INTRODUCTION

The beautiful 17 year old sat calmly under the shade tree, weeping. Her tears fell softly on the head of her six-month-old son as we talked. Grandma Marlene (all names are pseudomyms), a tiny woman in her seventies, was unyielding. "I've had enough of these people in this here Project knocking at my door in the night. I can't sleep and I'm sick. So I'm leaving here. Vanessa can stay here with the baby. I'll leave the electric on and your brother can watch out for you."

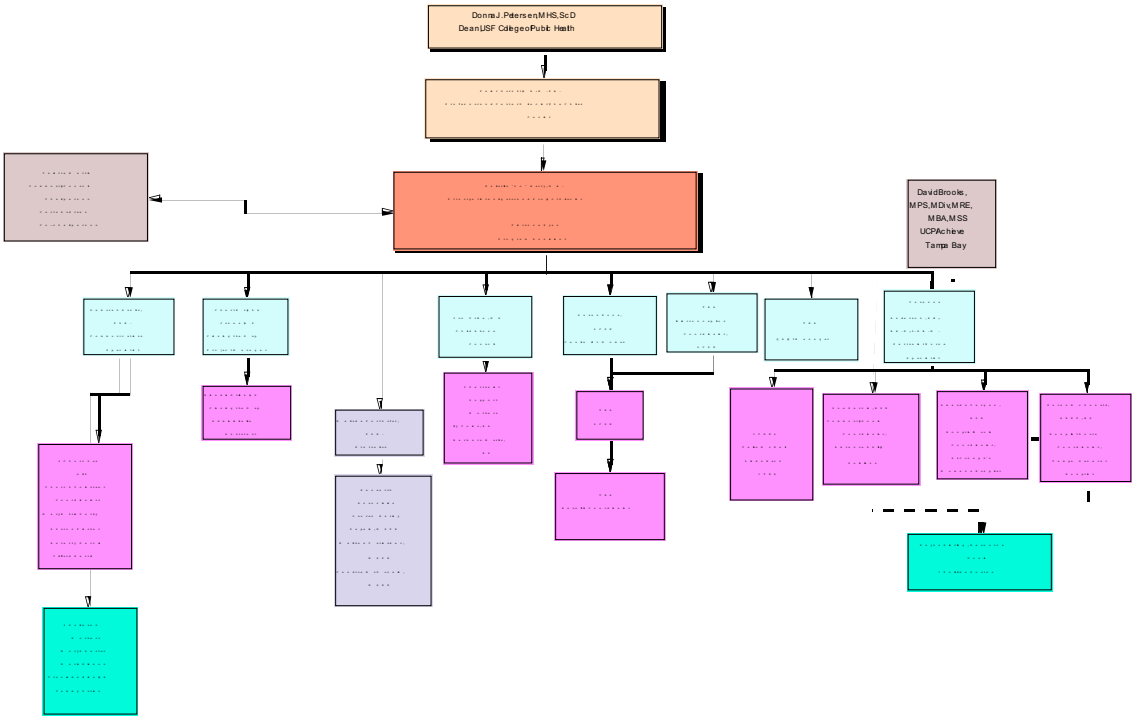
The young mother continued to weep silently clutching her son to her. She cautiously turned to face me and said so softly I could barely hear her: "We can't stay here cause my Auntie sells drugs. That's why they be knocking on the door all the time. My brother is just out of prison for drugs. With Granny gone, when I go to work at night, no one won't watch my baby and they do real bad things here. Can you help me?"

Vanessa, the mother of a precious baby boy, received her transfer into the Central Hillsborough Healthy Start area in October of 2001. She was seventeen years old, HIV positive, with both parents incarcerated for drug charges. At the initial screening, the Community Health Nurse (CHN) found Vanessa along with her baby, paternal grandmother, uncle, and cousin in a substandard two-bedroom apartment in Robles Park Housing Complex. Vanessa had delivered her baby, her first child, on May 14th, by C-Section at Sarasota Hospital because of her failure to progress during delivery. Because of her HIV status, the delivery room staff was advised to begin prophylactic treatment. The baby was found to be HIV negative later that month.

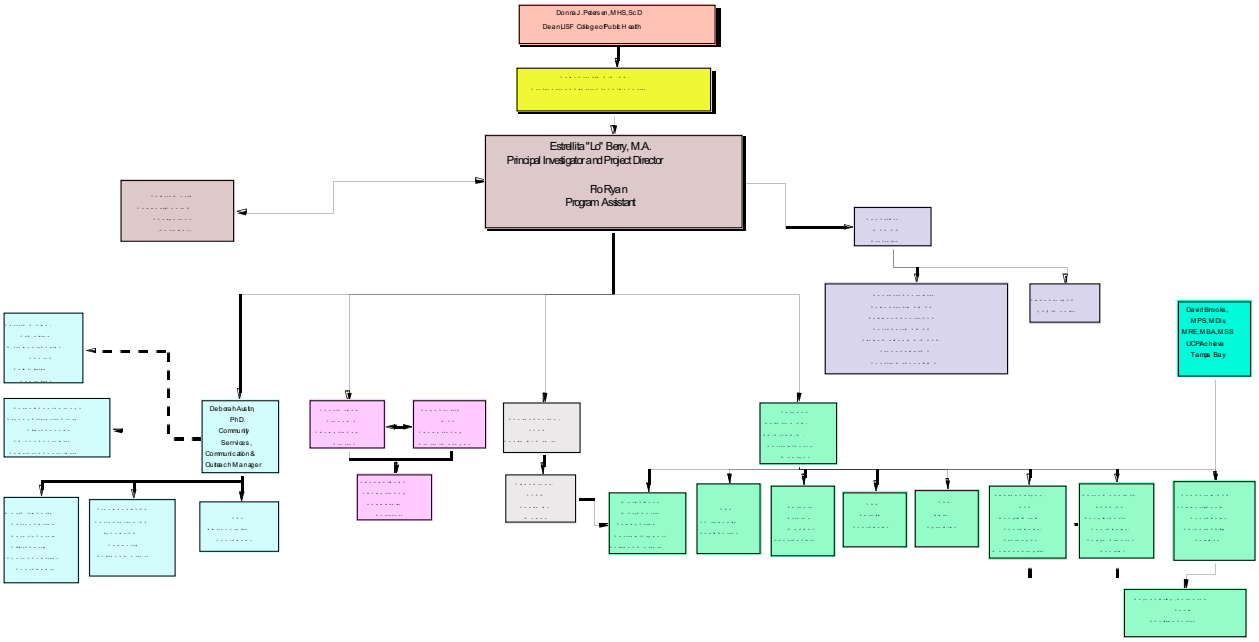
Meeting Vanessa's many needs took the commitment of various members of the dynamic Central Hillsborough Healthy Start Project (CHHS) staff. CHHS has gone from an Idea to an Innovation to Social System Change….

In 2001, the Central Hillsborough Healthy Start Project (CHHS) received continuation funding to narrow the gap in the racial disparities in perinatal outcomes among mothers and infants who experience a disproportionate share of adverse outcomes in Hillsborough County. The project provided services to mothers and babies in 17 of Tampa's urban census tracts where over 70% of the births are to Black mothers who are typically young, unmarried, undereducated, and Medicaid eligible. Despite the economic, health, and social challenges, the service community stakeholders, program participants, project staff, and project partners pooled and mobilized their unique resources to level the playing field for Central Hillsborough's Black mothers and infants. Together program participants, residents, churches, schools, health care providers, and project staff committed their efforts to reach out, engage, support and guide the emerging families toward a more healthy beginning. Over the past four years, we have reviewed and revised our existing CHHS Project Model and services, eliminated ineffective strategies, maintained those proven to be successful and added evidence based and data driven innovations. In the process CHHS staff and leaders have earned the acceptance, trust, and respect of clients and program partners. CHHS has evolved into a significant change agent for improving perinatal health and health care for not only Black mothers and infants, but for all.

Central Hillsborough Healthy Start Project



Central Hillsborough Healthy Start Project



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

In 1997, The Central Hillsborough Healthy Start Project (CCHS) initially targeted fourteen census tracts that had consistently higher rates of infant mortality and other poor health outcomes than the rest of Hillsborough County. In March 2000, three additional census tracts were added. The Project area contains four zip code areas (33602, 33603, 33605 and 33610) within the four zip codes we served 17 census tracts (10, 18-22, 30-35, 39, 40, 41 and 51).

CHHS service provision was absolutely critical because the perinatal health outcomes in the CHHS project area from 19991 to 1997 were the worst in the county and exceeded national and state averages in indicators of infant mortality (total, neonatal, and post-neonatal) low birth weight and teen births.

For the past four years, the CHHS Project service area included 17 contiguous, urban census tracts in the center of Tampa with a total population of 42,303. Compared to the rest of the county, families in the project area tend to be poorer with half the median income, double the unemployment rate, four times more households headed by single women; and twice the number of women over the age 25 with no high school diploma. Black households were fare worse than whites in the CHHS project area except in the proportion of women over the age of 25 with no high school diploma and median incomes where Blacks and Whites experienced the same poor rankings compared to their counterparts countywide. Data from the 2000 U.S. Census clearly shows the disparities in socio-economic challenges and stressors families in the 17 CHHS Census Tracts face.

Table C. U.S. Census Data for 2000

2000 Census Data	17 Census Tract Data		Hillsborough County Data	
	#	%	#	%
Population Total population 25 years & older	25,717	100.0	702,588	100.0
Black population 25 years & older	16,727	65.0	80,195	11.4
White population 25 years & older	7273	28.2	519,517	73.9
Household Information Total Households	9,087	100.0	241,699	100.0
Black households	6,875	75.6	35,287	14.6
White households	2,125	23.3	199,963	82.7
Single female household head	1,813	19.9	11,255	4.6
Single fem headed household with children <18	1,675	18.4	10,276	4.3
Black single female household head	1,605	17.7	6,084	2.5
B single female household with children <18	1,476	16.2	5,722	2.4
White single female household head	193	2.1	4,915	2.0
W single female household with children < 18	193	2.1	4,316	1.8
Household income in 1999 below poverty level	2,585	28.4	20,281	8.4

Table C. U.S. Census Data for 2000				
2000 Census Data	**17 Census Tract Data**		**Hillsborough County Data**	
B household income in 1999 below poverty level	2,140	31.1	7,890	2.4
W household income in 1999 below poverty level	430	20.2	11,718	5.9
Median household income	$20,157		$40,663	
Black median household income	$19,519		$20,689	
White median household income	$20,689		$43,646	
Education Females > 25 years old	13,997	100.0	334,326	100.0
Black Females > 25 years old	9,420	67.4	44,061	13.2
White Females > 25 years old	3,682	26.3	269,535	80.6
Females >age 25 with no high school diploma	5,612	40.2	62,864	18.8
B females >age 25 with no high school diploma	3,694	26.4	11,701	3.5
% of Black females >age 25 with no h.s. diploma		39.2		26.6
W females >age 25 with no h.s. school diploma	1,464	10.5	44,557	13.3
% of White females >age 25 with no h.s. diploma		39.8		16.5

An analysis of health status indicators within the service population reveal a number of disparities between Black and White mothers and infants within the four Zip Codes that contain the 17 project census tracts. An additional analysis shows the disparity between the Black mothers and infants within the four Zip Codes and White mothers and infants in all other Zip Codes of the county and state summarized in the following tables. The following tables contain the frequencies and rates for key perinatal variables by race (Black and White only) for 1999-2002.

Table E. Perinatal Health Status Indicators Black Vs. White 1999-2002, Racial Disparities
CHHS ZIP CODES 33602, 33603, 33605, 33610

		FREQUENCIES					RATES				
	RACE	**1999**	**2000**	**2001**	**2002**	**TOTAL**	**1999**	**2000**	**2001**	**2002**	**TOTAL**
LIVE BIRTHS	BLACK	816	786	701	698	3001					
	WHITE	583	551	530	529	2193					
INFANT DEATHS	BLACK	13	15	12	15	55	15.9	19.1	17.1	21.5	18.3
	WHITE	1	2	3	12	18	1.7	3.6	5.7	22.7	8.2
DISPARITY RATIO							9.3	5.3	3.0	0.9	**2.2**
NEONATAL DEATHS	BLACK	7	9	6	10	32	8.6	11.5	8.6	14.3	10.7
	WHITE	1	2	2	10	15	1.7	3.6	3.8	18.9	6.8
DISPARITY							5.1	3.2	2.3	0.8	**1.6**

Table E. Perinatal Health Status Indicators Black Vs. White 1999-2002, Racial Disparities

CHHS ZIP CODES 33602, 33603, 33605, 33610

		FREQUENCIES					RATES				
	RACE	**1999**	**2000**	**2001**	**2002**	**TOTAL**	**1999**	**2000**	**2001**	**2002**	**TOTAL**
RATIO											
POST NEO	BLACK	6	6	6	5	23	7.4	7.6	8.6	7.2	7.7
DEATHS	WHITE	0	0	1	2	3	0	0	1.9	3.8	1.4
DISPARITY RATIO							7.4	7.6	4.5	1.9	**5.5**
VLBW 400 – 1,499	BLACK	25	24	26	29	104	3.1%	3.1%	3.7%	4.2%	3.5%
GRAMS	WHITE	4	6	5	16	31	0.7%	1.1%	0.9%	3.0%	1.4%
DISPARITY RATIO							4.4	2.8	4.1	1.4	**2.5**
MODERALTELY LBW	BLACK	82	102	78	63	325	10.0%	13.0%	11.1%	9.0%	10.8%
1,500 – 2,499 GMS	WHITE	36	43	34	30	143	6.2%	7.8%	6.4%	5.7%	6.5%
DISPARITY RATIO							1.6	1.7	1.7	1.6	**1.7**
LOW BIRTH WEIGHT	BLACK	107	126	104	92	429	13.1%	16.0%	14.8%	13.2%	14.3%
<2500 GRAMS	WHITE	40	49	39	46	174	6.9%	8.9%	7.4%	8.7%	7.9%
DISPARITY RATIO							1.9	1.8	2.0	1.5	**1.8**
1ST TRIMESTER	BLACK	608	572	532	529	2241	74.5%	72.8%	75.9%	75.8%	74.7%
PRENATAL CARE	WHITE	487	452	452	450	1841	83.5%	82.0%	85.3%	85.1%	83.9%
DISPARITY RATIO							0.9	0.9	0.9	0.9	**0.9**
NO PRENATAL CARE	BLACK	8	9	6	8	31	1.0%	1.1%	0.9%	1.1%	1.0%
	WHITE	8	10	4	8	30	1.4%	1.8%	0.8%	1.5%	1.4%
DISPARITY RATIO							0.7	0.6	1.1	0.7	**0.7**
INADEQUATE CARE	BLACK	109	117	99	79	404	13.4%	14.9%	14.1%	11.3%	13.5%
KOTELCHUCK	WHITE	51	59	43	37	190	8.7%	10.7%	8.1%	7.0%	8.7%
DISPARITY RATIO							1.5	1.4	1.7	1.6	**1.6**
INTERPREG INTERVAL	BLACK	262	211	199	184	856	32.1%	26.8%	28.4%	26.4%	28.5%
<18 MOS	WHITE	122	125	110	126	483	20.9%	22.7%	20.8%	23.8%	22.0%
DISPARITY RATIO							1.5	1.2	1.4	1.1	**1.3**
MOTHERS =<19	BLACK	84	63	54	60	261	10.3%	8.0%	7.7%	8.6%	8.7%
PARITY = >0	WHITE	33	20	17	11	81	5.7%	3.6%	3.2%	2.1%	3.7%
DISPARITY RATIO							1.8	2.2	2.4	4.1	**2.4**
UNWED	BLACK	682	641	585	559	2467	83.6%	81.6%	83.5%	80.1%	82.2%
	WHITE	269	255	261	269	1054	46.1%	46.3%	49.2%	50.9%	48.1%
DISPARITY RATIO							1.8	1.8	1.7	1.6	**1.7**
< HIGH SCHOOL	BLACK	333	277	271	239	1120	40.8%	35.2%	38.7%	34.2%	37.3%
EDUCATION	WHITE	149	132	128	124	533	25.6%	24.0%	24.2%	23.4%	24.3%
DISPARITY RATIO							1.6	1.5	1.6	1.5	**1.5**
< HS EDUCATION	BLACK	197	138	141	127	603	24.1%	17.6%	20.1%	18.2%	20.1%

Table E. Perinatal Health Status Indicators Black Vs. White 1999-2002, Racial Disparities

CHHS ZIP CODES 33602, 33603, 33605, 33610

		FREQUENCIES					RATES				
	RACE	**1999**	**2000**	**2001**	**2002**	**TOTAL**	**1999**	**2000**	**2001**	**2002**	**TOTAL**
PARITY > 0	WHITE	72	69	73	65	279	12.3%	12.5%	13.8%	12.3%	12.7%
DISPARITY RATIO							2.0	1.4	1.5	1.5	**1.6**

Table F. Perinatal Health Status Indicators Black Vs. White 1999-2002,Racial Disparities Hillsborough County

Non CHHS Zip Codes

		FREQUENCIES					RATES				
	RACE	**1999**	**2000**	**2001**	**2002**	**TOTAL**	**1999**	**2000**	**2001**	**2002**	**TOTAL**
LIVE BIRTHS	BLACK	2114	2189	2237	2246	8786					
	WHITE	10447	10517	10655	10835	42454					
INFANT DEATHS	BLACK	30	35	41	22	128	14.2	16	18.3	9.8	14.6
	WHITE	56	58	68	70	252	5.4	5.5	6.4	6.5	5.9
DISPARITY RATIO							2.6	2.9	2.9	1.5	**2.5**
NEONATAL DEATHS	BLACK	21	21	25	16	83	9.9	9.6	11.2	7.1	9.4
	WHITE	44	37	43	43	167	4.2	3.5	4	4	3.9
DISPARITY RATIO							2.4	2.7	2.8	1.8	**2.4**
POST NEO	BLACK	9	14	16	6	45	4.3	6.4	7.2	2.7	5.1
DEATHS	WHITE	12	21	25	27	85	1.1	2	2.3	2.5	2.0
DISPARITY RATIO							3.9	3.2	3.1	1.1	**2.6**
VLBW 400 - 1,499	BLACK	56	48	58	62	224	2.6%	2.2%	2.6%	2.8%	2.50%
GRAMS	WHITE	119	109	125	132	485	1.1%	1.0%	1.2%	1.20	1.10%
DISPARITY RATIO							2.4	2.2	2.2	2.3	**2.3**
MODERALTELY LBW	BLACK	188	195	209	233	825	8.9%	8.9%	9.3%	10.4%	9.40%
1,500 - 2,499 GMS	WHITE	592	597	627	609	2425	5.7%	5.7%	5.9%	5.6%	5.70%
DISPARITY RATIO							1.6	1.6	1.6	1.9	**1.6**
LOW BIRTH WEIGHT	BLACK	244	243	267	295	1049	11.5%	11.1%	11.9%	13.1%	11.90%
<2500 GRAMS	WHITE	711	706	752	741	2910	6.8%	6.7%	7.1%	6.8%	6.90%
DISPARITY RATIO							1.7	1.7	1.7	1.9	**1.7**
1ST TRIMESTER	BLACK	1653	1717	1751	1849	6970	78.2%	78.4%	78.3%	82.3%	79.30%
PRENATAL CARE	WHITE	9233	9251	9470	9670	37624	88.4%	88.0%	88.9%	89.2%	88.60%
DISPARITY RATIO							0.9	0.9	0.9	0.9	**0.9**
NO PRENATAL CARE	BLACK	19	21	17	14	71	0.9%	1.0%	0.8%	0.6%	0.8%
	WHITE	48	51	56	51	206	0.5%	0.5%	0.5%	0.5%	0.5%
DISPARITY RATIO							1.8	2.0	1.6	1.2	**1.6**
INADEQUATE CARE	BLACK	278	234	222	186	920	13.2%	10.7%	9.9%	8.3%	10.%
KOTELCHUCK	WHITE	681	693	626	587	2587	6.5%	6.6%	5.9%	5.4%	6.1%
DISPARITY RATIO							2.0	1.6	1.7	1.5	**1.7**

Table F. Perinatal Health Status Indicators Black Vs. White 1999-2002,Racial Disparities Hillsborough County											
Non CHHS Zip Codes											
		FREQUENCIES					RATES				
	RACE	**1999**	**2000**	**2001**	**2002**	**TOTAL**	**1999**	**2000**	**2001**	**2002**	**TOTAL**
INTERPREG INTERVAL	BLACK	561	536	505	548	2150	26.5%	24.5%	22.6%	24.4%	24.5%
<18 MOS	WHITE	2215	2228	2229	2260	8932	21.2%	21.2%	20.9%	20.9%	21.0%
DISPARITY RATIO							1.3	1.2	1.1	1.2	**1.2**
MOTHERS =<19	BLACK	117	131	104	113	465	5.5%	6.0%	4.6%	5.0%	5.3%
PARITY = >0	WHITE	259	244	256	242	1001	2.5%	2.3%	2.4%	2.2%	2.4%
DISPARITY RATIO							2.2	2.6	1.9	2.3	**2.2**
UNWED	BLACK	1421	1483	1505	1517	5926	67.2%	67.7%	67.3%	67.5%	67.4%
	WHITE	3054	3133	3290	3581	13058	29.2%	29.8%	30.9%	33.1%	30.8%
DISPARITY RATIO							2.3	2.3	2.2	2.0	**2.2**
< HIGH SCHOOL	BLACK	517	526	511	525	2079	24.5%	24.0%	22.8%	23.4%	23.7%
EDUCATION	WHITE	1421	1415	1458	1580	5874	13.6%	13.5%	13.7%	14.6%	13.8%
DISPARITY RATIO							1.8	1.8	1.7	1.6	**1.7**
< HS EDUCATION	BLACK	270	259	271	296	1096	12.8%	11.8%	12.1%	13.2%	12.5%
PARITY > 0	WHITE	698	681	725	793	2897	6.7%	6.5%	6.8%	7.3%	6.8%
DISPARITY RATIO							1.9	1.8	1.8	1.8	**1.8**

The analysis clearly shows the persistent disparities between Black mothers and infants living in the CHHS project area as compared to their White counterparts within and outside the service community. Black CCHS infants' mothers are more likely to be a teen, have a repeat pregnancy with a short interpregnancy interval, be unwed, be enrolled in Medicaid, and have less than a high school education. Significant disparities in key indicators within the project area are even more pronounced when compared to those of the White population outside the project area.

