notify the public of contacts for women wanting prenatal care, but who do not know or have barriers that can be reduced, allowing access to healthcare. The panel also recommends the creation of opportunities for input from a diverse population from the black community (<http://www.state.nj.us/health/fhs/bim.htm>).

Healthcare providers and community agencies would also provide outreach through written referrals on high-risk pregnant women and infants/children under two years of age. Information packets and education were provided to the agencies, along with a copy of the referral form. The Project Coordinator was responsible for implementing this outreach strategy, which was chosen because it was a known effective strategy set-up through established linkages between the Saginaw County Department of Public Health and the provider community.

Case management services were established based on a tiered system of multi-disciplinary staff members consisting of a Registered Dietitian (RD), Registered Nurse (RN), Registered Social Worker (RSW), Outreach/Health Advocates, Peer Mentors, and a Maternal Matriarchal Mentor (MMM). This approach utilized existing Programs like the State-funded Maternal and Infant Support Service (MSS/ISS) professional and Maternal and Infant Health Advocate Service

(MIHAS) Program and incorporated them with new Programs like the Peer Mentor and Maternal Matriarchal Mentors.

The new Programs were chosen based on a lack of culturally appropriate childbirth and parenting education as well as peer mentors in the Saginaw Community. The Peer Mentor Program was developed based on the “Sisterly Support, Healthy Babies” Program used by the Birthing Project in Sacramento, California who had demonstrated effective outcomes of reducing African American infant mortality by 30%. The MMM Program was developed using the Parenting Empowerment Project (PEP) curriculum offered by the National Black Child Development Institute for parenting health education. This curriculum was designed by and for lower income African Americans and had demonstrated effectiveness. Childbirth health education was offered through Doula Certification provided by the International Childbirth Education Association (ICEA).

The final component of case management services was development of a community action team called the Embracing Families Group (EFG). This group was designed for very high-risk families. Multiple community agencies meet to discuss and develop an action plan that assists the families in meeting set goals and objectives. Direct involvement of the family was important, as one of the EFG’s goals was to empower the family to take responsibility and ownership of the plan.

Many of the components of case management services meet the Blue Ribbon Panel Report on Black Infant Mortality Reduction. The report recommended the fostering of a healthcare environment sensitive to the specific emotional and physical needs of black women. Specifically to address this, the report recommended the recruitment of healthcare professionals who reflect the diversity within the community. The report also recommended the establishment of mentoring Programs to foster leadership in an effort to encourage members of the black community to participate in policy-making boards, councils, and governing bodies. Finally, the panels report recommended promoting behaviors and lifestyle choices that facilitate improved pregnancy outcomes despite psycho-social stressors. Healthy Start case management services encompass all of these elements (<http://www.state.nj.us/healthy/fhs/bim.htm>).

In addition to meeting the Blue Ribbon Panel Report’s recommendations, case management services met the National Cultural Competence guidelines for recruiting, retaining, and promoting, at all levels, a diverse staff characteristic of the service area. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and consumer involvement in designing and implementing strategies.

Health education was offered through many venues, such as health fairs, media campaigns, one-on-one interaction, formal training and group education. The venue chosen was dependent on the target population and the message to be delivered. All health educational messages are delivered in respect of the target populations educational background and primary language.

Health education and training will be provided to staff, consortia members, community members, participants, and healthcare providers. The offering of health education and training met the National Standards for Cultural Competence guidelines that healthcare organizations ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery (<http://www.omhrc.gov/CLAS/finalculturalia.htm>).

Health education services were offered at two prenatal care clinics in Saginaw. Health Delivery, Inc (HDI) and Synergy Medical Educational Alliance (formerly Saginaw Cooperative Hospital Inc) provided risk behavioral counseling and health education on the topics of smoking, sexually transmitted diseases, HIV/AIDS, alcohol use/abuse, illicit substance abuse/use, domestic violence, weight gain, and male involvement. The topics were changed over the grant cycle, which will be discussed in Section B. This strategy was chosen as it met the Blue Ribbon Panel Report's recommendation to ensure that obstetrical providers conduct comprehensive health need assessments, including psycho-social factors (<http://www.state.nj.us/healthy/fhs/bim.htm>).

Consortia members received formal training on topics related to infant mortality prevention at their monthly meetings. Annually, information on Saginaw's infant mortality rate was to be presented by the FIMR Nurse. Information included FIMR findings and recommendations as a means of increasing knowledge and awareness. This strategy was chosen as it met the Blue Ribbon Panel Report's recommendation to develop a public awareness campaign that highlights black infant mortality (<http://www.state.nj.us/healthy/fhs/bim.htm>).

The Saginaw Healthy Start project offered health education, annually, related to racial disparity in perinatal health, targeting community healthcare providers. Health education to healthcare providers and to community members would be provided through the FIMR Nurse. Provider and community education met the Blue Ribbon Panel Report's recommendation to educate providers about health problems more frequently associated with African Americans, including black infant mortality and to sensitize health care centers and private practitioners on the need to provide patient educational services to at-risk families (<http://www.state.nj.us/healthy/fhs/bim.htm>).

Another strategy developed and implemented by the Saginaw Healthy Start project was the development and distribution of prenatal and infant health screening and educational manuals. The goal was for universal usage within our community. Again this strategy was chosen as it met the Blue Ribbon Panel Report recommendations to promote the use of comprehensive guidelines among all providers and to work with medical societies, and managed care organizations, to encourage providers of women's healthcare to incorporate discussions regarding preconceptual family planning into all health supervisory visits, and to ensure that obstetrical providers conduct comprehensive health needs assessments, which include psycho-social factors (<http://www.state.nj.us/healthy/fhs/bim.htm>).

Cultural competence training was offered annually. The workshops focused on racism, culture, and the history of networking and accountability to the community that is value-based and action-oriented.

In addition to the cultural competence workshop, a community cultural awareness two-day session was provided to medical residents, nursing students, and local providers. This workshop included spending one day at SCDPH observing in a clinic; Family Planning, Sexually Transmitted Disease, or Early-On. The second day was spent at a community agency such as; Underground Railroad, the Rescue Mission, Head Start, or a substance abuse treatment facility. This strategy was eventually incorporated into the Synergy residency training program and Healthy Start discontinued this strategy as a part of our project's work plan. Both the cultural competence training and the workshop met the Blue Ribbon Panel Report's recommendation to provide cultural awareness and competency training seminars, as part of orientation Programs for all healthcare providers, and to sensitize health centers and private practitioners to the need to provide patient educational services for at-risk families (<http://www.state.nj.us/healthy/fhs/bim.htm>). It also met the National Standards for Cultural Competency Guideline that health care organizations use to ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery (<http://www.omhrc.gov/CLAS/finalcultural.htm>).

A final health education strategy was to develop and implement an annual media campaign. This campaign was based on FIMR findings and recommendations specific to African American infant mortality in Saginaw. Again, this strategy was chosen as it met the Blue Ribbon Panel Report's recommendation to develop a public awareness campaign that highlights black infant mortality.

Interconceptual care and postpartum depression screening and referral services were begun in 2002. Interconceptual care and depression screening and referral were developed to be part of Healthy Start case management services. Integration of these services into case management services was a logical linkage. Training, monitoring, and program development is more effectively monitored when initiated internally.

Interconceptual care services consist of health education related to the importance of 24 month spacing of pregnancies, family planning options and referral, follow-up on the chosen method of birth control, and behavioral risk reduction strategies related to positive screening areas. In addition, Healthy Start monitored the number of repeat pregnancies for Healthy Start case management participants within a 24 month span.

Depression screening was developed and implement through the use of the Edinburgh Postnatal Depression Scale (EPDS). The EPDS is known to be effective in depression screening and initially was used for all participants who delivered and were between 6-8 weeks postpartum. The screening was conducted by any case management staff member. Positive screens were referred to the Saginaw County Community Mental Health Authority (SCCMHA) for re-screening and diagnosis/treatment, as appropriate. Implementing community-wide depression screening was anticipated to encounter resistance

from the provider community, thus this would be a long-term goal and implementing depression screening, education, and referral services through case management services was a more realistic and achievable goal.

The “Great Beginnings” project developed the local health system action plan based on local FIMR findings that were specific to the prevention of African American infant mortality. The two goals of our local health system action plan was to ensure that all pregnant women in Saginaw, who are seeking prenatal care, are assessed, examined, and provided with education and appropriate referrals, in a standard manner, regardless of income, race, ethnicity, or the location where the service is provided. The second goal was for all women in Saginaw County to have information about proper sleep surfaces and education about the number of preventable deaths occurring to infants in Saginaw County, due to improper sleep surfaces. Lack of early and regular prenatal care and infant deaths due to positional asphyxia are issues identified as preventable causes of African American infant deaths in Saginaw County.

A consortium was previously formed through the Healthy Start project offered at Synergy. This consortium was embraced by the SCDPH “Great Beginnings” Project. The consortia continued with its original by-laws, met monthly, and had elected positions of Chair, Vice-Chair, Sergeant at-Arms, and Secretary. There was a new Consortia Coordinator for the group. Outreach included representation from the rural and suburban areas, as the previous project focused specifically on the City of Saginaw.

The SCDPH Healthy Start Project used many of its already established and strong linkages between internal SCDPH programs and community human service and perinatal provider in Saginaw County. The SCDPH coordinated service delivery with its Family Planning, Early-On, Child Well-Being, FIMR, Child Death Review (CDR), MSS/ISS, MIHAS, Mich-Care, the SIDS grief counseling nurse, immunizations, sexually transmitted disease clinic, and the Women, Infant, Children (WIC) Nutrition Program.

Collaboration with the State of Michigan occurs through a contract between the State and the SCDPH for a variety of Maternal Title V Programs. In addition, the SCDPH plans programs in conjunction with the National Healthy People 2010 goals and the State of Michigan Maternal V Block Grant objectives. The SCDPH also participates in monthly meetings with the State of Michigan through the various Executive Staff members who serve on a variety of committees and forums offered through the State. Communication lines with the State of Michigan are established through the use of State Program consultants and liaisons. There were also quarterly Healthy Start network meetings organized by the State liaison and hosted on a rotating basis by each Healthy Start project.

The “Great Beginnings” sustainability plan included planning and training for Healthy Start staff members, including attendance at a Regional meeting that was provided as technical support through Grants Management. Funding efforts were pursued through our local Qualified Health Plans and at the State and Local level. Sustainability is considered to be an important part of our program, however, there is a lack of adequate funding sources within our community and now at the State level, making sustainability efforts more difficult to achieve.

- B. Healthy Start outreach services consist of outreach workers canvassing the neighborhoods, the use of a toll free number, attendance at community health fairs and events, provider referrals, Consortia referrals, the Police and Parent Partnering Program (PPP), and outreach to the faith-based community. All of these outreach services remain, with the exception of the PPP Program, which was eliminated due to budget cuts and staff reductions experienced by the Saginaw City Police Department. An additional outreach strategy has been internal coordination with SCDPH Community Resource Nurse and referrals by the Saginaw City Police Department.

Outreach services were initially conducted through the hiring of 3 F.T.E. Healthy Start Outreach/Advocate workers. Two F.T.E. additional State of Michigan Maternal and Infant Health Advocate Service (MIHAS) workers complemented the Healthy Start outreach workers. MIHAS workers were familiar with the community, and peers, who live in the target community and were on public assistance programs at one time. Integration of the Healthy Start and MIHAS Advocates was effective in providing role models for the new Healthy Start Advocates with MIHAS program's proven effectiveness in outreaching pregnant women within the community.

Changes that occurred in staffing of the outreach workers consisted of adding an additional outreach worker to the Healthy Start Project with the elimination of the State funded MIHAS Program and the need for additional Outreach/Advocates. One of the original Healthy Start Outreach/Advocate workers left the program and thus the two MIHAS advocates became Healthy Start staff for a total of 4 F. T. E. Outreach/Advocate workers. This change occurred during the 2003 program year.

The outreach workers were supervised by the Co-Project Director, which remained consistent. A Healthy Start Coordinator was also added in the 2003 program year to assist the Co-Directors in monitoring, providing support, education and outreach. This has been an asset to the program as the Coordinator can be a liaison between the supervisor, staff and within the community.

A toll-free number was established by the Healthy Start "Great Beginnings" Project and remains as a useful outreach mechanism. The number is promoted on brochures and in the annual media campaign. The toll free callers are connected to the Saginaw County Department of Public Health's (SCDPH) Community Resource Nurse, who provides education, screening and referral, as appropriate. The Community Resource Nurse links pregnant women with a prenatal care provider, initiating phone follow-up to assess for successful access to prenatal care. The outreach workers receive a referral on pregnant women without a phone to provide a home visit contact to follow-up on prenatal care access. Access to health insurance and WIC is also available through SCDPH, promoting a "one-stop" shopping atmosphere. Finally, the Community Resource Nurse links women with Family Planning services as appropriate.

The Police and Parent Partnering program was a subcontract with Healthy Start and targeted high risk families living in the City of Saginaw. High-risk is noted as

families experiencing domestic violence, substance abuse, history of or current child abuse and/or neglect and any crime related history. A trained Saginaw City Police Officer would visit the family within one month after delivery and provide support, resources, and education on safety issues such as car seats, cribs, safe sleep environment, gun security, and smoke detectors. The Family Independence Agency would assist in identifying families in need of these services. This program has changed and Healthy Start funding ended. Currently, City Police officers make direct referrals on families seen who need additional community resources. This change was made in June of 2002.

Healthcare providers and community agencies provide outreach through written referrals on high-risk pregnant women and infants/children under two years of age. Informational packets and education were provided to the agencies, along with a copy of the referral form. The Healthy Start Project Coordinator was responsible for implementing this successful outreach strategy, which promoted awareness of Healthy Start services within the Saginaw Community.

Health fair and community event requests are screened for the anticipated presence of either pregnant women, women of childbearing age, and/or families with children under the age of two years, specially targeting the attendance of residents from the African American community. This effort has been successful in increasing education and awareness of the disparity in infant mortality and perinatal health issues.

Outreach/Advocates canvass neighborhoods to dispense information on Healthy Start and look for potential participants. Originally all Outreach/Advocate workers conducted this outreach whenever possible. There was duplication and sporadic use of this strategy. In an effort to correct this, the Outreach/Advocate workers are assigned specific months in which they are responsible for canvassing neighborhoods and communities to dispense Healthy Start information. This has been successful in promoting accountability and in decreasing duplication.

Outreach/Advocate workers provided two valuable services that are lacking in Saginaw County, transportation and translation services. Two of the Healthy Start Outreach/Advocates are bilingual, speaking both Spanish and English. This is an important asset for our project and there continues to be a lack of translators for perinatal providers in the community. In addition to the Outreach/Advocates, translation services are available, without cost to the participant, through Corporate Language Services. Voice is used for deaf participants and visually impaired clients have verbal instructions with confirmation of understanding.

All Outreach/ Advocates possess a chauffeur's license and provide direct transportation when needed. Bus tokens and taxi vouchers are available for participants who need transportation to prenatal care visits, WIC, childbirth or parenting education, etc.

A subcontract with the Saginaw Black Nurse's Association for outreach to the faith-based community was implemented through the 2003 program year. Since 2003, outreach with the faith-based community has occurred through our provider consortium. This outreach strategy has experienced barriers in a lack of

consistent commitment from members of the faith-based community, as well as a lack of participation. However, engaging members of the faith-based community continues to be important and different outreach approaches are currently being used by the provider consortium, the Saginaw County Infant Mortality Coalition (SCIMC).

Case management services were collaboration between SCDPH MSS/ISS and Healthy Start Programs. Participants who meet the eligibility for MSS/ISS are enrolled in the MSS/ISS Program and assigned a Healthy Start Advocate for support services. Participants who do not qualify for MSS/ISS, or are over one year of age, are assigned to the Healthy Start nurse case manager and an Advocate. Participants on Healthy Start-only who need the services of a Registered Dietitian or Registered Social Worker are provided these services through SCDPH MSS/ISS staff, despite the inability to bill for services.

Case management services consist of home visits, case conference, care plan development, a comprehensive assessment, intensive health education, referrals with documented follow-up, transportation assistance, healthcare monitoring, counseling, support, and translation services. Intensive one-on-one health education related to parenting and childbirth education was provided by the Maternal Matriarchal Mentors. Frequent contact for support and encouragement was provided by volunteer Peer Mentors.

Case management services offered through SCDPH are provided by a multi-disciplinary team. The team consists of health professionals, paraprofessionals, and volunteers. The health professionals, staffed by Healthy Start, consist of 1 F.T.E. RN Case Manager. Additional health professionals consist of the State funded Maternal/Infant Support Service Program staff, which is a RN, RD, and a RSW. All of these staffing patterns remain consistent, with some staff turn-over in the nurse case manager position. Direct supervision of the health professional staff was provided by a Healthy Start Co-Director, which remained consistent throughout the grant cycle.

Paraprofessionals consisted of 3 F.T.E., Healthy Start funded, Outreach/Advocates and 2 F.T. E. state-funded MIHAS workers. All Outreach/Advocate workers were trained by staff from Wayne State University using the Strengthening Family Connections Curriculum. Modules accompanied the training and were purchased for use during home visits. The modules are colorful and provide information on topics of nutrition, family planning, sexually transmitted disease prevention, substance abuse risk, smoking, importance of regular prenatal care, and parenting education.

Changes that occurred in staffing of the paraprofessionals consisted of adding an additional Advocate worker to the Healthy Start Project with the elimination of the State funded MIHAS program and the need for additional Advocates. One of the original Healthy Start Advocate workers left the program and thus the two MIHAS became Healthy Start staff for a total of 4 F. T. E. Outreach/Advocate workers. This change occurred during the 2003 program year.

The Outreach/Advocate workers were supervised by the project Co-Director, which remained consistent. A Healthy Start Coordinator was also added in the

2003 program year to assist the Co-Directors in monitoring, providing support, education and outreach. This has been an asset to the program as the Coordinator can be a liaison between the supervisor, staff and the community.

