

**Introduction:** This Impact Report is submitted by the Cleveland (Ohio) Department of Public Health for its federally funded Healthy Start Project, *MomsFirst*, (formerly called Cleveland Healthy Family/Healthy Start). This project began operation in October 1991 as one of the original 15 Healthy Start sites. A Final Report, covering Phase I (October 1, 1991 to May 31, 1997) was submitted in October 2001, and an Impact Report covering the Phase II time period (June 1, 1997 through June 30, 2001) was submitted in October 2002. This Impact Report covers the time period June 30, 2001 through May 31, 2005.

**Background:** During the Healthy Start demonstration phase beginning in 1991, the Cleveland Healthy Family/Healthy Start (HF/HS) Project, with the Cleveland Department of Public Health (CDPH) as the grantee, worked within areas which had, in 1990, the region's highest rates of infant death -- fifteen Cleveland neighborhoods, and the City of Warrensville Heights. A citywide Consortium of consumers and providers was formed in 1991, to provide coordination of Healthy Start activities with other maternal and child health programs in the area. All Project activities were carried out through subcontracts administered by the grantee and overseen by the HF/HS Consortium. The Consortium included 6 Neighborhood Consortia groups, comprised of community residents and led by Community Organizers. The models implemented in 1991 included outreach and home visiting, Infant Mortality Review, and father/partner involvement. Subcontractors were also used to conduct local evaluation and public relations activities.

**Experience in Phases I & II:** Following six years of implementation, and faced with reductions in funding in Healthy Start Phase II, several changes were made to the Project. Warrensville Heights was eliminated as part of the Project Area. Outreach and case management, adolescent services and risk reduction services were given a higher priority, while father/partner programming was discontinued. Further, during Phase I of the Project, a risk assessment process was initiated. A large number of women who appeared to be at little or no risk for poor birth outcomes were being enrolled. Beginning with Phase II, only high-risk women were enrolled as HF/HS participants. The Infant Mortality Review Team ceased collecting data and concentrated on data analysis and the development of public health recommendations. Most local evaluation and public relations activities were transferred to the grantee in Phase II. The Consortium structure remained; Neighborhood Consortia continued to meet, although fewer Community Organizers were employed by the Project. The Project also added a mobile medical unit, the MOMobile, to help deliver medical care and raise community awareness of the need for prenatal and well child care.

**The *Eliminating Disparities* Project Period:** Under Healthy Start *Eliminating Disparities* funding, the project further evolved and improved. Beginning in 2001, the project focused on eliminating racial disparities in infant mortality and morbidity rates by enrolling high risk African American women. Even in the face of funding constraints, the project was able to expand its target area to encompass the entire City of Cleveland. Throughout this project period, core services were provided by the Project in three arenas: the community at large, schools, and institutions.

The citywide Consortium remained in place, and despite the elimination of Community Organizer positions, Neighborhood Consortia remained intact, providing an avenue for community involvement and health education. Through significant collaboration with the state's Title V program under a grant it received from the Health Resources Administration's Community Access Program, the processes of outreach and client recruitment, case management and health education were made consistent across the project, and workers who conducted home visits began receiving standardized, college-level training. A uniform data collection and tracking system was implemented across all project components. This professionalization and standardization was undertaken as a key strategy in sustainability. As part of that strategy, during this time period, the title of the project's Outreach Worker position was ultimately changed to Community Health Worker (CHW), since CHWs in Ohio have the greatest chance of having their work deemed reimbursable by Ohio Medicaid.

The project's depression screening and referral process was also initiated during the project period, serving as a catalyst for statewide and regional information dissemination and resource development. It was also during this period that the project acquired its current name, *MomsFirst*, (which will be used throughout this report) and the project's mobile medical unit -- the MOMobile --was renamed the HealthMobile.

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

*Disparities to be Addressed:* Because of the significant African American population in the City of Cleveland, and following the results of the initial needs assessment, *MomsFirst* identified this population as being most in need of targeted perinatal services and support in order to reduce and eliminate disparities in infant mortality and morbidity. Highlights of the 2000 needs assessment are given below.

*Initial Needs Assessment:* At the time of the initial needs assessment in 2000, 1990 census data showed the City of Cleveland, located in Cuyahoga County in Northeast Ohio, to be a densely populated urban area, with over 500,000 residents, Cuyahoga is the most populous and urbanized of Ohio's 88 counties, with more than 1.4 million residents. At the time of the 1990 census, Anglos comprised 49.6 percent of Cleveland's population, African Americans 46.5 percent, Asians and Pacific Islanders 1.0 percent, and Native Americans 0.3 percent. The remainder were of mixed heritage or did not report ethnicity. Latinos, who may be of any race, comprised 4.4 percent of the city's population at that time. According to 1990 census data, 24% (123,581) of city residents were women of childbearing age (15-44 years), with 45% being Anglo, 46% African American, 5% Latina and 4% of other ethnic origin.

*Poverty:* In 1990, nearly 43% of families with children under the age of eighteen in the City of Cleveland lived at or below 100% of poverty, as compared to approximately 7% of families in the remainder of Cuyahoga County. At that time, estimates indicated that 28% of Cleveland's Anglo children, 54% of its African American children, and 50% of its Latino children lived in poverty. By 1995, the City of Cleveland's poverty rate was nearly eight times higher than that of surrounding suburbs; nearly 45% of the total

population of the City of Cleveland lived below the poverty level. The county's highest levels of poverty were concentrated in the City of Cleveland.

*Educational Levels:* 1990 census data revealed that over 40% of adults over the age of 25 in the city of Cleveland lacked a high school or general equivalency diploma, with the rate for African Americans approaching 45%. At that time, only 34% of students who began the ninth grade in the Cleveland Municipal School District ultimately graduated.

*Unemployment Rates:* Significant disparities existed in rates of unemployment in the region. Suburban unemployment rates were decreasing dramatically at that time, but Cleveland's 1997 unemployment rate was still nearly double that of its suburban neighbors. Further, in 1997, the city's Anglo population experienced an unemployment rate of 2%, while its African American population experienced an unemployment rate of 8%.

*Birth Rates:* Statewide, the birthrate was 13.6 per 1,000 population in 1998, with rates being higher for African Americans (17.5) and others (19.9) than for Anglos (13). The average annual number of births in the City of Cleveland between 1996-98 was 8,617, with 36% (3,100) being births to Anglo mothers, 52% (4,462) being births to African American mothers, 9% (743) to Latinas and 3% (312) to mothers of other ethnic origins.

*Infant Death Rate (IDR):* According to the Ohio Department of Health's (ODH) *Title V 2001 Needs Assessment*, the Infant Death Rate statewide was 8 per 1,000 births in 1998. However, the IDR among the African American population (14.2) was more than double that of the Anglo population (6.9).

Similarly, in Cleveland, the average IDR across the population between 1996-98 was 12.7 per 1,000 births. Among Anglos the rate during that time period was 9.0, for African Americans 16.6, for Latinos 9.4 and among people of other ethnicities, the rate was 1.0.

At the time of the initial needs assessment, data from the 1999 Cuyahoga County Child Death Report revealed that between 1990-99, among all children in the county from birth up to the age of eighteen, 71% of deaths occurred among those children under the age of one year. During that time period, the majority of all child deaths occurred in the City of Cleveland.

*Neonatal Deaths:* In Ohio, the neonatal IDR (deaths occurring in the first 28 days of life) was 5.3 per 1,000 live births in 1998. While neonatal deaths among African Americans had been decreasing statewide, in 1998 that rate was (8.9), still nearly double that for Anglos (4.7).

In Cleveland, the average neonatal death rate from 1996-98 was 8.2 per 1,000 live births. However the rate was 5.8 among Anglos, 10.5 among African Americans, 8.1 among Latinos, and 1.0 among people of other ethnic origins.

Postneonatal Deaths: According to the ODH *MCH 2001 Needs Assessment*, the postneonatal mortality rate (deaths between 29 and 364 days) statewide was 2.6 per 1,000 births in 1998.

In Cleveland, the average postneonatal death rate was 4.5 per 1,000 live births between 1996-98. Among Anglos the rate was 3.6, among African Americans 6.1, among Latinos 1.4 and among other ethnic groups, 1.0.

Low Birth Weight: Ohio's rate of low birthweight (infants born under 2,500 grams) was 7.7% of all live births in 1998. However the rate for African Americans was nearly twice that of Anglos, 13.2% versus 6.8%. Over all populations, low birth weights in the state were highest among live births to teens.

In Cleveland, the rate of low birthweights between 1996-98 was 11.25% overall. Among Anglos the rate was 8.9%; among African Americans it was 14.01%, for Latinos the rate was 7.0 and among other ethnicities, 4.81%.

Very Low Birthweight: Data from ODH indicated the rate of live births under 1,500 grams was 1.5% in 1998. Again, very low birthweights among African American women (2.9%) was twice that of Anglo women (1.3%).

In Cleveland, the rate of very low birthweights between 1996-98 was 2.48% overall. Among Anglos the rate was 1.77%, among African Americans it was 3.32%, for Latinos the rate was 1.212% and among other ethnicities, 0.98%.

Births to Teen Mothers: Births to teen mothers, defined by ODH as 10-19 years of age, began declining in the early nineties. However, in 1998, the rate of births to African American teens was still shown to be three times that of Anglo teenagers statewide.

In Cleveland, 15.5% of all births between 1996-98 occurred among girls age 18 and younger. Among these births, 20% occurred among Anglos, 59% occurred among African American girls, 12% occurred among Latinas, and 9% among girls of other ethnic origins. Further, among all births to Anglos during this time period, 9% occurred among teens; among all births to African Americans, 18% occurred among teens; among all births to Latinas, 20% occurred among teens; among births to women of other ethnic origins, 44% occurred among teens.

Prenatal Care: According to ODH data, in 1998, 85% of pregnant women in Ohio began prenatal care in the first trimester of pregnancy, as recommended. Over 87% of Anglo women statewide entered care in the first trimester in 1998, compared with 72% of African American women.

In Cleveland, an average of 71% of women entered care in the first trimester of pregnancy between 1996-98. Among all Anglo women giving birth, 81% entered care in the first trimester. Among African American women, this figure is 66%; among Latinas, 72%; among women of other ethnicities, 40%.

Between 1996-98 in Cleveland, on average, 8.4% of women giving birth reported having no prenatal care prior to delivery. Among all of these births, 10% occurred among Anglos, 66% occurred among African Americans, 3% among Latinas, and 21% among women of other ethnicities. Among all births to Anglos, this percentage was 2.2, among African American births, 11%, among Latinas, 3.5%, and among births to women of other ethnic origins, 48%.

*Adequacy of Care:* According to ODH Needs Assessment data, only 49% of women delivering live infants statewide in 1998 received an adequate level of prenatal care according to the Kotelchuck index. Between 1996-98, an average of 57% of women in Cuyahoga County received adequate prenatal care. In Cleveland, among all births between 1996-98, 56% of women had at least one prenatal appointment before 12 weeks of gestation and nine or more prenatal appointments over the course of the pregnancy.