Racial disparities in perinatal health in Florida have remained unchanged over the past four years.

Perinatal Health Indicators in Florida	1999		2000		2001		2002	
	#	Rate	#	Rate	#	Rate	#	Rate
Total Live Births (per 1000)	196963	12.6	204030	12.7	205800	12.5	205580	12.3
White Live Births (per 1000)	146329	11.3	150115	11.4	151623	11.3	152127	11.1
Non-White Live Births (per 1000)	50473	18.2	53622	18.7	54177	18.3	53453	17.6
Infant Deaths (per 1000)	1442	7.3	1423	7.0	1495	7.3	1548	7.5
White Infant Deaths (per 1000)	815	5.6	810	5.4	839	5.5	892	5.9
Non-White Infant Deaths (per 1000)	625	12.4	611	11.4	655	12.1	656	12.3
Births < 2500 Grams Weight (percent)	16126	8.2	16284	8.0	16812	8.2	17350	8.4
White Births < 2500 Grams (percent)	10116	6.9	9897	6.6	10349	6.8	10833	7.1
Non-White Births < 2500 Grams (percent)	5995	11.9	6355	11.9	6463	11.9	6517	12.2

Results of the Zip Code population analysis provides project stakeholders, staff, and advisors reason to maintain focus of efforts on the current service population: mothers and infants living

in the 17 urban census tracts that lie within four Tampa Zip Codes (33602, 33603, 33605, & 33610) in the central portion of Hillsborough County. Additional information gleaned from the 2000 U.S. Census, shows that families that live in the 17 census tracts are among the economically poorest in Hillsborough County.

II. Project Implementation

CCHS Core services: 1) Outreach and Client Recruitment; 2) Case Management; 3) Health Education and Training; 4) Interconceptional Care; and 5) Perinatal Depression Screening and Referral were designed and implemented in coordination with the Local Health System Action Plan (The Hillsborough Healthy Start Service Delivery Plan); the Community Consortium (CHHS Community Council) other community consortia (Healthy Start Coalition of Hillsborough County, Racial and Ethnic Approaches to Community Health/To Heal Racial Ethnic Disparities (REACH/THRED), and the State Title V (Florida Department of Health, Florida Healthy Start and Closing the Gap Programs) and other agencies (Agency for Health Care Administration). The following discussion outlines the rationale for the services and system building efforts at three levels: the state; the county; and project community.

State: In 1991, the Florida Legislature enacted the Florida Healthy Start Program to improve maternal and infant health outcomes by assuring all mothers and infants access to health care and related services. State wide strategies included an expansion of Medicaid eligibility for pregnant women and infants; increased Medicaid reimbursement rates for obstetrical care; enhancement of the Regional Perinatal Intensive Care Program. In addition the state established a community based system for voluntary prenatal and infant risk screening and referral to risk reduction services. Florida statute authorized the establishment of Community Coalitions to plan, implement, manage, and evaluate local Prenatal and Infant Healthy Start screening, referral, and risk reduction services. In 2002, the State of Florida was granted a Medicaid Waiver to expand Florida Health Start Services for mothers and infants enrolled in Medicaid. The Florida Department of Health and the Agency for Health Care Administration (administrative home for the Florida Medicaid Program) collaborated to secure and implement the Waiver entitled the Mom Care Program. Healthy Coalitions implement the program at the local level.

County: CHHS functions as a Hillsborough County Healthy Start Case Management/Care Coordination Unit serving mothers and infants in the 17 target census tracts neighborhoods. The CHHS Care Coordination/Case Management Team adheres to the performance standards and guidelines established by the HSC and participates in HSC quality assurance and improvement activities. The 20 page Memorandum of Agreement between CHHS and the HSCHC is available upon request. As an official Care Coordination/Case Management provider for the Hillsborough Healthy Start Coalition, the CHHS staff and community volunteer leaders are included in the various decision making committees and work groups that guide and govern the Hillsborough Healthy Start Program. This association also enhances our linkages to the Florida Healthy Start Program and other related Title V activities.

Service Community: Consortia and Interagency Management Team (IMT). The IMT assists in coordinating services, sharing lessons learned and developing and implementing qualitative and

quantitative evaluation strategies. Both these modalities of services are discussed in detail in the upcoming section of this report.

OUTREACH AND CLIENT RECRUITMENT

A. How we decided on our approach to service

Service availability does not guarantee utilization. Previous negative experiences with research programs led community constituents to initially view the project with distrust and skepticism. Clients were hesitant to consent to services. To encourage and facilitate client participation in Healthy Start services, staff efforts focused on building positive relationships with groups and individuals living and working in the service community.

Strategies included:

1. Engendered trust in the community we served.
2. Replaced distrust of university research studies and service programs with knowledge of CHHS's mission, vision and values.
3. Recruited, employed, and supported indigenous Outreach Workers adept in two major arenas: connecting with women whose life experiences are similar to their own and connecting with community organizations and agencies that provide services to the same population.
4. Adhered to high standards of professional practice and cultural competency was particularly important. Staff consistently demonstrated commitment to the Project's mission, vision, and values.
5. Developed formalized relationships with the faith community. From their inception in the late 1700s, Black churches became and continue to be the focal point of almost any movement for change in the communities. Black people turn to their churches for guidance, support and leadership, making it a natural venue for providing CHHS services. With the assistance of pastors and other church leaders as well as review of evidence-based practices, CHHS became acquainted with strategies for making the faith community a part of the project. We learned that there were special considerations for successfully collaborating with churches. Three of the most important considerations include: paperwork kept to a minimum; results of study provided to the church; university interaction with church as partners, not research subjects. (Alice Ammerman, Giselle Corbie-Smith, Diane Marie M. St. George, Chanetta Washington, Beneta Weathers, & Bethany Jackson-Christian, 2003, "Research Expectations Among African American Church Leaders in the PRAISE! Project: A Randomized Trial Guided by Community-Based Participatory Research," *American Journal of Public Health*, 93.10:1720-1727.)
6. Demonstrated evidence-based community development competencies and practices including: consulting with community members before new programs are introduced; using feedback from the community to make decisions on these programs; working to address problems identified by the community; having a formalized procedure for community residents to give feedback; working cooperatively with other organizations/agencies; exchanging resources with other agencies or organizations;

identifying the strengths as well as any weaknesses in the communities served; conducting community and agency assessments and using these findings in our service provision and research; and presenting findings to agency staff as well as community stakeholders, including residents. (Edith Parker, Lewis H. Margolis, Eugenia Eng, Carlos Henrquez-Roldan, 2003, "Assessing the Capacity of Health Departments to Engage in Community-Based Participatory Public Health," *American Journal of Public Health*, 93.3:472-476.)

7. Expanded outreach to include males. Carla Andrews, CHHS consumer and co-chairperson of the Community Consortium served as a vocal advocate for reaching out to fathers. From her perspective, a woman's decision regarding everything from well-woman's health, to prenatal care, to baby spacing, is positively or negatively influenced by the father of the baby or other significant male(s) in the life of the woman. Moreover, a study by Giblin, Poland, and Ager (1990, *Journal of Community Health,* 15.6: 57-368) found a clear association between the level of tangible/behavioral, emotional, and informational support of expectant fathers and prenatal care use and health behaviors exhibited by the expectant mother. The study shows that women were more likely to participate in prenatal care and quit risky behaviors if the expectant fathers provided them with all three of those types of support. Thus, the informational support of the expectant fathers is as essential as emotional and behavioral support. Informational support is exhibited by the roles of information provider and information seeker. Also, research conducted by Westney, Cole, and Munford (1998, *Journal of Adolescent Health Care*, 9:214-218) suggests that the expectant mother is more strongly influenced by input from her partner than from any other significant person, including other relatives and healthcare professionals. This research suggests that expectant fathers were most influential in getting the expectant mother to comply with medical protocol and exercise good health behaviors.

This Outreach and Recruitment component was managed by the Communication Specialist who also participated in workshops, seminars, trainings, health and outreach fairs and other events and activities to advertise and market the Central Healthy Start Project.

B. Components of intervention and resources

OUTREACH WORKERS

CHHS's Outreach Workers represented the service community's culture and demographic profile and spent the majority of their time in the community actively looking for and recruiting potential clients into the program or the Community Consortium and administering surveys that assess client satisfaction. The Outreach Workers did not provide direct services to the clients. However, in order to enhance the effectiveness of the Project, the Outreach Workers performed various critical functions. They included:

Satisfaction Survey Administration

Outreach Workers administered client satisfaction surveys to determine the client's feelings about the quality of services they received from the Care Coordination/Case Management Teams, the health care providers and the Doulas (labor assistants). The surveys were administered at various intervals throughout the prenatal and postnatal period—every 90 days while the consumer case was active and no more than 60 days after the case was closed.

Consumer Recruitment

The Outreach Workers actively recruited consumers to the Project and Community Consortium through participation in community, health and job fairs, serving as liaisons to various community agencies, organizations and businesses and approaching pregnant women in the course of their everyday activities.

Case Finding

During this initiative, case finding became a more important part of the Outreach Workers' protocol. In this regard, they supported care coordination/case management staff in locating consumers they had trouble finding so that they might provide requested services. The community we serve tends to be transient and knowing where consumers are is necessary for service provision. This transience was made even more frustrating after the Hope VI Project demolished two of the housing projects in which many CHHS consumers resided. Although Tampa Housing Authority collaborated with CHHS in tracking consumers on paper, Outreach Workers were instrumental in determining where consumers actually resided.

Provided Support to Church Volunteer Coordinators

Outreach Workers met weekly with church volunteer coordinators to help keep lines of communication open and clear between coordinators and Project staff. Outreach Workers rotated between churches on a monthly basis so that all of the volunteer coordinators and Outreach Workers could get to know each other. Starting in 2003, Outreach Workers also began to assist the churches in locating consumers they had trouble finding so that they might provide requested services

Another change that began in 2002 was to have the churches rotate giving a report on their activities at the monthly Interagency Management Team meetings so that the churches would feel more like equal partners. Prior to this time, the churches attended the meetings and participated in all discussions and decision-making efforts but did not report on their own activities.

Served as Liaison between CHHS and Community Agencies/Organizations

Outreach Workers served as liaisons between CHHS and various community agencies and organization in order to facilitate the development of stronger and more effective partnerships in the reduction of infant mortality and morbidity. Serving as liaisons to some

40 community agencies and organizations was also critical in CHHS's outreach efforts. These organizations, which are very diverse, included the Salvation Army, SAMI/DACCO (Substance Abusing Mothers and Infants/ Drug Abuse Comprehensive Coordination Office), Johnson and Kenneth Court Apartment Complex, and Day Star Food Pantry. Having constant contact with other organizations that provided services to the same or related targeted populations allowed a reciprocal relationship in which CHHS and other organizations could refer our patients/clients/consumers. These organizations also relayed information to audiences that experienced minimal exposure to our program.

Provided Emergency Assistance to Care Coordinators/Case Managers

In cases of great need or emergency, care coordinators/case managers asked Outreach Workers to assist in providing minimal services to consumers, such as making a trip to deliver bus passes, diapers, and/or formula. However, the objectivity of the Outreach Workers in the administration of satisfaction surveys was not compromised because they did not participate in frequent home visits and/or service provision.

Provided Leadership to the Incentive Program

In conjunction with the Program Assistant, the Outreach Workers provided leadership to the Incentive Program. This Incentive Program proved invaluable in encouraging participation in CHHS activities. A number of attempts at increasing consumer participation overall and attendance at Community Council meetings met with limited success. In order to encourage program compliance and consumer attendance, and to mitigate common barriers to consumer attendance, an Incentive System was created in which consumers received a pre-determined number of points for attending meetings, health education classes, support groups, and for completing child immunizations and medical visits. The points accrued were exchanged for gift certificates which the consumer used as she wished. The Outreach Workers helped provide the multiple layers of accountability required for such a program. Their work included calling and attending meetings, making recommendations for adjustments in the program, assisting in point redemption at the Community Consortium meetings, and delivering gift cards to consumers when needed. As a consequence of the Incentive System, consumer attendance increased significantly (50%).

FAITH INITIATIVE

CHHS subcontracted with four churches who served as CHHS "satellites" in the community. The Community Consortium meetings rotated between the churches and other activities were available based on the church's subcontracts. These included accessible facilities, van transportation, classrooms, food pantries, G.E.D. and computer classes, support groups, babysitting support, screening areas and administrative support. All churches had a Volunteer Coordinator who coordinated all that church's activities and non-paid volunteers who assisted consumers in numerous ways. For each of the four years of the initiative, these volunteers gave more 1,000 non-paid hours.

The success of the church involvement was impetus for beginning discussions on expanding the program by bringing in other churches, on a fully volunteer basis, as faith partners. Understanding the faith community and the importance of pastors communicating with other pastors rather than Project staff, a proposal is being developed to bring on a pastoral consultant who will solicit support and resources from other area churches. This support may be granted in the form of advertising and marketing, recruitment and retention, volunteers, material resources, etc. Additionally, we expect that these churches and faith institutions will educate their congregations on maternal and child health issues and generally encourage them toward more healthful behaviors that will reduce infant mortality and morbidity.

FATHERHOOD INITIATIVE

In the spring of 2004, CHHS subcontracted with Mr. Byron Roquemore, Program Manager Residential Facilities 2 and 3, Drug Abuse Comprehensive, Coordinating Office (DACCO), to facilitate male support groups dealing with self-esteem; demystification of the definition of manhood and fatherhood; accountability and responsibility; and CHHS clinical outcomes. Two of the groups were originally scheduled for the DACCO residences and two for the significant others of CHHS consumers outside the DACCO environment.

The sessions scheduled for the significant others of consumers were not well-attended. The decision was made to seek expert advice from a male consultant on the best strategies for engaging males, particularly for involving them in mentoring activities.

C. Resources or events that facilitated or detracted from successful initiation and implementation

The Outreach staff made gigantic strides during this grant period despite personnel hardship. During June, CHHS was distressed by the loss of Outreach Worker Jacqueline Reed to breast cancer. The search to fill this position allowed us to hire Tammy Sutton who began work on October 1, 2002. Ms. Sutton was a former Outreach Worker with DACCO (Drug Abuse Comprehensive Coordination Office), one of our collaborative agencies.

With the addition of Ms. Sutton, two of the four Outreach Workers lived in CHHS's Project Area. Another worker lived in an area to which many Central Healthy Start consumers moved as a result of the dislocation caused by the Hope VI Project. This Outreach Worker, however, had a great deal of experience working with the target population as a former staff member of an area domestic violence program. The fourth Outreach Worker, who is bi-lingual, worked with the state Healthy Start Project with the same target population for seven years.

With the addition of a grant from the Florida Department of Health, CHHS was granted the opportunity to address health disparities throughout Hillsborough County, FL. This grant also provided one of our Outreach Workers, Maria Gibson, the opportunity to spend 20% of her time working with the Closing the Gap Project. In this position, she represented the Closing the Gap Project at community events and health fairs as well as making CHHS visible outside our 17-census track service area.

A very special opportunity was afforded the Outreach Workers during this initiative. With a workforce development grant received by The Chiles Center, three of four of the Project's Outreach Workers completed a 21 credit hour training program for Family Health and Support Workers. Upon completion of this program, in December 2004, they earned an Applied Technology Diploma in Maternal and Child Services. (The fourth Outreach Worker was enrolled in the Masters of Public Administration Program at University of South Florida and opted not to enroll in the ATD program.). Thus, CHHS was able to improve our Outreach Model by creating a two tier outreach system. With the support of the Healthy Start Coalition of Hillsborough County, entry level Outreach Workers, positioned as Community Outreach Workers, can be promoted into Perinatal Support Outreach Workers who are case managers. The three Outreach Workers gained a10% increase in salary when they transitioned into case manager positions.

CASE MANAGEMENT/CARE COORDINATION

A. How we decided on our approach to service

Case Management/Care Coordination (CM/CM) services were continued from the previous funding period for a number of reasons: 1) to provide continuity between clinical care and the individualized risk reductions services; 2) to promote maternal and fetal/infant attachment during pregnancy, childbirth, and immediate postpartum periods; 3) to facilitate systems building with the county and state Healthy Start Program; and 4) to enhance the potential for project sustainability. The interdisciplinary CM/CC staff was supervised by a Professional Nurse with extensive experience in perinatal nursing and included: 2.5 FTE community health nurses, 2.0 FTE case manager/social service coordinators, 1.0 FTE licensed clinical social worker, 1.0 FTE benefits coordinator, 2.0 FTE hospital nurse coordinators, 3.0 FTE outreach workers and 8.0 FTE doulas. The nurses were employees of the project and the others were employed through subcontracts with other agencies, but located at the CHHS Office.

1) Most of the risk reduction services necessary for promoting optimal birth and infant health outcomes in Hillsborough County were not being offered or coordinated by clinical providers, but rather by various social service and health education agencies. Providers made referrals to CHHS with the expectation that qualified personnel would assess their patient's/family's perceived needs, develop a service plan, link their patient to needed services, and orchestrate the arrangement, coordination, and monitoring of those services. The CHHS Case Managers provided services in coordination with the medical plan of care to achieve positive clinical and social outcomes for the family.

2) High rates of postneonatal mortality in the Project stemming from illnesses and injuries provided the impetus for implementing an evidence-based intervention to foster the maternal and fetal/infant attachment process. Doula services were added to the CHHS CM model for that purpose to "mother the mother" to provide emotional, informational, and physical support during pregnancy, birth, and immediate postpartum. Doulas focused on the mothers' needs for a positive birth experience, bonding, and breastfeeding. The doulas were women from the community who were recruited, specially trained and employed to work in the Project and served as inspirational role models for women in the community.

3) Case Management/Care Coordination is the cornerstone of the Florida Healthy Start Program statewide and in Hillsborough County. The CHHS Project and the Healthy Start Coalition (HSC) of Hillsborough County entered into a formal agreement to designate the CHHS CM Team as the official Care Coordination Team for the clients living in the CHHS Project Census Tracts. Under the agreement the CHHS CM/CC's adhered to HSC standards and guidelines and participates in quality assurance activities, but were able to provide more intensive services for their clients through the CHHS Outreach, Health Education, Inteconceptional, and Perinatal Depression program components and resources. Benefits of the arrangement include enhanced system and service integration; inter-program communication; and increased opportunities for influencing local maternal and child health services.

4) By providing CM/CC services under the auspices of the Hillsborough County Healthy Start Program, the CHHS Project was awarded a subcontract to expand services to additional census tracts within and outside the CHHS service Zip Codes, beginning in late 2005. The Project is well positioned to expand its role as a CM/CC service provider for the local system of care.

   Care Coordination served as the mechanism for integrating services to meet the individual needs of clients. Functioning in teams, Care Coordinators assess the individual's/family's perceived needs, develop a service plan, link the consumer to needed services, and orchestrate the arrangement, coordination, and monitoring of those services. The assessment process is a systematic approach to the development of a holistic Family Support Plan to meet the consumer's identified and prioritized needs. The Family Support Plan delineates what services are needed and desired by the family, where they are obtained, what degree of progress can be reasonably expected by the consumer, and how the initiative will be supported. The Family Support Plan is consumer oriented, family-driven, and Project supported and coordinated to maximize positive outcomes.

B. Components of intervention and resources

Components of the CHHS CM services were provided by a team that included professionals and paraprofessionals as mentioned above.

The CHHS Perinatal Nurse Manager (PNM) provided supervision for employed and subcontracted, professional and paraprofessional members of the CM/CC Team. In addition, the PNM provided on-site consultation and support to clinical health providers at 3 health clinics (Exodus, New Life and Genesis) and their staffs to facilitate administration of the Florida Healthy Start Screen and referral for Healthy Start CM/CC services. The PNM reviews consumers Healthy Start screens to assure accuracy and completeness and facilitates effective communication between the providers, clinic staff, and CHHS project. She also provided home visiting services for clients as needed.