Outreach/Advocate workers provided two valuable services that are lacking in Saginaw County, transportation and translation services. Two of the Healthy Start Outreach/Health Advocates are bilingual, speaking both Spanish and English. This is an important asset for our project and there continues to be a lack of translators for perinatal providers in the community. All Outreach/Advocates possess a chauffeur's license and thus are able to provide direct participate transportation.

Case management services are primarily offered in the home setting. Professionals complete an assessment of needs. Within one week of a completed assessment, case conference is held with all Healthy Start and MSS/ISS staff members to develop a plan of care, based on the assessment findings. A case manager and Advocate are assigned to all cases unless there is a refusal of a specific discipline, made by the participant. The case manager is responsible for communicating with the participant's primary healthcare provider and managing the case.

The Healthy Start Advocates visit participants every 4-6 weeks, unless the participant is in a crisis situation and when frequent visits are necessary. Professional staff visit on a quarterly basis, unless the participant is in a crisis situation, where more frequent visits are needed.

Case management participants receive screening, health education, risk reduction counseling, referrals and follow-up related to the priority topic areas discussed under the health education section. Paraprofessionals provide support, direct transportation assistance, general health information, community resource referrals, translation services, and tracking of referrals. The specific health education offered is discussed, in this section, under health education.

"Great Beginnings" offered intensive one-on-one health education services, in the home setting, through case management services. Maternal Matriarchal Mentors were to offer intensive education on childbirth based on the ICEA Doula Curriculum and parenting education based on the PEP Curriculum offered by the National Black Child Development Institute (NBCDI). Health education was also offered by the case management professional and paraprofessional staff on the topics of family planning, immunizations, nutrition, sexually transmitted diseases, HIV/AIDS prevention, smoking, substance abuse, and other risk factors added over the grant cycle, are discussed in Section B.

Additional paraprofessional staff consisted of six F.T. E. Maternal Matriarchal Mentors provided by a subcontract with the Saginaw Black Nurses Association. The MMM's were to provide culturally appropriate childbirth and parenting education in the home setting. The mentors were trained using the PEP Curriculum and Doula Certification Program, as discussed above. Both parenting and childbirth education was to be provided one-on-one in the home setting. The subcontract with the SBNA was discontinued due to performance issues and this staffing discontinued due to the inability to find another provider.

Peer mentors were Consortia volunteers who would be trained by the Healthy Start Coordinator using the “Sisterly Support, Healthy Babies” Program by the Birthing Project out of Sacramento California. Members from the Birthing Project provided one-on-one direct training to the Healthy Start Coordinator and a group of volunteer Consortia members. Consortia volunteers proved to be difficult to maintain due to a lack of commitment and a lack of interest by the membership. To continue this program, community volunteer outreach was pursued through radio, word-of-mouth, and presentations at churches and local agencies. Unfortunately there was an ongoing lack of interest in recruiting volunteers to train to be peer mentors. This program required much time for outreach, recruitment, and follow-up with volunteers.

Health education for Healthy Start staff was not an issue during the project period. SCDPH offered monthly inservices, which were attended by Healthy Start staff members. Healthy Start supports and encourages attendance at perinatal trainings by Healthy Start staff, including the annual Healthy Start meeting. SCDPH also has a functioning cultural diversity committee, which sponsors inservices and events related to different cultures. These events are attended by Healthy Start staff members. Healthy Start staff members receive information on Saginaw’s infant mortality rates and FIMR findings, as well as Healthy Start data results at staff meetings. Additional community inservice opportunities for the Healthy Start staff were the monthly Birth-through-Five trainings. These opportunities not only provided staff with health education, but allowed networking with other home visiting staff within our community.

Two major prenatal care clinics provide comprehensive screening, health education, referral and follow-up services, as a sub-contractor for the “Great Beginnings” Healthy Start Program. This service utilized two F.T.E. health educators, one at each site. Topics discussed included smoking, sexually transmitted disease, HIV/AIDS, substance abuse, domestic violence, weight gain and male involvement was provided. Services were expanded to include alcohol, depression, weight (under/overweight), dental infections, asthma, diabetes, history of low birth weight infant or perinatal loss, and repeat pregnancy within two years of the last pregnancy. Male involvement screening was discontinued due to the complexity of the issue.

In addition to expanding screening areas of focus, expansion with the tracking of health education, referrals and follow-up with referrals was begun at the two clinical sites. This expansion was needed in order to improve tracking of the comprehensive services provided through Healthy Start and improvement of our evaluation and reporting. The expansion was met with some resistance related to the extra time needed to offer these services, as well as documentation for evaluation purposes. However, over the last year, both clinical sites provided complete summary information. Quarterly audits were conducted at each clinical site to confirm that the information submitted was consistent with the clinical documentation. These audits were conducted on a regular basis, however, reviewing the record for health education, referrals and referral outcomes proved to be time-consuming and information submitted documented little inconsistencies, thus, audits focused on demographic and screening information.

Provider health education was to be subcontracted with the Saginaw County Infant Mortality Coalition; however, this did not occur as accessing the community providers proved to be difficult and time intensive. Healthy Start resumed this activity and provided health education through many different venues; however, some provider health education events targeted a broader audience like Department of Human Services (formerly Family Independence Agency) workers, Teen Parent Support and Community Mental Health workers.

Provider health education events included annual cultural sensitivity/competency training. A two-day cultural competence training titled "Undoing Racism" by the Peoples Institute for Survival and Beyond was held. Participants were not receptive to the messages being delivered and thus this program was not effective. Healthy Start changed the provider and reduced the time involved to one day. The second conference was held with a sub-contractor of COR Communications, L.L.C. This one day conference was better received, however, a lack of participants committing to a day was still an issue in our community. Another session with the same provider was held over four half day sessions. This produced a marked increase in attendance. The final cultural competence workshop was provided by an African American speaker, Dr. Renee Canady, Ph.D. from Michigan State University. It was offered over two, four half day sessions. Participants in attendance provided excellent feedback and have requested a part two.

Physician health education events included evening programs and offerings through the monthly physician grand rounds by Synergy Medical Educational Alliance at Covenant HealthCare. Evening events offered minimal attendance, even with Healthy Start reminders and direct individual contact to provider offices encouraging attendance. Physician Grand Rounds has been the most productive mechanism for engaging the community providers and was a collaboration between Synergy and Healthy Start.

Provider cultural competence training was also provided, through mid grant cycle, by coordinating two days of observance at community agencies and the SCDPH for residents, physicians, and nursing students. This activity was discontinued by Healthy Start as Synergy Medical Education Alliance offered this service as part of their residency training and became a duplication of services.

A provider screening, education, and referral manual was developed by Healthy Start. A manual was developed specific to Ob, Family Practice/Pediatric and community providers. The manuals were distributed to every provider office in Saginaw County, along with individual instructions on their intention and use. Healthy Start quickly received many requests for more manuals, which became larger than the expected number of copies needed. Attempts were made by Healthy Start to obtain formal feedback through written surveys on the manuals usefulness, use in the practice setting, and problems/strengths. Only six responses were returned and thus formal feedback was difficult to obtain. A copy of the provider manuals have been included.

Healthy Start staff training was provided through monthly in-services offered at the SCDPH. Staff training was also provided through various community and

state trainings offered on topics related to perinatal health. Most community and state trainings are offered at low to no cost, thus cost has not been an issue.

Community health education activities included a community-wide infant mortality summit, a Town Hall Meeting on substance abuse, several articles in the Saginaw News and Saginaw Voice, television and radio interviews. In addition, community sessions offered by speakers through technical assistance from the HRSA, MCHB was provided. The two speakers were Dr. Ira Chasnoff from the Childrens Research Triangle in Chicago who spoke on perinatal substance abuse and Dr. Michael O'Hara from the University of Iowa who spoke on perinatal Depression. Brochures used for these programs have been provided.

Another community health education venue was an annual media campaign using all forms of media; cable television, billboards, radio and the newspaper. The form chosen was based on the message(s) to be delivered and advice of our consortiums. The most successful venture related to our media campaign was our cable television messages. Consumer Consortia members had direct, active participation in the creation of the "spots", which not only empowered them, but was a useful tool in outreach. In addition, consumers were active in selecting on which stations to "air" the messages, in order to reach our target population. Examples of media campaigns used by Healthy Start and articles have been included.

In November of 2003, community substance abuse "baby showers" were developed in response to an identified gap in preventive health education for pregnant women on the effectiveness of substance abuse and how to access treatment. The showers are held monthly, transportation is provided, and are open to any pregnant woman living in Saginaw County who registers. Attendance has been near the maximum of fifteen each session. Presenters include substance abuse health education from a treatment facility and breastfeeding health education through Michigan State Cooperative Extension.

Health education specific to male involvement was provided through a subcontract with First Ward Community Center. The intention was to target Healthy Start male partners. This was met with problems of lack of male involvement in the pregnancy/family unit and a lack of male interest in attending. Changes to the program were made to incorporate males with children and males of reproductive age as our target population. Also, health education was incorporated into activities that were appealing to men, i.e. basketball, gym time, etc. This assisted the program, however, attendance was lower than expected throughout the grant cycle despite several outreach efforts.

Individual health education to participants was offered by SCDPH case management staff, who were trained as discussed below. All Healthy Start Advocates participated in training on the Strengthening Families Curriculum and module offered by Wayne State University's Community Health Worker Training Program, Institute of Maternal and Child Health, 2001. Training was provided by staff from the university.

Areas of focus for the pregnancy included pregnancy do's and don'ts, nutrition, getting ready for your baby's birth, and care for yourself after the baby is born.

Each area has sub-categories, for pregnancy do's and don'ts the topics are getting prenatal care, eating a well-balanced diet, getting rest and exercise, don't smoke, drink alcohol, or use medications or drugs. Information under nutrition included weight gain, nutritional needs, ways to improve your diet, and myths about food and pregnancy. The section on getting ready for baby included information on basic things needed, packing a bag for the hospital, making arrangements for your hospital stay and knowing when to go to the hospital. Finally, under care for yourself after the baby is born, information is given on bodily changes, mood swings, sexual activity, and postpartum check-up.

For interconceptual care, the curriculum covered the topics of reproductive health, which covered family planning, birth control methods, and sexually transmitted diseases. The area of family planning included planning your family, benefits to family planning, things to consider when choosing a birth control method, how pregnancy occurs, and types of birth control available. The section on birth control methods discusses things to know about birth control methods, birth control pills, birth control shots, condoms, diaphragms, hormonal implants, IUD, and rhythm method. The final section on sexually transmitted diseases discusses what are STD's, how do you get them, how do they affect you, what to do if you think you have an STD, how to protect yourself, and HIV/AIDS.

Infant health education from this curriculum and modules covers birth through one year of age. The main topic areas include infant care and feeding, infant growth and development, and parenting.

Infant growth and development is age-specific for the months of one, two, and three and includes tips. From 4-6 months of age, motor skills, sensory development, and helping your baby learn. Finally, the sections from 7-9 and 10-12 months cover information on how your baby grows, motor skills, sensory development, and tips. The section on parenting includes "being a parent is a full-time job", challenging and demanding, rewarding, and an opportunity.

The section on infant care and feeding focus on the areas of bathing your baby and special care tips for your newborn, keeping your baby healthy, keeping your baby safe: accident prevention, and feeding your baby the first months, 4-6 months and 7-12 months. Bathing your baby and special care tips for your newborn covers what you need to bathe your baby, sponge bath, tub bath, care of the umbilical cord and care of genitals. Keeping your baby healthy covers need for regular check-ups, immunizations, and when to call the doctor if the baby is sick. Keeping your baby safe provides education on bathing, care and house safety. For feeding your baby the first months, information covers what your baby needs, breast-feeding, bottle-feeding, and the importance of nutrition. Nutrition information for 4-6 months covers information on the signs for solid food introduction, first foods, feeding from a spoon, and first feedings. Finally, 7-12 month nutrition covers breast and/or bottle feeding, solid foods, drinking from a cup, and independence.

A gap from 1-2 years of age was identified and thus teaching standards were developed to cover this timeframe. Teaching standards were also developed for the professional staff in order to promote consistency in the minimum amount of health education information offered to participants on the priority topic areas.

The priority topic areas for children between the ages of one and two years of age are asthma, development/developmental delays, disability/chronic illness/other special needs, family violence, growth and development, not attaining appropriate growth, HIV/AIDS, homelessness, immunizations, mental health, prenatal alcohol exposure (Fetal Alcohol Syndrome, FAS), safety/unintended injury, second-hand smoke, and substance abusing parent. The priority topic areas for a pregnant/interconceptual woman include asthma, alcohol/substance abuse, birth control, cholesterol, dental hygiene/periodontal infections, diabetes, domestic violence, family history of breast cancer, fecal occult blood testing, group b streptococci, high risk sexual behaviors, HIV/AIDS, homelessness/housing, hypertension, depression, sexually transmitted diseases, smoking/environmental smoke, lack of physical activity, and over/under weight. The priority areas for infants through one year of age include asthma, breastfeeding, development/developmental delays, family violence/unintentional injury, growth/not attaining appropriate growth, HIV/AIDS, homelessness, immunizations, lead poisoning, mental health, prenatal alcohol exposure (FAS), prenatal drug exposure, safe sleep environment, second hand smoke, unintentional injury/safety, and other special healthcare needs.

All Healthy Start staff have been trained in the “Smoke Free for Baby and Me” smoking cessation program offered by the Michigan Department of Community Health (MDCH). Substance abuse training was provided by Dr. Ira Chasnoff from the Children’s Research Triangle, in Chicago, through a HRSA technical assistance grant. Training on perinatal depression was also provided through a HRSA technical assistance grant by Dr. Michael O’Hara from the University of Iowa. The Saginaw Underground Railroad provided training on domestic violence and the MDCH offered training on blood lead poisoning. Healthy Start staff also participates in annual cultural competency training, as well as other state and local trainings related to perinatal health issues.

Interconceptual care services began in 2002. The services were offered through four F.T. E. Healthy Start funded Advocates and a one F.T.E. Healthy Start funded Nurse in collaboration with SCDPH ISS professional staff consisting of a RN, RD, and RSW. Services were offered primarily in the home setting and include screening, health education, transportation, translation, support, referrals, and tracking of referrals.

“Great Beginnings” offered interconceptual care services from delivery through two years of age. An assessment of need for the mother and infant was conducted, after delivery, by a health professional. Within one week of completing the assessment, case conference was held with all Healthy Start and ISS staff members to develop a plan of care. An Advocate and case manager are assigned to the case at case conference. Follow-up visits are made every 4-6 weeks by an Advocate and quarterly by a health professional unless the participant is in need of more frequent visits.

Two year spacing between pregnancies, in interconceptual care, was a major focus in our program. Health education, on the importance of planning and spacing pregnancies was discussed, along with family planning options, referrals, and follow-up for compliance with method of choice, as appropriate. Healthy

Start staff attempt to incorporate participation by the woman's partner, in order to improve compliance.

Compliance with postpartum, well-child, and other provider appointments is tracked and documented. Insurance status for participants is assessed and referrals to the Saginaw County Health Plan or to the Department of Health and Human Services are made, based on eligibility. Immunization status is assessed and documented. Referrals are made to SCDPH Immunization program or the participant's healthcare provider, as appropriate. Specific health education related to interconceptual care has been discussed in this section under health education.

Depression screening, education, referral and follow-up services have been offered through the "Great Beginnings" Program. Pregnant women are assessed, through direct one-on-one questioning; using the ACOG questions at the two clinical sites and through the MSS assessment depression screening questions at SCDPH. Interconceptual women are screened using the Edinburgh Postnatal Depression Scale (EPDS). Any staff member can screen for depression, however, health professionals are the primary screeners.

Women with a history of depression are closely monitored for signs of current depression, and screened as appropriate. Women with a positive depression screen are referred to either their primary healthcare provider or to the Saginaw County Community Mental Health Authority (SCCMHA). Positive screens are scores of 12 or more on the EPDS or verbal admission by the woman. All women with signs of severe depression or psychosis are immediately referred to the SCCMHA's Crisis Hot-Line, which is open 24 hours a day, seven days a week.

Saginaw's Healthy Start Local Health System Action Plan (LHSAP) was developed based on the community assessment and local FIMR findings, along with input from both the consumer and provider consortiums. Updating and prioritization occurred through discussions with Consortium members, FIMR team, Saginaw Leadership Team, Healthy Start staff members, and our State of Michigan Title V Consultant. The two Co-Directors, and Healthy Start staff members, were responsible for implementing and updating the LHSAP.

The original LHSAP has two major objectives. The first objective was to ensure that each woman seeking prenatal care in Saginaw is assessed, examined, and provided with education and appropriate referrals in a standard manner regardless of income, race, ethnicity, or the location where the service is provided. Strategies to accomplish this objective included using the consumer Consortia to evaluate services related to cultural competence, developing and implementing a standardized, comprehensive assessment tool for use at two major Ob providers, within the community, and to provide cultural competence awareness for providers in Saginaw County.

To accomplish our first objective the following activities were initiated through the Healthy Start Program. Cultural competence training was provided annually for providers through workshops, for the life of the grant. Cultural competence training was also initiated through community observations by medical residents,

nurses, and physicians. This activity is being continued through the Synergy Medical Education Alliance residency program. Another cultural sensitivity activity accomplished by Healthy Start was consumer Consortia selected culturally appropriate art for four major provider waiting rooms, which was presented to the offices by the Consortia members.

Healthy Start and many community members and providers participated in an Infant Mortality Summit sponsored by the State of Michigan in 2002. A result of the summit was an identified need for more effective communication between providers of services to families in Saginaw County and a need for community resource information. Healthy Start worked to fill these needs through the development of a calendar that is used by families depicting which agencies are involved with the family and when they have a scheduled appointment. The calendars were developed through a collaboration between Healthy Start, the Child Abuse and Neglect Council, Saginaw City Police, and the Saginaw Public Libraries. The calendars have been successful in not only increasing communication between providers, but in assisting families to keep scheduled appointments. The calendars are made to go inside a WIC coupon booklet.