The needs assessment data provided the Consortium with confirmation that the city's African American population should be the primary target of its recruitment efforts. Further, as part of its own planning and needs assessment process, the Ohio Department of Health (ODH) identified racial disparities in health outcomes, particularly in birth outcomes, as being of primary concern. The *MomsFirst* Project followed the model of those proposed by the Title V program. Specifically, Ohio's Title V Annual Plan had as a primary performance measure the reduction of the ratio of the black perinatal mortality rate to the white perinatal mortality rate. The *MomsFirst* Project chose to mirror Title V activities across the state by: identifying subpopulations in the African American population at risk for poor birth outcomes; expanding programs to employ Community Health Workers to improve access to care through culturally competent care coordination and other social support; and raising community awareness of the disparity issues to build commitment in reducing that disparity by mobilizing the community.

## **II. Project Implementation:**

The models under *Eliminating Disparities* funding included the continued implementation of outreach and client recruitment, case management, and health education and training from Phases I and II. Interconceptional care and depression screening and referral were added during this project period. All Core Systems-building efforts were also continued from Phases I and II.

### ***Outreach and Client Recruitment***

*A: Outreach and Client Recruitment Rationale:* At its outset, the main strategy of the *MomsFirst* Project was the development of a community based outreach program. During the Project's initial planning stages in 1991, the Perinatal Outreach Project was an active program of MetroHealth Medical Center's (the county hospital) Title V Maternal and Infant Health program. Operating in a small number of Cleveland neighborhoods over three years, the Perinatal Outreach Project effected a 36% decrease in infant mortality from its baseline. During *MomsFirst's* first two Phases, significant reductions in infant

death rates in the target area were also observed, declining from 23.3 deaths per 1,000 births in 1990 to 15.9 deaths per 1,000 births in 2000. The impact of the project was also seen in the IDR for the entire city of Cleveland: the city's 1990 IDR was 18.0 in 1990, and dropped to 11.2 by 2001.

Outreach was the starting point for all other core services, since CHWs who conducted outreach activities also carried out case management and health education with enrolled participants. Outreach and the other core services were conducted in three areas: *community based* services, designed to reach the community at large through six Neighborhood Centers in Cleveland and deployment of the HealthMobile; *school based* services to reach adolescents through the Cleveland Municipal School District (CMSD); and *institutionally based* services to serve special populations of women in prisons, shelters and substance abuse treatment facilities, through Northeast Ohio Neighborhood Health Services, Inc., (NEON) a system of health clinics on Cleveland's east side, funded under Section 330 of the Public Health Service Act.

*B. Outreach and Client Recruitment Components/Resources:* Outreach was implemented during Phase I of the *MomsFirst* Project, however, the subcontractors originally employed were not community-based agencies. During Phase II, community based outreach was carried out from settlement houses, or Neighborhood Centers. Neighborhood Centers are trusted institutions in the Cleveland area, originally established to help immigrants assimilate into American life. Since their founding, they have served the neighborhoods surrounding them with a variety of services. Today these include Head Start, senior services, meal programs, after school activities, early childhood education, recreational opportunities, and child day care. From 1996-2002, the *MomsFirst* Project carried out community based outreach activities at various Neighborhood Centers through a contract with the Centers' umbrella organization, Neighborhood Centers Association. There were some advantages to this arrangement, including centralized communication and fiscal responsibility. However, experience showed that performance suffered as a result of this additional management layer. Beginning in June 2002, the grantee entered into direct contracts with each of the six Neighborhood Centers taking part in the project.

Beginning in Phase II and through out the *Eliminating Disparities* funding period, school based outreach was conducted to reach middle and high school students in the Cleveland Municipal School District. Institutionally based services were provided through the High Risk Team (HRT) at NEON. )

The *MomsFirst* Project used an indigenous outreach model to conduct community based outreach, wherein community residents are employed as Community Health Workers. CHWs continued to use creative ways to reach women, including recruitment in neighborhood gathering places such as laundromats, bingo halls, meal programs, grocery stores and check cashing establishments. The Project's high visibility in the community led to many self referrals and referrals from other social service agencies. Friends and relatives also frequently referred women to the Project, and the Project's HealthMobile facilitated enrollment and health care as it traveled in the Project neighborhoods. Such

grassroots outreach proved critical to reaching and enrolling high risk African American women in an inviting and friendly manner.

The Cleveland Municipal School District's yearly enrollment of over 70,000 students makes it the largest in the state, and an obvious vehicle for reaching Cleveland teens. The School Outreach Team operated under the direction of a Case Manager. Intervention Specialists provided outreach and case management services while Prevention Specialists worked with teens on pregnancy prevention and other prevention programming.

As a federally designated Community Health Center located on Cleveland's east side, NEON's clinics are located within some of the city's most impoverished and medically underserved neighborhoods. As such, NEON staff possessed a keen awareness of the needs of special populations of women who require enhanced maternal and child health services. In many Project Area neighborhoods, the families most at risk for poor birth outcomes and infant mortality were those where the mother was homeless, incarcerated, or was re-entering the community after incarceration. HRT staffing in the *Eliminating Disparities* period included a Program Manager, two Health Educators and a part time Community Re-Entry Specialist.

*C. Facilitators/Barriers to Successful Implementation of Outreach and Client Recruitment:* The Project's most significant challenge came in its first year of the *Eliminating Disparities* funding period, when there was an unanticipated extension of the previous project year until June 30, 2001. This extension left contractors with no funds for this extra month in the budget year, and resulted in the temporary layoff of all *MomsFirst* contractor staff members as of May 31, 2001. Many of these employees found other work and in some cases contractors were not fully staffed with trained and oriented employees again until October 2001. Participants who were enrolled as of May 31, 2001 were referred to other programs or graduated from the program. When the program resumed in the fall of 2001, each component was essentially starting fresh, and began recruiting participants and re-creating caseloads. Hence, programmatic activity was significantly slowed for as long as twelve weeks at the beginning of that program year as caseloads were being rebuilt, thus diminishing the project's overall effectiveness.

A diminished funding level for the first year also required the grantee to reduce staff both across contractors and at the administrative level. During July and August 2001, contractors submitted revised budgets and staffing levels. Therefore, program goals were revised in August 2001, to reflect this reduction in human resources.

Also, while directly contracting with the Neighborhood Centers had several advantages, the process had its own "learning curve" as Center directors and staff became familiar with the project's reporting requirements and contractual responsibilities, as well as the new expectations of staff. The grantee now had to administer and monitor six contracts and communicate with six directors instead of one central agency. This initial period of adjustment slowed the project's progress. However, a monthly meeting with the directors of each Neighborhood Center helped to address concerns as they arose.

Finally, reporting the true impact of the project became more complex. Prior to the *Eliminating Disparities* funding period, the project measured its progress based on improvements in infant death rates and low birthweight rates for women in the 15-neighborhood target area. Beginning in June 2001, the project altered its objectives and began focusing on the reduction in disparities in these rates between Anglos and African Americans across the entire city, making comparisons to the Project's earlier baselines and accomplishments less meaningful. Demonstrating progress was further hampered by lengthy delays in the receipt of vital statistics data from the State of Ohio.

### ***Case Management:***

*A. Case Management Rationale:* Outreach and client recruitment were highly successful during Phases I & II as workers across all project components fostered relationships within their communities, and developed creative methods to reach pregnant and parenting women. However, by the start of the *Eliminating Disparities* funding period, it became clear that a greater level of case management and care coordination was needed to serve the very high-risk women which were now being enrolled in the project. Case Managers were put in place as supervisors of CHWs.

*B. Case Management Components/Resources:* In the *MomsFirst* Project, the CHW who initially conducted the outreach, recruitment and enrollment of a participant then became that participant's home visitor and health educator. Case management in the Project was actually care coordination and consisted entirely of home visits. Once an initial assessment determined a woman's particular risk factors, the CHW discussed perceived needs with that participant. The CHW and Case Manager consulted to determine a service plan. Subsequent visits were used to conduct one-on-one instruction and support regarding her specific needs. Additionally, CHWs within the school district conducted a visit in the school building to ensure the teen was keeping up with her work, and helped to identify where supports were needed to keep her in school. Likewise, as the High Risk Team visited participants in various institutions, they were able to determine what supports were necessary, as well as those which would be needed to transition back into the community.

With this structure as a basis, during the *Eliminating Disparities* funding period, significant changes in home visiting and case management were implemented through a partnership with the state's Title V program at the Ohio Department of Health.

In 2000, ODH's Bureau of Child and Family Health Services convened several outreach and home visiting programs in the state, including *MomsFirst*, to enable programs to share ideas and improve services. The group adopted a common name for Community Health Workers – Community Care Coordinators (CCCs) which generated the name Community Care Coordination Collaborative (C4). The group immediately recognized the need to standardize training and service delivery for CCCs, particularly in order to receive Medicaid and other third party reimbursement.

In September 2001, C4 secured a Community Access Program (CAP) grant from the Health Resources and Services Administration's Bureau of Primary Care. This CAP program focused specifically on reaching high risk pregnant women across the state, to link them to available insurance and health care services. As part of this program, and as the largest outreach and home visiting program for pregnant women in the state, *MomsFirst* Case Managers and CHWs began taking part in standardized college level training in the areas of health care, social services, communication skills, individual/community advocacy, health education and service skills and responsibilities. CHW training consisted of a one week intensive core module on the basic competencies, followed by a two week module on maternal and infant health. Students then entered a 32 week supervised field experience with a weekly seminar. The curriculum was approved by the Ohio Board of Regents, and led to a Community Care Coordinator certificate.

The training through the CAP program also included standardized care processes. *MomsFirst* CHWs (i.e., CCCs) used "Pathways" to determine appropriate action with participants. Pathways were similar to clinical practice guidelines, in that they outlined the best course of action for a particular health risk. Workers were guided through the recognition of the problem, steps to rectify the issue and closing/completion steps.

Finally, as a result of the CAP funding the *MomsFirst* Project began utilizing a standardized database developed for all of the participating Ohio sites. The Outreach Tracking System (OTS) was an information system that identified community and individual needs as they related to the client. Pathways were also integrated into the database, and assigned timelines for completion by providers, enabling CHWs and their supervisors to track progress and reach closure for participants. The database was also designed to assist workers in linking participants to health insurance programs such as Medicaid and SCHIP.

Therefore, beginning in the *Eliminating Disparities* project period, for the first time all *MomsFirst* CHWs were following identical, standardized case management protocols and entering data in a common, centralized database, and were being overseen by Case Managers who were following standard supervisory protocols.

*C. Facilitators/Barriers to Successful Implementation of Case Management:* The core competencies required for Case Managers and CHWs, Pathways and accompanying Outreach Tracking System, while designed to improve client outcomes, also brought significant challenges to the program. The use of a personal computer was mandatory in order for CHWs and Case Managers to complete their work. Many longtime project employees were not computer literate, and required extra assistance to keep up with these new demands. The system also made clear when protocols were being followed and when work was complete. This higher level of accountability proved to be a challenge to some – and the rate of turnover among CHWs was high during the first years of this funding period, leading to lower than expected enrollments.

The installation of the OTS was itself a challenge. All contractors received new hardware to implement the system. Like many IT installations, there were numerous delays as

hardware, phone line and software problems were resolved. These delays resulted in data entry backlogs, as old data was manually entered into the new system. During the first years of the project period, CHWs worked to eliminate these backlogs, which took time away from their outreach and client recruitment efforts, leading to lower enrollments for a time.

Additionally, the project had set an ambitious goal for the enrollment of women who were in their first trimester – a minimum of 70% of all enrollments of pregnant women. This proved to be particularly challenging for obvious reasons – many women aren't visibly pregnant at that time, and indeed, many don't learn of their pregnancy until their second trimester. Women in their first trimester are also often undecided about carrying the pregnancy to term, and are uninterested in a prenatal care program.

