

HEALTHY START IMPACT REPORT

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

Disparity of Focus and Needs Assessment

The focus of the Genesee County Healthy Start initiative is the disparity between the infant mortality rates of African Americans and whites in Genesee County and Flint. A comprehensive needs assessment, which was accomplished during 1998-2000, included a specific focus on the state of maternal and child health within the county and city. In addition to quantitative data from sources such as the Michigan Department of Community Health, the Genesee County Health Department, area hospitals and numerous community agencies, it included qualitative data from community members during two different assessment periods. The first community data source contained written surveys by 120 low-income families and 38 providers, plus information from 23 focus group participants obtained in 1998. The second community data source contained information gained from 32 community focus groups under a one-year planning grant from the Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health (REACH 2010) during 2000.

1. Birth Data

Infant mortality data highlighted the disparity between African-Americans and other racial and ethnic groups. Between 1996-1998, the infant mortality rate among African Americans in Genesee County was more than twice the white rate (21.4 compared with 8.9) and more than three times the state's white rate of 6.1. The infant mortality rate for African Americans in Flint for this three-year period was 19.4, over the state's African American infant mortality rate of 17.3 and well over the state's white rate of 6.1.

The racial disparities between Low Birth Weight (LBW) and Very Low Birth Weight (VLBW) infants are even more striking. As noted above, 28% of all infants born in Genesee County during the three-year period of 1996-1998 were African American. However, 42% of all LBW infants born during that period were African American. In Flint, 54% of all infants born between 1996-1998 were African American yet 65% of all LBW were African American and 67% of all VLBW infants were African American.

2. Adequacy of Prenatal Care

The disparities between African American and white Genesee County and Flint mothers and their levels of prenatal care were also significant. In 1999, 86.9% of white mothers in Genesee County received adequate prenatal care whereas only 70% of African American mothers did. Further, 22.9% of African American mothers received intermediate care whereas only 10.4% of white mothers did. And 7.1% of African American mothers received inadequate care compared with only 2.7% of white mothers.

3. Entry into Prenatal Care

A review of 1999 statistics of the percentage of mothers with prenatal care beginning in the first trimester also revealed a disparity between white and African Americans. In Genesee County, while 83.7% of all pregnant women entered care within the first trimester, 88.7% of white women entered care within the first trimester whereas only 71.3% of African American women entered within the first trimester. This same disparity exists in Flint; while 77.4% of women entered care in the first trimester, 85.4% of whites entered care within the first trimester whereas only 70.2% of African American women entered within the first trimester.

4. Provider and Consumer Input

Qualitative data was gathered from different sources at two different times. One process included written surveys of low-income families and providers and focus groups conducted in 1997. The second process was composed of 32 community focus groups conducted during the summer of 2000 with a planning grant from the Centers for Disease Control and Prevention to reduce disparities in infant mortality under its REACH 2010 Initiative.

The 1997 Community Information Process: In 1997, community members, providers and parents of young children who were already enrolled in several ongoing programs in Flint offered their insight and perspective on infant mortality. Individuals participated or responded to family surveys, health care provider surveys, Flint Family Road focus groups or Genesee County Health Department focus groups. A total of 120 families and 38 providers responded to the written surveys and 23 individuals participated in the focus groups.

Family surveys identified lack of knowledge about reducing risk factors, such as smoking, as a major barrier to having healthy babies. The surveys from the providers/health care professionals identified teen pregnancies and a lack of information related to risk factors. Providers emphasized the need for education, risk reduction including smoking cessation and substance abuse counseling and family planning.

Transportation as a barrier was ranked highest by families participating in two focus groups. Providers who work with pregnant women and infants ranked transportation as one of the top two problems.

Lack of child care was also ranked as one of the most significant barriers to perinatal services by families, providers and focus group participants. A common theme from families and focus group members was the high cost of child care and a concern about the child care facilities and providers that were affordable and available to them.

The 2000 Community Information Process: In the summer of 2000, community members and providers again offered information as part of a planning grant from the Centers for Disease Control and Prevention's REACH 2010 Initiative -- Racial and Ethnic Approaches to Community Health. Views such as the need for enhanced social support in the African American community, education and environmental concerns, disparity in insurance coverage, frustration with the health care provider system, racism, lack of parenting skills, structural distrust and cultural disintegration were expressed. Local Fetal and Infant Mortality Review (FIMR) findings were examined; "trench" analysis through structured focus groups was performed; public presentation and reaction sessions were held; and a major community-wide forum was sponsored. The new knowledge which grew out of this process led to the development of a four-year Community Action Plan titled *Justice in Health: A Community Under Construction*. This Community Action Plan formed the strategic vision for our community and a way to organize the conceptual framework, practical relationships, and specific activities to address infant mortality and racial disparities.

5. Target Population Identified

As a result of the comprehensive needs assessment, the target population chosen was high-risk pregnant African American women and/or infants up to age two who were living

in three zip codes: two in the City of Flint (48503 and 48504); and one in what is known as Beecher/Mt. Morris Township (48458). These three zip codes are three of the four areas targeted by our local health system action plan (*Justice In Health* initiative). The fourth zip code (48505) is served through the REACH 2010 project. Among these four zip code areas are the highest infant mortality rates and the highest African American infant mortality rates in Genesee County and Flint.

II. PROJECT IMPLEMENTATION

A. Outreach and Recruitment

1. Approach and Rationale

The five partner organizations -- FACED (Faith Access to Community Economic Development), Flint Family Road, Genesee County Health Department, Genesys Home Health and Hospice and Hurley Medical Center -- encounter low-income, high-risk pregnant African American women and infants throughout their respective programs and services. However, some women and infants continue to “fall through the cracks.” For myriad reasons, many delay prenatal care or do not continue after an initial prenatal visit. Staff sometimes first encounter high-risk infants in the hospital’s neonatal intensive care unit, thus they do not have the opportunity to work with the mother during the pregnancy.

Given this knowledge and these experiences, our outreach and recruitment strategies were grouped into four approaches. They included: Outreach by Partner Agency and Staff, Outreach by Community Members, Outreach by Clients, and Outreach by Physicians.

2. Components, Resources, and Changes over time

Outreach by Partner Agency Staff: Often it is non-clinical staff at an agency, such as the receptionist or an administrative manager, who recognize a woman or infant at risk. Through staff education and agency presentations, we planned to create a heightened level of consciousness amongst all staff within our partner organizations about the Healthy Start program and the target population. In this way, staff could help identify high-risk clients who would benefit from our Healthy Start program.

Outreach by Community Members: Outreach that is confined to our partner organizations will miss many in our target population or will bring them late into the program. To address this, Maternal Infant Health Advocates (MIHAs) who live in our target area and have experienced many of the same issues faced by our target population, were hired into the Healthy Start program. These MIHAs provide advocacy as well as engage in client outreach and recruitment. They bring to their work a personal commitment to helping other women who are now where they “have been.” Our MIHAs are an integral part of the care team who provide or assure needed services for pregnant women and their infants from the time of enrollment into the program until the infant’s second birthday.

To initiate community outreach, the MIHAs scheduled and conducted presentations at various sites to assist staff and community residents in understanding the project, its scope of services, the value of utilizing these services, and its link to the issue of racial disparity in infant mortality among African Americans in Genesee County. Our community outreach efforts are also akin to our staff education efforts - designed to

create a community consciousness about both the program and the needs of our target population. Community residents then become informal outreach workers for our program.

Outreach by Clients: Clients involved in a program are frequently the most effective outreach workers. They have direct experience with the program and its staff, and can serve as a role model for their pregnant relatives, neighbors or friends. Current clients regularly refer others into the program. In addition to helping meet clients' needs, the Healthy Start staff provides clients with program information they can share with others in need.

Outreach by Physicians: Physician involvement is a critical component of our outreach strategy. As a function of outreach, physicians have been asked to participate in community presentations that address issues of infant mortality, pre and post natal care, healthy lifestyles and patient involvement in care plans. Opportunities for cross fertilization of both ideas and strategies through dialogue and information exchange between physicians, their patients, and the care team (described below in the section on Case Management) have been critical to our success.

Outreach was coordinated with existing efforts in order to strengthen our ability to reach hard-to-reach women. Several of our partner agencies were already engaged in outreach. All existing outreach efforts at each organization were identified and strategies developed to take advantage of these efforts to refer eligible clients to Healthy Start. All outreach activities, as with all activities of the Healthy Start program, are under the direction of the Healthy Start Coordinator. A Healthy Start Coordinating Team, consisting of representatives from each of the five partner agencies, meets regularly to provide program oversight and direction and to ensure collaboration.

The Healthy Start MIHAs are housed at FACED and are under the direction of a MIHAs supervisor (currently a Masters-prepared registered Nurse). This arrangement assures experienced supervision and direction of our outreach workers within an agency whose mission is to work directly in the community. It also provides a "home" for them with other outreach workers and community advocates, expanding opportunities to share program information and enable others to help identify at-risk women for our program.

Changes over time included increased church-based outreach activities, increased involvement of fathers, recruitment through FACED support groups, and the addition of health fairs and other health-related events. All proved to be effective resources for outreach and recruiting.

3. Resources and Events

Detractors from successful implementation were often the result of the diminished overall resources available due to federal, state, and local budget reductions.

Until January 2003, a portion of Title V funding was used to support Medicaid outreach and enrollment efforts to reach women and children. Staff provided pregnancy testing, outreach, enrollment and referrals to community programs. As a result of the state budget cuts eliminating the Medicaid outreach and enrollment activities, three staff positions were eliminated. Remaining staff who are familiar with Medicaid enrollment procedures continue to assist clients; however, it is not possible to provide the previous level of service. This has presented continuing and significant challenges for our

program and our clients.

An ongoing public misconception regarding the nature of FACED services has also been a detractor. The public and other providers often believed that the primary mission of FACED was to provide items such as diapers and other baby supplies, rather than efficacy-building services such as advocacy, support, and goal-planning. Erroneous expectations sometimes resulted in disappointment on the part of clients and impacted recruitment and retention.

B. Case Management

1. Approach and Rationale

Our proposal utilized the strengths, assets and experiences of the three existing maternal infant support programs in Genesee County – the *Maternal Support Services* (MSS) and *Infant Support Services* (ISS) programs provided through Hurley Medical Center and Genesys Home Health and Hospice, and the *Maternal Infant Health Advocates Services* (MIHAs) program provided through FACED – along with a community-based comprehensive infant mortality reduction program, *Flint Family Road*; the existing *Healthy Start Consortium*; and our *county public health department* as its core.

The MSS and ISS programs are Medicaid-funded programs established by the State of Michigan to reduce infant mortality and morbidity among Medicaid recipients. MSS and ISS provide services through an interdisciplinary professional team consisting of a social worker, registered nurse, and registered dietitian. The MIHAs program provides community advocates (called MIHAs) to seek out, assist, advocate and provide referrals for pregnant women and infants. Flint Family Road is a community-based infant mortality reduction program that links comprehensive services for low-income families with an education program in a “one-stop shopping” setting. The Genesee County Health Department, in addition to providing outreach and direct services to low-income women, coordinates numerous programs and services for mothers and infants.

The Genesee County Healthy Start envisioned clients joining the program through a variety of entry points, such as meeting a MIHAs at a community presentation, entering prenatal care at Hurley Medical Center, attending a class at Family Road or visiting their hospitalized infant at Genesys Regional Medical Center (the parent organization of Genesys Home Health and Hospice). If a client is interested in becoming part of the program, staff at any one of these points of contact can complete parts of the assessment tool that are appropriate. The form will then be sent to the Healthy Start Coordinator, who assigns the client to a care team. The care team then determines how best to complete the rest of the assessment.

2. Components, Resources, and Changes over time

Interdisciplinary Care Team: Upon enrollment in the Healthy Start program, each client is assigned to a care team. This care team is an interdisciplinary team consisting of a nurse, social worker, dietitian and a MIHAs. Teams are drawn from three existing programs: the nurse, social worker and dietitians come from Hurley and Genesys’ MSS/ISS programs; the MIHAs come from FACED. The team meets bi-monthly to case conference each client’s care plan, progress and needed changes.

Individualized Care Plans: All clients are assigned to a care team. The team conducts

an assessment and develops an individualized care plan designed to address the needs of the family and to ensure a healthy birth and infancy. Services by the care team are provided in-home, with referrals to other services as needed. Additionally, all clients receive health education. Clients receive services until their infant reaches age two.