Three Community Health Nurses employed by the Project and two subcontracted Social Services Coordinators served as CHHS Case Managers/Care Coordinators. Collocated at the CHHS

office, the CM/CC's provided home visiting and community-based services with a high degree of teamwork and supported other Project staff. Direct support included a medical records clerk, an Intake Coordinator, three Outreach Workers, and a data entry clerk.

CHHS subcontracted with Achieve Tampa Bay (formerly United Cerebral Palsy of Tampa Bay) to offer doula services for Project clients. Services were provided by 8 paraprofessional doulas and a Nurse Supervisor who were collocated at the CHHS Office. The doulas received referrals from the CHHS Project staff and provided community and home based services.

C. Resources or events that facilitated or detracted from successful initiation and implementation

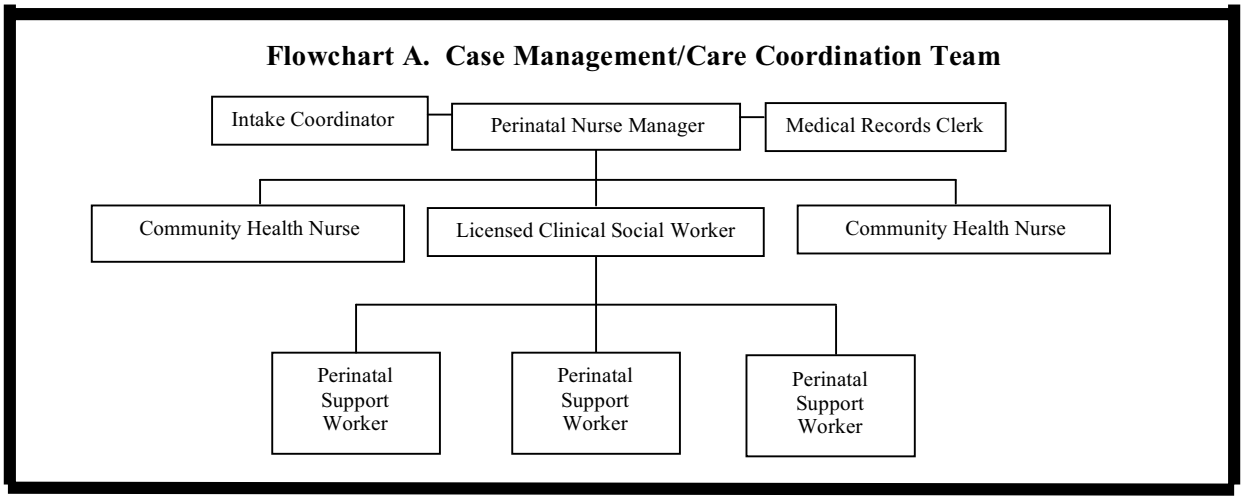
Qualified nurses have remained problematic throughout the state of Florida. In addition, the areas in which project services are rendered, the high participant case load and low salary are contributing factors to high nurse turnover. A request was submitted to the College of Public Health and approved for the change in nursing qualification criteria from a bachelors degree to an AA Degree. That request was approved in July 2005.

Reduction of grant support to the agency providing doula services resulted in a significant change in the service delivery model. The model moved from a home visiting approach to a clinic-based childbirth education model.

Other barriers that detracted from successful initiation and implementation were:

- New staff orientation at 3 clinic offices on a continual basis to accommodate its high turnover of staff
- Manual documentation system utilized initially
- Misperception that doulas were representatives of Department of Children and Family Services (Child Protection Services)
- Initial difficulty in developing consistent policies and procedures for recruiting, retaining staff, maintaining quality performance and decreasing triangulation among staff that were supervised by multiple agencies

In this current funding cycle (2005-2009), our care coordination infrastructure has been enhanced to include an additional case manager (perinatal support worker), an intake coordinator and two additional outreach workers. The following chart depicts CHHS direct service provision from the case management/care coordination team.



HEALTH EDUCATION AND TRAINING

A. How we decided on our approach to service

Creating venues to promote good health outcomes and health literacy is critical to closing disparity gap of infant mortality and morbidity. Promoting community awareness of issues around health is essential to improving public health. Thus, during the past six years, the CHHS Health Education objective has been to change health behaviors and positively impact traditionally poor health outcomes through a participatory community education and training initiative. Health Education Services involved training of Project staff, program participants, consortium members, public and private healthcare providers and a communications network.

Please refer to Appendix A for the numerous (more than 30) trainings that are offered. More than 50% of trainings are mandated to CHHS project staff.

Our Health Education focus was not chosen haphazardly. A close review of the 2000 Period of Risk Analysis of Infant Deaths to Women in Hillsborough County determined that babies born to unmarried, high school educated black women, ages 18-34 are at highest risk for infant mortality and that prematurity is the primary cause of death to black infants in Hillsborough County. While the need to address various health topics (stress, obesity, cardiovascular, asthma, diabetes, etc.) is vast, CHHS chose to focus upon Bacterial Vaginosis and Periodontal Disease as the top two preterm birth health issues for the women in our project area. Working in concert with Florida Department of Health (DOH), the Closing the Gap funding (State budget DOH, CBHC), has afforded CHHS the opportunity of serving women outside of our targeted census tracts for maternal infections and periodontal screenings.

Bacterial Vaginosis (BV) is the most common vaginal infection (not a sexually transmitted disease) in women of childbearing age. BV is associated with preterm births and is almost three

times more common in Black women .Research suggests that this may be due to douching or an altered immune response to infection. We do know that douching increases the risk of many types of vaginal infections and is a more common practice among American Black women than any other racial/ethnic group. (Eschenbach, D.A., Garett, M.G., Chen, K.C., Hoyme, U.B.,& Holmes, K.K. (1984).

Sydel LeGrande, MD, a board certified family practice physician, subcontracts with the CHHS Closing the Gap Project to provide maternal (vaginal) infections screening to women in the community. She completes the BV screen and diagnosis and provides treatment or makes referrals for more extensive treatment if necessary. She provides the program participant with a prescription, if needed, and has also secured medication as a donation from a pharmaceutical corporation for women who cannot afford them. During the screening, Dr. LeGrande individually educates each participant about maternal infections, periodontal disease, baby spacing and maternal nutrition. She emphasizes how each of these health areas contributes to poor health outcomes.

Dr. LeGrande and her office staff have screened over 1100 black women between the ages of 18-44 for maternal infections. Of the 616 black women screened in FY 2002-2003, 389 tested positive for a vaginal infection, Bacterial Vaginosis, and/or Trichomonas (57.6%). As of September 30, 2004, of the 536 black women screened, 301 tested positive for a vaginal infection (56%). Dr. LeGrande has been generous to the project. She has provided $35,400 in-kind services annually.

Dr. Albert Boholst subcontracted with the CHHS Closing the Gap Project and began Periodontal Disease screening in 2004 to Black women ages 18-44. He completed the screens and diagnosis and provided referrals for treatment when necessary. From March 1, 2004 to September 30, 2004, 64 Black women were screened, with 35 testing positive for Periodontal Disease (55%). Knowing how important it is to understand the role periodontal disease plays in poor health outcomes, he gave both oral and written educational materials and information to participants during the screening.

Also, promoting and advocating personal health to staff is as essential as promoting and advocating good health outcomes to program participants. Unfortunately, too many (more than 40%) of the existing Healthy Start staff suffer from medical ills (stress, obesity, diabetes, cardiovascular, smoking). For this reason, CHHS will develop its own Wellness in the Workplace Program. After several literature reviews, project management has chosen two models that are congruent with CHHS philosophy and guiding principles for health. The two models are:

- *The Live Well. Work Well. Corporate Wellness Program,* an Organizational Corporate Model guides employees on how to live healthier, live longer and live better by teaching them to manage and reduce stress—at home and at work—and to make healthy lifestyle choices every day that make them more productive, more motivated, more satisfied and less stressed. (i) educational workshops and lunch & learn sessions focused on life skills and behavior change; (ii) information sessions; (iii) health & wellness fairs; (iv) health risk assessments; (v) health screenings; (vi) employee health promotion communications; (vii) fitness programs; and (viii) Employment Assistance Program (EAP) counseling.

- The *Wellness Program at Illinois State* University, a Public Academic Workplace Model offer opportunities that improve quality of life for employees in an environment that fosters personal growth, positive lifestyles, attitudes and values. This is accomplished by realizing that wellness is not just about 'the absence of illness', but moving beyond that paradigm to explore balance in all of the following areas: Social, Occupational, Spiritual, Physical, Intellectual, and Emotional.

B. Components of interventions and resources

Initially, the project's health education component was led by a full time Health Educator subcontracted through the health department who subcontracted out 90% of the trainings. In 2002, CHHS hired a full time Health Education Coordinator who was responsible for the coordination of staff education as well as client health education services (50% of the training we provided in-house, 25% in-kind from community agencies/organizations and 25% provided by paid consultants). Health education is now directed at the community-level, eliciting support and hands-on participation from consumers/participants and other community stakeholders.

Currently, the primary method for program participants to receive health education is clinical support groups and one-on-one instruction during home visitations by Case Managers (Community Health Nurses and Perinatal Support Outreach Workers) and/or Doulas (nurse assistants). Mandatory instruction to program participants by Community Health Nurses and Perinatal Support Outreach Workers include in-depth interconception health education, ongoing support and guidance in child health development. Doulas will provide instruction on childbirth education, breastfeeding and bonding, parenting education and health literacy.

Additional methods used to conduct program participant health education are multifaceted, including support groups (non-clinical), marketing campaigns, health fairs and participatory lectures.

In the current project initiative, three 1.0 FTE Community Health Nurses and three 1.0 FTE Perinatal Support Outreach workers who serve all program participants in Case Management (400 per year) in health education and provide 10% of their efforts in this component. Two 1.0 FTE HRSA funded Doulas will serve at least 175 program participants annually and will provide 20% of their efforts in this component.

Support groups will serve 200 families per year. The marketing campaign will disseminate a minimum of 1,500 brochures to program participants and community members and 30 health fairs per year will serve community residents. Additionally, Dr. Sydel LeGrande's participatory audience will total 400 women per year and Dr Albert Boholst's participatory audience will total 100 women per year with the FL DOH Closing the Gap Project (state funded).

Additional staffing for Health Education Component consists of three 1.0 FTE CHHS Community Outreach Workers who will spend 40% of their time in Health Education activities; and four subcontracted Church Volunteer Coordinators will coordinate church volunteers to provide 1,000 volunteer hours during health education activities. Dr. LeGrande will provide 50

hours of training; Dr Boholst will provide 50 hours of training; and Health Department Nutritionist will provide 10 hours of training.

The Health Education component consists of Churches and Church Volunteer Coordinators, Community Outreach Workers, Doulas, Department of Health Closing the Gap Program Coordinator, Licensed Clinical Social Worker, Perinatal Support Outreach Workers and Community Health Nurses. Health Education Services involve training of project staff, program participants, consortium members, public and private sector health care providers, and a communications network. Dr. Deborah Austin, Community Outreach and Communications Specialist/Project Manager will provide oversight and management of this function.

C. Resources or events that facilitated or detracted from successful initiation and implementation

Working in concert with Florida Department of Health (DOH), the Closing the Gap funding (State budget DOH, Children's Board of Hillsborough County), has afforded CHHS the opportunity of serving women outside of our target census tracts for maternal and periodontal screenings.

On June 8, 2000, Governor Jeb Bush took another step in addressing racial and ethnic disparities in Florida when he signed HB 2339, The Patient Protection Act, into law. HB 2339 provides the Department of Health $5 million for the creation and administration of the "Reducing Racial and Ethnic Health Disparities: Closing the Gap Grant Program." The prevention grants target infant mortality rates, immunizations for children and adults, HIV/AIDS, diabetes, cardiovascular disease and cancer. The Central Hillsborough Healthy Start Project (CHHS) is a recipient of one of the three "Closing the Gap" awards that focuses on maternal and child health. The mission of CHHS's Gap Grant is to mobilize the community and organize its resources in support of effective and sustainable programs that will assist in the reduction of racial and ethnic differences in the area of infant mortality and morbidity. The funding affords CHHS the opportunity to develop a coordinated system of community activities that capitalizes on the strengths of local people with the goal of developing community capacity for improving healthcare and social support. Our gap strategies/activities were lifted from a Community Action Plan devised by a grass roots community forum, REACH/THRED (Racial and Ethnic Approaches to Community Health/Task Force for Healing Racial and Ethnic Disparities), which addressed root causes for health disparity in infant mortality and morbidity in Hillsborough County.

1. **Increase screening for Bacterial Vaginosis (BV)** among Black women for early treatment and decrease the incidence of premature deliveries by Black women;
2. **Educate provider**, including distributing ACOG guidelines for BV screening and provider education materials on the increased risks of premature delivery in Black women due to higher incidence of BV;
3. **Educate consumers** about the risks associated with douching practices (intergenerational behavior) and BV, and benefits for treating BV as soon as it is detected; consumers will also receive information on maternal nutrition, periodontal disease and interconceptional care; and

4. **Train the trainer workshops** as a mechanism for the implementation of strategies that educate and support Black women on BV, maternal nutrition, periodontal disease and baby spacing.

The Closing the Gap Project Manager and the Consortium Advocacy/Education/Outreach Committee will continue to provide the leadership in recruiting new partners, garnering additional financial support and refining/retooling the REACH/THRED local health system/ community disparity action plan on a continuous basis. In addition, the CHHS staff will continue its participation on the local Title V Strategic Planning Committee.

Strategic Planning: The Healthy Start Coalition is required to submit a service delivery plan to the Florida Department of Health every three years. The committee that has been responsible for the development of this plan for the past 13 years has been the Plan Development Committee (PDC). Beginning in August 2004, PDC began the strategic planning process for the 2005-2008 Service Delivery Plan. This plan outlines the fund allocation of state Healthy Start service dollars, the quality assurance plan to monitor providers of Healthy Start services and the community-based strategies that the Coalition will address during the next three years.

PDC is chaired by Brian McEwen, PhD, Associate Executive Director of the Child Abuse Council, with Leisa Stanley, MS, Associate Executive Director of the Coalition as staff lead. This is the first time that the Coalition has hired an outside facilitator to guide the strategic planning process. Anne Cope is the former Executive Director of the Healthy Start Coalition in Brevard County and was responsible for the development of its service delivery plans. From September-December, the committee met for four hours each month and met for three hours in January. This process included an extensive needs assessment of the maternal child health indicators in Hillsborough County and the Healthy Start system of care. Once the committee had reviewed and analyzed the data, models for service delivery were developed and discussed. The committee then determined a method for provider selection for the new plan which will take effect November 2005. PDC will now turn its efforts to the development of a quality assurance system over the new system of care and the development of community-based strategies for key MCH issues. The selection of providers for the new plan will now fall under the auspices of the Coalition's Board of Directors. Materials used during this process can be found on the Coalition's website, www.healthystartcoalition.org, under the tab for Research and then under the tab for Service Delivery Plan.

PDC members have donated almost 20 hours per member to this effort. The role of the community in developing the service delivery plan has been a cornerstone of planning for this Coalition since 1992. This committee is composed of hospitals, social service agencies, agencies that fund services, the university, Healthy Start providers, and other MCH planning groups. The committee membership can be found on the website. Members with a direct conflict of interest are required to abstain from any vote concerning their agency. In addition to PDC, the work of other Coalition committees is processed through PDC and used in decision-making. CHHS project staff, Lo Berry and Delores Jeffers, were participants throughout this process.

INTERCEPTIONAL CARE

A. How we decided on our approach to service

In the initial Project Plan, Interconceptional Care was a modality of service within Care Coordination/Case Management. In this Project Period, Interconceptional Care has become a core service component with services and interventions outlined in a service delivery plan.

Interconceptional Care for High Risk Women/Infants is targeted at: pregnant women with a high risk condition requiring hospitalization; women identified as high risk at time of delivery (including women without prenatal care; women with fatal loss) who were not already enrolled; and women who deliver a high risk infant. Addressing interconceptional care for women in our service delivery plan and including community agencies has increased the availability of and access to a system of integrated continuum of care.

Current staffing capacity was not adequate to address the immense need of interconceptional care. In addition to their scope of work, existing staff shared responsibility of addressing interconceptional care. Staff time is limited because of caseload. Currently the benefits coordinator, the licensed clinical social worker and Perinatal Support Workers serve as high risk case managers and track women to obtain needed primary and specialty care. The Outreach Workers attempt to identify and recruit infants born with complications or special needs regardless of their enrollment in Healthy Start.

To enhance/improve current systems of Interconceptional Care, CHHS included in its proposed plan for services in calendar year 2003 to: create policies that define and fund staff/consumers ratios; hire a full time staff to serve as a high risk case manager to track women to obtain primary and specialty care; and coordinate and monitor the assessment, linkages for ongoing health care up to two years.

During the past three years, CHHS Interconceptional Care was addressed primarily by the Community Health Nurses and a Benefits Coordinator. Special outreach efforts were made at relevant sites such as the Project Area three clinics, community activities and hospitals during birth and delivery. Case managers guided and tracked high-risk women and infants as they accessed and received services through ongoing care coordination documentation, completion of encounter forms and through the referral system process. However, this was not enough to adequately address the unique needs of high risk women in the Project area.

Dr. Michael Lu of the UCLA School of Medicine, in his PPPSWH August 2004 Webcast, *Racial & Ethnic Disparities in Birth Outcomes: A New Perspective*, frames this component beautifully. He says, “If we’re serious about reducing disparity we have to start taking care of women before they get pregnant. And I’m not talking about the three months pre-conceptionally. I’m talking about when she was a baby inside her mother’s womb, an infant, a child, an adolescent, a young adult and we have to do more than healthcare. We have to take care of all the underlying causes of the disease and the multiple determinants of health (life course perspective).”

Thus, the Project will enhance Interconception services by implementing a new Interconception Care Component/model. This model will build its’ infrastructure by hiring an Interconception Care Coordinator who is critical to the future success of the Project. This staff position will be a member of the CHHS Project Senior Management Staff. Its primary function is developing the

Interconception component to include strategies that continue to engage previous and existing program participants to stay connected to health related services from their child's birth to two years old and to provide oversight to the peer support group network and address gaps in the current health education delivery system to change the attitudes of the target population and its community about preventative health. In addition, this position will work in concert with the Community Outreach and Communication Manager, Perinatal Nurse Manager and Licensed Clinical Social Worker. We anticipate that the increased staff capacity will allow additional series of support groups to be offered. The series will consist of six, six week long, semi-open groups of up to twelve program participants and their children.

B. Components of interventions and resources

Interconception services has been conducted by Healthy Start staff, subcontracts, state grant project and local providers. The CHHS staff provided one-on-one intervention; the Closing the Gap Project (State Grant) provided maternal infection and periodontal disease screens; the mental health subcontractor evaluated women with mental health issues and provide treatment and referrals; and a local provider, the Healthy Start Coalition of Hillsborough County, provided oversight and management of the Zero Exposure substance abuse pregnancy screen Pilot Project.

Oversight and management of Interconceptional Care will be provided by the Interconceptional Coordinator (a USF employee to be hired) who will further develop the interconception component to include strategies that further engage previous and existing program participants to stay connected to health-related services from birth to two (2) years old. The Scope of Work will include but is not limited to, managing and providing oversight to the peer support group network and addressing gaps in the current health education delivery system to change the attitudes of the target population and its community about preventive health care.

Services that will be provided to women and infants/toddlers through interconceptional care services are clinical support groups, peer support network groups, nutrition and baby spacing/planned parenting classes and one-on- one consultation with the Interconception Coordinator.

CHHS provides care coordination for infants and toddlers up to 2 years of age by case managers employed in the CHHS program: (Community Health Nurse (CHN)-The Chiles Center, Perinatal Support Outreach Support Worker (PSOW)-The Chiles Center and Licensed Clinical Social Worker (LCSW)-Family Service Association). Developmental screenings are provided by a local provider, ACHIEVE Tampa Bay, at CHHS monthly Community Consortium Meetings.

The frequency of contact with Healthy Start staff and interconceptional program participants will vary case by case. Interconceptional Care activities will be held several times a week at church sites and partnering agencies. The monthly community consortium meetings will be the primary venue for face-to-face contact with administrative project staff and community service providers.

Community Outreach workers will complete a home visit/interview with all program participants at six weeks after delivery/birth as well as a satisfaction survey that contains additional health behavior items, including a question asking whether or not a woman completed her postpartum

check up with a medical provider. Additionally, program participants who received Incentive points for completing this check up can be tracked through the Incentive Cards.

Successful Interconception Care interventions and strategies that have been in place are: (1) Annual one and two year old birthday party (2) satisfaction survey administered 6 months and 1 year after case is closed (3) developmental screenings at monthly Community Consortium meetings (4) postpartum baby care plan completed by Benefits Coordinator and (5) peer support network groups.

The Peer Support Network Groups have proven to be the most popular activity for program participants. The program participants themselves have been instrumental in engaging women to participate in the group activities. Some of the women who have participated are women who were not already enrolled in Healthy Start and who have had previous adverse outcomes.

Additionally, the developmental screenings were provided by a licensed physical therapist at the monthly Community Council Meetings. Seventy-two screens have been provided since FY 2003. Of those screens, 39 children were diagnosed with developmental delays.