### ***Health Education and Training:***

*A Health Education and Training Rationale:* From its inception, the Consortium recognized the need for health education, both for Project and community participants. Health education conducted during CHW visits focused on pregnancy and parenting, using a common approach (Pathways) and a variety of tools and curricula. Education for community participants covered a broad range of topics over the project's history – from home safety and welfare reform to African American history and HIV/AIDS prevention. Under *Eliminating Disparities* funding, the focus of health education topics for both types of participants was narrowed to those topics which directly impact improved birth outcomes, provided in a culturally appropriate manner, an approach designed to maximize project resources.

*B. Health Education and Training Components/Resources:* Health education for program participants during the *Eliminating Disparities* project period was carried out by the Neighborhood Centers, the CMSD, and the HRT of NEON.

During this funding period, topics within the Health Education Pathway included: wellness/health education; nutrition; SIDS, breast feeding; prematurity & LBW prevention; tobacco & substance abuse; STD/HIV/AIDS; self esteem/empowerment; close interval pregnancy; family planning/preconceptual planning; schooling; child abuse; domestic violence; home safety; injury prevention; immunization; early intervention; newborn care; infant stimulation; and exercise.

CHWs working with teens in the schools also crafted specific health education Pathways to support their participants. These included: attendance problem remediation, guidance counselor service referral, home instruction and proficiency testing.

Intensive health education through Pathways was undertaken by the HRT through both group sessions in the facilities, and ongoing and repetitive individual sessions. Two Pathways were developed especially for the incarcerated population: Incarcerated Women Parenting and Legal Advocacy. Other topics included pregnancy, women's issues, HIV/AIDS and STD prevention, substance abuse, self esteem, domestic violence,

mental health and child abuse. Parenting classes were offered twice weekly in six week sessions. Health education, and linking women to wellness resources when they returned to the community, was viewed as a key element to risk reduction among this very high risk population.

Community participant involvement in the *MomsFirst* Consortium at the grassroots level was accomplished at the Project's inception through the establishment of Neighborhood Consortia (NC) at each Neighborhood Center. NC membership included participants, interested residents, clergy and representatives of community businesses and organizations. Each Neighborhood Center was required to obtain approval from the grantee for all NC health education activities. Contractually, each Neighborhood Center was required to conduct 8 NC activities with a minimum of 8 neighborhood participants each year. A 200 word written evaluation of every completed NC event was submitted to the grantee, which detailed the event, Highlights, Problems, and Possible Solutions.

Additionally, Peer Advisory Groups in the school buildings offered the opportunity for teens to explore health and wellness topics such as teen pregnancy and prevention, peer pressure and self esteem, and healthy relationships. Average attendance was 25-40 students per building at monthly meetings in each of the 16 high schools. Within the middle school buildings, the prevention curriculum, "Draw the Line, Respect the Line" was used in health education classes; CHWs also used this curriculum to reinforce its messages with teens in the community. "Sobriety Celebrations," conducted by NEON for the participants residing in institutions, also included educational topics and speakers.

*C. Facilitators/Barriers to Successful Implementation of Health Education and Training:*

In conducting home visits, the Project's implementation of Pathways was helpful since Pathways outlined the best course of action for a particular health risk for a participant. However, content was not strictly dictated and there was no evidence based, professionally evaluated health education curriculum by subject area. CHWs used several information sources, which varied by site. Also, there was limited coordination between existing health education resources within the CDPH and those of the Project. At the close of the project period, this was being addressed through the introduction of a standardized, evidence based curriculum.

Notably, CHWs also were inclined to only address those issues with which they were comfortable. For instance, a CHW might be hesitant to conduct the Smoking Cessation Pathway, if she herself were still a smoker. Further training, and support and education of CHWs, helped to alleviate this issue.

Conducting health education sessions for community participants also became more challenging over the life of the project. With increased requirements for work or schooling required by welfare reform, many community residents did not have time to attend health education presentations. Incentive items, offered to community participants who attended a minimum number of health education sessions, improved participation.

### ***Interconceptional Care***

*A. Interconceptional Care Rationale:* Family planning is viewed as a very private, personal and individualized decision, and one which requires continual support and reinforcement. Therefore, interconceptional care was provided in the *MomsFirst* Project through health education during home visiting and case management. Participants were assisted in learning about family planning methods, choosing the right method for them, and accessing supplies. Through a partnership with Planned Parenthood, the HealthMobile was also used to reach women with interconceptional care throughout Cleveland neighborhoods.

*B. Interconceptional Care Components/Resources:* Interconceptional care for program participants was carried out by CHWs at Neighborhood Centers, CMSD and NEON. Program participants in the interconceptional phase were given information regarding the health benefits of birth spacing, methods of contraception, child development, child management, general wellness, and preconception care. Participants were also supported in improving their attitudes toward pre-conception care, their general desires to seek health care, and removing barriers to that care. A postpartum risk assessment was used to collect information about the choice of a family planning option. Where a woman had not made that choice, the CHW reviewed all possible methods of birth control from abstinence to sterilization, and helped the participant choose a method. Both verbal and written information were provided, and CHWs were provided with both male and female “demonstrators” of barrier methods. Referrals were made to family planning clinics as requested by participants.

Additionally, pregnancy tests, family planning information and supplies were made available through CHWs, as well as aboard the Project’s HealthMobile as it visited target neighborhoods

*C. Facilitators/Barriers to Successful Implementation of Interconceptional Care:* Implementation of interconceptional care was facilitated by the purchase of male and female condom demonstrators for each outreach site, along with supplies. However, off site distribution of supplies was required at some Neighborhood Centers which were operated by faith based organizations whose religious beliefs conflicted with comprehensive family planning service models. Also, school personnel were not permitted to conduct pregnancy testing or discussions of birth control on school grounds; such activities were conducted during home visits.

### ***Depression Screening and Referral***

*A. Depression Screening and Referral Rationale:* The prevalence and ramifications of perinatal depression have been well documented nationally. However, at the start of the *Eliminating Disparities* funding period in 2001, no comprehensive assessment of the incidence or prevalence of perinatal depression in Cleveland existed. The Project’s initial approach was to conduct a needs assessment. From the results, a plan for further collaboration and resource development was created during the project period.

*B. Depression Screening and Referral Components/Resources:* In 2002, the *MomsFirst* Project entered into a contract with the Cleveland Regional Perinatal Network (CRPN) to conduct the area's first assessment of perinatal depression among African American women. The CRPN is a multidisciplinary regional professional outreach program which provides a forum for regional planning and problem solving. The group coordinates and designs programs to meet the needs of perinatal provider groups. Acting as the lead agency for this study, the CRPN also collaborated with University MacDonalld Women's Hospital, MetroHealth Medical Center, NEON and United Way of Greater Cleveland. Together, these organizations have, in some way, cared for more than 50% of the African American women who give birth in Cleveland each year.

The CRPN assessed nearly 400 pregnant, African American women residing in the city of Cleveland for perinatal depression, in order to estimate its prevalence. Surveys were used to identify screening and referral practices by health care and social service agencies, as well as available mental health services in Cuyahoga County. Focus groups made up of health care, social service and mental health providers, were presented with this data in order to recommend an implementation plan for addressing gaps in service.

The research revealed there was no cohesive system of care for women who appeared to be at risk for perinatal depression, and few mental health resources available. The primary reason for this is that *MomsFirst* participants were also enrolled in Medicaid HMOs. (All Ohio Medicaid recipients in Cuyahoga County were required to enroll in a managed care plan). These HMOs did not offer mental health or substance abuse treatment. Rather, these services were "carved out" and separate federal, state and local funding streams were used to pay for this care for indigent clients.

In Cuyahoga County, this funding was allocated to the Cuyahoga County Community Mental Health Board (CCCMHB). This funding agency in turn entered into contracts with various service providers in the community. The availability of mental health services in general, and specifically for perinatal depression, was extremely limited. However, partially in response to the results of the Project's Perinatal Depression Survey, an existing provider added a satellite office in Cuyahoga County which became available to provide counseling for perinatal depression, bringing the total number of sites to four. This site also provided client transportation and child care, essential to serving *MomsFirst* participants.

A completed plan for integrating perinatal depression screening throughout the *MomsFirst* Project, using the Edinburgh Perinatal Depression Screening Tool, was completed in October 2003. At that time, CHWs and Case Managers received extensive training in the use of the Edinburgh Scale; in November 2003, they began conducting perinatal depression screening in the project, as part of home visits across all three components. Where a participant scored 12 or more on the Edinburgh screen, a standardized letter, signed by the CDPH Medical Director, was forwarded by the CHW to the client's primary care physician. The letter stated that the patient is likely at risk, that she should be more thoroughly assessed, and identified resources in obtaining further help. Project administrators felt that a "physician to physician" letter would send a strong

message about the urgency of the issue, and would prompt doctors to address this treatment need. Primary care physicians then acted as gatekeepers, providing further assessment, and determining whether additional treatment was needed. CHWs verified with the participant that the physician did, in fact, address this topic with her at her last appointment. CHWs followed up with all participants to verify that appointments for perinatal depression treatment were kept. Where they were not, the CHW worked with the participant to remove any barriers.

Additionally, grantee administrators and CRPN researchers met with administrators of the two area HMOs which serve the Ohio Medicaid population, the head of the county's mental health board and community based mental health providers to discuss the insurance coverage options for screening, referral and treatment of perinatal depression among participants enrolled in these two plans.

Through the *MomsFirst* Project's funding of the community's first comprehensive assessment of perinatal depression, the Consortium began its collaboration with Dr. Amy Heneghan, a local researcher in the field of perinatal depression. Through this collaboration, the *MomsFirst* Project created the "Guide for Moms." The Guide was an easy to read compilation of many resources that may be needed by mothers and providers alike. It contained information on many topics – parenting support, alcohol, tobacco and other drugs, legal assistance, etc., so that its description of the signs and symptoms of perinatal depression, and the steps to take to get help, were embedded in a larger context and were therefore less intimidating or stigmatizing. The Guide also contained suggestions for help: talking to a clergy person, contacting one's primary care provider or health insurance provider. A list of three local mental health service agencies which treat depression was also included. Program participants who received the Guide were asked to evaluate its usefulness. Participants found it very helpful and easy to use and read. The Guide was freely available from the CRPN website and was distributed by area HMOs serving Medicaid clients.

During the *Eliminating Disparities* project period, the *MomsFirst* Project led the way in addressing perinatal depression as a public health issue in Ohio. No state or local mental health, nor MCH program, conducted activities regarding perinatal depression prior to the Project's need assessment. The efforts of the Project provided the catalyst for other programs and agencies to begin to address the issues with training and resource development. The success of the "Guide for Moms" led to its purchase and distribution throughout Ohio. At the close of the project period, Dr. Heneghan was preparing to conduct a study of referral protocols and results for program participants within the state's current Medicaid HMO structure. County administrators were also pursuing the implementation of screening for perinatal depression as well as working with the *MomsFirst* Project to build community awareness and strengthen the mental health system's infrastructure to address the problem.

