

Richmond Healthy Start Impact Report

I. Overview of Racial and Ethnic Disparity Focused On By Project

The goal of the Richmond Healthy Start Initiative (RHSI) during the 2001-2005 project period was to reduce disparities in perinatal health for African American women and infants living in Richmond, Virginia. RHSI's community needs assessment showed disparities for African American women across numerous perinatal indicators including double the percent of low birth weight infants born, late entry into prenatal care (less than half of all program participants in the previous project period started prenatal care in the first trimester), and infant mortality rates three times higher than white infant mortality rates. Other factors included high rates of poverty, low educational attainment, high unemployment, poor family support systems, inadequate housing, and high crime in target neighborhoods etc. Undiagnosed and untreated depression was also thought to be prevalent. Women and infants most affected by these risk factors lived in two areas of Richmond, the East End and South Side. RHSI target census tracts were 103, 105, 106, 107, 108, 109, 110, 111, 210, 202, 203, 204, 205, 206, 208, 209, 210, 211, 212, 301, 302, 305, 601, 602, 603, 604, 607, and 706. These census tracts comprise most of the city's low income and public housing communities.

In 2000, when the needs assessment was done for the reporting period, the number of Hispanic women living in Richmond City was very small and perinatal outcomes for these women were similar to those of white women living in Richmond. Therefore, Hispanic women and infants were not targeted for services. However, the number of Hispanic women living in Richmond increased by 400% and their perinatal outcomes began to worsen during the project period. The RHSI contractor serving the South Side (where most Hispanic families live) expanded their target population to include Hispanic women at risk and added a translator to their staff to assist these families. Major risk factors for this group are accessing health care and domestic violence. Many Hispanic women coming to Richmond are undocumented and fearful of the health care system. RHSI has also noticed that domestic violence is an issue for many Hispanic women seeking services. It is not known if perinatal Hispanic women are abused more often than women of other races/ethnicities are, or if Hispanic women tend to complete appointments regardless of visible signs of abuse whereas White and Black American women may not. Risk factors for poor Hispanic perinatal outcomes will be explored further during the 2005-2009 project period.

II. Project Implementation

The Richmond Healthy Start Initiative (RHSI) subcontracts the core services of outreach and client recruitment, case management and health education to three community based organizations that provide an array of enabling services to perinatal women and infants living in Richmond neighborhoods with the highest social and reproductive risk. The Community Based Organizations (CBOs) are Children's Health Involving Parents (CHIP),

a medical case management home visiting model, East District Families First/Healthy Families Richmond provides case management through home visits using the Healthy Families America model and the Richmond Behavioral Health Authority (RBHA) provides substance abuse treatment services through intensive outpatient therapy. While RHSI contractors participate in Consortium and the Local Health Systems Action Plan, RHSI central office staff is responsible for coordinating and implementing these efforts.

Outreach and Client Recruitment

- A. The Virginia Department of Health (VDH) designated the City of Richmond an under served perinatal area due to under-utilization of perinatal services (1998). The VDH also assessed that Richmond City had an adequate number of providers and facilities to meet the city's perinatal needs. In 1998, approximately 76% of women giving birth in Richmond City reported receiving prenatal care in the first trimester (compared to 90% statewide). Early entry into prenatal care was even lower for Richmond's African American mothers. Less than half of African American women receiving Healthy Start services during the 1998-2000 project period reported receiving prenatal care in the first trimester. Therefore RHSI outreach efforts targeted African American women for early and adequate prenatal care. During the project period, barriers to early prenatal care for low-income African American women in Richmond City were explored and addressed in a number of ways. With limited resources, outreach efforts began to target communities as a whole and subcontractors were encouraged to step up their efforts to retain interconceptional clients to increase birth spacing as well as improve health behaviors related to prenatal care should a pregnancy occur.

Outreach and client recruitment strategies have evolved and have been influenced by a number of things including the nature of the neighborhoods and the service model of the RHSI contractor. Key partners and stakeholders also had an impact on the development of outreach strategies as we attempted to collaborate and coordinate with others.

Improvement in the health of women and infants was the goal of the city's Task Force on Health and Human Services (1994) to decentralize city services and open offices on the east end to improve access to services for neighborhood residents. Since then, local government has had a strong presence in Richmond's East End where Healthy Families provides outreach and client recruitment services. Healthy Families is co-located with WIC, Social Services and the Vernon J. Harris Clinic and participates regularly in inter-agency activities and planning. This has created a strong referral base for Healthy Families as well as visibility and easy access for women seeking other services in the building. Healthy Families also participates in the East District Civic Association, which is a collaboration of public and private entities with the goal of improving the overall quality of life in east end neighborhoods. The partnership facilitates Healthy Families' access to businesses such as hair and nail salons to advertise

services. Word of mouth however has always been Healthy Families' greatest source of referrals.

The Richmond Behavioral Health Authority (RBHA) requested an outreach worker during the planning for the 2001-2005 project period and the need for getting perinatal women who have substance abuse into care was a high priority in our needs assessment. Needs assessment data also showed that the majority of pregnant women with a substance abuse diagnosis at hospital discharge in Richmond City reside in RHSI target neighborhoods. RBHA hired an outreach worker who is certified in substance abuse, and very familiar with the target neighborhoods. The later is just as important as her certification because it allowed her to blend into the community and establish relationships with residents. While outreach efforts did result in some women with substance abuse disorders seeking care earlier in their pregnancy, most of RBHA's clients come through Child Protective Services after giving birth to a baby with a positive toxicology screen. Preventing the birth of a substance-exposed infant is a major objective of RBHA's outreach efforts. Unfortunately, it is very difficult to locate and change the behaviors of pregnant substance abusing women.

Holistic health for the family was also identified as a need in our assessment. Children's Health Involving Parents (CHIP) is a medical case management model that pairs a nurse with two Family Intervention Specialists to improve family functioning leading to improved family health outcomes. Outreach is targeted to women with household incomes less than 200% FPL, living in Richmond's South Side, with children up to the age of six. Healthy Start provides funding for perinatal women with children up to the age of two. CHIP services are in very high demand; and there is a six-month waiting list for most services, however high risk perinatal women are prioritized into care. CHIP receives referrals from obstetricians, pediatricians and other medical providers, but word of mouth is also one of CHIP's greatest sources of referral.

Overall, the percent of African American women seeking early prenatal services improved in Richmond during the project period. However, a large number of pregnant women receiving Healthy Start services did not enter prenatal care early. This suggests closing the early entry into prenatal care gap between white and African American women needs more time, resources, and innovation to reach women most at risk.

