

IMPACT REPORT

Project Period June 2001 – May 2005

I. Overview of Racial and Ethnic Disparity

The communities of Alorton, Alton, Belleville, Brooklyn, Centreville, East St. Louis, and Washington Park, Illinois comprised the project service area for Southern Illinois Healthcare Foundation (SIHF) Healthy Start initiative. East St. Louis, with a population of 31,530, formed the urban core of the service area. **Table 1** below highlights data from the local needs assessment that compelled SIHF Healthy Start to concentrate its efforts on reducing infant mortality, improving perinatal indicators associated with infant mortality, increasing access to care, and closing the gap in health disparities among African Americans in the project service area.

TABLE 1: NATALITY AND MORTALITY DISPARITIES

Source: Vital Statistics Illinois Department of Public Health. Three-year average 1996-1998.

- Infant mortality rate of 18.9 (2x that of whites)
- Neonatal mortality rate of 10.1 (3x that of whites)
- Post neonatal mortality rate of 8.7 (2x that of whites)
- Low birth weight percent of 12.9 (almost twice the rate of whites)
- Very low birth weight percent of 2.7 (2x higher)
- Teen births under the age of 17 of 14.2% of all births (2½x that of whites)
- First trimester entry of 59.6% (10 percentage points lower than that of whites)
- No prenatal care of 3.4% (1½x higher than that of whites)
- Adequacy of care based on Kessner index of 46% (almost 40% lower than whites)
- STD's – Syphilis rate that is 68 times higher and gonorrhea rate that is over 40 times higher than general population.
- HIV/AIDS - (African Americans represent 54% of all AIDS cases yet only 22% of total population)

In addition to the statistical data, the SIHF Healthy Start project plan addressed community needs identified through consortium meetings, surveys, focus groups, and Illinois Project for Local Assessment of Needs (IPLAN). The Healthy Start project plan also incorporated health priorities identified by the state's MCH Title V agency and the Healthy People 2010 national health maternal and child health priorities.

Through surveys, community and program participants identified the following needs.

- Assistance with obtaining employment
- Incentives for participation in Healthy Start classes and programs.
- Financial assistance with purchasing over the counter medications.
- Child care during participation in Healthy Start programs and meetings.

Healthy Start Consortium members and project staff identified barriers that hindered service utilization and participant compliance. These service barriers identified by

consortium members and staff were:

- lack of reliable transportation
- stigma associated with receiving particular services
- participants' personal priorities/hierarchy of needs
- participants' belief that they are not in need services

In July 2000, Jeffery Mayer, PhD from St. Louis University School of Public Health, facilitated a focus group with 12 pregnant and parenting women as part of the Every Visit Counts project, funded by March of Dimes. The Every Visit Counts focus group discussion was recorded, transcribed and analyzed. Myths, beliefs and feelings about prenatal care revealed during the focus discussion influenced design of SIHF Healthy Start interventions and strategies. Some of the beliefs and feelings focus group participants shared regarding the importance of prenatal care visits included:

- prenatal visits too short for anything important to happen
- anything missed at one appointment could be addressed at the next appointment
- repetitious – same thing done at every visit
- pregnancy unplanned or unwanted
- unresponsive providers
- prenatal care visits not as important for subsequent pregnancies

Southern Illinois Healthcare Foundation was one of fifteen community partners who worked with the project area's two local health departments to complete the Illinois Project for Local Assessment of Needs (IPLAN). The purpose of the IPLAN was to assess health needs and community resources, and identify major health problems that affect community residents. When the community needs assessment (IPLAN) was completed, both local health departments, St. Clair County Health Department and East Side Health District, identified the primary health problems impacting the project area and established priorities for addressing these concerns. The identified problems and established priorities are:

- reduction of infant mortality rate
- reduction in teenage pregnancy
- reduction of low birth weight
- increased compliance of childhood immunizations

Other health concerns identified in the IPLAN needs assessment include sexually transmitted diseases and HIV/AIDS, childhood lead poisoning, family violence, alcohol and drug abuse, and smoking.

SIHF Healthy Start priorities are also reflective of the priorities and goals outlined in the 2005 Illinois Maternal and Child Health Block Grant plan for the general population of women and children. These priorities are:

- the reduction of infant mortality rate
- the reduction of the low birth weight rate
- the increase in the proportion of very low birth weight infants born in Level 3 facilities or perinatal centers
- increase the proportion of pregnant women that begin prenatal care in the first trimester

- increase the proportion of children that receive primary care services as recommended in the guidelines for Health Supervision of the American Academy of Pediatrics
- reduce the fertility rate among girls aged 15-17 and reduce the rate of child abuse and neglect
- establishing priorities for children with special health care needs that included the coordination of specialized medical services
- enhancing the comprehensive community based cultural sensitivity of the coordination of this system and implementing the medical home concept for these children
- facilitating the enrollment into the state Child Health Insurance Program (KidCare or Medicaid) and increased assistance for SSI

The Healthy People 2010 Initiative has identified Maternal, Infant and Child health as one of 28 focus areas. This study also emphasized the disparity of care between Caucasian and minority women in this focus area. Healthy People 2010 objectives relevant to our Healthy Start program goals and objectives include:

- Reduce fetal and infant deaths
- Increase proportion of pregnant women who receive early and adequate prenatal care
- Increase the proportion of low birth weight infants born at level III hospitals
- Reduce the rate of very low and low birth weight
- Reduce the number of preterm births
- Increase the proportion of infants put to sleep on their backs
- Increase abstinence from alcohol, cigarettes and illicit drugs among pregnant women
- Increase the proportion of access to medical homes for children with special health care needs
- Increase the proportion of access to service systems for children with special health care needs

II. Project Implementation

The SIHF Healthy Start project plan was the road map for taking action to address health concerns, service gaps, and disparities specific to the project service area. These concerns and disparities included infant mortality, low and very low birth weight, early entry into care, and adequate prenatal care. The SIHF HS multidisciplinary team revised and enhanced the marketing, design, and delivery of services to be provided based on the focus group recommendations.

At the participant level, SIHF provides: outreach, case management, health education, screening for perinatal depression, prenatal and interconceptional continuity of care, and direct linkage to the KidCare program for medical coverage. At the community level, the local health system action plan (LHSAP) drives an integrated service delivery system that better serves program participants. The LHSAP incorporates the social and medical needs of pregnant and parenting women and their infants. Also at the community level, Southern Illinois Healthcare Foundation (SIHF) maintained an active Healthy Start

consortium and strong collaborative partnerships with state and local Title V agencies to ensure health interventions and service needs were addressed without duplication of services. The SIHF Healthy Start project plan was a multi-faceted approach that was designed to:

- generate community involvement to improve birth outcomes and reduce infant mortality
- increase access to quality health care and promotes utilization of preventive services
- provide comprehensive case management services for high-risk pregnant and interconceptional women and their infants
- address cultural perceptions and promote healthy lifestyle behaviors

OUTREACH AND CLIENT RECRUITMENT

Survey results and analysis of focus group transcript provided insight that many community residents were not fully aware of disparities in birth outcomes and did not have an understanding of risk factors that contribute to low birth weight and infant mortality. Focus group participants expressed belief that missing a prenatal care appointment was okay, especially if a woman had previously had a healthy baby. These responses and the statistic that only 59.6% of pregnant women in the service area began prenatal care during the first trimester and less than 46% of women received adequate care, compelled SIHF Healthy Start to focus outreach efforts on increasing awareness of existing disparities and associated risk factors, establishing an effective referral system that would improve access to and increase utilization of prenatal care services, and educating women on the importance of early and regular prenatal care.

SIHF Healthy Start's approach to outreach included a plan of action to identify and fully engage the communities' most difficult and hard to reach women and families. This target group included pregnant women who delay or do not seek prenatal care due to either a lack of knowledge, access barriers, or personal reasons such as substance abuse or negative response from family and friends. To increase awareness, educate residents on the importance of prenatal care, and to develop an effective referral system to link pregnant women with medical and support services, SIHF Healthy Start implemented a comprehensive outreach program that consisted of three primary components: 1) Establishing and maintaining strong partnerships with area organizations and businesses that families were likely to turn to for assistance. These organizations and businesses included service providers, community organizations, schools, and health care providers; 2) Neighborhood canvassing to educate residents on health issues and available health services; and 3) Participation in community and special events.

The first component of outreach concentrated on reaching out to community agencies and service providers, businesses, schools, health departments, and area health care providers to create a referral network to link women and their infants with health care and other support services. Project staff successfully developed relationships to 36 community agencies, business owners, and health care and service providers and provided training and education on issues that impact infant mortality and services available through SIHF Healthy Start program.

SIHF established relationships with area job training, GED, and literacy programs. These relationship-building efforts generated referrals of children and pregnant women in need of health care and other Healthy Start services including referrals for eligibility assessment and enrollment into the State's SCHIP KidCare and FamilyCare insurance programs.

Social service and community agencies were also important links to families and individuals in need of health care and Healthy Start support services. Collaborative partnerships with social service agencies became a critical source of referrals for Healthy Start health education and case management services. Working in partnership to best assist families, Healthy Start on service agencies established a mutual referral network that promoted resource sharing and avoidance of service duplication.

Outreach to the providers included in-service and training for staff on topics relevant to infant mortality reduction, women's and infant health. Provider trainings included screening for postpartum depression, fetal alcohol syndrome and substance use and abuse during pregnancy, and HIV perinatal transmission. In addition, outreach to health care providers involved establishing trusting relationships in order to work together to identify women and families who would benefit from Healthy Start services (health education, case management, transportation).

The second outreach component involved direct outreach to residents and potential participants through targeted *neighborhood canvassing*. Healthy Start staff engaged individuals face to face to promote healthy life styles, encourage early and regular prenatal care, and to distribute literature on available health services in the community. Canvassing activities involved outreach staff going door-to-door or setting up exhibits and information table in locations with high volumes of target population traffic.

Community events are the third component of the SIHF Healthy Start outreach plan. Participation in organized community events such as health fairs provided another method for project staff to promote healthy lifestyles and to inform the target population of Healthy Start services. Community events also created opportunity to partner with other agencies and enhance collaborative efforts.