C. Resources or events that facilitated or detracted from successful initiation and implementation

Two of the major barriers presented to this component were:

1. Lack of adequate coordination to enroll infants and toddlers whose mothers were not enrolled in our Healthy Start Project. Thus we have created a referral process to interconception care group/activities for infants and toddlers whose mothers were not enrolled in CHHS. Each hospital in the project area is now responsible for completing a Healthy Start Postnatal Screen on the baby, which is also processed through Hillsborough County Health Department and forwarded to Healthy Start units. Additionally, our outreach workers will complete CHHS internal referral forms.

   In addition, weekly care coordination team meetings are held with representatives of all care disciplines (CHN, Doulas, Perinatal Support Workers, LCSW, Benefits Coordinator and Management). This team provides linkages with the system of care that provides the primary specialty care services for high-risk infant/toddlers (Children Medical Services, Florida AIDS Network, Protective Services, Department of Children and Families, Substance Abusing Mothers and Infants – SAMI/DACCO, Advance/Ability Solutions, etc.)

   CHHS will continue to collaborate with State and Local Title V Agencies to create policies that define and fund staff/consumers ratio. In addition, we are requesting to hire a full time staff person to serve as a high-risk case manager who will track women to obtain primary and specialty care; coordinate and monitor the assessment; and provide linkages for ongoing health care up to two years.

2. Staffing capacity is not adequate to address the immense need of interconceptional care. In addition to their scope of work, existing staff share responsibility of addressing

interconceptional care. Staff time is limited because of case load of high risk clients who are serviced in-home.

DEPRESSION SCREENING AND REFERRAL

A. How we decided on our approach to service

In 2002, CHHS implemented a depression study protocol under the guidance of Cecelia Jevitt, CNM, Ph.D. to determine if community health nurses could use the Edinburgh Postpartum Depression Screen (EPDS) as part of their routine prenatal and postpartum assessments. Further the study attempted to determine if depression could be diagnosed prenatally using the EPDS, enabling mothers to receive help before the demands of newborn care.

Conclusions from the study indicate that the EPDS can be used by nurses to identify women at risk for depression; can be used prenatally and prior to 6 weeks postpartum to screen for depression; and can identify potential depression in adolescents and Black women. Lowering the cut-off score for a positive EPDS may identify Dysthymic Disorder. Depression and Dysthymia are significant problem for this population as evidenced by routine prenatal screening.

As a result of these findings, CHHS incorporated training topic, "I am too comfortable with being "down in the dumps"!" into the Clinical Support Groups and offered Dysthymic Disorder trainings to other MCH agencies locally and statewide.

At the time the depression diagnosis protocol was developed in 2001, no Tampa prenatal care provider did routine prenatal or postpartum depression screening. Central Hillsborough Healthy Start had a team of three community health nurses who provided case management including home assessment, prenatal and childcare education, newborn physical and developmental screening and lactation support. The CHNs made referrals for social services, GED completion, and housing. The model was similar to British District Nursing limited to Perinatal and newborn care. CHN's were assigned 4-7 census tracts. The number of census tracts assigned was balanced for the average number of open cases within the census tract. One Spanish speaking CHN covered all 17 census tracts for women who spoke only Spanish and, therefore, were assigned a smaller permanent census tract area. CHN had a baseline productivity expectation of 5 home visits per day.

The Edinburgh Postpartum Depression Scale was chosen as the depression-screening instrument because it is the only depression scale validated for use in the postpartum period. The EPDS is a ten item self-administered survey. It can be completed quickly by the program participant and scored easily. The depression screen is administered to a program participant at the initial contact visit by the Community Health Nurse or Perinatal Support Outreach Worker.

CHHS has adapted the screening process to account for cultural differences by having a Spanish speaking nurse and African American staff to administer the tool when necessary. The EPDS screen has been translated/modified in Spanish. Staff can also read the instrument to assist the women that have problems with literacy.

B. Components of interventions and resources

Initially, 2002, a certified nurse midwife (CNM) was hired, via College of Nursing contact, to provide a higher level of maternal and newborn assessment and diagnosis in the postpartum period. When USF College of Nursing ceased participation in the Perinatal depression study, May 2003, (Nurse Manager did not have extra time needed to dedicate to the project), the component was restructured so that the Community Health Nurses and Perinatal Support Outreach Workers (case managers) could administer the EPDS. This test is administered upon entry to the program. The levels that are scored in the test are described as follows:

1. **LEVEL 1 PRN Support Needs**---- If the Edinburgh Postpartum Depression Scale is scored at 9-10, the program participant is considered a level one and needs to be referred to the Licensed Clinical Social Worker (LCSW). The LCSW will be responsible to initiate services within 5 business days from referral date.
2. **LEVEL 2 Routine Service Needs**----If the Edinburgh Postpartum Depression Scale is scored at 11-15, the program participant is considered a level two and needs to be referred to the LCSW. The LCSW will be responsible to initiate services within 3 business days from referral date.
3. **LEVEL 3 Complex Service Needs**---- If the Edinburgh Postpartum Depression Scale is scored at 15 or higher, the program participant is considered a level three and needs to be referred to the LCSW. The LCSW will be responsible to initiate services within 24 hours of referral date.

The services and the provision of these services are as follows:
Upon entry into the program, the nurses and the Perinatal Support Outreach Workers (PSOW's) administer the EPDS. The LCSW review all Edinburgh Postpartum Depression Scales that are generated. However, those Edinburgh Postpartum Depression Scales that are administered and are scored significantly high enough to become a level I, II, or III are passed on immediately to the LCSW along with a referral including the program participant's demographics. At this time the LCSW reviews and responds to the referral. The LCSW is subcontracted through The Centre for Women/ Family Service Association of Greater Tampa, Inc. It is a private not for profit organization that was founded in 1907. The mission of the organization is to promote and strengthen the family unit, to empower individuals to achieve self-sufficiency, and to promote a supportive sense of community through mental health, social services, family life education, and advocacy to the residents of Hillsborough County. The LCSW responds to the referral in the timeframe specified by the leveling system.

During the provision of mental health services, it may be apparent that a program participant could benefit from attending a group. As a result, the LCSW and other Healthy Start staff can initiate a referral to one of the groups offered. There are English and Spanish groups available. These groups are held at local churches and at the Family Service Association. Transportation is provided to and from the group.

All staff will be able to educate program and community participants about signs and symptoms of depression. The staff were provided with instruction via workshops and seminars and other relevant activities and materials to educate them about the signs and symptoms of perinatal

depression. This education prepares the staff to become better equipped to inform the program participants and the community at large about the signs and symptoms of perinatal depression, child abuse, neglect and other mental health topics. When a staff member becomes aware of a program participant's depression through the observation of visual signs and/or symptoms of depression or as they administer the EPDS and receive its results, education of the program participant begins. Once the mental health therapist initiates work with the program participant, further education is possible and the therapeutic process will begin. Peer support groups, each approximately two hours in length, also provide education and promote the facilitation of mental health receptivity. Additionally, a brief segment entitled "Mental Health Minutes" is presented during the monthly Community Consortium meetings to help increase the community's awareness of mental health issues.

C. Resources or events that facilitated or detracted from successful initiation and implementation

Events that facilitated successful initiation and implementation include:

All Care Coordination staff members who provided direct care to program participants were mandated to complete three culturally sensitive mandatory staff trainings provided by CHHS Project management staff in order to enhance/strengthen community based intervention services. Trainings: 1)Signs and Symptoms of Maternal Depression 2) Debunking Myths of the Black Family and Access to Mental Health Treatment and 3) Screening for Perinatal Depression.

In addition, the Licensed Clinical Social Worker and Project Director provided three basic mental health trainings for all staff to learn how to identify types of postpartum depression and risk factors, discuss treatments modalities, demystify the conditions and identify the stereotypes. Clinical staff received three additional trainings to learn how to quantify their recognition of the symptoms of depression using relatively simple instruments and expose them to the diagnostic criteria and treatment options.

As a result of CHHS efforts, community capacity for integrating depression screening into local health care within our seventeen census tracts has increased. CHHS established a Perinatal Depression Committee that established a Rapid Response Treatment Plan for CHHS moms identified with depression. As a continuous quality improvement event, the committee has quarterly patient care monitoring meetings to address high risk cases (depression, substance abuse, legalities and deaths), liability concerns and appropriateness of care. Treatment strategies/interventions are used in cross trainings of various agencies.
Currently, the local and several of the 31 state Healthy Start Coalitions are exploring using the EPDS for Healthy Start project sites throughout the state.

Using 10% incidence as an estimate of postpartum depression along with the projected number of 400 mothers being served by CHHS, we anticipated at least 40 mothers a year will need an initial Psychiatric Evaluation, thus, the need for ongoing psychiatric care. Between September 2002, and April 2003, the CHHS project staff conducted a pilot study to identify the prevalence of perinatal depression in the CHHS project service population. CHNs administered the Edinburgh Perinatal Depression Scale (EPDS) to 180 mothers being served by the project. Sixty

(33.3%) women screened positive for depression and were referred to a licensed clinical social worker (LCSW) for diagnosis and treatment. Diagnostic testing was completed on 26 (43.3%) of the women referred: 5 (19.23%) received a diagnosis of depression, 14 (53.85%) received a diagnosis of dysthymic disorder; and 7 (26.92%) were not depressed. Thus, 19 of 26 women (73.1%) receiving diagnostic testing were depressed or dysthymic. Applying this percentage to the 60 women referred for further assessment due to elevated EPDS scores, it is estimated that 44 of 180 women screened, or 24.44% of the target population were depressed or dysthymic.

Since April 30, 2003, an additional 68 women have been screened for depression from 11/2003 to 9/30/2004. Of those, diagnostic testing and mental health assessment was completed on 32. Of women receiving diagnostic testing, 7 (21.9%) were diagnosed with depression, and 8 (25%) received a diagnosis of Mood Disorder/Dysthymic Disorder.

CHHS has identified Dr. Renea Hainey who is willing to treat pregnant women who are diagnosed and undiagnosed with mental illnesses. Services will be reimbursed based upon current Florida Medicaid rates.

CHHS was privileged to be one of the eleven Healthy Start sites to receive free technical assistance (HRSA funding) from Dr. Michael W. O'Hara, Professor of Psychology, University of Iowa and Co- Director of the Iowa Depression and Clinical Research Center. Dr. O'Hara provided two days (8/25-26/2004) of Perinatal Depression training to CHHS and community service providers. The training prompted two staff people to seek mental health services. Both are currently in therapy. Dr. O'Hara stated that he was impressed with the depression component, particularly the trainings that CHHS provides.

FOUR CORE SYSTEMS-BUILDING EFFORTS

LOCAL HEALTH SYSTEM ACTION PLAN (LHSAP)

A. How we decided on our approach to service

Our community utilizes LHSAP and a supplemental Local Health System/ Community Disparity Action Plan. The Local Health System Action Plan for comprehensive prenatal care is the Service Delivery plan for comprehensive perinatal care developed by the Healthy Start Coalition of Hillsborough County and approved by the State of Florida Department of Health (DOH). This plan allocates state funds for Florida Healthy Start services in Hillsborough County to provide Care Coordination and risk reduction services for pregnant women and infants who accept risk screening and participation in the program. The CHHS Project became a Care Coordination provider for the Healthy Start Coalition (HSC) of Hillsborough County in 2001, targeting only women in the CHHS project area census tracts.

The primary planning body addressing perinatal healthcare and outcomes is the Healthy Start Coalition of Hillsborough County. The HSC conducts the community needs assessment, oversight, and evaluation of perinatal wrap around services. Healthcare institutions, providers, program participants, and other stakeholders are actively engaged in those processes. See

Appendix B for LHSAP Local Performance indicators. The entire document is 15 pages and is available at HRSA Office, Lieutenant Gail Davis.

The supplemental Local Health System/ Community Disparity Action Plan was created because the Local Title V LHSAP did not include strategies/activities to address infant mortality disparity among Blacks in 1999. Under the leadership of REACH (Racial Ethnic Approaches to Community Health)/THRED (Task to Health Racial and Ethnic Disparity), Central Hillsborough Healthy Start, Program Participants, Partners, Healthy Start Coalition and Community Stakeholders assisted in the development of the REACH/THRED Local Health System Disparity Action Plan.

The REACH/THRED Local Health System/ Community Disparity Action Plan (see Appendix C) that address maternal and child health disparities was created by broad based citizenry (41people) who represent the Black communities in Hillsborough County. This planning process helped these communities to understand that they have the capacity to become major stakeholders in a public health initiative. Community members were able to come to the table and join others in developing policies and procedures for comprehensive health planning, accessibility and utilization of appropriate health and human services. This plan has been embraced by the CHHS Closing the Gap and CHHS Projects. The plan is a continuous process. While we have addressed some service gaps during the past year, many continue to exist in our local Perinatal system of care.

B. Components of interventions and resources

A broad base of participants were involved and continue to be involved in developing and implementing the LHSAP's. Some of which are: State Title V Health Office, Hillsborough County Healthy Start Coalition, Operation MedCare, Veterans in Business Inc., Children's Board of Hillsborough County, Family Enrichment Center, National Conference for Community and Justice, REACH Projects, Wages Coalition, Head Start, Corporation to Develop Communities of Tampa (CDC), USF College of Public Health, Hillsborough County Health Department, Florida AIDS Network, faith community, and community and program participants.

CHHS, in conjunction with REACH/THRED and Hillsborough County Healthy Start Coalition (Title V), identified that the primary cause of infant death in Hillsborough County for Black infants as pre-term birth, which is associated with the Maternal Health/ Prematurity Period of Risk. Among the contributing risk factors to premature delivery identified by THRED were Maternal Infections/ Bacterial Vaginosis, maternal nutrition, periodontal disease and baby spacing. Strategies and detailed action steps were developed to address these causes of prematurity in Black births.

The development of the Supplemental Local Health System/ Community Disparity Action Plan began with a review of secondary data sources, such as Florida Vital Statistics, Fetal and Infant Mortality Review (FIMR), and Periods of Risk Analysis provided by Healthy Start Coalition. Primary data tools were designed and used to collect data through 14 focus groups and 480 surveys targeting Black women of childbearing age (18-44) and their partners. The results of this data were also presented to REACH/THRED to provide an empirical rationale for the

selection of intervention activities. Task Force members utilized the findings in the literature and the primary and secondary data sources to select and prioritize the primary cause of death and contributing factors that are tied to education and prevention.

CHHS Closing the Gap has taken the lead on five of 13 strategies:

1. Create a self-management training to educate individuals who will, in turn, be prepared to train others and become "change agents" in the community. Training will consist of information on behaviors that can reduce infant mortality, including douching practices and Bacterial Vaginosis; maternal nutrition; periodontal disease; and baby spacing.
2. Consumer Education about the risks associated with douching practices and BV as well as periodontal disease.
3. Provider Education will include the distribution of ACOG guidelines for BV screening and treatment and provider education pamphlets on the increased risks of prematurity in Black women due to higher incidence of BV infection associated with douching practices. In addition, practitioners will be educated about the risks of periodontal disease and prematurity.
4. Increase Screenings for Bacterial Vaginosis among African American women for early treatment and to decrease the incidence of premature deliveries by African American women.
5. Increase Screenings for Periodontal Disease among African American women for early treatment and to decrease the incidence of premature deliveries by African American women.

Nine major gaps in access to and quality of perinatal services have been identified in this plan: Culturally Competent Health Care Providers, Transportation, county wide Perinatal Depression Screenings, Rapid Response Intervention, Health Education Training, Waiting Lists, Medicaid Enrollment, Accessibility of Ps, and Substance Abuse Screening for Pregnant Women. A detailed description of the entire Local Health System Disparity Action Plan that describes ongoing collaborative mechanisms and intended efforts to work with existing community services to achieve an integrated system of care for the targeted population is available upon request (14 page document).

In 2001-2003, CHHS's Community Consortium took the lead on two of the nine service gaps that were found to exist in our local Perinatal system of care: culturally competent health care provider gap and transportation gap. In December 2003, the Florida State Healthy Start Program (Healthy Start Coalition of Hillsborough County) took the lead on reestablishing Fetal Infant Mortality Review (FIMR) in Hillsborough County.

In 2004, a new initiative was launched by the Hillsborough County Kids' Health Foundation to design a model maternal and child health care system in preparation for the eminent restructuring of the Florida Medicaid Program. The work group to develop the plan is being facilitated by the Chiles Center. Health care leaders involved in the planning include senior representatives of the Hillsborough County Health Plan, USF College of Medicine, Healthy Start Coalition of Hillsborough County, Hillsborough County School District, private practitioners, the Children's Board of Hillsborough County, and the Central Hillsborough Healthy Start Project.

C. Resources or events that facilitated or detracted from successful initiation and implementation

The REACH/THRED LHSAP Community Disparity Action Plan was developed in 1999. At the time of creating the plan, the biggest barriers were the political environment, i. e. being inclusive of the broader community while maintaining the lead in the effort and the lack of sufficient resources to address all the strategies outlined in the plan. Henceforth, the biggest barriers are maintaining the momentum and high level of participation and lack of sufficient resources to address all the strategies outlined in the plan. The ways in which we will overcome these challenges are: Broadening our level of constituents to the consortium, Inter agency Case Conference Reviews, Interagency Management Team Meetings, Cross Agency Trainings and Cultural Competency Trainings.

The LHSAP assists in setting priorities for Healthy Start programming by identifying service gaps. Some of the service gaps that exist in our local perinatal system of care include:

1. Culturally Competent Health Care Providers –This gap is being addressed by REACH and CHHS Community Consortium.
2. Transportation –This gap is being addressed by the CHHS Faith Initiative and Community Consortium.
3. Perinatal Depression Screen –The CHHS Rapid Response Treatment Team (RRTT) and Florida Federal Healthy Start projects are addressing this issue.
4. Lack of Adequate Health Education Trainings –The CHHS Health Education Trainings address this gap.
5. Waiting Lists –This gap is being addressed in the CHHS Interagency Management Team Forum along with Project plans to subcontract with a local psychiatrist who is willing to accept Medicaid reimbursement rates.
6. Medicaid Enrollment – Inability to access Medicaid eligibility in a timely fashion. The CHHS Perinatal Support Outreach Workers and The Chiles Center Kid Care staff are addressing this issue.
7. Accessibility of Program participants – Mobility and transience of pregnant and postpartum moms. CHHS subcontracts for transportation. The Hope VI Project, Children's Board of Hillsborough County, and Allegany Franciscan Foundation will address this gap.

Some of the other organizations involved include local hospitals, Hillsborough County Health Department, Florida Perinatal Associates, local community agencies, Florida Birth Defects Registry/Department of Pediatrics/College of Medicine. The Healthy Start Coalition of Hillsborough County also provided the Perinatal Periods of Risk Assessment for the entire county.

The LHSAP and REACH/THRED Disparity Action Plans focused political attention on specific priorities/deficiencies in Maternal Child Health Care. Both plans have contributed to influencing the Children's Board in some of its focus in the 2012 Strategic Plan. The Children's Board of Hillsborough County (CBHC) is a special taxing district FY Budget $30,711,216 dedicated to improving the lives of children and families by developing local prevention and early intervention services. Their 2012 Strategic Plan has expanded their focus to develop

comprehensive and integrated services to pregnant women and children from birth to age eight, and their families.

The LHSAP REACH/THRED Disparity Action Plan provided the CHHS Consortium with priorities/direction: The CHHS Consortium and Closing the Gap Committee added the strategy of Periodontal screening in the CHHS/Closing the Gap Grant Application July 1, 2003. The periodontal screenings was refunded for July 1, 2004 – June 30, 2006. While the need for periodontal screening is clear, as is evidenced by latest data from March 2005 wherein 64.6 % of women screened positive for periodontal disease, the service is underutilized. REACH/THREAD members will address strategies/interventions to promote screening and enhanced level of comfort receiving orthodontal treatment.

The LHSAP REACH/THRED Disparity Action Plan provided a framework for developing collaborative relationships: One of the collaborative partnerships facilitating community perinatal health systemic change was the Healthy Start Intake Day: In this venue, CHHS initiated Family Wellness Fairs to target pregnant Haitian women. Some of the other providers who will continue participating to engage this hard to reach population include: Hillsborough County Health Department, WIC, Tampa AIDS Network, Catholic Charities, Medicaid and State Healthy Start.

The LHSAP also provided local Maternal and Child Health agencies with priorities/direction: The Lawton and Rhea Chiles Center, through a cooperative agreement with the Center for Disease Control and Prevention and other collaborating partners, has created/funded the National Friendly Access Program. This initiative systematically addresses and evaluates access and utilization of services available to Medicaid eligible women, as well as the barriers they experience.

Jane Murphy and Leisa Stanley of the local Title V Agency, the Healthy Start Coalition of Hillsborough County, reinstated the Fetal Infant Mortality Review (FIMR) in our community in December 2003. Some Chiles Center team members include: Chair, Dr. Charles Mahan, USF Chiles Center, Lo Berry, USF Chiles Center/CHHS and Dr. A. Peter Gorski, USF Chiles Center.