Case Management services: The Healthy Start Initiative was designed to assure all at-risk African American pregnant women and African American infants in the three targeted zip codes have access to case management services that include:

- A support team consisting of a registered nurse, registered dietitian, social worker and community advocate to provide a range of services from point of entry through the infant's second birthday. One or more of the team members provides regular home visits with the mother and infant. Referrals and linkages to services for both mothers and infants are provided, including not only prenatal and well-baby care but also housing, job training, education, food and other needs that help ensure a healthy infant. Transportation and emergency assistance are also available as needed.
- A uniform assessment tool that encompasses the data needs from all partner agencies so that clients are not asked to provide the same information multiple times to multiple providers.
- Uniform case management protocols that are utilized by all team members to ensure consistency among service providers.
- Education programs that provide information on infant care, nutrition, money management, healthy promotion/prevention, child and infant safety, housing, transportation, family enhancement and other needed skills and information.
- A specific adolescent-based education curriculum for teen mothers.
- Programs that target specific interventions directly related to birth outcomes, such as: smoking cessation; prevention, early identification and treatment of HIV and STDs; and substance abuse prevention education.
- Ongoing support groups.

Changes over time included: a changed approach to the educational component and greater emphasis on the need for training. In addition to education provided during home visits, Flint Family Road provides an educational component (Healthy Start Classes). In an effort to overcome the challenges of attendance, the staff from Flint Family Road was integrated into the Care Team to facilitate participation in the classes. Additionally, certain trainings that were previously available (state-conducted trainings) to MIHAs and MSS/ISS were discontinued. Participation in workshops, conferences, and other trainings from outside organizations proved to be inadequate. Ongoing, comprehensive, planned trainings, facilitated by the Health Department, have been emphasized.

3. Resources and Events

Detractors centered around staff training and case conference procedures. As the project progressed, the severity and multitude of our clients' risk factors became obvious and required greater staff skill development than originally anticipated. As discussed in the above paragraph, the necessity of a more comprehensive and continuous staff training program was realized. Similarly, case conference procedures were further developed to provide structure and efficiency to case conferences.

C. Health Education and Training

1. Approach and Rationale

The health education and training component of our Healthy Start Initiative was designed to build upon the health education and training initiatives envisioned or already underway in our Community Action Plan. The health education and training plan was based on: utilization of the results from the needs assessment, application of a health behavior change model, and a broad strategy of “bringing the information to the people”.

Our training program has provided focused education and support for our Healthy Start direct service staff, the Healthy Start Coordinating Team, clients and the broader community on topics including: local infant mortality facts; infant safe sleep education; fire safety; community resources; and cultural competence in working with diverse populations.

Client education (identifying areas where new information is needed, where old myths need to be dispelled and where basic skills need to be imparted) was performed by staff during home visits and through the Healthy Start Classes. In addition to an educational curriculum, educational support groups were established at Flint Family Road and continue to be conducted through FACED

Health professionals participated in **community education** presentations that addressed issues of infant mortality, pre and post natal care, healthy lifestyles and patient involvement in care plans. In addition, the Healthy Start Consortium continued to undertake various community education activities which will be discussed in the Consortium section of this report.

2. Components, Resources, and Changes over time

Staff Education: Education for Healthy Start staff and coordinating team members includes ongoing training programs to help build cultural competence and the sense of being a team, various specific skills such as outreach, and knowledge of community resources and health education. Four program areas were identified: Cultural Competence/Team Building; Skills Training; Community Resources; and Health Education.

Client Education: As soon as clients are enrolled in the Healthy Start program, they are referred to Flint Family Road to participate in a 12-week structured educational curriculum that includes the following topics:

- Childbirth preparation
- Nutrition education and healthy cooking
- Breastfeeding
- Safety, including car seat safety, fire safety and use of smoke detectors
- Infant development
- Infant food/feeding
- Attachment/bonding
- Brain stimulation during the first two years
- Effective discipline

Support Groups: At Flint Family Road, women were to meet in groups of 8-10 monthly or more frequently for support, information, help and sharing. Under the previous Healthy Start grant, Genesys developed an adolescent-specific support group format that was very successful in engaging pregnant teens and sustaining their involvement. This format was modified for use with our current target population. FACED’s MIHAs

continue to offer monthly support groups at Flint Family Road that provided information programs in a relaxing, fun format.

Changes over time to the educational components resulted in: greater client participation; the development of a unique and comprehensive client curriculum; “brand” recognition of the Healthy Start initiative; and the establishment of therapeutic support groups.

Prior to the start of the 2001-05 grant cycle, the classes at Flint Family Road were varied subjects, provided by personnel from many agencies. The implementation of the Healthy Start curriculum offered a comprehensive, all-inclusive program that was specifically designed for our clients. The addition of transportation, child care, snacks, and “Loving Bucks” enhanced client participation. “Loving Bucks” are credits for new baby items that can be “purchased” from the store located at Flint Family Road. An African American nurse was recruited from a local hospital to teach the curriculum, and the continuity and skill she provides is evidenced by the positive client feedback.

As a result of consumer/client input at the Consortium meetings, the format originally planned for the Healthy Start support groups was altered. During discussions at several Consortium meetings and through focus groups, clients expressed the need and desire for support groups that contained a therapeutic focus. They recognized that confidentiality, group trust, and personal exploration were important to personal change. This could only be accomplished in a closed, therapeutic format lead by a trained person such as a Masters-prepared Social Worker. The support groups were implemented and have proven to be popular as well as successful. Evaluation feedback from clients is described in Section VI Local Evaluation. Women focus on understanding their own contribution to their lives and how to gain control so as to effect their desired changes. The confidentiality and group support has been invaluable to their emotional well-being. Women who assess for depression or other mental health issues, and are deemed appropriate for group activities, are offered the opportunity to participate.

3. Resources and Events

The major detractor to successful implementation was getting moms to the classes. This continues to be a challenge but has been partially overcome through follow-up phone calls, verification of transportation and child care, and integration of the Flint Family Road staff into the Care Team. Additionally, the class schedule has been flexible to accommodate client schedules.

D. Interconceptional Care

1. Approach and Rationale

The Healthy Start interconceptional services were to be conducted by the same Healthy Start staff that provided prenatal services. Though interconceptional services were not an initial grant requirement, they were a part of our original plan. A bio-psychosocial or holistic approach would be utilized with a shift in focus from prenatal health needs to long-term health needs such as family planning, chronic disease prevention and treatment, and parenting support services. Staff would emphasize the health and other benefits of lengthening time between pregnancies to 18 months or more. Staff would also provide child health education through activities such as assisting in tracking medical appointments and strongly emphasizing well-child visits. Finally, our Healthy Start program would offer different levels of individualized case management to

coordinate care as appropriate to each situation.

2. Components, Resources, and Changes over time

Women's Health: Identifying a medical home for interconceptional clients is a priority. Many women are ineligible for insurance after child birth, are in a challenging back-to-work transition, and/or have a gap in medical care and insurance. In addition, this is a critical time to assure access to family planning services to prevent unwanted repeat pregnancy. Staff will provide information and enroll clients in the Genesee Health Plan, a county health plan. Staff continue to promote family planning and connect women with local service resources. Clients receive monitoring, referral, and education for chronic health problems identified. Clients are also assisted with utilizing third party payment through their health insurance plans for transportation to medical appointments, or referred for transportation services.

Infant/child health: The Healthy Start program provides skilled medical services during home visits to infants and toddlers that include immunizations, full health screenings, growth and development checks, nutrition services, parenting education, and other services as needed. Referrals are made to health care providers as well as to the State Department of Human Services (welfare) or other organizations for additional services. Healthy Start staff also attempt to assure that infants have a primary care provider. The Healthy Start program tracks whether an infant received a newborn visit within four weeks of hospital discharge by inquiring during the home visit. The visit and information reported during the visit are documented in the client's progress notes. The level of case management for infants and toddlers is based on the need of the child

Changes over time included identifying strategies to better connect clients to insurance and a medical home, educate and motivate clients regarding the value of contraception, and adjusting to the reduced level of community resources to which clients could be referred. Additionally, the level of services began to be stratified in order to maximize personnel time and enable staff to provide the most services to the neediest clients.

3. Resources and Events

The major detractor was the dwindling availability of community resources, as well as the Medicaid cuts that began during 2005. Local community resources rely on state, federal, and local government funding as well as private sources. As a result of national economic down turns, decreases at all levels of government funding have affected local community resources. Private sources have also decreased or have not been able to compensate.

Events that facilitated successful implementation was the recognition that our clients desired a "family approach" to services that went beyond mother and child(ren) to include fathers and extended family. The strengths inherent in family involvement have become an important, highly beneficial element of our program.

E. Depression Screening and Referral

1. Approach and Rationale

Healthy Start perinatal depression screening services were to be conducted by the same Healthy Start personnel who provided prenatal services and interconceptional services, as part of the initial assessment. The Edinburgh Depression screening tool was

selected based on national recommendations. The scores would be used to determine risk level and appropriate services and referral. Because of the unique trust that may develop between the MIHAs and our clients, it was hoped that the MIHAs would also be helpful in identifying depression and facilitating services and referral.

2. Components, Resources, and Changes over time

Screening: Clients are screened during the initial assessment by nurse, social worker, or dietitian. The Edinburgh screening tool is utilized for all clients as it has been accepted as the screening tool of choice for our target population.

Education and Referral: Our Healthy Start staff educates clients about the signs and symptoms of perinatal depression and provide written material during home visits. Following a positive screen for depression and dependent upon client need, clients not already receiving mental health services are referred to a primary care physician, outpatient services at a mental health clinic, and/or our therapeutic support group.

Referral: Treatment services are offered through Community Mental Health and mental health clinics as stipulated by the Medicaid managed care plans. In addition, Healthy Start sponsors and funds a therapeutic support group which deals with issues of depression.

Referral Follow-up: The status and outcome of referrals made to mental health providers is tracked through self-reporting during home visits. The home visitor discusses missed appointments to determine the cause for the missed appointments and identifies strategies or assistance needed to attend appointments in the future.

Changes over time: It was identified that many women are receiving mental health services prior to Healthy Start services. As part of our screening, we will better record data regarding the prior and continued receipt of mental health services. In addition, we plan to repeat the depression screening twice during the time of service.

As discussed in the Education and Training section, it was identified in the second year of the project that clients needed and desired a closed, therapeutic format lead by a trained person such as an MSW. The support groups were implemented by Genesys using Healthy Start funding. Women who screen positive for depression or other mental health issues, and are deemed appropriate for group activities are offered the opportunity to participate.

3. Resources and Events

Detractors to successful implementation include: limited mental health services available to Medicaid recipients, lack of awareness of depression, stigma associated with treatment of depression, and lack acceptance of the need for mental health services.

Many of our clients as well as the general public do not recognize their own depression and are not generally aware of the symptoms of depression. In addition, there still exists a widespread stigma toward seeking mental health services. The number and myriad of barriers to receiving much needed mental health services will continue to be a challenge for our program staff.

F. Local Health System Action Plan

1. Approach and Rationale

“Justice in Health: A Community Under Construction” is the vision of REACH 2010’s four-year project. A Community Action Plan (CAP) was designed to address racial disparities in infant mortality and morbidity. It was developed over the course of 12 months by ten Genesee County agencies/organizations through funding from the Centers for Disease Control and Prevention. The CAP was submitted in July 2000, and a Phase II implementation grant was awarded in September 2000.

CAP interventions were designed to promote personal and health system change, such as cultural competency training among Flint area health care providers. Additional interventions include organizational changes designed to improve and coordinate important public health and medical services, such as perinatal services. Still other interventions are in the realm of primary prevention – to assist African American women before they become pregnant (or become pregnant again); to develop healthy attitudes and behaviors in young African American women and men; to support African American expectant and new fathers; and to create a more positive community cultural climate that promotes infant health. Finally, and significantly, the CAP promotes continued dialogue, advocacy, and community mobilization to address structural barriers, particularly racism, that create social conditions harmful to infant health. Thus, the CAP includes fundamental interventions aimed at healing racism in our community and offering a supportive and protective cultural framework for African Americans in the targeted geographic zones.

2. Components, Resources, and Changes over time

Our Healthy Start project contributed to the Local Health Systems Action Plan through; 1) merging the hospital-based Maternal/Infant Support Systems (MSS/ISS) and the community-based Maternal Infant Health Advocate Services (MIHAs), 2) the development of a referral system within GCHD that links WIC (Women Infants and Children Supplemental Food and Nutrition Education Program), Family Planning, pregnancy testing, and insurance services for the purpose of identifying and referring potential Healthy Start clients, 3) generating and participating in a steering committee that focuses on providing substance abuse services to pregnant women, 4) improved linkages with DHS (state welfare organization), 5) implementing a safe-sleep class that provided a complimentary crib to attendees, and 6) heightening the awareness of safe sleep practices to the extent that a community-wide safe sleep campaign was generated.

3. Resources and Events

Merging MSS/ISS and MIHAs has served as an important model and has effectively provided a cross-pollination of the strengths and skills of two pre-existing programs. In addition to linking the two services, working together has resulted in closer linkages of a variety of community-based organizations, health providers, and government agencies. **A mutually beneficial referral system** has helped to effectively and efficiently connect clients to services that are often difficult to readily identify. Through personnel, funding, and organizational changes, we have learned that a working referral system must be constantly cultivated to assure the most accurate and up-to-date information is disseminated.