Effective implementation of outreach strategies and activities included identifying the appropriate individual within the business, agency, or provider office with whom to coordinate services. In some cases, the departure of a staff member (Healthy Start or the partner's agency) led to delays in providing services and referrals. Perceived competing interests for funding sometimes presented challenges when attempting to establish new partners and maintaining referral arrangements with existing partners. However, with strong leadership on both sides, good communication between partnering agencies, and commitment to serve the community, concerns were addressed and resolved to the maximum level possible.

Our project experienced challenges maintaining trained and disciplined outreach workers

hired to carry out canvassing activities. Outreach workers frequently lacked reliable transportation or auto insurance, an SIHF policy, to get to outreach locations, a required job activity. In other cases, reliable outreach workers once adequately trained were drawn to other employment opportunities within and outside of SIHF.

Other challenges associated with neighborhood canvassing included vulnerability to the weather conditions. Rain, hot summer months and cold winters limited opportunity for neighborhood canvassing. In addition, obtaining approval to set up booths and exhibits can be a lengthy process. High crime and security concerns also present challenges for implementing some canvassing activities. SIHF Healthy Start revised outreach policy and procedures to require outreach staff work in pairs when canvassing higher crime neighborhoods. SIHF Healthy Start also provided outreach staff with cell phones for use in emergency situation or to initiate referrals on the spot for individuals encountered.

Southern Illinois Healthcare Foundation (SIHF) Healthy Start outreach staff consisted of four full-time staff (4 FTEs).

CASE MANAGEMENT

Service area natality statistics, participants' views on the importance of prenatal care, identified service barriers, and high no-show rates for prenatal care visits were critical factors considered when developing the case management program. Therefore, in addition to risk assessment and care coordination, SIHF Healthy Start's case management program incorporated free Healthy Start transportation service, health education, and risk reduction counseling to encourage behavior change and empower participants to make informed decisions regarding their health and the health of their infants.

Components of SIHF Healthy Start case management program included:

- Assessment and follow up to identify needs and potential risks that may adversely affect pregnancy and birth outcome
- Development of an individualized service plan based on identified need and risks
- Care and service coordination
- Initiation, documentation, and tracking of referrals
- Risk reduction and prevention education
- Free transportation to medical appointments and education classes.

SIHF Healthy Start employed four case managers (4 FTEs) and a case management supervisor (1FTE). Healthy Start case managers were co-located in medical provider offices and community health centers. Assigning Healthy Start case managers to health center locations permitted assessment and counseling sessions to take place at the "doctor's office" in a private confidential setting and reduced the need for home visits by the case manager. Surveys and focus group revealed that participants were not receptive to Healthy Start staff coming to their homes. Placing case managers in health centers allowed participants to perceive case management services as an extension of medical services. Also, co-locating case managers in health centers increased visibility of Healthy Start services among participants and providers.

In addition to participants' dislike for home visits, for many in the community, case

manger or case management has a negative connotation and is frequently associated with State social service agencies. Therefore, to address the stigma participants commonly associated with case management services, Healthy Start case managers were referred to as Healthy Start representatives and not case managers

The Healthy Start multidisciplinary team consisted of case managers, case manager supervisor, a obstetric provider and registered nurse, a pediatric provider and registered nurse, and a domestic violence counselor. This team met at least monthly for case conferencing to review participant progress, determine strategies for improving compliance and progress among less motivated program participants. These multi-disciplinary meetings allowed the team to collectively resolve barriers for those most challenging participants who were not compliant with prenatal care visits.

SIHF Healthy Start maintained two contracts during the project period. One of the two contacts was with Touchette Regional Hospital to provide transportation for Healthy Start participants. Through this contract with Touchette Regional Hospital, SIHF was able to provide participants with free transportation for scheduled appointments to medical, mental health, case management sessions, and health education programs. SIHF Healthy Start also contracted with Southern Illinois Home Health to conduct home visits with program participants following hospital discharge. Services provided during postpartum home visits included:

- Maternal, newborn, and home assessments, with a primary focus on screening for postpartum depression and newborn development.
- Health education for new moms regarding postpartum care and infant care.
- For each home visit conducted, the nurse provided a written copy of completed assessments to participant's Healthy Start case manager and health care provider.
- Participant survey.

In addition to personnel, other resources required for carrying out case management services included office space for staff, personal computers, copier and fax machines, and leased vehicles to provide free transportation.

Other factors effecting the local delivery of prenatal care and support services were due to Illinois State budget cuts and skyrocketing cost for malpractice insurance. While the budget shortfall and malpractice crisis did not directly effect or impede implementation of Healthy Start case management, our local health department case management programs were impacted by State budget problems. Budget problems also resulted in the departure of the State's Title V Director who was dedicated supporter of Healthy Start's collaboration with State Title V services. In addition, the high cost of medical malpractice insurance caused many OB/GYN providers to close their practices and leave the area. While the loss of OB/GYN providers did not directly effect implementation of Healthy Start services, the loss of providers raises concern for women's healthcare as the number of obstetricians in St. Clair County continues to decline.

HEALTH EDUCATION

SIHF utilized a multi-pronged approach to educate community participants, program

participants, and health care and service providers. This multifaceted approach included group presentations, one-on-one sessions, special events and health fairs, in-service training, and media campaigns. Health education and promotion activities were responsive to needs identified through our local community assessment and also reflective of project goals to increase awareness and promote healthy lifestyles. Settings for delivering health education activities included health centers, hospitals, community agencies, schools, and churches. Education services were designed to reach community participants, program participants, and health care and service providers.

Education programs and messages concentrated on:

- Infant mortality and contributing risk factors
- The importance of early and regular prenatal care
- Utilization of preventive care services
- Preconception/interconception health
- Accessing Family Planning services
- STD and HIV education and prevention
- Substance abuse and pregnancy
- SIDS education and prevention
- Lead poisoning education and prevention
- Shaken Baby
- Postpartum depression

Consortium members, health care and service providers received education and training on screening for depression and substance use/abuse during pregnancy, HIV and perinatal transmission, and SIDS prevention.

The SIHF Healthy Start program employed three full-time health educators and a Program Manager. The project contracted with Touchette Regional Hospital for a registered nurse to assist the Healthy Start staff with the development and instruction of prenatal classes. SIHF health educators were responsible for the development, coordination, and implementation of:

- Monthly maternal child health education (prenatal, breastfeeding, childbirth, infant health and safety)
- Adolescent education and teen pregnancy prevention education
- health promotion and marketing (media campaigns, community events, education campaigns, development of program publications such as educational literature, and newsletters)

Through community workshops, health fairs, special events, and community presentations, health educators provided information to community participants on the following topics:

- Nutrition and wellness
- STD/HIV testing and prevention
- Preconception/Interconception health
- Substance abuse prevention
- Depression
- Domestic violence

- SIDS prevention and safe sleep
- Lead poisoning
- Shaken Baby
- Post partum depression

The most successful media campaign was the use of the movie screen advertisements at local theaters. These messages relayed the importance of early and regular prenatal care with the number of Healthy Start staff. As part of community education efforts, the project also advertised on the shopping carts of local grocery stores to deliver Healthy Start messages to the community.

Challenges implementing health education services included motivating participants to attend classes and other educational programs. For some prenatal classes, the no-show rate was as high as 50%. After obtaining feedback from participants, discussions with providers, and case managers, modifications were made to the number, time and frequency of the educational sessions. Responding to input from participants: 1) SIHF Healthy Start began to issue personalized “certificates of completion” to participants who completed workshop series; 2) Changed the name of the education program to be more consumer friendly and decorated meeting/classrooms to make environment more exciting and appealing to participants; 3) Incorporated more activities to generate audience/participant involvement; 4) SIHF Healthy Start applied for and received a one-time grant award from March of Dimes to implement the Baby Bucks incentives for those who attended prenatal education classes.

Securing participation of health care providers in education and training activities presented challenges that also required creative solutions. Providers are extremely busy and it's often difficult to get providers or clinical staff to commit to participation in in-service training when the training is not mandatory or if there are no CMEs or CEUs offered.

One successful strategy utilized to reach providers was the incorporation of Healthy Start provider training sessions into already scheduled provider meetings. For example, the SIHF Obstetrics & Gynecology Department held a regular monthly provider meeting and a mandatory quarterly meeting. Healthy Start staff was able to arrange Healthy Start trainings at these already prescheduled meetings. SIHF Healthy Start also partnered with St. Clair County Health Department and the Health Commission to sponsor training conferences that provided CME and CEU credits. These conferences focused on State of the County: infant mortality, gestational diabetes, and screening for domestic violence.

In addition to personnel, other resources required for implementing education services included meeting rooms for classes and workshops, audio visual equipment, educational literature and videos, and teaching models. Basic office equipment and supplies such as personal computers, and copier and fax machines were also required.

INTERCONCEPTIONAL CARE

SIHF Healthy Start interconceptional case management operated in conjunction with the

Illinois Department of Human Services Adverse Pregnancy Reporting System (APORS). The APORS program follows infants who are born prematurely or at medical risk from birth to twenty-four months. Goals of the APORS program are: 1) to ensure infant's optimal development; 2) Minimize any potential disability; and 3) Prevent complications, and avoid future preventable high-risk perinatal situations. Public health nurses conduct home visits to monitor infant progress and provide counseling, education, and developmental screenings, along with referrals for local health care services and social resources. Healthy Start project staff provide education to interconception women through the following methods: 1) Hospital visits with postpartum women prior to discharge; 2) Group classes; and 3) Individual one-to-one sessions.

Healthy Start health educators conducted hospital postpartum visits prior to hospital discharge. During the visit, if the participant had not yet scheduled a six-week postpartum visit with her provider, the health educator assisted the participant in that process by contacting the provider's office from the participant's hospital room and scheduling the six-week postpartum visit. The health educator did the same for the infant's two week well-child visit.

Healthy Start Case managers completed an initial interconceptional assessment during the participant's six-week postpartum visit. Case managers had responsibility for following up with the participant during the interconceptional period to ensure she kept appointments and maintained an active record with her medical home provider. Case managers and outreach specialists worked together to contact women who failed to complete their six-week postpartum visit or who did not have verified medical home. With assistance from outreach staff, case managers attempted to determine if the participant still lives in the project area. If it could be determined that the participant still resided in the project area, the case manager attempted to schedule a meeting with the participant to assess potential barriers that might have prevented the participant from accessing services. SIHF Healthy Start provided interconceptional case management and care coordination services for women and infants and who were not initially enrolled in prenatal case management. Many of these women were identified and referrals generated from the hospital postpartum visit.