To fill the need for a community resource guide for providers, Healthy Start incorporated information on community resources into the provider screening and health education guide. The provider guides were separated into Ob-Gyn, Pediatric/Family Practice, and Community. All provider offices were provided with a copy of the guide with individual one-on-one instructions given by the Healthy Start Coordinator. Community agencies were also provided a copy of the guide with instructions. Despite a lack of formal feedback, there were numerous inquiries by providers and agencies to receive additional copies of the guide. Thus, this was felt to be useful and valued within the community.

To improve universal screening for all pregnant women in Saginaw County, Healthy Start formed the Leadership Team. The Saginaw County Leadership Team consisted of 16 community leaders, including representatives from Michigan State University (MSU); Saginaw Intermediate School District; Representative Carl Williams, Michigan House of Representatives; Covenant HealthCare Neonatologist; Director of Women and Child Health, Covenant HealthCare; Child Protective Services, Department Human Services; Saginaw Bay Area Substance Abuse Coordinating Agency, Women's Intake; Saginaw City Police Department; Ob-Gyn provider; Michigan State FIMR Consultant, Healthy Start Co-Directors, SCDPH FIMR Supervisor, Healthy Start Coordinator, Health Delivery, Inc, and a local Pediatrician. All members, except for two members, attended the Leadership Institute in Chicago, Illinois, from September 19-22, 2002 for training. A plan for implementing universal substance abuse screening was developed at this training. This plan has been implemented and continues to be monitored and updated, as needed. In early 2005, all major Ob providers in Saginaw County had received training and were using the 4 P's Plus Substance Abuse screening tool.

A final activity, implemented through Healthy Start was to promote early and consistent prenatal care, and access to health insurance and a provider, through pregnancy testing, counseling, referral and tracking services by a Public Health Nurse at SCDPH. The nurse sees women requesting a pregnancy test and

provides counseling, specific to the test results. Women with a negative test result are offered a referral to either Family Planning or an Ob provider, if wanting to get pregnant. Women who have a positive test result are screened for health insurance, a healthcare provider, and given prenatal education. Direct assistance with health insurance eligibility is made at SCDPH and a list of providers offered. The nurse also provides follow-up contact on whether the first prenatal care appointment has been kept. If the nurse cannot make phone contact, a Healthy Start Outreach/Advocate is given a referral to make a home visit attempt.

The second objective in the LHSAP was for all women in Saginaw County to have information about proper sleep surfaces for infants and education about the number of preventable infant deaths occurring in Saginaw County due to improper surfaces. Each woman would be asked to share the information with other women she knows. In 2004, the objective was revised to specifically add no co-sleeping education, due to the high percentage of African American infant deaths directly attributed to co-sleeping situations, documented through FIMR, in Saginaw County.

The specific activities to achieve this goal included a media campaign on billboards, radio and cable television that depicted a safe sleep surface. Education on the preventable causes of infant deaths, which included co-sleeping and deaths due to asphyxia, were provided to both consumer and provider Consortia members by the FIMR nurse. Health education materials and a crib displaying a safe sleep and non-safe sleep environment were used at a variety of community health fairs and events.

Another initiative in Saginaw County is the provision of cribs to families in need. This initiative was started through Healthy Start partner, the Saginaw City Police Department, and continues through grant funding secured by the Partnership Center in Saginaw County. The Saginaw City Police Department also created a crib display that demonstrates an improper and proper sleep surface. A similar display is also used by the FIMR nurse at education events offered within the community.

A community infant mortality summit was organized by Healthy Start, in collaboration with the provider Consortia and the SCIMC. This summit targeted community leaders, providers and others involved with perinatal health issues. This event had media coverage through the local television stations, radio, and the local newspaper. Speakers at the summit included; Rosemary Fournier, RN State FIMR Consultant; Dr. Joseph Marshall, MSU; Dr. Peter Vasilenko, MSU; Dr. Renee Canady, MSU; Dr. Peter De Jong; and a panel of parents who experienced personal infant loss, sponsored by the Michigan Tomorrow's Child Alliance. Break-out sessions were held in the afternoon to identify the community's strengths, and weaknesses, related to perinatal health. This information was provided to the provider Consortia for follow-up.

The Saginaw Black Nurses Association began outreach with the faith-based community, which has continued through the Provider Consortia (SCIMC). Despite several efforts to engage the faith-based community, there has been a lack of response, and commitment, by members of the faith-based community in

Saginaw to get directly involved. Information has been shared with members of the faith-based community on the disparity in infant mortality and safe sleep practices by our consumer and provider Consortia members. Thus, increased awareness has been achieved.

Consortia activities consisted of outreach and health education. The Consortia originally consisted of a group of consumers that was formed by the previous grantee. This Consortia focused on residents from the City of Saginaw. SCDPH expanded the grants focus to the entire county. This expansion was met with resistance of the Consortia members in existence, however, over time, the issue was resolved and the group has become cohesive. By-laws are reviewed and updated annually and officers elected.

The Consortia group meets monthly. An honorarium is provided for members who attend on a regular basis. Childcare was provided and then discontinued in the mid-grant cycle. Consortia members were not utilizing the childcare services provided due to discomfort in leaving their children with "strangers". Nutritional supplements are provided, along with transportation by either an Advocate or taxi voucher. Both transportation and nutritional supplements are necessary components in promoting regular attendance by participants.

The Consortia acted as an advisory group to the Healthy Start Project, along with the Healthy Start management team, which consisted of the partners, providers, and members from community agencies. The administration from Healthy Start acted as a liaison between the Consortia and the management team. This arrangement worked well during the initial start-up, but was burdensome to members on the management team who were attending monthly management and the Saginaw County Infant Mortality Coalition meetings.

To avoid this duplication, the SCIMC became a second consortium, which acted as a provider Consortia. Liaison of the two Consortium was accomplished through the consumer Consortia chairperson attending the Saginaw County Infant Mortality Coalition monthly meetings. To assist and mentor her, a Health Advocate also accompanies her. She is given an honorarium toward childcare expenses for attending these meetings. This arrangement has been working well, has increased communication, collaboration and coordination of services within our community. This arrangement has promoted Healthy Start within the community and increased awareness of the disparity in infant mortality.

The consumer Consortia was originally staffed by a 1 F.T.E. Consortia Liaison. This staffing pattern was changed to a .5 F.T.E. position as the Consortia members assumed more responsibility. Also, the Consortia Liaison position was experiencing frequent turn-over, which was a problem for consistency and follow through. A decision to have an Advocate work as the part-time Consortia liaison was made. This decision proved to be sound, as regular participation by consumers has increased and the Consortia members are becoming more active within the community in the provision of outreach and health education services.

The consumer Consortia receives health education/training at least one half of its regular meetings. Annually, there is a FIMR summary and findings presentation. Healthy Start activities and issues are reviewed at meetings, with

recommendations being brought back to the Healthy Start management team. Annually, the consumer Consortia develops goals that it would like to accomplish and areas of focus, i.e., male involvement, prematurity, back to sleep. In 2003, the consumer Consortia began a quarterly newsletter. This newsletter offers health education information, spotlights a Consortia member, provides information on upcoming events and feature stories of Consortia accomplishments. Copies of the Consortia newsletter have been included.

The provider Consortia meet monthly to discuss and plan community action for the prevention of infant deaths. The meeting has an agenda and FIMR, MDCH and Healthy Start are all part of the monthly agenda. Often there is not only input into Healthy Start activities, but collaboration on community activities.

Collaboration and coordination with State Title V and other agencies was initiated through the use of established relationships and linkages while establishing new relationships as needed. SCDPH has been in existence within Saginaw County for 75 years and has a long-standing history of collaboration and coordination with the perinatal health programs in the community. The Health Department contracts with the State of Michigan to provide a variety of Maternal Title V programs as well as a Title X Family Planning Program. Program goals and activities at SCDPH are planned using local data, the Healthy People 2010 goals and the State of Michigan Maternal Title V Block Grant objectives.

Programs at SCDPH that collaborate and/or coordinate services are discussed below. The Childhood Lead Poisoning Prevention Program offers health education and an environmental in-home inspection by a public health nurse and to children with blood lead test results over 10 ug/dL. This program coordinates services with the Healthy Start case management staff.

In 2004, blood lead testing began, through the WIC Program, in order to increase the number of children, 1-5 years of age, in Saginaw County who have had a blood lead test. Healthy Start management was part of the advocacy for this service and participated in state and local meetings that addressed this issue. Blood lead testing is offered to Healthy Start participants through WIC, without cost to the participant. Insurance is billed as applicable.

The Child Well-Being Program was a collaboration between the Michigan Department of Community Health and the Department of Health and Human Services (DHHS). The goal of the program was to prevent children, in families affected by changes in welfare benefits, from experiencing missed opportunities. Home visits were provided to assess the safety status of children in the home. Education and community resource information was provided on subjects of Medicaid, food stamps, WIC, immunizations, daycare, and other needed resources for which the family would be eligible. The target population was families with children whose FIP cases were closed due to noncompliance with work requirements. This program was discontinued between 2002 and 2003.

SCDPH Family Planning Program offers general reproductive health assessment, comprehensive contraceptive services, health education and counseling, and referrals to any one requesting these services, regardless of ability to pay. The primary target population is low income women and men.

Family Planning collaborates with Healthy Start through the provision of health education materials and resources and the acceptance of direct referrals of Healthy Start participants.

Saginaw's Fetal Infant Mortality Review (FIMR) Program was one of the first programs in the State of Michigan. This program reviews all infant deaths and looks at preventable factors that may have contributed to the death. The FIMR team is community-based. One of the main goals of FIMR is to make recommendations for system changes to the community action team. In Saginaw, the Saginaw County Infant Mortality Coalition, Healthy Start's provider Consortia, acts as FIMR's action team. The FIMR nurse position originally was grant funded through the State of Michigan. Grant funding was discontinued and SCDPH funded the position until 2004, when further budget reductions by the State of Michigan were made. The Healthy Start case management nurse assumed FIMR duties on a part-time basis in order to keep FIMR in Saginaw.

The Saginaw Child Death Review meetings are attended by the Healthy Start nurse case manager. Bereavement counseling for families with an unexpected infant death is offered through a SCDPH Public Health Nurse through home visits. The nurse coordinates with Healthy Start staff members when bereavement counseling is needed for a Healthy Start participant or their family member.

Hearing and vision screening is offered at SCDPH to children free of charge. This service is both school-based as well as clinic-based at SCDPH main site. There is an extensive referral basis for children who fail their screening and are in need of a diagnostic evaluation. Assistance with eye glasses is also provided, if needed. This service is available for children of Healthy Start participants.

The State of Michigan funded Maternal/Infant Support Service Program has a goal to reduce infant morbidity, mortality, and child abuse/neglect. This is accomplished through addressing psychosocial, nutritional and health issues that have been identified through a comprehensive assessment by providing health education and referral(s). MSS/ISS targets high risk pregnant women, and infants through one year of age, who are receiving Medicaid and live in Saginaw County. Families needing continued services, after the infant's first birthday, are transferred into the Healthy Start Program, until two years post-delivery.

In Saginaw County, there are two MSS/ISS certified State of Michigan providers; SCDPH and Health Delivery, Inc. (HDI), which is a Federally Qualified Health Plan. HDI and SCDPH have worked the past last four years to establish a system where duplication is kept to a minimum through direct communication between the two agencies. HDI and SCDPH MSS/ISS staffs meet quarterly, along with the Healthy Start Coordinator and Co-Director.

Transportation assistance through the qualified health plans, bus and/or taxi vouchers are available. The transportation provided through the qualified health plans has many barriers and is not a user friendly system. This is an extra burden for the Healthy Start Program to assist with transportation needs. Healthy Start is working with the State of Michigan to address this system and make the MSS/ISS transportation assistance more user friendly.

The MSS/ISS staff works directly with a Healthy Start Advocate in the provision of Healthy Start case management services. This system avoids duplication of services and allows for efficient services through direct collaboration.

SCDPH offered services through the State of Michigan funded MIHAS. This program was designed to outreach to high risk, low income (185% poverty or below) pregnant women and their infants. The purpose of the program was to support early and consistent entry into care. Services could be provided through eight weeks postpartum or through the infant's first birthday. MIHAS was staffed by a one F.T.E. Nurse Coordinator and two Advocates. The MIHAS Advocates worked directly with the Healthy Start Advocates, and case manager, as well as the MSS/ISS professional staff.

In 2003, the MIHAS Program was discontinued due to budgetary constraints by the State of Michigan. This change resulted in 4 F.T.E. Healthy Start Outreach/Advocate workers. This staffing pattern was an asset to the program, as the demand for Outreach/Advocate services was high.

The Maternity Outpatient Medical Services Program (MOMS) was funded through the State of Michigan. The program offered direct MOMS application assistance to eligible pregnant women along with general health education and assistance with accessing prenatal care. Assistance with Medicaid, MICHild, and Healthy Kids applications was also provided to eligible families. This program enhanced access to health insurance and health care. In 2002, the State of Michigan discontinued this program due to budget cuts. Healthy Start advocated the need for this service and it was continued through funding by SCDPH.

Early-On Services in Saginaw are coordinated with the Healthy Start case management staff. The Saginaw Regional 4 C program is responsible for Early-On Services. SCDPH contracts with the Saginaw Regional 4 C program for the delivery of Early-On Services. The SCDPH Early-On nurse collaborates with Healthy Start in service delivery and Healthy Start case management staff can make direct, immediate, referrals to Early-On, as needed.

Children's Special Health Care Services (CSHCS) is a State of Michigan funded health insurance program for infants and children with chronic health conditions. The program funds a 1 F.T.E. Public Health Nurse who provides case management services for families enrolled. Healthy Start staff can make direct referrals for CSHCS, when needed, and work to coordinate services for families enrolled in both programs.

The Women, Infant, and Children (WIC) nutrition program collaborates with Healthy Start through the provision of outreach for eligible pregnant women in need of case management services. WIC also provides walk-in services for pregnant women.

Healthy Start collaborates and coordinates services with the Yellow and Checker Cab Company and the Saginaw Transit Authority in the provision of transportation services to participants. Healthy Start has advocated for changes in the bus routes and bus shelters. Bus routes were expanded and bus shelters

added to routes. In 2004, the Saginaw Transit Authority experienced financial difficulties, which caused a decrease in the number of buses and routes. This has widened the gaps and need for transportation services in Saginaw County.

Healthy Start collaborates and coordinates service delivery with two other home visiting programs servicing Saginaw County. Teen Parent Services (TPS) and the Birth through Five Program have monthly health education sessions. Healthy Start staff attends these sessions. This has allowed for increased communication and coordination of services. In addition, the Healthy Start Co-Director participates on the monthly management team for Birth through Five services, which acts as an advisory group for the program.

Healthy Start participated in quarterly network meetings where all the Michigan Healthy Start Programs met with the State of Michigan Consultant. These meetings were beneficial for planning, networking, and coordinating efforts. In 2004, the network meetings were discontinued due to a change at the state level. The meetings resumed in the summer of 2005 and are to continue with newly assigned State of Michigan Healthy Start Consultant, Rosemary Fournier. Healthy Start also participates in State of Michigan FIMR meetings.

Healthy Start collaborates with the Saginaw County Leadership Group and SCIMC. The Leadership Group and Healthy Start have collaborated to develop and implement a community plan to promote universal substance abuse screening by all perinatal providers in Saginaw County. This plan was developed and implemented. Training has been provided to all major Ob providers, who have begun using the 4 P's Plus screening tool. Healthy Start purchased treatment guides for use by the Ob providers in providing health education. Healthy Start also provides quarterly feedback, to all providers, on screening conducted throughout the county, as well as within their own agencies. Feedback is given based on data submitted and entered into a database.

In addition to implementing universal substance abuse screening, Healthy Start has collaborated with the local substance abuse treatment facilities, DOT Caring Center, Odyssey House, as well as the coordinating agency, Treatment and Prevention Services (TAPS). DOT Caring Center is offering a 24 hour, seven day a week, toll-free number that can be used by any perinatal health provider in Saginaw County to refer a woman into substance abuse treatment services. Immediate transportation will be provided for the woman, when needed. Odyssey House is a residential treatment center and provided a substance abuse speaker for the monthly "Baby Showers".

Covenant HealthCare collaborates to provide childbirth education classes for Healthy Start participants. TPS offers group parenting education to Healthy Start participants, at no cost.

The Saginaw City Police Department collaborates with Healthy Start to provide outreach for case management services. A police officer will make a referral on families, with children under two years of age, who need additional assistance. The City Police have also participated in health fairs, offering a powerful visual "crib" display, depicting a safe and unsafe sleep environment. The original program was designed for a police officer to visit families in the City of Saginaw

after the delivery of an infant. The Police Officer would offer safety information and a “gift” basket. Training was completed; however, the program was not fully implemented due to budget cuts in the City Police Department, which continue to be experienced.

To promote community wide collaboration and coordination of services, a calendar was developed that would fit into a WIC coupon booklet. This calendar would be used to document what agencies were in the home and when visits were scheduled. The calendar was initially funded by Healthy Start and then funded through a Saginaw Community Foundation grant submitted by the SCIMC. The calendar is used by the majority of providers to track home visits and coordinate services.

Baby Bucks was a collaboration between Healthy Start and the community Baby Pantry. The program rewards pregnant women for keeping prenatal care appointments, participating in childbirth education, good school performance, and keeping home visit appointments with case management staff. The “Baby Bucks” program allows women to earn points that can be redeemed for a gift certificate at a local retailer that can be used to purchase infant items. The maximum redemption was \$50.00. The Baby Pantry provided funding and Healthy Start provided staffing, monitoring, and recruitment of participants.

Sustainability has been a difficult issue for the “Great Beginnings” Program due to both local and state funding issues. There have been several reductions in programs, including Medicaid, which impact Healthy Start services and the ability to secure billing and funding for Healthy Start services. Despite the financial difficulties experienced at the state and local level, efforts to obtain funding for sustainability have been, and continue to be, a focus of our program.