The Disparity LHSAP has promoted a comprehensive system of Perinatal Care. CHHS will continue to contribute to a comprehensive system of care and the local system action plan to improve maternal and infant health. The closing the Gap Project Management Team and the Consortium's Advocacy/Education/Outreach committee will provide the leadership on recruiting new partners, garnering additional financial support and refining/retooling the REACH/THRED Local Health System/Community Disparity Action Plan on a continuous basis.

CONSORTIUM

A. How we decided on our approach to service

The Community Consortium, which was organized in 1998, provides the mechanism by which CHHS Project Area program participants, providers, and residents actively participate in the process of building community capacity for supporting and nurturing pregnant women and

infants. It is the conduit for input and feedback on critical issues and is vital in the sustainability of Project services. The Consortium was created to have a venue whereby consumers and community residents could take leadership roles in assessing the community's ongoing needs. The Consortium has built strong ties between consumers and Healthy Start service providers.

B. Components of interventions and resources

A major component of the consortium is the faith community. During the past six years, four churches have continued to be an intricate component of the Community Consortium. Church Volunteer Coordinators must be commended for going above and beyond their contractual duties in providing services to CHHS program participants. For example, one church enlisted their volunteers to teach a new mom, in jeopardy of losing her child to the foster care system, how to keep her apartment clean and orderly. In another instance, a couple whose baby died was visited by one of our pastors and his wife during their time of bereavement. Still another Volunteer Coordinator donated a dress suitable for a wedding to a program participant who decided to get married.

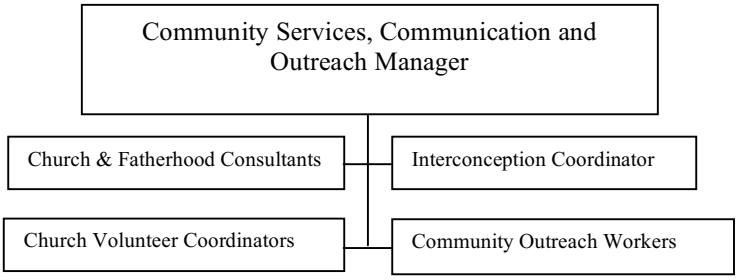
CHHS continues to work diligently to assure that we have a participatory process. We strive for our process to be equal in inquiry, discovery and change. CHHS Community Consortium embraced the various contributions that community folk brought to the table. CHHS is totally committed to broad-best community representation and involvement at all levels of the Healthy Start Project. As the momentum of the Consortium remains high, the commitment to the original goal of the community becoming the primary stakeholder in the Healthy Start Initiative is enhanced. We are excited that our most recent HRSA award allowed us to hire Carla Andrews, a program participant, who served as the Consortium Co-Chair for 3 years, in the position of Community Outreach Worker. Carla graduated from the University of South Florida with a degree in Interdisciplinary Social Sciences in December 2004.

The consortium is aligned with the select construct Community Engagement and Mobilization Team. The Community Engagement and Mobilization Team is responsible for mobilizing community assets to provide mothers and their partners and families, educational, emotional, and physical support during pregnancy, childbirth, and early parenting aimed at promoting maternal and infant health and social outcomes. Team staff include:

- The Community Services, Communication, and Outreach Manager, with a high degree of expertise in family communication, literacy, and community dynamics, who coordinates the Community Consortium and supervise the other members.
- Interconception Coordinator (1.0 FTE) who establishes and lead peer support groups for expectant and new mothers aimed at ameliorating perinatal depression while promoting healthy pregnancy spacing, maternal/infant attachment, parenting behaviors, and family literacy.
- Community Outreach Workers (3.0 FTE) who recruit program participants into prenatal care and the Project, conduct program participant satisfaction surveys, encourage program participants to participate in Community Consortium and other community based Project activities;

- Community Church Volunteer Coordinators (4) who coordinate an agreed upon set of services for Project program participants which includes use of church facilities for program participant educational and interaction activities and transportation to Community Consortium meetings.
- Church Ministerial Consultant who engage other Pastors and Congregations in providing additional support in the form of health advocacy and education, recruitment and retention, volunteers and material resources.
- Fatherhood Consultants who engage dads into Healthy Start services in concert with other team members and promote fatherhood involvement in MCH activities.

Flowchart B. Community Engagement and Mobilization Team



C. Resources or events that facilitated or detracted from successful initiation and implementation

One of the major goals of the Consortium was to assess the community's ongoing needs. Three activities undertaken by the Consortium to assess these needs were the Community Consortium Subcommittees, Interagency Management Team and Consumer Panel. The subcommittees within the Community Consortium assessed the Project's progress toward goals and objectives. The subcommittees identified barriers and gaps in services and then strategized to eliminate these barriers. These committees: a.) provided examples of how a community consortium can be instrumental in sustaining viable services within the community, b.) encouraged the mobilization of professionals and non-professionals to work in a holistic and inclusive manner that fostered self-sufficiency among families and, c.) emphasized the urgency in defining the key participant as the consumer, who is the recipient of services.

A major accomplishment for the Community Consortium is its level of commitment and participation. Attendance (average 65) is consistent. Since the Project's inception, program participant/consumer participation improved 200%, ranging from 40% to 64% the past four years. Additionally, the cost of managing the Community Consortium decreased significantly (from $150,000 to $83,000) because of the amount of community services generated by community resources.

D. **<u>Additional</u> elements:**

1. As part of CHHS, the Community Consortium established an alliance between providers, community leaders, and consumers to increase the community capacity for the reduction of infant mortality and morbidity. Consortium members include community residents, consumers, stakeholders, churches, hospitals, local businesses, private and non-private agencies, social services and a community library.
2. At project inception, the Consortium was managed and over sighted by the local Healthy Start Coalition (Title V Agency). In October 1998, CHHS management team began providing oversight of the Consortium component. Since February 1998, the Community Consortium has provided invaluable input and feedback on critical issues and needs within the project area. The following table shows a racial and ethnic profile of the consortium members who regularly attend meetings:

Table H. Previous Breakdown Of Consortium By Percentage For 2001-2005

Race/Ethnicity	Percentage
White	21%
African American	65%
Pacific Islander	<1%
Hispanic	13%

Table I. Anticipated Breakdown Of Consortium By Percentage For 2005-2008

Race/Ethnicity	Percentage
White	19
African American	*64
Pacific Islander	< 1
Hispanic	15
Bosnians	<1

The following categories are represented on the consortium:

- state or local government (G): 5%
- program participant (PP): 50%
- community participant (CP): 10%
- community-based organizations (CBO): 15%
- private agencies or organizations (not community-based)(PAO): 5%
- providers contracting with the Healthy Start program (PC): 15%

3. The Consortium meets on the first Wednesday of each month. The meetings rotate at four church sites. The meetings last 1.5 hours and lunch is provided by the host church. Attendance ranges from 45-72 people, with an average of approximately 65 people. The number of Community Consortium roster members has ranged from 170-184. The service providers, stakeholders, volunteers and community residents actively participate in the

creation and implementation of CHHS project activities. Activities include: 1) Integration of Health Literacy into Community Consortium to address maternal education status; 2) Participation in Local Health System Action Plan (LHSAP); 3) Participation in a "Community Baby Shower/Health Fair/Family Day"; 4) Participation in the Fatherhood Initiative emphasizing the role of men in parenting through education and culturally sensitive marketing techniques; 5) Participation in Interagency Management Team Meetings; 6) Participation in the Cultural Competency Trainings; 7) Participation in Community Health Summit, co-sponsored by March of Dimes; and 8) Participation in Community Consortium Leadership Trainings designed to encourage and support the goals of reciprocal investment and participation by consortium members in the planning, implementation and evaluation of services provided by CHHS.

4. Our neighborhood is defined as the East Tampa Neighborhood, a vibrant and culturally rich community which continually sustains itself despite the disproportionate economic, health and social challenges presented year after year. Within the project area there are numerous churches, schools, revitalized housing units, a community college and a library. CHHS continues to work diligently to assure that we have a participatory process. We strive for our process to be equal in inquiry, discovery and change. CHHS Community Consortium embraces the various contributions that community folk bring to the table. CHHS is totally committed to broad-best community representation and involvement at all levels of the Healthy Start Project. As the momentum of the Consortium remains high, the commitment to the original goal of the community becoming the primary stakeholder in the Healthy Start Initiative is enhanced.

   Community strengths include but are not limited to:
   1. Resiliency
   2. Inherent ability to nurture family
   3. Volunteerism
   4. Innovative Thought
   5. Passion and Determination
   6. Sustains itself despite disproportionate economic, health and social challenges
   7. Unafraid of new challenges
   8. Celebration of successes
   9. Open to partnerships and collaboration
   10. Charitable and benevolent
   11. Extensive intellectual capital

5. Barriers that had to be addressed in order for the consortium to move forward were:
   a. Consumer participation (consumer participation has increased from <2% to 60% during the past seven years)
   b. Maintaining critical stakeholders in memberships as the amount of consumer participation increased
   c. Competing agenda of member organizations
   d. Insufficient state resources to support goals of the consortium

6. The strategy most effective to increase consumer participation was the incentive program, which was designed to increase participation in Healthy Start activities and promote the completion of family support plan activities. This program is a point redemption system. This means that consumers are not given cash for utilizing a particular service or participation in any particular activity. Instead, they are awarded a certain number of points. At the beginning of each new month, the consumers bring the cards to the Community Council meeting where points are compiled and gift cards, in multiples of $10.00 are distributed according to the points accrued. The CHHS Incentive Program would be defined as a completion-contingent rewards program. The goals of the CHHS Incentive Program are not only to encourage the use of services but also to place the consumers in an environment where they are able to observe and appropriate, through relationships with persons who become role models and mentors, positive attitudes toward and motivation to develop beneficial health behaviors.

   Please see Appendix D for Incentive Point System Chart. Hillsborough County Closing the Gap Project has been instrumental in providing incentives to community residents who participate in health related activities.

7. Consumers played a vital role in an advisory capacity as well as Project implementation. As stated previously, the CHHS consortium Co-chair has been a consumer of Healthy Start Services. Self-advocacy and self-empowerment are major vehicles for bringing about individual and community enhancement. In order to carry out the goals and objectives in this initiative, empowerment and leadership training activities were provided.

   Closing the Gap Marketing – Consortium members have participated in the development of culturally sensitive brochures, posters and community advertisements (Closing the Gap Marketing Materials are on file with Project Officer, Lieutenant Commander Gail Davis).

   Consumer Participation/Outreach & Recruitment – Led by a Senior Outreach Worker and Administrative Assistant, this committee oversees the Incentive Program. The Incentive Program is designed to increase participation in Healthy Start activities and promote the completion of family support plan activities. Incentive cards are on file at Project Officer's office.

   The consumers have participated on Search Committees with University Administration and staff to select key positions such as QI/QA Manager, Interconception Coordinator, Clinical Records Clerk, and Outreach Workers. Consumers review evaluation data collection instrument/tools. Consumers also participated in Summit II Workshop by sharing their personal Healthy Start stories and advocating for the continuance of the Project.

8. Consortium members led the development of the creation of culturally sensitive brochures, posters and community advertisements; assisted in design of the incentive program; assisted with development of Disparity Community Action Plan; and co-led community baby shower and community toddler birthday party.

COLLABORATION AND COORDINATION WITH STATE TITLE V AND OTHER AGENCIES

A. How we decided on our approach to service

CHHS has incorporated Florida FY2001 Maternal Child Health Needs Assessment into its Workplan and Local Health System Action Plan. The Title V Needs Assessment of Florida (2000) reported that strategies and interventions funded by Florida's Title V MCH Block Grant have supported many of the gains in MCH outcomes. However, data trends, MCH research and HRSA CHHS eliminating disparities data suggests that future gains in the areas of health disparities in maternal and child health will become more difficult to achieve as providers encounter underlying factors related to the most difficult health problems.

As discussed previously, Healthy Start Coalition of Hillsborough County (HSCHC) established a Memorandum of Understanding with The Chiles Center allowing CHHS to become a Care Coordination service provider for East Tampa Area (17 census tracts) with the poorest health and social outcomes. CHHS delivers prenatal, postpartum, and labor and delivery services to women in 17 census tracts from zip codes 33602, 33603, 33605 and 33610 in central Hillsborough County.

CHHS and its Community Consortium are represented on the HSCHC Systems Committee and Planning Development Committee. The Healthy Start Systems Committee was established to bring together Healthy Start providers and other providers of Maternal and Child Health (MCH) services on a monthly basis. Issues within the Healthy Start system and the larger MCH system are discussed and resolved at these meetings. The Committee serves to improve linkages among home visitation providers. Healthy Start's Planning Development Committee has the responsibility of monitoring and reviewing system issues affecting the care coordination and MCH systems. Membership on this committee is reserved for representatives from area planning and funding agencies and systems that intersect with Healthy Start. The at-large membership comes from the HSCHC Board of Directors and/or Voting Membership.

In June 2001, after a decade of experience, the State of Florida was granted a Medicaid MediPass Section 1915 (b) (1) Waiver to address barriers and systems issues to continue progress towards the reduction of infant mortality and morbidity. To avoid inappropriate billing for Care Coordination services that are currently funded by Federal Healthy Start dollars, the Hillsborough County Healthy Start Coalition neither bills the state for CHHS-provided Healthy Start services nor compensates the CHHS Project for its services with funds earned from the Medicaid Waiver. However, the CHHS Project continues to document the level of services provided program participants and reports all SOBRA (program resulting from the provisions of the Sixth Omnibus Budget Reconciliation Act) eligible program participants for counseling on selecting a provider. In addition, CHHS Perinatal Nurse and Project Outreach Workers refer all potentially eligible program participants residing outside of the Project Area to the County Health Department for services.

In addition to our collaboration with HSCHC, CHHS works with Florida's Title V MCH Director, Annette Phelps, ARNP, MSN, to integrate perinatal systems of care statewide. An

additional statewide effort that is addressing maternal and child health care is the March of Dimes Florida Chapter's emphasis on prematurity. One of CHHS Community Consortium members, Dr Charles Mahan, CHHS Consortium member is the March of Dimes Prematurity Campaign Chair.

KidCare/SCHIP: Florida has the third largest SCHIP program in the nation. For the past four years, The Chiles Center received funding from Medicaid and Robert Wood Johnson Foundation, Inc. to improve the FL KidCare Children's Health Insurance Program and increase the number of children enrolled in FL KidCare outreach efforts throughout the state. CHHS provided in service training to Florida KidCare Program Directors and was featured in the Florida KidCare Innovation Newsletter highlighting innovative outreach strategies. CHHS partnered with The Chiles Center KidCare Marketing and Public Relations Committee led by Jodi Ray to promote the January 1-30, 2005 open enrollment for Healthy Kids and KidCare. More than 342,000 Florida children already benefit from this health insurance program but many more are eligible.

B. Components of interventions and resources

CHHS has been successful in its inclusion of service providers, hospitals, health centers, schools/university, churches, community-based and minority organizations in planned coordination and service coordination. All of the community-based organizations embrace specific goals/objectives of Healthy People 2010. Collaborations include: United Cerebral Palsy/Achieve Tampa Bay; Family Service Association of Greater Tampa; Child Abuse Council; Tampa General Hospital; St. Joseph's Women's Hospital; St. John Progressive Missionary Baptist Church; and College Hill Church of God in Christ.

In addition to the aforementioned formal partnership/collaborative efforts, CHHS has significantly increased field placement/internships and partnerships with various community consultants. We now accept a maximum of eight students annually that serve on a semester basis rather than a maximum of 2 students.

Dr. Kay Perrin, who teaches several Internet courses for undergraduate students at the University of South Florida, volunteered to take the existing state-approved Internet Education curriculum and design two Internet Parenting Program (IPP) courses. The new resources ($1500.00) from CHHS will assist in the update and conversion of IPP from the Internet format to CD-ROM format to improve the quality and accessibility.

CHHS partnered with The Workforce Development Grant at The Lawton and Rhea Chiles Center at the University of South Florida's College of Public Health to expand the duties of the three Outreach Workers who completed the Applied Technical Diploma (ATD) Program at Hillsborough Community College. The goals and objectives to expand current Outreach Worker skills and roles in ATD Program were realized.

The CHHS project will join forces with the Hillsborough County Health School Initiative addressing obesity in children. The focus of the "The Healthy School Initiative" is to educate parents, promote community awareness, and encourage community involvement in developing

healthy lifestyles at an early age for our children. This program represents an effort to prevent and reverse the growing problem of obesity and chronic diseases in children and adults, and implement strategies to promote good nutrition and increased physical activity. Part of this initiative provides expanded growth and developmental screening. Other parts focus on helping schools, parents, and children understand the importance of good nutrition and physical activity in maintaining a healthy lifestyle. CHHS Community Health Nurses will educate parents during home visits about the Body Mass Index (BMI) screenings mandated by the Florida Department of Health and required by state law (381.0056 School Health Services Program) to track the physical development of school children.

In addition, the weekly Care Coordination Team Meeting and monthly Interagency Management Team (IMT) Meeting assists in coordinating services and sharing lessons learned. The Care Coordination Meeting is a multi-disciplined approach to managing the care of program participants. The Team approach is based upon identifying the needs of each program participant through assessment, monitoring, facilitation and follow-up on the utilization of needed services.

The IMT is comprised of senior level representatives of organizations and agencies that, through contractual agreements and memoranda of agreement/understanding, have a responsibility for providing CHHS services. Representation from all Project Partners include: The Lawton & Rhea Chiles Center for Healthy Mothers and Babies, The College of Public Health Department of Epidemiology; The Hillsborough County Health Department; The Child Abuse Council; The Centre for Women; College Hill Church of God in Christ; Greater Mount Carmel African Methodist Episcopal Church; St. John Progressive Missionary Baptist Church; St. Matthew Missionary Baptist Church; Tampa General Hospital; St. Joseph's Women's Hospital, Healthy Families and ACHIEVE Tampa Bay. The Project evaluation staff participation in the IMT is critical. It is important that management and partners feel ownership of the evaluation component. The Evaluation Team utilizes ongoing data collection, analysis, and reporting for project services and outcome improvement in program models. At the beginning of each quarter, select service and outcome data will be reviewed with Service Model staff, the IMT, the Community Consortium, and perinatal care providers participating in the project. Each group is given the opportunity to develop strategies for improving particular quality indicators. The IMT is one of the governing groups that guide project development, operation, and improvement.

C. Resources or events that facilitated or detracted from successful initiation and implementation

One of the most beneficial aspects of The Federal Healthy Start Initiative (HRSA funded) is the opportunity it affords the community to put in place a comprehensive system of care for projects and program participants. This is especially true in Florida where service models can be developed and integrated with Florida Healthy Start Programs (State funded), Regional Perinatal Care Centers, Departments of Health and others. Project resources make it possible to offer program participants access to a perinatal care system that encompasses many of the principles and essential elements described in Perinatal Health Strategies for the 21st Century.

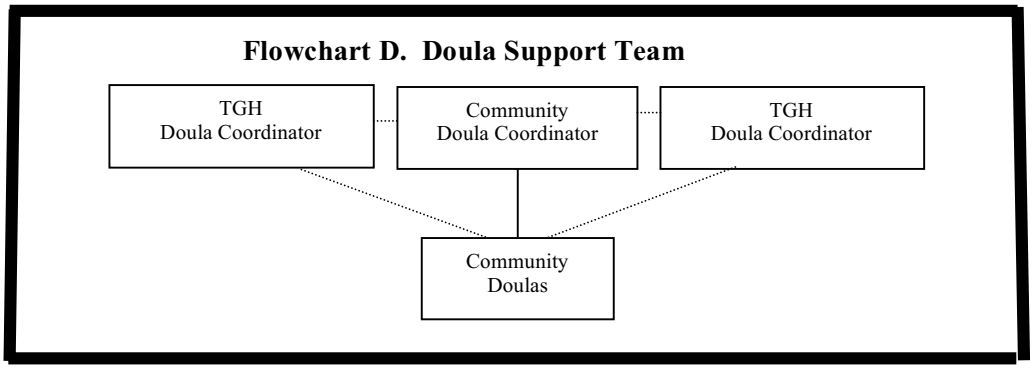
The Collaboration with the aforementioned partners and TitleV/Department of Health (DOH) has been critical to the success of this project. The supplemental funding from DOH for strategies/interventions (maternal and periodontal infection screenings) have allowed us to provide services that we would not otherwise be able to do with HRSA funding. The project has worked hand in hand with the DOH and Title V Health Officer to close the gap of infant mortality and morbidity. Since our participation in the Racial and Ethnic Approaches to Community Health (REACH 2010) which addressed the local factors related to racial and ethnic disparities specifically impacting Low Birth Weight and infant mortality/morbidity, we have received 5 years of funding ($1,106.629) from Florida Department of Health (HB2339, The Patient Protection Act) for the Reducing Racial and Ethnic Health Disparities--Closing the Gap Grant Program. The Gap grants target infant mortality rates, immunizations for children and adults, HIV/AIDS, diabetes, cardiovascular disease and cancer. We have received $281,462 in matching funds from the local Hillsborough County Children's Board

In addition to our partnership with the Title V Initiative, CHHS has contributed to systemic change in MCH System of Care; successfully utilized the Edinburgh Post Partum Depression Screen for its African American population (discussed in perinatal depression section); demonstrated an increase in the number of direct program participant social services contacts; improved the credibility of hiring paraprofessionals in hospital settings; and involved the faith community as a social service health venue without Church and State conflict.