During the first year of the project, SIHF Healthy Start experienced encountered challenges with the implementation of interconception services. The term and concept of "interconceptional care" was relatively new to our community in 2001. Many service and health care providers were not familiar with the term or concept and how it fit with Healthy Start. However, with on-going education with providers and consortium members on the concept and components of our interconceptional program plan (pregnancy planning, spacing of pregnancy, continuation of healthy behaviors learned during pregnancy, promotion of preventive health form women and infants) we were able to overcome barriers to effective implementation. Working closely with health center OB/GYN staff and East Side Health District (our local health department), and Touchette Regional hospital, we successfully implemented our interconception program with strong support from OB/GYN and pediatric providers. Healthy Start case mangers and health educators had primary responsibility for carrying out interconceptional services.

DEPRESSION SCREENING

SIHF Healthy Start utilized the Edinburgh Postnatal Depression Scale (EPDS) to screen both pregnant and interconceptional participants for signs of depression. Case managers were trained on administration and scoring of the EPDS instrument and had responsibility for completing the participant's initial screen. Participants who scored 12 or higher on the Edinburgh Postnatal Depression scale received a referral to a mental health provider for further assessment. Case managers screened prenatal and interconceptional participants at the following intervals:

- Prenatal when enrolled into the SIHF Healthy Start Program.
- Postnatal at five days postpartum
- Postnatal at 3 to 6 weeks postpartum
- Postnatal at 3 to 6 months postpartum
- Postnatal at 6 to 12 months postpartum

All women enrolled in Healthy Start case management received education on the signs and symptoms of postpartum depression through both one-on-one and group sessions. Case managers had responsibility for the one-on-one education sessions, while health educators had responsibility for group education. All maternal and child health curricula were revised to incorporate teaching on the signs, symptoms, and treatment of postpartum depression into prenatal orientation, Pregnancy Workshop™, and childbirth classes.

Community participants received health education and information on the signs and symptoms of perinatal depression through:

- In-service training
- Community workshops
- Presentations at local agencies, schools, daycares and churches
- billboards, shopping cart, movie theatre screens, bus and other transit advertisements
- Health fairs and special events

Health educators had primary responsibility for coordinating training and in-service programs for project staff and providers. Project staff partnered with a local mental health provider to provide education and training for clinicians and service providers. Education efforts to increase awareness of depression targeted case managers, health care professionals, service providers, and others who provided direct services to women in the service area. During the project period, SIHF Healthy Start sponsored two community trainings on postpartum depression and screening for depression. The goal of both training programs was to increase awareness of maternal depression and its impact on the emotional health and quality of life for both parent and child and to promote more aggressive screening. Training attendees were educated on the incidence, risk factors, symptoms, diagnosis, and treatment of postpartum depression. Administration and use of the Edinburgh Postnatal Depression Scale was demonstrated and discussed.

A lack of mental health providers that accept Medicaid reimbursement or uninsured individuals, long waits for mental health appointments, cultural beliefs, and the stigma

associated with obtaining mental health services were major barriers that effected implementation and referral completion rates. While participants were generally open to learning about depression and coping skills, few were open to receiving further assessment or counseling session with a counselor of mental health provider. Participants often communicated to case managers that their high EPDS score (above 12) was temporary due to stress of the day or particular situation.

Local Health System Action Plan

SIHF Healthy Start developed its LHSAP plan in 2000, and began implementation in 2001. The LHSAP (2000-2004) consisted of six objectives. The first four objectives were associated with the local health department and State Title V program goals. The final two objectives were implemented through the grantee's strategic planning process, and were designed to enhance delivery of health services and quality of patient care. Project staff, consortium members, Touchette Regional Hospital, St. Clair County Health Department, East Side Health District, regional and local Illinois Department of Human Services, and Southern Illinois Perinatal Association were key community stakeholders involved with development and implementation of the SIHF Healthy Start LSHAP.

Community health priorities and service gaps identified in the 1999-2005 IPLAN (Illinois Project for Local Assessment of Need) were the cornerstone for development of the LHSAP. Like the Healthy Start project plan, the LHSAP served as the guiding document for interagency collaboration and action. It also directed Healthy Start program activities as well as the strategic planning for grantee's 18 community health centers. The plan also supported advocacy for legislative policy change and funding priorities.

Healthy Start staff and consortium, SIHF senior management, and Board of Directors had accountabilities for working toward achievement of goals contained in the Healthy Start local health system action plan.

1. In collaboration with the St. Clair County Health Department's Maternal Child Health Data Use/Infant Health Committee, SIHF Healthy Start aggressively pursued negotiations with the Illinois Department of Public Health to access provisional data for maternal and infant health indicators by September 1, 2002. **Completed.** *The St. Clair County Health Department was approved to receive provisional data from the state Health Department. Presently they are the only entity that can access the data sets. We are still looking at ways to share the data without violating any concerns the state Health Department has with the provisional data.*
2. With assistance from the Illinois Department of Human Services and East Side Health District (local health department), we were able to develop a fully integrated information system utilizing the State's Cornerstone Database. Healthy Start's utilization of the States Cornerstone database eliminated the need for repetitive patient registration among the Healthy Start project and public health entities for those patients who consent to have their information placed within the Cornerstone Data system and available for the

participant registration information. **Completed.** *In August 2002, four Cornerstone workstations were installed in SIHF health centers for use by Healthy Start case managers. Case managers attended Cornerstone training in Springfield, Illinois in June 2002.*

3. Successfully established effective integration of case management services between the public health departments and Healthy Start to enhance service delivery and avoid duplication of services. **In progress.** *This effort has resulted in shared case conferencing and proposed initiatives for additional program services such as possibility of locating a WIC office within SIHF Healthy Start centers.*
4. Implementation of an education campaign addressing SIDS prevention and prematurity prevention and awareness. **Completed.** *Education and Awareness campaigns implemented in conjunction with the St. Clair County Health Commission's Infant Mortality Reduction Committee.*
5. Establish increased access to underserved and uninsured pregnant women for all obstetrics and gynecological services in Madison County. **Completed.** *OB/GYN and Healthy Start case management services are provided at both the Bethalto Health Center in 2000, Koch Health Center in Granite City in 2001, West Belleville Health Center in 2002, Belleville Adolescent and Pediatric Center in 2003, and the Mother and Child Dental Clinic in 2005.*
6. By December 1, 2004 redesign the patient flow and patient registration process at our Mother and Child Care facility in Centreville, Illinois that will lessen wait times and improve customer satisfaction outcomes to 90% or greater among all women and children that are seen for services at that facility. *Redesign plans have been drafted. Unfortunately, we have not secured funding to begin the redesign.*

While SIHF Healthy Start did not experience any significant challenges achieving goals of current action plan, changes in management at one of our local health departments and the departure of a key MCH staff at the State level, combined with state budget problems may result in future delays and challenges as a new LHSAP is developed. To overcome these potential challenges, the Healthy Start Project Director and SIHF leadership are working diligently to establish relationships with new administrations at both local and State MCH agencies to obtain commitment and support for continued collaboration and partnership with their agency.

CONSORTIUM

The Healthy Start consortium was formed in 1999. The consortium serves as an advisory board to project staff and provides direction on all aspects of program planning and development for the Healthy Start program. The SIHF Board of Directors is the

governing body for the grantee, and therefore for Healthy Start. The SIHF Board of Directors was established in 1985. The SIHF Board of Directors is made up of SIHF health center patients and residents from the Healthy Start project service area.

Under guidance of the Project Director, a member of the project staff served as Consortium Coordinator and was responsible for the coordination of consortium activities. The Consortium established three sub-committees. The sub-committees are education, training, and special events. Consortium members chair the subcommittees. The full consortium meets at least quarterly, with the subcommittees meeting more frequently as needed.

The diversified Healthy Start Consortium consists of the following 21 members.

- State and local government – 5
- Program participant – 2
- Community participant – 1
- Community-based organizations – 4
- Private agencies/organizations – 1
- Providers contracting with the Healthy Start program – 1
- Other providers – 4 (health care providers/clinicians)
- Other – Faith-based organizations – 1
- Other – SIHF Board of Directors – 2

Seventy-six percent of the consortium's membership is African American and 24% White. All but one of the consortium members are women.

COLLABORATION AND COORDINATION WITH STATE TITLE V AND OTHER AGENCIES

The Healthy Start program works collaboratively with the St. Clair County Health Commission's Infant Mortality Reduction Committee. The Healthy Start Project Director serves as the committee's co-chair. SIHF Healthy Start is also a partner with the Lessie Bates Parenting For Success Advisory Committee, and a member of Head Start Early Intervention Advisory Council. Each of these three agencies have members on the Healthy Start consortium which strengthens the ability to work collaboratively on common projects, assess community needs, and evaluate gaps in community services.

During the early stages of consortium development the project struggled somewhat with maintaining active members in the work of the consortium and experienced low meeting attendance. These problems were often due to member's conflicting schedules, reluctance to commit to another project, other priorities and commitments. In addition, there were already at least two other coalitions already established in the service area. To overcome these barriers, the Project Director and the grantee's COO met individually with each member consortium member to discuss the Healthy Start program, efforts to establish an active consortium to focus exclusively on the needs of women's and children's health issues and provide guidance to program staff. In addition, Healthy Start staff emphasized the common mission and goals and power of working together for the good of the community. We polled members on preferred meeting days

and times to avoid conflict with other advisory meetings in the community. Over a two year period, we held consortium meetings on various days and times until we were able to determine the time and day that resulted in the greatest participation.

Difficulty retaining consistent active participation from program participants presented the greatest challenge to the effectiveness of the Healthy Start consortium. To address this area of weaknesses and to generate greater involvement from program participants, we established the Sister Circle transition program in 2004. Sister Circle is a peer support group designed to develop leadership skills among program participants targeted for involvement in the Healthy Start consortium. Participants were introduced to the consortium through Sister Circle. While Sister Circle meetings are separate from consortium meetings, Sister Circle members are involved with activities common to the consortium and are gradually integrated into the larger consortia. We found it effective to have participants become comfortable giving input and engaging in discussion with their peer group before asking them to become involved with larger group, which might be intimidating. We also discovered that asking participants to agree to a shorter service commitment (three months instead 12 months) and a specific project resulted in greater and consistent participant involvement in the consortium.