Healthy Start staff members received training on grant writing. The Healthy Start provider Consortia is pursuing 501©3 status to improve their ability to obtain donations and apply for grant funding. Healthy Start shared accomplishments with local and political leaders, emphasizing the programs effectiveness toward accomplishing infant mortality reduction.

Part of Healthy Starts sustainability plan is to incorporate Healthy Start services within already established systems and programs. Healthy Start works to begin system changes and then allows them to be taken over by the community. This was demonstrated through the development of the calendars that were used within the community to improve communication and service delivery. Calendars were developed by a community team, including Healthy Start and funded initially by Healthy Start. The need for continued calendars was voiced within the community and continued funding was obtained by the SCIMC through the Saginaw Community Foundation.

- C. The collaboration and coordination of services within SCDPH facilitated service delivery in outreach. Coordination of resources has provided a more effective and efficient service delivery system, which is necessary with the fiscal issues seen at both the state and local level. It also provides consumer satisfaction.

The biggest barrier in the provision of outreach services was the discontinuation of programs and services due to state and local budget cuts. The MIHAS and Maternity Outpatient Medical Service (MOMS) program were both eliminated by the State of Michigan due to budgetary constraints. Two MIHAS workers were hired by Healthy Start, after the elimination of the program, in order to continue with adequate services. SCDPH provided funding to continue the outreach and health education services of the MOMS Program through a Public Health Nurse.

At the local level, the City Police Department experienced a reduction in its workforce. Planned outreach activities with Healthy Start had to be modified significantly. In addition, the Department of Health and Human Services was not able to assist in outreach for Healthy Start, as originally planned, due to staff constraints.

Case management services were enhanced through the addition of a Healthy Start Coordinator. The Coordinator position assists the Co-Directors in implementing services within the community and in oversight of the case management staff. This change in staffing pattern has been an asset to the program and filled an identified need.

Another resource to case management services was the availability of multiple trainings and workshops for staff, at both the state and local level. There were many opportunities for staff to participate in continuing education at no or low cost. Monthly trainings were offered by the Saginaw Intermediate School District's Birth through Five Program, free of charge for Healthy Start staff members. SCDPH offers monthly in-services, also free of charge. In addition, many State of Michigan trainings are offered at no or low cost.

A program enhancement that occurred over the life of the grant cycle was the ability to move the two clinical providers, from providing information and tracking on health screening, to documentation on screening, health education, referrals and a referral outcome. This enhancement allowed for improvement in the Healthy Start evaluation, as well as services for Healthy Start participants.

The tracking of referrals, through a referral log, also enhanced services. The referral log is used by all staff members involved and allows each staff member to assess an outcome on referrals made by other staff members, without reviewing all documentation. This system has also enhanced our evaluation and reporting.

Factors that were issues for case management services were the budget issues encountered by the City of Saginaw Police Department. This issue caused a decrease in the number of police officers, which impacted the ability of Healthy Start to implement the Police and Parent Partnering Program. Efforts to collaborate, however, were pursued and outreach is being accomplished through a direct referral by a Saginaw City Police Officers, to Healthy Start, through a Public Health Nurse at the SCDPH. This is enabling Healthy Start to outreach and offer services to families considered high-risk due to involvement with the law.

Another issue that impacted case management services was performance issues that caused the Maternal Matriarchal Mentor Program to be discontinued. A reorganization of our tiered system for offering case management services was completed and participants were offered services dependent on a three-tiered system instead of the intended four. Healthy Start feels this reorganization minimally impacted case management services offered to participants, as the program was not fully operational when performance issues were discovered.

State of Michigan budget deficiencies affected case management services. Healthy Start increased funding for 2 F.T.E. Advocates due to the elimination of MIHAS, as previously discussed.

Recruitment of volunteers to be Peer Mentors was also an issue encountered by Healthy Start. Much time and effort was spent on recruitment of volunteers to become peer mentors. Due to the value placed on this program, efforts were continued and participants identified with no support systems were offered a peer mentor.

Health education was implemented with little difficulty. The biggest event that impacted health education was the difficulty in engaging the physicians. Several venues were used to engage providers, with minimal results. Physician Grand Rounds have been the most successful avenue of engagement for providers.

The technical assistance offered through the MCHB at HRSA was an asset for health education. The provided speakers gave Healthy Start an opportunity to offer health education on specific topics of substance abuse, and depression, to the community. Healthy Start was able to target different members of the community; i.e. providers, residents, educators, etc., using different venues that were appropriate to each individual's needs and learning level. The community response was positive, including the formation of the Leadership Group.

Finally, health education was enhanced through the development of pregnant, infant, and interconceptual teaching standards. These standards assisted the Healthy Start case management staff in providing consistent information, as well as documenting health education in a concise fashion to improve evaluation tracking and reporting.

Interconceptual care and depression screening, education and referral services have been planned and implemented successfully. The biggest barrier encountered in implementing depression services was a lack of referral providers for participants with a positive screen. The SCCMHA accepts all referrals made by Healthy Start for possible depression; however, this provider is overburdened and provides services based on assessed priority of need. Healthcare providers are also used as a referral mechanism. Due to a lack of mental health providers for residents without private insurance, SCCMHA is used.

The technical assistance on perinatal depression, provided by the MCHB of HRSA, facilitated more efficient service delivery for these services by offering health education and training, specific to the Edinburgh Postnatal Depression Scale, which is the screening tool used by our program. Staff comfort with screening and referral improved after receiving the training.

The “Great Beginnings” local health system action plan experienced unexpected issues due to budget constraints by the State of Michigan. Several outreach programs for pregnant women were eliminated by the State of Michigan, over the grant period. This impacted the ability of Healthy Start to achieve its goal of ensuring that all pregnant women seeking prenatal care are assessed, examined, and provided with education and appropriate referrals. The biggest impact was the elimination of the state funded MOMS Program that offered assistance in accessing health insurance and prenatal care, along with providing general health education. There was a gap in service and need with the elimination of MOMS, thus the SCDPH provided a Public Health Nurse to fill in part of the gap by offering health education and assistance in accessing prenatal care with follow-up. Assistance with health insurance is mainly provided by the Saginaw Department of Human Services, due to funding and staffing shortages at the SCDPH.

An asset to the LHSAP was the implementation of the “Baby Bucks” program. This program was collaboration between Healthy Start and the Baby Pantry. A financial incentive is provided by the Baby Pantry, to pregnant women who keep their prenatal care appointments, attend childbirth education classes, and keep home visits with case management staff. This program promotes regular and consistent care and follow-up with the Healthy Start staff members.

The implementation of “universal substance abuse screening” experienced resource limitations of staff time, cited by the providers, as a reason for not participating in universal screening. Despite this limitation, all major Ob provider staffs have received training on the 4P’s Plus screening and each provider office receives a quarterly report on how screening is proceeding throughout the county, as well as in their individual office. There has been provider support; however, universal use is still sporadic due to cited staff limitations.

In implementing the second objective of our LHSAP, FIMR recommendations and support were instrumental in making “Back to Sleep” and “no co-sleeping” standard messages in our community. This has made implementation successful. The only negative impact is a lack of resources to secure cribs for families in need. The SCIMC is applying for 501©3 status which will allow the consortia to accept donations and apply for grant funding for cribs.

Both the consumer and provider consortia have been successfully implemented. An asset to Healthy Start was having two consortium; a consumer and provider group. The two groups are linked through the consumer chairperson, who attends both monthly meetings. Another positive was having the .5 F.T.E. Healthy Start Consortia Liaison position as part of a Healthy Start outreach/advocate position. This change promoted an increase in regular attendance at the consumer consortia meetings and the consumer consortia members have become much more active in Healthy Start activities. Resources to offer items for the consumer consortia members have become difficult to obtain due to the economic issues being experienced in the State of Michigan.

The financial state of the State of Michigan also impacted Healthy Start’s collaboration and coordination with the State and our sustainability plan. The

State of Michigan, due to limited staffing, was unable to continue to offer a consultant at the quarterly Healthy Start network meetings. This made coordination and communication more difficult. Saginaw “Great Beginnings” provided written quarterly reports to the State Consultant to continue communicating Healthy Start events and issues. Gradually, Healthy Start, and the State of Michigan, has reconnected to focus on issues of African American infant mortality.

Due to the economy in the State of Michigan, more collaboration and coordination of services has occurred at the local level. This is an asset to more effective and efficient service delivery. The community is recognizing Healthy Start as a leader, which has strengthened Healthy Start’s ability to implement system changes. Healthy Start is coordinating and collaborating with many community agencies to avoid duplication of services and to maximize utilization of resources within the community.

The economy in the State of Michigan has impacted Healthy Start sustainability plans. Many programs that were used in the coordination of services, supported by the State of Michigan, have been eliminated, causing increased needs, and gaps in services in the Saginaw Community. Efforts at reimbursement for Healthy Start services are difficult to obtain, as many preventive services, previously covered by health insurance plans, are being eliminated due to the budget deficit.

The provider consortia, SCIMC, is currently attempting to obtain 501©3 status to assist in sustainability efforts. In addition, over the four years of this grant cycle, there has been community concern and awareness over the issue of disparity in infant mortality seen in Saginaw County. This will assist Healthy Start to implement system changes, that should be sustained by the community, in recognizing infant mortality as a priority issue that must be addressed by the community.

D. For the consortium, please address the following additional elements:

1. Highlight how the consortium was established and identify any barriers that emerged in its establishment and how they were addressed.

The consortium was initially established through the previous Healthy Start grant. It consisted mainly of residents from the City of Saginaw, which was the target area of that grant. The “Great Beginnings” grant targeted African American women and infants/children, less than two years of age, living in Saginaw County. The expansion from the City to the entire County had our project needing to expand the consortia membership to include residents from the suburban and rural areas of our county. This task would prove to be difficult due to transportation barriers and a need to keep the consortia located within the City of Saginaw, where bus routes are easily accessible, and the majority of our target population resides. We feel this barrier has been overcome as the consortia is growing, has become more active in direct Healthy Start activities, and is known within the community.

Healthy Start began with one consortium. This consortium consisted of women and men of reproductive age; however, there was limited representation from the provider community and active Healthy Start participants. Active recruitment of Healthy Start participants, from Healthy Start staff, increased Healthy Start participant attendance at the consortia meetings. An attempt to acquire more providers to the consortia meetings was met with resistance from providers, who cited too many meetings with the Healthy Start management meeting and the Saginaw County Infant Mortality Coalition, both meeting monthly. To accommodate this, Healthy Start consolidated the management team with the SCIMC and invited the consortia chairperson to join. The SCIMC evolved into a second consortium, consisting of providers, which has a liaison to the consumer group through the Consortia Chairperson and the Healthy Start Consortia Liaison. This arrangement has worked well for Saginaw. There is great provider and consumer representation along with input from both groups into Healthy Start planning and activities.

2. Briefly describe the working structure of the Consortium, which was in place for the majority of the implementation, its composition by race, gender, and types of representation (consumer, provider, government, or other). Also, please describe the size of the consortium, listing the percent of active participants.

“Great Beginnings” has two working consortium, the provider (SCIMC) and a consumer group. Each group has by-laws that, are reviewed and updated annually, and elected positions. The Consumer consortium has an elected chair, vice-chair, secretary and sergeant at arms. The provider consortium has an elected chair, chair-elect, treasurer, secretary, and community member at-large. Both groups meet monthly at a regular location and time. Minutes are kept.

The consortia consisted of 65 members, 36 consumers and 32 providers from the SCIMC. Three providers attend both consortia meetings on a regular basis. There were 83% of consortia members who were considered active (attend more than 5 meetings per year). The consumer consortia has 100% active members and 56% of the provider consortia members were active.

The representation breakdown had 11% state/local government, 51% consumers (mainly program participants), 1% community at-large, 17% community-based organizations, 8% private agencies/organizations, 3% Healthy Start partners, 6% perinatal providers, and 3% other (city police and a representative from Michigan State University).

The racial/ethnic breakdown on our consortium has 61% African American, 33% Caucasian, 1% American Indian and 5% of Hispanic ethnicity. A gender breakdown has approximately 93% female and 7% male representation. The consumer consortia racial/ethnic breakdown has 3% American Indian, 3% Caucasian, 86% African American and 8% of the membership is of Hispanic ethnicity. A gender breakdown has 95%

representation of females and 5% males. The provider breakdown has 34% African American and 66% Caucasian representation. The membership consists of 91% females and a 9% male gender breakdown.

3. Describe the activities this collaborative has utilized to assess ongoing needs; identify resources; establish priorities for allocation of resources; and monitor implementation. Describe your relationship with other consortia/collaborative serving the same population.

The consortia's both utilize community FIMR and infant mortality data to assess for needs within the community. The FIMR nurse gives monthly updates on FIMR findings and infant deaths, in Saginaw County, at the provider meetings. The consumer consortium receives annual health education from the FIMR nurse on FIMR findings and infant mortality statistics. Evaluation findings from Healthy Start are shared with the consortia annually, along with the MDCH's infant mortality statistics for Saginaw County that is updated annually.

Focus groups were held with the consumer consortia to gather input on the strengths and weaknesses of the perinatal health system and barriers to services. A provider survey to gather information on the community needs had a minimal return rate.

The identification of resources primarily occurs through "word of mouth." Upon identification of resources a presentation is requested or further information obtained and brought back to the membership. Prioritization of resources was mainly allocated based on the overall goals and objectives identified by Healthy Start. The consortia annually set goals and objectives.

The monitoring of implementation occurred through the evaluation data base and participant surveys. Consortia activities were monitored by the consortia liaison, Healthy Start Coordinator and Healthy Start Co-Directors. Feedback is provided to each perspective consortia during the monthly meetings.

The Healthy Start consortium directly collaborates and coordinates with the FIMR team, Saginaw Leadership Team and the Birth through Five collaborative. These are the other main initiatives, in Saginaw County, that work toward infant mortality reduction. FIMR findings are shared at the provider monthly meetings and annually with the consumer consortia. Birth through Five is represented at the provider consortia meetings and a Healthy Start Co-Director participates on the Birth through Five management team. The Healthy Start Co-Directors and Coordinator are members of the Saginaw Leadership Team and have been active in the provision of health education for the providers regarding perinatal substance abuse. The Healthy Start Program also tracks the use of the 4P's Plus screening form through its evaluation database, reporting on a quarterly basis.

4. Describe the community's major strengths which have enhanced consortium development.

A major strength for the Saginaw Community is its commitment to the prevention of infant deaths. Leaders and residents alike acknowledge Saginaw County's high infant mortality rate and are now acknowledging that our community has a disparity problem. This has assisted Healthy Start in assessing resources for the consortia as well as recruiting members, such as a neonatologist and a Representative from the State of Michigan. This has also assisted the consortia in implementing system changes and programs within the community.

Another strength in our community is the involvement of members from the African American community. The SCIMC has involvement from members of the African American community who can provide insight into the best outreach approaches, to be used in our community, in targeting African Americans and cultural issues relevant to the issues being discussed. These consortia leaders are also assets in the provision of actual outreach and health educational activities.

5. Describe any weaknesses and/or barriers which had to be addressed in order for the consortium to be moved forward.

A major weakness of our consumer consortia was the use of a consortia liaison not from the target community. Consumer consortia members were hesitant to become involved in Healthy Start activities due to a lack of "trust". A Healthy Start outreach/advocate worker assumed the role of the consortia liaison, which has brought increased membership and participation, in Healthy Start activities, by consumer consortia members.

The second weakness for our consumer consortium was a lack of knowledge about the issues surrounding infant mortality and specifically the disparities seen between African American and Caucasian infant deaths. To overcome this weakness, health education is offered annually on FIMR findings, and infant mortality statistics, specific to Saginaw County. Health education has been made a priority for the consumer consortia, with Healthy Start offering health education to this group on a bimonthly basis. This has assisted in the empowering of members, who during the last year of the grant period became more directly involved in implementation of activities within the community.

Finally there was an issue with the consumer consortia and a lack of regular active participation among participants. This occurred when "Great Beginnings" discontinued the monthly honorarium and nutritional supplements offered at each meeting. Upon return of these two elements, active regular participation was accomplished.

The provider consortiums have seen a major weakness in the lack of follow through by the coalition for planned activities. The group has recognized this weakness and is working to focus on a few activities, with follow-up, rather than many activities with little or no follow-up. Stronger

leadership within the officers has assisted this progression. The coalition is in the process of writing a work plan that has both short and long term goals. This will assist the group in keeping focused.

6. Discuss what activities/strategies were employed to increase resident and consumer participation. How did these change over time?

At the beginning of the grant cycle, a community-wide media campaign was implemented to increase awareness to the disparity seen in infant mortality. The campaign used billboards throughout Saginaw County and it promoted our toll-free number. Callers were provided information about the consortia and invited to participate.

Healthy Start staff members actively discuss the consumer consortia with current participants. Outreach/advocates offer to provide transportation and are present at the meeting to provide mentoring. The Healthy Start Coordinator makes reminder phone calls during the week of the meeting to ascertain attendance and transportation needs. These strategies have increased active membership by Healthy Start participants.

The provider consortia membership has remained fairly consistent over the years of the grant. Annually the roster is reviewed, looking for gaps in membership, assessing for members who have not been attending, and the racial/ethnic breakdown. Upon review of the roster, members provide direct outreach to potential "new" members. Current members and members who have not been attending on a regular basis are mailed a letter requesting updates in demographic information and interest in continuing on the coalition. These strategies are successful and the percent of African American representatives on the provider consortia increased from 29% in 2003 to 34% in 2004.

The only change in activities used to increase consumer/resident participation was the initiation of consistently implementing messages about the consortia and inviting new members. The consumer consortia newsletter consistently discusses the consortia and invites "new" members to participate. The majority of Healthy Start community health education activities offer information on how to become involved in the consortia. Finally, current consortia members are consistently reminded to ask others to join the group as active participants.