The Doula Project has been instrumental in the successful implementation of project services. Doulas are women who provide labor assistance services for low income, medically and socially at risk pregnant women, new mothers and their families. Doulas are paraprofessionals recruited from the service community or coming from similar backgrounds. Recruitment and hiring focus on attracting women who are black, Hispanic and bilingual, and who speak either Spanish or Creole. The women are trained to address the unique needs of women and their families who are living and raising children in the service community. The doulas provide physical and emotional support to women from late pregnancy through the labor and delivery. They do not provide medical care or advice. Services provided to CHHS Project by doulas from CY 2003 were 763 direct program participant contacts in hospitals; 1346 direct program participant contact home visits; 240 direct program participant contact classes. Doulas provided more than a total of 2,500 services during Project Year 2004-2005.

The Doula Support Team is responsible for providing prenatal and postpartum education in strategic community based settings within the project and hospital support system at Tampa General Hospital (TGH) and St. Joseph's Women's Hospital (SJW) where the vast majority of the women in the project area give birth. With extensive training and intense supervision, the doulas function in home, community and hospital settings. The Doula Support Team includes: Community Coordinator (1.0 FTE funded by Achieve Tampa Bay) who is a perinatal nurse with a high degree of experience and success in supervising the team of paraprofessional doulas; Hospital Doula Coordinators (2 - one at each hospital @ .675 FTE each – or 27 hours each). The Coordinators are obstetrical nurses who oversee the doulas when they function in the hospital setting. The Community Doulas (7.0 FTE) are women who have for the most part been recruited from the service population or who are racially and culturally congruent with CHHS program participants. CHHS funds two FTE's and ACHIEVE funds five FTE's.

The Community Engagement Team and the Care Coordination Team will work closely with United Cerebral Palsy/ACHIEVE Tampa Bay to implement a strategic marketing plan to engage providers and program participants in the Doula Support Program. ACHIEVE is a private, not for profit agency that has been a stable organization in the community for nearly 50 years. Programs and services include: Therapy Services, Developmental Preschool and Childcare, Childcare Outreach, Respite Care, Supported Living, Employment and Training, SibShops, and the Doula Program. Services will include small support group sessions that are designed to address issues relevant to the woman's trimester of pregnancy, including the postpartum/early parenting period; hospital labor and early bonding/breastfeeding support; and home postpartum bonding/ breastfeeding support. Once the early postpartum period has concluded, Doula Support Program participants will be given a personal and warm link to community based interconception services. Mothers will be linked to small group support sessions and males will be linked to the Fatherhood small group support sessions.



Centre for Women Family Services Association in CY 2004 has provided services to more than 300 women. As of October 30, 2004 a total of 248 have been screened for perinatal depression and 34% were provided mental health services.

From Project inception to October 31, 2004, Child Abuse Council has provided more than 8,489 direct program participant contacts and made more than 4,359 social service referrals (smoking cessation, domestic violence, child abuse reports and drug abuse).

Hospitals total number of doula birth and deliveries at the hospitals from Project inception to October 31, 2004 is 1,056. More than 40 women have been trained to be Doulas. Doulas are racially diverse (Black, Spanish, White). Two are the Doulas are Spanish-speaking, 1 speaks French, and 1 speaks French and Creole.

Four churches continue to be an intricate component of the community consortium. The churches are: Pastor Charles Davis, College Hill Church of God in Christ, Pastor Harry Dawkins, Greater Mount Carmel African Methodist Episcopal Church, Pastor Bartholomew Banks, St. John Progressive Missionary Baptist Church and Pastor W. D. Simms, St. Matthew Missionary Baptist Church. Volunteer Coordinators provided 1,439 non-paid volunteer hours during the period from January 1 – December 31, 2003.

Additional partnerships that share activities, strategies, and funding resources are: the March of Dimes and its Prematurity Campaign/Advocacy and Community Summit; and CHHS and its KidCare Outreach efforts in the faith community efforts. KidCare/SCHIP served 194,819 families.

The Lawton and Rhea Chiles Center for Healthy Mothers and Babies Workforce Development Grant has developed, in conjunction with Hillsborough Community College and St. Petersburg College, a 21 credit hour training program for family health and support workers.

The CHHS Project looks forward to maintaining our relationship with Title V to ensure that pregnant women, infants, and all children receive the care they need to live healthier lives. CHHS Project Director, Lo Berry participated in the 2004 Department of Health/Community Health MCH Needs Assessment Advisory Committee to provide insight and advice towards the completion of the June 2005 five year MCH Block Grant Application.

SUSTAINABILITY

A. How we decided on our approach to service

CHHS has worked diligently and successfully to sustain services by building community capacity to reduce infant mortality and morbidity. Thus, we know that we must be inclusive in the process of initiating, developing and maintaining viable services to our service population. One of our guiding principles is sharing liability and responsibility of sustaining services. The success of the project hinders on the reciprocity of genuine partnerships and relationships. In a climate as political as Hillsborough County, participating and playing leadership roles in the development and implementation of county level maternal and child health care initiatives is an absolute must. At the state level, CHHS and the Chiles Center are actively involved in numerous Florida Department of Health, Title V and March of Dimes related work groups and task forces. Dr. Peter Gorski is a member of FIMR and FL KidCare Coordinating Council. He actively participates in the MCH Program through teaching, student advising and service on communities. With his leadership, the Center provides rich opportunities for student experience on research projects, program evaluation and policy analysis.

B. Components of interventions and resources

In an attempt to develop a systematic, multi-agency approach to improving Perinatal health outcomes, CHHS will continue to demonstrate and establish linkages to Title V, MCH, Title X, Family Planning, Title XXI SCHIP, local empowerment zones, hospitals and many other key state and local services and resources. We will continue to link and interface with more than 40 agencies/programs to provide maternal and child health services within the community. CHHS will strengthen its ties with the East Tampa Empowerment Zones and University of South Florida collaborative involvement in East Tampa Revitalization. The collaborative has begun to build stronger community - university relationships by introducing community leaders to faculty and students with similar interests. CHHS will partner with Dr. Harold Keller (USF/Education), Dr. Richard Briscoe (USF Florida Mental Health Institute) and Evangeline Best (Corporation to Develop Communities of Tampa), to support two of

four ($800) parent, school, and community stakeholders Saturday Group Sessions for Community Development and Family Health.

C. Resources or events that facilitated or detracted from successful initiation and implementation

In addition to federal funding, state and local funding have attributed to the project's sustainability efforts. In November 2004, The Allegany Franciscan Foundation, Tampa Bay Inc., a private Catholic foundation, awarded CHHS $100,000 for a two year project to implement a Community Engagement Neighborhood Project Model that will increase community capacity to provide family-friendly community-based healthcare outreach and education and to promote fiscal stability and social justice. The goal is to develop and implement neighborhood-based strategies for health education and chronic disease management education. Strategies will include community leveraging of funds, promoting health wellness vs. healthcare, developing a neighborhood health council and making innovation neighborhood grants. The CHHS Project staff and stakeholders have initiated efforts to transition from a university based program dependent upon grants to a private community based foundation.

D. <u>Additional</u> elements:

1. CHHS Project staff is currently working with the Hillsborough County Children's Board to develop the capacity for earning Medicaid reimbursement for Targeted Case Management services for qualified program participants. The Children's Board is leading the effort to create an integrated children's service delivery system in Hillsborough County and build the capacity for drawing down all available funds for local maternal and child health services.

   The local State Healthy Start Program participates in statewide Medicaid Waiver to draw down federal dollars for providing choice counseling to women eligible for Medicaid during pregnancy. CHHS Project and Hillsborough County Healthy Start Program leaders are in dialogue regarding the possibility of allocating additional resources to bolster services in the CHHS project area.

   CHHS hired Delores Jeffers (.20 FTE) a community consortium resource development staff member to provide assistance and guidance in formulating a plan to increase third party revenues (Medicaid), including services provided by the Outreach Workers which may qualify for Medicaid reimbursement as targeted case management. Dee Jeffers is the Chair of the Foundations MCH Plan Development Committee, a member of the Hillsborough County Kids Health Foundation, a member of Action Lab for decreasing racial disparities advisory committee and a member of the DOH Women's Health Advisory Committee.

2. CHHS has made great strides in sustaining Project efforts since its inception. CHHS received $2million a year in its initial HRSA application 1998-2001 and received $1.5 million a year in subsequent award 2001-2005 from HRSA. However, services, activities and infrastructure have increased. CHHS during the past four years has leveraged an additional $1.1 million per year to maintain footing that HRSA dollars have made and to

build community capacity for reduction of infant mortality and morbidity. CHHS plans to continue building its relationship and partnerships with multiple service agencies to leverage funding required to maintain services.

In addition, we identified resources that have provided funds to the community we serve. Some include: The Children's Board of Hillsborough County; Allegany Franciscan Ministries; Florida Department of Health; Ounce of Prevention Fund of Florida; and March of Dimes, Tampa Bay Chapter. In the 12/05 Reapplication, we will discuss grants and Invitations to Negotiate Contracts we have submitted since 3/05.

Our most recent HRSA funding will allow CHHS to be an even greater HRSA investment. We know that investing in human capital has a bigger return on the dollar. This is why we have created a model to employ the people we serve. During the past four years, we have trained over 40 women as Doulas and/or Outreach Workers and have hired 38 (Achieve Tampa Bay and CHHS).
Within the next four years, CHHS has hopes of: (1) establishing a 501(c) 3 authorization for Community Consortium, (2) establishing a Minority Health Foundation, (3) completing a Neighborhood Community Engagement Project to be replicated throughout Florida local communities and (4) implementing the third tier outreach component .

The challenge of sustaining a project the magnitude of CHHS is compounded by two factors. First, private funding organizations and foundations rarely provide long-term funding, and second, public agencies that fund services for the low income are suffering from significant budget reductions and are either reducing or eliminating social programs.

To address these challenges, the CHHS project staff and Consortium aim to establish the REACH-UP Foundation as a non-profit organization to achieve revenue generating objectives. REACHUP will seek reimbursement from private, public, state and local sources, beginning with Medicaid Targeted Case Management. CHHS staff is currently being trained by the Children's Board of Hillsborough County to put in place the financial and quality assurance structures and processes necessary to bill Medicaid for qualifying program participant services.

In collaboration with the Community Council, the Chiles Center, the CHHS staff and community stakeholders will recruit and train a corps of research associates and assistants, The Reach-Up Community Participatory Research Team (CPR Team), who in addition to generating revenue, sustaining the project and creating new employment opportunities for community residents, will be a tremendous asset to researchers in study design, data collection, interpretation of findings, and reporting results in ways that benefit the community rather than alienating study subjects. The CPR Team will also facilitate supervised training and student experiences in the community.

Reach-Up could also seek other revenue generating projects in partnership with other community based contributors willing to develop products and services to sustain the project. For example, local production of baby products could generate a portion of

sales to the project. As a free-standing organization, The REACH-UP Foundation will be positioned to attract and maintain such partnerships.

CHHS is one of the lead agencies in the Tampa Bay Health Care Collaborative (TBHCC) consisting of not-for-profit health and human service agencies in Hillsborough and Pinellas counties. The mission is to promote the health, wellness, and safety of individuals in our community through coordinating existing resources and promoting increased access to health care. TBHCC was influential in the recent decision by the Allegany Franciscan Foundation to award CHHS $100,000 to establish a Neighborhood Engagement Model within the next 2 years with hopes of the model being replicated throughout the State.

3. Overcoming barriers and decreasing negative impact is no easy task in sustaining viable services. Our community will continue utilizing both LHSAP's described earlier, work hand in hand with state and local Department of Health to leverage funds and maximize efficient spending and procurement of services.

III. Project Management and Governance

A. The Project Managers that oversee program services and implementation of activities are Deborah Austin, Ph.D., who manages the Community Outreach, Community Consortium activities and Vanessa Anderson, BSN Perinatal Nurse Specialist. Deborah Austin, Ph.D., manages the Community Outreach Workers and initiatives, as well as coordinates interagency and community communication. This role expanded to state, national advocacy for funding Healthy Start services and social marketing activities. Vanessa Anderson, B.S.N., serves as the clinical liaison between the providers' offices and the Hillsborough County Health Department and Healthy Start Coalition of Hillsborough County, Inc. (HSCHC). Ms. Anderson also assists care coordination clinical planning, treatment and adherence to state guidelines, protocols, and procedures for delivering state Healthy Start services and medical records clerk responsibilities. Project activities, policy decisions and communication are coordinated through a minimum of ten monthly meetings of the Interagency Management Team (IMT), a body consisting of representatives of agencies and organizations receiving Federal Healthy Start dollars through this Project. Estrellita Berry, MA, Project Director/Principal Investigator, chairs the IMT. Estrellita Berry is responsible for administration, management, implementation of Project service models, and adherence to the Institutional Review Board guidelines. She participates in local, state and national MCH programs/boards to strengthen partnerships for perinatal systems of care.

Project management and administration success has been tied to 90% retention of passionate and capable management team guidance oversight of project plan goals/objectives.

B. The Central Hillsborough Healthy Start Project Management approach is broad based partnerships with inclusive planning for project activities/services. CHHS partners with more than 40 community agencies to provide services to our consumer/participants. Our broad based citizenry provides volunteerism as well as multiple services that range from

food, clothing, housing and employment. The CHHS project has leveraged an additional 1.1 million per year from 2001-2004 from local, state and national resources (Children's Board of Hillsborough County, Allegany Franciscan Ministries, Ounce of Prevention Fund of Florida, March of Dimes Florida Department of Health and Health Resources Services Administration).

C. The CHHS Management team has 90% retention rate during the past four years. Only one manager left the project to become a full time parent. The Chiles Center Executive Director changed administrative leadership from Dr. Stanley Graven to Dr. Peter Gorski. In 2002. Dr. Peter Gorski, a nationally recognized pediatrician and child development specialist, assumed the position of Director of the Center. He is Professor of Public Health, Pediatrics and Psychiatry at the University of South Florida. Dr. Gorski is very active in the American Academy of Pediatrics, serving on the Early Childhood Expert Panel rewriting the Bright Futures Guidelines and leads an international collaboration on children's rights, equity and justice in health (The Equity Project), a joint initiative between the AAP and the Royal College of Paediatrics and Child Health (UK). An additional major change in management was the nursing component being transitioned from health department to USF College of Nursing department to Chiles Center/CHHS Care Coordination/Case Management component. The biggest change in program operations management and governance that occurred over time was the development and implementation of the CHHS Interagency Management Team (IMT) entity discussed earlier in this document.

D. The process to assure appropriate distribution of funds is shared with the Project Management team, Chiles Center leadership, USF College of Public Health accounting department and USF Sponsored Research Division. Fiscal and program monitoring to support implementation and monitor program status is provided by the University of South Florida, College of Public Health (COPH), The Lawton and Rhea Chiles Center for Healthy Mothers and Babies: Judy Sommers, Director of Research Administration, COPH; Reggie Robinson, Senior Grants Specialist, Division of Sponsored Research (Pre-Award); Alma Castro, Senior Accountant, COPH; and Cheryl Pla, Senior Grants Specialist, Research Financial Management. The monitoring system used by USF Accounting is People Soft8. SAS is the software program used to analyze the data. The Florida Department of Health provides raw identified data from Vital Statistics using infant birth and death records. Data also includes prenatal and infant health screens from the Florida Healthy Start program. The data is also merged with WIC and Medicaid enrollment identifiers.

In addition, USF GEMS Personnel Effort Reporting Tool (PERT) utilizes a web-based system to document effort performed on sponsored projects. PERT assures Federal agencies and sponsors providing Federal funding that monies paid to the universities for the salaries and wages of individuals working on sponsored projects have been appropriately expended. We will include an "In Kind Grid" that reflects dollars in-kind and additional grant funding leveraged by CHHS and community partners in the 2005 Reapplication.

E. The primary additional resources obtained for quality assurance, program monitoring, service utilization and technical assistance obtained were:

a. CHHS Care Coordination weekly team meetings. In this forum, the multidisciplinary team discusses particular program participants and other services plans. The attendees include the Medical Director of the Chiles Center, Perinatal Systems Specialist, Perinatal Nurse Manager, Community Health Nurses, Doulas, Benefits Coordinator, Licensed Clinical Social Worker, Perinatal Support Outreach Workers, Community Outreach Workers and any other manager as needed. USF nursing students, DCF or other agencies are invited when necessary. Problems and strengths are identified for both program participant and staff involved in the case. Supervisory direction is given to the group as a whole and individually as needed. Each of the disciplines will receive ongoing communication about the program participant and any opportunities for improvement is discussed. After actions plans are developed and implemented, case managers check on the program participant's progress. Strategies for adaptation of old plans or implementation of new plans is evaluated if the original plan is not working. The process is one of Continuous Quality Improvement.

b. Quality Assurance Monitoring of CHHS Care Coordination/Case Management services is provided by Healthy Start Coalition of Hillsborough County. The Care Coordination/Case Management services include risk assessment screens utilizing statewide leveling system on the Florida Healthy Start Prenatal Risk Screening Instrument, addressing health/medical needs, anticipatory guidance and connection with available community resources.

- **Trainings:**

1. Documentation training - Home visiting curriculum model training by Florida State University Center for Prevention and Early Intervention Policy
2. IRB Training – All management staff completed the Institutional Review Board (IRB) training and is now certified. Staff who collect and/or review data from human subject population must be certified. The Principal Investigator is responsible for protecting the rights and welfare of human research subjects and for complying with all applicable provisions of the university policies dealing with protection of human subjects.
3. HIPAA Training – The purpose of this training is to provide information regarding the Health Insurance Portability and Accountability Act and the ramifications it has on health professional and information systems. HIPPA is a federal law requiring that patient information is kept private and secure.

F. CHHS has always had a diversified staff in the implementation of program services, reflective of the community it serves. African American participant population has ranged from 76% to 86%, Hispanic 4% to 10% and White 2% to 4% since the Project's inception. Below is an ethnic and racial profile of CHHS staff.

Central Hillsborough Healthy Start Staff Race/Ethnicity

MANAGEMENT AND PROGRAM SERVICE PROVISION STAFF	
Position Title and Name	Race/Ethnicity
Project Director/Principal Investigator Estrellita "Lo" Berry, MA	Black or African American
Perinatal Nurse/Manager Vanessa Rowland-Anderson, RN	Black or African American
Communication Specialist/Manager Deborah Austin, PhD	Black or African American
Perinatal Systems Specialist/Evaluation Team Leader Delores Jeffers, MPH, RN	White
Perinatal Support Outreach Worker (PSOW) Maria Gibson	Spanish/Hispanic/Latino

Position Title and Name	Race/Ethnicity
Perinatal Support Outreach Worker (PSOW) Mary Shorter	Black or African American
Perinatal Support Outreach Worker (PSOW) Tammy Sutton	Black or African American
Community Outreach Worker (CORW) Tracy Andino	White
Community Outreach Worker (CORW) Ivy Colon	Spanish/Hispanic/Latino
Community Outreach Worker (CORW) Carla Andrews	Black or African American
Q/QI Monitor Nurse Linda Beck, RN	White
Community Health Nurse Felita McNeill, RN	Black or African American
Medical Records Specialist Barbara Brinson	White
Program Assistant Florence Ryan	White

These figures do not include subcontracted staff.

Management and Program Service Provision Staff:
White: 5 = 36%
Black or African American: 7 = 50%
Spanish/Hispanic/Latino: 2 = 14%
3 of 3 (100%) Management Staff is African American

EVALUATION TEAM	
Position Title and Name	Race/Ethnicity
Sr. Program Consultant Peter Gorski, MD, MPA	White
Research Director Kathleen O'Rourke, PhD	White
Data Manager David Darr, MD	White
Program Analyst Jason Salemi, PhD (c)	White
Research Associate Kirsten Wallace	White
Graduate Assistant Candace McDonald	Black or African American

Evaluation Team:
White: 5 = 83%
Black or African American: 1 = 17%
Spanish/Hispanic/Latino: 0

Cultural Competency Trainings

CHHS has been conducting cultural competency trainings since its inception. CHHS contracted Delores Cain, from Florida Mental Health Institute, to facilitate the mandatory workshop in 1999. Beginning in 1998, CHHS took the lead with the other Florida federal Healthy Start sites and contracted staff from Georgetown National Center for Cultural Competence on two different occasions: Dr. Suganya Sockalingam on October 3, 2001 and Dr. Richard Aronson, who made the opening presentation for the Florida Perinatal Partners in Health Sharing Solutions Conference, on November 28, 2001.

In April 2000, CHHS conducted a two day mandatory Cultural Competency training facilitated by Gwen Wright, Florida Mental Health Institute, Dr. Roberta Baer, USF Cultural Anthropologist with expertise in Latin America, Jim Shearer, expert on Hip Hop culture, and Shelby Jiggetts-Tivony, Color Me Human-Tampa Bay (Institute for the Healing of Racism). The training was offered again in June of that year for staff from the Florida state Healthy Start program. From the information collected for this training, CHHS began the development of its own cultural competency training curriculum.