Surveys, program activity evaluations, and focus groups were methods utilized to gain input from Healthy Start consumers/program participants. Consumer input gathered through these means was utilized and considered in program planning and development and reflected in new program components being added (male involvement program/education for male partners, job readiness/interview preparation, participant involvement in community service projects).

Locally, SIHF Healthy Start created strong collaborative relationships with multiple community-based organizations, health departments, health care providers, and social service agencies. The strongest relationships were maintained with East Side Health District and St. Clair County Health Departments. Collaboration with these local Title V agencies included Healthy Start's participation in the St. Clair County Health Commission and co-chairing of the countywide Infant Mortality Reduction Committee. The St. Clair County Health Department is the lead agency for the Health Commission. The Health Commission is composed of representatives from the area's four hospitals, Healthy Start, and the two local health departments.

Healthy Start's collaboration efforts involved bringing together health care and service providers, health departments, and community participants to fully assess and prioritize community needs and mobilizing community resources and program services. Service integration with the two local health departments focused on increasing utilization of maternal child health services, early and continuous access to prenatal care, and the partnership of Healthy Start case management services and the health department's case management services for highest risk pregnant women and infants. This integrated case management approach was supported by the utilization of a shared case management database (Cornerstone), monthly case staffing, and joint training and staff development. SIHF Healthy Start and the two local health departments collaborated to obtain funding

for a pregnancy and domestic violence project that trained providers and case managers to screen, identify and assist pregnant women in abusive relationships. Other joint training programs during the project period included postpartum depression, Fetal Alcohol Syndrome and Alcohol use during pregnancy, Promoting and Increasing Breastfeeding among Case Management Participants, and HIV Screening and Perinatal Transmission.

In addition to partnerships with our local MCH agencies, during the project Healthy Start also partnered with our local March of Dimes Chapter, Regional Maternal Child Health Coalition, Southern Illinois Perinatal Program, Violence Prevention Center, and Children's Research Triangle address domestic violence, substance during pregnancy, prematurity prevention, and reduction of low birth weight. These agencies provided training, education, funding, and technical assistance to SIHF Healthy Start. Other local partnerships included collaboration with East St. Louis School District 189. Healthy Start staff coordinated with school administrators and counselors to implement teen pregnancy prevention programs in middle and high schools. SIHF Healthy Start maintained partnerships with numerous community-based organizations including Lessie Bates Providing a Sure Start and Healthy Families programs, Call for Help Transitional Living Program, Parenting for Success, The Violence Prevention Center, Child and Family Connections, Uni-Pres Kindercottage Day Care, and Bits and Bytes Training Institute. Relationships with these agencies included mutual service referrals, Healthy Start health educators providing risk reduction and prevention education for agencies' clients, joint staff training and development, and Healthy Start outreach coordination.

An example of on-going collaboration among the State Title V Agency, our local health departments, and SIHF Healthy Start is utilization of the Cornerstone database. The Cornerstone database is a statewide network that allows MCH agencies across the state and Healthy Start projects to document and track WIC, case management enrollment, service utilization, immunization status, and birth outcome of case management participants (including Healthy Start participants). With assistance and support from our local health departments, the State MCH agency, Department of Human Services, installed and maintains four Cornerstone workstations in SIHF health centers for use by Healthy Start case managers. These Cornerstone workstations permit Healthy Start to standardize its assessment and enrollment process with that of the two local health departments, and allow the sharing of participant data, joint case management, and tracking of referrals.

Throughout the project period, SIHF Healthy Start maintained a strong collaborative partnership with our State Title V agency, Illinois Department of Human Services (DHS). Like our collaboration efforts with the local Title V agencies, our partnership with DHS concentrated on increasing access to and appropriate utilization of maternal child health services. Evidence of SIHF's linkage and partnership with our State Title V agency is the Department Human Service selection of Southern Illinois Healthcare Foundation as a funded contractor to provide family planning services, STD screening and treatment, genetics counseling and screening, and HIV testing and counseling. During the past four years, Southern Illinois Healthcare Foundation received from DHS increased funding for

expansion of family planning services, making SIHF the largest family planning provider in the Healthy Start project service area. This increase was greatly the result of promotion of interconceptional care and family planning services through the SIHF's Healthy Start program.

Collaboration with our state Title V agency also consisted of SIHF Healthy Start association with the Healthy Start Illinois Partnership. The Illinois Partnership is a collaboration that links all six Illinois Healthy Start programs together to ensure effective coordination of services with the State Title V program, the Medicaid program, and the perinatal care system in the communities we serve. During the project period, the Illinois Partnership:

- Implemented the State's first community-based screening programs for perinatal depression
- Conducted a joint leadership training program for the consumers of all six consortia
- Presented at the American Public Health Association in 2001
- Conducted a statewide Healthy Start Leadership Conference for consortium members

SIHF Healthy Start maintained its status with the Illinois Department of Public Health (IDPH) as a KidCare Enrollment Agent responsible for assessing eligibility and initiating enrollment of children and pregnant women into the KidCare insurance (State Child Health Insurance Program) and Medicaid Presumptive Eligibility programs. SIHF Healthy Start is the leading KidCare agent in Southern Illinois, enrolling more families into the KidCare and FamilyCare insurance program than any other agency outside of Chicago. SIHF Healthy Start was also selected by the Illinois Department of Public Health to educate area providers on the significance of interconceptional care and eligibility and enrollment of postpartum women into the Illinois Healthy Women program. The Illinois Healthy Women program allows women who are losing Medicaid benefits after giving birth to have continued access to essential preventive and reproductive health care services.

SUSTAINABILITY

Southern Illinois Healthcare Foundation has been successful in obtaining grant funding to target specific service gaps and to support service needs within our Healthy Start project area.

- **KidCare Program** (Illinois' Medicaid/SCHIP) – Southern Illinois

Healthcare Foundation maintains a contract with the Illinois Department of Public Aid as a satellite center for KidCare eligibility intake and enrollment. SIHF receives a technical assistance payment of \$50.00 from the State for each applicant enrolled in the KidCare program whose application was initiated and submitted by Healthy Start staff.

- **Transportation** –Southern Illinois Healthcare Foundation, in collaboration with Touchette Regional Hospital, obtained a contractual agreement with the Illinois Department of Public Aid for patient transportation reimbursement. SIHF submits each transportation ride provided for a medical office visit to Public Aid for reimbursement. Only those transportation rides not approved for reimbursement by Public Aid are then billed to SIHF Healthy Start. SIHF also secured a grant from the Illinois Department of Transportation for replacement vehicles, which resulted in the replacement of a Healthy Start transportation van that had well over 100,000 miles. The replacement vehicle received through this grant is now utilized for transportation of all patients including women and children.
- **Adolescent Health** – Funding was acquired through SIHF Section 330 Federally Qualified Healthcare Center application for \$75,000 per year to replicate the activities implemented through the Healthy Start adolescent health education program.
- **Family Planning** – SIHF received a grant from the Illinois Department of Human Services to operate family planning clinics in four of SIHF’s 18 community health centers. The family planning grant provides just under \$436,000 on an annual basis. This funding supports family planning services at three SIHF health centers in the Healthy Start project area. Family Planning provides comprehensive services related to pregnancy prevention, planning and spacing of pregnancies.
- **Stand Against Cancer Initiative (SAC)** – In January 2004, SIHF received \$40,000 in funding to provide comprehensive breast and cervical screening for uninsured women with incomes at or below 200% the federal poverty level. The Stand against Cancer Initiative is a new program funded by the Illinois Department of Public Health. The Fiscal Agent for the program is Access Community Health Network in Chicago. Addition of the SAC program will provide an enhanced, coordinated system of care for African American and Latino women focused on reducing racial and ethnic disparities in the early detection of breast and cervical cancer.
- **HIV Risk Reduction and Prevention** – This \$70,607 grant through the Illinois Department of Public AID supports HIV outreach, testing, and counseling for both outreach sites and fixed testing sites throughout St. Clair County.
- **Ryan White Title III** – Since 1998, SIHF has been a Ryan White Title III Early Intervention Services grantee. This \$605,000 grant that provides comprehensive primary care system for HIV positive individuals who are uninsured or underinsured. Ryan White Title III coordinates with Ryan White Title III to provide prenatal care to HIV positive pregnant women and neonatal care to exposed newborns.

With the exception of transportation, the SIHF Healthy Start program does not provide services eligible for third party reimbursement. SIHF submits reimbursement requests for transportation to medical appointment for women and children to the local Public Aid office for reimbursement.

The SIHF Board of Directors, senior management, and project director have responsibility for obtaining funding to secure sustainability of the Healthy Start program. With endorsement of the SIHF Board of Directors and support from the Healthy Start consortium members, project staff aggressively pursues funding from private and public sources to enhance and sustain Healthy Start core services.

III. PROJECT MANAGEMENT AND GOVERNANCE

Ninety percent of current Healthy Start program staff and management have been with SIHF for at least three years and are greatly familiar with Healthy Start's focus and goals. The Project Director is responsible for management of the Healthy Start program. The Project Director has been with the Healthy Start project for five years, serving as the Project Director for three of those five years. The Project Director reports to the grantee's Chief Operating Officer of Southern Illinois Healthcare Foundation (SHIF). The Chief Operating Officer (COO) served as the Healthy Start Project Director for three years, 1998 through 2001, before turning over the reign to the current Director. The COO reports to the grantee organization's Chief Executive Officer (CEO). The Chief Executive Officer and the Chief Operating Officer report to the SIHF Board of Directors.