*C. Facilitators/Barriers to Successful Implementation of Depression Screening and Referral:* Allocation of federal Healthy Start resources for the implementation of Depression Screening and Referral were the critical resource in establishing this

component. Project administrators and their partners were literally starting from scratch in investigating the nature and scope of the problem among the *MomsFirst* population. The CRPN and its researchers proved to be strong partners in conducting the research, identifying solutions and locating further potential resources in creating the “Guide for Moms.”

However, at the close of the project period, the major barrier in this component remained the lack of mental health resources for the indigent population, a nationwide dilemma. There was a general lack of awareness of mental health issues/treatment/resources among physicians as well. Also, Project administrators recognized the need to develop screening tools that are age appropriate. CHWs in the CMSD reported that the Edinburgh Scale is not necessarily sensitive to the needs of teens. Technical assistance was requested to develop a more age appropriate version of the instrument as well as to develop a more effective referral follow up protocol.

### ***Local Health System Action Plan (LHSAP)***

*A. Local Health Systems Action Plan Rationale:* The Consortium used the glaring lack of information surrounding the important topic of perinatal depression to reinvigorate its Local Health Systems Action Plan. Therefore, the Depression Screening and Referral component became the Project’s Local Health System Action Plan during the *Eliminating Disparities* funding period.

*B. Local Health System Action Plan Components/Resources:* Please see the “Depression Screening and Referral” section, above. It was notable that enthusiastic local support among local MCH providers for screening and referral for perinatal depression was a key element in the success of the LHSAP.

*C. Facilitators/Barriers to Successful Implementation of Local Health System Action Plan:* Please see the “Depression Screening and Referral” section, above. As noted, the greatest challenge to fully implementing the LHSAP lie in a 1) lack of local treatment resources for perinatal depression and 2) and general lack of awareness of mental health issues/treatment/resources among physicians. While the Consortium and its partners continued to seek solutions to these challenges, available funding and existing medical practice presented significant barriers to finding solutions in a timely fashion.

### ***Consortium***

*A. Consortium Rationale:* The Project’s approach to creating a Healthy Start Consortium was to create a structure which would enable the involvement of participants, government agencies, private organizations, religious bodies, businesses and concerned citizens in addressing the issue of infant mortality. First established in 1991, the several subcommittees of the Consortium continued to meet during the *Eliminating Disparities* funding period, with participant involvement and feedback at all levels.

*B. Consortium Components/Resources:* As is more fully described in Section D, Consortium, below, the selection and funding of Cleveland as one of the fifteen original Healthy Start sites began the process of unprecedented program integration among maternal and child health agencies, and those interested in the issue. A broad range of consumers, elected officials, clergy, program administrators and policymakers and concerned citizens served on the *MomsFirst* Consortium, including representatives of the state's Title V program, hospitals and federally qualified community health centers.

The Consortium's structure consisted of four committees and the Neighborhood Consortia. The committees are Executive Council, Administrative Management Group, Social/Clinical Services Committee, Center Directors' Meeting and the Consortia Leadership Committee. Neighborhood Consortia (NCs) are groups of community participants who meet at the neighborhood level to receive and share information concerning infant mortality, disparity in healthcare, interconceptional care, and perinatal depression. Each committee inter-links with each other and communication flows between committees and the Neighborhood Consortia.

*C. Facilitators/Barriers to Successful Implementation of Consortium:* Several barriers to the successful implementation of the *MomsFirst* Consortium were encountered during the funding period. For example, as funding levels declined over the project's history, staff time dedicated to relationship building across organizations dwindled. Also, Community Organizers were at one time employed by the project, which significantly increased the number of community events and participants.

As a supportive home visiting program using indigenous outreach workers, the *MomsFirst* Project succeeded in providing linkages to health and social services in the community. However, a particular barrier in conducting its work was a lack of critical stakeholders in its membership, i.e. the medical community. Longtime efforts to leverage the Project as a way to create a partnership with medical practitioners at the participant level – to help engage clients in early, continuous prenatal care, and to monitor that care in conjunction with physicians -- was an ongoing challenge. Some of this was due, in part, to the fact that many Consortium members served at the highest levels of their organizations, and it was difficult to compete for their attention among many priorities. Also, while there were many organizations dedicated to MCH in the area, many were competing for the same customers, as well as for government, foundation and United Way funding.

Collaboration also became a significant challenge. It is often a lengthy process to approach organizations and other systems to collaborate on the issue of infant mortality reduction, since it can sometimes be seen as peripheral to their mission. For example, the improvement of women and children's health through the treatment of perinatal depression was sometimes seen as one among many more urgent priorities when viewed from the perspective of the mental health community. Likewise, issues of "jurisdiction" often impeded the Consortium's progress. Other MCH programs were only be willing to collaborate when there was funding available; or were unwilling to collaborate because a geographic area did not fall within their service area.

## ***Collaboration and Coordination with State Title V and Other Agencies***

### ***A. Collaboration and Coordination with State Title V and Other Agencies Rationale:***

Inviting representatives from the State Title V program and other governmental, private, and religious organizations to be a part of the Consortium and its committees is the primary approach used in the Project to ensure the involvement and input of key players. The Consortium has enjoyed the active participation and assistance of the State Title V program since 1991.

### ***B. Collaboration and Coordination with State Title V and Other Agencies***

***Components/Resources:*** The Title V program in Ohio is administered by the Ohio Department of Health. Title V staff always played a critical role in the *MomsFirst* Consortium by facilitating communication between Project administrators and ODH, arranging meetings between ODH and the CDPH, serving on the Project's Executive Council and exploring alternative funding arrangements. The Project's involvement in C4 during this funding period further solidified its collaboration with Title V.

In addition to coordination and collaboration at the state level, the Consortium sought the involvement of partners among city and county government, as well as private nonprofit agencies which, by mission, mandate or practice, address the issues of maternal, child and family health.

Finally, the grantee's mobile medical unit, the HealthMobile, was utilized to enhance the Project's opportunities for outreach, community education, health screening and collaboration in the area of women's health and interconceptional care.

Collaborative relationships during the *Eliminating Disparities* funding period are more fully described in Section V, *Project Impact*.

### ***C. Facilitators/Barriers to Successful Implementation of Collaboration and Coordination with State Title V and Other Agencies:***

Early in the *Eliminating Disparities* funding period, the project's longtime advocate within ODH, the Division of Family and Children's Health Chief, Kathryn Peppe, R.N., retired her position. She was replaced by Dr. David Schor, M.D., M.P.H., a strong supporter of maternal and child health programming, who assumed Ms. Peppe's seat on the Project's Executive Council and continued to encourage collaboration between the programs.

## ***Sustainability***

***A. Sustainability Rationale:*** The Project's primary approach to sustainability has been to identify those program elements which may be reimbursable under the Medicaid program.

***B. Sustainability Components/Resources:*** An important component in sustainability planning during this project period was working with ODH to explore Medicaid Administrative Match in covering administrative and home visiting costs. Discussions

included the specifics of the MAM claiming procedure and the responsibilities of each agency, as well as the responsibilities of ODH in contracting with service providers.

C. Facilitators/Barriers to Successful Implementation of Sustainability: Early in the project period, ODH and the C4 partners engaged the services of Ms. Hansine Fisher, of the Institute of Human Services Management. Ms. Fisher is a nationally recognized expert in Medicaid administrative match (MAM) financing for the maternal and child health population, and is the author of *Federal Funding for Early Childhood Supports and Services: A Guide to Sources and Strategies*. Ms. Fisher visited the C4 projects and collected data regarding the potential for the organizations' services to be reimbursed through MAM.

The comprehensive training and certification of CHWs through the HRSA CAP grant was also an essential component of this sustainability strategy. With a standardized curriculum for training, and a standardized set of care protocols (Pathways), the work conducted by CHWs could be quantified and measured. This was a critical first step necessary to documenting activities in applying for MAM.

#### **D. Consortium**

1. Establishment of Consortium: In response to the federal Healthy Start Initiative, a broadly representative Consortium was established to foster community-wide collaboration between the public, private and academic sectors in the City of Cleveland to address the problem of infant mortality. The *MomsFirst* Consortium consisted of participants, institutional health care providers, managed care organizations, academic organizations, public schools, nonprofit organizations, state and local government agencies, community based organizations, clergy, and community residents. Upon receipt of Healthy Start funding, the Consortium conducted the Project's original needs assessment and continued to provide oversight and guidance regarding the Project's overall direction.

2. Working Structure of Consortium: Rather than creating one central Consortium as the majority of original Healthy Start sites did, Cleveland established an interconnected system of committees which made up its Consortium. This structure maximized opportunities for local organizations and community residents to take part in the planning and decision-making activities directly affecting each neighborhood. Consortium bylaws stated its composition and mission as being, "...a collection of city-wide committees, neighborhood consortia, and interested agencies, organizations and individuals who strive to reduce infant mortality through promotion of healthy families, preventive, holistic coordinated care and personal and community empowerment [which aims] to facilitate optimal utilization of community resources through recommendations, education, coordination and communication. The *MomsFirst* Consortium's intent is to be supportive, proactive, innovative and dynamic through creating an environment that draws on individual expertise as well as encourages group process for collaborative problem solving. The Consortium fosters sensitivity to racial, cultural, religious and economic differences."

### *Cleveland MomsFirst Project*

The Consortium's official governing body was the Executive Council (EC), chaired by the Mayor of the City of Cleveland. The EC provided general oversight for the *MomsFirst* program. Its primary functions were the development of policies related to oversight, review of annual budgets and approval of the comprehensive program. Several committees made up the *MomsFirst* Consortium. These included Administrative Management Group (AMG) an operations committee consisting of the Grantee and subcontractor representatives; the Center Directors Meeting (CDM), made up of the grantee and the directors of the six Neighborhood Centers; the Clinical/Social Services Committee, designed to provide input regarding medical and social factors impacting *MomsFirst* participants, and the Consortia Leadership Committee (CLC) and Neighborhood Consortia (NCs) which provided the forum for grassroots community input.

The AMG provided the operational oversight for the Project. The primary function of the AMG was to bring together the grantee and subcontractors for policy dissemination, and discussion of operations such as training needs and other management issues relevant to the improvement of the performance of the front line staff.

The Center Directors' Meeting was established as a monthly forum to communicate with each of the six Neighborhood Center directors. Because the majority of core services are provided through the Project's community based workers, a monthly meeting was put in place to ensure both programmatic and fiscal requirements were communicated and discussed with this group of leaders.

The Clinical/Social Services Committee was established to provide consultation to the Consortium on clinical and medical service issues. Responsibilities of this committee included developing and recommending clinical protocols and interventions to participating providers and the Consortium, and providing oversight and monitoring services regarding clinical care. Other Committee functions included developing and recommending social service programs and interventions which would enhance family life and self reliance and reduce social dysfunction, and providing oversight and monitoring of the social services programs being provided in the target area.

The Consortia Leadership Committee and Neighborhood Consortia are discussed in the Sections 6-8 below, which pertain to consumer participation.

3. Consortium Process for Needs Assessment: The Consortium continuously assessed community needs through review of available demographic and epidemiological data, as well as participant views. No formalized procedure or instrument was employed. The Consortium's infrastructure was designed to maximize the input of all community and *MomsFirst* participants, at all levels of the Project.