7. How did you obtain consumer input in the decision-making process?

Consumers are provided information on planned Healthy Start activities and provide input into their development whenever possible. This is accomplished mainly through our consumer consortia. The consortia liaison, or a member of the management team, attends consumer consortia meetings to present information on planned activities. Feedback is elicited at that time. Brochures, media campaigns, flyers, and other materials developed by Healthy Start are taken to consumer consortia meetings for review, suggestions, and approval.

Another form of input from consumers is through surveys and focus groups. Focus groups are held annually to obtain information from consumers that can be used in programming and to plan upcoming activities. Surveys are also used to elicit input on specific topics, such as best venue for a media campaign.

8. How did you utilize the suggestions made by the consumers?

Input from consumers is incorporated into Healthy Start implementation activities whenever possible. Consumers suggested the calendar be made to go into the WIC coupon book, this was accomplished. Consumers discussed that childcare at consumer consortia meetings was not needed and this was discontinued. The Healthy Start consumer consortia members gave suggestions for the annual media campaign message and venue chosen. The consumer consortia members' annually choose one to two goals that they would like to accomplish. These goals and activities are supported by Healthy Start.

- E. For sustainability, please address the following additional elements:

1. Describe your efforts with managed care organizations and third party billing.

The SCDPH has current contracts will all the managed care organizations serving Saginaw County. Third party reimbursement is continually pursued and in 2004, access for reimbursement of blood lead testing was obtained. The Healthy Start Co-Director met with representative of managed care organizations to discuss collaboration and coordination of services. Even though third party billing and reimbursement for direct Healthy Start services was not obtained, collaboration for the promotion of preventive health services like blood lead testing, immunizations, hearing and vision is pursued.

2. Describe the major factors associated with the identification and development of resources to continue key components of your interventions without Healthy Start funding.

The Saginaw Healthy Start Program has identified frequent, open communication with the MDCH, as necessary in obtaining sustainability. Our program collaborates with MDCH programs (Family Planning, MSS/ISS, blood lead, Early-On, CSHCS, STD, HIV/AIDS) in order to provide more efficient service delivery. Healthy Start participates in monthly Infant Mortality Coalition Network meetings, lead by the State of Michigan. A small amount of funding has been provided by MDCH to the provider consortia, with the purpose of developing and implementing a work plan that can be used toward making community system changes, that will decrease African American infant mortality.

Another effort obtaining sustainability is working with the community providers to make universal screening, education, referral and follow-up services universal for pregnant and interconceptual women and infants

and children in Saginaw County. This is a slow process that is evolving. To assist in this process, Healthy Start has been working with the State of Michigan to redesign the current MSS/ISS Program. Healthy Start communicated the need to reimburse for advocate services and the use of proven, effective screening tools, such as the Edinburgh and the 4 P's Plus.

The final major factor that is important to identify in obtaining sustainability resources is to develop and maintain a strong evaluation component. Evidence of positive outcomes is essential when pursuing funding, reimbursement, or billing.

3. Describe whether or not you were able to overcome any barriers or to decrease their negative impact.

Great Beginnings has worked to build a strong evaluation component. This will assist in our sustainability efforts by proving evidence of improved outcomes. Healthy Start advocates within the community for perinatal programs and services, especially with the current state and local fiscal outlook, where many programs and services are being eliminated.

III. Project Management and Governance

- A. Briefly describe the structure of the project management, which was in place for the majority of the project's implementation.

The Healthy Start management structure for "Great Beginnings" remained fairly consistent throughout the grant period. The program had two Co-Directors, Kimberly Sutter and Deborah K. Gibson and a Healthy Start Coordinator, Linda Dann and then Susie Garlick. Saginaw Valley State University (SVSU) was the original evaluator, through a contractual arrangement, however; Co-Director D. Gibson, assumed the evaluator role late in the grant period. The Co-Directors had direct continuous communication, with one Co-Director overseeing all Healthy Start staff and the consortia and the other working with the sub-contractors and community partners. This arrangement has been successful.

Fiscal oversight was provided by SCDPH Accounting Supervisor, Kathy Meyer. Ms. Meyer was accessible on a daily basis, if needed. There was frequent communication regarding budgetary issues between the Accounting Supervisor and the Co-Directors. Dr. Joseph F. Marshall, M.D., FACOG, Professor of Obstetrics, Gynecology and Reproductive Biology and Chairperson at Michigan State University, was the medical consultant for our program. Dr. Marshall participated in the management team meetings and is an active member of the provider consortia.

In the year 2001 this administrative team met with all Healthy Start partners and consumers on a monthly basis. Issues in provider attendance, due to the multiple monthly meetings, became a barrier early on; thus the management team combined with the Saginaw County Infant Mortality Coalition, which became our provider consortia. A second issue was the lack of attendance by

consumers at these meetings. Thus separate consumer and provider consortia evolved and have been successful for our program. Healthy Start has linked the two consortia groups through the consumer chairperson and the consortia liaison, who attend both meetings on a monthly basis.

- B. Describe any resources available to the project which proved to be essential for fiscal and program management.

Resources supplied by SCDPH were essential to the Healthy Start management team. SCDPH provided funding for the Healthy Start Co-Director, Co-Director/Evaluator, and Fiscal Manager. SCDPH coordinated FIMR services with Healthy Start for most of the grant period. MDCH offered resources to management through the use of a state nurse consultant. This proved to be valuable in networking and communication with the State on Healthy Start and issues important to our program.

Another resource for the Healthy Start Program was the Medical Consultant. This resource was valuable for our program being a new provider and as the program developed, use of this resource decreased. The Medical Consultant offered consultation in programming and health educational messages and information to be used by the program.

A final resource that was essential for Healthy Start management was a working relationship with the leadership in the local community, including the perinatal healthcare providers. This relationship facilitated the coordination and collaboration of services between Healthy Start and other providers, as well as assisted in accessing local resources and support, at community health educational events. This is essential in order for community health education events to be successful and effective in making a difference and promoting change within the community at-large.

- C. What changes in management and governance occurred over time and what prompted these changes?

The management team remained consistent except for one change in the Healthy Start Coordinator position. The governance structure changed as discussed in Section A. This change occurred due to a lack of consistent provider participation and a lack of consumer participants. The new structure has proven to be successful in obtaining input from both providers and consumers into Healthy Start programming. This structure has also seen increased regular and consistent attendance in both consortia groups.

- D. Describe what process had to be developed to assure the appropriate distribution of funds and what happened with the process over time.

The Healthy Start budget was developed by the Co-Project Directors, Evaluator, Coordinator and Fiscal Manager, with direct input from the two advisory coalitions on planned activities. Contracts are managed by the Fiscal Manager, with direct oversight provided by the Co-Project Directors. Contracts were renewed on an annual basis based on satisfactory performance. The process to distribute funds remained consistent throughout the grant cycle.

- E. As the project moved forward with implementation, what additional (non-HS) resources obtained for quality assurance, program monitoring, service utilization, and technical assistance became important especially as contractors were funded or additional staff members were hired?

The Saginaw County Department of Public Health provided staffing resources of the Co-Directors and Fiscal Manager. The SCDPH also provided staff resources of the Community Resource Nurse. This resource was instrumental in assisting in outreach and health education services related to our Healthy Start project. Another resource provided by the SCDPH was staffing assistance and promotional items to be used at community health fairs in conjunction with Healthy Start staffing and other resources. This enabled the project to reach more participants at these events.

The Healthy Start evaluator was funded at times by the SCDPH. The evaluator conducted quarterly chart audits at the two clinical sites and analyzed data from the data bases and from participant surveys. All of these functions assisted in monitoring and quality assurance.

Technical assistance was provided by the HRSA, MCHB for perinatal substance abuse education and perinatal depression. Both technical assistance speakers, Dr. Ira Chasnoff and Dr. Michael O'Hara, offered in-depth education, consultation, and support for our community on these topics. The momentum generated by these speakers allowed our community to make system changes of substance abuse universal screening for pregnant women and to increase screening and referral of pregnant and interconceptual women on depression using the Edinburgh Postnatal Depression Scale. This was vital to our project and provided access to our hard to engage providers.

A March of Dimes grant was obtained for the consumer consortia. This grant provided additional resources for operating their monthly meeting during the last year of the grant cycle. The community foundation was also used by the provider consortia to fund the community calendar project, which improved service delivery and efficiency between the community perinatal providers.

- F. To what extent was cultural competency of contractors and of project staff an issue? If cultural competency was an issue, how was it addressed and were any noticeable benefits realized?

The cultural competency of contractors and project staff was not an issue for the "Great Beginnings" Healthy Start project. The majority of Healthy Start staff members are minorities, two advocates speak fluent Spanish and all of the Health Advocates have been on assistance. Many of the staff members from the contracting agencies were also minorities. Annually, Healthy Start reviews both the consumer and provider consortia rosters, looking at the percentage of African Americans represented on each and developing a plan to recruit more representatives if, upon review, more representation is needed.

Even though "Great Beginnings" did not experience an issue of cultural competency with direct project staff, raising awareness to cultural competence is

a priority in our program. Participant surveys were collected and analyzed annually. Focus groups were also held annually. Information obtained through both surveys and focus groups offered feedback on cultural appropriateness of service delivery.

The consumer consortia assisted in assurance of cultural sensitivity by reviewing health educational materials proposed to be used by Healthy Start. The consumer consortia also reviewed the proposed annual media campaign and members directly participated in the development of our television ads. The consumer consortia members selected pictures for physician offices within our community that they felt were culturally appropriate. These pictures were offered by the consumer consortia members to staff at each office site.

Another strategy utilized by our project was offering a community cultural competence/race workshop, targeting perinatal healthcare providers. This strategy proved to be positive and valuable, per evaluation responses, except when the focus of our workshop was solely on racism.

“Great Beginnings” has a priority focus to work toward universal comprehensive screening by all perinatal healthcare providers serving the Saginaw Community. A referral resource guide was developed for Ob, pediatric, and family practice providers. This resource guide discussed recommended screening tools, areas to be screened and the frequency of screening. Community referral information was also provided to assist the providers in accessing resources, when needed. In addition, our project has worked over the grant cycle to implement universal substance abuse screening for all pregnant women using the 4P’s Plus screening tool. All major Ob providers have begun. A common referral mechanism into substance abuse treatment was also led by the Saginaw Healthy Start project. All providers can access treatment services by calling a 1-800 number 24 hours a day, seven days a week. The facility contacted will either come to the office or send transportation, when needed, to facilitate entry into a treatment facility. Implementing universal comprehensive prenatal screening has been difficult, as providers cite a lack of staffing and reimbursement as barriers. Despite these concerns, progress has been made within our community.

IV. Project Accomplishments

- A. In discussing “Great Beginnings” accomplishments, each project period goal/objective, strategies and activities will be summarized using the suggested format. Goals/objectives covered three main areas, health, systems, and process. Health objectives concentrated on what the program wanted to achieve overall in terms of healthier perinatal outcomes. System objectives focused on community-wide system changes that our project wanted to obtain and process objectives documented what our project planned to accomplish within our specific program. See attached.

There were two main barriers encountered that affected programmatic objectives. Budget cuts experienced by the City of Saginaw forced the ending of the implementation of the Police and Parent Partner Program due to staff reductions. Efforts to continue collaboration and coordination of services

between the Saginaw City Police Department and “Great Beginnings” were pursued. An agreement for outreach services through a referral to the Community Resource Nurse at the SCDPH. The Community Resource Nurse will screen referrals for eligibility for Healthy Start services and provide an assessment when eligibility is met. The second barrier was unexpected performance issues, resulting in the Maternal Matriarchal Mentor service being discontinued.

- B. Saginaw “Great Beginnings” mentored with New Orleans, Louisiana’s Great Expectations program from October 22-24, 2001. This experience was valuable to our program. Time was spent during direct service activities, which allowed us to observe and interact with staff and clientele for consortia and health education. Time was also spent with staff members and community partners as an information gathering and sharing experience. This assisted us to gain knowledge on practices that worked well while also learning about what hasn’t worked well and why. We felt this gave us insight into how to develop our program using successful interventions and avoiding known mistakes.

Technical assistance from the Health Resource and Service Administration, Maternal and Child Bureau, was received for perinatal substance abuse and perinatal depression. Both of these experiences provided valuable information to Healthy Start staff and assisted our program to increase awareness within our community for the need for system changes related to both of these areas.

Dr. Ira Chasnoff from the Children’s’ Research Triangle in Chicago, Illinois provided technical assistance from April 22-23, 2002. The focus was on perinatal substance abuse. Dr. Chasnoff’s visit gave the impetus within our community to form the Saginaw County Leadership Action Team, which developed and implemented a community-wide plan for universal substance abuse screening by all OB providers in Saginaw County. The plan included one phone number, is available 24 hours a day, seven days a week, that is used by all providers. Transportation to the treatment facility is provided, when needed, by the treatment provider. Healthy Start staff members learned knowledge and developed skills in substance abuse screening and referral. This was important in increasing the number of participants screened, due to staff discomfort with the subject, previous to the visit.

Dr. Michael O’Hara, from the University of Iowa, provided technical assistance on perinatal depression on October 18-19, 2004. Dr. O’Hara was effective in increasing awareness to the importance of screening women for depression and effective interventions to use for women with a positive screen. Healthy Start staff members gained knowledge and skills for depression screening and referral.

V. Project Impact

- A. Systems of Care: Describe how the project has enhanced collaborative interaction among community organizations and services involved in promoting maternal and infant health and social support services.

1. Describe the approaches utilized to enhance collaboration.

“Great Beginnings” used multiple approaches to enhance collaboration. One effective approach was to increase communication and coordination of services internally at the SCDPH. This approach has been effective to improve coordination and collaboration of services to promote a “one-stop” shopping environment. Direct collaboration occurs between the Healthy Start staff and MSS/ISS, Early-On, Children’s Special Health Care Services, the Community Resource Nurse for prenatal care coordination and health education (outreach), Immunization, WIC, HIV Counseling and Testing, Family Planning, MOMS and Healthy Kids Insurance, and the Sexually Transmitted Disease Program.

An internal referral form has been developed for use between the programs, which assist in tracking the completion of a referral for follow-up. To assist in coordination of service delivery, many of the programs allow walk-in clients and work with staff to coordinate appointments with transportation and translation needs. This is important in making services more accessible to the participants.

External collaboration was enhanced through participation in quarterly, State of Michigan, Healthy Start network meetings. This made networking between the Healthy Start sites available and offered an opportunity for information sharing through speakers arranged by the state consultant. The meetings involved State staff members, which promoted communication between Healthy Start and the MDCH. In addition to attending quarterly network meetings, our project submitted quarterly reports to MDCH through our State Consultant. This kept MDCH informed of Healthy Start activities and progress.

Another approach used by our project was to coordinate efforts with the State Title V, Michigan Child Health Block Grant. Several of the area’s of priority for the MCH Block Grant are consistent with Healthy Start: reduce the percentage of low and very low birth weight infants, reduce the overall infant mortality rate, reduce pre-term birth, reduce unintended pregnancies, reduce teen birth (aged 15-17 years), increase the percentage of mothers who breastfeed at hospital discharge, and increase the number of children aged 1-6 years of age who have a blood lead test. Healthy Start services also focus on these areas, specifically targeting the African American community. These common priorities enhance coordination of efforts.

“Great Beginnings” directly involved community agencies and members to participate in health educational activities, specifically the technical assistance offered through HRSA, MCHB on perinatal substance abuse and perinatal depression. By directly involving the community at all levels there was increased awareness and commitment within the community to direct efforts at improving services related to universal substance screening and referral for pregnant women and screening and referral for depression in women.

Collaboration was enhanced through Healthy Start communicating with consumers and providers through the two Consortia’s. These advisory

groups were provided with information monthly on Healthy Start purposed activities, barriers, and progress. Members were given an opportunity for input. Whenever possible, recommendations were implemented into Healthy Start programming to enhance collaboration and coordination of efforts within the community, promoting a team approach.

A calendar was developed, and initially funded, through Healthy Start. This calendar was made to fit inside the WIC coupon book. The purpose of the calendar was to assist participants with appointment dates and to improve communication between providers, by allowing providers to document who is involved with the family and scheduled appointments. The calendar has been well received by both participants and providers. A Saginaw Community Foundation Grant was obtained by the SCIMC (provider coalition) to continue funding the calendars, due to demand within the community. Agencies that use the calendar to coordinate efforts included OB, Family Practice and Pediatric providers, Early-On, Healthy Start, MSS/ISS, CSHCS, Birth through Five, TPS, WIC, and the Saginaw County Community Mental Health Authority.

Another approach used was to plan activities and strategies with community partners. This allowed our project to offer more activities as there were more resources available to plan and implement strategies and activities. The community also recognized Healthy Start as a potential partner for maternal-child health activities within our community and often Healthy Start was approached to develop and implement community activities.

On September 25, 2003, Healthy Start, in collaboration with the SCIMC, held a community infant mortality summit. The summit encouraged involvement of the community and had break-out sessions, where an assessment of the community's strengths and weaknesses were discussed, related to the perinatal healthcare system. The breakout sessions allowed for input by the community. Presentations were made by Dr. Joseph Marshall, MSU, on the historical overview of infant mortality reduction efforts in Saginaw County; Rosemary Fournier, RN, State FIMR Consultant reviewed current infant mortality statistics for Saginaw County; Dr. Peter Vasilenko, MSU, discussed the preventable causes of infant death; Dr. Renee Canady, MSU, discussed racism and cultural sensitivity, and Dr. Peter DeJong spoke on home interviewing tactics, when discussing difficult topics, along with a panel of parents from Michigan's Tomorrow's Child, that shared their personal loss experiences. The summit fostered interest in the issue of infant mortality and the disparity seen in Saginaw County.

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

The only policies and procedures written for the purpose of system integration were those written specifically for SCDPH Healthy Start case management staff. Policies and procedures were developed and implemented to assist staff members in documenting all referrals made

on a common referral log. The common log sheet was shared by all Healthy Start and MSS/ISS staff. All staff members were expected to review the referral log before making a home visit and to document referral outcomes. This increased our ability to manage and track referrals more efficiently.