The Healthy Start Project Director oversees program planning, implementation, monitoring, and evaluation of the Healthy Start program. Key responsibilities include:

- Recruiting, hiring, and orienting project staff
- Recruiting consortium members
- Supervision of project staff
- Managing project budget and approving all expenditures of project staff and subcontractors.
- Preparation and submission of project reports
- Attending local, regional, state, and national meetings related to the project.
- Assuring project goals and objectives are met.
- Ensuring project sustainability

The Project Director manages the program's budget and fiscal matters with assistance from the organization's fiscal department. The Assistant Chief Financial Officer (CFO) oversees fiscal management for all SIHF grant funds and is responsible for all general accounting functions, federal invoicing and draw down for the grantee. The Assistant

CFO prepares financial statements, financial status reports, tracks funds utilized by subcontracted agencies for project administration, monitors cost account expenses, program income, payroll and benefits, processes purchase orders, and check requests. The SIHF Fiscal Department prepares and submits monthly financial statements to the Healthy Start Project Director for review.

The latest version of the “Great Plains” accounting system is used and a tracking system is in place along with written SIHF Accounting and Finance Department Policies and Procedures. A records retention policy is in place. SIHF receives an annual audit. There are no audit exceptions, the audit found internal controls are adequate, and all grant reporting was in compliance according to grant specifications. The Board’s finance committee meets monthly to review all checks written, pulls random checks for proper documentation and compliance with SIHF policies and grant requirements, and reviews the overall financial status of the organization.

The grantee’s Information System Manager is responsible for maintenance of the participant information database and generating participant outcomes data reports. The IS Operation Manager also oversees the maintenance of all communication equipment utilized by the Healthy Start grant (computers and printers, e-mail, telephones, fax machines, copiers, etc.)

To meet modified Healthy Start reporting requirements, the grantee’s IS team worked closely with project staff to create new templates and databases to gather the required data. The IS manager continues to work closely with Healthy Start managers to obtain data for reporting and evaluation purposes.

SIHF Healthy Start project did not encounter issues or problems related to the cultural competency of project staff. SIHF Healthy Start maintains a long-standing commitment to providing services in a manner responsive to the needs and culture of program participants and the community. SIHF Board of Directors, consortium, project staff, grantee support staff and clinicians are reflective of the Healthy Start service community.

Southern Illinois Healthcare Foundation (SIHF) is committed to maintaining training and policies that support development of attitudes, behaviors and knowledge necessary to serve program participants in a culturally and linguistically competent manner. To ensure cultural sensitivity, SIHF Healthy Start ensures that videos, printed materials and other intervention resources used in the program reflect the cultures of the families served. Likewise, displayed pictures and other décor appropriately reflect cultures and backgrounds of the community and individuals served. SIHF utilizes bilingual-bicultural health care providers and program staff during medical examinations, health education sessions, meetings and other events for individuals and families who do not speak proficient English and require or prefer a translator.

IV PROJECT ACCOMPLISHMENTS

Major accomplishments of the SIHF Healthy Start program include:

- Increased access to prenatal, interconceptional, and infant health care with the opening of four new health centers and two dental clinics in the project service area

- Removed barriers to accessing health care and program services by providing free transportation. Healthy Start provided more 3,000 rides annually for Healthy Start participants.
- Contributed to efforts that reduced the three year infant mortality rate in the project service area from 18.9 (1996-1998) to 16.9 (2000-2002). The Healthy Start program experienced eight infant deaths among 914 live births (8.7) which is nearly half that of the project service area.
- Increased percentage of children with a medical home from 49% to 82%. Established medical homes for 2,181 uninsured children. SIHF Healthy Start is the leading KidCare agent in Southern Illinois, enrolling more families into to the KidCare and FamilyCare insurance program than any other Illinois agency outside of Chicago.
- Increased percentage of Healthy Start participants who began prenatal care in the first trimester from 37% baseline in 2000 to 48% in 2004.
- Increased immunization rates from 81% to 85% among Healthy Start participants.

The SIHF Healthy **Start Implementation Plan/Final Report** located in *Appendix A* contains a complete listing of project objectives and accomplishments.

V. PROJECT IMPACT

SYSTEM OF CARE

Through leadership, collaboration, and advocacy, Southern Illinois Healthcare Foundation and Healthy Start have developed the most comprehensive women's health care delivery system in Southern Illinois. Approaches utilized to enhance collaboration with agencies and organizations providing maternal and child health and social support services included joint training and staff development, resource sharing, mutual referrals, and joint advocacy, community needs assessment and planning.

Efforts to ensure comprehensive system of care and coordinated service delivery begins with Healthy Start case managers. Case management services include:

- Assessment and screening for social and behavioral factors which pose risks that may impact pregnancy and potentially result in an adverse birth outcome.
- Development of individual service plan based on identified need and risks.
- Connecting participant with a health care provider.
- Initiating referrals to link participants with needed services.
- Documentation and tracking of referral outcomes.
- Health education to promote and support healthy behaviors.

East Side Health District and St. Clair County Health Department provide intensive medical case management to high-risk pregnant women through the Targeted Intensive Prenatal Services (TIPS) program. Because the TIPS program targets the highest risk women, TIPS enrollment capacity is limited to 100 women for each health department's program. To ensure effective delivery of case management services and to avoid

duplication of services, Healthy Start case managers referred to the health department's TIPS case management program the highest risk pregnant women who meet criteria for TIPS enrollment. In these instances, SIHF Healthy Start case management staff continued to provide coordination of services such as transportation, appointment scheduling and reminders, registration for medical appointments and health education programs, and referral tracking. The TIPS case manager conducted participant home visits, completed additional environmental assessments, developed service plan, and initiated and monitored medical referrals. Both the Healthy Start case manager and the health department case manager monitored the participant's progress by accessing the Cornerstone database. These shared cases were also discussed at the monthly case staffing.

The SIHF Healthy Start program utilized two methods to verify participants' completion of referrals. The first and preferred method involved Healthy Start staff verifying with the agency or provider directly that the participant presented and received scheduled services, thereby completing the referral. The second and less preferred method of referral verification was the use of self-report by the participant.

Healthy Start case managers refer HIV positive participants to Southern Illinois Healthcare Foundation's Ryan White Title III program, which enrolls the participant in care services to reduce perinatal transmission. SIHF has an integrated network of prenatal, obstetric, and HIV care providers through Ryan White Title III funding and in conjunction with the Ryan Title IV grantee, Washington University's Project ARK. Coordination of care for HIV positive pregnant women ensure these women received anti-transmission therapies to prevent infection to the newborn.

SIHF health care providers screen prenatal program participants for HIV twice during pregnancy, first at their initial prenatal visit and again at 36 weeks of pregnancy. Exposed children born to HIV positive mothers are then followed for 18 months to determine HIV status by the Infectious Disease Department at Children's Hospital in St. Louis, Missouri and SIHF Ryan White Case Manager.

Efforts to establish participants with a medical home include Healthy Start case managers linking interconceptional care participants with family planning services through SIHF family planning clinics. Participants receive HIV testing and counseling at family planning visits and risk reduction counseling. Efforts to link women and their infants with a medical home also include Healthy Start outreach staff assessing uninsured pregnant women and children for eligibility and enrollment into the State's KidCare and Medicaid Presumptive Eligibility (MPE) programs. KidCare is the name by which Illinois markets the State Child Health Insurance Program (S-CHIP). For eligibility assessment and enrollment purposes, the Illinois Department of Public Aid has authorized SIHF to serve as KidCare agents. (Something about the impact of accessing service once they have coverage) As part of the KidCare eligibility assessment, Healthy Start outreach staff assists individuals with gathering all required documents, completing the enrollment application, and submitting the completed application to the Illinois Department of Public Health (IDPH) for processing. Healthy Start outreach staff is responsible for tracking the

status (approval or denial) of all submitted applications.

Healthy Start health educators conduct hospital visits with postpartum women prior to discharge from the hospital. If a woman has not yet selected a pediatrician for her newborn, the health educator assists the participant with that process and contacts the pediatrician office from the hospital to schedule the baby's initial well-child visit. Staff provides the same assistance if the woman has not scheduled her six-week postpartum visit. This ensures the scheduling of both the newborn and postpartum visits prior to participant leaving the hospital and enrollment in the interconceptional care program. Healthy Start health educators forward the appointment dates to the participant's case manager and the utilization tracker. The utilization tracker records the appointment in the program tracking system and generates reminders to the participant as appointment date draws near. The utilization tracker is also responsible for verifying and documenting appointment disposition. The utilization tracker provides case manager a roster of completed visits and no-show participants. Case managers follow-up with participants who do not keep scheduled appointments to identify possible barriers to offer solutions for future visits, i.e. transportation arrangements through the Healthy Start system.

IMPACT ON THE COMMUNITY

SIHF Healthy Start accomplished project goals through the following: 1) effective delivery of Healthy Start core services; 2) maintenance of a Healthy Start Consortium; 3) on-going collaboration with state and local Title V agencies, and both local and State Health Departments; 4) and development of a local health system action plan that ensures women and their infants have access to quality health care. Through system building, strong partnership and collaborative planning, SIHF Healthy Start has emerged as a leader in the effort to reduce infant mortality and improve perinatal outcomes. During the four-year project period, Southern Illinois Healthcare and the SIHF Healthy Start program have:

1. Established collaborative relationships and created a system of care in greater East St. Louis which contributed to the reduction of infant mortality rate (IMR) among African Americans in the project service area from 18.9 (82 of 4,345), 1996 – 1998 to 16.9 (22 of 1,304), 2000-2002. Among Healthy Start participants (2001-2004), there were eight infant deaths among 914 live births (8.8 IMR).
2. Integrated, comprehensive healthcare delivery systems for pregnant and interconceptional women and their infants through joint case staffing, co-location of services, database sharing, system and resource planning, and joint grant proposals with our local and state Maternal Child Health (MCH) agencies
3. Increased access to women's and children's health care with the opening of four new community health centers and two dental clinics in project area.
4. Established medical homes for 2,181 uninsured children.

SIHF Healthy Start's success and impact on the community is reflected in the increase among Healthy Start participants who received early prenatal care, accessed family planning services, and increased infant immunization rates. Project goals and accomplishments are provided in the **Implementation Plan/Final Report** located in *Appendix A*.