The PRIDE (Programs to Reduce Infant Deaths Effectively) Medical Services Committee works to enhance the perinatal system of care in Genesee County. Following two

instances in which pregnant women were unable to access appropriate substance abuse treatment services, the Medical Services Committee began to address the topic. Although there are two existing local facilities specializing in substance abuse treatment services for women, the particular services desired were unavailable. Two local addictionologists along with the staff from the Regional Substance Abuse Coordinating Agency (also housed within the Genesee County Health Department) were invited to attend the Medical Services Committee and now attend regularly. The committee focused on a vision “to create a formal system to manage substance using pregnant patients in Genesee County.” In addition to formalizing a working relationship between the addictionologists and prenatal care providers, plans are underway to hold substance abuse trainings for physicians and their staff; finalize an algorithm of care for identifying and treating pregnant patients; designate a specialized assessment and treatment facility for pregnant women; and put into place widespread use of the 4P’s substance abuse screening tool in prenatal care settings.

G. Consortium

1. Approach and Rationale

The idea of a consortium for the Healthy Start Initiative provided a unique opportunity for key members of Flint’s ongoing infant mortality reduction efforts to step back, study their history and purpose, examine their collaborative efforts to date and discuss possible future roles and purposes. At the start of the 2001-05 grant cycle, there were three active and important coalitions in Genesee County focused on infant mortality. These were the REACH 2010 Team, the PRIDE Coalition and the previous Adolescent-focused Healthy Start Consortium.

Several activities of the previous Consortium were planned to continue with the new Consortium. These included: co-sponsoring conferences that focused on community progress made and lessons learned regarding reducing racial disparities in infant mortality; continuing to promote and distribute the *Family Pages* Resource Guide and client brochure; conducting Consortium training focused on issues of how consumers can be effectively involved as Consortium members and leaders; developing team building workshops; participating in Consortium trainings on the relationship of racial disparity and the perinatal system of care on infant mortality issues; and participating in REACH 2010 dialogue groups and anti-racism trainings.

2. Components, Resources, and Changes over time

Consumers continued to demonstrate an active voice in the Consortium by participating in the planning of programs, workshops and special events of the Consortium. Consumers will also continue to be invited to participate in non-Healthy Start sponsored community trainings and workshops on leadership issues, systems of care, infant mortality reduction strategies, racism and other topics that facilitate their active involvement in the Consortium and their leadership within it. The vision was that, over the next four years, these three coalitions/consortiums will be joined into one overall consortium whose focus will be on reducing racial disparities in infant mortality.

Providers participate regularly in Consortium activities. They have been very responsive by assisting with meeting support, education, information and referral, babysitting, and transportation.

Peer Helpers have been integral in the development of the Consortium as well as the Healthy Start Curriculum. Their hard work has been critical in recruiting, planning, and assurance of cultural appropriateness throughout all components of the Healthy Start initiative.

The Consortium has continued to **evolve over time** as local needs were clarified. During the second year the responsibility shifted from the Health Department to Flint Family Road. Moving the Consortium under a community based organization allowed for a greater voice from the community. The original plan to merge existing coalitions/consortiums was re-evaluated. Due to the number of organizations and groups addressing infant mortality (which has continued to grow), and the investment that each had made in their visions, we decided to work with each of them to align our focus and goals in a way that would be complimentary but not duplicative.

3. Resources and Events

There were several significant **detractors** to successful implementation, with one detractor also serving as a facilitator. As discussed in the above paragraph, the shifting of the Consortium to Flint Family Road was viewed as a positive change. The detractor in that process was the challenge for that organization, working with a limited budget, to make the transition to consortium leaders and facilitators while maintaining the structure and activities. Additionally, it has been a continuing struggle to identify successful strategies for full inclusion of our consumers into functioning leadership roles. The last detractor is the realization of the overwhelming needs and barriers of our clients to improving their health and the health of their children.

4. Consortium establishment, barriers that emerged, and how they were addressed

The Consortium was **established** in accordance with federal grant requirements. **Barriers** included the number of other infant mortality efforts and collaborative bodies that also existed. Folding these efforts under the Healthy Start Consortium was not possible and would not necessarily lead to any improvements in our local effort. The partnering organizations were all participating in one or more of the other collaborative bodies and we determined that our continued presence and the sharing of information would be more beneficial than a concerted (and probably futile) effort to become the one infant mortality collaborative body in Genesee County.

5. Structure of the Consortium, composition, and percent of active participants

The percentage of consumers participating in the consortium averaged 57.5% for the years 2002-2005. Provider participants averaged 34.7% for the 2002-2005 period, 76.8% of participants were African American and 18.6% were white. Further details are provided in the table below.

Year	Active Participants (attended 2 or more)	Total	Gender		Race			Type of Representation			
			F	M	AA	W	Oth	Cons	Prov	Gov	Oth
2002	27(34.2%)	79	73(92.4%)	6(7.6%)	55(69.6%)	19(24.1%)	5(6.3%)	29(36.7%)	41(51.9%)	9(11.4%)	0
2003	46(28.6%)	161	141(87.5%)	20(12.5%)	125(77.6%)	31(19.3%)	5(3.1%)	105(65.2%)	46(28.6%)	8(5.0%)	2(1.2%)
2004	33(23.9%)	138	128(92.8%)	10(7.2%)	111(80.4%)	21(15.3%)	5(3.3%)	92(66.7%)	38(27.5%)	4(2.9%)	4(2.9%)
2005	13(22.8%)	57	52(91.2%)	5(8.8%)	43(75.4%)	10(17.6%)	4(7.0%)	24(42.1%)	26(45.6%)	2(3.5%)	5(8.8%)
Total	119(27.4%)	435	394(90.6%)	41(9.4%)	334(76.8%)	81(18.6%)	20(4.6%)	250(57.5%)	151(34.7%)	2(5.3%)	11(2.5%)

6. Activities utilized to assess ongoing needs, identify resources, establish priorities for allocation of resources, and monitor implementation. Relationship with other consortia/collaborative service the same population
Assessing needs and establishing priorities for allocation of resources is accomplished through the budgeting process and is balanced against the limited funding. Additional resources are acquired through: in-kind facilities provided by Flint Family Road; speakers and resources provided by their parent organizations; referrals to other organizations; and in-kind resources tapped through the participation of non-Healthy Start funded staff and programming from Healthy Start partnering organizations and others. Implementation is monitored through monthly reporting to the fiduciary.
7. Community's major strengths which have enhanced consortium development
Infant mortality awareness has increased due to the totality of infant mortality efforts and projects in the county. Additionally, placing the Consortium under the Flint Family Road umbrella has enabled the emphasis of a community-based approach.
8. Weaknesses and/or barriers which had to be addressed in order for the consortium to be moved forward
The internal **barrier** was transitioning from the old consortium, which focused on adolescents, to a new, broader consortium. This necessitated recruiting busy adult consumers, who usually have to juggle jobs, family, and other children. The provision of babysitting, transportation, and dinner helped to get our adult consumers to consortium meetings and consumer participation has regularly exceeded 50%. Once there, we found that they needed a reason to come back. We have continually sought more and better strategies to engage consumers (and professionals) in the subject of infant mortality through the discovery of the consumers' personal circumstances, using this information to prioritize consortium activities. Lastly, various meeting locations were explored for a better meeting setting.
9. Activities/strategies employed to increase resident and consumer participation, and change over time
In addition to the comments in G.8., a number of activities and strategies were employed to enable greater and more meaningful consumer participation. Small group discussions were conducted on numerous occasions to gather recommendations for the Consortium. In 2004, two program participants were sent to the regional conference and reported the results at the next consortium meeting. At each meeting, a graduation ceremony is conducted and certificates presented to participants who complete the Healthy Start curriculum. Testimonials have proven to be beneficial. In 2004 a Consortium newsletter was developed that includes articles written by consumers.
10. Obtaining consumer input in the decision-making process
As discussed in the above sections, small groups have been quite beneficial. A focus group was conducted in 2003 and surveys are completed after each meeting.
11. Utilizing consumer suggestions
Activities, meeting topics, and speakers are entirely geared to the requests and suggestions from the consumers. In 2004 we held our first holiday celebration as the

result of program participant requests for more fun, family-oriented activities and rituals. In May of 2005 we began to invite dads to the meetings (as requested by consumers). In 2003 we began our therapeutic support groups (discussed in C.2.), which were a direct result of consumer requests during consortium meetings.

H. Collaboration and Coordination with State Title V and other Agencies

1. Approach and Rationale

Ongoing collaborations between GCHD, the Healthy Start Initiative in Michigan and the Michigan Department of Community Health (our state's Title V Agency) had occurred for several years prior to the inception of this grant. These activities and relationships were expected to continue during the grant period. The GCHD and all Healthy Start partners participated in and/or conducted a wide range of activities that relate to maternal and child health. All of these activities were expected to continue during the grant cycle. Additionally, the Genesee County Healthy Start partners planned to participate in any new efforts that related to maternal/child health. The rationale behind our approach was to foster comprehensive collaboration by seeking any and all collaborative opportunities to improve services, identify and reduce racism and disparities, identify and reduce gaps in services, and bring a consumer voice to all maternal/child health-related activities.

2. Components, Resources, and Changes over time

GCHD Coordination with Title V: GCHD receives Title V funding to support a range of services for pregnant and parenting women, including Children's Special Health Care Services to pay for specialized medical treatment, equipment and supplies for children with long term health conditions; the Fetal and Infant Mortality Review (FIMR); and grief counseling for infant deaths. Healthy Start is collaborating with Children's Special Health Care Services (CSHCS) to identify, cross-refer, and coordinate services. Local data gathered through FIMR is utilized to increase awareness and understanding of the contributing factors to infant mortality. As a result of budget shortfalls at the state level, funding for outreach and enrollment into Medicaid programs for pregnant women and children was eliminated from local health department budgets.

Michigan Healthy Start Projects Collaborative Network was launched by the Michigan Department of Community Health (MDCH) and includes all Healthy Start funded projects. There are three overall functions of this Network: 1) provide a forum to share and discuss barriers to success and how to overcome them, programs that have worked, procedures and forms, critical issues such as prematurity, teen pregnancy and domestic violence, evaluation strategies, administrative and sustainability issues, and potential collaborative projects and funding strategies; 2) provide a supportive atmosphere to mutually benefit all programs; and 3) share expertise obtained by an individual program or the Healthy Start network with other state or federal officials, policy makers, and funders.

Michigan Title V Block Grant: Our Healthy Start Initiative continued to share data with MDCH for inclusion in the report of Michigan's Title V Block Grant. This sharing of data will help improve information related to outcomes of Healthy Start participants and will help in long-term sustainability.

Collaboration with Key State and Local Maternal/Child Health Agencies: The GCHD and other Healthy Start partners collaborate with a broad array of perinatal providers and other public and private agencies. The PRIDE (Programs for Reducing Infant Deaths

Effectively) Coalition was established by the GCHD in the mid-'80's as a community-based consortium to address infant mortality and is composed of over 30 health and human services organizations, individuals and agencies in Genesee County. The PRIDE Coalition focuses on perinatal systems changes through work such as development of a county-wide uniform Prenatal Assessment Tool and health professional trainings in topics such as infant mortality and Cultural Competency. Three Healthy Start Coordinating Team members are active members of the PRIDE Coalition.

Closing the Gap and Friendly AccessSM are two collaborative projects lead by the Greater Flint Health Coalition, a local organization that addresses a broad array of health issues. All Healthy Start partnering organizations also participate in both projects. Closing the Gap focuses on reducing gaps in resources and services that impact African American infant mortality. Friendly AccessSM focuses on addressing health care access issues that impact health disparities among mothers, infants and children.

REACH 2010: The GCHD serves as the Central Coordinating Agency for REACH 2010. Three Healthy Start Coordinating Team members also serve on the REACH Team. The local REACH 2010 project focuses on reducing racial disparities in infant mortality by enhancing the baby care system, fostering community mobilization and reducing racism.

The *Fetal Infant Mortality Review (FIMR)* is an ongoing local effort for assessing, planning, improving and monitoring the service system and broad community resources that support and promote the health and well being of women, infants, and families. The information gathered from the process is used to develop recommendations to improve the overall perinatal system of care. The overall goal of infant mortality review is to enhance the health and well being of women, infants and their families. This is accomplished by improving the community resources and service delivery systems available to families.

Hamilton Community Health Network is a Federally Qualified Community Health Center delivering primary medical and dental services to the residents in the north end of Flint and the unincorporated area adjacent to it, including the Flint Enterprise Community Zone. One of its sites is located in one of the Healthy Start zip codes (48503), and some Healthy Start clients receive prenatal care at this site. Hamilton is an important contributor in Genesee County's efforts to reduce infant mortality. In 2003, GCHD began a partnership with Hamilton to provide services in a new and additional location in Burton, adjacent to the 48503 Healthy Start zip code.