- B. RHSI provided funding for a total of 5.5 FTE outreach workers for the project period. Four full time and one part time outreach workers were spread over the three RHSI contractors and there is one outreach worker position at RHSI. While similar across contractors, some specific outreach activities were varied by contractor model which were based on unique qualities of individual target neighborhoods. However, the basic components of outreach and client recruitment in terms of how activities were carried out were the same. RHSI has determined that the ability to establish trust is essential to meet outreach goals to

enroll at risk perinatal women into case management services. The basic components of outreach are staff recruitment, hiring and training practices that foster cultural competence along with more traditional competencies (record keeping, etc.) and the RHSI referral network and partners. Outreach workers who value diversity, have the capacity for self-assessment, awareness of the dynamics inherent when cultures interact, institutionalized cultural knowledge and the ability to adapt service delivery that reflects cultural diversity are highly valued. College degrees are not required for outreach worker positions, as the qualities mentioned above are more efficacious than education alone. Activities of outreach include staffing community health related events, collaborating with agency partners to develop or disseminate educational materials, make face to face contacts with potential participants through street outreach, provide educational talks to groups, formal and informal screening to assess needs, make referrals, conduct intake and assessment, assist in the development of individualized services plans, assist case managers, and conduct follow up for participants lost to care.

- C. In addition to budget cuts associated with the attack on the World Trade Centers, Virginia experienced a billion-dollar budget crisis associated with eliminating the state car tax. Cuts at the national level and Virginia's budget deficit impacted RHSI in a number of ways. In 2002, The Director of the Richmond City Department of Public Health (RCDPH) froze all unfilled positions at RCDPH including RHSI staff positions. Fortunately, the RHSI project director is funded by city general fund dollars. In order to staff the project, the RHSI project director retained a contract worker through Virginia Commonwealth University for technical assistance and program coordination until the freeze was suspended and staff could be hired. Several changes in city and department leadership during the project period also affected hiring RHSI staff located in the health department. The RHSI outreach worker wasn't hired until 2005 and staff for Community Development and Consortium was hired in 2005. These vacancies affected the central office's ability to affect systems change and decreased funding for evaluation (the contract person was funded by the evaluation).

The state budget cuts also affected funding for RHSI contractors that received additional funding through TANF. This could have reduced the number of outreach workers as a whole at RHSI contractors, which would have resulted in increased case loads, less service intensity, etc. Fortunately, lobbying efforts were successful and TANF funding was not cut for Healthy Families and CHIP.

Case Management

- A. Please refer to the above description of RHSI contractors that provided case management services during the 2001-2005 project period.

Building on the public health nurse practice of visiting new moms in their homes after delivery, case management has been widely regarded as the best practice to ensure women transitioning from public to private Medicaid providers would be able to access needed health services. In 1996 when Richmond City became a pilot for privatized Medicaid, there was great concern that low-income pregnant women would need case management and this was one impetus for submitting the first Healthy Start proposal. Case management services are subcontracted to three community-based organizations located in neighborhoods most at risk of poor birth outcomes.

In addition to home visits as the conduit for case management, our approach has been holistic and family centered. Lack of family support and a plethora of social problems associated with living in Richmond's high risk neighborhoods were identified during the planning for the project. Our case management services begin with an organization specific assessment to identify high priority needs, the development of a service plan that is done with the participant and other key family members (husbands, partners, mothers, etc.), and the execution of the plan, monitoring and adjusting when necessary. Case management is intense and a long-term commitment for both the worker and the participant.

Administratively, staff was encouraged to work together to conduct case conferences and establish relationships with external partners, such as providers. Participants sign waivers for providers to release information about them. Regular supervision of staff is the responsibility of the subcontractors, while staff development is shared between individual subcontractors and the RHSI office.

- B. Some of the components of case management were mentioned in the description of our approach above in the first paragraph of this page. Effective case management is a delicate science, structured around a core set of ongoing services and activities aimed at improved health status of the participant. The framework for case management services includes risk assessment, service planning, identification of resources, assistance, coordination accessing resources, monitoring progress, counseling and guidance to determine next steps, reassessment, planning, coordination and continued assistance and guidance. Health education is a thread that runs through the entire process. Cultural sensitivity is core to case management.
- C. The national, state and local budget deficits described above affected case management services the same as outreach.

Health Education

- A. RHSI health education is generally not a discreet activity, rather, health education is part of all RHSI core services as the thread that links outreach efforts to case management, and advocacy efforts. RHSI's first objective was to

make the community aware that African American women were more likely to have adverse birth outcomes as it was not widely known even in the African American community. Health education topics were identified for the different groups RHSI hoped to reach, but the first key message was that African American women are at greater risk and specific behaviors reduce the risk. For RHSI pregnant participants, the health education topics focused on early and regular prenatal care, folic acid consumption, signs and symptoms of preterm labor, nutrition etc. For providers the message was women are falling through the cracks, what can be done to increase access and utilization of health services? Cultural appropriateness was always the center of these discussions. Unplanned pregnancy and birth spacing were also identified in our needs assessment and family planning education along with assistance to increase employment opportunities were part of interconceptional care health education.

RHSI's approach to health education for substance abusing women was determined using a behavioral change theory based on research by Prochaska, with health education topics related to child bearing and substance abuse. Also, there was in depth education about the affect of substance abuse and counseling to change that specific behavior. Depression and other mental health issues were also identified as major unmet needs and should be addressed in more intense and direct ways with women who have substance abuse.

- B. All members of RHSI conduct health education. The topics and approach varied depending on the circumstances. The major components of health education are the identification of core messages to reduce low birth weight, preterm labor and accidental deaths due to poor sleeping environments. Health education is culturally appropriate, is provided with consideration to readiness and ability to change behaviors, and uses primary, secondary and tertiary health promotion messages. Health education is provided to participants and the general public through a variety of media, such as brochures and videos. All health promotion materials are culturally sensitive and messages are provided individually as well as for groups. RHSI worked with other organizations such as the March of Dimes on a low birth weight campaign and Richmond Enhancing Access to Community Health (REACH) by expanding prenatal services for Hispanic women and supporting efforts to increase the number of women and children enrolled in Medicaid and SCHIP programs.
- C. Barriers and facilitators have been described in previous sections of this report.

Interconceptional Care and Depression Screening and Referral

- A. RHSI submitted separate proposals for interconceptional care and depression screening and referral because short birth spacing, poor family planning and untreated depression were identified as high priority needs in planning for the project. The proposal for interconceptional care was approved but not funded. Without additional funding, these two components of RHSI services were

considered part of case management, as they were not called core services in the RFP for Eliminating Disparities.

RHSI's approach to interconceptional care and depression screening and referral was based on the existing efforts and experience of two contractors, CHIP and RBHA. Since CHIP serves families with children up to the age of six, interconceptional care was already a strong component of the program. Likewise with RBHA, evidence based practices to identify and treat co-existing disorders is a component of mental health services for perinatal women. RHSI followed the lead of these contractors who pre-emptively incorporated these services as core components of their programs. Therefore at the beginning of the project period, only CHIP reported data related to interconceptional care services and RBHA reported on depression screening and referral.

- B. Staffing for interconceptional care and depression screening and referral varied throughout the project period for reasons stated above. At the beginning of the project period, all contractors provided services up to two years post partum, however, only one contractor with two nurses and two outreach workers collected data in ways that mirrored the full scope of interconceptional services and very actively tried to retain women in case management services up to two years post partum. CHIP's demonstration project, if you will, showed that retention rates went up during the post partum period if case managers incorporated assistance with pursuing educational and employment goals of the participant. This also was linked with improvement in the use of contraceptives to prevent unwanted pregnancies. In addition, a family centered approach and case managers who understand and respect the lifestyles of these women seem to be essential components of interconceptional care.