IMPACT ON THE STATE

Advocacy of the Healthy Start Illinois Partnership (six Illinois Healthy Start projects) and collaboration with our State Title V agency led to implementation of the State's first community-based screening program for perinatal depression and provider reimbursement for depression screening. Healthy Start consortium led activities contributed to increasing access to healthcare and advocacy efforts for the KidCare SCHIP program expansion. SIHF Healthy Start worked for and supported legislative advocacy activities led by the Illinois Maternal Child Health Coalition to expand the KidCare program (Medicaid and SCHIP) to cover parents of eligible children. In July 2003, KidCare eligibility expanded to include parents whose family incomes are up to 90% of the federal poverty level. Another success includes KidCare eligibility expansion to include children whose family incomes are up to 200% of the federal poverty level. This expansion resulted in the enrollment of 1,458 statewide. In addition to expansion of eligibility, the process of applying for KidCare is now easier for families. As of January 1, 2004 families applying for KidCare only need to provide one pay stub to verify income when applying for KidCare coverage. SIHF Healthy Start leads the Southern Illinois region in KidCare eligibility assessment and enrollment.

LOCAL EVALUATION

SOUTHERN ILLINOIS HEALTHCARE FOUNDATION HEALTHY START

Prepared by

Paula Brodie, MSHPE, Director of Community Programs
Ronni Thornton, B.S., Program Development Manager

When comparing the project service area for the Southern Illinois Healthcare Foundation

(SIHF) Healthy Start program, two very different pictures emerge. Poverty and disparities in perinatal health among African Americans are in some instances as much as five times higher than that of the Caucasian population. The goal of the SIHF Healthy Start program was to reduce the infant mortality rate and close the gap in racial disparities in birth outcomes that contribute to infant mortality. A project area infant mortality rate of 18.9 (1996 – 1998), lack of access to health care, and increasing disparities in pregnancy outcomes among African Americans, was the impetus that drove the SIHF Healthy Start project plan and evaluation design.

The SIHF Healthy Start local evaluation for project period June 2001- May 2005 was developed and conducted by project staff under the direction of the Healthy Start Project Director. The evaluation contained formative, process, and outcome components. The overall design of the SIHF Healthy Start evaluation consisted of 1) input and feedback from program and community participants, consortium members, health care and service providers, school officials, local health departments, and project staff, 2) implementation and delivery of core services; and 3) comparison of aggregate and participant level data for infant mortality, low and very low birth weight, entry into care, and adequate care as measured by the Kessner index.

Key questions to be addressed through the local evaluation are: (1) Did the infant mortality decrease in the project service area; (2) Did Healthy Start participants show improved outcomes continually over the program period compared to baseline data; (3) Did Healthy Start participants show evidence of reduced or eliminated health disparities; (4) Were Healthy Start core services successfully implemented.

FORMATIVE EVALUATION

As the Healthy Start project period progressed, project staff modified project plan strategies and activities in response to feedback from participants, consortium members, providers, and staff experiences. Modifications to the SIHF project plan influenced by results of the formative evaluation included redesign of prenatal education classes, planning for the development of a male involvement program component, creation of new education messages and materials, development of the Baby Bucks incentive program, expansion of transportation service to include more routes and an additional vehicle, locating case managers and outreach staff in health centers, and utilization of a mobile van to enhance outreach efforts.

The formative component of the SIHF evaluation consisted of gathering input and feedback from the following community stakeholders:

1. Program and community participants
2. Consortium members
3. Health care and service providers
4. School officials
5. Local Health Departments (Title V agencies)

Program and community participants contributed to the evaluation through participation in focus group discussions and completion of surveys and program evaluations. Completed surveys helped to identify participants' needs, barriers to accessing and utilizing services, and health priorities. Focus groups provided insight into participants' thoughts and attitudes about prenatal care, personal goals, priorities, and satisfaction with Healthy Start services and the grantee's health care services and staff. Participants' surveys and focus group discussions revealed the following:

Why women do not seek early and continuous prenatal care

- Prenatal visits too time consuming
- Prenatal care is not important
- No problems with previous pregnancy. Know what to expect.
- It's okay to miss appointments, as long as you the next appointment is kept or as long as you "don't go too long without seeing the doctor".
- Long waits at the health centers
- Long wait for transportation van after completing visit with doctor
- Lack of evening appointments
- Poor customer service & unresponsive providers

Participants also identified the following needs and priorities

- Assistance with obtaining employment
- Incentives for participation in Healthy Start classes and programs.
- Financial assistance with purchasing over the counter medications and infant care items
- Assistance with getting infant car seat and crib/mattress
- Child care during participation in Healthy Start programs and meetings.
- Programs for spouses and partners.

A focus group of eight men, all spouses or partners of Healthy Start participants expressed beliefs that the role of fathers during pregnancy is more "on the home front" (taking care of finances, shelter, providing emotional support) and the pregnancy itself and prenatal care are the responsibility of the woman.

The majority of focus group participants (six of eight) expressed interest and indicated willingness to participate in a male involvement program if available in the community. According to focus group participants, a male involvement program should assist men with the following three needs:

- knowing and better understanding oneself
- self respect
- role models and guidance

Information gathered through the formative process (focus groups and surveys) influenced the structure and content of prenatal and parenting classes by: 1) Awarding certificate of recognition for completion of workshop series; 2) Marketing messages to males to increase participation and support from participant's spouse or partner; 3) Implementation of an incentive program that assist participants with obtaining infant care and safety items; and 4) Planning for development and implementation of a male involvement program component Also in response to information obtained during the formative phase of the evaluation, Healthy Start transportation service was expanded with the addition of new routes and an additional vehicle in effort to reduce participant wait and ride time. In addition, a customer service training program was developed and implemented at all SIHF health centers improve customer satisfaction.

Feedback gathered from survey of consortium members and individual interviews with community stakeholders such as health care and service providers, local health departments and school officials revealed following.

Describe Characteristics of a Healthy Community

- Access to quality health care for all residents
- Absence of health disparities by race and income
- Safe environment (lead-free, low crime, community-based police, parks)
- Strong infrastructure (police, fire, good streets/roads)
- Affordable housing
- Employment opportunities with livable wages.

What are the Barriers to Prenatal Care in Our Community

- Lack of health care insurance
- Lack of reliable transportation

Reasons Women Do Not Seek Early and Continuous Prenatal Care

- Hiding pregnancy or denying pregnancy.
- Consider prenatal visits too time consuming.
- Lack of knowledge and understanding of the importance of prenatal care
- Preventive health care/prenatal care not always the highest priority. Higher priority may be lack of utilities (water, lights, heat, food, etc.).
- Actively engaging in risk behaviors

Responding to input from community stakeholders, In November 2001, SIHF Healthy Start assumed direct delivery of case management services. Prior to 2001, SIHF Healthy contracted for case management services. Case managers and outreach staff directly employed by Healthy Start and were co-located alongside OB/GYN and pediatric providers in community health centers. With community stakeholders (school nurses and counselors, medical and service providers), project staff established a referral network and process to link families to Healthy Start and other community services.

Healthy Start enhanced transportation service by adding new routes and an additional vehicle. Additional outreach workers were hired to conduct outreach services at health

centers, schools, and community agencies in identifying pregnant women and linking them with care. All Healthy Start outreach and case managers were trained to assess for eligibility and initiate enrollment into the state's SCHIP and Medicaid programs.

SIHF Healthy Start designed and implemented campaign to increase awareness and knowledge of the importance of early and regular prenatal care. In addition, Healthy Start staff established a collaborative partnership with to local school districts to teach life skills and risk reduction education during the school day. SIHF Healthy Start also partnered with two school-based clinics to provide risk reduction education focusing on teen pregnancy prevention and STD/HIV education and prevention.

PROCESS EVALUATION

Process evaluation monitored the implementation of Healthy Start core service intervention of outreach and client recruitment, case management, health education, interconceptional care, and depression screening and referral. Each core service was evaluated separately.

Process evaluation measured the following:

1. Implementation of case management services with a central intake process.
2. Enrollment of participants into case management program.
3. Implementation of outreach activities
4. Implementation of health education programs and classes
5. Implementation of education campaign focusing on early prenatal care, prematurity
6. Implementation of screening for depression.
7. Implementation of interconceptional care education and case management service for interconception women.

Data Sources:

1. Cornerstone Database
2. SIMIS Database
3. Participant Case Management Records
4. Participant Medical Records
5. Health Education Tracking Forms
6. Outreach Tracking Forms
7. Consortia & Participant Surveys
8. Program Evaluations & Surveys

Outreach and Client recruitment

SIHF Healthy Start is recognized in the service area for the ability to implement extensive and aggressive outreach program that promotes healthy lifestyles and utilization of preventive care services. SIHF Healthy Start utilized four (4 FTEs) outreach workers to identify potential participants for Healthy Start services. Outreach workers maintained a strong presence and high visibility in project area neighborhoods. Many outreach activities were carried out using the SIHF outreach van. The van increased program visibility, served as traveling resource library, and offered individuals

privacy should they wish to sit in the van with outreach workers to complete assessments, discuss needs, or receive HIV testing. Outreach workers were equipped with cell phones and were able to call in to health centers to schedule medical appointments or contact other agencies to inquire of services on behalf of the participant.

While the project experienced some turnover in outreach staff during the four-year project period, SIHF Healthy Start sustained a core team of committed and experienced outreach workers. Outreach workers were residents from the project area and familiar with specific residential neighborhoods and local gathering places. Being familiar with the service area, having a regular presence in neighborhoods and years of experience providing direct outreach to the highest-risk populations including drug users, the homeless, and sex workers, earned Healthy Start outreach workers the trust and respect of community residents.

In addition to providing program information and education to participants on the street, Healthy Start outreach workers utilized Healthy Start transportation to bring women into the health centers for family planning services such as pregnancy tests and STD screening and treatment. Outreach staff worked with health educators to conduct the Ladies Education and Awareness Program (LEAP) education sessions. The LEAP program was implemented in 2004. Forty-two women participated in LEAP education sessions. Healthy Start project staff specifically designed LEAP sessions for participants identified through street outreach activities. Outreach workers used the Healthy Start van to pick up women and bring them to the location of the LEAP session. The outreach workers attend presentations with recruited participants. The average attendance for a LEAP sessions was six to 15 women per session.

During the project period, outreach staff assisted 1,345 families. Outreach workers initiated 1,972 referrals to link individuals to Healthy Start and other health care services. Outreach workers enrolled 2,684 uninsured women and children into the KidCare/FamilyCare Medicaid program, and performed 591 HIV/AIDS tests through community outreach activities.