The *Ready, Set, Grow! Passport Program* is a Genesee County-wide membership program providing pregnant women and parents of babies born after January 1, 1998 with information and incentives intended improve school readiness among children age 0-6 years. The Passport Director receives all information related to the Healthy Start Consortium and supports further collaboration in the community's efforts to achieve a more integrated maternal and child health service system in this county.

Priority Children is a non-partisan, broad based non-profit corporation of community volunteers and organizations that advocates for the improved quality of life for children and families in Genesee County. Healthy Start shared data with Priority Children in order to help inform their strategies on behalf of Genesee County children, and Priority Children regularly gathers and publishes data regarding child well-being in Genesee County.

Genesee County Healthy Start

Genesee Health Plan is a county health plan offering health benefits including doctor visits, prescriptions, lab tests and x-rays for low income adults age 19-64.

Hurley Medical Center Continuing Medical Education Department continues to partner with the PRIDE Medical Services Committee to hold CME events for local physicians.

The Greater Flint Health Coalition (GFHC) is a broad-based organizational partnership focused on improving the health of the citizens of Genesee County. As a member of both the PRIDE Coalition and the REACH Team, the president of the GFHC has committed to implementing the “Undoing Racism” components of the REACH 2010 Community Action Plan. A number of “Healing Racism” and “Undoing Racism” workshops took place from 2001 to the present. Key persons from health care organizations participate. The goal of these workshops is to increase the awareness of how the pervasive effects of racism affect health care, with the goal of improving the health care environment, reducing barriers to health care, and ultimately, eliminating the disparity in infant mortality. The GFHC also leads Friendly AccessSM, which addresses local health care access issues. Closing the Gap is the coalition’s most recent project that is designed to address African American infant mortality.

The *Neighborhood Roundtable*, a coalition of neighborhood organizations including block clubs and violence prevention groups that sponsor leadership training, networking meetings and activities related to important neighborhood issues, is one of the ten REACH partners. The Roundtable is a potential avenue for community presentations by MIHAS to provide information to promote community awareness about infant mortality issues, the role of MIHAS, and the Healthy Start Initiative.

The *Flint Community Schools* and the *Genesee Intermediate School District (GISD)* operate Project SKIP (Successful Kids=Involved Parents), expecting to reach 33,000 Genesee County families with a comprehensive network of services aimed at: early intellectual and literacy development in young children; creation of a stable family unit; establishment of strong, nurturing bonds between parents and children; early learning problem identification and intervention; and ensuring that children enter kindergarten with the foundation they need to succeed. The Ready, Set, Grow! Passport Program, described above, is the foundation for Project SKIP. The GCHD is one of seven agency partners, and the project involves schools in the Healthy Start zip code area.

Governor Granholm Challenge is a state-initiated effort that tasks local communities to identify gaps in services and resources that negatively affect school readiness. Two Healthy Start partnering organizations participate in this effort.

Planned Parenthood of East Central Michigan continued to participate in the Healthy Start Consortium. In addition, collaborative relationships will be sought with their services to ensure that Healthy Start clients have access to family planning services in addition to those offered by GCHD. Because Planned Parenthood conducts a number of adolescent-centered services, the Healthy Start Team has begun identifying mechanisms to coordinate those services with the adolescent-specific services described in the Healthy Start plan.

Collaboration/Coordination to Address Substance Abuse & Mental Health: As the

Coordinating Agency (CA) for substance abuse funding in Genesee County, GCHD coordinates a full continuum of publicly-funded substance abuse prevention and treatment programs in the county. Two residential treatment providers specialize in substance abusing pregnant women. The Women and Families Case Manager, located in the coordinating agency at GCHD, is integral in planning case management services for pregnant women and women with children who are in substance abuse treatment. The Women and Families Case Manager is also an active participant in the Healthy Start Consortium and refers to two existing women and children long term inpatient treatment programs. (i.e., Flint Odyssey House and Transition House). Division Directors in the Health Department with responsibility for substance abuse and maternal and child health activities have developed a closer working relationship over the past several years.

The Genesee County Department of Human Services (DHS) is an active member of the Healthy Start Consortium. DHS is the state agency that determines eligibility for Medicaid and other financial assistance to low-income families as well as the agency that operates Child Protective Services. DHS and GCHD maintain a close relationship. DHS refers clients to various services offered by GCHD, Mott Children's Health Center, and Flint Family Road. Because DHS and the GCHD are located in the same building, staff have established a collaborative working relationship and have developed mechanisms for reducing barriers to referrals.

3. Resources and Events

Detractors: Due to reduced Medicaid funding levels, the GCHD is no longer able to provide pregnancy testing and assistance completing MICHild and Healthy Kids (SCHIP) insurance applications. The Genesee County MIHAs program was discontinued in March of 2005 due to funding reductions from the State. This program provided MIHA services to women in the zip code areas of the county not reached through Healthy Start.

Facilitators: MISSING Links, a committee staffed by the GCHD, is a committee that was re-convened to improve coordination and collaboration among home visiting and support programs for pregnant and parenting women in Genesee County. Important partners such as health care providers, community-based organizations, social service agencies, health plans, and school system representatives are working to develop a systematic plan to promote existing programs, reduce duplication, and create seamless service provision.

I. Sustainability

1. Approach and Rationale

MSS/ISS and MIHAs outreach and case management services were two pre-existing programs operated by Hurley Home Health Care, Genesys Home Health and Hospice, and FACED using funds from sources other than Healthy Start. The allowable MSS/ISS visits authorized by managed care organizations and funded through Medicaid dollars were to be billed to Medicaid, though the clients would be identified as Healthy Start recipients from the time of their enrollment. Additional visits, as necessary, were to be funded by Healthy Start dollars. An existing community-based organization (Flint Family Road), which provides education and other services, coordinated with the maternal and infant support programs to implement the Healthy Start curriculum as an adjunct to case management. Speakers, funded through multiple sources, will be recruited from the existing Flint Family Road speaker roster, matched to topic area of the curriculum, and oriented to the Healthy Start curriculum component. The curriculum will be in place for

Flint Family Road to use on an ongoing basis with their clients.

The Consortium membership includes key members from existing maternal and child health organizations. Their participation in the consortium activities is important as they provide leadership for the organizational changes necessary to effect not only the implementation of Healthy Start but the sustainability of Healthy Start strategies and activities after grant funding ends. The Consortium continues to identify and recruit persons who: 1) are in a position to initiate and sustain change within their organizations; and 2) desire to champion “systems change” that will improve the perinatal health system community-wide.

2. Components, Resources, and Changes over time

MSS/ISS, WIC, and other services: Healthy Start activities are sustained by incorporating them as standard practice in MSS/ISS services, WIC services (including recruitment by WIC staff), including Healthy Start clients in educational support groups and baby showers which are provided through other funding streams and the Flint Family Road store which is funded through other means and provides incentives to Healthy Start clients who complete the Healthy Start curriculum. Continuing educational opportunities for Healthy Start staff are provided by other organizations through other funding streams.

The Health Department currently co-chairs MISSING Links, which includes Early On, Headstart, Genesee Intermediate School District, Healthy Start partners, Hamilton Community Health Network, and many other State and Local funded organizations. MISSING Links is focused on improving coordination of maternal/child health support service programs in Genesee County.

3. Resources and Events

Detractors: Funding shortfalls in state and local funding have affected all health-related organizations in Genesee County. This will have a short-term and long-term affect on sustainability. One particular example is the MIHAs program, which was funded through three sources, REACH, Healthy Start, and a state grant. The state grant was discontinued in March of 2005 and services to women outside the four REACH and Healthy Start zip codes were discontinued. The lack of other funding availability did not allow for any substitute funding to replace the loss of state funding thus far.

4. Managed care organizations and third party billing

As discussed in G.1., Medicaid HMO's are billed for home visiting and transportation services.

5. Major factors associated with the identification and development of resources to continue key components of interventions without HS funding

As discussed in G.3., the major factor that affects continuation of key components is the lack of available funding.

6. Major barriers overcome or negative impact decreased

Client transportation that cannot be funded through Medicaid HMO's is provided by FACED through a Community Foundation of Greater Flint grant.

III. PROJECT MANAGEMENT AND GOVERNANCE

A. Project management structure for majority of implementation

Fiscal and administrative management of this project has been under the direction of Robert M. Pestronk, M.P.H., Health Officer, Genesee County Health Department. Direct oversight was under the direction of Lillie Moore Wyatt, Director of Personal Health, Genesee County Health Department. As the fiscal agent, the GCHD provided oversight for the solicitation, awarding and monitoring of contracts and subcontracts.

A 1.0 FTE Healthy Start Program Coordinator was hired by the Genesee County Health Department to facilitate communication and collaboration among Healthy Start partners, the Healthy Start Consortium and others in the community-at-large, administer contracts and assure that work described in this proposal was completed. A Healthy Start Supervisor provided supervision to the Healthy Start Program Coordinator. A secretary was employed to provide clerical support for Healthy Start.

The Genesee County Health Department entered into contractual agreements with individual agencies, organizations and service providers including Hurley Medical Center, Genesys Home and Hospice Care, FACED, Flint Family Road and a consultant for evaluation services. These contracts delineated the scope of services to be performed, the time frame, costs, and method of reimbursement or payment. These were signed by the Genesee County Board of Commissioners, Director of the GCHD and the sub-contracting agency executive director. A staffing chart including positions within our partner agencies can be found below.

Healthy Start Initiative Staffing/Services Chart

Title	GCHD	Hurley	Genesys	FACED	Flint Family Road	Eval.
Supervisor	1.0 FTE					
Project Coordinator	1.0 FTE					
Project Secretary	1.0 FTE					
Healthy Start Nurse		X	X			
Healthy Start Social Worker		X	X			
Healthy Start Dietitian		X	X			
MIHAS				X		
Health Education					X	
Healthy Start Evaluator						X

Decision-Making Processes and Operating Relationships: The structure for our Healthy Start project provided for a smooth integration of relationships that facilitate decision-making. The project coordinator was housed at the Health Department and provided coordination of all activities. This, combined with housing the administrative and fiscal activities at the GCHD provides an integration of these functions that enhance the project. Second, the Healthy Start Coordinating Team, which is comprised of all of our partner organizations, was facilitated by the project coordinator, thus providing constant communication. Finally, all members of the Coordinating Team attended the Consortium meetings, enhancing communication between partner agencies and the Consortium.

The **governance of the program** consisted of a partnership approach among all the funded organizations. Though it was necessary for some funding and contract decisions to be determined at the fiduciary level, attempts were continuous to accomplish a multilateral

decision-making process that included all organizational managers. The participation and governance of two community-based organizations, two health care organizations, an evaluation team, and the public health department, facilitated a plethora of skills, perspectives, and resources that enriched project planning.

A Coordinating Team was formed, that was to meet regularly to provide operational level planning. The direct-service or “front-line” staff formed the Care Team. In the early years of the project these two groups (along with the organizational managers) were usually joined for meeting and planning but, as will be described in section C, a more effective and productive configuration was developed.

B. Essential resources for fiscal and program management

The funded partnering agencies identified various resources to be essential, though not funded by Healthy Start. Hurley Medical Center relied on in-kind resources through their accounting department, management personnel, and additional, but necessary, personnel time. Other infant mortality projects, such as REACH 2010 and PRIDE, provided personnel, referral, and other resources that were critical to successful implementation. Many community resources were important for referring our clients such as SKIP, YWCA domestic violence program, shelters, Catholic Charities, Heartbeat, DHS, WIC, insurances, Genesee Health Plan, Mott Children’s Health Center, and more. Connections among partners outside of Healthy Start activities, and to other organizations, greatly enriched our service provision.

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

As mentioned in (III, A.), the *decision making process transitioned* from a somewhat unilateral to a multilateral, consensus-building process that included managers from all the funded organizations. This was necessary in order to: effectively address components that needed more direction and structure; identify and resolve cultural competency issues; and improve communication. The staff meetings were re-organized to reflect three tiers: the managers or directors meet as a group to plan, strategize, address evaluation and quality assurance, and make programmatic decisions; the coordinators from each organization meet to carry out directives and accomplish operational level planning; and the direct-service staff meet in a structured format to develop and employ coordinated care plans for the clients.

Managers and staff have been pleased with the feelings of camaraderie and trust that have developed as a result of dividing into the Director’s Group, Coordinator’s Group, and Care Team. The intermingling of personnel from each organization, but at their own organizational level, has enhanced communication and productivity, and facilitated programming that better meets the needs of our clients. Separating front-line staff from Director’s meetings allows the managerial staff to freely analyze and problem-solve, and make decisions through consensus-building within their peer group.