All RHSI contractors provided interconceptional care throughout the project period, but clearly CHIP has been most successful. CHIP has done a very good job of leveraging resources to provide a comprehensive continuum of care for at risk women that has resulted in reductions in unwanted pregnancy, healthier infants and children (appropriately immunized, fewer ER visits, enrolled in Early Head Start programs) and more women working towards independence and employment that provides a livable wage. Other RHSI contractors provided interconceptional services but without additional resources, intense extended services are limited.

Depression screening and referral has been a component of RBHA's assessment process since first funded by RHSI in 1994. As part of the Virginia Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS), RBHA has been the driving force behind prioritizing problems associated with substance abuse including depression. RHSI followed RBHA's lead to understand the problem of perinatal depression and the basic components of screening and referral. One of the lessons learned about screening and referral for depression is there are a limited number of mental health providers

to refer low-income women to for further assessment and treatment. Services are limited and sometimes the only way to get treatment is if there is a crisis, such as a threat to oneself or someone else.

The primary components of depression screening and referral are identification of a screening instrument. With encouragement from MCHB, RHSI used the Edinburgh, but modified it by rephrasing some of the statements so participants could understand and respond better. A critical component of depression screening is a referral network. Richmond City has limited resources for low-income women seeking mental health services. Virginia's Medicaid program does not provide reimbursement for substance abuse services. Follow up and reassessment are also key components of depression screening. Participants continue to be case managed with extra consideration given to their mental health status.

- C. Barriers and facilitators have been discussed on previous sections of this report.

Local Health Systems Action Plan

- A. The approach to develop a Local Health Systems Action Plan (LHSAP) was to bring consortium members together and discuss the successes and barriers of the previous project period and to ask what should be done in the next four years. The lively discussion also identified needs of African American women of childbearing age in Richmond. The host of problems associated with living in RHSI target neighborhoods was well known by then (2000) and the wish list generated during that discussion grew into an ambitious Local Health Systems Action Plan. The approach was comprehensive addressing policy makers, institutions, communities, families and individuals. In the fall of 2001, RHSI held a series of meetings with consortium members to begin implementation of the LHSAP, but it wasn't until the fall of 2003 that the plan was implemented. Barriers and facilitators have been discussed in previous sections of the report; these apply to implementation of the LHSAP.
- B. The goal of the LHSAP was to engage the community in a campaign to reduce African American infant deaths in Richmond City, with RHSI office staff to coordinate the effort with RHSI Consortium. The components of LHSAP are to identify committed individuals to assist with implementation, provide activities aimed at motivating and preparing the group, establish priorities and timelines, monitor the process, provide guidance and support, assess progress and refine the process when needed. This is a dynamic process that requires strong leadership, patience and persistence. RHSI's early attempts to implement the LHSAP were affected when staff positions were frozen. In the fall of 2003, city government breathed new life into the RHSI Consortium creating more opportunities to implement the LHSAP. The LHSAP has not been reviewed

since early in the 2001-2005 project period and should be revisited to meet current needs and the mission of the RHSI Consortium.

- C. The barriers to program implementation that have already been discussed had the greatest impact on RHSI's ability to implement systems related activities such as the LHSAP and consortium. Without dedicated staff to work on these components of the project, only minor progress was made until city government became interested in infant mortality. RHSI has been the lead agency for the city's initiative to reduce infant mortality, called Children And Families First Initiative (CAFFI), which has evolved into the RHSI Consortium. CAFFI is holding a retreat in October 2005 to establish its structure and identify committee members and strategies (LHSAP).

Consortium

- A. A core group of individuals have supported efforts to improve maternal child health in Richmond for a number of years. The RHSI Consortium grew out of the interest of these individuals led by the director of public health at the time. The RHSI Consortium began in 1994 and has experienced periods of extreme activity and periods with less activity. The approach for this project period was to renew the consortium's spirit by capitalizing on the energy of new members from the African American community including academia and the church. The early days of the project period were spent identifying new members while cultivating relationships with existing members. Some members complained too little was done during the 1998-2000 project period and there would be, "no more meeting to eat". There was great excitement and energy because the new funding for Healthy Start (2001-2005) represented a significant increase over the previous HS funding and advocates came forward. This group clearly believed racism had a lot to do with poor birth outcomes in Richmond and the approach could be described as an invitation to participate in organized activities to reduce racism in Richmond, with the end goal of improving birth outcomes for African Americans.

Problems with staffing the project have been described. Racism is not a popular topic in a city that prides itself for being the capital of the Confederacy. There is an unhealthy and unstable racial tension in Richmond. With encouragement from RHSI, CAFFI will continue to explore the role that race and racism play in social and health outcomes of African American women living in Richmond's low income neighborhoods.

- B. Ideally the Local Health Systems Action Plan is part of consortium, so components of both are similar. Consortium has more formal structure with roles and expectations defined in the By-laws, while the LHSAP does not. As described, RHSI seized the opportunity to re-organize and restore the consortium via mandates from city leaders through CAFFI.

- C. The same barriers and facilitators apply, especially those for LHSAP.

Coordination with State Title V and Other Agencies

- A. While it's understood that coordination with Title V and other agencies is a good strategy for a number of reasons, this specific collaboration was not described as a core service in the RFP for Eliminating Disparities In Perinatal Health. Fortunately, RHSI and Virginia Healthy Start (in the Title V office at the Virginia Department of Health) received partnership dollars from MCHB to increase collaboration between RHSI and Title V. This funding was awarded at the end of the 1998-2000-project period and the work extended into 2002. The approach RHSI took to collaborating with Title V was a reflection of the activities we were currently working together on, which was a Pregnancy Risk Assessment Monitoring System (PRAMS) pilot study targeting Richmond City for RHSI and Norfolk for Virginia Healthy Start. RHSI and VA Healthy Start had also worked collaboratively on three statewide conferences to share information about barriers to accessing perinatal care and learn more about Medicaid with additional dollars in 1999. These were very structured well-planned activities and generally regarded as one-time projects, not ongoing. These joint projects presented the opportunity to establish relationships between RHSI and the Office of Women's and Infants' Health, which administers Title V funding for RCDPH nurse case management services. RHSI interacted regularly with local Title V when the director of RHSI was named Acting Deputy Director, responsible for managing RCDPH Clinical Services, including nurse case management. In this capacity, RHSI Project Director directed, at the local level, the application and reporting process for Family Planning (Title X), MCH (Title V) and funding. This ensured that the City of Richmond continued to receive funding that served women, children and their families. The approach to working with Title V was driven more by circumstances than strategy; however, the end result is improved collaboration between both.

- C. Barriers and facilitators have been discussed.

Sustainability

- A. In 2002 and 2003, the RHSI Project Director successfully lobbied the City of Richmond for continued support of \$300,000.00 to fund Healthy Start services with City General Funds. In 2004, RHSI successfully directed efforts to obtain additional funding through Title IV-E to support pregnant/parenting teens. For the period 2001-2005, additional funding was received to support women, children and their families through successful grant applications designed to reduce out-of-wedlock births. In addition, for the time period 2001-2005, RHSI Project Director leveraged resources of other RCDPH in-house programs such as Nursing Case Management (Title V, Title X) and Immunizations, to increase our

ability to meet the perinatal needs of local women, and other services for their children and families. The combined budget of Family and Child Health was approximately 1.7 million dollars annually and included a staff of 14 employees who served to improve the health of women, children and their families.