Case Management

SIHF Healthy Start case management program utilized the Cornerstone database, SIMIS database, Excel spreadsheets, and hard copy participant files to document patient demographics, completed assessments, care coordination and linkage, referral compliance, prenatal visit compliance, pregnancy and birth outcomes, postpartum visit compliance, and infant immunization compliance. Case managers submitted monthly reports summarizing program participants' activities and progress. Each quarter, the Case Management supervisor completed a quality assurance review of program participant records and data related to prenatal care, birth outcomes, postpartum care, infant

immunization rates, and infant deaths.

The Cornerstone 700 Prenatal General Assessment and Service Barriers tool was used to assess participants' needs and determine risk level. The Cornerstone 700 assessment tool is utilized statewide by all Title V agencies to assess risks and needs of women enrolled in prenatal and family case management services.

Risk level classification dictated the intensity of intervention and frequency of contacts with the participant. Based on completed assessments and identified risks, the case manager classified participants by risk level into one of three categories. The three risk level categories are high, moderate, and low. *Appendix B* contains a listing of risk indicators utilized when determining risk level classification.

High Risk Level Category: Participant with more than two risk indicators. The health care provider or program supervisor may determine a participant with fewer than two indicators be placed at the high risk level due to extenuating circumstances.

Moderate Risk Level Category: Participants with two risk factors. The health care provider or program supervisor may classify a participant at a lower or higher risk level due to extenuating circumstances.

Low Risk Level Category: Participant having just one risk factor or “*other psychosocial issues*” only. The health care provider or program supervisor may classify a participant at higher risk level due to extenuating circumstances.

During the first two years of the project period (2001 – 2002), the majority of case management participants were classified as moderate or low risk for adverse pregnancy outcome. In 2001, only 16.3% of participants were high risk and 16.9% in 2002. However, with continued aggressive outreach and a strong partnership between Healthy Start staff and health care providers the percentage of high-risk women referred to and enrolled in Healthy Start case management increased significantly during the later years of the project period. In fact, by 2003 more than half (65.5%) of case management participants were high risk and in 2004, 67% of case management participants were high risk. As the percentage of high-risk participants increased, so did evidence of alcohol and substance use/abuse during pregnancy, smoking, STD infections and bacteria vaginosis, lack of family support, and lack of permanent housing, all factors known to impede early and regular prenatal care. In addition, the percentage of participants with a previous preterm or low birth weight delivery, and the proportion of teen participants (under age 17) also increased as the caseload shifted from majority moderate risk to majority high-risk.

During the four-year project period, 1,940 pregnant women were referred to Healthy Start. All women were assessed for risks and 77% (1,498 of the 1,940) of the women referred were enrolled into Healthy Start case management. Fourteen percent (212 of 1,498) of participants were under age 17. Eighty percent (1,205 of 1,498) of case management participants were African American, 13 % Caucasian, and 7% Hispanic.

Among those enrolled, 40% (605 of 1,498) were high risk, 49% (728 of 1,498) were moderate risk, and 11% (165 of 1,498) were low risk.

Table 2. Participant Demographics

	Enrolled	Black		White		Under17	
		#	%	#	%	#	%
2001	294	235	79.9	28	9.5	35	11.9
2002	486	372	76.5	56	11.5	69	14.2
2003	403	316	78.4	77	19.1	96	23.8
2004	315	262	83.2	40	12.7	54	17.1
Total	1498	1205	80.4	201	13.4	212	14.2

Table 3. Participant Risk Level Classification

	Enrolled	High Risk	% of Total	Moderate Risk	% of Total
2001	294	48	16.3	223	75.8
2002	486	82	16.9	390	80.0
2003	403	264	65.5	88	21.8
2004	315	211	67.0	27	8.6
Total	1498	605	40.4	728	48.6

During the project period, there were 914 live births among Healthy Start case management participants. Of the 914 live births, there were 8 infant deaths for an infant mortality rate of 8.8. Sixty-six percent (599 of 914) of case management participants began prenatal care during the first trimester of pregnancy, and increase from the baseline of 37%. Fifty-seven percent (522 of 914) of mothers with live births received adequate care as measured by the Kessner index. Six percent (54 of 914) of live births among case management participants were low birth weight, a decrease from baseline of 12.9%. 1.9% (17 of 914) very low birth weight, a decrease from the baseline of 2.7%.

Table 4. Participant Outcomes

	2001	2002	2003	2004	Total	%
Live Births	88	356	268	202	914	
Infant Deaths	2	3	2	1	8	8.8 IMR
Low Birth Weight	4	17	9	24	54	5.9
Very Low Birth Weight	1	4	4	8	17	1.9
First Trimester Entry into Care	41	329	133	96	599	65.5
Adequate Prenatal Care Kessner Index	73	225	143	81	522	57.1

Health Education

Southern Illinois Healthcare Foundation (SIHF) Healthy Start utilized both group and one-on-one methods of instruction to provide risk reduction counseling and prevention education to program and community participants. Healthy Start education activities, based on the social learning theory, incorporated feelings, attitudes, and beliefs to promote behavior change. In addition to traditional lecture and discussion, group classes included demonstrations, hands-on learning activities, and tours of hospital labor and delivery rooms. Settings for conducting health education activities were:

- Health Centers
- Hospitals
- Community Agencies
- Participant's Home

The March of Dimes *Pregnancy Workshop* curriculum was used for group instruction and the What to Expect Foundation's *Baby Basics* curriculum was used for individual one-to-one teaching with case management participants.

During the project period, Healthy Start education activities were monitored utilizing monthly reports prepared and submitted by Healthy Start health educators. For every education group presentation, class/workshop, and special event, health educators documented in an Excel spreadsheet the number of participants attending Healthy Start education activity and the topic(s) presented. Health educators submitted to the program manager a monthly summary report detailing all education activities. Data from the educator's monthly report was then evaluated for progress toward achievement of program goals contained in the project implementation plan.

Nearly eighty-two percent (1,228 of 1,498) of case management participants attended at least one Healthy Start prenatal education or parenting class. Eighty-seven percent (201 of 344) of pregnant and parenting women who participated in SIDS prevention education indicated increased awareness and willingness to place infants on their backs to sleep. Ninety-five percent (2,088 of 2,196) of program participants and adolescents reported increased knowledge of risks associated with alcohol, tobacco, and drug use during pregnancy. Among program participants and adolescents participating in HIV education programs and sexual health and responsibility programs almost all, 99.7% (2,184 of 2,190) reported increases knowledge of HIV and sexually transmitted diseases and methods for protection. Ninety-seven percent (4,226 of 4,366) of community and program participants (including adolescents) participating in life skills programs reported increased knowledge. Two hundred and sixteen adolescents participated in the "Baby Think It Over" teen pregnancy prevention program.

Interconceptional Care

Efforts to achieve optimal pregnancy outcomes and reduce infant mortality must be inclusive of interconceptional care. The interconceptional period provides a unique opportunity to counsel women in the period between the birth of one child and the conception of another. SIHF Healthy Start provided interconceptional services to women and their infants through case management and health education. Interconceptional

services are provided in the interval between birth and up to two years, or until a subsequent pregnancy occurred.

Case management services provided to interconceptional participants included:

- Assessment and follow up
- Development of service plan based on completed assessment
- Care and service coordination
- Initiation of and monitoring of referrals

Documentation of completed referrals and participant compliance was recorded in the case manager's progress notes, which documents each encounter and attempted contact with participants. Progress notes contain a summary of the participant's compliance with referrals, family planning appointments, health education and other actions outlined in the care plan. Healthy Start case managers initiated follow-up with interconception participants at least quarterly. Women receiving Healthy Start interconceptional services received education and information regarding healthy lifestyles, sexual health, family planning and birth control options, depression, and domestic violence.

In 2002, SIHF Healthy Start health educators began conducting hospital visits with postpartum women prior to hospital discharge to educate new moms on interconception health and to remind participants of the need for a postpartum visit for themselves and well-baby visit and immunizations for their newborn. During the visit, a congratulation gift bag containing educational materials and health and safety items was presented to each new mom. Included in the hospital postpartum visit, educators counsel postpartum women on birth control options, how to access family planning services, importance of spacing between pregnancies, and need for on-time well child visits and infant immunizations. During the hospital visit, if mothers had not yet selected a pediatrician for their newborn, the Healthy Start educator conducting the visit assisted mothers with choosing a health care provider for the baby. The representative also scheduled postpartum visits for the mother during the hospital visit. The appointment dates were discussed with the mother, and if needed, Healthy Start transportation arranged. The health educator then forwarded the appointment dates to the case manager and utilization tracker for purpose of making reminder calls and sending postcards to the mother. During the four-year project period Healthy Start Staff conducted hospital visits with 659 postpartum women at Touchette Regional Hospital.

Frequency of contact with interconceptional case management participants was established at 5 days postpartum, again at 6 weeks postpartum, and then at least quarterly thereafter. Frequency of contact for infants enrolled in case management services are: within 2 weeks of birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months and 24 months. Healthy Start staff holds health education classes monthly. Interconception participants were encouraged to participate in at least one parenting skills class or parenting support meeting quarterly.

Sixty-five percent (595 of 914) of Healthy Start interconception participants completed postpartum visit with their health care provider within eight weeks of delivery. Eighty-

two percent (531 of 613) of Healthy Start case management infants two years old and younger received recommended immunizations. Among prenatal case management participants, 18.7% (134 of 718) had a short spacing interval of less than 24 months between the current and last pregnancy.

Depression Screening and Referral

Women are twice as likely to develop depression as men. Furthermore, studies show that as many as 10 to 15 percent of women experience clinical depression during pregnancy or after the birth of a baby. It's been reported that as many as 80% of women experience the "baby blues" in the days immediately following childbirth.

In August 2002, SIHF Healthy Start took steps to address this critical issue by implementing depression screening and referral for pregnant and postpartum women. Healthy Start case managers used the Edinburgh Postnatal Depression Scale (EPDS) to assess participants for symptoms of depression. The Edinburgh Postnatal Depression Scale is a short 10-question self-administered screening instrument. The EPDS instrument is not used to diagnose depression. Rather, the tool is used to identify women who have signs of depression and who may require additional assessment by a licensed clinical social worker or mental health provider.