The internal referral form was also developed by SCDPH to assist in monitoring and tracking referrals. This form was instrumental in strengthening our internal communication between programs.

The only external procedure established was a system to document visits by agencies using calendars. Each agency was given a different sticker that would identify what agency was involved with the family. The calendars would also document scheduled appointments and when appointments were kept.

3. Describe key relationships that have developed as a result of Healthy Start efforts covering the following areas:
 - a. Relationships among health service agencies; between health and social service agencies; and with community-based organizations.

Healthy Start has formed relationships, for referral and service delivery with the following agencies. Health Delivery Inc, a Federally Qualified Health Plan accepts referrals from Healthy Start for medical and dental services, especially for participants who are uninsured, underinsured, and/or immigrants. Healthy Start and HDI have quarterly staff meetings, which are used to identify barriers, coordinate service delivery efforts to avoid duplication of services, and to establish consistent health educational messages and practices. HDI collaborated with Healthy Start in the provision of screening, health education and referral services.

Healthy Start collaborates with Synergy Medical Education Alliance in offering health education for providers at Physician Grand Rounds and within the community. There is collaboration with Synergy on referrals for medical care, especially for participants who are uninsured and underinsured. Synergy collaborated with Healthy Start to provide screening, health education, referral and follow-up services to pregnant women.

The Saginaw City Police Department has collaborated with our project to provide outreach and health education through a crib display at community events. The Department makes a referral on high risk families with children who need further resources and assistance. An actual crib displaying both a safe sleep and unsafe sleep environment was used at many community events, such as the Infant Mortality Summit, Towne Hall meeting, etc.

This visual was effective and promoted interaction between residents and a police officer at these events.

There was collaboration with the DHHS, formerly known as the Family Independence Agency (FIA), for referral of Medicaid, MOMS and Healthy Kids Insurance, as well as other financial assistance that participants would be eligible for. Staff from DHHS would participate in Healthy Start formal health education events, such as the cultural sensitivity workshop, perinatal substance abuse, and depression offerings.

The SCCMHA collaborated to accept referrals for depression and other mental health issues identified in Healthy Start participants. Staff would also participate in the health education events sponsored by Healthy Start as discussed above.

There was collaboration with the Saginaw Intermediate School Districts Birth to Five program. Healthy Start staff members were invited to the monthly health educational sessions free of charge. Staff would network after the meetings and communicate on families being serviced by both agencies. Staff from Birth to Five also participated in many of the health educational sessions offered by Healthy Start. This participation could have been either direct participation as a participant, providing a speaker, or offering a play to learn group.

The Leadership Team was developed in September, 2002 through Healthy Start. This team attended the Children's Research Triangle's National Training Institute from September 19-22, 2002 in Chicago, Illinois. Representatives on the Leadership Team were previously discussed in Section II B.

The Leadership Team collaborates to develop and implement a plan for universal substance abuse screening for pregnant women in Saginaw County. This plan was implemented, with all four major OB providers using the screening form in 2004. Training was conducted by Leadership members. Healthy Start maintains an evaluation database, sending our reports to all providers on a quarterly basis.

A universal system of referral was also established through this collaboration. DOT Caring Centers, Inc., through a memorandum of understanding with Healthy Start, provides staffing for a 24 hour, seven day a week, toll free number that can be used by anyone in Saginaw County to make a referral for substance abuse treatment. DOT will provide direct transportation service, when needed, to assist women in receiving an assessment of need.

Health education for pregnant women on substance abuse prevention and the effects during pregnancy were held through a monthly "baby shower" provided by a trained staff member from

Odyssey House. The baby showers were expanded to include breastfeeding information through collaboration with Michigan State Cooperative Extension.

There is direct referral made to the SCDPH, WIC Program, from Healthy Start staff on pregnant, breastfeeding, and postpartum women and infant participants who are eligible for WIC but have not accessed WIC services. Pregnant women can “walk-in” for WIC services during operating hours. WIC staff coordinates appointment with Healthy Start case management staff, especially when transportation is going to be provided. WIC staff also makes referrals to Healthy Start on pregnant and interconceptual women and infants identified as needing case management services.

Family planning provides health education materials for Healthy Start staff and works to facilitate participant appointments. Family Planning staff coordinates services with Healthy Start staff in order to facilitate efficient service delivery. There is also a sharing of information between the staff in Family Planning and Healthy Start. This assists Healthy Start staff to provide up-to-date and accurate health education related to family planning options and interconceptual planning. The SCDPH, HIV Counseling and Testing, and STD Clinic also provide walk-in services. Participants can access these services through a referral from Healthy Start.

The nurse for CSHCS accepts referrals from Healthy Start staff and collaborates on case management services. The Early-On Program in Saginaw collaborates with Healthy Start through the coordination of services, outreach, and referral. The SCDPH Immunization Program collaborates with Healthy Start to assure participants are up-to-date on their immunizations. The Immunization Program staff will assess the Michigan Childhood Immunization Registry (MCIR) for records on participants and will coordinate with Healthy Start Program staff to assist program participants identified as needing immunizations to have their immunizations up-dated. Brochures and education materials are provided to the Healthy Start Program by the Immunization Program and staff can attend Immunization education events, as offered.

Healthy Start collaborated with the SCDPH MOMS Program, which provided direct application assistance to pregnant women for state funded MOMS health insurance coverage. Direct application assistance for Healthy Kids and MICHild state funded health insurance was also provided to Healthy Start participants. This collaboration occurred until state funding ended in 2002. Through advocacy of the Healthy Start Program, the SCDPH provided application assistance for MOMS, Healthy Kids, and MICHild health insurance when needed.

The SCDPH Community Resource Nurse makes a Healthy Start referral for services on eligible pregnant women seen with a positive pregnancy test. The Community Resource Nurse also provided prenatal health education, referral to a prenatal care provider and follow-up. Healthy Start advocates collaborate with the nurse to assist in providing follow-up services on pregnant women who do not have a telephone or who can not be reached after three attempts by the Community Resource Nurse.

Healthy Start collaborates with the State funded MSS/ISS Programs. MSS/ISS professional staff, a RD, RSW, and RN, work with a Healthy Start advocate to provide case management services. The MSS/ISS staff writes a plan of care that is used by the advocates, who provide general health education, transportation, translation, community resource information and support. A Healthy Start nurse case manager also collaborates with the MSS/ISS health professionals to coordinate dietary and social/emotional services for participants who are not eligible to receive MSS/ISS services.

Healthy Start collaborates with the FIMR nurse and team. The Healthy Start Co-Director participates in the monthly FIMR meetings along with the Healthy Start nurse case manager. The Healthy Start evaluator collaborate on health statistics collection and analysis. The FIMR nurse provides information to Healthy Start staff and the Consortia, along with recommendations and findings specific to our community.

There was also direct collaboration with the FIMR Action Team, the SCIMC. Healthy Start is a member of the SCIMC, which receives monthly programming reports on Healthy Start activities. The SCIMC and Healthy Start collaborate on community health education offerings, such as the Saginaw Infant Mortality Summit, the Towne Hall Meeting, health fairs, and outreach with the faith-based community.

Healthy Start formed a relationship with First Ward Community Center. First Ward Community Center offered the "Quality Time for Dads and Kids" Program through a contract with Healthy Start. Consortia meetings were held at First Ward Community Center free of charge. First Ward also collaborated with Healthy Start on a Father-Child Safety Day at Haithco Park.

Saginaw Great Beginnings developed a relationship with Cheryl Lauber, our State Consultant. The project sent quarterly progress reports to Ms. Lauber and participated in the quarterly state network meetings. These meetings were used to share information, ideas, and data between MDCH and each of the Healthy Start sites. This relationship provided a linkage between Healthy Start and MDCH.

- b. Relationships that focus on involvement of consumers and/or community leaders (who are not employed by a health or social service agency) with any of the agencies/organizations listed above or any additional agencies.

The Saginaw “Great Beginnings” project formed a relationship with Wilmer Jones-Hamm, Mayor of the City of Saginaw. This relationship was important in building and developing both community trust and involvement. The Mayor supports Healthy Start community health education events and was present at our Towne Hall Meeting. Her presence and commitment helped Healthy Start gain recognition within the community.

Another important relationship developed during the grant period was the involvement and support of State Representative Carl Williams. Representative Williams was a member of our Saginaw Leadership Team and attended many community health education events. This support increased participant attendance and assisted in gaining media coverage. Mr. Williams also provides advocacy at the state level for the Saginaw Healthy Start Project.

The Baby Pantry assisted Healthy Start with assessing community resources for our participants. This relationship offered financial incentives for participants who kept regular and consistent prenatal care visits. Another community agency that has assisted Healthy Start with resources was The Partnership Center. The Partnership Center offered cribs for Healthy Start families with an identified need.

A relationship with a consumer, April Long, proved beneficial for the Healthy Start Program. Ms. Long became involved with the project early in this grant cycle and became the consumer Consortia president. She has been active in contacting state representatives to advocate for the Healthy Start Program and funding. Ms. Long has worked to bring the consumer Consortia together, along with the Consortia liaison, Linda Stacy. In addition to working toward regular, consistent members, Ms. Long has been a role model for being active with outreach and Healthy Start advocacy in the Saginaw community.

- 4. Describe the impact that your Healthy Start Program has had on the comprehensiveness of services, particularly in the following areas:
 - a. Eligibility and/or intake requirements for health or social services. Healthy Start works to educate pregnant women, and families with children, to obtain necessary requirements to receive services before attempting to access services. For example, residents trying to apply for Medicaid at the DHHS must have pictured ID. Healthy Start staff members will refer residents to agencies that will assist in accessing a picture ID.

Healthy Start staff members directly assist pregnant women, and families with children, in completing applications for state funded health insurance, MICHild, Healthy Kids, and MOMS. Healthy Start staff will also provide translation services, when needed, to assist pregnant women and families with children to access necessary services.

Healthy Start has worked with the WIC program to make services more user-friendly through staff meetings. Through these meetings WIC staff now accepts many forms of ID to confirm eligibility and Healthy Start staff understand what is needed for participants to enroll in WIC.

The SCDPH Family Planning Program and Healthy Start collaborated through staff meetings to improve access to Family Planning services. Healthy Start staff can provide an intake packet to interconceptual women, before their Family Planning visit, to assist them in completing the necessary paperwork ahead of their appointment, which decreases waiting time during their appointment.

- b. Barriers to access and service utilization and community awareness of services.

A barrier to accessing services is a lack of transportation within our community. Public transportation is provided through the Saginaw Transit System or Yellow Cab. The Saginaw Transit System only offers services in the City of Saginaw and there has been a decrease in routes due to budgetary issues. Yellow Cab is an expensive option for residents in the suburban and rural areas of the community. To assist in addressing this issue, Healthy Start has strategically placed advocates in the suburban and rural areas of Saginaw County in an effort to cluster participants for more effective home visit utilization and transporting of participants when needed.

Healthy Start works with both the Saginaw Transit System and Yellow Cab to offer more efficient service delivery. For consumer Consortia meetings and community health education events, Yellow Cab is contacted prior to the event with the date, time, place, and number of participants needing transportation assistance. Both Healthy Start and Yellow Cab coordinate services to meet the needs in the most efficient manner possible. When planning community health education events, location is important in order for access to the Saginaw Transit System.

The need for additional transportation is continually brought up by Healthy Start at community coalitions, meetings, and events. The Healthy Start Program in collaboration with MSS/ISS provides

much needed transportation service throughout the county. This barrier continues to impact access to services.

A second barrier to service utilization is the State of Michigan requirement for Work First. Work First is mandated for all adults who receive financial assistance through the DHHS. This created a barrier of lack of access to participants, when attending Work First or a job. Healthy Start has worked with Work First, which is now allowing Healthy Start workers to access participants while they attend the Work First Program. To access participants who work, Healthy Start staff is allowed to flex their schedule for evening and weekend appointments, when necessary. This barrier has been decreased.

There is a barrier to accessing mental health services, for participants who need services, but may not be in a current crisis situation. The SCCMHA is prioritizing services due to an overload on the system. Healthy Start works with SCCMHA to address this barrier through advocacy and has developed a system where phone consultation can be used for participants until services can be accessed.

A barrier to accessing substance abuse treatment services and screening was identified through Healthy Start and the Saginaw County Leadership Group. Two issues impacting access to substance abuse treatment services were one; pregnant women's perception that their children were automatically removed by Children's Protective Services upon acknowledging that they are a substance abuser and two; physicians stating a lack of accessibility to treatment due to a lack of understanding of who to call and when.

A health education effort was made by Healthy Start and the Saginaw County Leadership Group to educate staff at treatment centers and healthcare providers that acknowledgment of a current substance abuse problem does not automatically mean removal of children from the home. The DHHS made a formal presentation and presented written statements. Pregnant women also were provided with information from providers to clarify this misconception, emphasizing the need to be drug-free during pregnancy and at-delivery. These efforts continue throughout our community.

To assist in assessing substance abuse treatment services, one 24 hour, seven day a week, toll-free number is available to all Saginaw County providers to make a direct referral into treatment. The treatment facility will make transportation arrangement, if needed, to their facility for intake and follow-up. This has assisted the community to make services more accessible.

Staff comfort in asking screening questions and making referrals for substance abuse and depression were barriers. This was an identified problem within our community upon further assessment by Healthy Start. To assist in decreasing this barrier, knowledge and skill building were used. Dr. Ira Chasnoff from the Children's Triangle in Chicago, Illinois met with Healthy Start staff, offering knowledge and skills on substance abuse screening and referral. Dr. Chasnoff also met with the healthcare providers and other perinatal providers to disseminate information.

To address issues with depression screening, Dr. Michael O'Hara from the University of Iowa, provided knowledge and skill building for Healthy Start staff, providers, community mental health workers, and other perinatal providers throughout our community. Both of these speakers made a difference in increasing awareness, knowledge, and offering skills related to substance abuse and depression.

Community awareness of services has been promoted by Healthy Start throughout the entire grant period. Through attendance at local and state meetings and coalition, services are discussed and shared, which raises awareness to available services. Healthy Start participates on many state and local coalitions and/or meetings. Locally, Healthy Start is on the SCIMC, Birth through Five Advisory Team, Even Start Advisory Board, Community Wrap-Around, Obesity Task Force, Emergency Providers Meeting, Saginaw County Human Services Collaborative Body, and the Social Services Club. At the state level, Healthy Start participates in the Healthy Start Network Meeting, MSS/ISS Coordinators meeting, Infant Mortality Network, and the state FIMR meetings.

Healthy Start has raised awareness through attendance at multiple community health fairs and events. Services offered by Healthy Start and the SCDPH are shared during these events, along with outreach for potential participants. Television, radio, and the Saginaw News, covered many Healthy Start activities.

The annual media campaign offered through Healthy Start is another venue that raised awareness of services within the community. A media campaign was held in 2002 using billboards throughout Saginaw County. The campaign targeted raising awareness to the issue of disparity between the black and white infant mortality rates and to increase awareness of the Healthy Start Program and its services by targeting pregnant women with our toll-free number.

In 2003, a billboard and radio campaign was held over a five month period. The campaign targeted safe sleep practices, risk of unknown sexually transmitted infections during pregnancy, the importance of early and regular prenatal care, unintended pregnancy, and risk of smoking and alcohol use during pregnancy.

Another radio campaign was run, over thirteen weeks, targeting safe sleep practices.

In 2004-2005, a television media campaign was conducted on the topics of safe sleep practices, early and regular prenatal care, male involvement, substance abuse during pregnancy, and depression. This media campaign had direct involvement of the consumer Consortia, who were active participants, along with community healthcare providers. This was empowering to our consumers and providers.

Start's interaction with the media. The Saginaw News ran several articles on Healthy Start services. On February 5, 2003 an article entitled "Birthing Buddies" discussed the peer mentor program. On September 25, 2003, an article entitled, "Racial Disparity Called Puzzling" discussed the current disparity seen in Saginaw between the black and white infant mortality rates. An African American newspaper, the Saginaw Voice, ran an article from September 8-14, 2003, discussing Healthy Start's Progress in 2002. In 2002, The Saginaw News featured two articles on the Healthy Start Program. The first article focused on services offered by Healthy Start and the second article focused on the issue of perinatal substance abuse. Healthy Start sponsored an ad in the Saginaw Voice promoting the community "baby showers".

The radio was also used to disseminate information about Healthy Start, infant mortality, and health education. On September 14, 2003, the Healthy Start Coordinator participated in a radio presentation discussing the project's purpose and services, along with infant mortality statistical information. This presentation was aired on stations Z93, Wheels, WIOG, and Oldies 96. On August 7, 2003, the Healthy Start Co-Director participated in a radio interview on WSAM discussing substance abuse during pregnancy.

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

On December 4, 2001, the Saginaw Healthy Start Program participated in the State of Michigan infant mortality summit. During the summit, diverse members from the Saginaw community participated in a community assessment, looking at the strengths and weakness of the perinatal health system in our community and making recommendations for specific strategies needed to improve the perinatal healthcare system. The Saginaw Healthy Start Program took the lead in implementing recommendations that came from the summit.

A recommendation that was implemented by Healthy Start was the development and distribution of a community resource guide for providers. It was identified that often referrals are not made because a lack of awareness of available services. Healthy Start developed a community resource guide that was distributed throughout the community. Verbal feedback was positive and the demand for these guides overwhelmed the number of guides printed for distribution.

In addition to the community resource guide, a universal screening manual was developed and distributed, specific to Family Practice, Pediatric, and OB-Gyn providers. This manual was developed to promote universal screening by all providers. Input regarding the manual was obtained from a prominent Pediatrician and OB-Gyn. All three manuals were completed December 2002. Distribution occurred in 2003.

Care coordination was promoted using a community calendar developed in 2002 and sponsored initially by Healthy Start. This project has been previously discussed in Section V A.1.

