Impact report 2001-2004

1. Overview of Racial and Ethnic Disparity Focused On By Project
In 2001 the racial disparity between the infant mortality rates for Blacks compared to other groups within the Project Area was a major concern. From the onset Boston Healthy Start Initiative’s new model of service focused on Black pregnant women. The project experienced some success in decreasing infant mortality within their Project Area by the end of the Demonstration Phase when the rate for Black infants dropped nearly in half from a rate of 19.5 to 10.8. However Blacks continue to experience a 30% higher rate in comparison to other groups of women. For example during 1996-1998 the Black infant mortality rate of 11.3 stood in contrast to the infant mortality rate for White (9.9) and Hispanic (5.9) infants in the BHSI Project Area.

Due to the high infant mortality rates occurring in specific communities the BHSI Consortium voted to keep the original Project Area and focus on Black women. They defined a sub-population that included African American, Cape Verdean, Caribbean, African, Haitian, and Latino women who self-identified as Black. Ninety percent of these women live in the Boston neighborhoods of Roxbury, Dorchester, and Mattapan; these were the communities that continued to have the highest rates of infant mortality in the city.

Prior to determining the services for this phase BHSI developed a comprehensive plan based on a through review of the needs assessment that included current data reflecting the project area’s socio-demographic characteristics, indicators of material health status, pregnancy outcomes, and pregnancy-related risk factors. In addition, a detailed analysis of existing service capacity and referral patterns, this information informed the basis of the plan to address unmet needs and to argument the current perinatal system of care. The data clearly revealed that Black women experience infant deaths, preterm births, low and very low birth weight infants and maternal complications at disproportionate rate in comparison to other women in Boston. These disparities persisted despite Black communities being adjacent to some of the world’s finest medical institutions and Boston’s renowned reputation as a center for academic medicine and state of the art hospital care.

The information was complied from a wide range of sources, and several strategies were employed to ensure input from all relevant constituencies. First, data was collected from the federal census, vital statistic records (birth and deaths), state and municipal institutional data bases such as the Massachusetts Department of Public Health and the Boston Police Department, pertinent academic and governmental studies of the project area, and local programs delivering services to pregnant and parenting women. Second, major health care providers in the project area including hospitals and community based organizations, were surveyed to determine their capacity. Third, consumers were surveyed on health care utilization and accessibility of services. Fourth, focus groups of community residents and local providers were conducted by community based organizations in conjunction with the Healthy Start team.

The foregoing data, in combination with information on service capacity, revealed major deficits in services in the Project Area. Despite an enviable array of services for women and children in Boston, service problems in the BHSI Project Area included: inadequate pediatric and prenatal
sessions; shortages in perinatal substance abuse treatment; lack of health education and insufficient family planning resources and funding; under utilization of women’s health services; lack of case management and homevisiting, particularly after 30 days postpartum; lack of adequate housing; lack of childcare and transportation needed by women to access services and insufficient bilingual/bicultural staff at specific agencies.

There were also problems with the service system that pertained to the organization of health care services, inter-agency relationships, and community-agency relationships. These problems included: fragmentation of care and limited capacity to offer a continuum of care beyond prenatal services, no health coverage after 6 weeks postpartum and varying eligibility requirements for free care pool. There were additional problems such as the lack of adequate follow-up for high risk infants and women who have had adverse outcomes; insufficient planning for the development and application of protocols and standards of care in many areas; insufficient referrals between health and human service providers as well as the lack of linkages between family planning, primary care, maternity hospitals and neo-natal intensive care units.

As the planning process for the Boston Healthy Start Initiative progressed, it became clear that specific intervention models were required to ameliorate the problems identified through BHSI’s needs assessment, community forums and lessons learned. Following submission of its comprehensive plan to the BHSI Consortium they voted to focus on Black women within the BHSI project area and implement the four core services; outreach and client recruitment, case management, health education, interconceptional care, and depression screening and referral. To address the systemic problems of service fragmentation, lack of cultural competence, and limited mental health resources BHSI’s plan included systems-building strategies in the local health action plan, Consortium development and collaborative efforts to enhance services within the BHSI project area.

Based on the synthesis and analysis of data and consumer input BHSI defined priority areas for the implementation of phase III. These were; comprehensive system of health care that offered a continuum of services for Black women and their infants from pregnancy to two years after delivery, a formalized protocol for depression screening and referral and interconceptional care, including annual physical, pap smear, consistent STIs’ screens and mammograms when age appropriate. The system action strategies also focused on efforts to promote community leadership, increase public awareness of perinatal health disparities, increase consumers capacity to govern the project and enhance BHSI agencies and providers’ cultural competency and service provision.

The Boston Health Start Initiative began as a community driven effort and as the project moved from one phase to another to address the major issues that impact infant mortality and create disparities in perinatal health the project learned the importance of involving the consumer. It was recognized that a service is more effective if those using it believe in its worth. Hence, the only way to sustain improvement in infant mortality rates and eliminate disparities is to sensitize the consumers and health care providers to the value of their involvement in program development and implementation.
For example, the BHSI women needed to learn that maintaining good health prior to pregnancy can play a major role in improving their birth outcomes and their overall quality of life. BHSI Health care providers needed to learn how to improve their interaction with patients from different cultural and psychosocial experiences to prevent bias in diagnosis, and improve their patients’ access to quality and equal medical treatment. This would provide the necessary impetus to adopt preventive methods for lowering various risk factors, which contribute to the higher rates of infant mortality and to the poor health status that many of Boston’s Black pregnant women experience. Improving the health of women in between pregnancies and building a more user-friendly health care system brings BHSI closer to preventing the problem at its source and implementing a program that will produce lasting results in improving the health conditions and eliminating disparities among Black women living in the BHSI Project Area.

II. Project implementation

BHSI’s Consortium membership, including providers and consumers decided that the combination of case management services during pregnancy and continuing through the 2nd year post partum was a practical approach to promote a continuity of care to improve maternal and child health among Black women in the Project Area. BHSI learned through the needs assessment that many Black women were in poor health prior to pregnancy; some lacked health coverage, mistrusted the medical system, others frequently utilized the emergency services at hospitals as their primary care provider. Consequently they developed sporadic patterns of utilization frequently entering prenatal care late and dropping out of the medical system soon after their delivery.

BHSI developed the case management model to specifically capture these women it was expected that by providing early case management services to Black pregnant women at risk for a poor birth outcome would reduce the incidence of low birth weight and detect unfavorable factors affecting pregnancy or subsequent infant development. The minimum set of services provided included: coordination of care, screening for perinatal depression, home visiting, education related to self-care during pregnancy and after delivery, nutritional education, and informing families about the resources available to them and how to access those resources, for two years postpartum.

BHSI Consortium decided to contract with community health centers and community based organizations to provide the case management program. The project has had success in the past with this approach to service provision. Boston has a strong community health center system that is an integral part of the health service delivery system in the City and they have the capacity to provide a wide array of services including obstetrics, gynecology, adult medicine, family medicine, dental care, mental health services, and home care and specialty referrals. Community health centers provide comprehensive primary and preventive health care and social services, and serve medically underserved individuals and families, regardless of their ability to pay. Each health center strives to address community health needs in linguistically and culturally competent ways.

BHSI moved toward implementation with the issuance of a series of requests for proposals (RFPs). It was decided early on that given the service infrastructure which already existed in Boston, the most efficient and effective approach to service delivery would be through a subcontracting arrangement that has proven to be a successful approach. A unique, equally inclusive proposal review process was developed; community residents were recruited from the Consortium and
project area to join review panels. They accounted for nearly 30% of all reviewers and two-thirds of all reviewers were people of color. Reviewers were also recruited from academia, international health consulting firms, birthing hospitals, community and city agencies, the state’s Department of Public Health, other state agencies, and consumer and community advocacy groups.

Boston Healthy Start Initiative (BHSI) successfully implemented a strong perinatal case management system offering services by sub-contracting with 14 local programs within the Project Area: 8 community health centers; 5 community based agencies that target special populations (Haitians, Cape Verdeans, Latinas, substance abusers or homeless women and 1 hospital site that works with pregnant adolescents). Contracts were awarded through non-competitive continuation process.

Outreach and Client Recruitment

A. Approach

The primary purpose for outreach was to find pregnant Black women who were disconnected from care and services and offer them case management support services that allowed them to be more engaged and access the services they needed. BHSI also outreached to women of childbearing age to provide health education, and written information on how to access health care coverage, and the importance of receiving primary care in between pregnancies. Data from a variety of sources indicated that many women in Boston are inadequately connected to the health care system; and receive only episodic care consequently many are in poor health prior to pregnancy putting them at risk for a poor birth outcome.

BHSI outreach activities included aggressive efforts to reach these women in places they frequented in their daily activities, such as in supermarkets located in their community, hair salons, youth clubs, Laundromats. BHSI worked closely with community leaders and faith-based initiatives that were committed to support their communities in addressing their social and health needs. Further, BHSI built its relationship with programs that targeted specific high risk populations like the Boston Health Care for the Homeless (BHCH) program, and the Department of Transitional Assistance (DTA), in efforts to reach high-risk women.