RHSI is co-located with Richmond Department of Social Services, which administers Medicaid and local SCHIP programs and communicates regularly with staff about referrals, enrollment process, eligibility, etc. RHSI as a program within the RCDPH collaborates with the Vernon J. Harris Health Center, funded by HRSA as a Federal Health Center, to provide referrals from their family planning clinic (in part funded by RCDPH) to Healthy Start sub-grantees.

At the community level, RHSI seeks to create permanent change in the systems that affect African American women living in Richmond to improve perinatal outcomes. RHSI recognizes this long-term goal will take the efforts of many to reach. RHSI's LHSAP identified major systems to target such as the Department of Social Services, housing etc. To increase sustainability, RHSI assisted other community-based organizations such as, Richmond Enhancing Access to Community Health (REACH), Early Child Development Coalition (ECDC), Boys and Girls Clubs, with developing proposals to increase their services for RHSI's target population. In doing so, RHSI helped to increase funding, but more importantly, strengthened the foundation for collaboration. A fundamental belief of RHSI has always been that sustainability depends on the capacity of organizations to maintain and provide needed services. RHSI's primary approach to sustainability has been to collaborate with others to increase their capacity to enhance or expand services.

B. The components of sustainability begin with a plan for sustainability, the resources to execute the plan, and mechanisms in place to periodically review and update the plan. Key components are matching potential funding sources to the goals of the project, competent staff to pursue appropriate funding opportunities, identification of an appropriate lead agency.

C. Barriers and facilitators have been discussed.

D. Additional Consortium Elements

1) The RHSI Consortium has been in existence since 1994. It began as a coalition to address Richmond's teen pregnancy problem but expanded its focus to include women and infants as a result of lessons learned and the city's concern about infant mortality. Influential city leaders were members of the RHSI Consortium during its infancy and consortium efforts benefited from their support. Over time, these leaders remained part of the consortium, but did not actively participate as much as they had in the beginning and delegated participation to line staff, which did not have the same power. Many of the new

replacement staff delegated to participate in RHSI Consortium were African American. By the time the 2001-2005 project period began, more African Americans were on the consortium and health disparities between races was at the top of the list of consortium concerns. Funding for the new project period renewed everyone's interest, however the budget crisis mentioned earlier affected all human service agencies in the city. Many organizations lost staff leaving fewer people with more work. Organizations were forced to limit involvement in efforts beyond their own commitments. As resources shrunk, competition grew and collaboration suffered. Some groups ceased sharing anything, even information, to maintain any advantage. Despite these barriers, a core of committed individuals continued to support consortium efforts. By 2003, infant mortality rates for the city became a topic in political circles and the city manager made decreasing infant mortality a city priority. This brought many of the original Healthy Start power brokers back to the table to work with activists to improve conditions for African Americans living in RHSI target neighborhoods. This powerful collaboration began a process in 2003, to redefine and reorganize with a broader mission of improving the quality of life for Richmond's children and families. The reorganized consortium is called Children and Families First Initiative or CAFFI.

- 2) For the majority of the project period, the RHSI Consortium structure was made up of a steering committee comprised of major stakeholders in RHSI including subcontractors who were required to chair committees such as policy and planning, marketing, training, data and evaluation, etc. Unfortunately men are a small minority on consortium making up approximately 5% of the membership. African Americans comprise slightly more than half of the membership. The consortium is made up of representatives from public agencies (43%), community based organizations (7%), private agencies (30%), providers contracting with RHSI (13%), although consumers have participated in consortium activities, no consumers have participated recently. While the consortium roster is extensive, approximately 30 core members participated regularly.
- 3) The RHSI Consortium has used a variety of strategies to assess ongoing needs. Needs were assessed at the end of the 1998-2000 project period at two half day consortium meetings. Discussions from these meetings were used to develop the Local Health Systems Action Plan for the upcoming project period which was to be used as the consortium's work plan. In addition, the local evaluator conducted a pilot PRAMS study in Richmond that provided information about the attitudes and behaviors before and around the time of pregnancy of Richmond women. RHSI also completed the first phase of the Perinatal Periods of Risk model to learn more about the causes of infant mortality in Richmond and identify interventions to improve birth outcomes. The Richmond Infant Mortality Review conducted case reviews of infant deaths and disseminated recommendations to decrease preventable infant deaths. RHSI also conducted an assessment of needs associated with perinatal women and substance abuse in

preparation for a two-day training with Dr. Ira Chasnoff. Resources were identified primarily through networking and actively searching for needed resources. Resources were allocated based on need and potential for success. Implementation was monitored through quarterly and annual progress reports. RHSI members participated in numerous other collaboratives with similar missions including REACH and ECDC in supportive roles including technical assistance. RHSI is regarded as experts in community health and successful, sustainable programming for Richmond's hardest to reach populations.

- 4) Richmond is a rather small community, and many health and human service providers have been in the field for many years and know each other, so there is a shared history and mutual respect. These relationships facilitate coordinating efforts. Richmond is also a very political community. When political will is in RHSI favor, it greatly increases visibility and support.
- 5) Weaknesses and barriers have been discussed in earlier sections of this report. Briefly, budget deficits had negative impacts on RHSI's ability to adequately staff the project and the ability of partners to share resources. The deficit was resolved in time and the city manager's office made reducing infant mortality a city priority which brought city leaders to the table, strengthening consortium efforts.
- 6) Consumer involvement is highly valued, but very difficult to sustain. RHSI employed a number of strategies to increase consumer participation including offering incentives, offering child minding and transportation, and holding meetings in more convenient and familiar locations. Consumers have expressed their discomfort interacting with professionals and have complicated lives that make this kind of activity a low priority for them. RHSI recognized the need for leadership training to improve consumer confidence and competence to participate in consortium. For the current project period, RHSI has full time dedicated staff to work with communities, consortium and family advisory group in such a manner.
- 7) Consumer input has been easier to get than consistent participation in consortium activities. Input was gathered informally such as asking questions while delivering services, individually and in groups. Consumers feel honored to be asked their opinion about things and take pride in their contribution.
- 8) Consumer suggestions have been used in developing standards for program implementation as well as the design of print materials.

E. Sustainability

- 1) The Richmond City Department of Public Health (RCDPH) is the lead agency for RHSI. In 1996, RCDPH stopped providing clinical services including prenatal care and family planning services and contracted these services out to

Virginia Commonwealth University Health Systems, formerly the Medical College of Virginia. Therefore, RCDPH never applied to become a Medicaid provider for pre-natal and family planning services. RHSI and subcontractors met with managed care providers to learn how to become a Medicaid provider and determined that as relatively small community based organizations, they did not have an adequate infrastructure in place to manage the process. Sub-contractors also felt that the reimbursement providers were willing to pay for case management services was insufficient to invest the resources needed to make them capable of managing third party billing. Medicaid HMO's that reimburse for case management typically employ telephonic case management, which is significantly less expensive than case management done through home visits. Also, RCDPH resumed providing prenatal care and family planning services in January 2005 and became a Medicaid provider for these services.