Healthy Start worked within the SCDPH to initiate care coordination between all programs offered by the agency. The SCDPH has worked to provide a "one-stop" service attitude for clients accessing services. Many programs now offer walk-in services, immunizations, family planning, STD, HIV Counseling and Testing, Saginaw Health Plan, MSS/ISS/Healthy Start, WIC for pregnant women, hearing and vision screening, and blood lead testing.

An internal referral form was developed and implemented at the SCDPH to assist programs in tracking referrals and to assess whether individuals followed through with a referral or not. Healthy Start developed and implemented the use of a universal referral log. All Healthy Start staff members would use the referral log when making a referral. The next staff member in contact with the participant is responsible for tracking an outcome, which is documented on the referral log. Healthy Start advocates would provide follow-up to participants where an outcome was not obtained in order to assess follow-up and the need for further services. Participants who do not follow through with a referral are assessed for barriers, with the goal of eliminating barriers in order for needed services to be accessed.

Healthy Start meets quarterly with staff from the Federally Qualified Health Plan, Health Delivery, Inc. The purpose of the meeting is to coordinate service delivery and care coordination. Healthy Start staff meets with staff from Teen Parent Services and Birth through Five during monthly health education sessions. Care coordination often occurs at this time. Care coordination

also occurs between Healthy Start, Teen Parent Services, and Birth through Five through phone contact.

Healthy Start staff periodically meets with staff from the SCDPH WIC Program and Family Planning Programs to discuss care coordination, issues that are barriers to accessing services, and ways to improve service delivery. Healthy Start consults with staff from the SCCMHA when needed. Early-On and CSHCS coordinate care with Healthy Start through direct contact, as both of those services are located in SCDPH.

Healthy Start staff members participate in a monthly staff meeting. This meeting is used to discuss issues, barriers, and to problem solve solutions. The importance of internal communication between staff members is emphasized for care coordination.

Quality assurance audits were conducted quarterly at HDI and Synergy by the Program Evaluator. These audits would look at the accuracy of information being submitted to Healthy Start. The Healthy Start database was used as a quality assurance tool to assess what areas need improvement, staff member caseload size, number of successful visits, along with tracking for several program indicators. Reports were periodically run and reviewed by the program evaluator and co-directors, looking for areas needing improvement and areas of strength. This information was shared with staff members during staff meetings.

Co-Director Kimberly Sutter and Healthy Start Coordinator, Linda Dann met with staff from Covenant HealthCare to develop a universal policy for drug screening on pregnant women and infants. This policy was developed in July of 2002 and has been implemented at Covenant HealthCare.

The Healthy Start Coordinator, Linda Dann, collaborated with Covenant HealthCare, Teen Parent Services and Synergy to establish childbirth educational classes specific to teens at Synergy. Teen classes were implemented as a result of this collaboration.

Care coordination for universal screening of pregnant women for substance abuse using the 4 P's Plus was lead by Healthy Start. The Saginaw Leadership Team was formed by Healthy Start, which has previously been discussed.

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

Improvements in the efficiency of agency records has occurred in the Healthy Start Project through the purchase of tablet computers that will allow staff members to electronically chart during case

management visits. The use of tablet computers will allow all staff to access a participant's record, on-line, and decrease the amount of time spent documenting. Filing of charts and forms will be eliminated, once the system is fully operational.

Electronic charting will allow staff to make address, and phone number changes, at the time services are delivered. Physician feedback is anticipated to be offered through email, which will improve communication between Healthy Start and community providers. There will also be improvement in the Healthy Start database, through real-time reporting, instead of the current system where data is entered at assessment of the pregnant or interconceptual woman, and/or infant, and updated after the pregnancy or at case closure.

Sharing of data across providers has not occurred during this grant period in the Saginaw community. However, many community agencies and providers are recognizing a need for more data sharing in order to maximize staff time and increase participant satisfaction. Currently the MSS/Healthy Start assessment is being looked at to be added within the current WIC assessment in order to capture duplicate information by asking questions once. This is occurring at the state level and is supported by the Saginaw Healthy Start Project.

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

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

Providers in the Saginaw community have been hard to engage in maintaining client participation in the system. There is one provider, Health Delivery, Inc. (HDI), that offers transportation and translation assistance. HDI also offers a migrant program that has services designed specifically to assist migrant families in accessing healthcare and other needed benefits.

The remaining providers in Saginaw County will make referrals to Healthy Start case management for clients identified as having barriers to keeping physician appointments and/or who do not follow-up with physician recommendations. Providers will also make referrals for transportation assistance and translation services, when needed.

A barrier, identified by community providers, was a lack of knowledge of community resources that can be used for referrals. Providers cited a lack of identifying barriers due to this lack of knowledge on how to assist clients in overcoming barriers. Healthy Start, in response, developed a community resource

guide and screening manual for community providers, including specific manuals for pediatricians/family practice and OB-Gyn providers. The manuals contained information on multiple community resources related to such things as food, shelter, mental health, etc. These manuals had a positive response within the community, as evidenced by the multiple requests for more manuals. However, attempts at a formal evaluation were not successful due to a lack of response by the provider community.

The Saginaw Great Beginnings Healthy Start Program has offered annual cultural sensitivity training for the community's healthcare and perinatal providers. On November 28, 2001, a conference titled, "Doctor: Our Babies Need You, They Can't Save Themselves" was presented by Dr. Yvonne Wesley, RN, PhD from the New Jersey Black Infant Mortality Coalition, in conjunction with Dr. Joseph Marshall, MD, FACOG, MSU, Obstetrics, Gynecology, and Reproductive Biology. The conference addressed the issue of racial disparity in infant mortality. There were 42 participants, which included 11 physicians (neonatologist, OB-Gyn, family practice, and pediatricians).

On May 6-7, 2002, a workshop titled, "Undoing Racism" facilitated by The People's Institute for Survival and Beyond, New Orleans, Louisiana, was held. There were 37 participants. Unfortunately this program produced tension and anxiety in participants, which was reflected in the program evaluation. Thus, a new facilitator was obtained.

On January 13, 2003, COR Communications, L.L.C. facilitated an all-day conference on cultural sensitivity and racial disparity. There were 31 participants, with a more favorable response, as reflected in the program evaluation. Additional trainings were offered through four half day sessions on May 7-8, 2003 by COR Communications, L.L.C. There were a total of 118 participants.

On September 25, 2003, Dr. Renee Canady, Ph.D, M.P.A. Assistant Professor for the College of Nursing at MSU, gave a presentation on cultural sensitivity at our Saginaw Infant Mortality Summit. There were 97 participants with overwhelming positive response for more presentations by Ms. Canady on the subject. Thus, on September 30-October 1, 2005, Dr. Canady facilitated four half-day workshops on cultural sensitivity. There were 119 participants in attendance, with an overwhelming response to have Ms. Canady return to build on these sessions.

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

The consumer Consortia was active in identifying a lack of culturally appropriate displays in the four major OB provider waiting areas. Healthy Start worked with the consumer Consortia members to select culturally appropriate pictures, and frames, that were purchased and given to each provider for display in their waiting rooms. The pictures were presented to each office for their waiting rooms by consumer Consortia members.

The consumer Healthy Start Consortia members reviewed the health education messages and chosen venue for our annual media campaign. For the last media campaign, actual consumers were used as participants in the television messages, which were well received.

The consumer Consortia developed and implemented outreach health education materials related to safe sleep practices. These materials were provided to seven faith-based churches. The consumer Consortia also reviewed health education materials, including posters and health fair displays, used by the Healthy Start Program for cultural and linguistic appropriateness.

The consumer Consortia in 2003 began developing a quarterly newsletter. The newsletter discusses current information on maternal and child health issues and spotlights a consumer member. This newsletter is distributed to both Consortia and is offered to all OB-Gyn, Pediatric and Family Practice offices for distribution to their clients.

The consumer Consortia in 2001-2002 developed and distributed a Healthy Cookbook. This cookbook offered recipes submitted by consumers with healthy substitutes made by a Registered Dietitian. The cookbook was distributed widely throughout the community.

The Healthy Start Consortia liaison and Coordinators obtained input from the consumer Consortia members annually through a written survey, on topics of interest for future health education presentations. Topics of interest would be presented over the next project year through different speakers.

Consumers were incorporated into articles written by the Saginaw News, whenever possible. Consumers were also invited and attended the Healthy Start Towne Hall Meeting held to raise awareness within the community to the issue of perinatal substance abuse.

The consumer Consortia collaborated with Healthy Start in the development and implementation of the community calendar project. Consumers reviewed and provided feedback, which was specifically useful in determining the size of the calendar, i.e. to fit into a WIC coupon booklet and the linguistic and cultural

appropriateness of the messages and graphics contained within the calendar itself.

In 2002, the consumer Consortia identified a need for a quick resource with emergency and important information for contacts. During a monthly meeting, each consumer Consortia member present completed information that they would use in an emergency and important information. This information was laminated and made to fit into their WIC coupon booklets.

The consumer Consortia provided input into the community resource directory that was developed and distributed to the community providers. Consumers made suggestions on what agencies and areas should be included in the guide and also gave feedback on agencies where barriers were experienced.

Consumer feedback consisted of the following specific to the DHHS received positive comments on assisting clients with assistance for condemned housing and security deposits, however, improvements were needed in returning phone calls, more explanation of services, and the need for more referrals to community resources. This information was communicated to Healthy Start staff and the SCIMC. As a result, the community resource guides were distributed to assist in increasing referrals made within the community. Unreturned phone calls and more explanation of services continues to be a barrier.

Consumers identified a gap in transportation services. Taxi service was described as being slow. Healthy Start worked on this issue by collaborating with Yellow Cab in planning for transportation of participants to appointments through pre-scheduling. Healthy Start also collaborates with Yellow Cab for group health education events, in order to decrease wait time.

A lack of bus transportation on Sundays was identified as well as a lack of routes for many areas of our community. Attempts to increase routes and times of operation have been met with resistance due to budgetary issues experienced by the Saginaw Transit Authority. Healthy Start continues to work on this issue.

Areas identified as meeting their needs were financial assistance, medical assistance, clothes, baby items, and food. Areas where there were gaps were transportation (discussed above), increased recreational activities for adults, more coordination of services and a need for cribs and car seats for both infants and toddlers.

Healthy Start and the SCIMC collaborated to obtain both cribs and car seats. A grant from the State of Michigan was obtained for infant and toddler car seats along with a donation from Ford Motor Company. An SCDPH Public Health Nurse was trained as a Certified Car Seat Installer through the Safe Kids Coalition. Car

seats were given after health education was offered and the seat was installed by the certified care seat installer. Healthy Start and the SCIMC identified crib funding and cribs were available through the Saginaw Partnership Center. Both of these needs pose continual funding challenges for Healthy Start and the SCIMC.

To coordinate services, the community calendar was developed and implemented. Consumers were involved in this process, as discussed above.

B. Impact to the Community: Describe the impact the project has had on developing and empowering the community, at a minimum, in the following areas:

1. Residents: knowledge of resource/services availability, location, and how to access these resources.

Healthy Start worked with the SCDPH to improve service delivery related to both internal referrals for residents seeking services at the Health Department. An internal referral form was developed and implemented at the SCDPH. The form has been included and discussed where services can be obtained and what is needed to access services. A copy of this form is given to residents when an internal referral is made and is reviewed verbally by the staff member making the referral. This form not only assists the residents seeking services, but it assists staff internally to track referral follow-up.

Another tool developed with Healthy Start was an Internal Resource Guide. This guide was developed to assist residents who would call the SCDPH regarding internal services. Each department/program is depicted with information describing what services are available, location and hours, and contact staff information. This information could be used to assist callers and walk-in residents to access needed services. It was also used by Healthy Start staff during home visits when making a referral to the SCDPH. A copy of the guide is enclosed.

Healthy Start established and promoted a toll-free number through a year-long billboard media campaign throughout Saginaw County, along with the message "Pregnant? Need help? Call 1-866-449-2229. This number was connected to the SCDPH Community Resource Nurse who made referrals to residents who called requesting assistance.

Healthy Start collaborated with the Saginaw City Police Department to assist in care coordination and referrals. High-risk families, seen by a Saginaw City Police Officer, can be referred to the SCDPH Community Resource Nurse, using the developed and enclosed referral form. The Community Resource Nurse will provide contact and follow-up for these families by making referrals to various community agencies. Information was given on the agency, location, service times and necessary information needed to access services.

To assist pregnant residents needing prenatal care, the SCDPH Community Resource Nurse will offer to make an appointment during the provision of service delivery at the SCDPH. In addition, she will follow-up with a phone call or make a referral for a Healthy Start advocate to provide a home visit for follow-up to track entry into prenatal care.

A community resource guide was developed to assist community healthcare providers and agencies in making referrals as well as providing information on the referral agency to the residents they are serving. Information contained in the resource guide includes the name of the agency; services provided, location, hours of operation, and phone contact information. This guide was developed in response to an identified need by providers of service and consumers. The guide was distributed by Healthy Start to all OB-Gyn, Family Practice, Pediatric, and other agencies such as DHHS, TPS, SCCMHA, etc., that serve the perinatal population.

To increase knowledge of our consumers, speakers from available community resource agencies are invited to speak at the monthly Consortia meetings. The speaker will provide an overview of the service(s) offered, location and hours of services, and a description of the process to be expected when accessing services. This has been helpful to increase knowledge of the various community resources available.

This tactic is also used to increase the knowledge of the Healthy Start staff. Speakers from various community resource agencies, i.e. Teen Parent Transitional Housing, Work First, etc. have been invited to speak at either a divisional or Healthy Start staff meeting. The speaker gives an overview of the service(s) available, location and hours, and then answers staff member's questions/concerns. This has been very helpful in assisting staff with providing correct and accurate information when making a referral.

Healthy Start staff members disseminate information on available resources at various community coalition and meetings. The Healthy Start Coordinator attends the Emergency Provider meeting, which provides updated information on community resources. This information is then brought back to Healthy Start and shared among staff members and within the SCDPH. Healthy Start Outreach/Advocates also attend the monthly Social Service Club meetings. These meetings are useful again to obtain knowledge and information on available community resources that can be used to make appropriate referrals for residents.

Whenever possible, flyers and/or brochures are obtained to offer to residents on the community agencies a referral is being to. Information provided often contains the service(s) provided, location and hours of operation, as well as contact information.

2. Consumer participation in establishing or changing standards and/or policies of participating service providers and local governments that

affect health or welfare of the community, and have an impact on infant mortality reduction.

The consumer Consortia collaborated with Healthy Start in the development and implementation of the community calendar project. Consumers reviewed and provided feedback, which was specifically useful in determining the size of the calendar, i.e. to fit into a WIC coupon booklet and the linguistic and cultural appropriateness of the messages and graphics contained within the calendar itself. This calendar affected how community providers communicated with each other and improved service delivery. Community providers indicate a scheduled and kept visit on the calendar through stickers and/or signing their initials. The back of the calendar has room for additional contact information. By all providers using the calendar there is coordination of services through scheduling of appointments and well as increased awareness to all of the agencies involved with a family, along with contact information for questions/concerns and to coordinate services. This is being used throughout the community.

The consumer Consortia provided input into the community resource directory that was developed and distributed to the community providers. Consumers made suggestions on what agencies and areas should be included in the guide and also gave feedback on agencies where barriers were experienced.

Consumer feedback consisted of the following, specific to the DHHS; positive comments on assisting clients with assistance for condemned housing and security deposits, however, improvements were needed in returning phone calls, more explanation of services, and the need for more referrals to be initiated by DHHS staff for community resources. This information was communicated to DHHS and the SCIMC through Healthy Start. As a result, the community resource guides were developed and distributed throughout the community.

Consumers identified a gap in transportation services. Taxi service (Yellow Cab) was described as being slow. Healthy Start worked on this issue by collaborating with Yellow Cab in planning for transportation of participants to appointments through pre-scheduling. Healthy Start also collaborates with Yellow Cab for group health education events in order to decrease wait time. In the community, there is now an increased awareness of the location of health education events and fairs. It is important for these events to be located near a bus route in order to improve access of services.

A lack of bus transportation on Sundays was identified as well as a lack of routes for many areas of our community. Attempts to increase routes and times of operation have been met with resistance due to budgetary issues experience by the Saginaw Transit Authority. Healthy Start continues to work on this issue along with other members of the Saginaw Community.

Areas identified as meeting their needs were financial assistance, medical assistance, clothes, baby items, and food. Areas where there were gaps were transportation (discussed above), increased recreational activities for adults, more coordination of services and a need for cribs and car seats for both infants and toddlers.

Healthy Start and the SCIMC collaborated to obtain both cribs and car seats. A grant from the State of Michigan was obtained for infant and toddler car seats along with a donation from Ford Motor Company. An SCDPH Public Health Nurse was trained as a Certified Car Seat Inspection through the Safe Kids Coalition. Car seats were given after health education was offered and the seat was installed by the certified car seat inspector. Healthy Start and the SCIMC identified crib funding and cribs were available through the Saginaw Partnership Center. Both of these needs were identified through consumers.

To coordinate services, the community calendar was developed and implemented. Consumers were involved in this process, as discussed above.

The consumer Consortia was active in identifying a lack of culturally appropriate displays in the four major OB provider waiting areas. Healthy Start worked with the consumer Consortia members to select culturally appropriate framed pictures that were purchased and given to each provider for display in their waiting rooms. The pictures were presented to each office for their waiting rooms by consumer Consortia members promoting increased awareness to the need for culturally appropriate displays and messages within the clinical environment.

Consumers were incorporated into articles written by the Saginaw News. Consumers attended the Healthy Start Towne Hall Meeting held to raise awareness within the community to the issue of perinatal substance abuse. The Towne Hall Meeting was instrumental in the development of universal substance screening for all pregnant women in Saginaw County using the 4P's Plus screening tool.