As discussed in above sections, the *coordination of the Consortium transitioned* from the Health Department to Flint Family Road during the second year of the project. In the third year of the project, it was determined that more active support was needed from all partnering organizations in planning and conducting the Consortium activities. By enlisting staff from all the Healthy Start partnering organizations, improvements have been noted in

higher quality communication with clients, better use of limited funding, and more effective Consortium activities.

D. Process that assured the appropriate distribution of funds and changes over time

Three basic methods were used to determine the distribution of funds: 1) originally each partner identified what they needed and presented a budget to the fiduciary, 2) as funding requests grew and the Healthy Start budget remained at the same level, a more fiduciary-driven process was employed (the fiduciary determined the distribution of funds), 3) most recently a service-driven method from an evaluation perspective has been implemented, basing funding levels on prioritization of services and adapting a fee-for-service distribution method. The change in methodology was driven by stagnant funding and rising fiduciary costs. It became challenging to meet the federal mandates that dictate resource allocation in the face of climbing costs and local needs. As fiduciary costs rose, and in the absence of other local funding due to continual state and county budget reductions, partnering agencies' budgets were reduced. More open discussions over time with partners helped to develop and maintain positive working relationships. Unfortunately, alternate funding has not been entirely identified to compensate for reduced funding, resulting in some staffing changes in partnering organizations.

E. Additional (non-HS) resources obtained for quality assurance, project monitoring, service utilization

The Health Department employs an epidemiologist, who has been utilized for technical assistance and to meet data requirements for monitoring and reporting. Corporation Counsel has been consistently utilized to develop contracts, which address monitoring, quality assurance, and service utilization requirements. The Management Information Systems (MIS) department has also been utilized for database development and maintenance of computer assets, to include all software and systems functions. Hurley Medical Center utilizes their MIS resources to maintain their database and computer assets. Flint Family Road has contracted for technical assistance with their computer system.

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?

During the early stages of the project, staff interactions were difficult and at times affected staff-client interactions. Through open dialogue, it was recognized some of the problems were recognized as cultural competency–related issues. To address this barrier the meetings were re-structured to allow for more culturally sensitive communication, and interactions among staff were improved. This experience reinforced the importance of evaluating and addressing cultural competence deficits on an ongoing basis. The Coordinating Organization will continue to monitor and seek opportunities to build cultural competency within our project staff.

IV. PROJECT ACCOMPLISHMENTS

A. Barriers, Lessons Learned, and Corrective Action

Data Collection:

Mastering effective data collection was a continuing challenge. Developing and implementing a case management team through the unification of five organizations, utilizing preexisting program and organizational protocols, and supplementing with Healthy Start- specific protocols and tools without drastically increasing the volume of paperwork proved to be more difficult than was foreseen. Assessment and data collection tools were revised in 2005 and the database has been redesigned to accommodate the federal data requirements and produce a meaningful local evaluation.

A common focus on data collection was also difficult to establish. Direct service providers are focused on client needs and service provision. Managers are focused on budgets and meeting program requirements. Evaluators are focused on data. Communications planning between and among the three entities (and organizations) have now evolved to the degree where we have designed a comprehensive system to meet all needs without causing an overwhelming (and unrealistic) burden to the service providers. The new data collection tools and database have now been designed “around the project and provider needs”, rather than attempting to design the project and provider procedures around the database and data collection.

Assessment:

The case management strategy was originally designed around the MSS/ISS and MIHAs programs. Women are assessed prenatally (MSS) and when the child is born or enters the program (MIHAs). Both programs were united to form Healthy Start. Through experience we found frequently that clients do not desire to participate in both programs. As a result of this, women who declined the MSS/ISS services but chose to receive MIHAs services were not assessed. Additionally, the ISS assessment did not yield the same information as the MSS assessment, which did not provide all data needed for the data collection. The new tools and database, as well as new protocol that requires a complete assessment when women enroll, will enable complete data collection.

Leveling system and Case Conference Protocol:

In order to collect the same data at each assessment and more effectively track client goals, risk levels, and service plans, a Leveling System will be implemented. Though the MSS/ISS and MIHAs were united as a team, the case management was not united. Staff from each agency (Hurley and FACED or Genesys and FACED) would visit the same clients, but utilizing separate goal and service plans. Through Case Conferences, utilizing the Coordinator from the Health Department to keep the Case Conference Goal Log and Goal and Service plan, we will assess risk in 14 domains (at a minimum) at entry, after birth, and upon discharge. This method will be accomplished through the use of 2 tools that will be maintained by the Health Department Coordinator and shared by all. This information will be fed into a database that can yield frequent reports detailing goals established and met in each domain, and the risk level progression through time of service. This “early” and constant feedback should also assist the Care Team staff to objectively view success as well as trends needing correction, e.g. lack of focus on goals during home visits

B. Objectives, Strategies and Accomplishments

Below are listed major Objectives, Strategies, and Outcome data for calendar year 2005. Individual activities and dates of completion are listed in Attachment A. Unless otherwise noted, all baseline data is from the Michigan Department of Community Health.

Objective 1: Prenatal Care

Project Period Objective: By 6/1/05, the percent of women prenatally receiving Healthy Start services who initiate prenatal care in the first trimester will be increased to 75%.

Baseline: While 13.9% of Genesee County's live births (1996-1998) and 14.4% of Flint's live births (1997-1998) were to women who did not enter care in the first trimester, current MSS data from Genesys indicates that fewer than 50% of women in the MSS program initiated prenatal care in the first trimester.

Project Performance Indicator: The percent of high-risk African American pregnant clients who initiate prenatal care in the first trimester of pregnancy in 2005 was 67.5%.

Objective 2: Low Birth Weight Infants

Project Period Objective: By 6/1/05, the percent of low birth weight infants born to women who prenatally receive Healthy Start services will be decreased to 10%.

Baseline: While 10.7% (1999) of infants in Flint were low birth-weight, current MSS data from Genesys indicates that 17% of infants born to mothers enrolled in the MSS program were born with low birth weight.

Project Performance Indicator: The percent of low birth weight (LBW) singleton infants born to women who prenatally receive Healthy Start services in 2005 was 14.3%.

Objective 3: Very Low Birth Weight Infants

Project Period Objective: By 6/1/05, the percent of very low birth weight infants born to women who prenatally receive Healthy Start services will be decreased to 1.5%.

Baseline: While 2.2% (73) of all infants born in Flint were very low birth weight in 1999, 1.3% of European American babies were very low birth weight as compared with 3.1% of all African American infants.

Project Performance Indicator: The percent of very low birth weight (VLBW) singleton infants born to women who prenatally receive Health Start services in 2005 was 0%.

Objective 4: Pre-Term Infants

Project Period Objective: By 6/1/05, the percent of pre-term singleton infants born to women who prenatally receive Healthy Start services will be decreased to 40%.

Baseline: Estimates from the MSS program at Genesys are that 55% of infants who meet the risk factors for ISS are born pre-term.

Project Performance Indicator: The percent of pre-term singleton infants born to women who prenatally received Healthy Start services in 2005 was 19.5%.

Objective 5: Breastfeeding

Project Period Objective: By 6/1/05, the percent of women who prenatally receive Healthy Start services and who initiate breastfeeding will be increased to 28.5%.

Baseline: Data from Hurley Medical Center indicates that, while 47% of all women who gave birth in 2000 initiated breastfeeding, only 8.5% of high-risk mothers initiated breastfeeding.

Project Performance Indicator: The percent of mothers who prenatally receive Healthy Start services and who initiate breastfeeding in 2005 was .03%.

Objective 6: Immunizations

Project Period Objective: By 6/1/05, the percentage of infants up to age two who are enrolled in the Healthy Start program who have received the full schedule of age-appropriate immunizations against measles, mumps, rubella, polio, diphtheria, pertussis, tetanus, H. influenza, and hepatitis B will be increased to at least 85%.

Baseline: In 1997, immunization levels for children ages 19 to 35 months in Genesee County were 72.2%, below the state's immunization level of 80%. In 1998/1999, the percentage had decreased to between 67.5% and 69.5%.

Project Performance Indicator: The percent of two year-olds who have received the full schedule of age-appropriate immunizations against measles, mumps, rubella, polio, diphtheria, pertussis, tetanus, H. influenza, and hepatitis B in 2005 was 85%.

Objective 7a: Smoking Cessation During Pregnancy

Project Period Objective: By 6/1/05, the percent of pregnant women receiving Healthy Start services who smoke and who self-report lowered frequency or elimination of this risk behavior will be increased to 80%.

Baseline: While 20.8% of Flint pregnant women (1999) smoked while pregnant, current MSS data from Genesys indicates that 75% of pregnant women enrolled in the MSS program smoke while pregnant.

Project Performance Indicator: The percentage of pregnant women receiving Healthy Start services who smoke and who self-report lowered frequency or elimination of this risk behavior in 2005 was 25%.

Objective 7b: Smoking Cessation After Pregnancy

Project Period Objective: By 6/1/05, the percent of mothers receiving Healthy Start services who reduced or eliminated smoking during pregnancy and who self-report sustained lowered frequency or elimination of this risk behavior after the birth of their infant will be increased to 50%.

Baseline: Estimates from the MSS and ISS programs at Genesys and Hurley Medical Center indicate that at least 75% of mothers who reduce smoking during pregnancy increase their smoking after the birth of their infant.

Project Performance Indicator: The percentage of mothers receiving Healthy Start services who reduced or eliminated smoking during pregnancy and who self-report sustained lowered frequency or elimination of this risk behavior after the birth of their infant in 2005 was 66%.

Objective 8a: Substance Abuse Cessation During Pregnancy

Project Period Objective: By 6/1/05, the percent of pregnant women receiving Healthy Start services who abuse substances and who have reduced frequency or elimination of this risk behavior as indicated by substance abuse treatment reports will be increased to 88%.

Baseline: Data from a 1999 MDCH prevalence study indicated that 12% of people in Genesee County have substance abuse problems.

Project Performance Indicator: The percentage of pregnant women receiving Healthy Start services who abuse substances and who have reduced frequency or elimination of this risk behavior as indicated by substance abuse treatment reports in 2005 was 67%.

Objective 8b: Substance Abuse Cessation After Pregnancy

Project Period Objective: By 6/1/05, the percent of mothers receiving Healthy Start services who reduced or eliminated substance abuse during pregnancy and who sustain lowered frequency or elimination of this risk behavior after the birth of their infant as evidenced through self-reports or through substance abuse treatment reports will be increased to 80%.

Baseline: Estimates from one of the two women-specific substance abuse treatment programs in Genesee County are that at least 50% of mothers who reduce or eliminate substance abuse during pregnancy increase their use after the birth of their infant as evidenced through substance abuse treatment reports.

Project Performance Indicator: The percentage of pregnant women receiving Healthy Start services who abuse substances and who have sustained reduced frequency or elimination of this risk behavior as indicated by substance abuse treatment reports. This data was not adequate to determine a percentage.

Objective 9: Completed Referrals

Project Period Objective: By 6/1/05, the percentage of completed referrals among case-managed Healthy Start participants will be increased to 85%.

Baseline: Estimates from the MSS and ISS programs at Genesys and Hurley Medical Center indicate that 65% of referrals are completed.

Project Performance Indicator: The percentage of completed referrals among case-managed Healthy Start Initiative participants in 2005 was 46%.

Objective 10: Completed Referrals Among Infants with Special Health Care Needs

Project Period Objective: By 6/1/05, the percentage of completed referrals among case-

managed Healthy Start infants with Special Health Care Needs will be increased to 85%.

Baseline: Estimates from the MSS and ISS programs at Genesys and Hurley Medical Center indicate that 65% of referrals are completed. Genesee County Early On program currently has a total of 32 children with SHCN cases in our three target zip codes (see map in Appendix F).

Project Performance Indicator: The percentage of completed referrals among case-managed Healthy Start Initiative infants with Special Health Care Needs in 2005 was 100%.

Objective 11: Consumer Participation on the Consortium

Project Period Objective: By 6/1/05, the percentage of consumer participation in the work and activities of the Consortium will be at least 50%.

Baseline: Currently, 56% of Healthy Start Consortium members are consumers as evidenced by the most recent evaluation of the current Healthy Start Initiative.

Project Performance Indicator: The percentage of consumers who participate in the work and activities of the Consortium in 2005 was 42.1%.

Objective 12: Consortium Capacity

Project Period Objective: By 6/1/05, at least 90% of Consortium members will report increased capacity (knowledge and skills) through provided training.

Baseline: A total of 97% of current Healthy Start Consortium members report increased capacity (knowledge and skills) through provided training.

Project Performance Indicator: The percentage of Healthy Start Consortium participants who report increased capacity (knowledge and skills) through provided training as evidenced by the most recent evaluation of the current Healthy Start Initiative in 2005 was 100%.

C. For those projects that received mentoring or technical assistance from another site, please discuss any activities/lessons learned from those projects that you utilized in your project. If you provided technical assistance, describe your activities, feedback received on them, and any other lessons learned.