- 2) Local resources to sustain key components of RHSI are public and private in nature. City general funds supplement RHSI contractors for case management services, and provide space as well as pay the program director's salary. The United Way and the Robins Foundation also fund RHSI contractors to provide case management services. In both instances, case management services are offered in areas adjacent to RHSI target neighborhoods. RHSI seeks to identify resources that share the philosophy that a multi-pronged approach is needed to address the root causes of poor health and social status of RHSI participants. Potential funders must understand that direct services are only the stopgap for improved perinatal outcomes and lasting improvement depends on institutional changes that will foster healthy development.
- 3) A number of strategies were used to reduce negative impacts associated with barriers to sustainability. The most successful however is perseverance. As stated above, funding projects for the long term to address complex issues is not for the faint of heart. A fundamental understanding of the problem and knowledge is necessary for projects to succeed. An unenlightened person in a position of authority can do much harm. It's important that project staff are well trained and can articulate their activities and intentions clearly and with conviction. It is also important to capitalize on opportunities and demonstrate a willingness to work with others. None of these can happen if hope is lost and staff succumbs. These types of programs need leaders who commit to the long haul. Part of RHSI's success and Healthy Start in general is due to the persistence of staff to promote the mission in spite of setbacks.

III. Project Management and Governance

- A. The Richmond City Department of Public Health (RCDPH) has been the fiscal agent for the RHSI with the primary responsibility of grants

management for RHSI services since 1994. As a program within the City of Richmond, RHSI is subject to policies and procedures of Richmond City to ensure high quality practices. RHSI staff reported to the manager of Family and Child Health (FCH), which was a division within RCDPH Clinical Services. The FCH manager is the project director for RHSI and reported to the Director of Clinical Services, who in turn reported to the Director of RCDPH and to the Chief of Staff for the City Manager in the absence of an RCDPH Director. The Director of RCDPH reported to the Director of Health and Human Services who reported to the City Manager. In the fall of 2004, Richmond changed the system of government by voting to replace a city manager with a popularly elected mayor.

Contracts for RHSI contractors are awarded every four years with an annual option to renew based on performance criteria. Contractors submit requests for reimbursement to the RHSI project director. After the RHSI project director signed off on requests, the clinical director reviewed them for final approval. Timely reimbursement is desired and the average turn around time for contractors to receive payment was two weeks. All of RHSI contractors are sole source as they are the only home visiting programs in Richmond.

Contractors provided direct supervision to their employees who performed outreach, case management and health education for RHSI. All RHSI contractors are affiliates of evidence-based programs and are required to adhere to quality assurance standards set by the program and/or their parent organization.

One of the roles of the RHSI Consortium is to provide guidance for the implementation of the Healthy Start grant. During the 2001-2005 project period, the consortium did not provide guidance for implementation in the sense that direction of the project was voted on by the members. Only consortium related decisions, such as reviewing the mission, core values and guiding principles of the consortium were guided by members as part of the reorganization of the RHSI Consortium.

Last Fall RHSI participated in a performance review conducted by HRSA's Office of Performance Review (OPR). The entire review process took approximately 12 weeks to complete. The purpose of the review was to 1) measure program performance, 2) analyze factors impacting performance including HRSA policies and 3) identify effective strategies and partnerships to improve program performance. All aspects of RHSI program management activities were reviewed in depth. The OPR was extremely impressed with RHSI and in fact stated that it was one of the better Healthy Start programs at the conclusion of the site visit.

- B. An essential resource for fiscal and program management of RHSI was the support of Richmond City for funding the FCH manager position for grants management and dedicated administrative support for finance in health and human services (HSIS).
- C. Leadership for RCDPH was unstable for most of the project period. During the period, RCDPH had two acting health directors and two health directors. RCDPH underwent two reorganizations during the project period, which was disruptive. Each of the leaders came with their own way of operating and ideas about how to “fix” the health department. In doing so, over an eleven-month period, RHSI had seven different supervisors.
- D. The distribution of funds is based on the numbers of clients served by the contractor as well as their overall performance.
- E. Additional staff was not hired for RHSI during the project period. However, contractors were able to acquire additional funding and expand their services and service areas from the United Way and the Robins Foundation.
- F. Cultural competence is a core value that informs all aspects of RHSI. The lack of culturally competent staff in other fields (health and social services for example) that impact the lives of our participants is alarming.

Noticeable benefits are not evident in health statistics. However, there are more subtle changes, such as the level of interest in discussions about cultural competence have occurred. It appears that more professionals are aware that cultural competence is an issue and demonstrate a willingness to explore and perhaps quietly self assess.

IV. Project Accomplishments

- A. Please see Attachment A for a complete description of accomplishments related to the project’s stated goals and objectives.

RHSI employed strategies using Healthy Start core services to accomplish 15 project period performance objectives aimed at eliminating disparities in perinatal health in Richmond City. At the beginning of the project period (2001), the African American infant death rate was 25.2 per 1000 live births. In 2004, African American infant death rates were 18.0 deaths per 1000 live births. The rate of infant death for African Americans in Richmond continues to be unacceptable; however the rate did improve during the project period. Of interest, the infant death rate for 2001 was the highest. Funding for RHSI services in 2001 was significantly less than the annual award amount for 2001 – 2005 because the first half of that calendar year RHSI was funded at the previous project period amount, which was

only a third of the 2001-2005-grant award. Also, it was September of 2001 before RHSI received official notification of grant award and was able to send letters of grant award to RHSI contractors so they could load their budgets to pay for services. In summary, funding for Healthy Start services in Richmond was limited in 2001. During the project period, RHSI served approximately 1,500 women and their families. During the same time period there were approximately 12,000 births to Richmond City mothers. RHSI services target women at the highest risk for poor perinatal outcomes. It's estimated that approximately 2,000 mothers giving birth during the same timeframe were high risk for poor perinatal outcomes.

Barriers to success have been discussed in previous sections of this report. Briefly, national, state and local budget deficits affected RHSI's ability to hire staff in a timely manner when the hiring freezes were imposed that extended into the fall of 2002. Frequent changes in RCDPH leadership disrupted implementation because each new leader had to be educated about RHSI and most often made major changes to the way things were done to suit their personal preferences, not out of necessity.

RHSI is fortunate in that the individuals who are responsible for implementing the project are seasoned administrators and line staff. All of the administrators for RHSI contractors have been with the project since 1994, and many of their staff have been with the project that long as well. The forward thinking and ability of the RHSI project director to secure additional support from Virginia Commonwealth University for technical assistance for program coordination diminished the harm caused by protracted hiring freezes. Barriers during implementation had less of an impact because of the experience and expertise of the entire RHSI staff.

- B. RHSI did not receive mentoring or technical assistance from another site during the project period.