Direct input from CHWs' experiences with clients was the Project's most important gauge of community needs. Residents' input through Neighborhood Consortia and the Neighborhood Action Plans also provided feedback regarding community issues (see below). During this funding period, an annual Participant Satisfaction survey was

conducted, providing further participant feedback. Among adolescents, the Peer Advisory Groups organized throughout the CMSD provided information regarding the challenges and obstacles faced by teens. The quarterly sobriety celebrations held by NEON's HRT enabled women in institutions to provide feedback on matters of special interest to them. Topics and speakers were then selected for subsequent celebrations based on this participant input.

4. Community Strengths Relative to Consortium: The development of the Cleveland *MomsFirst* Consortium was enhanced by the significant number of institutions and agencies in existence in the community, which were designed to assist children and families, and the willingness of the leaders of those institutions to come together to address the issue of infant mortality. The Consortium was particularly fortunate to have a network of Neighborhood Centers through which residents could readily be mobilized.

5. Weaknesses/Barriers: One of the major barriers to the Consortium's activities was the initial location and times of meetings. The various Consortium and committee meetings had to be scheduled with the needs of participants and community residents in mind. For instance, following community feedback, the time and location of Executive Council was made more convenient for *MomsFirst* participants and community members. These meetings had historically been held at City Hall in downtown Cleveland, where parking is scarce and expensive, particularly during the weekday times at which EC was held. EC meetings were subsequently at community locations and frequently occurred in the evenings to better accommodate community participation.

The use of jargon was also perceived as a barrier to involving community residents. Efforts were made to conduct meetings which included the use of appropriate language and explanations of technical and culturally specific terminology where necessary.

6. Increasing Resident Participation: Building on the principle of resident and provider involvement at all levels, the Consortium structure was established to integrate the knowledge, skills and abilities of community members in the needs assessment, resource identification, planning, decision-making, implementation and monitoring involved in the *MomsFirst* Project. This was accomplished through the active participation of consumers and community residents in Neighborhood Consortia and the Consortia Leadership Committee. Their participation provided immediate and direct information regarding consumers' needs.

Neighborhood Consortia were designed to mobilize community residents to address the problems contributing to infant mortality. The overall goal of the NCs was to promote consumer participation in all aspects of the Consortium. Members of NCs included *MomsFirst* participants, neighborhood residents and health care providers, social service providers, and representatives from businesses and educational and religious organizations operating in the Project Area. Each NC developed a Neighborhood Action Plan to provide health education on the Healthy Start health education topics which directly impact infant mortality. NC members were then responsible for the plan's implementation and monitoring.

Recruitment of NC participants took place through referral of *MomsFirst* participants as well as community canvassing and other organizing activities carried out by Neighborhood Centers. NCs met at least eight times per year.

7. Consumer Input: The Consortium Leadership Committee (CLC) was established to further ensure consumer input. The CLC consisted of four leaders from each Neighborhood Consortia. The primary responsibilities of CLC members were to represent all NCs in the larger *MomsFirst* Consortium, to disseminate information to and from the NCs, to oversee the development of Neighborhood Action Plans, and to provide consumer input regarding Consortium priorities and activities.

8. Using Consumer Input: Consumer input was used to change the process and administration of the Consortium itself, as noted above, when consumers indicated that times and locations of meetings had to be adjusted. CLC and NC members also identified topics for NC and citywide CLC health education and training activities. Participant Satisfaction surveys have also highlighted project components which have worked well, and items which are barriers.

## **E. Sustainability**

*1. Managed Care/Third Party Billing:* During this funding period, ODH continued to pursue Medicaid Administrative Match (MAM) financing for services delivered to the maternal and child health population. Meetings between ODH and the Ohio Department of Jobs and Family Services (ODJFS), the state Medicaid agency, were held to discuss the specifics of the MAM claiming procedure. Collecting information on “billable outputs” continued, in order to define the services of Community Health Workers.

State legislation pending at the close of the *Eliminating Disparities* funding period would enable certified Community Health Workers to bill for case management and home visiting services as independent practitioners. The grantee provided input and support for this legislation, seen as one path to sustainability for Project activities beyond federal funding.

*2. Identifying and Developing of Resources:* The Project’s most significant resource development activity was the ongoing work of the statewide Perinatal Planning/Financing Workgroup through the C4 collaborative. These agencies came together to address service delivery and potential funding strategies. Meeting on a monthly basis, this group began discussions with the Ohio Department of Jobs and Family Services regarding a Medicaid Administrative Match for Healthy Start services and other home visiting programs statewide. The group established the curricula for CHWs which would provide them with a standardized certification, leading programs like *MomsFirst* to become eligible for Medicaid Administrative Match funding.

*3. Overcoming Barriers:* The Project’s major barrier to attracting additional funding has been its placement within a publicly funded agency. Overcoming this barrier would entail the Project’s becoming a part of the city’s General Fund budget. Barring this, the Project

must become an independent, nonprofit organization, in order to attract philanthropic dollars.

### **III. Project Management and Governance**

A. Structure of Project Management: The Cleveland Department of Public Health continued to serve as the Grantee agency during this funding period. The CDPH's *MomsFirst* administrative staff included a Project Director, Deputy Project Director, Management Specialist, Quality Assurance Analyst/Research Associate, Budget & Management Analyst, and HealthMobile Driver. Funding reductions during this budget period resulted in the loss of the Project's Grants Administrator and Office Manager positions.

*MomsFirst* administrators oversaw daily operations of the Project, and executed and monitored all subcontracts. The CDPH administrators met monthly with subcontractors through the Administrative Management Group and Center Directors' Meeting. The Clinical/Social Services Committee also met monthly during the funding period. Each Neighborhood Consortia met between 8 - 12 times per year. Active NC participants then took part in quarterly Consortia Leadership Committee meetings. The Executive Council met quarterly and was attended by CLC representatives, subcontractors, other Consortium members and the community at large.

B. Fiscal and Program Management Resources: As a part of the Cleveland Department of Public Health, the *MomsFirst* Project was part of a larger web of support and resources which were essential for program management. Fiscal support and oversight was provided to the Project by the Department's Chief Financial Officer, who was the Project's link to the city's Office of Budget and Management. The Department's Chief Biostatistician provided substantial data analysis to the Project. Program oversight and support was provided by the Commissioner of Health and the Department's Director.

Through the CDPH structure and two community health clinics, the Project also had access to staff in the Divisions of HIV/AIDS, nursing, mental health and substance abuse, lead poisoning prevention and immunization services. This proved to be particularly critical in the deployment of the HealthMobile and allowed for increased access to these services.

C. Changes in Management and Governance: The major change in project management occurred in the second year of *Eliminating Disparities* funding, when outreach activities were transitioned from the Neighborhood Centers Association directly to the Neighborhood Centers. This change was undertaken to make the community the foundation for systemic change and Project input.

D. Process of Distribution of Funds: In order to ensure fiscal accountability, the Grantee oversaw the award of subcontracts, and carefully monitored subcontractors' use of funds. Written fiscal policies and procedures were developed in Phases I & II to ensure appropriate expenditures. During this project period, the process was refined, as the

grassroots organizations which were now carrying out program activities became accustomed to a higher level of financial and programmatic accountability.

E. Additional Sources of Funding: Between 2002-2004, the Project received support from the federal Health Resources and Services Administration, Bureau of Primary Health Care and its Community Access Program. CAP funding provided the resources for CHW training and certification at the community college level, as well as new MIS equipment, software and training, and Pathway development.

F. Cultural Competence of Contractors/Staff: No issues of cultural competence regarding Project implementation were brought to the attention of the grantee during the *Eliminating Disparities* funding period. The majority of Case Managers in the Project were African American and nearly 99% of CHWs were African American or Latina, reflective of the population being served. This has been an important benefit in developing Project programming. For instance, the grantee relied heavily on contractor staff during the development and evaluation of Pathways to ensure this model could appropriately serve community participants' cultures. Staff feedback and their difficulty with the Pathway Model-despite extensive training and support-were a significant reason for considering a new Health Education curriculum at the close of the funding period.

#### **IV. Project Accomplishments**

A. Project Strategies: During this funding period, the *MomsFirst* Project's purpose was to build upon its prior success in improving birth outcomes, particularly a reduction in infant mortality in the Project Area, by focusing on eliminating disparities in poor birth outcomes between Anglos and African Americans across the entire city of Cleveland.

The Project's major strategies were the provision of core services to women in the three areas discussed above: residents in the community, teens in the Cleveland Municipal School District, and among women in institutions: jails, treatment centers and shelters. Outreach, case management and health education were provided in each of these three areas, with interconceptional care and depression screening integrated into these activities. Please refer to the Project's *Objective, Strategy and Progress* charts in **Attachment A** for a detailed report of each of these strategies. Brief descriptions of each follow.

##### ***Community Based Outreach, Case Management and Health Education***

*Description*: As noted above, community based outreach, case management and health education was carried out through Community Health Workers, supervised by Case Managers, located at six Neighborhood Centers in the city of Cleveland. Outreach strategies included: door-to-door canvassing, both during weekdays and weekends; posting of tear-off flyers; a consistent presence at community sites (e.g. shopping centers, parks, hair and nail salons, churches, clinics, hunger centers, TANF and food stamp offices); and presentations at community meetings, forums and health fairs. CHWs also

followed up on self-referrals as well as referrals made by Consortium partners for enrollment. Priority was placed on enrolling women in their first trimester of pregnancy.

CHWs administered a risk assessment to determine a woman's eligibility for enrollment, completed the enrollment process and worked with Case Managers to develop individual service plans for participants. Neighborhood Center staff also worked closely with the CDPH to ensure the CHW's active involvement with the Department's HealthMobile schedule. On-site health screening, pregnancy testing and information on contraception was provided on the vehicle. The HealthMobile maintained a regular monthly schedule in eight Cleveland neighborhoods with the highest rates of infant death, in addition to appearances at Neighborhood Centers and other city events. The unit's visibility, and the availability of screening services right in the neighborhood, added to the Project's outreach efforts.

Home visits were carried out by the CHW who originally conducted the outreach to that participant. Home visits began immediately upon a client's enrollment in the program and were conducted based on information collected in the risk assessment. Periodic re-assessment enabled CHWs to adjust home visiting activities to accommodate a participant's changing needs.

Home visits included care coordination, health education and emotional support. Tangible incentives were also provided: bus tickets for trips to the doctor, vouchers for cribs or other substantial items, or emergency formula and diapers. By contract, CHWs were required to conduct two face to face home visits with all clients each month, along with one phone contact, for three contacts each month. Once a woman had delivered her baby, the CCC was required to see the infant face to face at least once per month. By the close of the funding period, depression screening (using the Edinburgh Scale) and referral had become an important component of risk assessment and home visiting in the Project.

Participant health education was conducted during home visits through a combination of one-on-one instruction, written materials, and referral to other providers. CHWs initiated health education sessions through a perceived need, or through a client's request. Case Managers could also assign a health education Pathway to be followed based on their review of a participant's risk assessment information.

Once the need was identified, the CHW accessed resources on hand through the *MomsFirst* program (i.e., pamphlets, brochures or flipcharts) or referred a woman to an outside source. For example, if smoking was identified as a risk factor on the risk assessment, the CHW might have begun by engaging the woman in conversation about the dangers of smoking during pregnancy, asking her a series of questions to gauge her knowledge. She might have then shared some brochures from the American Cancer Society, or the March of Dimes. If the woman expressed a desire to quit, the CHW would encourage her to write this down to discuss with her doctor at her next appointment, or schedule the participant for a smoking cessation class put on by the Red Cross. She would complete the Pathway by verifying that the woman understood the risks and knew the risk reduction strategies. Health education sessions included interconceptional care, as

CHWs discussed the importance of birth spacing, proper nutrition, and offered information regarding various methods of contraception.

