

## HEALTHY START IMPACT REPORT

### **Crozer-Keystone Healthy Start Grantee: Crozer-Keystone Health System**

#### **Introduction**

**The purpose of the Healthy Start (HS) Impact Report is to provide a written summary, from the grantee's perspective, of the experience and impact of Healthy Start. Please use the following outline in writing your project's Impact Summary. (Narrative must be limited to 100 pages).**

Crozer-Keystone Healthy Start's experiences, lessons learned and accomplishments from this project period have vastly informed the project and aided in the provision of services to vulnerable high-risk pregnant girls and women, families and sick young children. The project identified the following areas within the defined service area as priorities: children with special health care needs, folic acid intake and neural tube defects, breast feeding education, disparities in birth outcomes, access to Medicaid and CHIP and childhood immunizations. Many of these health issues and health status priorities areas are also identified as priority needs in the state MCH Needs Assessment and are Healthy People 2010 goals.

Crozer-Keystone Healthy Start's proposed project plan implemented those strategies and activities necessary to positively impact health status outcomes in the identified priority areas. The over arching goal of Crozer-Keystone Healthy Start is to reduce infant mortality and morbidity in the project's service area. Through outreach and recruitment, case management, health education, perinatal depression screening, social work and collaboration the project provided services to aid each program participant enrolled in achieving better maternal and birth outcomes and work toward self sufficiency.

The project was implemented with a committed staff of twelve. The project has lost only one staff person in almost eight years of service. Project goals were achieved through active case finding of eligible program participants. By aiding pregnant girls and women to seek prenatal care earlier and obtain an adequate level of prenatal care. Through health education, program participants increased their health literacy; perinatal depression screening identified mental health concerns and access to care and treatment were facilitated. The project's services contributed to better birth outcomes resulting in fewer very low and low birth weights and babies that are small for gestational age being born. All program participants have a medical home, are screened for risk factors and receive referrals to be linked to needed community resources. Children are immunized on time and new moms will receive timely postpartum visits.

Through tried and true methods, collaboration, partnership, commitment and innovative strategies, Crozer-Keystone Healthy Start has delivered services to pregnant girls and women, interconceptional women, families and children age 0 – 24 months. Ultimately, all

proposed project services have aided families in helping their children to get off to a healthy start and achieve self-sufficiency.

Via the Local Health System Action Plan and the project's Public Education Campaign, Crozer-Keystone Healthy Start has contributed significantly to community residents' knowledge of community resources/services related to maternal and child health. In the community there is an enhanced understanding of the availability, location and how to access resources/services for pregnant women, pregnant and parenting teens, resources for special needs children, supplemental nutrition, food cupboards, food banks, homeless services and more.

Consumer input has assisted the project, community resources and service providers in changing hours of operation, standards, forms, policies and protocols. Joint, co-case management and inter-agency collaboration occurs now in greater frequency. Coordination of care and "hand-off" from one organization to another continues to become more effortless and seamless. Consumer utilization of resources and services has increased and consumer satisfaction is no longer dismissed or taken for granted. Consumers are empowered, have a voice and expect a certain standard of care.

In this project period, the project added five full-time jobs in the community. Local residents occupy each of the five positions.

**I. Overview of Racial And Ethnic Disparity Focused On By Project**  
**Identify the racial, ethnic or other disparities that your project focused on. Highlight from your initial community needs assessment the data that led to your community's decision to focus on the identified disparities.**

The Crozer-Keystone Healthy Start (CKHS) project focused on eliminating disparities in access to health care, birth outcomes, healthy behaviors and good health during the first two years of life among pregnant and parenting African American and Latino women and their families in the project service area. The initial community needs statement for this project noted that, compared to other families in Delaware County, particularly white families, both Black and Hispanic families are far more likely to have incomes below the federal poverty level (41.4% and 68.3% respectively), and to be at risk of having substance abuse problems, mental illness or becoming a victim of a perpetrator of violence.

Birth outcomes as measured by infant mortality rates and low birth weight rates highlight the disparities between racial and ethnic minorities in the service area compared to those living in the surrounding county. Access to health care is exacerbated by the limited availability of affordable child care and public transportation, and the complete lack of taxicab services. A growing number of individuals speak little or no English, and many have limited literacy skills; translation services are also inadequate to meet this growing need.

The CKHS project serves women and families in all racial and ethnic groups represented in the service area, but the project focuses on providing services to those most at risk: African American and Hispanic women and families. The program assists pregnant

Crozer-Keystone Healthy Start Impact Report  
Grantee: Crozer-Keystone Health System

participants to obtain prenatal care by providing tokens for public transportation and free van transportation for larger families and for those for whom public transportation is not easily accessible. The CKHS case managers provide transportation for the entire family, if necessary, so participants do not have to obtain child care for their other children in order to obtain prenatal care, well-child care or other services. Access to well child care and other medical, social and educational services are also enhanced for participants by the availability of CKHS transportation services.

CKHS has a strong commitment to assuring that participants receive adequate prenatal care (especially once they are enrolled in the program), that women receive postpartum medical care within the first 6-8 weeks after delivery and that infants and children up to two years of age receive the medical care they need. The CKHS case managers convey this commitment to the participants in their caseload and require that they share responsibility for being on time and keeping scheduled appointments. The case managers treat participants and their families with dignity and respect, and they also expect the participants to be active partners in the program.

During the past four years, CKHS responded to the growing number of Latinos in the service area by adding a bilingual case manager to replace the bilingual case manager who was promoted to the position of community liaison. Both staff provide translation services and together they address the case management, education and outreach components of the program for community residents whose first language is Spanish. In addition to providing CKHS services to participants who speak Spanish, these staff are also called upon to provide translation services for other providers in the service area who do not have sufficient bilingual staff. During the 2001-2005 project period, CKHS has recognized that the Asian and African population of the service area is growing and that the program will need to expand its approach to meet the linguistic and cultural needs of these groups.

The CKHS licensed social worker helps the project to address issues of substance abuse and mental health screening and treatment, thus reducing disparities for participants who are using alcohol or other drugs or who have mental health issues that have not yet been diagnosed and treated. All participants are screened for a range of mental health conditions including depression, anxiety, mood disorders and past or present physical or emotional trauma during the enrollment process. CKHS provides referral and follow-up for participants with substance abuse or mental health conditions.

Finally, CKHS is particularly able to focus on eliminating these and other racial and ethnic disparities because the staff of the project are indigenous to the community and are capable of reaching and interacting with the target population in ways that those in other formal systems cannot. The case management staff is known in the community and is welcome in the neighborhoods and homes of the target population. The commitment of the CKHS staff to eliminating racial and ethnic disparities in access to health services and healthy children is one of the hallmarks of the project.

## **II. Project Implementation**

Using as a framework the five Healthy Start Core Services identify how your Healthy Start **Project implemented each service and system intervention. (Refer to the 2001 Competing Application regarding goals, priorities and action steps.)**

**For each one, answer sequentially the following:**

- A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community's needs, service system and its challenges and assets. For example, you might acknowledge that in your area, improving the quality of available services was more crucial than increasing their number, and so you focused on quality improvement in your Local Health System Action Plan.**

### Outreach and Recruitment

Implementation of the outreach and recruitment component required many considerations during strategy and action plan development. The nuances, idiosyncrasies and tendencies of the community informed planning. It is important to note the communities the project serves are faced with many socio-economic problems, such as lack of affordable housing, drug and alcohol use, mental health problems, lack of job skills, lack of education and many more problems. One of the greatest advantages of Crozer-Keystone Healthy Start is the staff's familiarity with the community because they are indigenous to and reside in the community and understand the problems community residents' experience. Crozer-Keystone Healthy Start staff are also aware of and knowledgeable about the community resources program participants can access depending on their needs. One of the biggest barriers to outreach and recruitment is potential program participants who have multiple problems and often their main priority does not relate to their pregnancy or access prenatal care.

Due to many other concerns, prenatal care is the last thing on the priority list for most pregnant potential participant's the project might recruit. Many potential program participants' main concerns may be finding a job, finding affordable housing, matriculating in a GED program or finding affordable day care or even trying to find drugs to support their drug habit. It became apparent early on that it would be crucial for the Crozer-Keystone Healthy Start staff to assist program participants with their primary problems and to educate pregnant program participants about the importance of receiving early and adequate prenatal care. Once program participants build trust with case managers, enrolled program participants were more willing to attend prenatal visits and well-child appointments once the baby is born.

Negative experiences with other programs and services also created barriers to accessing essential service. Outreaching and recruiting program participants in their own community makes it more comfortable for them to become interested and willing to enroll in the program. Outreach and recruitment regularly throughout the project's target service area was obviously essential in establishing relationships

with potential program participants.

#### Case Management

With respect to case management, the project's implementation focus was two-fold and in some respects overlapping. The project sought to enhance its overall capacity and improve the quality of services delivered by the case managers.

In addition to Chester City, the project identified other contiguous municipalities around Chester (Chester Township, Upland, Parkside, Toby Farms, Woodlyn, Eddystone, Trainer, Linwood and Marcus Hook) that could benefit from Healthy Start services. This expansion seemed appropriate for several reasons. One reason involved the impact that some public housing initiatives had on the project's service population, who would be ineligible for Healthy Start services because of being displaced outside of the City of Chester into local municipalities (those aforementioned above). In some instances simply moving across the street or one block over placed a program participant outside of the defined service area. Another factor involves the fact that greater than 98% of the residents living in these areas receive care at Crozer-Chester Medical Center, which is part of Crozer-Keystone Health System, the Healthy Start Initiative grantee. Despite the former, the sizes of these municipalities (their populations) are not large enough to meet national Healthy Start's criteria for receiving individual grants even though there is an obvious need for the project's services.