V. Project Impact

- A. Systems of Care: RHSI is a strong community partner, rooted in principles of collaboration. The project's longevity makes it somewhat of an icon during an era when projects and collaborations come and go. RHSI is viewed as an expert source of information for the perinatal needs of Richmond's at risk population.
 - 1) There are different degrees of collaboration ranging from networking and sharing information to actually sharing resources. By definition, RHSI is a collaborator of the highest degree in that it exists to provide the administrative functions necessary to manage a major federal grant for funds to be distributed among small community based organizations unable to themselves, but best at providing needed services.

RHSI views collaboration as a natural function of health and human services. Our approach to enhancing collaboration is to identify partners with shared missions and partner with them to the extent that it is possible and that it is beneficial. Collaborative efforts must be supported by administration, which includes planning to adequately staff collaborative efforts.

- 2) Systems integration requires stability in the organizations that will be part of the systems change. The RCDPH has been through two major reorganizations in the last four years. This kind of disruption does not lend itself to proposing systems changes to other organizations. And often times (especially after the budget deficit in 2001-2002) many organizations were undergoing similar processes. In this case then, structural changes beyond the control of RHSI staff impeded systems change efforts until infant mortality became a concern of the city's highest official, the City Manager (Fall, 2003). At that time, agency department heads and leaders in the private sector answered the city manager's call to explore ways to integrate services provided by departments that comprised the city's health and human services portfolio and identify a role for the private sector in improving perinatal outcomes.
- 3) a. RHSI had existing relationships with health service agencies before the project period. Relationships did change however as often times the relationship is with individuals within an agency rather than the agency overall. This is particularly true of larger organizations. Because of this, some relationships were lost and others were created during the project period. Relationships with community based organizations were the most consistent as the relationship is most likely with the executive of the organization. It also seems that CBO's do a better job of passing contact information on so relationships are maintained even when there is a change in staff.

b. RHSI planned to partner with the Friends Association to provide additional training for their leadership development program. The Friends Leadership program was offered to residents living in the city's largest project, Gilpin Court. This was RHSI's primary strategy to involve consumers in program planning, evaluation and health promotion activities. The lack of staff at RHSI, and the resignation of the director of the program at Friends, ended plans to implement this strategy. Consumer involvement and consumer relationships are highly valued by RHSI and opportunities to interact with consumers have always been a priority. In large part, however, RHSI depends on information from contractors who interact with consumers on a daily basis to understand how the program and consumers relate.

4. a. Eligibility requirements for social services are regulated by the Department of Social Services (DSS) and not amendable to change from RHSI. RHSI has enhanced DSS services by providing additional services to clients not available through DSS, such as transportation, case management health education, outreach, etc.

RHSI did not change eligibility requirements for health services during the project period. RHSI increased the number of women eligible for health services by assisting them with obtaining health insurance through Medicaid, SCHIP or private insurance providers.

- b. RHSI program participants have many risk factors for poor perinatal outcomes. One early indicator for risk is entry into prenatal care. Only half of RHSI participants enter prenatal care in the first trimester and many who report early care do not receive regular care. Minimizing barriers to care is a primary objective of RHSI. Prenatal barriers are only part of the problem for RHSI participants however. Barriers to comprehensive women's health care for RHSI participants are always present. Financial barriers due to lack of health insurance, structural barriers due to transportation and other needed support and personal barriers due to poor social skills, low literacy levels and other factors influence client satisfaction and access to needed health services. One RHSI participant said, "I'm black, I'm not stupid" summing up her frustration with social services after applying for assistance. The challenge is to retain clients in RHSI services and to help them find solutions to meet their needs and increase the probability of resulting in improved health status.

Barriers to care are a frequent topic of discussion in community meetings. RHSI's goal is to get stakeholders thinking about access to care as it relates to financial, structural and personal barriers and to assist them in a process to improve their own service delivery systems.

- c. RHSI planned to hire a care coordinator for the project period but has been unable to do so due to barriers described in previous sections of this report. The budget deficit and transitional nature of leadership in RCDPH created barriers to hiring the RHSI care coordinator. RHSI contract case managers continued to perform the task of coordinating client care and follow up for client referrals. Quality assurance was the responsibility of the contractors' lead agencies including the Department of Mental Health Mental Retardation Substance Abuse Services, CHIP of Virginia and Healthy Families America.

- d. A goal of RHSI has been to reduce duplication of services and increase the capacity of the community based organizations providing

Healthy Start services. RHSI invested a lot of time and effort assisting contractors to participate in the RHSI evaluation, which generated standard procedures for data collection. As the MCHB established reporting requirements and the required data elements changed, procedures had to be revised. However, having gone through the process of developing a data collection protocol before, contractors are poised to make adjustments with ease.

5. a. Difficulties associated in maintaining client participation in program activities have been discussed in previous sections of this report. Essentially it is the responsibility of RHSI to honor the client's decision to participate or not participate in RHSI activities. RHSI can respectfully offer options to increase client involvement, but at the end of the day, it's our job to make their life less stressful, not more. Adding a voluntary activity to their schedule is asking a lot of people who already have more than they can manage. Involvement that provides short-term benefits to participants such as cash incentives would most likely result in increased and extended participation of clients.

RHSI worked closely with the Richmond Partners in Prevention Program (RPPP) at RCDPH to provide educational and mentoring services for African American males in Richmond. RHSI has a keen interest in restoring black fathers to black families and the collaboration with RPPP was an opportunity to enhance our understanding of African American gender relations from a male perspective.

B. Impact to the Community:

1. It's hard to estimate RHSI's reach in terms of impact on community knowledge of resources, location, etc. Secondary data shows a decrease in African American infant mortality during the project period and preliminary data for 2004 show the rate decreased even more. Given that word of mouth is a major source of referral for Healthy Start, it's certain that some dialogue is taking place in the community and it could also be assumed that many types of information are discussed including resources, service availability and location and how to access the services. This is not measured by RHSI however and these comments are supposition.
2. The Richmond City Department of Public Health ended a contract with Virginia Commonwealth University Health Systems for prenatal care last year and began providing the service in January 2005. Also in 2003, the Richmond City Manager charged his Chief of Staff with reducing infant mortality in the city. The new Mayor Elect L. Douglas Wilder continued to make infant mortality a high city priority. As

stated previously, the infant mortality rate in Richmond declined during the project period.

3. RHSI struggles most with powerful persons and organizations that make shallow attempts to act collaboratively and dismiss their failure by finding blame elsewhere. Typically the problem is with another person or thing that has somehow done something wrong. Their opinion is so strong that it effectively halts any opportunity for discourse. This type of behavior is very difficult to work with because in this case being right is more important than doing what is right.
 4. RHSI cannot comment on the creation of jobs in the community.
- C. Impact on the State: The Virginia Department of Health (VDH) is the state Title V agency and also has a Healthy Start program. RHSI and VDH have a collegial relationship through both Title V and Virginia Healthy Start. Representatives from Title V attended RHSI Consortium meetings during the project period. RHSI also has frequent contact with local Title V and Title X and assisted both with writing reports and proposals during the project period. RHSI also initiated a collaboration to standardize case management practices across all RCDPH case management programs but discontinued the work because of personnel changes implemented by a previous RCDPH director. RHSI and Virginia Healthy Start's most successful collaboration was with partnership funds allocated by MCHB specifically for partnership activities.