N/A

V. PROJECT IMPACT

A. Systems of Care

How the project has enhanced collaborative interaction among community organizations and services involved in promoting maternal and infant health and social support services.

1. Approaches utilized to enhance collaboration

Promotion and awareness: In the early stages of the project, a fundamental strategy used to promote the Healthy Start project involved collaborating with other local maternal and infant health and social support services to disseminate program information and

provide presentations to staff of those organizations. As service delivery began, increasing awareness of the contributory factors and affects of infant mortality was combined with project promotion at community locations.

Outreach, recruiting, and referral: As the project continued, the outreach and recruiting efforts were expanded by establishing relationships with organizations where referrals for services are exchanged. To increase awareness among doctors (and referrals) MIHAS advocates made presentations during grand rounds at local hospitals. Advocates and peer helpers began to recruit at the OB clinic at Hurley, a major source of prenatal care.

Consortium activities: A concerted effort has been made to identify and invite health and human services professionals to introduce their programs and have an opportunity to interact with consumers in a more casual atmosphere. This is an ongoing effort that has proven to be a mutual learning experience for both consumers and providers.

Support groups: FACED conducts educational support groups during which presenters are invited from other organizations to share information about their services and learn more about MIHAS, Healthy Start services, and other programs.

Other infant mortality projects: As discussed in Section I and II, all of the staff funded through Healthy Start participate in at least one other project or program that relates to maternal and infant health such as REACH 2010, Closing the Gap, Friendly AccessSM, MISSING Links, PRIDE, or the Governor Granholm Challenge. Unlike most other local infant mortality projects which focus on evaluation, research, or information dissemination, Healthy Start is a project that focuses on providing services. Because of daily interactions with clients and the health and human services delivery system, Healthy Start project staff provide valuable “front-line” information to other projects.

Resource guide distribution: In the third year of the project, The Family Pages, a comprehensive guide to services that benefit families with children, was updated, published, and widely disseminated by the Health Department. As it has been consistently identified during various forums, service providers are lacking information regarding other services. The Family Pages has greatly enhanced collaborative interaction among providers.

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

MIHAs and MSS/ISS: As discussed in Sections I and II, policies and procedures were developed to integrate the two pre-existing programs, joining the two hospital systems with a community-based organization.

Flint Family Road: Family Road is co-located with “Work First” which is a state-run program that provides financial assistance and job training to unemployed and under-employed persons. Those receiving assistance through DHS must attend that program for 40 hours (when not employed) or the balance of time between their working hours and 40 hours (when part-time employed). Policies and procedures are being developed to allow release time from the Work First program to allow participants to attend the classes at Flint Family Road.

Consistent Safe Sleep Messages: REACH, Friendly AccessSM, and FIMR each represent initiatives established to address service delivery in Genesee County, and with which

Healthy Start collaborates. Changes that have resulted from those projects include the implementation of consistent safe sleep messages in a local hospital and DHS (state welfare agency).

Medicaid and Prenatal Care: Through collaborations with the Center for Civil Justice and DHS, and as a result of feedback received from the MIHAS, it was learned that many women were receiving late prenatal care because of a procedural failure at DHS among some staff. Pregnant women who had no insurance, according to state law, can receive a letter of authorization for prenatal care at the DHS at the time of application for health care assistance. The letter is to be provided without proof of pregnancy and at their first visit to DHS. Though the policy existed, not all staff at DHS were providing the letter but erroneously stating to clients that they needed to come back with a positive pregnancy result or simply not providing the letter at their first visit, resulting in unnecessarily late entry into prenatal health care. This procedure has now been addressed by the Director of DHS.

3. Key relationships developed as a result of Healthy Start efforts

- a. Health service agencies, health and social service agencies, and community-based organizations:

Healthy Start partnering organizations have worked together at an unprecedented level. Prior to the project period, staff from the agencies rarely interacted in actual provision of services. Directors and managerial staff from the partnering organizations had previously served together on various health and infant mortality-related project committees. The current Healthy Start project was the first effort to join two hospitals, two CBO's, a local health agency, and the local health department in one project, using a team model to serve our clients. The relationships fostered while working as a team toward a common goal have enhanced the project and contributed toward meeting our goals and objectives.

Two of the three *local hospital systems* are funded partners in the project. The third hospital system and a major clinic (Hamilton), though not funded, participate in MISSING Links and other health-related projects with various Healthy Start staff. Through these activities, and because of the Healthy Start project, opportunities for relationship-building have been greatly increased between those hospital and clinics and the Healthy Start organizations. Examples include increased referrals and better follow-up, opportunities to recruit at local clinics, increased opportunities for consortium activities, information-sharing, and opportunities to bring the consumer voice into health systems planning.

Medicaid HMO's also participate in MISSING Links, which provides many opportunities to discuss barriers to accessing health care.

The Genesee Intermediate School District and other public schools conduct various early childhood health-related programs in our county. Representatives from those programs participate in MISSING Links.

Planned Parenthood is a local leader in women's health. Through the Healthy Start project, access to women's health and contraceptive services has increased because of relationships developed through the referral process.

DHS, *the local state welfare agency*, has recently become a major advocate of Safe Sleep in our county. Healthy Start staff participate with them in their county-wide, state-funded Safe Sleep workgroup that has adopted our model for providing Safe Sleep education along with a Pack-n-Play to mothers in need. Prior to the implementation of the DHS Safe Sleep class, due to limited funding, only one class was held each week and only a limited number of Pack-n-Plays could be provided through the PRIDE Crib Fund.

The Center for Civil Justice is a local health and legal advocacy agency that actively addresses government policy issues on behalf of citizens. The Healthy Start staff collaborate as appropriate in their activities and share their information with our clients. Staff work with them to address procedural issues at DHS. They have presented at our Consortium and attended Consortium meetings in 2004 and 2005.

The Greater Flint Health Coalition is a local organization that addresses health care systems issues as they relate to the general health of our county residents. Our associations with that group have increased because of their participation in REACH 2010, Friendly AccessSM, and their receipt of the Closing the Gap grant. The Healthy Start Team is interested in further building our relationship with them to address gaps to accessing services in our county.

- b. Relationships that focus on involvement of consumers and/or community leaders not employed by a health or social service agency:

Dress for Success is a local organization that provides work or business attire to low-income individuals seeking employment. As they are located in the building where our Consortium meets, volunteers from Dress for Success began assisting the Family Road staff with the Consortium meetings during 2004.

The REACH 2010 relationship with Healthy Start continues to build as the benefits of joining together in various projects have been identified. In 2005 we began to invite REACH 2010 advocates and clients to the Healthy Start Consortium. Additionally, the leader of the men's group (Black Men For Social Change), an all-volunteer group, spoke at the Healthy Start Consortium. In 2005 we will begin offering the Healthy Start Curriculum to REACH 2010 clients.

As mentioned previously, Healthy Start has partnered with the Center for Civil Justice to address a barrier for pregnant women who are eligible for Medicaid. Our Healthy Start Advocates identified that some women were accessing prenatal care later than necessary due to non-receipt of a "Guarantee Of Payment" letter from DHS. The Center for Civil Justice advocated with DHS to address the problem. Key relationships were developed among staff at DHS, CCJ, and Healthy Start organizations as a result of this effort.

The local *YWCA Women's Shelter* is an important referral source for our program. Relationships have been built with staff at that organization through the Healthy Start project.

The Resource Center is the largest referral source located in Genesee County. Their participation in MISSING Links has resulted in a closer relationship with Healthy Start organizations.

Early On, SKIP, Priority Children, and READY, SET, GROW! are three important local programs that deal with child health and school readiness issues in our county. Through MISSING Links, as well as other infant mortality projects, relationships with staff from these programs have been quite beneficial.

4. Project's impact on the comprehensiveness of services

a. Eligibility and/or intake requirements for health or social services:

Knowledge and awareness of eligibility is a major barrier for our clients. The identification of insurance and other health and social program eligibility is integral to all of our Healthy Start services. Additionally, advocating for services and educating our clients is a major goal of the project. Identification of insurance source, medical home, transportation and advocacy services, are all part of the mission of the Care Team. Following up at the next contact to determine if our clients kept their appointments and whether their health care was adequate is also a part of the Healthy Start services. As discussed above, when our clients do not access services (such as not receiving their "Guarantee Of Payment" letter), we identify the problems and work with the client toward a solution, including going with them to the agency, if necessary to ensure receipt of appropriate services.

Educating other professional organizations in MISSING Links regarding program eligibility and intake requirements, as well as gathering information for dissemination, is a component of each meeting.

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

Our project identified in its early stages that the *most immediate gap in our county* is the lack of awareness of health and social services. As discussed above, helping our clients to access services, along with sufficient follow-up after they access services, provides the most immediate and fruitful benefits to our clients. An example of how we have impacted access is best illustrated through the incident described above regarding the "Guarantee of Payment" letter.

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

A team case management approach, using shared tools and structured case conferences, has been developed. The participation of the MSS/ISS programs from the two major local hospital systems links the majority of doctors and clinics in the county. Linking the majority of health care providers in the county, including linking community-based organizations, as well as the local health department, has formed a strong base for continuity of care and referral. An area that has been identified for quality improvement is referral follow-up. During our next project cycle, we will utilize more refined tools and procedures to more actively and effectively collect information regarding referral follow-up. This will enable us to better identify steps necessary to increase referral follow-up among our clients as necessary.

The development of a database for data collection has encompassed client data for case management as well as data required for local and federal evaluations. The data collection enables us to identify areas for quality improvement. Included in the

database is referral, enrollment, assessment, and discharge data. Reports from this system can identify important information such as: visit frequency by agency and by client; referrals made and whether follow-up occurred; which clients attended Healthy Start classes and the Consortium; and a wealth of other information that can demonstrate the degree of continuity of care, as well as areas needing improvement.

Another area where continuity of care has undergone improvement is with Safe Sleep messages. Through the REACH 2010 work, Healthy Start partners became aware that materials distributed to new moms at one of our hospitals did not promote back-sleeping. Around that same time-frame GCHD staff also became aware that a significant number of DHS personnel were also not promoting back-sleeping. This has been corrected through replacing the hospital hand-out and re-educating staff at the hospital and DHS.

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

Shared forms and data are utilized by both hospital MSS/ISS (Hurley and Genesys), the CBO's (MIHAs and FFR), and the Health Department. The existing MSS/ISS tool required by the state has been incorporated and supplemented with any Healthy Start specific forms. The client consent form includes all partners, which allows for data sharing. State birth data and state immunization data is also utilized for input to our Healthy Start database.

5. Impact on enhancing client participation in evaluation of service provision:

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

Trainings in cultural competency and health literacy have been provided to the Healthy Start organizations as well as health care and social service agency personnel. REACH 2010 and the YWCA provide "Undoing Racism" and "Challenging Racism" workshops, respectively. Staff are highly encouraged to attend one of the racism trainings.

Focus Groups and Community dialogues, a Healthy Start focus group, a client phone survey, and Consortium surveys are utilized to identify needs of clients and information that will enhance services to clients.

Consortium activities are specifically designed to collect information from consumers that can be routed to health and social service organizations to enhance cultural sensitivity. Male involvement has been a frequent topic initiated by Consortium members and males are now being included in Healthy Start services as appropriate. The REACH 2010 project began a male mobilization group in 2004 (Black Men for Social Change).

MISSING Links is an important vehicle for sharing information among health and social service agencies. Information from consumers is frequently included in meeting agendas. The latest Health Literacy training was accomplished through MISSING Links.

- 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 Healthy Start Curriculum was developed by a Health Educator, paraprofessionals, and Peer Helpers. The role of the Peer Helpers was to help identify curriculum topics, ensure relevancy and appropriateness, and to assist in design. The Peer Helpers were selected directly from our target audience and we relied heavily on their advice and participation in developing the content and graphics. This curriculum will soon also be utilized by clients from outside the Healthy Start project.

A Healthy Start newsletter, designed for clients as well as professionals, was initiated in 2004. Articles are written by clients as well as Healthy Start staff. The content is geared to the interests of our clients, but it is also distributed to professionals on our mailing lists.

Our Healthy Start Therapeutic support group was a concept born out of Consortium members. This service has been tailored in direct response to a strong expression of need during Consortium meetings for a format that ensured confidentiality and focused on mental health-related issues in a constructive and safe setting.

FACED Educational Support Groups pre-existed the Healthy Start project but are also attended by Healthy Start clients. This group is also a response to requests from clients. It meets monthly and presents various speakers in a discussion format regarding topics of interest to clients.

- a *Tools utilized to determine clients desires and needs* include the consortium survey, focus groups, a phone survey, and other activities that take place at Consortium meetings.

B. Impact to the Community in developing and empowering the community

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

The Family Pages is a comprehensive resource guide for families of young children and expectant mothers. The previous Healthy Start project produced this guide and our project has followed with distribution and a second publication of the guide. The guide consists of a manual for service providers and a small purse-ready guide for consumers. Approximately 588 manuals and 18,436 guides have been distributed to providers and families throughout the county.