In order to meet the anticipated service needs of program participants, the project planned for seven case manager positions. In an effort to plan for the complexity of the cases, the project wanted to decrease the participant to case manager ratio and increase the technical support available to case managers. The desired ratio is 15:1. The rationale behind the former was that it was expected a majority of cases would have high acuity levels and the case managers would need to be able to provide each case with a prescribed level of attention and interaction. At the same time, the project wanted to ensure that case managers, who are both lay professionals and indigenous to the community, receive the technical support necessary to allow them to meet the needs of their program participants. The addition of the case management coordinator position represented a means to that end. Thinking in the same manner, the project anticipated that specialization with respect to the core service areas would provide case managers with added guidance and support, thus enhancing the overall quality of the project. The project also proposed health education coordinator, social work, and community liaison positions. Health education, the intake process, mental health services, and community outreach services, respectively, would all receive greater oversight.

As part of the implementation phase, cultural competency was an important consideration in anticipation of the large number of Latino's requiring services in the target area. The project planned to hire one bilingual case manager.

Staff development and increasing project efficiency/effectiveness were also part of the project's implementation focus. A major effort of the project regarding

implementation entailed ensuring that case managers were fully skilled and knowledgeable as the project moved towards becoming more efficient and effective. In preparation for implementation, procedures, protocols, and processes were reviewed and improved where necessary as the project moved towards greater standardization. Ensuring that case managers had the training necessary to support the changes made was of high priority. Core competencies were developed along with a comprehensive training schedule.

Implementation required that case managers not only receive training on internal issues but also that their knowledge of external issues increased. The project would be increasing collaboration efforts and having knowledge of those organizations that program participants would be involved with was paramount.

**B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes. For example, you might have decided that using indigenous community workers for outreach required a great deal of support and training, and therefore you gradually changed to an intervention where the outreach workers and case managers had more frequent contact.**

Crozer-Keystone Healthy Start proposed a multifaceted approach to outreach and recruitment. One position (community liaison) would lead and facilitate all project outreach and recruitment strategies and action steps. The community liaison position was filled in November 2001. The community liaison led and facilitated all ongoing efforts to develop strategies and plans to market and promote the project and recruit program participants. The following strategies were implemented:

- Create opportunities to market and promote the project and build relationships.
- Inform all levels of the community about the project across the project service area.
- Develop formal linkage agreements where appropriate.
- Identify consumers and community members to recruit for committee participation.
- Update and revise written materials to promote the project.
- Utilize community organizations to disseminate and promote events.
- Identify standing dates and times to staff tables at key organizations.
- Participate in community events.

The community liaison has successfully built relationships and established credibility with many organizations that serve the target population. Project staff work together to ensure that outreach and recruitment activities are consistent with organizational outreach and recruitment strategies. All staff took part in identifying organizations in the project service area where the program could recruit potential program participants. The community liaison scheduled meetings and presentations with community-based serviced providers and maternal and child health stakeholders. The community liaison joined committees with key organization contacts.

Crozer-Keystone Healthy Start Impact Report  
Grantee: Crozer-Keystone Health System

Crozer-Keystone Healthy Start does not have community outreach workers assigned to outreach. All project staff participate in outreach and recruitment efforts. These activities included trainings, health fairs, community events, youth activities, conferences and committee work.

The community liaison continues to identify new strategies to promote the project and programs. Project staff continuously identifies new community programs or staff in organizations in the project service area to promote the project to.

#### Staffing and Capacity

At the onset of the project period, the project proposed the following new positions:

- (1FTE) Health Education Coordinator
- (1FTE) Case Management Coordinator
- (1FTE) Community Liaison
- (1FTE) Licensed Social Worker
- (1FTE) Clinical Care Coordinator
- (7FTE) Case Managers
- (1FTE) Office Coordinator
- (1 FTE) Secretary
- (.5 FTE) Project Director

The final staff complement included:

- (1FTE) Health Educator
- (1FTE) Case Management Coordinator
- (1FTE) Community Liaison
- (1FTE) Licensed Social Worker
- (6FTE) Case Managers
- (1FTE) Office Assistant
- (1FTE) Clinical Care Coordinator
- (1 FTE) Project Director

After the grant award, a budget revision was necessary due to a decrease in the actual funding and the staffing pattern was reconfigured. Two full time positions were eliminated (a case manager and secretary). The office coordinator position was changed to an office assistant, leaving thirteen positions to fill.

The hiring process was protracted. It involved a large number of interviews in an effort to make the process collaborative. Personnel at all levels of the organization participated in interviews. An average of two interviews was conducted per candidate. The long search for case manager candidates, coupled with an internal promotion of one of the existing case managers placed a heavy burden on those case managers that were already actively managing cases.

During implementation the project experienced many challenges while attempting to hire. Caseloads were both high and complex. Some of the capacity issues were alleviated with the hiring of the licensed social worker in September 2001. With the inclusion of a master's level, licensed social worker to the program, the project was

able to assess, track, and monitor participants' complex psychosocial issues. The licensed social worker's contribution to the project was immediately realized. This addition enhanced the project's referral processes; ability to screen and assess; and ability to provide short-term relief to the project's behavioral health participants.

#### Licensed Social Worker Position's Impact on Case Management/Care Coordination Capacity

The functioning of case management /care coordination has, in a more direct way, benefited from the licensed social worker position. The licensed social worker's role initially with regard to the intake process alleviated aided the case managers. The licensed social worker's ability to provide case managers with a psychosocial summary has prompted the case management process to be better informed during the enrollment of a new program participant. Ever evolving, the licensed social worker eventually assumed full responsibility for the entire intake process. For the case managers the former translates into more time that has allowed more focus on other aspects of their jobs.

The benefits of the social work position with respect to case management/ care coordination are also evident when one looks at the added guidance that case managers receive, which manifest in several ways. One way is in case conferencing, where the licensed social worker regularly addresses behavioral health issues from a clinical perspective. Not only do the case managers receive added support but they also learn about behavioral health.

Another way entails the support that case mangers receive from the licensed social worker when crisis situations occur, whether they are mental health related or involve some other type of emergent situation. The licensed social worker has been available and willing to intervene both in and out of the office and not only with participants but also with service providers. This type of support offered to the case managers is invaluable because they are able to witness the licensed social worker model appropriate interventions.

Another payoff from the social work position involves the support provided in the area of collaboration. Initially during implementation the licensed social worker coordinated and facilitated interagency meetings for the project. The licensed social worker trained the case managers to coordinate and facilitate meetings and, as their capacity developed, they assumed responsibility.

A final positive impact that the licensed social worker position has had on the program is in the area of training. The behavioral health knowledge level of the case managers has increased 100% due to trainings offered by the licensed social worker.

#### Health Education Coordinator Position's Impact on Case Management/Care Coordination Capacity

The implementation of the health education coordinator position had a profound impact on case management in that it provided case managers with structure and

guidance. From the beginning, the health education coordinator devised a program format that provided case managers with guidance to follow. That format built on policies, procedures and protocols that were being utilized by case management/care coordination. It assisted the case managers in organizing and in knowing where to place emphasis with regard to health education.

The case managers' ability to track and monitor health education data was enhanced through the health education coordinator's participation in case conferencing and direct interaction with the case managers. The health education coordinator became a resource for the case managers and program participants. The health education coordinator also has had a positive impact on case management in that linkages have been formulated with health organizations, allowing the case managers greater access to expertise regarding maternal and child health issues. Access to these organizations translates into health education training; partnerships that share work with case managers; and, overall more resources.

#### Community Liaison Position's Impact on Case Management Care Coordination Capacity

The implementation of the community liaison position served to emphatically decrease the amount of responsibility that the case managers had in recruiting program participants. A majority of the outreach was both coordinated and carried out by the community liaison. This provided case managers with more time to devote to other case management duties.

The implementation of the community liaison position initiated the start of a public education campaign and the project's "Jumpstart" newsletter. Both served as valuable mechanisms for reaching program participants with vital information regarding women and children's health. The evolution of these projects over the project period has allowed the project to engage participants in ways that weren't possible before. The development of this position and its role has provided the case managers and participants with more resources.

#### Organizational Development

In response to the anticipated need to further develop internally with the potential for new staff and evolving roles, during the implementation phase the project sought to revisit policies and procedures to increase standardization and to support any necessary changes in operation. This process was accomplished through the project's administrative team meeting, case management meeting, and during allotted time for training. This process went according to plan throughout the project period with no impediments.

#### Training

To accommodate the knowledge and capacity needs of the project and staff an extensive training schedule was developed. Core competencies, health education,

Crozer-Keystone Healthy Start Impact Report  
Grantee: Crozer-Keystone Health System

internal policies and procedures, and systems training comprised a majority of the schedule. The following trainings were completed during the project period:

- Chester Healthy Start Operations
- Mission and Vision
- Office Administration
- Policies and Procedures
- Documentation
- Home Visiting
- Child Abuse/mandated reporting
- Early Childhood Development
- Cultural Sensitivity and competency
- First Aid/CPR
- Computer Education
- Conflict Resolution
- Team Building
- Domestic Violence
- Crisis Training/ Involuntary MH Commitments
- Facilitation of Meetings
- Depression
- Mental Health Disorders
- Department of Public Welfare
- Health Belief Model
- Education and Awareness Building Element
- Pregnancy (physical changes)
- Labor and Delivery
- Benefits of Folic Acid
- Effects of smoking, drugs, & alcohol on pregnant women
- Nutrition
- Breastfeeding Education
- Child Safety
- Birth Control Methods
- STD's and HIV
- And a host of agency presentations

The training component of the program was extremely successful in that it had a favorable effect on capacity. Case management/ care coordination was enhanced internally and externally through the diversified training schedule. The former will be apparent when accomplishments are discussed.