To assure that staff and partners received annual cultural competency training, CHHS sponsored cultural competency training for CHHS and Chiles Center staff and community partners facilitated by USF FMHI staff member Gwen Wright in 2002 and 2003 and CHHS LCSW Adrienne Dungee in 2004. In a second 2002 training, Ms. Wright was joined by Dr. Helen Masin from the University of Miami (FL). This cultural competency training was geared toward managers from the FL Healthy Start sites as well as representatives from the Florida Department of Health. CHHS has developed its own Cultural Competence curriculum (on file at MCH Library).

IV. Project Accomplishments

A. All evaluation project objectives, progress, strategies and activities are outlined in Appendix E. Both quantitative and qualitative success achieved is outlined in the appendix.

Some of CHHS accomplishments not addressed in Appendix E are:

Administrative:

- Supplemental funding for Health Disparities by state grant and local match
- Sustainable partnerships among member agencies
- Managed and cultivated an organization culture (formal and informal) that promotes a high performance agency. CHHS management team is not driven by money or current trends.
- Created and maintained a community-driven Community Consortium that provides oversight and management reflective of the community it serves.
- Since the second initiative (2000-2003), the Central Hillsborough Healthy Start program successfully attracted additional and complementary private and public finding sources (local, state and national) for projects that advance the achievement of the Project's goals and objectives. Acquired DOH and Children's Board of Hillsborough County funding for Closing the Gap Project ($1,106,629) from 2000-2006 to address health disparity in infant mortality and morbidity (maternal infections screening and periodontal disease screening). 90% retention of passionate and capable management team providing guidance, management & oversight of Project plan and implementation of services.
- Continued willingness of USF to participate in Community Based Research and Program Services in the East Tampa Community.

Programmatic:

- Enhanced ability of Healthy Start to address disparities in accessing and utilizing health services
- 80% retention of Community Partners (formal contracts) who support management team, program participants and embrace project vision, mission, and goals.
- High level of program participant satisfaction with CHHS Service Providers. The overall satisfaction composite mean score across all provider types was 2.41 with a score of 2 indicating mostly and a score of 3 indicating always. Doulas and PSW's received the highest scores 2.61.
- Created community capacity for economic development of the Project Area with the Doula Project (Maternal Attachment/Bonding) and Outreach Workers. Hired over 40 women from within the community to perform case management and outreach services.
- Partnered with the Maternal and Child Service Workforce development Program to expand duties of three outreach workers enrolled in the Applied Technology Diploma (ATD) Program. Three Outreach workers received their

ATD in National and Child Health Services from Hillsborough Community College, December 2004, allowing promotional growth and academic advancement for paraprofessionals.

- Facilitated inclusion of community churches (six) to empower individual and families and mobilized people to effectuate change (more than 2, 900 volunteer hours per year).
- Created a Perinatal Nurse System that coordinates and maintains communication regarding patient care between perinatal providers, prenatal women and infants. Maintained a 100% provider satisfaction rate with the Perinatal Nurse in three clinics.
- 93-100% of providers responding to satisfaction surveys report that they are satisfied with the enhanced clinical services provided by the perinatal nurse
- 93-100% of providers responding to satisfaction survey reported an increase in knowledge about the CHHS Project and Healthy Start Goals
- 92-100% is screening rate for the three offices served by the perinatal nurse; Hillsborough County as of 7/3/02 screening rate was 62.17%; State screening rate 59.02%
- Community recognized the value of the doula progra
- Increase the breastfeeding rate and reduce the cesarean section rate in CHHS consumers through providing a special breastfeeding support program utilizing doulas at Tampa General Hospital and St. Joseph's Women Hospital.

Clinical Outcomes:

- Since 1997, Infant Mortality and Morbidity rate has decreased from 18.5 per 1,000 live births to 10.95 per 1,000 live births in 2003 in the CHHS Project Area.
- Since 2001, the low birth weight rate has decreased from 19.2% to 10.71% in 2003.
- In 2003, Infant Mortality rate for black babies was 13.6 for the State, 17.0 for Hillsborough County and 10.95 for CHHS Project area.
- As of 2004, The project screened over 1,600 Black women between the ages of 18-44 for maternal infections. Of the 2,018 Black and Afro-Hispanic women, 1,210 tested positive for vaginal infection (60%)
- Periodontal disease screening began in November 2003. Of the 96 Black and Afro-Hispanic women, 62 tested positive for periodontal disease (64.6%)

B. **Trainings that were provided:**

1. Perinatal Depression TA: Sponsored by the Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA) and the USF College of Nursing, August 25-26, 2004
   Trainer: Michael W. O'Hara, Ph.D.
   Iowa Depression and Clinical Research Center
   Department of Psychology
   University of Iowa
   Iowa City, IA 52242

CE's were provided for CHHS nurses and licensed clinical social worker. They were also made available to those disciplines outside CHHS for $35.00.

Six major topics, developed in pre-training discussions with Dr. O'Hara and CHHS staff, were addressed: Overview of Perinatal Depression; Screening and Referral; Psychological and Medical Treatment for Perinatal Depression; Cultural Diversity and Depression Screening and Referral; Case Management of Perinatal Depression and Family and Community Support. All of the topics were useful to the CHHS staff, with the exception of Psychological and Medical Treatments for Perinatal Depression, which the staff considered somewhat useful.

The goals that were listed for this technical assistance and their usefulness included 1) assess the effectiveness of the Edinburgh Postnatal Depression Scale with the CHHS population – useful; 2) determine the efficacy of screening at various times prenatally and in the postpartum period – somewhat useful; 3) enhance the cultural competence component of the assessment process – useful; 4) enhance staff level of comfort in addressing mental health issues – very helpful; and 5) become more knowledgeable about psychotropic medications that can be used during pregnancy and postpartum – somewhat useful.

CHHS indicated to Dr. O'Hara that he could further help accomplish the goals of the project as they relate to Perinatal depression by citing more examples of programs that have successfully treated mothers using psychotropic medications as well as citing examples of the impact and outcomes of screening at various times prenatally and in the postpartum period. For example, is earlier screening more advantageous? In addition, discussing the ancillary services that non-direct service providers can bring to the table would be very helpful to the project's community partners and interested stakeholders.

Overall, one of the greatest values of the technical assistance training was the secondary gain of staff increased level of comfort seeking mental health treatment. Because we had already established our processes and screening instruments for maternal depression, one of the values of the TA was that it provided confirmation to managers and staff that we were on the right track in addressing perinatal depression in our system of care. This confirmation and enhancement of personal development were well worth the resources invested in the TA. The TA was just as beneficial to an established site as one that had not yet developed its depression component.

2. An Integrated Approach to Childhood Exposure to Violence and Implications for Brian Development, Sponsored by the Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA) and the USF College of Nursing, April 26-27, 2005

Trainers: Linda Chamberlain, PhD, MPH, Founding Director, Alaska Family Violence Prevention Project
Rebecca Whiteman, MA, Coordinator, California Clinic Collaborative, Family Violence Prevention Fund

A general session was held for any interested professional or paraprofessional in the area at the USF College of Public Health Auditorium who emailed CHHS manager Cheri Wright Jones. The second day was devoted to issues particular to CHHS staff and was held at the Allegany Franciscan Retreat Center.

CE's were provided for CHHS nurses and licensed clinical social worker. They were also made available to those disciplines and addictions specialists outside CHHS for $35.00.

Five major goals were developed in pre-training discussions with Dr. Chamberlain, Ms. Whiteman and CHHS staff:

- Addressing physical, mental, cognitive effects of violence on children and how it affects us as adults is very popular
- Addressing the broader spectrum of lifetime exposure to violence
- Examine existing assessment tools and identify opportunities to integrate assessment into existing practices
- Working with staff to enhance their comfort level with assessment for domestic violence, promoting empathy, boundary-setting and self-care, and defining what success is when working with clients who experience violence
- Incorporating interactive exercises on empathy building and self-esteem

The program evaluation conducted by the Department of Continuing Education reflected the success of the training. Using a scale of 1-Poor; 2-Fair; 3-Good, 4-Very Good; and 5-Excellent, the evaluation showed:

- Overall teaching skill: 4.68
- Relevance of content to objectives: 4.68
- Knowledge and expertise: 4.81

Written comments reflected the compassion and empathy as well as expertise of the trainers. Participants indicated that they planned to fully incorporate domestic violence screening in their protocols, to become more aware of and look for signs of DV during home visits; and put forth more effort to learn about and develop healthier personal

relationships. The group indicated that they would like to explore women of color and violence, the impact of family violence on boys; strategies for working with male domestic violence perpetrators; intervention with female domestic violence perpetrators; how to encourage local schools to address abuse and bullying; and identifying non-obvious signs of violence and abuse for future CE activities. Participants also indicated that their least favorite aspects of the training included session time too short, not enough community people involved, and the sometimes depressing nature of the topics.

3. Four P's Plus Training: sponsored by Health Resource and Services Administration (HRSA). The CHHS project was chosen as a federally Healthy Start Technical assistance site by Dr. Ira Chasnoff.

   Trainers: Dr. Ira Chasnoff
   The Children's Research
   Chicago, Illinois

   The technical assistance site visit was held February 11-12, 2003. CHHS was trained to implement a universal substance abuse screen for pregnant women (Four P's Plus). Screening of pregnant women at risk for alcohol and illicit drug use helps identify those women more likely to abuse during pregnancy. Identifying obstetrical patients in need of in depth assessment or follow-up monitoring has been clinical useful and has successful outcomes.

   In addition to this training, CHHS Project Director and several other community organization members were trained at the Children's Research Triangle which resulted in the development of the Zero Exposure Project for Hillsborough County with current involvement of 21 agencies. The primary focus of this effort is to build a solid infrastructure of support for women and families in need of referrals, services and treatment. The hope of this working committee is that women seeking treatment will find assistance with minimal barriers to care and easy access to services. To date, the Zero Exposure Project has screened 1,174 women for alcohol and substance abuse in Hillsborough County. For additional information please see www.zeroexposure.org.

V. **Project Impact**

A. Systems of Care:

1. Approaches utilized to enhance collaboration are vast and inclusive.
   CHHS has incorporated Florida FY2001 Maternal Child Health Needs Assessment into its Workplan and Local Health System Action Plan. The Title V Needs Assessment of Florida (2000) reported that strategies and interventions funded by Florida's Title V MCH Block Grant have supported many of the gains in MCH outcomes. However, data trends, MCH research and HRSA CHHS eliminating disparities data suggests that future gains in the areas of health disparities in maternal and child health will become more difficult to achieve as providers encounter underlying factors related to the most difficult health problems.

As discussed previously, HSCHC established a Memorandum of Understanding with The Chiles Center allowing CHHS to become a Care Coordination service provider for East Tampa Area (17 census tracts) with the poorest health and social outcomes. CHHS delivers prenatal, postpartum, and labor and delivery services to women in 17 census tracts from zip codes 33602, 33603, 33605 and 33610 in central Hillsborough County.

In addition to our collaboration with HSCHC, CHHS works with Florida's Title V MCH Director, Annette Phelps, ARNP, MSN, to integrate perinatal systems of care statewide. An additional statewide effort that is addressing maternal and child health care is the March of Dimes Florida Chapter's emphasis on prematurity. One of CHHS Community Consortium members, Dr Charles Mahan, CHHS Consortium member is the March of Dimes Prematurity Campaign Chair.

2. System integration has improved in the overall system of care, but much work is yet to be done. Local and state fiscal policies for addressing minority health disparities have occurred over the past four years. Please refer to the Collaboration and Coordination with State Title V and Other Agencies section of this report.

3. Key relationships that have developed as a result of Healthy Start efforts include:
   a. Collaboration with more than 40 agencies throughout the county. CHHS has 11 formal contracts with community based organizations, hospitals, churches, schools and universities. Most of these collaborative efforts and formal partnerships have remained intact for seven years.
   b. The most successful venues for building relationships that focus on involvement of consumers and community leaders who are not employed by a health or social agency is the monthly Community Consortium meetings and the Faith Initiative contract with four local churches.

4. The CHHS project has impacted services comprehensively:
   a. The CHHS Project ascribes to the eligibility and intake requirements of Healthy Start Coalition for Care Coordination Services described in the Local Health System Action Plan of this report.
   b. Barriers to access and service utilization and Community Awareness have included:
      1. Adequately differentiating Federal Healthy Start (CHHS) from State Healthy Start and County Healthy Start Coalition.
      2. Inability to provide intensive services/activities (doula and perinatal risk assessments) throughout the County
   c. As mentioned in the Project Implementation section _____ of this report. Care Coordination has extensive continuous quality improvement oversight provided by CHHS management team, Hillsborough County Healthy Start Coalition.
   d. Within the confines of Health Insurance Portability Accountability Act, The University of South Florida Institutional Review Board, The Central Hillsborough Healthy Start Guidelines, The Healthy Start Coalition guidelines and protocols and Department of Health policies, procedures and

partnership agencies guidelines and procedures, we are able to share data across providers.

In compliance with the Health Insurance Portability Accountability Act and the University of South Florida Institutional Review Board, program data collected by agencies serving CHHS clients are share for evaluation and service quality improvement purposes. In the project period 2004-2005, efforts were expanded to develop an interagency data sharing plan that will involve the CHHS Project, the Child Abuse Council of Hillsborough County, the Hillsborough County Health Department and the Healthy Start Coalition.

5. CHHS has enhanced consumer participation in the evaluation of service provision:
    a. Over the past six years, CHHS has made great strides in increasing the comfort and trust level of research, evaluation and service provision to a community which had been researched to death and exploited in many ways. The community we serve better understands the relevance of good service provision and evaluation. Providers have the responsibility of providing satisfaction surveys for input of consumers in developing the evaluation tools.
    b. Consumers/Participants have had a viable and active role in the development and utilization of evaluation tools and strategies to enhance perinatal service delivery. All instruments/tools developed with the aid of consumers/participants have been enclosed with this Impact Report.

B. <u>Impact to the Community</u>:
    1. Residents have gained increased knowledge and trust of CHHS services during the past seven years. Some reasons are:
        - Culturally competent staff
        - Culturally competent, effective marking strategies (advertising on buses, radio advertising, community health fairs, etc.)
        - Word of mouth by consumers/participants
        - Dissemination of information and networking of agencies at monthly consortium meetings
    2. The primary goal of CHHS is to increase the awareness and capacity of the community at large to enhance the prevention of infant mortality and morbidity with at risk populations. CHHS empowers lay and professional groups to join forces with national and other initiatives to ensure early intervention strategies with at risk segments of the community. These interventions enhance high levels of interdisciplinary human service delivery accessibility that ensures the overall survivability of children and their families.
    3. The CHHS leadership training component has focused on the Community Consortium as the primary vehicle through which the empowerment process is initiated. Leadership trainings focus on community empowerment, participation and leadership, capacity building and sustainability. Training sessions provide activities and exercises that are fun and inspiring. One major

area of focus in the training was conflict management and resolution and how to effectively relate to change, and how to come to an adoptive census that becomes a win-win situation for all involved. The attendees actively brought into perspective the fact that unity, cooperation and effective communication promotes and achieves success for all interactants.

4. Creation of jobs within the community has been one of CHHS's guiding principles and "promise" to the community we serve. CHHS has created community capacity for economic development of the Project Area with the Doula Project (indigenous nurse assistants who provide prenatal care, birth and delivery care and postpartum care and indigenous outreach workers who serve as community ambassadors and case manager. The project has trained over 50 women and hired over 40 women.

C. Impact on the State:

One of the most beneficial aspects of The Federal Healthy Start Initiative (HRSA funded) is the opportunity it affords the community to put in place a comprehensive system of care for projects and program participants. This is especially true in Florida where service models can be developed and integrated with Florida Healthy Start Programs (State funded), Regional Perinatal Care Centers, Departments of Health and others. Project resources make it possible to offer program participants access to a perinatal care system that encompasses many of the principles and essential elements described in Perinatal Health Strategies for the 21st Century.
Lo Berry, Project Director accepted an October 2004 invitation from Department of Health/Community Health to participate in the Maternal Child Health State Needs Assessment Advisory committee to provide insight and advice towards the completion of the June 2005 five year MCH Block Grant Application. In addition, during the past 4 years, four federally funded health start sties (Tampa, St. Petersburg, Jacksonville, Tallahassee) worked closely to strengthen our ties with State Title V Programs and the 32 Healthy Start Coalitions across the state, encouraged coordinated activities across sites. The federal projects combined efforts to improve systems of care locally and state wide. The federal Healthy Start projects participated in local and state wide Maternal Child Health Needs Assessment of Florida. Data trends, MCH research and HRSA's Florida federal project elimination disparities data was instrumental in confirming the need for the MCH state system of care to address health disparities. Our relationship to State Title V Agency, Early Intervention Program and Medicaid and SCHIP Program have been critical in addressing the needs of our participants.
KidCare/SCHIP: Florida has the third largest SCHIP program in the nation. For the past three years, The Chiles Center received funding from Medicaid and Robert Wood Johnson Foundation, Inc. to improve the FL KidCare Children's Health Insurance Program and increase the number of children enrolled in FL KidCare outreach efforts throughout the state. CHHS provided in service training to Florida KidCare Program Directors and was featured in the Florida KidCare Innovation Newsletter highlighting innovative outreach strategies. CHHS partnered with The Chiles Center KidCare Marketing and Public Relations Committee to promote the January 1-30, 2005 open enrollment for Healthy Kids and KidCare. More than

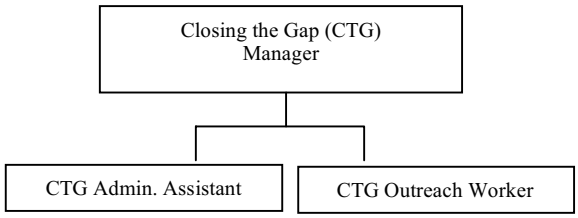
342,000 Florida children already benefit from this health insurance program but many more are eligible.

D. Local Government:
The Collaboration with the aforementioned partners and TitleV/Department of Health (DOH) has been critical to the success of this project. The supplemental funding from DOH for strategies/interventions (maternal and periodontal infection screenings) have allowed us to provide services that we would not otherwise be able to do with HRSA funding. The project has worked hand in hand with the DOH and Title V Health Officer to close the gap of infant mortality and morbidity. Since our participation in the Racial and Ethnic Approaches to Community Health (REACH 2010) which addressed the local factors related to racial and ethnic disparities specifically impacting Low Birth Weight and infant mortality/morbidity, we have received 4 years of funding ($1,106,629) from Florida Department of Health (HB2339, The Patient Protection Act) for the Reducing Racial and Ethnic Health Disparities--Closing the Gap Grant Program. The Gap grants target infant mortality rates, immunizations for children and adults, HIV/AIDS, diabetes, cardiovascular disease and cancer.

The Closing the Gap is a select construct of the CHHS project.

The Closing the Gap Project in Infant Mortality team is responsible for the maternal infection and periodontal screenings and provision of educational information on bacterial vaginosis, periodontal disease, maternal nutrition, baby spacing to Black women (ages 18-44, residing in Hillsborough County), their extended families and the community. The Team include: Project Manager (1.0 FTE), Administrative Assistant (0.5 FTE), Outreach Worker (0.2 FTE). The Manager is responsible for interfacing with Community Engagement and Mobilization Team component. This component is funded by Florida Department of Health and services are provided throughout Hillsborough County. This program is supplemental and does not supplant existing services.

Flowchart C. Closing the Gap in Infant Mortality Project Team



In addition to our partnership with the Title V Initiative, CHHS has contributed to systemic change in MCH System of Care; successfully utilized the Edinburgh Post Partum Depression Screen for its African American population (discussed in perinatal

depression section); demonstrated an increase in the number of direct program participant social services contacts; improved the credibility of hiring paraprofessionals in hospital settings; and involved the faith community as a social service health venue without Church and State conflict.

CHHS and its Community Consortium are represented on the HSCHC Systems Committee and Planning Development Committee. The Healthy Start Systems Committee was established to bring together Healthy Start providers and other providers of Maternal and Child Health (MCH) services on a monthly basis. Issues within the Healthy Start system and the larger MCH system are discussed and resolved at these meetings. The Committee serves to improve linkages among home visitation providers. Healthy Start's Planning Development Committee has the responsibility of monitoring and reviewing system issues affecting the care coordination and MCH systems. Membership on this committee is reserved for representatives from area planning and funding agencies and systems that intersect with Healthy Start. The at-large membership comes from the HSCHC Board of Directors and/or Voting Membership. CHHS Project Director was elected to the Hillsborough County Healthy Start Coalition Board of Directors, Spring 2005.

CHHS project has successfully:

- increased opportunities and resources to build the community's efforts to promote and protect the health and well-being of its citizens, especially mothers, infants, and young children and their families;
- cultivated and provided an environment in which university researchers can conduct community based participatory research;
- facilitated and advocated for CHHS Community's representation and perspectives in decision making activities of larger systems at the community, state, and national levels;
- engaged service community program participants, providers, and stakeholders in program activities and governance over time
- assured the direct flow of information from the larger community, state and federal systems to CHHS constituents;
- advanced federal and state health goals and objectives for populations experiencing the greatest racial end ethnic disparities in maternal and child health outcomes;
- integrated CHHS services across institutions and practitioners to positively impact the perinatal care delivery system for program participants.