There were a large variety of community outreach and service organizations in the Project Area, even before the creation of the Boston Healthy Start Initiative, numerous health and human service agencies as well as the health centers and community based organizations doing outreach to communities of color, especially Black women in the Project Area. These included churches, local grassroots organizing committees, and cultural associations, in addition to the established network of health and social service providers.

Although there were gaps in services, and many neighborhoods which had not received their fair share of institutional and governmental support, and the Project Area was by no means isolated or devoid of activity. Therefore it was possible to build upon the structured service programs and outreach activities already in place. This greatly facilitated the process of outreach and client recruitment for the program. In addition BHSI required that only programs that had a comprehensive outreach component and a demonstrated history of working with Black women within the project area were eligible to apply for funding.
A final rationale for BHSI’s approach to outreach was that increased funding was available through Title V to support outreach workers permitting the program to develop a streamlined approach to outreach activities. BHSI was able to focus on coordinated outreach efforts that produced consistent prevention health messages, eliminated duplication of services and enhanced efficiency of outreach efforts within the BHSI Project Area. In addition outreach workers expanded their capacity to deliver multifaceted messages using a variety of approaches that reached Black women from the different cultural groups living within the BHSI Project Area.

B. Components
Given that there were other sources of funding to support direct outreach and client finding activities at so many of the BHSI provider sites, it was decided to hire an outreach coordinator. The coordinator provided leadership for BHSI’s outreach activities, including the development of an annual outreach activity schedule, identifying events and coordinating staffing schedules to ensure representation of all BHSI contracted sites. This position mainly facilitated outreach activities and identified training needs and other support mechanism for the outreach workers. In addition to working with the BHSI outreach workers the coordinator worked with site health educators to identify cultural and linguistic appropriate educational materials by conducting quarterly literature review groups. The streamline approach permitted BHSI the benefit of purchasing substantial materials to support outreach efforts and to develop culturally appropriate materials that was not available.

The major component of the outreach service was the coordination of outreach efforts across all program sites. Although outreach activities occurred at each contracting site the benefit of having a staff person whose primary task is to coordinate outreach enhance the capacity of all BHSI sites to perform outreach and case finding activities, and develop outreach efforts that target difficult to reach Black pregnant women. This approach to outreach assisted BHSI in developing a strong networking system, and made a larger impact across the entire Project Area. All outreach workers met on a monthly basis to develop an annual calendar of events, share resources such as materials and incentives. They developed strategies and agency linkages to reach the most difficult of women living within the BHSI Project Area.

C. Resources that facilitated or detracted from implementation
As mentioned earlier the state Department of Public Health supported much of the outreach positions and activities across BHSI sites. During the implementation and development of BHSI this assisted the program in establishing their approach to outreach. However over the past four years, many of the sites have experienced major cuts in their prevention programs. This was mainly due to the budget cuts experienced by the state. Programs such as substance abuse prevention among pregnant women, HIV education, and MCH case finders for high risk pregnant women. As a result community health centers and other programs lost outreach workers and community health educators that worked closely with BHSI case managers.

Fortunately BHSI was in the third year of the project and the majority of clients where already enrolled and very little recruitment was required. To compensate for the outreach efforts to educate and inform communities about related health information BHSI depended on their summer outreach workers and coordinated efforts lead by the outreach Coordinator. BHSI revisited this approach for the upcoming phase of the program and facilitated planning meetings with the
contacted sites. Most community health centers felt that they could continue their own outreach efforts given their on-going relationships with the communities they serve. BHSI also decided to allow agencies that needed outreach workers to include them in their budgets. It also became clear that most of the case finding activities was more appropriate for the case managers that had an established relationship with their clients.

**Case Management**

**A. Approach**

The new expanded model of services ensured a continuum of care for pregnant and postpartum women that last for two years after delivery. The model incorporated interconception care and screening of pregnant women for perinatal depression. The BHSI case manager will follow the women from OB/GYN to primary care to ensure that the health team is well-informed about client’s needs and that the services provided are complementary. The case management team consisted of a nurse, social worker, and an outreach worker and case manager. The purpose of this new model is to ensure that woman and their families are connected to health and social services, specifically women who have dropped out of the system or who utilize the system sporadically. The approach is designed to address barriers, and identify supportive services to ensure that these women have access to care. This includes access to financial entitlements, transportation, interpreter services, and health education materials in their languages and at their appropriate reading level.

In BHSI's needs assessment, existing case management services were found to be insufficient especially for Black women. Services were sporadic, not culturally appropriate and some programs lacked case managers, community advocates, or nurses who were willing to venture out to the communities. Others had a waiting list, or, due to large caseloads, were unable to give adequate attention to high-risk women and infants. Both the research literature and local experience suggested that case management services could make a critical difference in affecting birth outcomes; early support and appropriate care could significantly improve both maternal and infant health status. Thus, high priority was given to case management/care coordination as a means of supporting women and increasing the chances of infant survival in high-risk situations.

**B. Components**

BHSI's case management has a number of components that include a series of assessments, home visits, health education, advocacy, and care coordination. The model was developed to ensure a continuum of care for Black pregnant and postpartum women. It uses a team approach that is coordinated by the case manager, who works with a nurse, midwife, nutritionist, health educator and physician. Services include a comprehensive health psychosocial assessment using a common screening tool that is used by all BHSI contractors, the Women’s Health Questionnaire (WHQ). BHSI developed the WHQ as a multifaceted risk assessment tool its purpose is to be helpful in better identifying the health and social risks of women in order to address them in a timely and appropriate way.

BHSI case managers utilize the WHQ to integrate medical and social services for women who often have the highest risk for poor outcomes, including perinatal outcomes, regardless of their state of pregnancy. It provides a method for coordination of care between prenatal and primary care services in addition to improving communication between women and their physician in order
to enhance the effectiveness of services. During the woman’s participation in the program she is assessed using the WHQ screening tool three times.

Home visiting services included a minimum of 9, with a mandatory home visit by a nurse within 72 hours of delivery. Additional home visits within the first month following delivery are to ensure that both mother and infant are reconnected with services, that the home environment is conducive to successful parenting, and to evaluate the safety and well-being of the infant; processes for referrals to postpartum care and follow-up.

Home visits may include health education related to self-care and infant care; nutrition, breastfeeding information and social support. Case management services also include other health education such as HIV and STI's, substance abuse, family planning, reproductive health, parenting support. The case managers support and guide women to appropriate resources and educate them on how to access and maneuver through the maze of services and systems and make effective use of resources.

Care coordination is a major component of case management given that many of the BHSI women will need on-going support to move to a comfort zone in dealing with the medical and social service systems. Many perceive these agencies as adversaries interfering in their lives when they or their families are in crisis. Much of the case managers work is assisting clients in accessing services prior to crisis and informing them on what documentation they may need to meet eligibility requirements and what the women could expect in terms of time frames, and the number of meetings before services could actually be received. Learning how to maneuver through the systems of care was and remains a very important area for women to receive support. One of the frequent concerns highlighted in the needs assessment mentioned by the women was the difficulty in negotiating the bureaucracy in order to receive public assistance in health insurance, child support, WIC, or housing support.

The final component of BHSI case management is the advocacy efforts that are of extreme value to the clients although much of the activities may vary women to women. Many of them come with an abundance of issues, from immigration, substance abuse, domestic violence, homelessness, to child protection cases. The case managers frequently coordinate case conferences, attend court cases, and in general work with all other agencies that may be involved in the woman’s live.

C. Resources that facilitated or detracted from implementation
The wealth of perinatal services in Boston facilitated the implementation of the new BHSI program. The case management service was implemented without too much difficulty due to its approach of augmenting existing clinical services within established facilities that were already serving the target population. The issue for many of the Black women living within the project area was not the lack of prenatal or post partum services but more the issue of access, coordination of services, the lack of awareness among Black women living in the BHSI project area of consequences of sporadic utilization of health services and the negative impact of being in poor health prior to pregnancy.

BHSI worked closely with their providers to configure a case management model that draws women into care, engages them throughout their pregnancy, and establishes an ongoing
relationship that transcends the delivery of the baby. Over the years BHSI learned through client focus groups that the main motivation for their continued involvement and completion of the program was the relationship with their case managers. The program has become more confident in their ability to address the role that maternal health, high risks due to social conditions, fragmentation in service delivery, and lack of provider sensitivity contribute to infant mortality.

The major role that BHSI consumers and community played in the governance of the project also facilitated the implementation of the program. They continue to be the main guiding force leading the direction and approaches to service. The program has been very successful in maintaining a strong consumer voice that has nurtured a sense of ownership by the community for the BHSI program. This sense of ownership promotes ongoing consumer involvement and ensures that the project’s services are designed and implemented based on culturally appropriate approaches that clearly address the situations and concerns of the women and their families.