*Goals, Objectives and Progress:* Goals and objectives were virtually identical across all three strategies, since the project's ultimate aim was the reduction in disparities in poor birth outcomes for all African American women.

**Project Period Objective: By May 31, 2005**

Reduce the Infant Death Rate disparity in the Target Area, City of Cleveland, by 9% between African Americans and Whites from the 1996 - 1998 baseline of 1.723 to a target of 1.568.

*Progress:* 2003 City of Cleveland Office of Biostatistics data indicate that the IDR among African Americans was 12.83 compared to 4.97 among Whites, representing a 33.2% increase from the baseline.\*

**Project Period Objective: By May 31, 2005**

Reduce by 9% the Low Birth Weight disparity between African Americans and Whites in the Target Area from the 1996-1998 baseline disparity of 1.5 to a target of 1.365.

*Progress:* 2003 City of Cleveland Office of Biostatistics data indicate that the LBW among African Americans was 13.46% compared to 9.03% among Whites, representing no change from the baseline.\*

**Project Period Objective: By May 31, 2005**

Reduce by 9% the Very Low Birth Weight disparity between African Americans and Whites in the City of Cleveland from the baseline disparity of 1.79 to a target of 1.66.

*Progress:* 2003 City of Cleveland Office of Biostatistics data indicate that the VLBW among African Americans was 3.19% compared to 1.5% among Whites, representing a 15.9% increase from the baseline.\*

**Project Period Objective: By May 31, 2005**

Increase Early Postpartum breastfeeding by 9% for infants of project participants from the baseline of 26.6% to a target of 29%.

*Progress:* This objective was designed in 2000 and coincided with a data collection system that supported it. A new data system was implemented in 2002. Customization and new procedures were developed on the new system to address

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\* Official Vital Statistics Records are not available past 2002. All 2003-2004 birth outcomes are based on unofficial records. The Project will amend the Impact Report with official birth records when they become available.

this objective. The design of the new system could **not** be modified and made the technical and procedural changes awkward. The design barriers were too great to overcome and data with reasonable validity was not available. This objective was dropped in the 2003 project year. However, the Project continues to encourage breastfeeding, and in 2004, it provided 371 participants with breastfeeding education, counseling and support.

**Project Period Objective: By May 31, 2005**

Increase by 12% the percentage of births meeting an Adequate Prenatal Care rating from a baseline of 55.58% to a target of 62.25%.

*Progress:* 2003 City of Cleveland Office of Biostatistics data indicate that the percentage of births meeting an Adequate Prenatal Care Rating, was 70% (4,986 of 7,122 representing a 21% increase from the baseline measure).

**Project Period Objective: By May 31, 2005**

Decrease by 15% participant enrollment risk levels over time based upon their Risk Score administered at 6-month intervals.

*Progress:* This objective was designed in 2000 and coincided with a data collection system that supported it. A new data system was implemented in 2002. Customization and new procedures were developed on the new system to address this objective. The design of the new system could **not** be modified and made the technical and procedural changes awkward. The design barriers were too great to overcome and data with reasonable validity was not available. This objective was dropped in the 2003 project year.

**Project Period Objective: By May 31, 2005**

Decrease by 10% repeat pregnancies from the baseline of 25.12% repeat pregnancies within 24 months to a target of 22.61%

*Progress:* Information on this objective is unavailable. The Project will amend the Impact Report with official birth records when they are available.

**Project Period Objective: By May 31, 2005**

Decrease by 10% repeat births within 24 months to women with a previous high risk birth from the baseline of 16.7% to a target of 15.01%.

*Progress:* Information on this objective is unavailable. The Project will amend the Impact Report with official birth records when they are available.

*Barriers and Solutions:* Identifying and serving women as early in their pregnancy as possible has always been the aim of the project, with the understanding that early and continuous prenatal care would significantly lessen poor birth outcomes. However, identifying women in their first trimester continued to be a challenge. CHW addressed this issue by their consistent presence in the community, building relationships and

gaining the trust of potential enrollees, and the community as a whole. Likewise, serving women during the interconceptional period proved challenging; CHWs learned that interconceptional care (i.e., help with family planning, birth spacing, proper nutrition and self-care) was not a one time event, but an ongoing process requiring repeated discussion and adaptation to a client's changing needs.

The implementation of Pathways protocols and the accompanying data system through the CAP-funded C4 project, while enabling the project to standardize its service delivery, also proved to be a barrier. Pathways were found to be a highly structured strategic decision making system and the data system was cumbersome. These components were labor intensive, and they required exhaustive training and monitoring among subcontractors. As a result of these complexities, many CHW's and Case Managers were never able to correctly use the components or they elected to prioritize their outreach and case management activities over data entry. The solutions to this barrier were to withdraw from the C4 project and redirect the service delivery model to proven practices. Specifically, at the close of this funding period, *MomsFirst* entered into a contractual relationship with another Healthy Start project, the Southern New Jersey Perinatal Collaborative, to implement its web-based data system. This had the benefits of common understanding of Healthy Start reporting requirements, cost sharing for upgrades, and proven performance. *MomsFirst* also returned to its traditional, social work-based model of service delivery that focused on consistent and meaningful contact with the client, evidence based interventions, and monthly case conferences between the CHW and Case Manager for each client.

An additional barrier was the State of Ohio's lengthy delays in the release of official birth outcome information. At the close of the *Eliminating Disparities* funding period, the most recent information available from the State was for 2002. The solution to this barrier was to advocate for more resources to be allocated to the State's Office of Vital Statistics. *MomsFirst* formally did this advocacy when it was a part of the Ohio Maternal and Child Health Bureau's Community Needs Assessment.

*Lessons Learned:* The most important lesson learned in the outreach component during the *Eliminating Disparities* funding period was the value of direct linkage with the community's grassroots organizations. Directly contracting with the Neighborhood Centers enabled the grantee to have a much better understanding of the culture and needs of the women in each of the city's diverse neighborhoods. Expansion of the target area during this funding period, to include the entire city rather than certain neighborhoods, allowed for greater enrollment and eliminated the arbitrary nature of enrollment based on geography. As stated above, CHWs also learned the necessity of having regular, ongoing discussions with clients about interconceptional care topics.

Other lessons included the importance of identifying and implementing established, and preferably evidence based, interventions for project enhancements. At the close of the *Eliminating Disparities* funding period, *MomsFirst* was in the process of implementing the Southern New Jersey Perinatal Collaborative's data system as well as *the Partners for*

a *Health Baby* Health Education Curriculum, both proven approaches with excellent results in other Healthy Start projects..

Finally Project Period Objectives should be selected to demonstrate public health impact. Such objectives should not be tied to a specific service delivery model or data collection system. *MomsFirst* applied this lesson by adapting the Project Period Objectives that were provided by HRSA for the 2005-2009 grant period.

### ***School Based Outreach, Case Management and Health Education***

*Description:* As described in Section II, outreach to adolescents in the Project was carried out through casefinding in the middle and high schools of the Cleveland Municipal School District, conducted by CHWs employed by the district. The social network of school nurses, teachers, counselors, social workers, administrators and students was used as a point of contact to identify teens early in their pregnancies, or to identify parenting teens in need of additional support, including returning to the classroom. (It is important to acknowledge that CMSD employees could not directly conduct or provide pregnancy tests; students were provided with information and education regarding pregnancy-testing services in the community.) Peer Advisory Groups were formed in most school buildings in which the project operated. These groups of young people came together to support one another and address health issues.

Once a participant was enrolled, school based CHWs ensured that one face to face visit each month was conducted in the home, while the other was conducted on school grounds. Health education was conducted during home visits, as described above. Discussion of interconceptional care was an important part of home visiting with the youth. While depression screening and referral was incorporated during this funding period, Project administrators were aware that an instrument more tailored to adolescents was needed to improve this component.

*Goals, Objectives and Progress:* Goals and Objectives for the school component were identical to those for the community based strategy, with the addition of a goal specific to adolescents:

#### **Project Period Objective: By May 31, 2005**

Decrease by 25% adolescents that gave birth and drop out of school from a baseline of 5.5% to a target of 4.4%.

*Progress:* City of Cleveland, Office of Biostatistics data for 2003, indicate that 3.78% of women under the age of 20 were behind their appropriate level of education. This is 32% below the baseline.

*Barriers and Solutions:* During the *Eliminating Disparities* funding period the District lost funding from the state's Wellness Block Grant, which traditionally had provided teen pregnancy programming which complemented the work of the *MomsFirst* Project. CHWs found that carving out time in the school day to conduct visits with the teens was a

challenge; CHWs dealt with this by relying on home visits to reach teens. Building principals also frequently transferred any pregnant girls to the District's school established specifically for pregnant teens. CHWs then spent significant time convincing these young mothers of the importance of continuing their education and reintegrating into their original school building following a 6 week maternity leave. CHWs also provided significant time and support to many young mothers where paternity (and father involvement and child support) could not be established with the baby's father. CHWs worked closely with teen moms to encourage breastfeeding because many of the girls' peers discouraged it as "nasty" and contributing to permanent body changes.

*Lessons Learned:* Valuable lessons in working with adolescents were learned by the grantee and all subcontractors in the project. First, teens truly need and value consistency in their lives. Having the same CHW, at home and in school, helps to keep youth engaged. Similarly, the presence of too many workers in a youth's life can lead to disengagement. Perhaps most importantly, it is essential to recognize that when dealing with teens, parents are part of the caseload. They must buy in to what's happening with their child in order to help in the work. Many times, the CHW must also work to connect parents with services *they* need in order to ensure that level of engagement takes place. It must be recognized that serving these adults is a part of CHW's work, and they must be afforded the time and resources to carry it out.

### ***Institution Based Outreach, Case Management and Health Education***

*Description:* As noted above, services for women in prisons and substance abuse treatment facilities were delivered through the High Risk Team at NEON. Outreach was carried out within the institutions. For example, all women in the county's correctional facility were given a pregnancy test. Those who tested positive were referred by jail staff to the HRT for in-house supportive services. Outreach was also conducted in shelters and residential substance abuse treatment facilities, as well as the county's juvenile detention center, through one-on-one visits by HRT members.

Once a participant was enrolled, Case Managers at the HRT generally saw each client one time per week. These program participants took part in weekly group health education sessions. Led by members of the HRT, these sessions covered topics such as parenting, hypertension and stroke, birth spacing and contraceptive choices, HIV/AIDS, and sobriety maintenance. Sessions were conducted using curricula obtained from collaborating organizations such as the AIDS Task Force, the American Heart Association and others. Depression screening and referral was also incorporated during this funding period.

*Goals, Objectives and Progress:* Goals and Objectives for the institution based component were identical to those for the community based strategy.

*Barriers and Solutions:* HRT members were challenged by the transient nature of their clients' lives. During their stay in a shelter, jail or residential treatment facility they were very engaged. But these are time limited situations. Often their stays did not allow for the

completion of a case plan, i.e., completing a GED course or a parenting class being offered at that institution. Those programs were not available to them upon discharge. Immediately upon leaving these institutions, they had high levels of need, and stayed very connected to their case managers. But their living situations were often not conducive to continuing the case plan. Over time, it was difficult, despite case managers' best efforts, to keep clients engaged.