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

Saginaw "Great Beginnings" has worked within the community to promote team building. Healthy Start led and sponsored the Saginaw Leadership Group. This group consisted of a variety of community leaders and providers: Doris Patrick, Substance Abuse Treatment Coordinating Agency, Michele Barkley, RN Saginaw Intermediate School District, Linda Sasse, RN, Healthy Start Coordinator, Rosemary Fournier, RN, MPHI State FIMR Consultant, Connie Reynolds, RN, MSN, Covenant Healthcare, Ronald Gwizdala, Saginaw City Police, State Representative Carl Williams, Patrick Fitzgibbon, Department of Human Services, Khawar Mohsini, MD, Covenant Healthcare Neonatologist, Joseph Marshall, MD, MSU Professor and Chairperson, Obstetrics, Gynecology, and Reproductive Biology, Tawnya Simon, RN, MSA, SCDPH FIMR

Supervisor, Deborah Gibson, RN, MSN, Healthy Start Co-Director, Sandra Lipmeyer, MD, Synergy Medical Educational Alliance, and Kimberly Kelley-Sutter, RN, MSN, Healthy Start Co-Director.

The Saginaw Leadership Group acted as a team to develop and implement a plan for universal substance abuse screening on all pregnant women in Saginaw County using the 4P's Plus. Team building occurred during a four day training that occurred at the Children's Research Triangle Leadership Institute for community teams. By developing the plan as a team, each member worked in the implementation process.

Another team building activity occurred at the Saginaw Infant Mortality Summit. In the afternoon there were breakout sessions where participants worked together to identify the community's strengths and weaknesses related to specific areas of infant mortality, i.e., teen pregnancy, male involvement, interconceptual planning, etc. The participants worked as a team to conduct a mini community assessment that was given to the SCIMC for follow-up.

The quarterly meetings held between HDI and MSS/ISS/Healthy Start promote team building within the two home visiting programs that target pregnant women and infants/children. Staff discuss common issues, work on coordination for service delivery, and share information. This has been beneficial in improving communication, decreasing duplication of services, and collaboration on projects with a common interest.

The community has worked to share resources. The Birth through Five Program offers MSS/ISS/Healthy Start staff the opportunity to participate in monthly inservices. This promotes networking and collaboration between the SCDPH Healthy Start/MSS/ISS Programs, Teen Parent Services, and Birth through Five. Healthy Start also invites these programs to participate in provider health education events.

The community has experience working with divergent opinions. Many community coalitions and meetings include a broad array of participants from diverse backgrounds. This includes the SCIMC, which acts as the provider advisory board for our Healthy Start Project. Feedback and recommendations from the consumer Consortia have been provided to the SCIMC, which has acted in collaboration with Healthy Start to implement the recommendations.

Healthy Start has worked with the SCIMC to annually review the membership roster, updating it, contacting members who are not attending meetings and looking for gaps. A plan is then developed to attempt to fill identified gaps, in order to obtain a diversified body that works toward infant mortality reduction efforts in Saginaw County.

The process for making decisions is often one of consensus. All viewpoints are encouraged and welcomed. Healthy Start communicates issues discussed by our consumer Consortia, within the community, and encourages consumer participation on coalition and advisory groups.

This practice has been looked at with the recent addition of a consumer on the Saginaw Intermediate School District's Birth through Five Advisory Group. The SCCMHA also uses consumer input on planning for services.

Conflict resolution has been limited for Healthy Start due to a lack of conflicts. For external conflict resolution there was only one situation where conflict arose between Healthy Start and a community organization. There was a lack of performance with a contracting partner during the grant period. Several attempts were made to improve performance, however, performance issues remained. Despite needing to discontinue our contract with the organization, there is still collaboration with the organization through the SCIMC with Healthy Start.

Internal conflict resolution is resolved by following the chain of command and involving all parties. Attempts are made to find a solution that everyone can live with even though they may not agree with it. There are ground rules for the monthly staff and divisional meetings. This also assists in laying the framework for team building.

4. Creation of jobs within the community.

Healthy Start has not had an impact on the creation of jobs within our community. The Saginaw Community has been and continues to have budgetary issues, especially within the City of Saginaw. This impacts the projects ability to impact job creation.

- C. Impact on the State: Over the past four years Healthy Start has supported activities to strengthen and develop relationships with the State Title V Program. In some states where there was more than one Healthy Start Program, the Division of Healthy Start and Perinatal Services encouraged coordinated activities across these sites. Describe the activities and impact that this approach has had on your relationship to the State Title V Agency, State Children with Special Health Care Needs Program(s), your state Medicaid and SCHIP programs, your State Early Intervention Program and other state programs. Highlight any benefits and lessons learned from these relationships.

Saginaw "Great Beginnings" participated in quarterly Healthy Start state network meetings. These meetings were held with representatives of all Michigan Healthy Start sites, Michigan State Consultant, and other representatives from the MDCH. These meetings were effective in promoting the sharing of information between all of the Healthy Start sites and the MDCH. Current activities, barriers, and successes were shared and discussed. The meetings also promoted coordination of efforts to reduce infant mortality.

Quarterly progress reports were submitted to the MDCH. These reports would highlight accomplishments, review current activities, and discuss planned activities. This narrative would inform the MDCH of current Healthy Start activities in Saginaw so that MDCH could coordinate efforts from the state level.

Goals and objectives of the State Title V Maternal Child Health (MCH) program and Healthy Start are similar. The seven priority areas for Saginaw's local MCH

Block Grant which correlate to Healthy Start's goals/objectives are reducing the percentage of low and very low birth weight infants, reducing the overall infant mortality rate, reducing the pre-term birth rate, reducing unintended pregnancies, reducing the birth rate in females aged 15-17 years of age living in Saginaw County, increase the number of children aged 1-6 years of age who have had a blood lead test and to increase the percentage of mothers breastfeeding at hospital discharge.

On May 24, 2004, the SCDPH and the Healthy Start Co-Director met with officials from the State of Michigan to discuss increased collaboration and coordination of services as well as financial resources. State officials in attendance were; Doug Paterson, Bureau of Family, Maternal and Child Health; Mary Scobic, Nurse Consultant; Dr. Kimberlydawn Wisdom, Michigan Surgeon General; Alethia Carr, WIC Director; Jean Chabut, Chief Administrative Officer; Loretta Davis-Satterla, Director HIV/AIDS/STD; along with representatives from the Department of Environmental Quality, Laboratory, Minority Health, and the Michigan Public Health Institute. This meeting was effective in increasing communication and linkages between Healthy Start and the MDCH.

On November 29, 2004, the Healthy Start Co-Director participated in the planning session to develop strategies on addressing health disparities related to the high African American infant mortality rate. The State of Michigan has made the addressing of high African American infant mortality a priority. A State Infant Mortality Coalition Network has been formed with the top eleven communities identified as having the highest African American infant mortality rates in Michigan. The Saginaw Healthy Start Program is participating on the State coalition, representing the Saginaw Coalition. There are monthly meetings. Funding for infant mortality reduction efforts has been given to the SCDPH for the coalition, which will be used to collaborate efforts with the Healthy Start Program to make community system changes needed to impact the African American infant mortality rate.

The Healthy Start Co-Director also attended the State Maternal and Child Health Needs Assessment Meeting on March 23-24, 2004. The SCDPH and Healthy Start had active participation with the State of Michigan, in its needs assessment, looking at the Maternal Child Health priorities. Written input was provided on the priorities from a state-wide and local perspective for pregnant women, mothers, infants, children, adolescents, and children with special healthcare needs.

Healthy Start has a coordinated effort with many State programs. The WIC Program at SCDPH provides screening and referral of pregnant women and infants eligible for MSS/ISS/Healthy Start. This outreach activity identifies many pregnant women and infants at-risk through positive identifiers on the WIC assessment form that are used to trigger a Healthy Start referral. WIC serves the majority of the pregnant and infant population receiving Medicaid insurance.

State Title X Family Planning services coordinate efforts with Healthy Start. Forms that can be completed before a participants Family Planning appointment are given by Healthy Start staff, to participants identified as wanting SCDPH Family Planning services, in order to decrease wait time. Healthy Start staff work

with participants to complete these forms and coordinate transportation, if needed, to Family Planning appointments.

Healthy Start Outreach/Advocates, Case Manager, and Coordinator directly collaborate with the State MSS/ISS Program. Program staff coordinates services through the use of joint care plans and a referral log, along with participation in case conference. The MSS/ISS Program at HDI has quarterly meetings with Healthy Start/MSS/ISS at SCDPH to coordinate service delivery and share information. These efforts have increased communication and coordination of services between the two agencies and programs.

Healthy Start Outreach/Advocates worked directly with the state-funded MIHAS Program, when the program operated at SCDPH. This collaboration again produced increased communication and service coordination until the program ended due to State of Michigan budgetary issues. The Healthy Start Program felt it was important to retain advocates and thus our project began funding for two additional outreach/advocates.

Healthy Start coordinates services with Immunizations, Early-On, and Children Special Health Care Services through the sharing of referrals for outreach. Program staff communicate and coordinate services for families served by more than one program. All of these programs are housed at the SCDPH, which promotes sharing of information and the coordination of services in an efficient manner.

Healthy Start coordinated efforts with SCDPH to provide assistance with accessing state funded insurance for pregnant women and families with infant/children. This service is completed on a walk-in or appointment basis with the SCDPH insurance application processor. MOMS state-funded health insurance for pregnant women can be accessed by the Community Resource Nurse for all women seen having a positive pregnancy test at SCDPH.

The Healthy Start Co-Director was an active member of the state funded Birth to Five Advisory Group. There was coordination of services, with Healthy Start staff offered to participate in the monthly educational sessions offered through Birth through Five Program.

- D. Local Government Role: Highlight activities/relationships at the state and local level that facilitate project development. Briefly describe barriers at the state and local level, and the lessons learned in dealing with these barriers.

It was important to the Saginaw “Great Beginnings” Healthy Start project to have involvement from representative from the state and local level. The involvement of key leaders at the state and local level assisted Healthy Start in becoming known throughout the community. Locally, Mayor Wilmar Jones-Hamm offered support for the Healthy Start project. She personally attended several of the community health educational events, which promoted the event for media coverage and participant attendance. Ms. Wilmar-Hamm also worked with Healthy Start to identify key leaders to invite to these events and offered suggestions on the format.

Locally, Dr. Joseph Marshall, MD and Dr. Khawar Mohsini, MD, were key leaders in engaging the medical provider community. Healthy Start provider health educational events were supported and encouraged by Dr. Marshall and Mohsini, which was important in gaining attendance from the medical providers. Both physicians discussed the importance of universal screening in pregnancy and the referral process to access substance abuse treatment services on June 9, 2003 to 24 Obstetrical providers through Physician Grand Rounds. This presentation started the momentum toward universal substance abuse screening in pregnant women in Saginaw County.

To increase awareness to the issue of racial disparity between the black and white infant mortality rates in Saginaw County, a conference entitled, "Doctor: Our Babies Need You, They Can't Save Themselves" was offered by Healthy Start. Dr. Marshall was a presenter, along with Dr. Yvonne Wesley, RN, PhD from the New Jersey Black Infant Mortality Coalition. There were 42 community members in attendance, including 11 physicians. Dr. Marshall was key to the physician participation and this event began interest within the medical community to look at the racial disparity issue.

There were barriers experienced also when working with the medical providers. Healthy Start attempted to formulate a physician workgroup to develop the physician screening and resource guide. There was a lack of physician participation due to time constraints and a lack of a common meeting time. To overcome this barrier, Healthy Start made the decision to work with one Pediatric and one Ob-Gyn physician on the development of the screening and resource guide. This effort was successful and the guides were developed and implemented.

Engagement at events without having physician assistance with recruitment was difficult despite offering health education in the evening and on weekends. Physician promotion made a difference in recruitment and attendance. Physicians were also reluctant to implement universal comprehensive screening, health education, and referral services due to a cited lack of time, resources, and funding.

Establishing the SCDPH as the lead agency was another key relationship to success of the Healthy Start project. Having Healthy Start as part of the SCDPH was an advantage in the coordination of many services, such as CSHCS, MSS/ISS, MIHAS, Family Planning, Immunization, WIC, STD, and HIV/AIDS Counseling and Testing Services. Healthy Start was able to coordinate efforts to offer a "one-stop" visit option for residents receiving services at the SCDPH. Outreach coordination was established, along with a more efficient system for making and tracking of referrals between the programs.

Another advantage at the SCDPH was the community recognized the Health Department as a leader. The Healthy Start project used many of the established linkages with the medical provider community to promote outreach, case management, and health educational components of the project. The SCDPH's linkages with the SCIMC and other community agencies was also beneficial to the Healthy Start project, as relationships were already formed and trust established.

A significant barrier experienced by the Saginaw “Great Beginnings” project was a lack of involvement from the faith-based community servicing the African American population in Saginaw. There have been many different strategies used to engage the faith-based community, direct contact through the consortia, SCIMC members, letters, and through the offering of health awareness events. Efforts continue through the SCIMC to engage the faith-based community. Current efforts are focusing on informal leaders within the community rather than the formal leaders.

Relationships with the State of Michigan have been instrumental to the success of our project. State Representative Carl Williams has been supportive and an advocate for our project. Mr. Williams was an active member on the Saginaw Leadership Group. Representative Williams attended several Healthy Start events. This increased attendance and media coverage. Another advantage to working with Representative Williams was the ability to link with other key community leaders, both formal and informal, through him.

Healthy Start’s attendance at the December 4, 2001 Michigan Infant Mortality Summit was beneficial for the project. The afternoon of the summit was devoted to community break-out sessions that focused on looking at the community’s strengths and weaknesses related to perinatal health. Healthy Start gained knowledge on what the community identified as strengths and weaknesses and took a lead role in addressing gaps in services. By taking a lead role and following through with activities, Healthy Start was able to gain respect within the community on addressing infant mortality.

The success of the Michigan Infant Mortality Summit lead Healthy Start to plan a local Saginaw Infant Mortality Summit in collaboration with the SCIMC. The Saginaw Summit was also successful. Awareness to disparity and cultural sensitivity issues was accomplished through the summit, as many community members identified a need for cultural sensitivity training, which was arranged by Healthy Start. In addition, the community again came together to identify strengths and weaknesses related to perinatal health through afternoon breakout sessions. This format has had a positive reaction within our community and works in identifying gaps in services from a provider aspect.

- E. Lessons Learned: If not discussed in any sections above, please describe other lessons learned that you feel would be helpful to others.

The Saginaw Healthy Start project implemented a program entitled, “Quality Time for Dads and Kids”, targeting men. This program was offered through a contractual agreement between Healthy Start and First Ward Community Center. The program was designed to target men involved with Healthy Start participants to provide health education on male responsibility and parenting. Difficulties were experienced in accessing men of the participants due to participants not wanting the biological man involved, participants with the same father of the baby, and a lack of interest in attending.

To address these issues, Healthy Start began targeting African American men with children. This assisted in increasing participation of men, however, there

was still a lack of interest in the programming. First Ward Community Center performed an informal assessment of barriers and it was identified that the men wanted more than just health education and lunch in order for them to participate. In response, First Ward Community Center began offering the program in conjunction with sport activities, i.e. basketball, weightlifting, etc. This approach worked to encourage attendance of between 10-15 men for each session held.

A Father and Child Fun Fest was organized and held through Healthy Start in collaboration with First Ward Community Center. This day was held at a park and offered health and safety information. The day was well attended, with 137 participants that were mostly men with their children. This event was successful and worked as a mechanism for recruitment of participants.

VI. Local Evaluation SEE ATTACHED REPORTS

VII. Fetal and Infant Mortality Review (FIMR)

Saginaw's FIMR program has been in existence for several years and have reviewed all infant deaths since 1991. There are monthly meetings of the Community Review Team, which are well attended. There is representation from law enforcement, mental health, ob and pediatricians, residents, nurse practioners, DHHS, Covenant Healthcare, Healthy Start, MSS/ISS/Health Delivery, Inc, SVSU Nursing Students, and Child and Family Services. There are approximately 20-30 deaths reviewed annually.

Saginaw's FIMR program focuses on the review of all infant deaths and not maternal deaths. Maternal mortality is not currently at a high level for Saginaw County as our infant mortality rate is. The Fetal Infant Mortality Review includes chart abstraction and information from law enforcement, mental health, department of human services, and other services if identified as being provided to the family. The SCDPH SIDS Nurse attempts to make a home visit on all families who have experienced an unexpected infant loss. The visit includes a FIMR home assessment that has been developed by the MDCH. Information from the home visit assessment is included in FIMR.

A grant from the State of Michigan was used to fund a .5 F.T.E. FIMR Nurse position at the SCDPH. The grant ended and the position remained at the SCDPH, funded through the Personal and Preventive Health Service Division at the SCDPH. However, in 2004, budgetary issues were leading to the elimination of the FIMR Nurse Position at the SCDPH. The Healthy Start funded the .5 F.T.E position by adding FIMR to the Healthy Start case manager position and decreasing the case management responsibility to a .5 F.T.E. position.

Saginaw has both a Community Review Team, discussed above, and a Community Action Team. The Community Action Team is the Saginaw County Infant Mortality Coalition, which has been in existence since February, 1990. The SCIMC receives information from the FIMR Nurse at their monthly meetings. Members on the SCIMC are from a broad array of agencies/organizations, including the SCDPH, Healthy Start, Consumer Consortia President, Covenant Healthcare, Child Abuse and Neglect Council, Saginaw Intermediate School District, Birth to Five, Underground Railroad, DHHS, MSU, Early-On, Synergy, Saginaw Black Nurses Association, as well as others.

The SCIMC looks at the FIMR statistics and recommendations in order to implement preventive community actions and strategies. The Coalition is responsible for implementing the strategies within the community, primarily offering health education and working on making system changes. The use of both a CRT and CAT for the Saginaw FIMR has been the process used since its inception and is accepted within our community.

VIII. Products

Copies of materials produced through Healthy Start have been provided.

IX. Project Data

For each year of the grant all of the required forms of the MCH Budget Details, 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 the Major Service Table (Table C) have been completed and submitted electronically as required.