**Health Education and Training**

**A. Approach**

Similar to BHSI’s approach to outreach the program required that all contracted agencies address essential elements of health education for pregnant and post partum women. BHSI’s contracted with local community based organizations and health centers to provide health education under the case management model. Agencies contracted with BHSI are required to have an existing health education component with the capacity to reach out to Black pregnant women who are not well connected to care. Most agencies already had health educators on staff. BHSI contracted agencies provide health education and they have the freedom to design and implement the education in formats appropriate for their specific population. The following are examples of health education strategies implemented by BHSI sites; prenatal and post partum support groups, monthly “expected mom luncheons” where difficult topics such as substance abuse and HIV are addressed by experts and consumers, newsletters, and community health fairs.

BHSI’s primary focus for this core service was on coordinating the resources to ensure there were consistent messages and that priority was given to topics identified by BHSI clients and through client program outcome data. One of the main strategies adopted to make the education and training model more effective was to use culturally appropriate educational material and to disseminate this information in the diverse languages spoken by sizable portions of the Project area population. All, innovative approaches (such as promoting health consciousness through participation in community activities) were adopted to engage especially difficult to reach vulnerable subgroups. Awareness building involved not only increasing knowledge about the risk factors for infant mortality but also providing strategies to overcome these problems.

In addition, the multifaceted education and training model developed by BHSI was premised on the view that improvements in community health which underpin the effort to reduce infant mortality are inextricably linked to socio-economic conditions. Thus, BHSI resources were leveraged to stimulate economic growth, employment, and training opportunities for project area residents. Services in the areas of adult basic education were identified in the needs assessment as a high priority for community residents, but were severely limited and under-funded in the Project Area. BHSI sought to address this problem through strategic efforts of education and training which targeted specific at-risk populations.
B. Components
The coordination and resources for this core service was shared between staff from the BHSI program and contracted sites. BHSI primarily coordinated trainings, provided consultants and supplied much of the educational materials to be distributed. BHSI also facilitated review sessions to identify culturally appropriate health education materials and fund translation of these materials if recommended by consumers.

BHSI required all contracted sites to provide a number of health education sessions, although they had flexibility to offer these topics in a manner that best served their specific population. The topics that needed to be covered included the following list of topics:
- Nutritional health during and after pregnancy
- Breast feeding
- Health education on interconceptional issues (including family planning, and the importance of postpartum and annual physicals)
- Perinatal depression, stress management, parenting support
- Smoking cessation, and substance abuse
- HIV and STD education
- Childbirth, early child development and parenting an infant
- SIDS including grievance support

BHSI also conducted activities during this phase under education and training. They included the following: Leadership training (though the consortium), women's health education, Public Information and education campaigns to raise community awareness of racial disparities especially infant mortality issues. They were the leaders in the development of health education materials and curricula to ensure that they were culturally relevant, multilingual, and written in appropriate literacy levels. BHSI's consumers developed the public service announcements (PSA's) that addressed a variety of health issues. Distribution of health education materials through outreach activities and contacts with health and human service providers and monthly "preview sessions" in which providers and consumers from the community were able to view and discuss videos and other educational materials.

BHSI conducted a substantial number of trainings as well. Trainings for service providers included; mental health, STI's, assessment techniques, domestic violence and substance abuse. Others were added to enhance knowledge of preconception health, family planning strategies, and chronic disease prevention that may affect future pregnancy issues - e.g. sexually transmitted diseases, hypertension, gestational diabetes, and the role of folic acid in reducing birth defects, exercise, nutrition, and health lifestyles. They also offered diversity and "undoing racism" training for consumers, and residents and health care providers working in the BHSI Project Area.

BHSI coordinated with a number of community empowerment projects and vocational training programs to outreach and recruit women from the program and as resources became limited BHSI continued to provide leadership training for consumers at Consortium meeting. Provider training was coordinated with the Public Health Commission training program CHEC. A standard set of trainings were offered annually that were identified through two major processes (1) by the BHSI providers who met on a quarterly bases (2) by consumers either through Consortium meetings, case management interaction, consumer satisfactory surveys, or focus groups, all which are
conducted annually. Therefore BHSI’s health education and training activities varied based on their lessons learned from each year of the project.

C. Resources that facilitated or detracted from implementation
The major resource that facilitated the implementation of the health education and training component was the programs’ connection with the city health department which supports all efforts to eliminate health disparities. BHSI was able to develop and implement coordinated media and public information activities that informed the project area residents, consumers and community based providers of the racial and ethnic disparity in poor birth outcomes, chronic diseases, and breast and cervical cancer. BHSI was able to saturate their project area with public health messages related to health disparities in a very cost effective approach, by participating in collective planning meetings and coordinating consumer involvement in the development of these messages across coalitions under the Boston Public Health Commission.

In addition to health education efforts BHSI collaborated on trainings with other Public Health Commission programs that targeted the project area residents, and medical and social service providers. The partnership permitted BHSI to train a substantial amount of people at a lower cost. For example they were able to offer Undoing Racism training to all their providers and over 50 BHSI consumers at a third of the cost. Another BHSI collaborative between the REACH 2010 projects to eliminate racial disparities provided the opportunity for a city wide conference that attracted over 600 people of color to address their concerns of how the issue of race impacts health disparity issues. BHSI has been fortunate to identify resources and participate in many events that support the programs’ goal to eliminate disparities in perinatal health the program has also been very successful in expanding the target populations awareness of public health problems and risks that may impact the high rates of infant mortality among Black women in the city of Boston especially those living in the BHSI Project Area.

Interconceptional Care
A. Approach
The BHSI case management model during the interconceptional period is designed to follow a woman from delivery to either the next pregnancy or (2 years) 24 months postpartum. This approach is to support women who in the past have not been consistent in maintaining their health. As mentioned earlier one of the major problems for women in the BHSI program has been their poor health prior to pregnancy and their sporadic utilization patterns of health care services. For this reason the case managers closely monitor and follow up with the women to ensure they keep required appointments, as well as connect her with the identified services she may need.

BHSI worked with the provider agencies to implement coordination of interconceptional care included in this process is continuous use of the Women Health Assessment Tool (WHQ). The second assessment is completed after pregnancy to determine what needs to be focused on during the interconceptional period. As mentioned before the WHQ produces two major reports one for the consumer and one for the medical provider. A woman’s health and social needs may clearly change after pregnancy and the reports are used as a guide to develop a care plan for the transition from prenatal care to primary care.
The case manager supports the woman through this transition and remains with her to coordinate the required services as well as provide social support for two years after delivery of the child. This approach was developed in response to the finding in the needs assessment where it indicated that the health care system provided services that were quite fragmented making it extremely difficult for women to receive a continuum of care from pregnancy, post partum through their interconceptional period.

The findings from the needs assessment also suggested that there was a lack of communication between OBGYN, adult medicine and pediatrics making it difficult for women to transition from one clinic to another. In addition consumers frequently complained about the lack of communication between them and their providers mainly their doctors. The use of the WHQ assessment tool especially the consumer and provider reports was designed to improve communication between the physician and patient as well as between the case managers. The expectation was that the WHQ reports would identify the woman’s concerns thereby offering the physician an opportunity to converse with the women based on her interest and concerns.

**B. Components**

BHSI’s core services of interconceptional care includes; 6-8 weeks post partum physical, family planning, breast feeding support, nutritional counseling, parenting support and, annual physical including pap and follow-up of needed, services identified through WHQ assessment. The foundation for the programs’ interconceptional care component actually starts during pregnancy at which time the relationship between the woman and case manager begins. The concept of a continuum of health care depends on this relationship continuing long beyond pregnancy. It is this relationship that will support the women in maneuvering through the maze of medical care for her and the infant guiding her through the transition from one kind of health service to another. Many of the BHSI women do not distinguish women’s health care by a specialist, "a doctor is a doctor". As a result many utilize their OBGYN as their primary care provider.

The BHSI case management model is designed to offer Black women the support and information to access a continuum of health care services that best meets their needs as they move from pregnancy. This is of value to women who prior to their involvement with BHSI were at risk for poor birth outcomes due to their lack of consistency and follow up with health care problems. The range of issues that continue to confront these women during the interconceptional period include accessing health insurance, not willing to move from OBGYN to adult medicine provider due to mistrust of the health care system, cultural beliefs that create barriers and prior patterns of sporadic utilization of emergency care.

During the course of this project period BHSI case management agencies have been very successful in increasing the programs’ client retention rate and supporting women through their transition from prenatal to primary health care services many of them have not found comfort in changing doctors. In response BHSI has revisited this expectation that women would automatically move from an OBGYN provider to a primary care provider. Currently BHSI works with all the contracting sites to ensure that their system has the capacity to support women who were not prepared to change physicians. Fortunately all BHSI providers were able to support these women in keeping their relationship with the physician of choice. The sites offer a family practice model or a woman’s health center where OBGYN and primary care services could be merged.
C. Resources that facilitated or detracted from implementation

There were two major systematic problems that detracted from the implementation of the interconceptional care component. (1) The lack of communication between medical providers, departments, and the different types of health care facilities. (2) The lack of protocols for what should be included in interconceptional care. BHSI’s need assessment highlighted the lack of coordination and communication between providers as having a major impact on the fragmentation of medical service delivery within the Project Area. Prenatal, primary care and pediatric providers did not talk to each other, hospitals and community health centers rarely communicated even if they were affiliates.