#### Cultural Competency

As planned, the project hired a bilingual case manager. The bilingual case manager proved very effective in meeting the needs of Hispanic women that primarily speak Spanish served by the project. Barriers to accessing services were discovered and addressed by this position. Hispanic women were empowered as advocates.

As the project progressed through the project period, a need to address the needs of some other cultures has become paramount. The Asian and African populations

are growing in the service population and there will soon be a need for a multicultural approach.

#### Health Education Component

Health education is a significant component in the effort to improve maternal and birth outcomes. Health education provides the means by which project participants gain knowledge, awareness and skills necessary to increase health literacy and positively affect behavior.

Crozer-Keystone Healthy Start utilized a client-centered approach in developing program participants' individual health education plans to address folic acid education, childbirth education, breastfeeding education, infant and child care, HIV and STIs/STDs education, and family planning. The health education component focused on assessing health needs, identification of deficiencies, development of individual goals, creating appropriate intervention strategies, implementing interventions and evaluating the results. This approach has encouraged and supported program participants throughout their pregnancy, after the delivery, and into parenthood and contributed to the success in delivery of quality health education services.

The development of the health education component of the project was completed in the second half of Year 01. During the first six months of Year 02, implementation of various elements of the health education component and the provision of intense training for staff were the focal points. The health education coordinator was responsible for the coordination and implementation of the processes and procedures of the health education component. The health education coordinator also provided technical assistance to case managers regarding health education strategies, educational techniques and health education outcomes.

The implementation process began with training for project staff on each element of the health education component: Health Belief Model, Health Assessment Pre/Post Health Education Survey, Individual Health Education Plan, One-to-One Instruction, Florida State University "Partners for a Healthy Baby" Curriculum, and American Cancer Society's "Make Yours a Fresh Start Family". Each new phase of the health education component was presented during the monthly health education meeting. The ongoing communication provided the staff the necessary training, support, and feedback regarding the health education component. This process successfully allowed the staff to learn and comprehend each element of the health education component. In addition the project staff received training on current health issues and trends.

Case managers and the health education coordinator were responsible for implementing the health education process. Case managers are supervised by the case management coordinator and receive direction from the health education coordinator on the health education process. The health education coordinator supports case managers in health education strategies, techniques and tracking

Crozer-Keystone Healthy Start Impact Report  
Grantee: Crozer-Keystone Health System

health education outcomes. In addition, group supervision occurs in case conferencing and case management meetings.

The project employed multiple strategies, conventional and unconventional to improve the health literacy of its target population (pregnant women, women-infant pairs and high-risk children between 0-24 months). The health education component is comprised of the following elements:

#### Health Assessment Pre/Post Health Education Survey

The project utilized a health education survey developed by the Philadelphia Health Management Corporation (PHMC), the project's evaluators. The health education survey is a series of questions developed to test program participants' knowledge regarding folic acid, nutrition, STIs/STDs and HIV, breastfeeding, pre-term labor, smoking, drugs, pregnancy, infant care, family planning, and sleep/safe environments. The purpose of the survey is to identify the program participant's strengths and weaknesses in knowledge as it relates to maternal and child health.

#### Individual Health Education Plans

An Individual Health Education Plan (IHEP) is developed for each program participant in the program. The IHEP includes a comprehensive formal lesson plan based on identified areas of learning need. Case managers, supervised by the health education coordinator, facilitate the learning process and present information based on the individual health education plan. Additionally, the IHEP includes program participant input in areas of interest and their need.

#### Perinatal Depression Screening

Although Crozer-Keystone Healthy Start was not one of the projects funded to screen and/or treat participants for perinatal depression, the project had the forethought to hire a licensed social worker. With the inclusion of a licensed social worker position, the project was able to develop and establish the necessary procedures to monitor program participants with seemingly disturbing emotional problems, while offering treatment options on site.

The licensed social worker has not only created the project's referral process (which improved the way eligible program participants entered the program for services), but the licensed social worker also established and maintained an important relationship with the behavioral health base service unit within the project's service area.

The role of the project's licensed social worker has enabled the project to begin and maintain important dialogue with the local and community mental health service providers. The relationships that the project's licensed social worker forged with behavioral health service providers has proven to be vital in helping program participants with mental health issues maintain their emotional/mental stability and overall health.

Crozer-Keystone Healthy Start Impact Report  
Grantee: Crozer-Keystone Health System

The licensed social worker was added to the project's complement of staff during the first half of Year 01 of the project period. During this time, the licensed social worker developed and implemented a new referral process (which enhanced the project's ability to identify and address the complex medical and/or psychosocial issues of program participants, while providing case managers with a brief assessment to serve as a guide for the development of family care plans). The referral process allowed the project to develop more complete and detailed comprehensive assessments, which has enabled case managers and the care coordination team to be more proactive in utilizing intervention strategies.

In Year 02, the project's licensed social worker made modifications to the referral process to include referral summary questions and preliminary risk profiling (this was done to improve the accuracy and integrity of the information gathered from service providers). The modifications enabled service providers and self-referred persons to provide the most accurate information, for purposes of completing a comprehensive bio-psychosocial assessment. The completed assessments identified medical needs and/or psychosocial stressors of program participants, while enabling the project to holistically determine program participants' appropriate level of risk. These modifications to the referral process placed greater emphasis on the project's case management component, because the assessments generated from the referral process has served to guide the case managers in their daily responsibilities. These modifications have also improved case managers' abilities to identify, assess, address, and assist program participants with their multitude of complex issues and/or needs.

Although the project was not funded to screen and/or treat program participants for perinatal depression, the project's licensed social worker engaged in extensive dialogue with the local mental health service providers. In Year 02, all projects were required to screen program participants for perinatal depression. Due to the project's licensed social worker's extensive background in mental health and social service, his knowledge and experience helped to facilitate discussions with the local mental health service providers with regards to perinatal depression, patient care (women in their perinatal periods), procedural changes regarding service utilization, and service integration. These discussions focused much needed attention on perinatal depression and other mental health illnesses' impact on prenatal care and mental health treatment compliance. These discussions emphasized the importance of the project's services' collaboration in pursuit of improving the overall health of women in their perinatal periods, which ultimately improves the health of infants and children.

The project's licensed social worker's experience in mental health and his position as a contracted therapist with the local mental health service provider further supported the collaborative effort. Through the collaborative efforts of the services, the project's licensed social worker has been able to not only be the point of contact for service referrals, but also monitor program participants' involvement in the mental health service, while also providing short-term counseling/therapy for program participants identified as having a need. As a result of the collaborative

Crozer-Keystone Healthy Start Impact Report  
Grantee: Crozer-Keystone Health System

efforts of the services, the project's licensed social worker has facilitated program participants' need for psychiatric hospitalization, as well as, provided interventions for crisis management.

The licensed social worker's experience informed his concerns. They were outlined and expressed to the project director regarding screening program participants who may have existing mental health illnesses. In an effort to address the unique needs of the project's participants, the project director and licensed social worker spoke with the Healthy Start Project Officer (David de la Cruz) and Maternal and Child Health Bureau Director (Maribeth Badura). The discussion focused on concerns regarding the implementation of perinatal depression screening for the program participant population of teenagers age 15 and under, and those already diagnosed with a mental health illness. The discussion concluded with a response that a tool would be available following the Grantee Meeting in September 2002. Unfortunately, the tool presented at the 2002 Grantee Meeting did not address all of the project's concerns, and was therefore deemed inappropriate for both populations by the project's licensed social worker and local evaluator. Fortunately, a follow up discussion with the Healthy Start Project Officer and Bureau Director concluded that participants with a pre-existing mental health condition were not required to be screened for perinatal depression, but that they should be monitored.

In Year 03, the project's licensed social worker continued ongoing discussions with the local mental health service provider around mental health and women in their perinatal periods. As a result of the seemingly success of the collaboration, the project's licensed social worker also began to include prenatal service providers and pharmaceutical companies into the discussions. The project reached out to these other entities because it was believed that they were all vital stakeholders in the pursuit of better health outcomes for women in their perinatal periods dealing with emotional issues. During this time, the project had not screened any of its participants for perinatal depression, because of the absence of an appropriate screening tool. However, from this extended collaboration, the project had acquired a tool that would screen program participants for depression (Zung Self Depression Scale - screened only pregnant participants). The project believed that it found an effective measure to screen participants for depression. The project's licensed social worker provided extensive training to the case management staff about "Baby Blues" and other mental health disorders that relates to mood and psychosis (training was ongoing). The project's licensed social worker also provided the case management staff with training on how to use the self-depression scale (screening was being done during enrollment).

Although acquiring a tool was beneficial, the project's licensed social worker believed that a more comprehensive tool was needed, due to the increased number of participants being referred with chronic mental health illnesses, and program participants being referred for mental health services. As program participants are referred to the project for services, their needs became more complex and their emotional issues became more entrenched, the project's licensed social worker focused more of his efforts in acquiring an appropriate screening tool. The licensed

social worker felt that the project needed a screening tool that screened program participants for a myriad of mental health symptoms (depression, anxiety, mood disorders, and past physical and emotional traumas). The brief short-term counseling and information provided by the case management staff about program participants growing complex issues prompted the change to utilize a more comprehensive mental health screening tool (National Depression Screening Day).

The National Depression Screening Day tool selected by the project was chosen because of its multi-use purpose. The screening tool not only allowed the project to screen for depression, but also mood disorders, generalized anxiety disorders, and post-traumatic stress disorders. In order to utilize the tool for its optimum effectiveness, the project's licensed social worker provided the case management staff with training on the use of the tool. The project's licensed social worker also provided staff training on Depression vs. Baby Blues, Mood Disorders (mood swings and increased irritability), Anxiety (mirroring symptoms of depression), and the impact of past traumas on women in their perinatal period. Together, the use of this more comprehensive tool and the training provided has enabled the project's case management staff to be more knowledgeable and effective in identifying subtle changes in participants' mental states.