An additional barrier for the HRT was the security issues in most institutions. For safety, most sessions had to be held in a group setting, which discouraged participants from really opening up to share important issues.

*Lessons Learned:* The most valuable lesson learned within this component was the importance of the early establishment of trusting, respectful relationships with the judicial system and others operating institutions. Approaching these leaders with an understanding of the legal and security constraints within which they operate, and being willing to abide by those restrictions, was critical to the implementation of this model. This rapport helped in disposition planning, advocacy, and client follow up. Over time, these relationships also enabled HRT members to bypass some of the bureaucracy to better serve clients. For example, once a pregnant woman was identified, the HRT was able to expedite her access to medical care, milk, and prenatal vitamins, which normally required a doctor's order in the jail setting.

B. Mentoring: During the *Eliminating Disparities* funding period, the *MomsFirst* Project neither received nor provided mentoring or technical assistance.

## **V. Project Impact**

### **A. Systems of Care**

1. Approaches Utilized to Enhance Collaboration: The *MomsFirst* Consortium, and its committees, were structured in such a way as to enhance collaboration across a number of organizations which addressed maternal and child health. At its inception, it was the first, the largest and the most comprehensive coalition of such organizations in the city, and the only one whose operations were designed to include significant resident input. The Neighborhood Consortia structure was unique to *MomsFirst*, and provided grassroots feedback and insight on all Project operations. This buy-in and acceptance led to higher levels of legitimacy in the community and enhanced collaboration with a wider variety of organizations than usually experienced by a public health program.

Additionally, Project organizers were careful to broadly define those factors which could impact infant mortality. This led to a Consortium whose worldview encompassed not only medical factors – such as early and continuous prenatal care—but poverty, education and other social factors. This approach enabled the Consortium to engage a wider variety of collaborative partners during its history.

2. Changes in System Integration: Cleveland is fortunate to have a large, comprehensive network of resources in its perinatal health care system. Yet, in the nearly fifteen years of the Project's operation, the environment in which it functioned changed dramatically. The community endured the advent of managed care in Ohio Medicaid and the health insurance industry, the dismantling of the welfare system as it had operated for over thirty years, and the closure of inner city hospitals and their affiliated community based clinics. However, positive changes also occurred. Research revealed the importance of the preconceptional, prenatal, and postpartum periods for women in ensuring the health of their infants, and both public and private agencies were willing to invest resources in supporting women during these critical periods. Locally, more programs to help find and engage women at risk for poor birth outcomes were initiated, modeled on the success of the *MomsFirst* Consortium. The Project was a catalyst for collaboration and integration, to ensure that the most at-risk women were linked to healthcare services during those turbulent times in the area's health care sector.

The major example of this was the Project's planning for integration with several programs which operated at the county level, primarily through the Cuyahoga County *Invest In Children* initiative (IIC). IIC oversees the local implementation of federal early intervention legislation as well as state early intervention initiatives. The comprehensive array of IIC programs includes Help Me Grow (HMG), the Ohio Department of Health's health promotion and outreach program that encourages women to seek prenatal and preventive care for their infants. During this project period, the Help Me Grow Collaborative was made up of three components:

*Welcome Home:* Every first time mother, and *every* teen mother, in Cuyahoga County was offered a "Welcome Home" visit by a registered nurse, regardless of their income or risk status. During the visit, the baby and mother received a health assessment as well as information on the child's care and available community resources and services.

*Early Start:* Early Start offered regular home visits to families of children up to age three, where parents needed additional support. This included families in which health factors, substance abuse, domestic violence or poverty may have put the mother and infant at high risk.

*Early Intervention:* The Early Intervention program was a system of experts who worked together to provide early identification and services to infants and toddlers with developmental delays or disabilities, and their families. The program ensured that children received appropriate services, and that their parents understood, and could meet, the child's current and long term needs.

The HMG program recognized the expertise of *MomsFirst* both in conducting outreach among the city's difficult-to-engage populations of pregnant women, and in developing effective home visiting protocols (Pathways). HMG and *MomsFirst* entered into a Memorandum of Agreement which ensured reciprocal referrals between the two programs.

The Project's perinatal depression screening project, as described above, also served as a catalyst for the beginning of significant integration among the medical, mental health and social service systems. With a systematic assessment of mental health treatment gaps and barriers for African American women in the community, further work was being planned for resource development.

### 3. Key Relationships

*a. Relationships Between Health, Health and Social Service & Community-Based Agencies:* The *MomsFirst* Project established several collaborative relationships with the state and region's health care, social service and community based agencies, which were strengthened and enhanced during the *Eliminating Disparities* funding period.

*Title V, Maternal and Child Health Bureau:* As noted above, the Project received continuous direction and support from the Ohio Department of Health's Title V Program Director, and staff from the ODH Division of Family and Community Health Services. Their advocacy on behalf of the Project at ODH and in the office of the Governor enhanced the Project's role as a model for other ODH-funded perinatal outreach projects statewide. MCHB staff attended the Project's Executive Council meetings to provide a statewide perspective on *MomsFirst* and its role in the perinatal system. The Project worked closely with the area's Title V providers and WIC program to ensure appropriate reciprocal referrals.

During this funding period, the most significant collaboration with Title V and other state programs occurred through C4, as discussed above. C4 included Ohio's two Healthy Start projects, the ODH Division of Family and Community Health Services, county Family and Children First Councils, the Community Health Access Program (CHAP) the State Child Health Insurance Program (SCHIP) and representatives of the Ohio Department of Jobs and Family Services (formerly the Ohio Department of Human Services), which oversees the state's TANF, Medicaid, and CHIP programs.

Convening such a group was critical. Federal and state welfare reform initiatives had begun to change the funding landscape for publicly supported programs in Ohio, as public assistance funding previously awarded via matching formulas was now being allocated to the state through a block grant. This flexibility in funding presented an opportunity to incorporate new and effective methods in the prevention of infant mortality and morbidity within the scope of publicly funded insurance programs. C4 enabled each of these programs to share best practice information and present a unified voice in advocating for changes in policy or funding parameters. The initiation of standardized curricula and training for CHWs through the C4 group greatly improved service delivery and professionalized the outreach, home visiting and health education components of *MomsFirst*.

*Ohio Medicaid/Healthy Start & SCHIP:* Locally, the Medicaid, Expanded Medicaid (Ohio Healthy Start), SCHIP and food stamp programs were administered by the county-

level agency, Cuyahoga Health and Nutrition (CHN). CHN administrators had been a part of the *MomsFirst* Consortium since its inception. Their participation in the Consortium proved to be an invaluable information source during this period of welfare reform. *MomsFirst* participant concerns were brought directly to CHN administrators at Consortium meetings. CHN administrators provided up to date information regarding access to public assistance programs in this changing environment. Together, Consortium members and CHN administrators developed strategies to serve the community such as reciprocal referrals across programs.

*Cleveland Infant Mortality Reduction Initiative (CIMRI)*: The CDPH, in collaboration with Cleveland's May Dugan Social Services Center was awarded funding from the Ohio Department of Health's Ohio Infant Mortality Reduction Initiative (OIMRI) to operate a prenatal outreach program in two neighborhoods on Cleveland's near west side. The Cleveland Infant Mortality Reduction Initiative was patterned after the *MomsFirst* Project.

*HealthMobile*: The Project's mobile medical unit was used as an effective tool for collaboration across the city, and during this funding period partnered with Planned Parenthood of Greater Cleveland to enhance the provision of women's reproductive health care through the unit. The unit was a sought-after addition to most community events, and enabled issues of maternal and child health to be made visible in a wide range of contexts. Locations included Neighborhood Centers, area hunger centers, public housing units, Head Start sites, homeless shelters, YMCAs, Cleveland's Empowerment Zone neighborhoods and numerous community organizations and churches.

*b. Involvement of Consumers*: Through the Neighborhood Consortia and Consortia Leadership Committee, described above, consumers attended meetings and served on committees with representatives from numerous health and social service agencies, both public and private. Through the project, neighborhood residents were provided with access to information, and opportunities to be a part of planning activities for the benefit of their communities. At the same time, government and nonprofit executives heard directly from their constituencies, particularly as welfare reform commenced, as noted above.

#### 4. Impact on Comprehensiveness of Services

*a. Eligibility/Intake Requirements*: Because the *MomsFirst* Project was not a benefits program with eligibility requirements (beyond that of pregnancy, health risks and city residency) the program did not impact the eligibility and or intake requirements of government funded health and social service programs.

*b. Barriers to Access/Community Awareness*: The Project had a significant impact on barriers to access for individual women. Beyond casefinding, the major activity of CHWs in the Project involved ensuring women's access to care. The best evidence of this was the reduction of disparities in poor birth outcomes in the community.

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At a systemic level, the Consortium called attention to gaps and barriers to access in the perinatal system of care. During this funding period, emphasis was placed on the scarcity of mental health treatment resources for women faced with perinatal depression.

Community awareness of the need for early and continuous prenatal care, and awareness of the resources for that care, was also bolstered by the Project. CHWs working in their neighborhoods disseminated information to individuals and community groups. The Consortium itself provided information across its several participating agencies, and supported other organizations in building community awareness.

*c. Care Coordination:* *MomsFirst* CHWs played a pivotal role in ensuring that consumers received appropriate referrals and follow up for prenatal and well child care, as well as non-medical services. CHWs arranged for transportation, mental health or substance abuse counseling, assistance with income maintenance, clothing, food, shelter and utilities, and acted as an advocate where necessary.

As noted above, the Project also worked closely with Cuyahoga County's *Invest in Children* initiative to coordinate care for families. Reciprocal referrals were in place to ensure that children in the city, from birth to three, were referred to appropriate county level resources.

*d. Recordkeeping/Data Sharing:* At the close of the funding period, *MomsFirst* began to implement a centralized database designed for Healthy Start sites in New Jersey. Use of the database requires CHWs to enter an initial data set on all participants, and to maintain data entry on subsequent visits and care coordination notes. Data regarding services provided and referrals made will also be included. A participant's progress is easy to ascertain by referring to this baseline data. In the future, this will enable Case Managers to easily monitor and "co-manage" cases with the CHW, as well to share HIPAA-compliant Personal Health Information with other providers as cross system collaborations are established.

## 5. Impact of Client Participation

*a. Provider Cultural Sensitivity:* The involvement of consumers throughout the Project enabled them to give providers feedback on service delivery. A significant result of this was the recognition of the need for information about all programs at health and social service providers in the city to be available in grade-appropriate Spanish translations, both oral and written. Since the Project's beginning, its staff and participants provided a voice at community meetings expressing the importance of such translations.

Similarly, consumer input enabled providers across the city to become much more sensitive to the needs of mothers with children below school age. Long waits for service, a lack of childcare, and a lack of services offered on bus routes presented a substantial access barrier for many women. Today, providers are far more likely to ensure the location of their services on major bus routes, or to provide transportation for their services.

*b. Consumer Participation in Developing Mechanisms/Tools:* During the *Eliminating Disparities* funding period, participants were asked to take part in a Participant Satisfaction Survey. The survey was originally designed by six African American professional staff, five of whom were female. Data was collected regarding the type and quality of services provided by the program in general, and by Community Health Workers in particular. Under the direction of the Consortium's Clinical/Social Service Committee, the survey was revised annually to reflect participant input regarding language and reading level. Surveys were conducted via telephone by local City Year workers, who were outside, unbiased data collectors. This improved both the number of surveys completed and the quality of the data.