As a result women either had a multiple of providers from a number of agencies in her life or lacked any provider contact after delivery. For example a woman who received her prenatal care at a community health center and delivered at a hospital may be referred to a physician at the hospital for a six week post partum visit, instead of being referred back to the health center. The woman starts receiving her medical care at the hospital as well as her infant and then returns to the community health center when she has an emergency or can’t get an appointment at the hospital. The lack of provider communication is not unique to the BHSI program and in fact it is a systematic problem that results in fragmented medical care for many of the most vulnerable populations in this country.

The other problem with the medical system is the gap in services available to women after delivery. Women often complain that they become invisible to the system once the baby is born and there is limited discussion from their doctors about what they should be doing to maintain their health beyond the benefits for their baby. BHSI found little research associated to what medical and psychosocial services should be offered between pregnancies that could result in improved birth outcomes. The case management program was designed to decrease fragmentation of services by offering a comprehensive care coordinated model of service.

The services offered during the interconceptional period assist in building a foundation that will help women to develop patterns of utilization that are motivated by their commitment to maintain good health for themselves and their infants. The objective of this core service is to improve access, remove cultural barriers, enhance patient and provider communication, and strengthen linkages in BHSI’s system of care between providers, health centers, hospitals, and community-based agencies. The interconceptional care services builds a bridge between the different medical and psychosocial services a woman may need in between pregnancies and during her reproductive period.

**Depression Screening and Referral**

**A. Approach**

The BHSI was not a grantee of the Depression screening and referral funding under Healthy Start. However the program recognized that depression in women was a significant public health problem, and the program needed to include this core service in the case management program. The results from the BHSI needs assessment and responses from consumer focus groups suggested that the women the program planned to target would most likely be at risk for maternal depression. The needs assessment also included a literature review of research that showed pregnancy and
childbirth may be “triggers” for the onset of depression in women already vulnerable and prenatal and postpartum depression is associated with marital problems, and unwanted pregnancy. BHSI felt that the increased prevalence of depression may be reflected by growing numbers of single mothers, high levels of stress due to the lack of housing, and the lack of spousal support.

Given the probability that many of the BHSI women would present these risk factors BHSI convened a Maternal Depression Working Group (MD Working Group). The purpose of the group was to develop a screening tool that would be easy to administer, and be used routinely to screen Black women for depression, and to develop a referral process for women in need of treatment. Although BHSI had no additional funding for this core service the program believed that their women were at risk for maternal depression and it was possible to implement a screening process with limited cost to the program.

B. Components
The major components include establishing a mental health working group, development of screening tool and implementing screening and referral protocol. During the first year of the project the MD Working Group met monthly and established what is currently called The BHSI Mental Health Task Force. Members included BHSI consumers and providers, and mental health and maternal and child health providers who had experience working with Black women. The Mental Health Task Force invested substantial time in reviewing screening tools and developing implementation protocols. They led the efforts and guided BHSI in developing a screening and referral process for clients. In addition they identified specific strategies to heighten community awareness of maternal depression among pregnant Black women in the Project Area.

The task force recommended that the project use an established assessment that was well respected and accepted by the mental health community rather than attempt to develop a new one. They identified the Beck Scale Depression Inventory as the most appropriate depression-screening tool. The Beck was field-tested with BHSI consumers and it was confirmed as the most widely used instrument for measuring depression among mental health providers working in the BHSI project area. The BECK can also be used for monitoring a woman’s therapeutic progress and is easily conducted since it only takes just 5 minutes to complete and is self-administered.

The depression screening and referral process was totally implemented by the second year of the BHSI project and all contracted providers, case managers and their supervisors were trained. All BHSI women are screened 3 times once at intake during pregnancy, a second at postpartum and again a year after delivery. BHSI has an integrated system of care and has one contract with each of the 14 agencies to provide this service under a case management system of care. BHSI developed a formal referral process for those women who are identified as needing mental services. BHSI provides a minimum of 4 educational sessions for consumers on effects of perinatal depression, and cultural issues associated with mental health, effective screening and intervention techniques. In addition all providers received 3 trainings from a psychologist on mental health 101, working with clients who may be depressed and developing techniques to support women who are not interested in receiving mental health counseling.
Over the last two years of this project period BHSI worked to build a strong mental health referral and linkage system to ensure that BHSI women had access to services. Early on the Mental Health Task Force recognized that the mental health system did not adequately meet the treatment needs of women whose depression was identified through the screening tool. The tracking of referrals is accomplished by Case managers who monitor outcomes of referrals, and report to BHSI. Monthly written reports are submitted to the Quality Assurance Manager who also meets with providers on a quarterly basis on-going provider forums were developed to support contracting agencies to develop the needed referral linkages.

During the last two years of this project period the Mental Health task force major focus was to address the issues and concerns identified by BHSI providers and consumers. The group was kept informed of any difficulties or delays encountered in obtaining mental health services for women screening positive for depression. BHSI, in conjunction with the Consortium and task force monitored referrals, identified service gaps and barriers to care, and developed strategies for addressing them. Due to the on-going issues associated with BHSI clients accessing mental health services the local health system action plan continues to include an objective to enhance the referral and treatment network for pregnant and postpartum women with depression.

C. Resources that facilitated or detracted from implementation

The resources needed to facilitate this core service included the BHSI administrative staffs’ time to coordinate the task force meetings and provider trainings, research the availability of related health educational materials, and the costs of BECK screening tools, and consultant for provider and consumer trainings. BHSI contracted sites developed linkages together to enhance their capacity to address the needs of women, who are not willing to get involved with mental health treatment, but who are willing to attend a support group or similar stress reduction activities.

The major detraction to the implementation of the depression screening and referral core service has been the limited mental health services available within the BHSI project area, and the cultural beliefs and fears of stigma attached to mental health. One of the primary concerns in implementing a depression screening service was not having sufficient services available for those women who scored high having symptoms. In response BHSI developed a referral network among the contracted sites. The program was fortunate to have a substantial number of health centers that had a mental health program.

A woman who screened high for depression could be seen at any of the centers by the case manager scheduling an appointment. However their were two problems the program had not considered; (1) there were substantially long waiting periods for appointments (2) many of the women who screened with moderate to high symptoms for depression did not agree with the scores.

BHSI hired a consultant to formal assess and counsel those women who screened moderate or high for depression and could not get a mental health appointment within two-three weeks. The problem of women not agreeing with the BECK screening scores was much more complicated because it included addressing cultural bias, and fear of stigma that was based on some legitimate concerns. Many of the women BHSI work with have been exposed to substantial trauma and on-going stress and as a result their threshold for depression may be much higher than others. They don’t think they need counseling or mental health services they believe their lives would be
improved with “a good job, better neighborhood for their children, and a good man”. From their perspective feeling sad may be just a burden of their lives and based on current life circumstances they will experience different degrees of feeling bad some worse than others. As many of them stated” it is just a way of life when your poor and Black and we don’t need the counseling society does.”

BHSI has learned by analyzing the results of the BECK depression screening over the past 3 years that in fact a significant number of those women who did not receive mental health services and had a moderate or high score in their first screening their score by the second or third screening was decreased. The case management services seem to have had a positive impact on lowering women’s level of depression symptoms. BHSI is currently evaluating this finding to determine what were the factors that may be associated these decreases.

There were a number of efforts that were implemented in year 3 & 4 that may have had some impact on these women, for example the program implemented two different approaches using a support group format one called the Sister Circle and the other Slim Down Sisters. Both efforts offered support groups that were based on an African traditional model of Black women coming together to share their stories, concerns and solutions. The Sister Circle support group focused on spiritual growth and a woman’s right to take care of themselves. Participants learned how to nurture the inner soul which in turn increased motivation to improve in all areas including their spiritual, physical and mental health development. Slim Down Sisters focused on taking care of your self using a weight management approach, focusing on nutrition and getting women to add more physical movement into their daily activities.

Although both used a support group format the weight management was more successful retaining participates for the total 8 wks. BHSI learned that many of the women needed to have concrete objectives, tasks and processes to measure changes of improvement that offered encouragement and increased motivation. Slim Down Sisters followed this approach by offering weekly weigh-ins, periodic body mass reviews, cooking classes on site, and practical homework assignments chosen by the women to resolve problems or questions brought up in the group discussions.

In contrast the Sister Circle project was much more fluid, offering methods of relaxation, getting in touch with the inner being. Methods that focus on making you feel better may have not been as successful with BHSI women because it is difficult to hold on to the abstract when so many other things in their lives continue to make them feel bad. This is reflected by the comment made by a consumer “A good feeling only last until the next bad feeling”. It appears that an approach like this would need to be offered over a longer period of time for women to experience some consistency in improved emotional feelings to become motivated in practicing techniques. The Sister Circle approach appears to have the same problem for BHSI women as the approaches used in mental health; it is not time limited, there is no clearly defined process to measure improvement and success depends on participants’ capacity to deal with their feelings in a completely abstract manner. Given all the challenges of screening and referral for maternal depression BHSI decided to included coordination of mental health services into their Local Health System Action plan.