In Year 04, the project's licensed social worker continued to hone the referral process, while making limited modifications to the process of screening program participants for perinatal depression. These limited modifications included:

- Training case managers on how to use the tool
- Screening program participants during enrollment
- Counseling appointments for program participants with positive scores
- Make referral to mental health services when warranted
- Offer on-site counseling if referral is rejected
- Accepted mental health referrals are tracked (project's licensed social worker maintains communication with mental health treatment team)
- Quarterly meeting with mental health service directors and service coordinators (to ensure effectiveness and compliance of treatment)

To continue with the momentum gained in Year 03, the project's licensed social worker has maintained the viability of the relationships developed with the local mental health service providers. This effort was supported by the use of quarterly and interagency meetings, to serve as quality assurance measures and indicators for service effectiveness and areas of needed improvements. Although this process was managed by the project's licensed social worker, the licensed social worker continued to address issues that arose in relation to women in their perinatal periods, while managing mental health illnesses. The project's licensed social worker has also been very instrumental in working with the local mental health service provider to modify their policies and procedures to be more sensitive to the needs of women in their perinatal period managing a mental health illness by:

- Instructing mental health staff to make direct referrals to the project for pregnant and/or parenting women living within the project area.
- Participate in interagency meeting for shared clients.
- Mental health case managers are to ensure that any pregnant patient maintain their routine med checks with psychiatrist.

These policy changes have led to a more productive collaboration with the local mental health service provider, as well as, more efficient and effective use of services by the project's participants.

**C. Identify any resources or events (i.e.: your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of each intervention.**

Outreach and Recruitment

The project held an Open House to introduce the program to local government officials, school districts, churches, neighborhood groups, public housing programs, and other organizations serving the project's service area. The project developed brochures in English and Spanish for consumers and service providers to promote the project's services.

The project has held several professional educational conferences including a Cultural Diversity conference, Public Benefits for the Undocumented roundtable and a Fetal Alcohol Syndrome conference that have been attended by many that work in organizations that provide services to pregnant women. The project has also assisted other organizations in planning and organizing other community conferences and events.

The project's community liaison contacts organizations within the project service area to regularly staff information tables to promote the project and provide community residents with health information. Some of these organizations include: the Department of Public Welfare, WIC Program, Crozer-Chester Medical Center; and many more locations for opportunities to outreach and recruit women early in their pregnancy.

Staffing and Capacity

Having the full complement of staff allowed the project to proceed with its plans for staff development and effort to enhance the overall functioning (program development) of the project. The project was able to implement many processes, policies and procedures; this supported standardization and the capacity to function in a routine fashion. This, in large part, can be attributed to the time and effort invested ensuring that the project had a strong administrative foundation.

Work groups were established that aided in facilitating change with respect to policies and procedures. With more staff, communication needed to be improved to minimize confusion of day-to-day functions. Policies were evaluated to see if processes could be made easier and to discern whether or not the appropriate staff is included, given staffing pattern changes. The process was beneficial for all staff.

The result of the above efforts is that the program components became integrated. Roles were clarified and work boundaries were set. The staff was oriented in terms of staff hierarchy and expectations were communicated with clarity. With diligence, patience, and dedication, the case management/interconceptional care component evolved. All the pieces of the puzzle began to come together and over the project period the project has continuously evolved and matured.

#### Quality Assurance

Case management, case conferencing, and training collectively were enhanced by the additions of those professional positions designated to oversee the respective core service components. Accountability for the case managers increased as greater structure was provided to them. In addition, the case managers' knowledge base expanded 100%. Case managers began to function with increased confidence and independence.

Case management charting and documentation have improved. Better tracking tools have been created. Chart reviews have been instituted. The checks and balances necessary to make the project more efficient and effective are being utilized.

#### Collaboration

Due to funding constraints the clinical care coordination position was eliminated in the first year of the project period. As a result the project sought other avenues of expertise and support to address tough medical/clinical cases and issues. Internally the project initiated a working relationship with the Crozer Chester Medical Center (CCMC) Pediatric Resident program. Over the course of the project period this program has proven to be an invaluable resource. The Residency Program is used to provide training and to assist in joint case management meetings for program participants with sick children. Externally the project works closely with ChesPenn Health Services, a Federally Qualified Health Center. Both relationships have proven to be advantageous for the case management component and program participants.

Having staff positions that coordinate each of the core service areas has allowed greater opportunity to cultivate relationships and linkages. An example of the former is the working relationship that has developed between the project's licensed social worker and the local mental health (MH) base service unit. The project's licensed social worker initiated a relationship that has led to joint case management and has also heightened awareness on behalf of MH regarding pregnant women with a MH diagnosis that receive medication.

The community liaison has developed relationships with many community based programs including the SABRE Project (a youth abstinence program) and with several welfare-to-work programs to aid the project in outreach and recruitment efforts.

### Perinatal Depression Screening

The inclusion of a licensed social worker with extensive mental health and social service experience has enabled the project to proactively approach the issues surrounding perinatal depression, in a way that kept the needs of women in the forefront. The project's licensed social worker's part-time employment as a contracted outpatient therapist with the local mental health service provider has been pivotal in the project's ability to facilitate discussions surrounding this issue; form a collaborative relationship to address it; and influence policy changes that are more sensitive to the needs of women in their perinatal period. With the development and implementation of a formal referral process, the project's licensed social worker has been able to provide screening and generate a bio-psychosocial assessment that has proven to be an effective, time saving asset to the case management component of the project.

Although the processes developed and implemented by the project's licensed social worker have proven to be very effective, there were some challenges and many lessons learned in doing so. As the project's licensed social worker developed the referral process and began its implementation phase, it was necessary to communicate with service providers and the project's collaborative partners the importance and necessity of change to the way persons are able to access and utilize services.

The processes of implementing depression screening were met with even more unique challenges, because of the culture of the service providing mental health services. The project's licensed social worker initiated and facilitated many ongoing discussions with the local mental health service providers that focused on educating their staff about perinatal health and women, as well as, the need to maintain their medical appointments with psychiatrists throughout the course of their pre/postnatal periods. As a result of the ongoing discussions, the project's licensed social worker was charged with managing the relationship and monitoring the process. The challenge of the relationship was for the project's licensed social worker to hold those accountable in mental health to provide a high level of care to women in their perinatal period managing a mental health illness without medication(s).

The challenges that the project's licensed social worker faced during the implementation phase of the referral and depression screening processes proved that successes are possible with the strength of a good collaborative relationship and a purpose that influences change.

### Consortium

**For consortium, please address the following additional elements:**

- 1) Highlight how the Consortium was established and identify any barriers that emerged in its establishment and how they were addressed.**

The Consortium for Crozer-Keystone Healthy Start, the Healthy Families Partnership (Partnership) was established prior to the development of a Healthy

Start project in 1993 as a community task force to analyze and develop strategies to address the high disparate rates of infant mortality and morbidity in the City of Chester, Pennsylvania. There were no barriers to the development of the Consortium.

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

The Partnership and its committees are comprised of project consumers; service area community members; public and private sector including elected officials; governmental agencies and departments, entitlement programs, local businesses; numerous service area organizations serving vulnerable families including education, health and human services. The Partnership and its various committees have specific roles relating to implementation and support of the project.

The Healthy Families Partnership is issue focused. The Partnership meets five times per year, September through May. The Partnership reviews and addresses prominent issues affecting maternal and child health and well being. It facilitates implementation of the Local Health System Action Plan; coordinates local level activities with MCH Block Grant identified areas of need; and coordinates with the Pennsylvania Department of Health State Health Improvement Plan (SHIP) approved activities where appropriate. The Partnership also contributes to the development of the project's Public Education Campaign. The Partnership has identified gaps in services and barriers to equitable access within the local service area. The Partnership also began the development of a local Fetal Infant Mortality Review (FIMR) in conjunction with the local service area Child Death Review Committee. It also began development of a formal Perinatal Services System for the project's service area. An ongoing, concerted effort is also made to recruit additional Partnership members.

The Youth Advisory Committee of the Partnership enhances community/consumer input from a teen perspective. This committee meets monthly September through May and is comprised of local service area community members and project consumers age 19 and younger. A minimum of two representatives from this committee are active members of the Partnership and report to the Partnership regarding committee activities.

Additionally, the Youth Advisory Committee contributes to the development of the Public Education Campaign and the Marketing Plan.

The Healthy Families Partnership (consortium) has 87 members. The consortium is comprised of individuals representing the following stakeholders:

- State or local government (G) –21%
- Program participant (PP) – 10.5%

- Community participant (CP) - 10.5%
- Community-based organizations (CBO) – 26%
- Private agencies or organizations (not community-based) (PAO) - 30%
- Providers contracting with the Healthy Start program (PC) –0%
- Other providers (OP) 2%

The racial composition of the Partnership is 49.6% White, 44.8% African American, 3.4%Hispanic or Latino and 2.2% other.

The project director works with the community liaison to identify additional potential members for the consortium for recruitment. The project has made every effort to insure the consortium is culturally representative of the community and program participants however; the project does not have control over designated representatives from community organizations.

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

In support of more effective collaboration, successful service delivery to vulnerable populations and the continued development of the Partnership, its committees, consumer and community involvement the Partnership has offered a variety of trainings. These training topics included:

- Perinatal Substance Abuse,
- Vulnerable Families and the Effects of Loss and Grief
- Cultural Competency
- How to Work with Vulnerable Populations
- Cultural Diversity
- Partnership and systems building
- “Entitlement resources for the Undocumented”
- “Dangers of Infant Co-Sleeping”
- “Making the Cultural Connection – Spotlight on the Hispanic Community”

The Partnership also held several events including an open house event for the expanded service area, a community health fair on community resources to address Grief, Loss and Depression and a Perinatal Health Fair. The Partnership continued to sponsor and produces the Chester Prenatal Care Directory. This directory provides information for service providers and consumers about every possible resource available in the local service area for pregnant women and families with young children and is available in Spanish.