- In 2005, the HSCHC completed its tri-annual service delivery plan for the State. In that plan the provider of care coordination services will transition to a new agency, the Child Abuse Council (CAC) and the CHHS Project. Beginning in October, 2005, CHHS will serve as a funded subcontractor to the serve as a County Care Coordination Unit serving clients in the existing CHHS ZIP Codes (33602, 336-03, 33605, and 33610) beyond current census tracts and in one additional ZIP Code (33607).

E. LESSONS LEARNED/OUTREACH:

- The critical nature of knowing and adhering to proper church protocol (whether or not you understand or agree)
- Time and patience in gaining community trust and support
- Importance of **true** community partnerships, especially grassroots partnerships
- The depth of commitment of time and resources needed for supporting and mentoring Community Health Workers
- The skills and knowledge gained by supervising and mentoring Community Health Workers
- The importance of and difficulties associated with resource sharing
- Value in and barriers associated with university affiliation
- Importance of sensitive, compassionate, critically attuned managers
- Importance of learning from everyone and everything (no condescension)

LESSONS LEARNED/CASE MANAGEMENT/CARE COORDINATION

- Make necessary program changes despite resistance
- Maintains open communication with provider offices to enhance trust between service providers and consumer/participants
- Continue to administer provider satisfaction survey to act as a gauge on how services are being perceived.
- Implement continuous quality improvement recommendations by provider office staff to improve service delivery and project buy-in.
- Community/system integration, collaboration and relationship building is not an easy process-it takes constant work. It's about relationship building.
- System refinement and program growth cannot be done in isolation and without collaboration.
- Data collection and documentation systems must match to make program contract reporting and program management more efficient and effective.
- Dedicated core group of staff is a must in order to persist despite the challenges and frustrations that are an inherent part of working in a large collaborative group.
- Link performance with accountability
- Continuous quality improvement of program implementation and evaluation should be a best practice standard

LESSONS LEARNED/HEALTH EDUCATION & TRAINING

- Acknowledge cultural and linguistic incompetence and take action against cultural destructiveness/cultural blindness
- Staff development and health education training is equally important as consumer health trainings

LESSONS LEARNED/INTERCONCEPTIONAL CARE

- Engaging males is critically important in addressing birth control and planned parenting
- Peer support group activities are effective strategies for family planning
- Women are more like to participate in prenatal care and quit risky behaviors if the expectant fathers provide them with emotion and informational support

LESSONS LEARNED/DEPRESSION SCREENING & REFERRAL

- Depression training promotes "openness" about one's own mental health status
- Many African-Americans view depression as a "weakness"
- Many African-American women view depression as "a way of life"
- Peer support groups is a key venue to address depressive issues

LESSONS LEARNED/CORE SYSTEMS-BUILDING EFFORTS/LOCALHEALTH SYSTEM ACTION PLAN

- Accept the ongoing process of community/system integration, collaboration, relationship, and partnership building
- Hidden agendas sometime supersede interest of community
- System refinement and program growth cannot be done in isolation

CONSORTIUM

- Goal-oriented behaviors and decisions of the Consortium may be evaluated on the basis of agreement, relevance and flexibility
- Participant/consumer investment in goals increases the probability of the goals being met
- One of the most important criteria through which the Consortium can be evaluated is the standardization of actions, decision, philosophies, and polices of organizations and components involved in the delivery of Healthy Start services.
- Satisfaction of Consortium members influence members retention and participation
- Keep hands on the pulse of the community
- Provide transportation to meetings/activities

LESSONS LEARNED/CORE SYSTEMS-BUILDING EFFORTS/ COLLABORATION & COORDINATION

- Speak honestly about what's in it for you as well as what's in it for the community at large (personal and professional gains)
- Identify other agencies that have established credibility join efforts

LESSONS LEARNED/CORE SYSTEMS-BUILDING EFFORTS/SUSTAINABILITY

- Sustainability needs to be accepted at local level then expanded to state level then to the national level (context-specific)
- Effective collaboration is necessary for fiscal survival

VI. Local Evaluation

Local Evaluation Component

A. The impetus of the local evaluation was to systematically track the impact of the CHHS program on select outcomes, as determined by an Evaluation Advisory Committee Group.

B. The local evaluation was designed during CY2001 as part of a collaborative process between the CHHS local evaluation team, led by Melinda S. Forthofer, PhD, the CHHS project director, other key project personnel, key stakeholders in the community, and experts in MCH research and evaluation. The Evaluation Advisory Committee Group recommended an outcome study comparing CHHS program clients versus non-CHHS program clients residing in the same project area. Due to the inability to gain access to identified vital statistics data for the project area, the local evaluation team was not able to compare CHHS clients with non-clients; thus reverted to tracking trends among clients across program years.

C. The study is a prospective cohort outcome evaluation tracking trends in CHHS program clients over time.

Key Questions/Hypotheses

1. Across program years, does the extent to which the Interagency Management Team exhibit evidence of capacity to provide integrated service delivery to CHHS program consumers increase?
    a. Hypothesis: The extent to which the Interagency Management Team exhibits evidence of capacity to provide integrated service delivery to CHHS program consumers increases across program years.

2. Across program years, does the CHHS program reduce racial disparities between Black and White prenatal women related to LBW and VLBW?
    a. Hypothesis: The racial disparities in LBW and VLBW between Black and White prenatal women will decrease across program years.

3. Across program years, does the CHHS program reduce racial disparities between Black and White pregnant women in the initiation of prenatal care in the first trimester?
    a. Hypothesis: The racial disparity in first trimester initiation of prenatal care between Black and White pregnant women will decrease across program years.

4. Across program years, does the CHHS program reduce racial disparities in the

proportion of consumers having a birth interval less than 24 months?

   a. Hypothesis: The racial disparity in the proportion of consumers having a birth interval less than 24 months between Black and White consumers will decrease across program years.

5. Across program years, does the CHHS program increase the rate of screening for perinatal depression among women clients?
   a. Hypothesis: The screening rate for perinatal depression among women clients will increase across program years.

6. Across program years, does the CHHS program improve the breastfeeding rate to above 50% among women clients served by a doula?
   a. Hypothesis: The CHHS program will improve the breastfeeding rate to above 50% among women clients served by a doula.

7. Across program years, does the CHHS program increase the percentage of consumers for whom care coordination is initialized that actually receive CHHS services?
   a. Hypothesis: The percentage of consumers for whom care coordination is initialized that actually receive CHHS services will increase across program years.

8. Across program years, does the CHHS program positively impact the Healthy Start screening rate of pregnant women in the three offices served by the CHHS perinatal nurse to at least 85%?
   a. Hypothesis: The screening rate of pregnant women in the three officers served by the CHHS perinatal nurse will reach/exceed 85% across program years.

9. Across program years, does the CHHS program increase/maintain the percentage of consortium members that are consumers to at least 45%?
   a. Hypothesis: The percentage of consortium members that are consumers will reach/exceed 45% across program years.

Section II. PROCESS

A. Primary analysis of data collected for programmatic purposes was conducted to assess trends over project years in select outcomes. Community and consortium members were involved in delineating the outcome measures to track over time, as well as providing input related to methods and timing of routine data collection. Evaluation findings are regularly reported back to community and consortium members during monthly consortium meetings held at community-are churches. The study was a prospective cohort outcome evaluation tracking trends in CHHS program clients over time. All clients were included in the cohort thus no sampling was involved. Due to the inability to gain access to identified vital statistics data for the CHHS project

area to enable linkage with the CHHS programmatic database, clients of the CHHS program were not able to be compared to controls, or women residing in the same project area not participating in the program.

B. Data sources included programmatic data maintained by CHHS project staff. All data collected for programmatic purposes were entered into a centralized Access database, linking mother and infant dyads, as well as repeat birth to women over time. This system was developed during the first and second funding years, and fully implemented during January 2003.

C. Several data collection instruments were used including:
   a. Florida Healthy Start Prenatal Risk Screening Instrument: The prenatal risk screening instrument is administered to all pregnant women in Florida during the first prenatal visit at the woman's provider's office. The screening instrument is completed by the client. All screens completed by clients within the 17 census tracts served by the CHHS project are transferred from the Hillsborough County Health Department to the CHHS project office
   b. Florida Healthy Start Infant (Postnatal) Risk Screening Instrument: The infant risk screening instrument is completed by hospital staff personnel following the infant's birth. Infant screens for infants residing in the CHHS project area are transferred from the Hillsborough County Health Department to the CHHS project office.
   c. Documentation of Initial Visit for Healthy Start Data Form: This form is a required state document for Florida Healthy Start participants. It is completed by the CHHS case manager to document initial client contact, or attempt to make client contact. Data from this form will be used to summarize contact data including the number of days elapsing between program referral and client contact (to ensure compliance with Healthy Start state guidelines), and to estimate the number and characteristics of clients that case managers are not able to contact.
   d. Edinburgh Postnatal Depression Scale: The EPDS is designed to assess probable maternal depression among postnatal women. It has subsequently been used to detect maternal depression in the prenatal period as well. The scale is completed by the client unless a language or literacy barrier exists, in which the case manager reads aloud the questions. The EPDS may be administered during the prenatal period, within 72-hours postpartum, and/or 4-6 weeks postpartum (depending on client entry and exit into the program).
   e. Prenatal Face Sheet: This form is completed by the case manager designed to gather additional demographic and medical characteristics of the client not available on the Prenatal Healthy Start Screen.
   f. Postnatal (Infant) Face Sheet: This form is completed by the case manager designed to gather additional demographic and medical characteristics of the client not available on the Prenatal Healthy Start Screen.

g. Participant Satisfaction Survey with CHHS Services: The participant satisfaction survey is designed to assess client satisfaction with the various service providers of the CHHS project. The client completes the survey unless there is a language or literacy barrier in which case the outreach worker administers via an interview format. The outreach worker does not provide direct CHHS services, and is thus in a role to be objective regarding client satisfaction.

h. Client Satisfaction Survey with Prenatal Providers: This satisfaction survey is designed to assess client satisfaction with prenatal care services received from their health care provider (not CHHS provider). The client completes the survey unless there is a language or literacy barrier in which case the outreach worker administers via an interview format.

i. Community Capacity Measures for the Interagency Management Team: This survey is designed to assess several aspects of capacity of community groups including project influence, group collective efficacy, perceived benefits of participation, and perceived cons of participation. The survey is administered at least one time a year to the Interagency Management Team which consists of key stakeholders from the various program partners across the County. The survey is adminstered by evaluation staff and completed as an anonymous self-report survey. Data are enterered and analyzed to identify process indicators. Comparisons are made across survey adminstrations.

Section III. FINDINGS/DISCUSSION

A. Please refer to Appendix E, for a complete presentation of findings across program years for key questions 1-9.

B. Program Successes At-A-Glance:
   a. Among Interagency Management Team members moderately or highly involved, statistically more agreed that the members 'share similar values', 'have concerns similar to my own', and 'care about one another' in CY2004 as compared to CY2003. This finding exhibits evidence of increased group collective efficacy related to shared beliefs and trust and represents increased capacity among IMT members.
   b. As compared to other community coalitions completing similar surveys in the Florida area, the perceived benefits of participation on the IMT are extremely high. Among IMT members moderately or highly involved, statistically more rated 'increasing collaboration with other community members,' as a benefit of participation in CY2004 as compared to CY2003.
   c. The racial disparity ratio in LBW between Black and White prenatal clients decreased from 7.9 in CY2001 to 1.1 in CY2004.
   d. The racial disparity ratio in the percentage of consumers having a birth interval less than 24 months between Black and White consumers decreased from 5.7 in CY2003 to 1.63 in CY2005.

e. Screening rates for perinatal depression, using the Edinburgh Postnatal Depression Screen, increased from 45% in CY2002 to 93% in CY2005.
f. The percentage of doula-served clients that reported breastfeeding at least half of the time at six weeks postpartum increased from 38% in CY2002 to 67% in CY2005.
g. The percent of consortium members that were consumers across all program years exceeded 45%.

C. Methodological Limitations: Methodological limitations in the evaluation include significant amounts of missing data on birth outcomes and other periconceptual outcomes such as breastfeeding and utilization of family planning methods. Many women in the CHHS program are closed to case management services prior to delivery, thus routine data collection of birth outcomes including birthweight, weeks gestation, and breastfeeding rates are not adequately assessed. All percentages reported in this evaluation document are among clients for which data were available. Although a significant limitation, those clients for which data are missing represent clients at *lower risk* than those clients remaining "open" during the entire prenatal and postnatal periods (currently, women who are lower risk are closed out to case management services earlier in the postnatal period than women who are higher risk, due to limitations on human resources).

Section IV. RECOMMENDATIONS

A. To increase the availability of birth outcome data and expand the potential for more robust analyses in the future, it is recommended to increase the amount of time clients remain open to case management services – at least long enough to adequately capture birth outcome data.

B. Seek access to identified birth record data from Florida Vital Statistics to allow for a true epidemiologic cohort study where clients exposed and non-exposed to the CHHS program are compared related to birth outcome data, controlling for potential confounders such as maternal demographic and medical characteristics.

C. Conduct a process evaluation of the implementation of the CHHS program and tie it to birth outcomes. Data will soon be available to track client encounters with case managers. The "Encounter Form" is designed to track all encounters of CHHS staff including initial contact with clients, initial assessment of clients, ongoing care coordination with clients, other healthy start services such as counseling and support, and administrative services. An analyses that looks at the impact of "length of prenatal exposure to to the CHHS program" on birth outcomes is critical at this time to advance the argument of keeping all prenatal clients (lower and higher risk) open during the entire perinatal period.

D. Conduct analyses looking at the impact of client satisfaction on program outcomes. It is hypothesized that clients more satisfied with the CHHS program will have better program outcomes. It is recommended that cleint satisfcation data be entered into the centralized

programmatic database, linked to other program data, to enable this analyses to be conducted.

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

A. Program staff will discuss options to enable case managers to keep all clients open during the perinatal period. Limitations in human resources pose a significant challenge.

B. Evaluation staff for the 2005-2009 project period plan to request identified birth record data for Hillsborough County, Florida to compare birth outcomes among women exposed and non-exposed to the CHHS program.

C. Evaluation staff for the 2005-2009 project period are designing more process measures to incorporate into the proposed evaluation.

Section VI. PUBLICATIONS

No manuscripts have yet to be developed and submitted for publication.

VII. Fetal and Infant Mortality Review (FIMR)

Infant mortality is viewed as a sentinel even in a community and a key indicator of its health and well-being. The Fetal Infant Mortality Review (FIMR) process was developed by the American College of Obstetricians and Gynecologists to provide a method for communities to review fetal and infant deaths and determine underlying system issues that may be contributing to those deaths. In 1993, Florida began to implement FIMR projects through the Healthy Start coalitions. Coalitions became institutionalized in this process when they were added to the Florida Statutes that protect information collected through mortality reviews from legal disclosure and provide immunity to participants in those reviews. As part of a community's public health activities, FIMR is exempted from HIPAA requirements for informed consent.

From 1994-1996, the Coalition administered a FIMR project. Due to funding reductions from the Florida Department of Health (DOH), this project ended after two years. In the fall of 2003, due to a rising infant mortality rate, HSC decided to re-start FIMR and completely fund the project through the agency's own resources. Our project is one of 24 projects in the state.

FIMR reviews fetal and infant deaths on a case by case basis. Medical information is abstracted for each case from the prenatal record, hospital records and autopsy report. In addition to this medical information, information is collected, where applicable, from Healthy Start, Healthy Families, Department of Children and Families and arrest records. A summary is presented of this information to a Case Review Team. All information presented through FIMR is de-identified and patient, doctor (s) or hospital names are not mentioned or provided to CRT members. Information presented at the meeting is collected at the end of the meeting and destroyed.

"The role of the CRT is to review case summaries and determine if there are underlying system issues in the health care system, social service system or community infrastructure that may have contributed to the death and provide recommendations for strategies to address those issues" according to Leisa Stanley, MS, the Coalition's Associate Executive Director and staff lead for FIMR. Hillsborough's CRT is co-chaired by Dr. Charles Mahan of the Chiles Center at USF and Dr. Robert Yelverton of Tampa Bay Women's Care who also co-chaired the original project. The CRT meets monthly for two hours to review four to six cases. CRT membership is provided at the end of this article.

There have been 35 cases reviewed since January 2004. The team focuses on specific causes of death in order to ascertain patterns in risk factors for those deaths. A retrospective review was completed on all 2002 and 2003 deaths due to homicide, Sudden Infant Death Syndrome and Suffocation. Currently, the CRT is reviewing infant deaths due to preterm births. Two initiatives were developed as a result of the retrospective reviews.

The Beds 4 Babies campaign was launched as a response to the number of SIDS and suffocation deaths where the infant was co-sleeping with an adult. In these cases, the co-sleeping was due more to socioeconomic issues and than a parent's desire to bond with her child. The families had no safe place for the infant to sleep. According to the American Academy of Pediatrics, the

number one precautionary measure to prevent SIDS is to place the infant in a safety-approved crib.

Thanks to the generous support of local businesses and individuals, the Beds 4 Babies campaign has funded cribs for over 100 families within the Healthy Start and Healthy Families system of care. The campaign was jumpstarted by Stacy C. Frank and George F. Gramling of Frank & Gramling Law Firm, who first contributed, and then distributed a solicitation letter to every member of the Hillsborough County Bar Association.

The second initiative was forming a partnership with the Hillsborough County jail. At any one time there are between 30 to 40 pregnant women housed in the infirmary at the Orient Road jail. Frequently, these women are also addicted to either alcohol and/or illegal drugs. They represent a high-risk group of pregnant women who need intensive intervention services. Through Healthy Start and THAP (Tampa Hillsborough Action Plan), a full-time position has been funded to work with these women while they are incarcerated. Kym Hessing works in the infirmary ensuring that these women are educated regarding Healthy Start, substance abuse treatment, HIV, healthy behaviors during pregnancy, etc. In addition, she assesses their need for community resources and provides linkages to those resources when these women are released. Through the Zero Exposure Partnership, the Drug Abuse Coordinating Council (DACCO) has hired a Women's Resource Specialist who works with this population. Kim Hayes role is to assess the women's need for substance abuse treatment and link them to a treatment provider when they are released.

The Coalition would like to thank the following members of the Case Review Team who have given generously of their time, expertise and insight over the past year. Their contributions will have a lasting impact upon our County's system of care for infants, women and families.

Vicki Addleson, Health and Social Services, Hillsborough County
Lo Berry, MA, Central Hillsborough Healthy Start
Margaret Mueller Boyer, RNC, MS, University Community Hospital
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Kim Hauser, MBA, The Birth Defects Registry, Dept. of Pediatrics, USF
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Craig Kalter, MD, Florida Perinatal Associates
Charles Mahan, MD, The Chiles Center, USF
Claudia Mahoney, RN, Tampa General Hospital
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Cyndy Miller, Mayor's Office, City of Tampa
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Richard Sheridan, MD, St. Joseph's Women's Hospital
Leisa Stanley, MS, The Healthy Start Coalition of Hillsborough County
Robert Yelverton, MD, Tampa Bay Women's Care

LAST NAME	FIRST NAME	ORGANIZATION	MEDICAL SPECIALTY	TITLE
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Berry	Lo	Central Hillsborough Healthy Start		MA, Project Director
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Breslow	Brenda	St. Joseph's Women's Hospital, Social Serv.		MPH, Mgr Clinical Res. Mgt
Counts	Slake	The Children's Board		MA, Community Serv. PM
Emden	Kris	Family Safety Program Office		Operations & Management Consultant II
Gorski	Peter	Lawton and Rhea Chiles Center	Developmental Pediatrician	M.D.MPA Executive Director
Gulino	Sam	Hillsborough Co Medical Examiner's Office	Pathologist	M.D.
Hauser	Kim	Florida Birth Defects Registry, Depart. of Ped, College of Medicine, USF		MBA, Project Manager
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Kalter	Craig	Florida Perinatal Associates	Perinatologist	M.D.
Mahan	Charles	USF/Chiles Center	OB/Gyn	M.D., Director MCH Policy
Mahoney	Claudia	Tampa General Hospital		R.N., Director of Nursing
McEwen	Brian	Child Abuse Council		PhD, Associate Director
Teauge	Sophia	City of Tampa - Police Department		Deputy
Mironchuk	Susan	Hillsborough Kids, Inc.		MSW, Clin. Oper. Specialist
Murphy	Jane	Healthy Start		MPH, Executive Director
Pullara	Jan	Women's Health Care	Midwife	CNM
Sheridan	Richard	St. Joseph's Women's Hospital	Neonatologist	M.D.
Stanley	Leisa	Healthy Start		MS, Assoc. Exec. Director
Yelverton	Robert	Tampa Bay Women's Care	OB/Gyn	M.D., Admin/Medical Dir.

VIII. Products

The following products have been forwarded to Material and Child Health Library, Resource and Reference Collection and to Project Officer, Johannie Escarne:

Manual: Central Hillsborough Healthy Start Cultural Competency Curriculum/Training (on file at MCH Library)

Calendar: Central Hillsborough Healthy Start Project 2003

Charting Documents

- Sample prenatal Healthy Start chart
- Sample postnatal Healthy Start chart

IX. Project Data

The following OMB Approved Performance Measure forms have been submitted electronically:

- 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)