Local Health System Action Plan

A. Approach
Priorities for the Local Health System Action Plan (LHSAP) were identified from the needs assessment conducted prior to this Healthy Start phase. The development of the plan also incorporated findings from the Infant mortality Reviews, consumer focus groups and provider surveys, the National Periods of Risks model and BHSI’s lessons learned as the phase was implemented. The LHSAP provided the direction for the BHSI project it was used to establish efforts on specific priorities and guided the programs on going focus and collaborative activities. It was also a method to measure and track accomplishments in relation to systems change and linkages that would enhance the case management model which is to follow women for two years after delivery from prenatal to primary care.

BHSI has been very successful in implementing their LHSAP. The project identified four major themes to guide their activities: 1) reducing fragmentation for women’s health services 2) incorporate the voice of the consumer in all aspects of the project 3) enhance the content and coordination of interconceptional care 4) increase access to mental health support for depression among women during prenatal, post partum and interconceptional period.

The challenges confronted in developing the plan fall between two main issues one was the difficulty in coordinating meetings and phone conferences among prenatal and primary care and mental health providers to work on a plan. The other issue was getting professional stakeholders to listen and truly hear the concerns of the consumers. The project has worked through these challenges by being consistent, keeping non bias and remaining in the role has convener and involving all stakeholders in the decision making process and always following through with bringing products and suggestions back to the appropriate groups involved in the LHSAP efforts.

B. Components
From the onset BHSI staff coordinated a number of diverse groups to develop the LHSAP. The BHSI Project Director worked with the Consortium Executive Board, State Title V and local public health representatives, directors of the mental health centers in the project area, and representatives from the March of Dimes and SIDS programs. The Quality Assurance Manager and the Outreach Coordinator worked with BHSI providers and consumers, faith-based and community advocates and the Consortium membership. The major responsibility of the LHSAP falls under BHSI’s staff largely on the Director of the project working with the Consortium Board and their sub-committees, although, some aspects of the plan was coordinated by either the Quality Assurance Manager, or the Evaluator of the project depending on the aspect of the plan.

The four major focuses of the plan was successfully implemented through a number of strategies the reduction of fragmented services were decreased by the case managers efforts that include case conferences, the distribution of the WHQ reports to their clients’ and physician and working with health centers to coordinate services from prenatal, to post partum to adult medicine and pediatrics. BHSI’s Consortium, community outreach and public information activities, consumer satisfaction surveys and on-going focus groups were the major methods to ensure consumers involvement in every aspect of the program. The consumer voice is what guides the LHSAP as well as informing the plans accomplishments. BHSI’s Director and Evaluator work closely with the Women’s Infant Working Group committee’s that focus on systems change that will impact interconceptional care working closely with physicians and other medical providers, local
researchers, and the March of Dimes, to develop a formal protocol for a standard of care for women during the postpartum and interconceptional period.

C. Resources that facilitated or detracted from implementation
The primary challenge that prevents BHSI from achieving some objectives of the LHSAP is the major budget cuts that many of the programs have experienced in the last year. These changes have caused funding for prevention health care and psychosocial supports to nearly disappear making it difficult to address the fragmentation of services and preventing our women from receiving a continuum of care. Specific cuts that impact the project are substance abuse treatment, health education, smoking cessation, HIV testing and counseling and medical insurance and other health and welfare benefits. The cuts have made it difficult for clients to access care and for the case managers to coordinate care between clinical and psychosocial services. The project continues to assess the interconceptional component of the program to determine if other services should be included. The collaboration with the March of Dimes may actually produce a protocol that could be used across all BHSI providers. During this last year the program has been very successful with the final focus of the LHSAP of screening all women in the program three times for maternal depression and establishing a formal referral and follow-up system for mental health services.

Consortium
A. Approach
The BHSI Consortium has been in existence for 12 years developed from the onset of the project that was specifically designed to be community-driven. In the planning and development of the program, a decision was made to ensure community participation and involvement at all stages of the project from design to implementation and to avoid the pitfall of a top down approach. It was felt that only such community driven efforts could ensure that the project would address maternal and child health issues from the community’s perspective.

The BHSI Consortium primary focus is to address maternal and child health issues by allowing the community voice to guide the project. The Consortium began as a community driven effort where consumers do not serve in an advisory capacity but are actively involved eliminating disparity in perinatal health by lowering infant mortality in their communities. The BHSI community Consortium was the strategy adopted for sensitizing the target population and to raise the level of community awareness about the overall benefits to be derived from a lower IMR, and at the same time enabling the residents in the Project Area to adopt lifestyles that would result in lower prevalence of such risk factors.

B. Component
As the BHSI project grew from planning to implementation the planning steering committee became the Consortium. Mainly executive directors of health and social agencies the make up of the Consortium changed from program directors and local and state public health officials to, community faith based representatives, community leaders/advocates, frontline staff and project area community residents and consumers. The Consortium membership has a current mailing list of 456 with 181 community participates, and 224 consumers and 51 agencies on the Consortium roster. BHSI’s Consortium meetings average about 75 members every month where topics of their choice are presented in combination with related health information. Every year at the first meeting
in June we develop a schedule for the year and the membership votes on topics and issues of their interest.

C. Resources that facilitated or detracted from implementation
The strategies that BHSI uses to facilitate the participation of consumers on the Consortium include on-site childcare, transportation and meals at meetings. In addition, monthly meetings always take place at the same centrally located site and always at the same time. Consortium members determine agendas at meetings continue to provide an important forum for discussion and decision-making. Major program decisions and recommendations are also reviewed at the monthly Consortium meetings, providing another avenue for consumer involvement. BHSI also offers consumers skills development trainings that enhance their opportunity for employment.

D. Consortium additional elements

1) The BHSI Consortium was established from the onset of the project in 1992 it was formed from the original steering committee that was developed to work on the planning grant for the BHSI project. The major barriers were establishing the lines of power and roles between the community and the public health department, establishing trust between both groups, and keeping community participates involved through the process. Roles were developed for both groups which addressed the issue of power. The Consortium would be directly involved in the development of program services and approaches and determine what the services would be and how much and what kind of resources would be assigned to each component and program effort. Formal By-laws were established to ensure substantial community/consumer involvement and equal cultural and racial representation.

2) The working structure of the BHSI consortium is led by a Governance body called the Executive Committee is a formal board established by a set of By-laws that provides a clear set of guidelines that included establishing an Executive Board and a number of sub-committees that would be voted in from the BHSI consortium membership. Each year the Consortium elects an Executive Committee of 15 members based on the following categories and percents-52% consumers, 40% providers, and 8% state/local government-which functions as the Project’s governance body. The sub-committees are headed by the Executive Committee and any Consortium member can volunteer to work on sub-committees. The Executive Committee is held accountable by the Consortium membership who has final say on all activities and program development.

To ensure a strong community voice recruitment efforts for the BHSI Consortium memberships emphasize is on consumers and community residents from the project area. The BHSI Consortium has active membership of 456, 181 community participates, 224 consumers and 51 agencies and the percentage that attends at least 50% of the meetings is 30%. Given that all BHSI clients are considered Black the project focus is on the ethnic diversity of membership the breakdown by the final year of this phase by percentage is as followed: African American-35%, Latino, 27%, African 8% (CapeVerdean, Somaliand, and Nigerian) White-14%.

The current percentages of Consortium members represent the following categories:
- Public agencies or organizations- 12
3) **The activities this collaborative has utilized** to assess ongoing needs is primarily accomplished by consumer involvement; they comprise the majority of the Consortium membership. Their role has not changed; it is an equal partnership between the community and the city with clearly defined roles. Much of the activities are overseen by the BHSI Executive Board and its committees. The following is a list of sub-committees and their responsibilities; the Executive Committee hires the Project Director and supports her with the daily management of the project, the Finance oversees the project budget, Evaluation reviews data and outcome progress reports, Public Information/Education develops health education materials and media campaigns and Membership Development coordinates recruitment, outreach and sustainability activities to support Consortium membership.

BHSI is a community-driven project where the Executive Board is responsible for general oversight of the program and keep the Consortium membership abreast of all program development and when changes must be implemented it is the full consortium membership that makes decisions, voting to approve or reject categories of service and how the services should be designed.

Consortium members involved in the Public Information/Education Committee have implemented public information and outreach efforts, as well as set the spring and summer schedule for community and media events, highlighting BHSI’s case management system of care. The Consortium created specific health materials to educate the community about BHSI and increase the community’s awareness about the associated health problems related to perinatal and interconceptional care, screening and intervention services for maternal depression. Consortium volunteers also attend public community forums and focus groups, to inform researchers of the issues in relation to racial disparities in perinatal health within the project area.

The Consortium members participate in other local consortia serving the same population. They attend local perinatal meetings sharing information to ensure that the community voice is always present. The BHSI Consortium has expanded over the years they have grown beyond just supporting BHSI activities. Many of our members are involved in other initiatives that impact their communities; they sit on their Empowerment Zone Board overseeing employment training activities, and the development of small businesses in their communities.