The Healthy Families Partnership has been at the forefront in this service area focusing on issues in perinatal health and disparities in access and care. The Partnership identifies those health and psychosocial issues that significantly affect vulnerable families. The Partnership via its membership learns about the issues, problems, available resources, services, needs and gaps.

The Partnership has held public forums on the above noted issues as a means to gain access to the community and consumer voice. Once the issues are understood, the Partnership links with other appropriate systems to resolve issues, address needs and fill gaps in resources and services.

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

The community's major strength is the commitment and dedication of a small number of community members and organizational staff who will not give up! These individuals have successfully motivated their neighbors, other community organizations and elected officials to pay attention to the needs of vulnerable families, especially women and children. Through their efforts, maternal and child health "stays on the table" and in one way or another is incorporated into most community initiatives from housing to violence prevention. Crozer-Keystone Healthy Start has whole-heartedly joined this effort.

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

The lack of or a decrease in funding has effected many local community organizations. This has had a direct affect on not only the number of available community resources but also their ability to partner and collaborate. Significant effort was required to convince organizations with limited capacity to maintain their level of involvement and commitment with the Consortium.

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

The project utilized the expertise of the case management staff to increase consumer participation on the Consortium. After an extensive information session regarding the Partnership, project case management staff were asked to identify program participants that might have an interest in participation on project committees. The project's case managers then meticulously went about recruiting program participants for the Partnership. These program participants received an extensive orientation and introduction to the project, staff and Healthy Families Partnership (Consortium). Program participants that became members of the Partnership were also invited to share suggestions and ideas with project staff, visit project offices more frequently, get to know other project staff members and join other project committees. All of the above contributed to an increase in familiarity

with the project and staff; and contributed to greater ownership and an increased comfort level by program participants and consumers.

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

Consumer input was obtained through the direct participation of program participants and consumers on committees and in decisions making focus groups.

**8) How did you utilize the suggestions made by the consumers?**

Consumer suggestions were utilized in numerous ways, from changes in questions on the Health Education pre-test survey to outreach and recruitment strategies. Program participants continually inform the project.

Sustainability

**For sustainability, please address the following additional elements:**

**9) Describe your efforts with managed care organizations and third party billing.**

Crozer-Keystone Healthy Start partnered with other Healthy Start projects (Chester County Healthy Start, West and Southwest Philadelphia Healthy Start and North Philadelphia Healthy Start) located in Southeastern Pennsylvania to work toward development of a product(s), marketing plan and strategies to develop a plan to market Healthy Start services to obtain third party reimbursement. The partnership also received technical assistance from the Family Planning Council of Southeastern Pennsylvania.

The Healthy Start grantees in Pennsylvania have worked with Dorothy Mann, Executive Director of the Family Planning Council to assist in obtaining agreements with Medicaid Managed Care Plans in the Health Choices program (mandatory managed care in Pennsylvania). Ms. Mann was chosen to work with the projects based on the track record of success that the Council has in negotiating and implementing contracts with Medicaid Managed Care Plans in Southeastern Pennsylvania, over the past 15 years.

The projects have agreed on a process that is anticipated to result in contracts between Healthy Start grantees and Medicaid Managed Care Plans (“Plans”). This process is summarized below:

Initial strategies will compare Healthy Start outcomes with health insurers HEDIS outcomes in an effort to determine areas where health insurers are deficient. The Healthy Start product(s) (still to be determined) will be drawn from the project’s service strengths that could aid health insurers to overcome HEDIS outcome weaknesses.

Initially the projects compared the following outcomes with health insurers:

- Identification by Trimester
- Health Risk Assessment
- Contact Rate
- Postpartum Care
- Low Birth Weight Rate
- Very Low Birth Weight Rate
- Prenatal Visit Rate
- Gestational Age
- Adequacy of Prenatal Care

Based on analysis of data from the Plans, the consultant will identify barriers and gaps in service delivery and disparities in health outcomes currently being experienced in the Medicaid Managed Care system. The Healthy Start grantees will collect data from their projects on these problems, to see if the Healthy Start project's performance will help the Plans improve in these critical areas of pregnancy services and outcomes.

Once these areas are identified, the techniques and approaches will be reviewed (such as case management, home visiting, etc.) and the consultant will assist in translating these into the appropriate HIPAA compliant billing procedures to improve health outcomes.

A proposal will be made to several Medicaid Managed Care Plans to provide the data on how a contract with Healthy Start will improve the performance of the Plan. The proposal will also include the procedures and rates described above and an estimate of the total cost of the services. The Healthy Start projects will develop a mechanism for claims processing to be discussed with the Plans who agree to enter into a contract for pregnancy related services.

It is anticipated Healthy Start services will deliver better maternal and birth outcomes than area health plans. The proposed project expects to have a formal third party reimbursement plan ready for implementation within the first year of the new project period. A contract for third party reimbursement is expected to be executed within the next year.

**10) Describe major factors associated with the identification and development of resources to continue key components of your interventions without HS funding.**

The grantee, Crozer-Keystone Health System has provided the only other source of funding for the project during this project period. The project has submitted several small grant applications to private sector foundations that were not funded.

The major factors that contributed to the lack of identified resources to continue key components of the project without Healthy Start funding were time (capacity) and valid prospects.

Crozer-Keystone Healthy Start is a small project with twelve employees. Administration and management of the project takes a significant amount of time. This leaves little time for funding prospect research, while prospect research is at the crux of grant writing. Next, few funding prospects have been available that are a good match for the project. Most funding sources want to fund pilot projects or new initiatives not existing projects.

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

The project has developed a Development/Sustainability Committee to support the effort to identify potential funding sources, write grant applications and make appeals for funding.

**III. Project Management and Governance**

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

The project is small. Crozer-Keystone Healthy Start has thirteen FTEs. Of the thirteen FTEs, six comprise the project's administrative team (project director, case management coordinator, social work coordinator, health education coordinator, community outreach and recruitment coordinator and administrative assistant) (the project's administrative assistant's position is funded in-kind by the grantee Crozer-Keystone Health System.) The project's administrative team meets monthly to review and discuss programmatic, fiscal, policy, human resource, training, monitoring and data issues; and develop solutions.

The project's administrative team also holds a monthly standing meeting with the project's evaluators. The project director also meets monthly with the Grantee's vice president and finance controller. The project director also holds quarterly meetings with the controller and accountants.

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

The project has benefited from fiscal management from the Crozer-Keystone Health System (the Grantee) Finance Department. This includes all routine accounting, reporting and fiscal monitoring. A grant accountant/analyst is assigned to the project and acts as a liaison with the project director on day-to-by day fiscal operating issues. Overall responsibility for project financial management compliance, annual audits, and any budget modification requests rests with the Senior Vice President and Chief Financial Officer of the Health System through coordination with the project director. These resources have been essential to the project.

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

There have been no changes in project management for the duration of the project period. The vice president within the Grantee organization that the project director reports to changed in 2003. This change proved to be more beneficial to the project providing better support to the project director and trouble-shooting when necessary.

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

Crozer-Keystone Healthy Start does not sub-contract for services; there has not been any distribution of funds related to sub-contracts for services.

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

The Grantee, Crozer-Keystone Health System provided technical assistance to the project regarding development of a new database product to meet the administrative and data collection needs. This information systems technical support provided via non-Healthy Start funds has aided the project tremendously and created new data analysis, quality assurance, program monitoring, service utilization and reporting capacity and opportunities.

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

The entire staff of Crozer-Keystone Healthy Start is comprised of people of color; representing several races, ethnic and cultural groups. This same staff has participated in several cultural competency trainings to insure there would not be any concerns regarding cultural competency.

The combination of a culturally diverse staff and cultural competency training produced a team of staff members capable of interaction and work with an ever changing community and consumer.

**IV. Project Accomplishments**

- A. **Describe each major strategy implemented, with its goals and objectives and accomplishments for this project period. Within the narrative describe in quantitative and qualitative terms the degree of success in achieving the goals and objectives. Describe any barriers that had to be dealt with during implementation and how they were addressed. Summarize all lessons learned. Strategies and goals and objectives that were commonly used across services can be cross-referenced. You may wish to use the Suggested Format, in Attachment A for this part of your report.**

#### Case Management/Care Coordination

The case management/interconceptional care components of the project benefited immensely from the organizational development that took place in the form of staff and program development. The accomplishments for the case management/interconceptional care component of the project were many.

Several accomplishments were made with regard to charting and documentation. These accomplishments, for the most part, can be attributed to the training that enhanced the case managers' skill-set and the increased capacity. They are as follows:

- 100% of all program participants have a family care plan
- 100% of all case files have a referral summary
- 100% of all case files have a current "Release of Information" form appropriately signed and dated
- 100% of all case files have a signed "Notice of Privacy Practices" statement signifying that they have received the project's information regarding health disclosures.
- The project has achieved the capacity to conduct its own internal chart audit with every case file receiving a formal chart review.
- 100% of smokers in the project's program participant population have been identified and their charts labeled.
- 100% of the pregnant women in the program received a health survey.
- 100% of program participants received depression screening.
- 100% of program participants have a medical home.

The above accomplishments are reflective of the collective effort that the entire project put forth to fine-tune the policies, procedures, and protocols; and to enhance knowledge where necessary for the project to grow and mature.

Another accomplishment involves collaboration and the development of the case managers as group facilitators. The number of interagency meetings held has almost doubled since the onset of the project period. With the guidance of the licensed social worker and case management coordinator, case managers have become meeting coordinators and facilitators. Given the large number of participants that are involved in multiple systems, this accomplishment is greatly needed and was significant. Again, training also was an integral part of this achievement.