The major benefit of collaborating with the state was the ability to implement larger scale projects. For example, the partnership collaboration between RHSI and Virginia Healthy Start was piloting PRAMS in Richmond City and Norfolk, Virginia. The data gathered from PRAMS was useful throughout the project period.

The RHSI Project Director was appointed by then Virginia Governor Douglas Wilder, (currently the Mayor of the City of Richmond) to serve as a parent representative to Virginia's State Interagency Coordinating Council (Early Intervention Services - EIS) and currently serves as the RCDPH's representative to Richmond's Infant and Toddler Connection (local EIS). A joint project by RHSI and EIS included a brochure for families describing early intervention services in Richmond. The project director serves as the Vice-Chairman of the Richmond Behavioral Health Authority and the Vice-Chairman of the Partnership for People with Disabilities.

- D. Local Government Role: RHSI's involvement with local government as it relates to other issues has been discussed throughout this report. The major barrier at the state and local level is that support from state and local officials is subject to political will. For this project period, funding was

awarded from the state department of social services to improve marriage initiatives and relationship building initiatives. Also, the state department of health made available funding to serve siblings of pregnant and parenting teens (GEMS) in an effort to reduce teen births, and increased funding to support the prevention of out-of-wedlock births, in adults ages 20-29 (PIP). These grants were awarded to programs within Family and Child Health where the Healthy Start Grant is located. Some of the healthy start program participants and staff attended workshops/sessions funded by these programs. However, it is necessary for state and local officials to commit to the long haul and increase allocated resources to sustain this kind of work.

- E. Lessons Learned: Lessons learned have been discussed throughout this report.

VI. Local Evaluation

The Survey and Evaluation Research Laboratory (SERL) at Virginia Commonwealth University provided technical assistance for program coordination and evaluation services during the project period. SERL has been the local evaluator since 1994. Collaboration is highly valued and infused in RHSI practices, so when staff was needed at RCDPH, SERL agreed to provide a program and policy manager for technical assistance to coordinate RHSI program activities. This was believed to be a temporary solution until staff vacancies were filled at RHSI, however for reasons described in other sections of the report, this arrangement continued throughout the project period. With evaluation dollars redirected to TA for program activities, funding for evaluation beyond basic evaluation activities of monitoring and reporting were limited. However, SERL conducted a pilot of the Centers for Disease Control and Prevention's, Pregnancy Risk Assessment Monitoring System (PRAMS) during 2001 and completed data analysis of fetal and infant deaths in Richmond City using the World Health Organization's Perinatal Periods Of Risk (PPOR) model in 2002. The primary evaluation objective has been to assist RHSI contractors to collect and report the Healthy Start Data Reporting Requirements (HSDRR) when these were approved and required in the Spring of 2003.

Please see Attachment C for more complete description of RHSI local evaluations for the project period.

VII. Fetal and Infant Mortality Review (FIMR)

RHSI has funded the Central Commonwealth Perinatal Council to provide case reviews of infant deaths that occurred to mothers living in Richmond City since 1995. Getting a FIMR up and running is an extensive task. Actual case reviews did not take place until 1996, when the state's Chief Medical Examiner

requested that a record of fetal and infant death certificates were provided to FIMR staff. The project was fully implemented during the reporting period with over 100 infant deaths reviewed. RHSI also provided a small amount of funding to assist with establishing a maternal mortality review using the FIMR model in 2001. RHSI discontinued that funding in 2002 because the Maternal Mortality Review had a state-wide focus.

The FIMR process relies on notification from the Richmond City Department of Public Health, Division of Vital Statistics. With the exception of homicide victims, all infant deaths and select fetal deaths from 20 weeks gestation to one year of age are reviewed.

Information is gathered from the birth and death certificates, physician, hospital, and social service records of the mother and child. This information is abstracted by trained registered nurses using tools modified from the National Fetal Infant Mortality Review Program of the American College of Obstetricians and Gynecologists (ACOG). All identifying information is removed to protect the confidentiality of patients, providers and health care facilities. Cases are analyzed regarding demographics, education, environment, lifestyle, medical intervention, public health, access to services and compliance with physician recommended health behaviors.

Home interviews with the mother are voluntary and conducted by nurses, social workers or lay health advisors trained in bereavement counseling. This aspect of the program provides the opportunity for the visiting nurse to facilitate the grieving process, assess the family's needs and provide resource information and referrals. A panel of experts from the Richmond area conducts case reviews monthly. Case review is not a scientifically rigorous approach to determine cause of death, rather it is an opportunity to identify episodes of health care system failures and the reasons behind such failures. The purpose of FIMR is to understand how a wide array of social, economic, health, educational, environmental, and safety issues relate to an infant loss on a local level. The goal of FIMR is to enhance the health and well being of women, infants, and their families through improved community resources and service delivery systems.

Major accomplishments include public health campaigns on Back To Sleep, access to prenatal care, Hidden Hazards of Adult Beds for babies, multiple educational materials for prenatal clients and professional education in maternal and infant health. This program includes a dedicated group of members as well as the director and chairperson who have been with the program since the program's beginning.

VIII. Products

- Brochure on Early Intervention Services (placed in newborn packages at hospitals)

Richmond Healthy Start Initiative
Impact Summary Report

- Video on Immunizations
- Poster and Flyer on hazards of co-sleeping (FIMR)
- Bus Campaign with March of Dimes (low-birth weights)
- Back to Sleep T-shirts

IX. Project Data

Please see Attachment D (OMB approved Performance Measure)

Local Evaluation Report

Section I. INTRODUCTION

Local Evaluation Component

- A. Discuss the impetus for the local evaluation. How was the local evaluation designed? Were project staff involved in conducting the local evaluation or was the evaluation contracted out? If contracted out, identify the name of the contractor.

The local evaluation was contracted out to the Virginia Commonwealth University (VCU), Survey and Evaluation Research Laboratory (SERL). The name of the person for the evaluation is Dr. Judy Bradford. However, Marilyn McLean who was also involved in program coordination was also part of the evaluation.

- B. Present a brief history of the local evaluation and describe all components. Was each of these components the subject of an evaluation study? Were some components of the evaluation added, dropped or modified? Please explain.

The Survey and Evaluation Research Laboratory, Center for Public Policy at Virginia Commonwealth University has evaluated RHSI program activities since 1994.

Performance indicators required by the National Healthy Start have been tracked and reported accordingly. No major change in the design of the evaluation occurred through the project period. Attempts were made to modify current data collection system to allow case managers to enter ongoing case management activities (such as completion of medical appointments) and other performance indicators during the project period.

- C. Discuss the type of study (e.g., formative, process, outcome, SEE DEFINITIONS), and the involvement of the community and the consortia in conducting the evaluation.

A formative and outcome evaluation was conducted to assess the work of the Richmond Healthy Start Initiative. A formative evaluation examined how the objectives and activities were implemented to accomplish proposed program goals. Performance objectives listed in the program narrative were also assessed as the project's outcome measures.