Consumers from the Consortium participated in leadership training provided by the REACH 2010 Breast and Cervical Cancer Coalition. The workshops focused on leadership, organizing and advocacy skills and were designed to facilitate the movement of community residents into positions as leaders, organizers and trainers. They also may be members of...
other community initiatives targeting their neighborhoods, such as the Safe community coalition that works to prevent neighborhood violence and designs efforts to decreased youth violence, and establish safe areas in the community for children and youth to play.

4) **The major strengths in the community** that have enhanced the Consortium are their resilience and ability to network among each other to address the crises that occur within their small neighborhood. BHSI built on their capacity to network and work with very little resources and to share that information by a substantial word of mouth strategy that could only be compared to the best newspaper and media effort in town.

5) **BHSI has overcome many of the potential barriers** identified over the last twelve years. Initially to ensure the development of a strong consortium BHSI hired a staff person whose primary responsibility was the recruitment, designed, and coordinate the consortium activities including on-going presentations at monthly meetings. The barriers included membership lacking critical stakeholders, unstable relationships among members and irregular attendance by key members. Most of these barriers were addressed using a team building approach meaning the director of the project had to have established an on-going relationship and be respected and strong enough to confront difficult issues with the group members.

The Consortium members needed to feel ownership of the project to want to stay and work through the problems. To develop ownership of the project consortium members must feel value and be recognized for contribution and be directly involved with defined tasks that produce concrete results based on their feedback and suggestions. To establish a strong Consortium their value must be recognized and be utilized in clearly defined tasks that produce concrete results.

6) **The strategies that BHSI uses to facilitate the participation of consumers** The level of resident and consumer participation in the Consortium has long been a hallmark of its success. Many different methods were employed to bring community residents and consumers into the Consortium, and to ensure their continuing involvement. Although most of the strategies and activities remained constant throughout, some changed as the Consortium evolved and as members gained more experience. Therefore, as community members became more sophisticated in dealing with a range of issues, the tools used to enhance their involvement became more refined.

During BHSI's planning stage, when the comprehensive plan was being developed, community outreach activities were designed and targeted specifically to inform community residents of the Health Start Initiative. Project outreach workers visited health centers, churches, schools, and businesses to encourage involvement and inform residents of the Project's activities. In addition to health education materials outreach workers distribute applications for Consortium membership. Prior to community meetings, they distributed flyers announcing the date and location of the meetings. Workers provided assistance to residents in getting to these meetings, arranging for transportation and child care when necessary. Outreach workers also distributed BHSI information sheets, which
contained facts about infant mortality, Healthy Start, the Project Area, and other relevant information.

To increase participation of public housing residents, targeted outreach was conducted at housing developments in the Project Area. The Massachusetts Union of Public Housing Tenants became an important allied of BHSI in developing the Consortium and many other collaborations ensued from this relationship, including the establishment of community centers and trainings for public housing residents as health outreach workers.

Consortium meetings were designed to be interesting and welcoming to community residents. They came to be perceived as a forum for joining with neighbors and other community members to share concerns about raising families, learn about existing resources, and advocate with like-minded individuals for changes in access to and availability of needed services. Outreach and recruitment activities are ongoing and extensive. They include distribution of flyers, advertisements on the radio and in community newspapers, and word of mouth recruitment by existing Consortium members. An orientation process for new members was developed, to help them gain familiarity with the goals, activities, and operations of BHSI and the Consortium. Each new member of the Consortium receives and orientation that includes the history and mission of BHSI, its goals and objectives, the role of the Project Director and the grantee, their roles and responsibilities as Consortium members, a study of the by-laws, and the funding process.

All people who attend the meetings receive a letter thanking them for their attendance, and flyers are mailed every month with the agenda for the upcoming meeting. The Project Director attends every meeting and provides a program update. She actively seeks out members who participate in the meetings to encourage their involvement in public policy activities. Consortium members come to know that the Director is available by phone and that they can rely on her to respond to their questions or concerns, provide them with information, and put their issues on the agenda of the next Consortium meeting. This has had the effect of making the Consortium a vital and responsive organization, and one that is accessible to consumers.

The membership committee actively engaged in recruitment of new community members, and facilitated the process of new members' orientation to the Consortium. The membership committee also took on the responsibility of encouraging new members to participate in BHSI committees and activities. For example the Consortium's mission statement was developed through a consensus-building process that included extensive consumer/resident participation. The mission statement emerged as a strong reflection of their priorities and concerns. It emphasizes education and advocacy by the community on its own behalf, and the formation of partnerships with service providers to ensure their responsiveness to community needs and strengths.

A hot meal was served at each Consortium meeting, which, along with the provision of child care and transportation, enables many mothers to participate who otherwise would not have been freed from pressing work and parenting responsibilities to attend a meeting. Consumer participation was also enhanced through ongoing training to broaden consumer
understanding of the policy issues and decisions the Consortium must make. Leadership development trainings were provided, and consumers were given encouragement and support to get involved in both the policy and project work of the Consortium.

In addition, monthly meetings always take place at the same centrally located site and always at the same time. Consortium members determine agendas at meetings. Every year at the first meeting in May members develop a schedule of topics for the year. Major program decisions and recommendations are also reviewed at the monthly Consortium meetings, providing another avenue for consumer involvement. BHSI also offers consumers skills development trainings that enhance their opportunity for employment.

7) BHSI was able to obtain consumer input in the decision-making process because consumers are part of the governance and policy making process for the program. This is accomplished mainly through the Executive committee activities, monthly consortium meetings as well as consumer focus groups and satisfaction surveys. The approach utilized by the program ensures that consumers are involved in every aspect of the program. It was the consumers that suggested that BHSI develop a comprehensive case management model of service for the new phase. They were part of the needs assessment process through focus groups, involvement in planning meetings, and participation in surveying BHSI neighborhoods to assess its’ individual resources. Consumers continue to be the leading force that guides the BHSI program any changes in service implementation, development or focus must be approved by the Consortium, first step is to present to the Executive Board then to the whole Consortium membership for their vote.

8) Consumers were utilized in determining the new case management model of services that the BHSI program implemented during this phase of the Healthy Start Program. Throughout the 4 years in addition to the governance of the program, consumers were involved in the following BHSI efforts: the development of Public information/education materials their suggestions directed the public information and outreach efforts, as well as set the spring and summer schedule for community and media events. They identified and/or created specific health materials to educate the community about BHSI and increase community awareness about the associated health problems related to perinatal health. Consumers were involved in the RFP process and establishing the criteria that all potential contracting agencies needed to meet to qualify for funding.

BHSI consumers suggested that the project focus on women’s health during and after pregnancy. They wanted to promote the importance of interconceptional care, as well as screening and intervention services for maternal depression. They identified culturally appropriate brochures and screening tools. Consortium volunteers also attended public community forums and focus groups to inform researchers of the issues in relation to racial disparities in perinatal health within the project area. The Consortium members participated in the local perinatal meetings sharing information to ensure that the community voice is always present.

Sustainability Approach
Planning for sustainability began early in the life of the project, with the understanding that a process must be put in place to ensure that BHSI’s mission would not be forfeited with the possibility of expiration of the federal grant. The Consortium established a sustainability committee which immediately began to consider its long term goals, and to look at how this might be realized. A comprehensive plan for sustainability was developed, which included objectives, activities, and a timeline for implementation. At the same time, it was recognized that the plan had to include efforts that focused on sustaining systems of care that BHSI had implemented as well as identifying funding sources.

Sustainability was looked at as an ongoing project, which would require the participation of many groups and individuals. BHSI is in a unique situation since all the core services occur at community based programs through a contract for services provision. Therefore BHSI’s efforts needed to support the sites to obtain alternative funding for some of the services initially funded by BHSI. It became clear that a variety of strategies must be used to identify creative alternatives, especially given the prevailing political climate. There is a current push for restraint in government spending, and an aggressive move from governmental responsibility for the poor, making reliance on conventional means not a sufficient approach to achieve BHSI’s sustainability goals.

Components
The primary responsibility for sustainability was with the project Director of BHSI working with the Transition Committee of the Consortium which has always been actively involved in sustainability planning. In an effort to maximize funding and avoid duplication of services BHSI developed the case management program integrating these services into existing MCH Title V programs within community-based agencies. Throughout this project period BHSI administrative staff worked vigorously with each contracting site to develop a boiler plate application that would help sustain established services. While at the same time BHSI Project Director worked with the Deputy Director of the Public Health Commission to negotiate with appropriate governmental agencies, and support consumers in advocating for legislative action to financially support maternal and child health services. In addition, BHSI expanded some of their existing partnerships to attract alternative funding resources including local and national foundations such as the Boston and Ford foundations.

BHSI participated in numerous planning groups, policy forums, and task forces to address the ongoing challenge of identifying resources to sustain maternal health services. Not only has the Project Director and BHSI staff been actively engaged in these efforts, but the Consortium has provided leadership and a community voice to health policy discussions in the city of Boston. Due to the projects’ heavy consumer involvement BHSI has had to be very careful to examine funding sources that are attached to some moral reflection of the current political agenda. Funding like abstinence only and promotion of marriage places judgment on some of the most vulnerable populations suffering from major racial disparities in perinatal health.