Crozer-Keystone Healthy Start Impact Report  
Grantee: Crozer-Keystone Health System

An increase in direct service contact over the project period was another accomplishment relative to case management. Over the course of the project period, specific attention was paid to the case managers' compliance with the "Minimum Standards of Care" related to the prescribed amount of service given an assigned risk level. As evidenced through case conferencing and chart reviews case managers have improved in this area every year. Continuing to improve in this area can only positively impact the quality of care given to program participants.

A majority of the communication within the project occurs through e-mail, where formerly it was via telephone or in writing. In addition, over the course of the project period, the project converted to completing the Daily Service Report electronically. Case managers also begin to maintain their respective care coordination logs on the computer, where they routinely make updates. An increase in the case managers' computer literacy was also another accomplishment.

The degree to which standardization occurs across the project represents another accomplishment. Currently there is much uniformity in the functioning of the case managers and the case management/care coordination component overall. The office assistant played a key role in bringing this goal to fruition. The office assistant took the lead in organizing files, charts, and in ensuring that all were uniform. The office assistant also serves as the gatekeeper of all information in the charts to ensure accuracy.

The project's case managers worked very hard to ensure that pregnant program participants received adequate prenatal care as measured by the Kotelchuck Scale. Every effort was made to facilitate pregnant program participants' entry into early and regular prenatal care. Transportation was consistently provided throughout the project period and the message that prenatal care is important was routinely delivered.

Another area of significance focused on by the case management component entailed childhood immunizations. Case managers were diligent about tracking and securing immunization records for children between the ages of 0-2. They worked extremely hard at building strong relationships with practitioners that assisted in their effort to positively affect immunization rates.

The improvements made to the case management/interconceptional care component of the program over the project period collectively served to affect decreases in the delivery of low birth weight, very low birth weight, and pre-term infants by women that received Healthy Start services prenatally. As with those practitioners that provide immunizations, relationships were developed with those agencies that provide prenatal/postpartum care. These collaborations lead to positive impacts on maternal and birth outcomes.

#### Health Education

The health education component has contributed to assisting program participants to achieve self-sufficiency and to increase their health literacy. Through health

Crozer-Keystone Healthy Start Impact Report  
Grantee: Crozer-Keystone Health System

education, program participants gain a greater understanding of many diseases and health conditions such as gestational diabetes, cleft palate/lip, jaundice, RSV (respiratory syncytial virus), asthma, HIV, heart murmurs, and pre-eclampsia that impact themselves and their families.

Implementing the health education component and the development of policies and procedures contributed to development of a solid foundation for the project. This has supported standardization and uniformity by the project staff in providing health education to program participants. The health education coordinator provided the management and the quality assurance necessary to improve on the delivery of health education services. The case manager's ability to establish warm, supportive and empowering relationships with participants created a positive reception to health education taught during home visits and health education workshops. The project's ability to actively listen to what program participants want from health education and to support their effort in reaching health education goals was a hallmark. This approach is encouraging and supportive to program participants throughout their pregnancy, after the delivery, and into parenthood and contributed to the success in delivering quality health education services.

Also the component's success is attributed to the ongoing training and continuing education provided to staff. This equipped the staff to meet the challenges presented by program participants with complex health issues and concerns. Elements of the health education component have provided program participants with a comprehensive approach to their health. The project's efforts to educate program participants on the effects of smoking, breastfeeding benefits, etc., were supported by the provision of training and education in these areas for project staff. As a result of this type of training the staff was able to encourage program participants and provide the skills for program participants to stop smoking. These efforts contributed to changing and improving program participant's behavior as they relate to health have been encouraging.

Evaluation of the health education component had contributed significantly to ongoing development of the component and identified the impact on program participants and determined what's working. The project had accomplished positive results from the pre/post health education survey developed by Philadelphia Health management Corporation (PHMC), the local evaluators. The survey process begins when a program participant enters the program, a program participant completes a pretest, then an individual health education plan is developed, one-to-one instruction is offered (through home visits), and the post-test is completed upon exit from the program or after delivery. According to the results, on average, program participants have shown a statistically significant increase in knowledge resulting in an 8.5 % increase in their level of knowledge over the results of their post-test. Specifically over the last two years, program participants have demonstrated increased knowledge in the importance of folic acid, STDs, dangers of smoking, signs of labor, healthy pregnancies, and the benefits of breastfeeding. The data provided positive feedback to staff. The evaluation had provided a clear understanding of the health education component's impact on program participants.

### Perinatal Depression Screening

Over the course of the project period, the project's licensed social worker has made many improvements to the way Crozer-Keystone Healthy Start services have been accessed and utilized. The development of the referral process by the project's licensed social worker has enabled the project to adequately assess an individual's social, relational, family, medical, substance abuse, and mental health histories to produce bio-psychosocial assessments. These assessments have served as guides in helping the project's case management staff to provide the most efficient and effective service to eligible program participants.

As part of the project's care coordination team, the project's licensed social worker has provided ongoing clinical supervision and support to the case management staff by way of case conferencing. This clinical supervision takes place on a weekly basis for each of the six case managers on staff. On some occasions, the project's licensed social worker has accompanied case managers on home visits, in order to provide crisis intervention to participants, who demonstrate a need for immediate counseling services. Also, the project's licensed social worker has served as a service mediator for program participants obtaining/ gaining access to emergency psychiatric hospitalizations and/or treatment.

To help minimize the need for such interventions, the project's licensed social worker has developed the policy and procedure for the implementation of screening all project participants for mental health issues. The screening tool chosen by the project's licensed social worker, the policy and procedure that oversee the screening process, and the licensed social worker's position as a contracted therapist with the local mental health service provider's outpatient mental health clinic has benefited the project's program participants. Possibly, the most significant benefit of the project's licensed social worker's role is the ability to not only facilitate program participants' access to mental health services, and track their involvement in the service, but to also provide the clinical counseling on site when necessary.

The capacity of the project's licensed social worker has enabled the project to not only adhere to the mandates of screening participants for perinatal depression, but also to develop formal collaborations with important stakeholders, who provide mental health services. The project's licensed social worker's efforts have enabled the project to initiate and facilitate discussions that have proven to be remarkably beneficial for the project and its program participants. As a result of the project's licensed social worker's ongoing efforts and dialogue, the project has been able to negotiate some procedural and policy changes that are shining examples that system collaboration and integration can work. Pregnant women with mental health illnesses living in the target area referred for Healthy Start services and pregnant women with mental health illnesses will maintain their appointments with their psychiatrist throughout their pregnancy.

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

**V. Project Impact**

**Based on a review of all of your project's HS grant submissions during the project period, and the services and strategies implemented, describe the impact of Healthy Start on your Project Area and community. Please organize your description using the outline below.**

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

1. Describe the approaches utilized to enhance collaboration  
Outreach and Recruitment

The project regularly works with peer service organizations throughout the project's service area to educate community members, consumers and new staff about maternal and child health issues, concerns and trends. Crozer-Keystone Healthy Start continues to participate in community events sponsored by schools, hospitals, clinics and government agencies. The project has assigned staff to participate on committees, coalitions and associations to facilitate relationship building.

Case Management

Crozer-Keystone Healthy Start has utilized several approaches to enhance access and service utilization. One process that is used is built into the case management component of the project and entails the use of the project's interagency process. This process involves family care planning between the involved parties (family members and service providers) for the purpose of setting goals, defining tasks and responsibilities and establishing timelines for completion. When service providers and family members participate together in the process and sign the family care plan, it signifies their willingness to work together collectively.

Another mechanism by which collaboration has been enhanced involves the development of formal linkage agreements. These agreements are composed in those instances where the project routinely interfaces with an organization. Details outlining how both organizations will interact are determined. The manner in which the working relationship is monitored is determined and all job duties and people accountable are identified.

Another means by which the project fosters and enhances collaboration is through its interactions with the greater service provider community. The project has initiated the start of several collaborative committees/work groups that concern maternal and infant health (Delaware County Teen Pregnancy Prevention Coalition, Hispanic Resource Center Advisory Committee and the Delaware County Infant Co-Sleeping Committee). In addition, representatives from the project's staff participate on and attend various coalitions/work groups that also address matters that affect maternal and child health issues (both directly and indirectly):

- Delaware County Homeless Services Coalition
- Chester Housing Authority Hope VI Advisory Committee
- Communities That Care Coalition (CTC) Chester and Chichester,
- Delaware County Children's Cabinet
- Chester Weed and Seed
- Delaware County Family Centers Advisory Committee
- Project ELECT/TAPP Advisory Committee
- Bernadine Center Advisory Committee
- Pennsylvania Perinatal Partnership
- Penna. Department of Health lead Advisory Workgroup
- Cribs for Kids Advisory Committee
- Delaware County Child Death Review Team
- DCIU Head Start Health Advisory Committee
- Delaware County Immunization Coalition

In addition, the project utilizes other strategies to enhance collaboration. Building organizational relationships is inherent in the philosophy of Crozer-Keystone Healthy Start. The project recognizes that the more organizations we have relationships with, the greater access the project has to resources and the better the project is able to care for the multi-faceted needs of the program participants served. With the former in mind, the project routinely both provides and receives presentations/trainings from other organizations. The former often fosters collaboration where the benefits are in-kind. The same holds true for attending/hosting health fairs.

#### Health Education

Crozer-Keystone Healthy Start placed great emphasis on efforts to enhance collaborative interactions with organizations as it relates to health education and training. Through collaboration these established relationships provided additional expertise in educating program participants and staff. This facilitated the ability to better assist the program's participants by providing them with the knowledge, skills and education needed to move them toward self-sufficiency.