The RHSI evaluation plan consists of three major goals; 1) monitor program implementation and development using MCHB minimum data sets, participant profile, major services data and outcome performance measures recently standardized across contractors 2) assess the impact of city wide maternal child health system coordination, linkages and integration of community resources 3) develop conceptual framework and instruments to measure increases in knowledge and change in behavior relative to health education efforts.

The evaluation continued to emphasize collection of data elements identified by MCHB for participant profile, major services and outcome performance measures. Core evaluation instruments for data collection purposes include the 1) Client – level Uniform Reporting System (CURS), a client level data reporting system for contractors and selected non – contractors. Non – Healthy Start data is not included in the annual progress report or calendar year report. The 2) Quarterly Implementation Progress Report (QIPR) which was used as a planning and monitoring document prepared by contractors and the RHSI administration/consortium to describe progress made towards stated goals and objectives on a quarterly basis.

CURS data were collected and submitted monthly to SERL. Each contractor was responsible for the quality and accuracy of their own data. SERL provided monthly aggregate reports to RHSI as well as individual contractors. The ability for contractors to create their own reports were included in the modification made every year.

Local also assessed the impact of the RHSI on city wide maternal child health system coordination, linkages and integration of community resources. In the past, the Inter-Organizational Survey was administered to gather information describing the state of collaboration among RHSI Consortium members only.

Key Questions/Hypotheses

Discuss key questions and hypotheses the local evaluation addressed.

The local evaluation along with the contractors assessed infant mortality rate attributed to unsafe baby sleeping behaviors. The finding indicated that significant number of infants died as a result of unsafe sleeping practices. As a result the RHSI implemented mass education campaign on safe sleeping practices.

Section II. PROCESS

- A. Discuss the procedures for conducting the local evaluation. Describe the role of the community or consortium in conducting the evaluation. Discuss the methodology (ies) in the local

evaluation (e.g., case study of five agencies, secondary analysis of vital records data, pre and post interviews with women participating in health education, etc.). Describe the sampling design, if any and any comparison or control groups used.

Data for the evaluation were primarily generated from the recipients of the RHSI. Individual level data were collected by the contractors and were reported to the SERL on a monthly basis. The SERL aggregates the data and provided report to the contractors/consortium.

Additionally, Pregnancy Risk Assessment Monitoring System (PRAMS) like survey was conducted in the city. The survey was conducted by recruiting women who had a baby and following them for 6months. The PRAMS like survey provided information on:

- To assess maternal and child health indicators (e.g., unintended pregnancy, prenatal care, breast-feeding, smoking, drinking, infant health).
- To enhance information from birth certificates used to plan and review state maternal and infant health programs.
- To provide comparable data among participating states.
- To identify groups of women and infants at high risk for health problems, monitor changes in health status, and measure progress towards goals in improving the health of mothers and infants.
- To plan, evaluate and review programs and policies aimed at reducing health problems among mothers and babies.
- To identify other agencies that have important contributions to make in planning maternal and infant health programs and develop partnerships with those agencies.

The local evaluation also completed data analysis of fetal and infant deaths in Richmond City using the World Health Organization's Perinatal Periods Of Risk (PPOR) model in 2002.

The primary evaluation objective has been to assist RHSI contractors to collect and report the Healthy Start Data Reporting Requirements (HSDRR) when these were approved and required in the Spring of 2003.

- B. Identify and describe the data sources.
 - Report from contractors on performance indicators
 - Survey (PRAMS)
 - Vital Statistics Data
 - Fetal Infant Mortality Review Data

- Key informant interview

- C. What measures were used? Describe any instruments used. Measures included the performance indicators required by the Nation Healthy Start – to gather the data local instruments were developed to capture the data. (refer to section I-C above)

Survey instruments were also developed to conduct the PRAMS like survey
Survey instrument were also developed to assess inter-organizational relationships.

Section III. FINDINGS/DISCUSSION

Present the findings of your local evaluation including a discussion of any methodological limitations of the evaluation (e.g., completeness and quality of data, and response rates to survey instruments).

Overall, the local evaluation found that RHSI employed strategies using Healthy Start core services to accomplish 15 project period performance objectives aimed at eliminating disparities in perinatal health in Richmond City. At the beginning of the project period (2001), the African American infant death rate was 25.2 per 1000 live births. In 2004, African American infant death rates were 18.0 deaths per 1000 live births.

Barriers to success have been discussed in previous sections of this report. Briefly, national, state and local budget deficits affected RHSI's ability to hire staff in a timely manner when the hiring freezes were imposed that extended into the Fall of 2002. Frequent changes in RCDPH leadership disrupted implementation because each new leader had to be educated about RHSI and most often made major changes to the way things were done to suit their personal preferences, not out of necessity.

The major challenge for the evaluation was completeness and quality of data obtained from several sources. Furthermore, it was difficult for each contractor to collect and maintain consistent data. Data collection was mainly affected by sources of funding and inter-agency requirements.

Section IV. RECOMMENDATION

- A. Present all recommendations that stemmed from the local evaluation. Please be sure to include policy, program, practice as well as other recommendations.
- 1) Major city wide health education campaign was conducted to educate families on safe sleeping behaviors for babies.

- 2) From the PRAMS like survey we were able to identify the issues:
 - Post partum depression which lead to training of service providers and program planners on the issue
 - Major stressors were identified as major problems for pregnant and post partum women which provided information to strengthen case-management services provided by the contractors
 - The issue of women in violence particularly domestic violence was also shown as a major issue in women
 - The prevalence of women who breast fed their children was also found to be lower which calls for action
- 3) Inter-agency and intra-agency communications: there was several service providing and non profit organization that provided services to the same target population.
- 4) Data share – currently data is being collected by several agencies that work with women and children in the city. Recommendation has been made to improve sharing of information

Discuss directions for further evaluation studied that emerged from the local evaluation.

In the future local evaluators should work on:

Obtaining consistent and accurate data from contractors.

Web based data collection and utilization of data by contractors

Methods for improved utilization of data by contractors and other agencies in the city providing public health and social services

Identify research questions and hypothesis to provide evidence for best practices

Plan for dissemination of information

Community participation in obtaining and utilizing data

Section V. IMPACT BASED UPON THE RECOMMENDATIONS /RESULTS OF THE LOCAL EVALUATION

- A. Describe changes in the perinatal system or any impact on the community in general that resulted from the local evaluation recommendations.
 - Awareness that lead to educational campaign to promote safe baby sleeping practices
 - Awareness of the impact of post partum depression that lead to several training of health care and public health practitioners
 - Inter-agency collaboration and communication to address the

needs of women and children in the city which lead to the creation of a consortium

- Awareness of disparities in perinatal health that was brought to the attention of local policy makers

Describe changes in project implementation, management or administration that resulted from the local evaluation results.

Impacted resource allocation – provided evidence to allocate healthy start and health department funding.

Address domestic violence issues in case-management

Improved referrals between agencies

Identification and referral for post partum depression

Section VI. PUBLICATIONS

Identify all publications resulting from the local evaluation(s) conducted. Give source, title and author(s). Place copy (ies) of any publication(s) in the appendices.

No peer-review publications. However, a monograph was published that was shared in the city on the PRAMS like study