Healthy Start case management participants were screened at three different times: 1) Prenatally when initially enrolled in case management. 2) Postnatal at three to six weeks postpartum. 3) Postnatal at three to six months postpartum. The case manager had responsibility for scoring the participant's EPDS. A score of 12 or above warranted a referral for additional assessment by a mental health provider or social worker. The case manager was responsible for initiating the referral and educating participant regarding the affects of depression on functioning, maternal and child health, and mother-child interaction. For women who score between 9 and 11, case managers conducted an additional screening at the next visit.

Using the Edinburgh Postnatal Depression Scale, Healthy Start case managers screened 71% (849 of 1,204) of case management participants for signs and symptoms of depression. Of the women screened, 251 (30%) scored twelve or higher and received a referral for further assessment with an SIHF mental health professional. Fifty percent (125 of 251) of women who scored above 12 on the EPDS, refused referral for follow up. These women often suggested that the high score was due to a temporary situation. Women who did not complete referral were monitored closely by their health care provider and Healthy Start case manager. Thirty-seven percent, 46 of the 125 women who accepted the referral completed the follow up assessment.

In January 2003, Healthy Start grantee, Southern Illinois Healthcare Foundation (SIHF), added to its medical staff Dr. Kimberly Ellis. Dr. Ellis is Board Certified in both psychiatry and primary care. The addition of Dr. Ellis enhanced SIHF's ability to develop a system of care that provides a continuum of care from prenatal through interconception period and integrates medical care and mental health services.

OUTCOME EVALUATION

The outcome evaluation measured SIHF Healthy Start impact on access to care, service utilization, and perinatal outcomes. The outcome evaluation was conducted on the following performance indicators.

1. Increased access to women’s and infant health care services in the project service area.
2. Reduced infant mortality among African Americans in the project service area.
3. Reduced low birth weight infants born to program participants.
4. Reduced very low birth weight infants born to program participants.
5. Increased proportion of program participants who begin prenatal care in the first trimester.
6. Increased proportion of program participants who receive adequate prenatal care as measured by the Kessner index.
7. Connecting uninsured children and pregnant women with a medical home through enrollment in the state’s SCHIP KidCare and FamilyCare program.

Data Sources included the following:

1. Illinois Department of Public Health Vital Statistics
2. Cornerstone Database
3. SIMIS Database
4. Participant Medical Record
5. SIHF Healthy Start Program Records

As discussed earlier in this report, motivation for implementation of the SIHF Healthy Start initiative was the tremendous racial disparities in infant mortality and other perinatal outcomes. The program’s project plan was greatly influenced by input from participants, community stakeholders, health care providers, and project staff.

Table 5 reflects the high incidence of harmful risk factors identified among Healthy Start participants. Special considerations should be noted about the identified risk factors which contribute to potential adverse pregnancy outcomes. While perinatal outcomes for SIHF Healthy Start participants improved from initial baselines and were better the outcomes among African Americans in the project service area, it should also be noted that these accomplishments we obtained with individuals that are especially difficult to reach because of their lifestyles. These high-risk participants are often difficult to retain in care, unlikely to achieve medical compliance, and sometimes unwilling to reduce risk behaviors during pregnancy.

Table 5. Participants with Evidence of:

	Depression		Domestic Violence		Smoking		Substance Abuse	
	#	%	#	%	#	%	#	%
2001	N/A	N/A	4	1.4	22	7.5	7	2.4
2002	28	17.1	18	3.7	54	11.1	8	1.6
2003	119	32.2	61	15.1	105	26.0	56	13.9

2004	104	33.0	40	12.7	71	22.5	57	18.1
------	-----	------	----	------	----	------	----	------

The percentage of Healthy Start participants with evidence of depression during pregnancy averaged over 30% in 2003-2004. The rate of women with evidence of domestic violence issues during pregnancy increased four times to an average of 14.1% during the last two years of the project. The average percentage of women who smoked during pregnancy more than doubled from 9.7% to 24.5% of participants. The most problematic barrier for staff was the level and intensity of substance use/abuse, which increased from 1.9% in 2001-2002 to 15.7% in 2003-2004.

Access to Care and Regular Prenatal Care

According to the 2004 RegionWise One Mother report, adequate prenatal care is an essential element in the prevention of low birth weight, premature birth, and infant deaths. The report states further that “prenatal care can encourage good health habits during pregnancy, lead to early detection of medical problems, and become a gateway to parenting support, education, and assistance with nutrition and housing”.

For the evaluation, access to care and the continuity of care was analyzed using different data sets: KidCare SCHIP enrollment, first trimester entry into prenatal care, and adequate prenatal care. SIHF Healthy Start enrolls more uninsured children and pregnant women into the State’s SCHIP KidCare and FamilyCare program than any agency outside of Chicago/Cook County. During the four-year project period, SIHF Healthy Start increased the percentage of children with a medical home from 49% to 82% by successfully enrolling 2,181 uninsured children into KidCare program.

Healthy Start grantee, Southern Illinois Healthcare Foundation (SIHF) reduced barriers to care by creating additional access points with the opening of new community health centers in the service area. SIHF opened four (4) additional health centers and two (2) new dental clinics for women and children. SIHF Healthy Start also reduced barriers to accessing care by operating three vehicles that provided free transportation to medical appointments and health education classes for participants and their children. The Healthy Start transportation system provided an average of 358 rides per month.

¹Region Wise One Mother report is an issue statement that reports on the progress in the St. Louis Metropolitan Region towards achieving Healthy People 2010 goals for prenatal care. The report was written by Jeffery Mayer, Ph.D., of the School of Public Health at St. Louis University.

The success of SIHF Healthy Start project is apparent when program participant data is compared against that of aggregate data of African Americans in the project service area. SIHF Healthy Start participants were 80% African American. Of the 914 live births during the project period, 65.5% of Healthy Start participants began prenatal care in the

first trimester, compared to 60.7 of African American women in the service area. In addition, this performance indicator of 65.5 percent of program participants entering care during the first trimester was a significant increase from the baseline of 37%. Likewise, 57.1 % of Healthy Start participants received adequate prenatal care as measured by the

Kessner index, compared to only 49.4% of African American women in the project area that received adequate care.

Table 6 Access to Care

	SIHF*	Project Area**		
		Combined	Black	White
Adequate Prenatal Care	57.1	63.8	49.4	84.1
First Trimester Entry	65.5	72	60.7	88

* SIHF Healthy Start Project Period Average 2001-2004 (SIHF Medical Records)

** Project Area 3 Year Average Most Current Data Available 2000-2002 Vital Statistics, Illinois Dept. of Public Health

Improved Birth Outcomes

Despite a majority of high-risk with evidence of drug and alcohol use, low education attainment, depression, domestic violence, women receiving Healthy Start services had improved outcomes when compared with performance indicator initial baselines and aggregate data from the project service area.

When comparing SIHF Healthy Start participant outcomes to that of the service area no sizable health disparities exist in infant mortality, low birth weight, or very low birth weight. Among Healthy Start participants (2000-2004), there were eight infant deaths among 914 live births for an infant mortality rate (IMR) of 8.8, which is nearly half the IMR of 13 for the project area. The project area three-year IMR decreased from 18.9 (1996-1998) to 15.0 (2000-2002). These analyses demonstrate a lower incidence of infant mortality, low birth weight (LBW), and very low birth weight (VLBW) among Healthy Start participants. Table 7 details perinatal outcomes for Healthy Start participants and for the service area.

Program participant outcomes demonstrate the impact and success of the SIHF Healthy Start program. When outcomes of program participants are compared against African Americans in the service area, the effectiveness and success of SIHF Healthy Start is even more impressive. The infant mortality rate was almost one half that of the African American rate of service area. The project area’s low and very low birth weight statistics doubled that of Healthy Start participants.

Table 7 Birth Outcomes

	SIHF*	Project Area**		
		Combined	Black	White
Infant Mortality	8.8	13.04	16.9	7.6
Low Birth Weight	5.9	11.3	13.9	7.6
Very Low Birth Weight	1.8	2.9	4	1.3

* SIHF Project Period 2001-2004

** Project Area Current Data Available 3 Year Average 2000-2002. Illinois Department of Public Health Vital Statistics

RECOMMENDATIONS

While the service area infant mortality rate decreased by nearly 11% (18.9 to 16.9) from one project period to the next, racial disparity among African Americans still remain more than two times higher than that of Caucasians in the same communities. While we celebrate our progress thus far, Southern Illinois Healthcare Foundation Healthy Start recognizes the need is still great in the communities of greater East St. Louis and Belleville, Illinois.

Healthy Start grantee, Southern Illinois Healthcare Foundation (SIHF), a federally qualified health center provides health care services to the poor, uninsured and medically underserved. SIHF is committed to closing the gap in health disparities through removal of barriers to care, increasing access to care, and improving perinatal outcomes which contribute to adverse pregnancy results and infant mortality. This evaluation report demonstrates impressive success of the SIHF Healthy Start program and also illustrates a continued need for Healthy Start services in the community in effort to achieve Healthy People 2010 goals.

According to the 2004 RegionWise One Mother report, the strongest need for services to improve prenatal care utilization “exist in five Illinois zip codes (i.e. 62201,62204, 62205, 62207, 62059)”. These are all zip codes within the Healthy Start project service area.

Recommendations based on this evaluation of SIHF Healthy Start program 2001-2004.

1. SIHF Healthy Start should continue aggressive outreach efforts which proved effective in identifying high-risk pregnant women and linking these women with health care and support services.
2. Maintain free transportation services to medical appointment and health education programs for women and children.
3. Continue providing education and risk reduction counseling related to pregnancy health, interconceptional health, and parenting skills.
4. Continue to seek funding to sustain and enhance Healthy Start services.
5. Improve data tracking and collection methods to enhance project evaluation (participant satisfaction with services, risk factors by race and age, participants with multiple risk factors).
6. Utilize pre and post-test to more effectively evaluate participants’ knowledge.
7. Contract with an independent evaluator for future local evaluation (project period 2005-2009).

¹Region Wise One Mother report is an issue statement that reports on the progress in the St. Louis Metropolitan Region towards achieving Healthy People 2010 goals for prenatal care. The report was written by Jeffery Mayer, Ph.D., of the School of Public Health at St. Louis University.
www.regionwise.org