These organizations include:

- Crozer Chester Medical Center Pediatric Residency Program – training on childhood diseases and general health issues;
- Delaware County Family Centers – training on parenting education and early childhood development;

- PACT (Parents and Children Together) Program – training on parenting education;
- Health Promotions Council, Literacy Council and March of Dimes – training on prenatal development Issues;
- Pearl Hall – training on prenatal development issues;
- Project ELECT – training on adolescent pregnancy and issues;
- Wellness Center - abstinence education;
- WIC (Women, Infants, and Children) – breastfeeding education; and,
- Catholic Social Services – training on parenting education in Spanish.

#### Perinatal Depression Screening

The project's licensed social worker was an integral part of collaborative efforts due in part to an extensive background in social services and mental health. In the beginning of the project period, the project utilized a Formal Linkage Agreement process. However, as program participants' issues became more complex, the project's philosophy toward and use of Formal Linkage Agreements was amended. A successful effort was made to achieve collaboration and system integration across broad systems versus with single organizations.

The process of behavioral health system collaboration and integration started with the project providing presentations to the local mental health service provider, and the project's licensed social worker beginning informal discussions with the director of behavioral health and service directors of substance abuse and mental health services. These informal discussions soon became ongoing scheduled meetings, which focused on women in their perinatal period, managing mental health illnesses and the efficacy of adequate treatment. Despite a slow process, the dialogue quickly gained momentum, as the issues of women in their perinatal period and the management of mental health illnesses started to become a national/international issue.

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

The project worked hard to become accomplished in recognizing and seizing opportunities to enhance collaboration within the maternal and child health community. The project made several procedural changes to facilitate collaboration over the project period. Oftentimes, the formalization of a relationship and interaction via a Formal Linkage Agreement with another service provider contributed to the success of the collaboration. Other times it could involve an informal commitment between the project and another organization to jointly manage cases. The project currently collaborates with the Project ELECT/TAPP, Crozer Chester Medical Center Pediatric Residency Program, Crozer Behavioral Health Services and ChesPenn Health Services (a Federally Qualified Health Center) in formal relationships.

With these relationships, monthly meetings were created and the project's case managers provide a monthly list of their mutual clients. Both administrative and case conferencing meetings occur monthly, ensuring optimal care coordination for program participants.

Another example of a procedural change that was implemented to enhance collaboration involved goals set on the case managers' annual performance appraisals. An overall goal of the project was to hold more interagency meetings. The overall goal was reflected in employee evaluations. Approaching the overall goal in this manner proved successful as the number of interagency meetings increased significantly.

Ongoing discussions and interaction facilitated by the project's licensed social worker with the local mental health service provider also proved successful, resulting in modification of policies and procedures and integration of the importance of Healthy Start into that service. Development of the policy and procedure that was most important now insures that all pregnant women maintain their appointments with their psychiatrists, in order to have their mental health status continually monitored. This policy alone changed the status quo of how pregnant women were treated during their pregnancy. This policy change also enabled the local mental health service provider to be more proactive about treatment options, when necessary.

When examining system integration, the efforts of the project's licensed social worker has given birth to a relationship rarely accomplished in service collaboration. Diligence to the importance of collaboration between services has assured that the project continues to be an important voice in future discussions regarding women in the perinatal period managing mental health illnesses. Perinatal depression screening, referral and access to services were further supported by accomplishments made by the project's licensed social worker's ability to convince the local mental health service provider to make direct referral (of any pregnant/parenting person residing in the project service area) to the project. The integration of these two systems is a strong relationship that continues to be maintained.

**3. Describe key relationships that have developed as a result of Healthy Start efforts covering the following areas:**

Crozer-Keystone Healthy Start collaborates with many health and social service programs that aid in addressing the needs of program participants. Below is a list of these organizations, a description of their services and how they interface with the project.

- Project Elect/TAPP- Serves pregnant teens that are in school and on TANF. The program provides some case management; also educational workshops that seek to support teens in their

endeavors to graduate and become self-sufficient. The project co-manages cases with Project Elect/TAPP. Both programs refer to each other and hold interagency meetings when necessary.

- Crozer Chester Medical Center Pediatric Residency Program - Resident doctors provide pediatric care in a community setting. The Residency Program provides services to many project participants. The Residency Program participates in interagency meetings and also provides clinical consults to case managers. Resident doctors provide training to project staff on maternal and child health issues and also clinical support to the project. The Pediatric Residency Program also refers potential program participants.
- Pearl Hall - Provides prenatal and postpartum care, family planning, and counseling services to pregnant women in the project service area. Pearl Hall and the project exchange referrals. Pearl Hall assists the project with tracking maternal and childbirth outcomes. The project assists Pearl Hall with monitoring joint participants' appointments and with transportation to appointments.
- WIC - provides nutrition services to pregnant women, new mothers, and infants/children. The project assists participants by helping them access WIC services. Both organizations refer to each other. WIC sometimes provides training on nutritional topics.
- Children and Youth Services (CYS) - serves those families that suffer from abuse and/or neglect. The project's case managers work closely with CYS to reunite families or in some instances to save children/ adolescents from abusive/neglectful environments. Both organizations refer to each other. In addition, interagency meetings are held when necessary and case management duties are shared.
- Ches Penn Health Services – (Federally Qualified Health Center)- Ches Penn is a medical home to a large percent of the project's pediatric population. The project works closely with Ches Penn by monitoring program participants' medical situations and communicating effectively with program staff. The project also assists program participants in making well child visits and tracking immunizations. Interagency meetings are held when necessary.
- Crozer Chester Medical Center's Children's Mental Health (MH) Services- Provides clinical and case management outpatient services to children/adolescents in the lower half of Delaware County. The case managers work jointly with them on cases. Both organizations refer to each other. Cases are monitored and

regular communication occurs between professionals. Interagency meetings are held when necessary.

- Crozer Chester Medical Center's Adult MH Services- provides clinical and case management out patient services to adults requiring mental health treatment and support. The project's case managers work closely with Adult MH on any joint cases. Both programs refer to each other. Interagency meetings are held and when necessary medication monitoring occurs should a pregnant participant require medication; if medication isn't warranted, technical support from adult MH is utilized to monitor symptoms.
  - Crozer Chester Medical Center's Drug and Alcohol (D&A) program - Provides D&A assessment and treatment to individuals living in the lower half of the county. The project's case managers interface with this program regularly on joint cases. Both programs refer to each other.
  - Delaware County Mental Retardation - provides case management services to adults/children that have been diagnosed with mental retardation. The project's case managers work with MR case managers on joint cases. Both programs refer to each other. When necessary interagency meetings are held.
  - Early Intervention - provides assessment and clinical services to infants and toddlers with special healthcare needs. Both agencies refer to each other. Joint case management occurs. Interagency meetings are held when necessary.
  - Delaware County Public Assistance Office - Provides cash and benefit assistance to low income families. Also assists low income families in moving toward self sufficiency. Crozer-Keystone Healthy Start refers to this program. Case managers assist program participants in navigating this system by regularly interfacing with their intake workers and case managers. The project's case managers advocate for program participants.
  - Delaware County Community Action Agency - provides case management services to homeless and near homeless individuals in the county. Case managers work closely with their case managers on accessing services. Both agencies refer to each other and have meetings when necessary.
- b. Relationships that focus on involvement of consumers and/or community leaders (who are not employed by a health or social service agency) with any of the agencies/organizations listed above or any additional agencies.

Through the project's participation and collaboration with the Delaware County Family Centers, Communities That Care Coalition (CTC) and Weed and Seed Tall Team, the project has built relationships that focus on and facilitate consumer and community involvement and input into project components, services, initiatives and activities.

**4. Describe the impact that your HS project has had on the comprehensiveness of services particularly in the following areas:**

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

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

Crozer-Keystone Healthy Start's bilingual staff provides information in Spanish to participants whose first language is Spanish on how to access services. Project bilingual staff also identifies and provide the program participant with a contact who can assist the program participant in their own language.

Crozer-Keystone Healthy Start has had an affect on the service provider community in general since its inception and, as the project has grown in popularity over the project period. With the influx of program participants with very diverse needs, it has become almost mandatory that the project address access and service utilization issues with local health and social agencies.

Via the Local Health System Action Plan (LHSAP) the project has developed a Public Education Campaign. The Public Education Campaign produces four maternal and child health related messages annually with accompanying written materials including a quarterly newsletter. Each message is supported by a resource directory of community resources and service providers that provide services to address that issue or concern.

The project's licensed social worker has supported improvement in pregnant women managing mental health illnesses access to care in outpatient mental health service through ongoing and in-depth discussions with the provider. These efforts have influenced how the local mental health service provider views women in their perinatal period and treatment options to help them to better manage their illnesses. In recognition, the local mental health service provider has integrated Crozer-Keystone Healthy Start into treatment options for their female patients.

There are many barriers to program participants' access, use and awareness of services. One of the barriers involves the disparities that are experienced by the target population when attempting to access or use services. Racism and discrimination based on social class still exist in many of today's formal healthcare systems/social service agencies. The former creates an overall lack of trust of formal healthcare systems/social service agencies within the target population. The result is that needed communication between the target population and these systems does not occur and relationships that need to be developed do not form.

Crozer-Keystone Healthy Start was able to address these barriers by hiring staff that are indigenous to the community that are capable of reaching and interacting with the target population in ways that these other formal systems cannot. Many of these organizations do not have the capacity to conduct the outreach and home visiting that Crozer-Keystone Healthy Start can nor are they welcome in the neighborhoods and homes of the project's target population. It is not uncommon for Crozer-Keystone Healthy Start case managers to locate potential participants in laundromats, community centers, churches, on the streets, etc. The project's comprehensive outreach component, which encompasses one full time person dedicated to its coordination, embodies an approach that is aimed at combating barriers and fostering relationships.