Once the survey was administered, results were shared and discussed with committee members. Based on these results, changes were made to improve overall program service implementation. This enabled the grantee to measure the effectiveness of services provided to consumers, and it allowed consumers the opportunity to make suggestions on how to improve mechanisms being used to provide services. For example, in the 2004 survey, program participants indicated that some of their significant barriers were childcare and transportation. The Project routinely provided bus tickets as incentive items, and CHWs worked with participants to identify and assemble a reliable support system of neighbors, family and friends, for both childcare and transportation. Dialogues held during NC and CLC meetings also provided feedback on the Project's service delivery, gaps and potential solutions.

Participant comments from the 2005 Participant Satisfaction Survey included:

Question: In what ways did having a home visitor make a difference for you during this pregnancy or after the baby was born?

*"Nice to have someone to talk to and to inform me about programs I wasn't aware of."*

*"My visitor brought stuff needed for the baby."*

*"People to talk to about things and advice about the baby."*

*"Positive, upbeat. Helped me with health problems."*

*"Questions answered. Understanding confidant."*

*"She showed me lots of new information about caring for baby."*

*"She answered questions. Helped me keep up with appointments."*

Question: Did your home visitor help you with other things that were going on in your life?

*"Problems with family and with telling my parents I was having a baby."*

*"Questions I wouldn't have asked anybody else."*

*"Depression; lots of issues with other children, other things."*

*"Employment training."*

*"Bathing, feeding, reading to the baby."*

*"Stress, depression, getting along with people."*

## **B. Impact to the Community**

*1. Knowledge of Resource Availability:* Each woman who enrolled in *MomsFirst* gained knowledge regarding the resources available to her, by working closely with her CHW. On a broader scale, participation in Neighborhood Consortia empowered residents with information regarding the rich resources in the Cleveland area, their location and ways to access those services. The topics covered in NC events during the *Eliminating Disparities* funding period indicate the breadth of available services and programs for women, children and families. These included:

- Effects of Second Hand Smoke
- Wellness and Health Education
- Celebration of Life
- Heart to Heart Discussion
- Shaken Baby Syndrome
- Nutrition and Breastfeeding
- HIV/AIDS and STD Education
- The Effects of HIV/AIDS on Infants, Children and Women
- Healthcare and Medicine Program
- Minority Health Fair
- Spring into Good Health
- Women Reclaiming Victory Over Adversity
- Community Health Fair
- Infant Massage
- Healthy Eats at the Zoo
- Family First, Encouraging a Family Approach”
- Community Safety Awareness Education
- Winter Home Safety Fair
- Is Love Supposed to Hurt?
- Budgeting and Home Safety
- Limits of Discipline
- Child Birthing Options
- Best Health Practices for Pregnant Women and Infants
- Getting Financially and Physically Healthy

Additionally, Peer Advisory Groups in the school buildings offered the opportunity for teens to explore health and wellness topics and to learn about community resources available to them. Topics included:

- Evaluating the Relationships in Your Life
- The Responsibility of Parenthood---Can You Handle It?
- Self-Esteem/Peer Pressure
- The Truth About Health Issues, Drugs and Alcohol
- Domestic Violence Within Teen Relationships
- Youth Summit --The Meeting of Young Minds

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- What You Need to Know to Get Your License
- Facts and Fiction about STDs
- Violence: Is it the answer?
- Promoting Healthier Parent & Teen Relationships
- HIV/AIDS
- Violence in School
- Date Rape
- Career Planning
- Tobacco Use
- Decision Making
- The Reproductive System.

2. *Consumer Participation in Changing Policies:* As mentioned previously, NCs were the mechanism by which participants and community participants were brought together with decisionmakers to identify concerns, point out community strengths and resources, and to develop solutions for neighborhood issues. The Consortia Leadership Committee served as part of the *MomsFirst* Consortium, providing the Project's managers with the critical link to community perceptions, needs and input. It is a testament to the empowerment of consumers in the Project Area that, during this funding period, the Neighborhood Consortia and CLC grew despite minimal financial and staff resources for this component.

3. *Community Experience in Team Building:* The establishment of the *MomsFirst* Consortium, and its extensive involvement of community residents and program participants, was unprecedented in the city prior to Healthy Start funding. Public and private agencies serving low income women were called upon to behave in new ways. Simply holding important meetings in the evening, or in neighborhoods (as opposed to downtown) was a major shift in organizational behavior. Agency staff had to learn to abandon jargon and to use layman's terms – not only for the sake of consumers, but also for the benefit of their colleagues outside of their field.

4. *Creation of Jobs:* At its outset, the *MomsFirst* Project provided significant employment opportunities, with the hiring of over 280 neighborhood residents as CHWs. Literally hundreds of people have been employed and trained throughout the Project's history in Cleveland. For most, it was their first job experience, which enabled them to gain skills, and move on to even greater employment opportunities.

### **C. Impact on the State**

The Project impacted Ohio's Title V program in fundamental ways. First, the Project brought together a broad spectrum of governmental and private agencies whose programs, while aimed at potential Title V participants, were highly fragmented in the City of Cleveland. The *MomsFirst* Consortium was the first, large scale attempt to bring together not only medical providers, but human service agencies and social service providers as well as neighborhood residents. The Consortium, through its several committees, enabled each of these key stakeholders – at the state, county and city levels -

to begin to collaborate to ensure a seamless system of service delivery for pregnant and parenting women.

Secondly, *MomsFirst* strengthened the services offered by Title V providers by removing barriers to access. Where Title V provided medical care or nutritional services, the Project provided the linkage to such services. On the practical level, this took many forms. They included individual education sessions with participants stressing the importance of prenatal care and the programs available to help; overcoming an individual's obstacles such as transportation or a domestic violence situation; and highlighting institutional obstacles, such as lengthy waiting times for appointments, or a need for childcare on site.

Beyond the close collaboration through C4 previously detailed, additional collaboration between *MomsFirst* and the state occurred when the State Title V program began its five year needs assessment process in 2004. This assessment was designed to include a review of current trend data and best practice information related to each of the Core and State Performance Measures. Data related to the achievements in infant mortality reduction and other birth outcomes in the *MomsFirst* project area were to be considered in this review. In addition, following the *MomsFirst* model, best practices in community based care coordination utilizing indigenous community health workers was applied to Title V MCH Block Grant funded projects in other urban areas in Ohio.

The Project was also a leader in Child Fatality Review in the state. ODH was charged with implementing a new law requiring that child fatality reviews be conducted in every county. The Title V program called on staff from Cleveland to share their experiences in infant mortality review with the rest of the state. Of particular significance was the information related to increased risk of death contingent upon sleep location and circumstances.

Historically, ODH hired a Regional Perinatal Education Coordinator (RPEC) in each of the six perinatal regions in Ohio. Over the years the RPECs became increasingly focused on the neonatal period of maternal and infant health. Utilizing MCH Block Grant funding, ODH initiated a process in 2003 to thoroughly review the function of the regional perinatal system in Ohio. The Cleveland *MomsFirst* Project also contributed financially by hiring a consultant from Johnson Group Consulting to facilitate the process and function as the topic expert. Using this *MomsFirst* resource, ODH convened regional teams consisting of hospitals, providers, local public health, and other interested parties to focus attention on opportunities to make further improvements in birth outcomes. With continued assistance from Johnson Group Consulting, ODH taught the method of birth outcomes analysis --Perinatal Periods Of Risk (PPOR) to the statewide regional groups to reenergize them in addressing perinatal outcomes.

#### **D. Local Government Role**

The Project's Infant Mortality Review component served as both a model and a catalyst for the establishment of the county's Child Death Review Committee. Noting the research and valuable information generated by the IMR concerning the deaths of infants, County Commissioners, concerned with the loss of too many children of all ages in the community, used the IMR case review model to establish a procedure to investigate the deaths of all children up to age eighteen. Over time, as data was collected and patterns emerged, the Committee produced recommendations regarding preventable deaths and developed public information campaigns regarding such recommendations. This has evolved into an annual review and report of child deaths in the county, designed to prevent such tragedies from repeating.

At the close of the funding period, Project administrators began discussions with the Title V-funded Help Me Grow program in Cuyahoga County, to further develop a seamless system of perinatal care for families from the prenatal period to the child's third birthday. Much like *MomsFirst*, HMG subcontracts with various providers across the county to carry out the program's direct services. In fact, HMG subcontracts with many of the same Neighborhood Centers which operate the *MomsFirst* Project. Help Me Grow administrators looked to *MomsFirst* for its expertise in finding and recruiting hard to reach women, and for its obvious success in improving birth outcomes in the City of Cleveland. Plans for future funding periods include consideration of co-case management of participants in the third trimester, adopting standardized formats for Individualized Family Service Plans and Child Behavioral Health Screens.

**E. Lessons Learned:** All lessons learned have been included throughout this report.

#### **VI. Local Evaluation:**

Please see the *Local Evaluation Reports*, in **Attachment B**.

**VII. Fetal and Infant and Mortality Review:** The Infant Mortality Review component of the *MomsFirst* Consortium conducted its reviews during the five years of Phase I of the program. Reviews focused only on those infants who were born alive and died prior to their first birthday. Fetal, maternal and child deaths were not included in the Cleveland Team's review. The IMR Team did not conduct home visits, nor maternal interviews. Funding for the IMR Team's review activities during Phase I came entirely from the CDPH as the grantee. During Phase II, the Team ceased conducting reviews and instead carried out research using the Cleveland IMR database, developed recommendations and made presentations to professionals and consumers. As the IMR staff took on a greater role with the County's Child Death Review, Cuyahoga County began funding a portion of the Team's activities.

During Phase I, the IMR Team reviewed all 755 deaths of infants that occurred in the city, including 425 within the neighborhoods making up the project area. This inclusive design set it apart from other sites across the country. In addition it provided a comparison group that helped to distinguish those factors differentially effecting the

women in the geographic catchment area served by the outreach model. The basic format included extensive case evaluation through comprehensive medical record review which includes prenatal care visits, visits to the emergency room, labor and delivery screening room or hospital, delivery records, as well as any infant well child care, emergency, clinic or hospital visits, coroner's autopsy reports, pathology reports, and police, EMS and social service records, as appropriate. This information was reviewed by a Community Review Team, consisting of both medical professionals and laypersons. The information gained by the IMR Team provided the basis of more than 65 local and national presentations on the process and results to a combined audience of over 2500 individuals. In addition, many educational materials for participants and Outreach Workers were developed.

In addition to helping establish the Child Death Review Committee in Cuyahoga County, an example of the Team's accomplishments was a comprehensive one-day training for "first responders," those professionals who initially are on the scene of a child's death. The training provided an overview of the common causes in the death of children, ways in which those deaths might be prevented, and techniques for investigating child abuse and neglect. Police officers, medical personnel and social workers participated in workshops and discussions regarding the particular issues in the sudden death of a child: dealing with grieving families, standardized reporting formats to be used countywide; the critical role of comprehensive investigations in shaping prevention/intervention strategies, identifying accidental fatalities as compared to abuse, and appropriate conduct at the scene, in the home and in the hospital.

## **VIII. Products**

Materials produced during this project period are found in **Attachment C**.

## **IX. Project Data**

Please see the attached Performance Measure Forms in **Attachment D**.