C. Resources that facilitated or detracted from implementation
Perhaps the most rigid barriers encountered that detracted from implementation of BHSI’s sustainability efforts was the general attitude of the current political leaders against supporting prevention health efforts and the medical and social service systemic resistance to change. In the world of health and human services, massive and complex systems have evolved over a long
period of time as discrete and independent entities. They have different structures, different rules and regulations, and different intricate bureaucracies. Therefore even small modifications, with obvious practical benefits, were difficult to come by. Negotiations were hampered by institutional protocol, and good ideas sometimes had to be abandoned. We found for example, that the integration of BHSI innovations/services with other entities such as Medicaid/managed care or MDPH, while not impossible, extremely complicated.

1) Efforts with manage care organization over the past 4 years have been difficult given the focus of local and federal government to cut back on health care benefits for many of BHSI’s target population, including the working poor and immigrants. The program continues to meet with Medicaid and Managed Care providers regarding cost-effectiveness of our services and to find ways to make outreach and case management services reimbursable. Towards the end of this year BHSI has found it difficult to keep this activity going given the major budget cuts that have occurred in the public health arena. The program has been forced to turn their focus on getting services that have been cut for mothers and their infants

In spite of these challenges during this reporting period BHSI continued to work with managed care and third party programs to restore some basic services such oral health, medical coverage during pregnancy especially for immigrant women, substance abuse treatment and coverage for ultra sounds. In the last year of the project period BHSI sustainability efforts have been basically put on hold and the program has had to focus on negotiation with appropriate governmental agencies, and advocating for legislative action to restore and promote maternal and child health services.

2) The major factors associated with the identification and development of resources may be summarized as follows;

• The development of a comprehensive plan early in the life of the program
• Community/Consortium involvement in all the sustainability efforts.
• BHSI expanded its collaboration with the Department of Revenue to develop programs focusing on male involvement and support.
• Further efforts in partnership with DOR resulted in the formation of a collaborative demonstration project with funding from the Ford Foundation to strengthen the role that health providers, schools, churches, and other service deliverers play in fatherhood development.
• Empowering consumers by providing advocacy training in accessing appropriate health care, improving communication between patients and physicians.
• The Boston Public Health Commission received $110,000 grant from CDC to replicate the Healthy Start community driven model in developing their REACH2010 Programs.
• The BHSI WHQ assessment tool is currently utilized in 13 community health centers within the project area, the REACH 2010 Breast & cervical Cancer program and the cities public health nursing program.

3) BHSI was able to overcome a number of barriers they encountered during this project period, one, which has already been mentioned, was the political climate related to funding of health and human services. Such factors as welfare reform, the tightening of immigration
laws, and an escalating profit motive in health care, contributed to a situation of greater need and less institutional commitment. This, in turn, led many programs, agencies, and initiatives to become fixed on protecting “their piece of the pie”, an attitude which negated most attempts at collaboration. Narrow self interest prevented many potential partners from exploring the mutual benefits from collaborative funding strategies. BHSI attempted to encourage others in project area, well as its own contractors to consider the advantages of joint funding pursuits. But this approach was often countered with hostility, at least in the beginning stages of sustainability planning.

The program decreased some the negative impact by coordinating efforts with consumers where they actually took the lead in approaching agencies as well as public service entities informing them of their need for specific services and collaborative efforts that promoted a more continuum of services. Other activities geared toward funding maximization include the restructuring of the project’s staffing pattern, program responsibilities and governance. BHSI was successful in building on the Healthy Start project by obtaining additional funding from the state, city and the federal government for the their Father Friendly Initiative which has become a separate self sustained program. BHSI has continued to implement a broad range of sustainability activities, which include negotiations with state and local government funding agencies, applications for private foundation funding, solicitation of in-kind contributions and exploration of public-private partnerships.

III. Project Management and Governance

A. Structure of the project management in place for the majority of implementation for the BHSI partnership between the Boston Public health Commission and the consortium comprised of consumers, providers and representatives of state and local government. The grantee for BHSI is the Boston Public Health Commission, who is the designated fiscal conduit. General oversight of the Project is handled by the Project Director who is answerable to the Consortium and its Executive Committee and the Commission.

Every year the members of the consortium elect an Executive Committee which functions as an uncompensated board of directors for the Consortium and its agent, BHSI. The Project Director supervises all managerial staff. During the project period BHSI administrative staff positions consisted of a Financial Manager, Executive Assistant for Director and Consortium Executive Board, an Outreach/Consortium Coordinator, Quality Assurance Manager, and an Evaluator. Outreach workers are hired as part time employees during late spring, summer and early fall to accommodate the demand due to major community events.

B. Resources available to the Project essential for fiscal or program management.

At the time it was created, BHSI's model of community empowerment and shared governance was a new phenomenon in the city of Boston. Understandably, there were many challenges which had to be met in order for the Project to move from the early stages of conceptualization and planning to full implementation. Because BHSI's structure differed radically from other programs under the Commission the major resource was the MOU agreement between the grantee and BHSI. The purpose of the agreement was to operationalize the rhetoric of empowerment and set bench marks and a formal understanding for what empowerment means in action. The agreement stated that the
management and operations of the grant are held by the BPHC and BHSI Consortium executive Committee. The role of the Consortium was defined as making decision about program design, the services and approach to service provision. BHSI is primarily a partnership of community residents and community organizations working together with the BPHC in a joint commitment to reduce infant mortality and eliminate health disparities in perinatal health.

Another resource that proved useful to BHSI in dealing with BPHC was their capacity as the fiscal conduit. BHSI was able to establish an efficient RFP, contract, and invoicing process. Quarterly meetings of the financial subcommittee and BHSI's financial manager were instituted to discuss funded services, the program's administrative budget. The finance subcommittee has continued to function as a check and balance on BHSI fiscal operations and to determine financial policy. They also introduced a team approach (involving the quality assurance manager, the evaluator, and financial manager) to contract negotiation and budget review. The team developed a billing packet, explaining BPHC and BHSI billing procedures, made available to all contracting sites and established protocols for site visits, data reporting, consumer satisfaction surveys, and client retention and discharge resulting in a more efficient contract management process and smoother communication between all the partners.

During this project period some of BPHC programs were a beneficial resource. By collectively pooling small amounts of program money BHSI was able to collaborate on more public information efforts, the development of health educational materials, expand provider and consumer trainings and skill building activities that promoted community empowerment. The partnerships with other programs permitted BHSI to reach many more people, produce high quality materials, and increase staff development efforts at a lower cost. The citywide conference on racial disparities in health is a primary example.

C. What Changes in Management and Governance occurred and prompted changes
Changes in management and governance took place at several points during this project period. Some of these changes were relatively minor, while others had far reaching implications. Much of the changes in management during this project period were associated to the change in BHSI’s service model. Administration staff needed to develop a total new support system for contracted sites. Grant management efforts needed to shift from just monitoring to substantial training and technical assistance. Not only did the program implement a new model it also developed a new data collection and reporting system.

The new program design brought additional tasks for the BHSI staff; the Quality Assurance Manager needed to enhance her computer skills in order to train providers how to input data and run queries, the Evaluator had to develop a MIS system for 14 agencies that included a entire program data base in Access in order to support the case managers to input assessment and screening results. An in-depth provider training had to be developed and implemented so case managers and their supervisors would be prepared to respond to the possible needs of women and their infants over a period of almost 3 years. During this project period BHSI learned that some of the possible reasons for health disparities may have more to do with unequal treatment, and institutional bias than access and service provision.
BHSI needed to develop strategies that encouraged systems of care to link when they usually did not work together. Over the course of the project period a whole new set of coordinated meetings, collaborations, task forces and working groups needed to be established. The new comprehensive case management model required that the BHSI support contractors by building a foundation that promoted care coordination to bring together service providers to address issues beyond health.

D. Describe what process had to be developed to assure the appropriate distribution of funds

At the outset, a RFP process was designed to include representation from all segments of the community innovative strategies were used to reach a many service providers as possible, including small, grass roots organizations. Special efforts were made to involve consumers, particularly those most heavily impacted by infant mortality, in proposal development and review. Service categories for the initial RFP were developed from a comprehensive needs assessment and analysis. Throughout its history, BHSI has funded direct services by subcontracting with local providers. These subcontracts were always the result of a RFP process which has evolved over time to suit the changing needs of the project and to ensure that services are uninterrupted.

Program categories and their scopes of services were developed with substantial input from consortium members, Project Area providers, and recommendations from the Infant Mortality Review group. Panels (consisting of Project Area residents, providers, and experts in the service provision category) were convened to review proposals and make funding recommendations. These were compiled and presented to the Executive Committee for final approval. Over the past twelve years the program has worked with most of the programs within the Project Area finally ending up with the best and most appropriate for the new model of services. As a result by Year 3, guidelines for continuation contracts for BHSI service providers were developed. Previously funded programs continuing to provide the same services were not required to respond to a new RFP. Decisions about program renewal were based on information provided as part of the contractor's compliance with service provision, reporting requirements, site visit findings, number of clients served, and retention of clients.