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

**Case Management**

The project has several mechanisms for ensuring continuity of care as referrals are made to other service providers. One tool that the project uses to identify those participants that have been successfully referred entails the use of the Care Coordination Log. Case managers routinely document involved agencies on the Care Coordination Log. It allows them to keep in front of them those agencies that require ongoing communication.

Another tool used to ensure that any person working on a case is aware not only of an involved agency but also of the contact person and their contact information is the Family Care Plan Part 3. The aforementioned information is documented any time a participant is referred to another agency.

In an effort to ensure continuity of care and to enhance communication so that appropriate follow-up may occur, the project

has served as the catalyst to improve communication systems when obstacles arise. The former is relevant in the case of the project's interactions with Children and Youth Services (County child protective services) (CYS). The project learned that when referrals were received or made to CYC, case managers encountered difficulty reaching the appropriate worker either because of this agency's high staff turnover or because of the layers of staff involvement that their cases seemed to experience. After bringing this problem to CYC's attention, they agreed to send a monthly staff roster complete with numbers and the organization's chain of command. This impact on their system allowed the case managers greater access to their staff.

Another source of enhanced communication and follow-up of referrals has to do with shared list that the project has with those agencies where a formal collaboration exist. Lists of mutual clients are updated monthly so that joint case management can occur. The project always seeks to facilitate change where necessary to positively affect continuity of care and to enhance access and communication.

#### Perinatal Depression Screening/Mental Health Services

Throughout the course of the project period, the project's licensed social worker's role has been multifaceted. The role has a presence as the "point of contact" for the project, monitoring participants' involvement in behavioral health services, and facilitated interagency meeting with agencies involved with the project's program participants. The duty performed by the project's licensed social worker assures continuity of care and quality of service, while it also ensures that relationships with involved agencies and collaborative partners will be maintained. Accomplishments this past project period substantiates the importance of the role of the project's licensed social worker given the unique ability to provide clinical direction to the case management staff, serve as liaison to social and behavioral health systems, and serve as a point of access to the project.

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

For each program participant, the project routinely requests authorization from each program participant in writing via the Release of Information form. This document is used when there is a need to provide or request all personal information (including HIPAA protected information). The Release of Information asks for permission to release and/or request information within a specified period of time from specific entities and organizations.

The project routinely provides data to other organizations upon request.

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

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

N/A

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

N/A

**B. Impact to the Community**

**Describe the impact the project has had on developing and empowering the community, at a minimum in the following areas:**

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

The project has had a positive impact on increasing awareness, knowledge and empowering program participants and the community regarding knowledge of resource/service availability, location and access to resources/services through general service provision and the project's public education campaign.

All program participants are provided with information about the variety of community resources and services to meet their needs. The project's Public Education Campaign under the Local Health System Action Plan always provides a resource directory related to each of the four annual public education messages.

For three of the four years of the project period, the project held a prenatal, baby and children's health fair. Numerous community resources and services participated in these events and provided first-hand information to consumers about their services, availability and location; including the ability for consumers to set-up appointments and obtain applications.

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

In relation to the above, in 2004, the project initiated a community effort to develop the Hispanic Resource Center (Center). This community resource was developed to meet the diverse needs of the English as a second language Spanish speaking population in this community. The Hispanic Resource Center is a drop-in site (open one day a week) staffed by volunteers. The Center is designed to help Spanish speaking community members obtain translation services and access a broad variety of community resources and services.

The Hispanic Resource Center has an advisory board comprised of representatives from the community and community resources of which Crozer-Keystone Healthy Start is a member. The Center has informed and educated the larger community about the needs of Spanish speaking community members and affected changes in service provision and utilization within several community resources.

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

The project has not had to negotiate the troubled waters of conflict. It has been fortunate to be surrounded by like minded programs and services and has expended its resources and energies on relationship and team building initiatives. The project is a part of several community partnerships and collaborations. The project is also a part of several team efforts regarding joint or co-case management and advocacy.

**4. Creation of jobs within the community.**

The project has not been responsible for the creation of jobs in the community beyond the positions in the project. Of twelve FTE positions, 83% (10) reside in the project service area.

**C. Impact on the State**

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

Crozer-Keystone Healthy Start has successfully developed a relationship with the Pennsylvania Department of Health, local Title V agencies and other Pennsylvania Healthy Start projects via the Pennsylvania Perinatal Partnership (PPP). The PPP has facilitated partnership and collaboration on maternal and child health issues statewide. This collaboration has also aided in broadening the communication

amongst the above noted agencies and has facilitated direct input into the most recent Title V MCH block grant five-year needs assessment.

Participation on the Partnership has also assisted with the development of a relationship with the Department of Public Welfare (administers Medicaid in PA.) This linkage supports evaluation of issues of access to services and related maternal and child health concerns (i.e.: under utilization of services, case finding of pregnant women, immunization rates, etc.)

During the project period, Crozer-Keystone Healthy Start has collaborated with the State Department of Health on many federal and state funded perinatal initiatives including the Pennsylvania Children's Health Insurance Program (CHIP), the Back to Sleep program, the state infant mortality review, and more. The project also partnered with the State on other MCH related initiatives including participation on the Lead Advisory Committee and the Pennsylvania Department of Health CDC National Environmental Health Tracking Program Planning Consortium.

Participation on the PPP has also facilitated development of a relationship and collaboration with the Pennsylvania Chapter of ACOG regarding perinatal depression. This relationship has facilitated a statewide effort to increase awareness about perinatal depression and advocacy for more resources, services and collaboration to support women suffering from perinatal depression.

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

**Highlight activities/relationships at the state and local level that facilitate project development. Briefly describe barriers at the state and local level, and the lessons learned in dealing with these barriers.**

As noted above the project has developed an excellent relationship with the Pennsylvania Department of Health and Department of Public Welfare. The project has also successfully developed excellent working relationships with local municipalities, county government and local offices of both the Departments of Health and Welfare. These relationships have facilitated access to information and inclusion on policy making, advisory and problem-solving committees. Additionally, this has resulted in the project and staff becoming recognized leaders and experts on MCH issues in the service area.

#### **E. Lessons Learned**

**If not discussed in any sections above, please describe other lessons learned that you feel would be helpful to others.**

In addition to the many lessons learned described above, the experience of the past four years has provided some additional lessons. The first of these is that it is very difficult for a program that does not provide direct medical care to enroll pregnant women early in their pregnancies.

Despite the fact that more than one-half of the pregnant women served enroll in prenatal care during their first trimester of pregnancy, less than one out of five

Crozer-Keystone Healthy Start Impact Report  
Grantee: Crozer-Keystone Health System

pregnant participants enroll in Healthy Start during their first trimester. Every year, a substantial percentage of participants do not enroll until their third trimester, and many only enroll after they have delivered a baby. Although there are benefits to participating in the program regardless of the timing of enrollment, it is difficult for CKHS to have a major impact on birth outcomes when enrollment is late in the pregnancy.

Late enrollments in CKHS (especially during the third trimester or after delivery) have been a major challenge for the project. Since the project does not provide direct medical services, women must learn about the project and self-refer or receive a referral from another service provider. The project has a major outreach component which involves all staff and is the full-time responsibility of the community liaison. Outreach has increased awareness of CKHS in the community both among other service providers and among community residents. CKHS has also developed formal linkage agreements with organizations that routinely interface with CKHS, and interacts routinely with the greater service provider community. These activities enhance awareness of CKHS among other service providers and provide a forum for the project to advocate for referrals to Healthy Start as early as possible in the pregnancy.

In addition to strategies to encourage early referrals, CKHS has also worked over the past year to make the enrollment process more efficient so that the time between referrals and enrollment is as short as possible. The project will continue to monitor enrollment to assess the effectiveness of these measures and explore new approaches to enrolling participants into the program as early as possible.

A second lesson that CKHS has learned during the past four years is that it is very difficult to recruit and retain consumer members on the project consortium. Despite the strong commitment that the project has to empower its participants, consumer representation on the project consortium - The Chester Healthy Families Partnership - has been small to date. There have been community residents who are members of the Partnership but until recently, only one program participant. The project has made many efforts to recruit participants, but for a variety of reasons, primarily work and education responsibilities, these efforts have not been successful.

On the other hand, the project does involve all participants in the development of a Family Care Plan and a Health Education Plan as part of their participation in the program. The program itself is client-oriented and participants are encouraged to be actively involved in every aspect of planning, modifying and carrying out these plans. Under the leadership of the community liaison, a youth advisory group meets on a regular basis to provide a "youth voice" for the program. The development of the health education survey was informed by the review and suggestions from the case managers and from two different groups of program participants. In these and in many other ways, program participants are involved in the program and their feedback is highly valued.

In the last year, the project has identified ten program participants to be members of the Healthy Families Partnership and they have accepted. These program participants have participated in an orientation and will attend Partnership meetings during the year and provide ongoing consumer representation to the group. The project plans to continue to work on increasing program participant involvement through on-going recruitment to enhance the role of project consumers as advisors and partners in CKHS. And, will facilitate their participation by providing training, transportation and child care.

**VI. Local Evaluation**

See Attachment C.

**VII. Fetal and Infant Mortality Review (FIMR)**

Not Applicable, the project has not developed or participated in a FIMR.

**VIII. Products – See attached:**

- Crozer-Keystone Healthy Start Prenatal Health Education Survey
- Crozer-Keystone Healthy Start Postpartum Health Education Survey
- Healthy Start Grantee Meeting Health Education Presentation

**IX. Project Data – See attached.**

- ***MCH Budget Details (Form 1)***
- ***Variables Describing Healthy Start Participants (Form 5)***
- ***Common Performance Measures and Intervention Specific Performance Measures (Form 9)***
- ***Characteristic of Program Participant (Table A)***
- ***Risk Reduction/Prevention Services (Table B)***
- ***Major Service Table (Table C)***