Outreach performed by Healthy Start advocates and other staff has included a strong presence at community events. Through conversations and information sharing with community leaders, increased awareness of contributors to prematurity and infant mortality is evidenced by the increased activity and participation among community members in health-related events.

Advocacy has been an important component of the Healthy Start project. Consumers are empowered when staff model system navigation as a part of our service provision. This is frequently accomplished as a part of visits. For example, when a client is threatened with eviction, Healthy Start staff assists them by providing information and

problem-solving that might include: informing them of tenant rights, helping them learn how to work with limited finances, negotiating with the landlord, house-hunting, and visiting shelters. Working through a critical time with our clients, using a skill-building approach, is an empowerment strategy.

Consortium Activities have been consistently well-attended by consumers, both Healthy Start clients and the community-at-large. This is evidence of interest and awareness among the community of maternal and child health issues.

Support groups have also been well-attended. There is usually a waiting list for the therapeutic support groups and the dialogue in the educational support groups is lively. Mothers are clearly interested in information that will help them effectively and positively care for themselves and their children. An example of empowerment has been accomplished through the FACED Educational Support group, where a “Mom’s Support Network” has been created by the consumers.

2. Consumer participation in establishing or changing standards and/or policies of participating service providers and local government, that affect the health or welfare of the community, and have an impact on infant mortality reduction:

Safe Sleep classes that now take place at Flint Family Road and DHS were a direct result of FIMR information and feedback from clients requesting information about safe sleep. After Healthy Start clients attend classes, a follow-up home visit is performed by a MIHA to ascertain whether the baby is sleeping in the crib and families are re-educated if necessary. A follow-up report is generated to document this activity.

As discussed in above sections, the therapeutic *support group*, is also a direct result of requests from consumers.

The PRIDE crib fund existed prior to the current Healthy Start project. A workgroup utilizes consumer feedback to determine how the funds can be used to respond to needs that are not currently met in the community. Previous to the DHS Safe Sleep program, which now disseminates Pack-n-Plays, the PRIDE Crib Fund provided them. At this time consumer feedback has informed us that car seats and sleepers are a need and the workgroup is addressing those issues.

Car seats and car seat safety education are provided by Flint Family Road in conjunction with Hurley Medical Center and General Motors (GM). Hurley and GM also work with local car dealers to provide car seat checks and some care seats at various local dealerships. Recently, two fire stations have also begun performing the car seat safety checks. All of the car seat safety activities are well-attended and have increased due to consumer demand.

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

The PRIDE Crib Committee consists of divergent opinions and a wide spectrum of people from government, health care, and community. There have been conflicts regarding the type of cribs to purchase and how to disseminate them. To resolve the conflicting views of purchasing portable “pack-n-plays” or the full-sized (more expensive) crib, the group held a vote; a consensus was reached and there was no further disagreement. Also, discussions about car seats and sleepers required working through different perspectives.

Therapeutic support group decisions also required working through differences in perspective on format and participation policies. Initially, some viewed an additional support group as a duplication of services. Through discussion, analysis of client needs, and clarification of the support group parameters. It was agreed to develop a clear distinction between the format and purpose of the two groups. FACED would continue to conduct an education-based “open” group and Genesys would conduct a series of “closed” groups with a therapeutic format for participants with mental health issues.

4. Creation of jobs within the community:

Though this is not an objective of our project, job creation has occurred. The project has employed 5 peer helpers, who represent our target population. Two of the peer helpers went on to other employment at Healthy Start organizations. One former peer helper now works as an advocate at FACED and one is a contractor for DHS. Additionally, three former Healthy Start clients are now employed at one of the hospitals and FACED.

C. Impact on the State: Activities and impact that coordinated activities with other Healthy Start sites has had on relationships to the State Title V Agency, State Children with Special Health Care Needs Program(s), state Medicaid and SCHIP programs, State Early Intervention Program and other state programs. Benefits and lessons learned from these relationships.

Relationships to State Title V programs existed prior to the project period. Because the local health department is the fiduciary for this Healthy Start project, working with Title V programs was and continues to be an ongoing function of the health department. Children Special Health Care Services (CSHCS) is located within the health department, which also works closely with DHS, the administrator of SCHIP Medicaid. The Family Planning and STD clinics are also examples of state programs operated by the health department.

The Statewide Healthy Start Network has met quarterly and is also attended by the state FIMR consultant, now also the state Healthy Start consultant. Information sharing has been beneficial and the group is currently planning joint statewide activities.

Lessons Learned from Title V relationships include: 1) consumers need advocacy and information regarding rights and benefits of state programs, and 2) information dissemination is most effective when repeated using varied avenues.

D. Local Government Role: Activities/relationships at the state and local level that facilitate project development. Barriers at the state and local level, and the lessons learned in dealing with these barriers.

FIMR information is used to guide our project and other infant mortality initiatives. Safe Sleep was the major area of promotion during the first project period. As this message has “caught on” with many other organizations and programs in our county, our project is preparing to promote awareness of risk factors related to prematurity and low birth weight.

The Governor Jennifer Granholm Challenge is a statewide effort to address school readiness. Through our participation in a workgroup that did not otherwise include health care representatives, we were influential in informing the group of the direct link between

infant and maternal health and school readiness. Though we were not originally invited to participate in that planning workgroup (because the focus was school readiness), we were informed by some within that group that our presence was needed to highlight the health issues as they relate to school readiness. We contacted the group leader and received an invitation.

Closing the Gap is another local infant mortality initiative with which we have had contact. As mentioned above, we hope to work more closely with that project in the future.

The Infant Mortality Coalition Network is the newest infant mortality initiative. The Michigan Department of Community Health (MDCH) has begun an effort to work closely with the eleven counties with the highest African American infant mortality rates in the state. The local health departments are responsible for implementing various activities and reporting progress to MDCH.

One major barrier in dealing with local government is the lack of awareness among providers when relating to various government agencies. Changes in leadership and staff at city hall and local hospitals have caused difficulty in addressing policy issues.

The consequences of funding cuts from federal, state, and local programs have created other barriers. Funding reductions always result in lower staffing and/or decreased services. A program or service that was available today may not be available tomorrow – with no alternative or replacement identified. This has posed ongoing problems for both Healthy Start staff and consumers.

A major lesson learned regarding government is the importance of educating our legislators. Though staff have participated in some legislative activities, there is recognition for the need to do more. Consortium activities in 2005 did include a consumer advocacy session regarding the recent Medicaid cuts, food stamp cuts, and education/work policy changes that resulted from federal appropriation changes. Looking forward, more consumer legislative advocacy activities in our project will be included.

E. Other Lessons Learned

Lessons Learned are many and varied but as we look backward and attempt to use what we have learned – we now ask ourselves “what impact did we have?” In an attempt to more effectively demonstrate impact, we have revised our data collection methodology.

More knowledge of what other Healthy Start sites are doing would be beneficial to us at this juncture. During the next project period, we will more thoroughly explore and discuss how we can utilize this information to improve our project.

Connecting clinicians with paraprofessionals (community outreach workers) on one functioning team was a goal of the project. This was not easily accomplished but the benefits have been realized. A multitude of skills and experiences are brought to our project through a multi-disciplinary team approach that values the contributions and strengths of women with experiences and backgrounds that are similar to our clients. Under our new case management structure, all members of our care team will participate in all case management activities, from assessment to goal planning and through the discharge process. Health department staff will begin attending case conferences to coordinate and maintain goal plans and case tracking. Flint Family Road (which has recently changed their

organizational title to Family Road) will also attend case conferences to provide a focus on the educational needs of the client.

A single focus goal(s) that results from collective planning at all stages and throughout all facets of the program has proven to be more beneficial than portioning programming functions into organizational “silos”. Though we did overall planning as one group at the start of our project, we became less co-joined in later stages of planning and through the operational phases. We have learned that, though a particular organization is the lead on a part of our project, the lead organization as well as the client benefit from the participation of staff from the other organizations. Additionally, utilizing a cross-organizational approach to development and implementation in each functional area is a team-building experience for the entire staff. The challenges of working through the transition from our individual silos to one team to the extent that we identify ourselves as “Healthy Start” and not just identifying with our parent organization, have been an enriching experience.

We have learned that we need to be multilingual. The language of medical and other professions is not readily understood by others that do not regularly operate in those environments. The language of the community is not well-understood by medical, social, and public health workers. The addition of paraprofessionals who speak the language of the community will help us to communicate more effectively with clients, enable better service utilization, and enhance quality of services.

The criticality of *trust building and team building* should not be underestimated. Joining public health, health care, and community-based organizations is not simply a matter of apportioning the money, dividing functions, and scheduling meetings. Each group brings their own practices and perspective, their own culture, and each is different from the other. The white culture that dominates health care, the African American culture, and the general community culture must be joined if we are to be successful. All three cultures are represented within our team. We are learning how to unite them without sacrificing the uniquely valuable facets of each group. Though it has been struggle, we have made great progress – but we know there is still much work to be done. As we often say, “African American babies are still dying and it is our job to change that.”

VI. LOCAL EVALUATION

Healthy Start Local Evaluation Report

Project Name: Genesee County Healthy Start
Report Title: Final Evaluation Report
Report Period: June 1, 2001- May 31, 2005

Report Author: Sue Ann Savas
Evaluators: Harold Pollack, Shan Parker (2001)
Barb Guthrie, Maureen Kirkwood (2001-2004)
Sue Ann Savas (June 2004- May 2005)

Section I: INTRODUCTION

Local Evaluation Component

A. Impetus

The original evaluation plan was designed to test the efficacy of the proposed Healthy Start program with the usual care/ standard support services traditionally received by women and infants in Genesee County. The evaluation was planned to test a comprehensive and collaborative (experimental group) system of support services that is focused on clients needs and respectful of clients values in order to promote better birth outcomes for infants as compared to women who receive the already existing support services within the perinatal system in Genesee county (comparison group). Impetus for the evaluation stemmed from the introduction of a more intensive home-based model for the prevention of infant mortality among high-risk African American women.

The evaluation was contracted to local university-based evaluators. The first phase of the evaluation was originally under the direction of Harold Pollack, Ph.D., Assistant Professor, Health Management and Policy, School of Public Health, University of Michigan in collaboration with Shandowyn L. Parker, Ph.D., University of Michigan-Flint. They served as the project evaluators during the development of the original grant proposal. Dr. Pollack left the Michigan area to pursue a tenured position in Illinois. Phase II of the local evaluation was contracted to Barbara Guthrie (School of Nursing Professor, University of Michigan). She worked closely with her Evaluation Assistant, Maureen Kirkwood during 2001-2004. In June of 2004, Sue Ann Savas (Adjunct Faculty School of Social Work, University of Michigan) was secured to complete the final year of the Healthy Start local evaluation. At the time, she was also serving as the local REACH 2010 Project Evaluator on a CDC-funded project to reduce disparities of infant mortality. The two projects were connected and her role on both was seen as instrumental for purposes of collaboration and study.

During all of the phases of the evaluation, Healthy Start staff members were involved in evaluation planning, identification of key evaluation questions, development and identification of the data collection tools, logic model development, requestors and consumers of evaluation reports, and participants in discussions to interpret results for program improvement.

B. Brief History

A description of the evaluation has been organized into three phases according to the tenure of each contracted evaluator. Phase I of the local evaluation, directed by Dr. Pollack, originally focused on evaluation planning, development of instruments, and participant consents. Phase II of the evaluation continued to build infrastructure with the development of a web-based/land-based information system to capture and manage the required data elements. The time needed to develop the system and enter program participant data was underestimated. Missing data as well as form revisions (assessment form, event logs, and program participant satisfaction surveys) continued to delay the use of data for evaluation and program improvement purposes. To ensure proper and timely completion of the required documentation, orientations were held with providers to review procedures for form completions. Phase II also focused on gathering information to answer key context and process evaluation questions. For example, a focus group was conducted with Healthy Start participants to inform evaluation questions specific to barriers and strategies used to overcome challenges during the implementation of the project. During Phase II, evaluators and Healthy Start partners determined that a comparison group design was not feasible given the Healthy Start requirement to serve those most at risk (equivalent comparison groups would not be possible). Consequently, the outcome design was changed to a single group pre/post design. Phase III of the evaluation focused on mining the database to report performance indicators and answer pertinent evaluation questions asked by the Healthy Start partners. Efforts during Phase III focused on evaluation of services to program participants with depression, referral patterns, home visit patterns, case conference procedures, health education classes utilization rates, infant outcomes, maternal outcomes, review of information system).

C. Type of Study

The local evaluation included a process and outcome component. Process evaluation activities were designed to answer these key questions: What activities, educational materials, and services are provided to the participants and their families? What is the level of involvement of participants in the project experience? What are the strengths of the project? What are the weaknesses/problems associated with the project? What are the factors that impede or facilitate change at the system and interpersonal levels? To what extent are participants satisfied with the project? What recommendations do participants have for improving the project? This evaluation was used to monitor program implementation and feed evaluation results to the Healthy Start partners for program improvement planning.

Specific to the outcome component, the original study suggested a quasi-experimental design to test the efficacy of a comprehensive collaborative Healthy Start program. A quasi-experimental design was suggested because participants could not be randomly assigned to

a particular group. All women in need of perinatal services were expected to receive services. A case overflow design was suggested as a means to create a comparison group. For the Healthy Start program, participants would be enrolled on a first come basis until the program had reached its maximum caseload of 400 women. Those participants who needed services after the program reached the maximum caseload would receive support services but under the existing perinatal state system. Women receiving traditional support services would act as the comparison condition. Participants from the experimental and comparison condition would be the same based on criteria established by the Healthy start proposal with the only differences being that the experimental group would receive the Healthy Start

support services and the comparison condition would receive the existing support services in the perinatal system (usual care).

Due to difficulties and delays in securing human subject protections for this quasi-experimental design, the outcome design was changed to a single group pre/post design. There are limitations to this alternative study design. Specifically, the program can not be identified as the cause or change in outcomes. There are numerous threats to both internal and external validity. Participants were asked to complete a pre-test assessment tool at baseline (which consists of a medical and behavioral component) and a post-test assessment. To evaluate longer-term changes, participants were to be re-assessed at 6 months, 12 months, and 18 months post-program. A member of the Healthy Start Team conducted these follow up assessments to evaluate participants' knowledge and skills acquired from the educational sessions. Due to changes in evaluation staff and shifts in priorities, the post-program follow-up survey component was eliminated from the evaluation plan.

Key Evaluation Questions

The context and process evaluation components focused on the following key questions: What activities, educational materials, and services are provided to the participants and their families? What is the level of involvement of participants in the project experience? What are the strengths of the project? What are the weaknesses/problems associated with the project? What are the factors that impede or facilitate change at the system and interpersonal levels? To what extent are participants satisfied with the project? What recommendations do participants have for improving the project? The outcome component was designed to answer the following key evaluation questions: To what degree did infant program participants gain and sustain the expected outcomes? To what degree did adult program participants gain and sustain the expected outcomes? Healthy Start partners expected to provide individualized services according to plan of care, implement the project according to the work plan, and establish consortium to address system level needs. Expected outcomes included risk reduction to adult participants, healthy development in infants, improvements in the local perinatal service delivery system.

Section II: PROCESS

A. Procedures

Multiple methods, both qualitative and quantitative, were used to gather critical evaluation data. Data collectors included the program providers and project evaluators. In collaboration with project staff, new collection forms were developed in-house to gather program participant characteristics, services and outcome data as the participants moved through the program. Standardized tools were used when feasible. For example, the standardized

Edinburg Post-natal Depression Survey was added to the assessment battery to screen participant depression levels. Paper and pencil Satisfaction Surveys were developed for single point administrations. A Telephone Satisfaction Survey was administered to increase completion rates by program participants. Pre and post tests were created to capture changes in knowledge from educational classes. Secondary data was used to gather vital birth record outcome data and immunization data. Focus groups and interviews were employed to capture key context and process data from participants. Evaluation observation was used to supplement other collection methods. A sampling design was only used with the telephone satisfaction survey. Respondents were randomly identified. The sample frame was not sufficient to be generalized to the larger population. With all other systematic collection, a census approach was employed.

B. Data Sources

Data sources included the program participants, the Healthy Start program providers, consortium participants, official vital statistics birth record data, state immunization system registry, Healthy Start program administrators, and local project evaluators (serving as observers).

C. Measures, Instruments

Birth Records: Data recording forms/instruments were developed to track information about both the mother and the infant. Types of information included birth weight of the infant, gestational age, initiation of prenatal care, number of prenatal visits, dietary habits, and smoking and substance abuse data information. The Kotelchuck Index was used to establish a rating of the quality of prenatal care.

Immunization Records: Data recording forms /instruments were developed to monitor whether infants have received age appropriate immunizations. The utilization of the Ready! Set! Grow! Passport Booklet and the state registration system was used to track infant immunizations.

Referral Forms: A data collection log was developed to document referrals to community services, reasons why participants were being referred to those services, and follow-up status of referral.

Assessment Battery: A number of questions were asked of the program participant by the program provider in a face-to-face interview format to capture critical assessment information. The assessment battery includes, but is not limited to information about screenings, risk factors, pre-natal care history, pregnancy history, basic needs, and social support. This included the Edinburgh Post-natal Depression Survey to assess depression levels.

Service Contacts: Contacts made by the Healthy Start providers to each participant were recorded on an Activity Log. The data included date of contact, provider, location, purpose of contact, status of contact (successful, unsuccessful).

Attendance Logs: Attendance for educational sessions, consortium meetings, and program administrative meetings was tracked using attendance logs and Sign-in sheets.

Pre and Post Tests: Pre and post tests of knowledge were developed and administered at

the beginning and end of educational class sessions, workshops, and provider trainings.

Satisfaction Surveys: Two surveys (paper and pencil, telephone) were developed and administered to assess satisfaction levels at various Healthy Start events and services.

Section III: FINDINGS/DISCUSSION

A. Evaluation Findings

- The program served the expected high risk population. Services were provided to at least 400 participants. In general, program participants were satisfied with services. Services were provided to participants based on need and established goals, including referrals to external community-based services/resources. Documentation of the status of referral follow-up was inconclusive.
- Program participant screening for depression identified individuals in need of mental health services. Some of the participants were involved in the Healthy Start sponsored therapeutic support group. Receipt of other community-based mental health services is inconclusive due to limited documentation in the case record/database.
- Health education classes were provided by a trained nurse in accordance with the Healthy Start curriculum (developed in-house). At the start of the grant, attendance was sporadic due to participant transportation issues, competing life demands, and education class schedules. No-shows were numerous, however participation in the Healthy Start curriculum improved over the course of the grant. Pre and post test results of a sub-sample of curriculum participants indicated improvement in knowledge. Skill change was undetermined.
- Therapeutic support group evaluation results indicated an improvement (self-reported) in self-efficacy over the course of the group. However, very few of the participants completed both the pre and post tests. Through satisfaction surveys, the group participants indicated an interest in on-going support group format.
- Expected outcomes were attained for most participants. Services were provided until the child turned two. Discharge status was undetermined due to limitations in the discharge documentation. Two Healthy Start infants experienced loss of life before their two year birthday. One was due to bronchial pneumonia and the other was due to positional asphyxiation. As a result of the program, participants were connected to a medical home. Intra-conceptual intervals were increased with some of the program participants; further evaluation is needed to better understand program effectiveness specific to lengthening intra-conceptual intervals. Outcome data sustained beyond the end of program was not captured due to the discontinuation of the Follow-up Survey.
- Planning and implementation of consortium activities improved over the course of the grant. Toward the last year of the grant, meetings were built on themes identified by consortium participants. Consortium membership was inconsistent (averaging 124 participants per year) and was broad-based by including service providers across various systems of care. Coordination with other infant mortality projects in the community was a focus of the 2005 effort.

B. Methodological Limitations

Quality of the data compromised the use of evaluation findings. Specifically, high rates of missing data and provider inconsistency in documentation was evident. The single group design limited conclusions linking the change in risk and other expected outcomes to the program interventions.

Section IV: RECOMMENDATION

A. Recommendations

This section includes policy, program and practice recommendations that stemmed from the local evaluation.

- Continue to serve the target population. Focus care team and participants on 14 life domains through identifying goals within each domain, service plans, and accomplishments.
- Referrals will be clearly documented in the case conference log and through a referral log, including status of referral.
- Screening for depression will continue with the EPDS. Participants will be triaged based on their screening score. Relationships will be established with the outpatient clinics and Community Mental Health. A mental health work group has been established to strategize and plan for a more effective response to mental health needs.
- Health education class curriculum will remain the same. The care team will emphasize the importance of the classes to participants. Efforts will be made to reduce barriers to access. Classes will be available to other infant mortality project participants within the community.
- The therapeutic support group will be expanded to meet demand. The maintenance group is in the planning stages. Individual counseling will be available via community programming. Support group changes are contingent on the procurement of additional funding.
- Case conference and discharge procedures have been refined to track needs, service provided and outcomes over time.
- A FIMR presentation will be hosted by Healthy Start to present infant mortality trends to other community based infant mortality projects. Strategies to reduce infant mortality and the racial disparity will be identified.
- The local health system action plan and consortium activities will become a part of a new state coordinated county-based initiative. Consortium activities will reinforce the work of the care team and the FACED educational support groups. Information and education was requested by participants. Empowerment through advocacy will be a major theme for the consortium.

B. Further Evaluation Study

New forms have been developed and have been piloted successfully. Clear procedures have been articulated. Upcoming evaluation efforts will also include a focus on follow-up: of referrals, of support groups, and follow-up beyond the program (intermediate outcomes and intra-conceptional intervals). The re-design of the information system will support ongoing

collection and management of program data. Focused evaluations will be implemented as requested by Healthy Start Directors group. For example, women with short intervals between pregnancies, young participants, and services to males have been identified for study. This ad hoc evaluation data will be managed and analyzed using SPSS V12.5. Evaluation reports will be shared and discussed with key stakeholders for program improvement planning.

Section V: IMPACT BASED ON RECOMMENDATIONS

A. Changes in Perinatal System

As a result of evaluation recommendations, the following perinatal system and community impact are evident:

- Capacity to serve high risk African American women and children has been expanded. Services and resources have been offered by one program eliminating disjointed service provision. Comprehensive services are now available within one program using a life course family-centered approach.
- Five organizations have been joined to provide one system of care. Resources have been secured and combined, resulting in efficiencies and reduction in duplication of effort.
- Expertise has been developed using multiple disciplines (health, social work, dietitian, and advocacy).
- Community awareness and knowledge of infant mortality has increased.

B. Changes in Project

As a result of the local evaluation results, changes to project implementation occurred. These were detailed in the recommendations section above.

Section VI: PUBLICATIONS

Publications to professional journals have not been produced. However, a number of project reports and presentations have been generated and disseminated to the local community.

VII. FETAL AND INFANT MORTALITY REVIEW (FIMR)

Genesee County's FIMR process began in 1997. Unfortunately, we do not include maternal and child reviews in FIMR. Child mortality is addressed through our Child Death Review (CDR) process. Maternal issues are not reviewed at this time. Components of FIMR include: Home visits, record abstractions, the development of a case summary that is presented before a case review team, and development of recommendations and actions that are then forwarded to an action team (Priority Children). Funding is provided through local, state and federal dollars (Centers for Disease Control and Prevention, REACH 2010). The major challenge is funding/staffing to sustain the process. Many positive changes have occurred between 1997 and 2005:

- There has been a substantial increase in participation by community physicians, agencies and organizations at the FIMR case review table over the years. More

participants produce greater insight leading to the development of recommendations and actions.

- Multiple community agencies are now working together to promote "Back to Sleep/Safe Sleep".
- Mass media campaigns have been created that include: billboards, bus boards, PSA (radio & TV); safe sleep classes with pack-n-play give-aways to participants; and our local slogan, "Always Alone in a Crib of Their Own" is now appearing on infant sleepers, awareness bracelets, and diaper bags.
- A standardized Prenatal Risk Assessment Tool (PRAT) which includes a comprehensive psychosocial assessment has been developed and implemented. There is an increasing interest to use this form among Obstetric and Family Practice physicians within the community. A database was developed to house the information collected from the PRAT for data analysis and dissemination in a de-identified form.
- An increased awareness and emphasis on the need for substance abuse screening during prenatal care has resulted in the incorporation of the 4P's tool into the PRAT as well as the development of a pathway to care algorithm (still under development).
- Physician grand rounds are utilized to disseminate information about infant mortality and issues related to back to sleep/safe sleep.
- The implementation of Medical Examiner Investigators in our County has been completed. They are now required to work in conjunction with local law enforcement agencies and adhere to death scene investigation protocols
- The FIMR Nurse now collects social medical history from families of deceased infants at the time of the scene re-enactment (social-medical history was not collected in past). Bereavement services are initiated at same time, allowing for a much quicker provision of bereavement services than in past years.
- Only forensic pathologists may perform infant/child autopsies. By utilizing only forensic pathologists, in conjunction with thorough scene investigation, causes of infant deaths are now much more conclusive. In the past a considerable number of infant deaths in this community were attributed to SIDS even though the circumstances of the death did not meet the diagnostic criteria. Since the utilization of a forensic pathology group for Medical Examiner cases in 2003, there have been no SIDS diagnosis; however, there has been an increase in the number of deaths due to asphyxia and infections.
- Safe Sleep/Back to Sleep has been presented by FIMR nurse to nursing classes at the University of Michigan, Flint as well as Mott Community College.