Contract refinement took the place of the RFP process this allowed existing contractors to highlight their accomplishments and specific qualifications that demonstrated their experience and capacity to continue service delivery. The process focused more on a continuum of services rather than development of new programs. This process ensured that funding went straight toward services as opposed to start-up costs, such as hiring and training new staff, and clients would have no interruption of services. As a result the project developed a comprehensive contracting process that greatly facilitated the appropriate distribution of funds.

E. As the project moved forward with implementation, what additional (non-HS) resources obtained for quality assurance, program monitoring, service utilization, and technical assistance the most significant were resources from the Public Health Commission to address racial disparities. Four years ago there were few existing health service programs that had experience on how to incorporate efforts to work on eliminating racial disparities. In the beginning of the project period BHSI struggled with issues of institutional racism, and provider bias. From the onset BHSI was confronted with some of these realities when some groups were extremely upset that the Consortium decided that the new program would target Black women, even though they were the group that was clearly experiencing disparities in perinatal health with the highest number of preterm births and a infant mortality
rate 3 times higher than any other group of women in the city. This was a difficult task for BHSI management team and the Boston Public Health Commission supported the project in a number of ways 1) They coordinated meeting with community leaders to support why the BHSI program was going to focus on Black women within the targeted Project Area. 2) They ensured that other pregnant women who may be at risk for a poor birth outcome would have services available to them through the Commission’s public health home visiting program (Healthy Baby Healthy Child) be They trained all BHSI staff on “Undoing Racism” a approach that combats institutional racism, the training was offered to consumers and community residents 3) Medical providers at many of the BHSI sites received a specific training from a physician hired by the Commission.

As the project moved forward other resources came from the BHSI contracting sites as the program used their funding as leverage to institute a comprehensive case management model. This new model required a major systematic change for many of the health care agencies in the BHSI project area. Forcing service departments within agencies to work together in order to provide a continuum of services beginning at intake which is at pregnancy following the women through prenatal and 2 years post partum to adult medicine. In addition the health agencies were required to developed strong linkages between their perinatal care and mental health services due to the mandated screening of all BHSI women for maternal depression. BHSI’s model of case management forces many of the community health centers in the BHSI Project Area into the position not only to develop formal referral process for mental health services but to implement a tracking system to follow up on results in obtaining mental health services and completion.

Over the course of the project period, BHSI developed many resources to improve the quality and responsiveness of services. These included assessment and screening tools and mechanisms for program monitoring, as well as for contract compliance and renewal. Technical assistance took many forms, and was cornerstone of BHSI’s program for quality assurance. The configuration of resources employed by BHSI evolved over a period of several years, as the Project did. From the time they were first identified or developed, these resources were fine turned and expanded to meet the changing needs and complexities of service provision and evaluation.

Every BHSI contractor expanded their quality assurance procedures that reached beyond just Healthy Start services. Many of them continued this process beyond BHSI services because many funders currently require a mechanism for consumer satisfaction to measured and reported on. Due to the heavy consumer focus of the BHSI project many of the contracted sites observed the benefits of on-going consumer feedback on the quality of services. In the first two years of Project implementation, BHSI created a quality assurance process for all direct service contracts. The process included the use of quality assurance monitoring tools, and agency review process, site visits, and forums with community providers. A quality assurance protocol, which was designed specifically for BHSI subcontractors, included instructions on how to evaluate program performance, site visit reports that offered corrective action, and specific trainings and technical assistance plan to support staff. Service monitoring became more sophisticated and comprehensive during this project period.

Technical assistance was supported by the Boston Public Health Commission, The Massachusetts Public Health Department (DPH), and The Children’s Trust Fund. Technical assistant needs were identified through program monitoring activities, quarterly provider meetings and consumer
satisfaction information. The quarterly provider meetings enable programs to learn from each other, and facilitated networking which led to better coordination, collaboration, and linkage. Additional technical assistance offerings were developed in response to common needs, some of which were identified by BHIS's Quality Assurance and Evaluation staff and some by the programs themselves. The Community Health Education Center (CHEC) a Commission program conducted a number of the provider’s trainings, on topics ranging from how to set limits with clients to home visiting assessment and DPH offered technical assistance in clients accessing public assistance for health care coverage, especially eligibility for legal immigrants. In addition BHIS case managers as well as consumers were often included in trainings that were funded by other programs such as The Children’s Trust Fund parent to parent program for families of color and consumer empowerment.

F. Cultural Competency of contractors and project staff as an issue; how addressed, and noticeable benefits one of the greatest strengths of the Boston Healthy Start Initiative has been the cultural competency of its contractors and project staff. Even in its planning stages, BHIS was driven by a commitment to serving the culturally diverse constituency of the Project Area. In every aspect of project planning and implementation, cultural competency was a priority. This is reflected in the composition of project staff, the awarding of contracts to agencies and community based organizations closely identified with the communities they serve and development of culturally and linguistically appropriate educational materials, and attunement to cultural variables in the delivery of services. Thus, cultural competency did not arise as a problematic issue.

Nonetheless, every effort was made to ensure that staff received the necessary support and training to sharpen their expertise in dealing with a culturally diverse population. This happened through a variety of means, including the following: Ongoing monitoring activities; Staff development sessions devoted to raising cultural awareness and competence; Consortium activities which provided a forum for cultural exchange and learning among consumers, staff, and providers. Diversity training for Project Area health care providers; Trainings for BHIS providers, organized on an as-needed basis, on topics of special training on culturally specific outreach models; and development of special projects and activities, within a cultural framework, to deal with the needs and concerns of particular groups.

IV. Project Accomplishments
Progress Report for the Boston Healthy Start Initiative Objectives

The primary goal of BHIS still continues to be reducing infant mortality in Boston by decreasing racial disparities in the perinatal system of care. This was done using a strong case management model that encompasses besides the regular case management care a number of services such as outreach, education, screening for depression and providing interconceptional care to the Black women in the Project Area. This report aims in identifying to what extent Boston Healthy Start Initiative achieved its project objectives and also to show the results from the depression screening and health screening tools and the satisfaction and outreach surveys.
Case management

BHSI’s case management begins with recruiting women early in pregnancy through outreach and follow-up at various sites in the Project Area. Intense case follow-up is continued through pregnancy and various issues identified, are closely monitored and the required services provided. The services are rendered at all 14 sites through approaches to meet the objectives set forth by BHSI. The results of the Project period objectives around case management are as follows:

PROJECT PERIOD OBJECTIVE 1(CM): By 6/1/05, increase to 85% the percentage of Black pregnant women within the BHSI-funded program receiving case management services from the first trimester of pregnancy.

Baseline: 74.5% of the Blacks in the BHSI Project Area received PNC in the 1st trimester. (1998 Vitals)

Project Performance Indicator: The percentage of Black pregnant women in the BHSI program enrolled in case management services from the first trimester of pregnancy.

Strategy: Aggressive case finding and recruitment of pregnant women in their first trimester.

Activities:
- Identify women through community outreach such as health fairs, public housing, and community events, targeted to Project Area women (Completed)
- Conducts outreach and in-reach through OB/GYN clinics at community health centers to identify and refer women for case management. (Completed)
- Follow-up with all identified women by case managers. (Completed)
- Monthly tracking of all positive pregnancy tests at each BHSI site to ensure that women are enrolled in prenatal care in the first trimester. (Completed)
- Provide outreach activities through various community agencies to identify women and engage women in care. (Completed)
- Monitor tracking system for all prenatal women. (Completed)

Progress: As of May 30, 2005, 1540 Black pregnant women have enrolled in the BHSI program for case management services. However we have information on 1391 cases (149 unknown) that were entered in the form for Pregnancy Services, which has the prenatal care information. Of the 1391 cases 1112 came in the first trimester = 80%, (BHSI Program data 05)

PROJECT PERIOD OBJECTIVE 2(CM): By 6/1/05, increase to 79% the percentage of Black pregnant women within the BHSI-funded programs receiving adequate Prenatal Care (PNC) through a case management service.

Baseline: 69.5% of the Black women in the BHSI Project Area received adequate prenatal care. (1998 Vitals)

Project Performance Indicator: Percentage of Black pregnant women within the BHSI funded programs receiving adequate prenatal care through case management services.

Strategy: Close monitoring of pregnant women by case management team.

Activities:
• Identify women through community outreach (health fairs, public housing, community events) targeted to high-risk Project Area women. (Completed)
• Conduct outreach, and in-reach through OB/GYN clinics at community health centers to identify and refer women for case management. (Completed)
• Follow-up with all identified women by case managers. (Completed)
• Intensive follow-through with women enrolled in case management services to ensure compliance with prenatal health care. (Completed)
• Link women with appropriate support services. (Completed)
• Coordinate case management with perinatal health care. (Completed)
• Coordinate monthly meetings with team to discuss clinical issues and monitor compliance with care and outcomes. (Completed)
• Coordinate care so multiple appointments can be rescheduled on same day to help clients receive adequate health care. (Completed)
• Provide intensive health education, including information on nutrition, signs of preterm labor, prenatal classes in English and other languages, breastfeeding, infant care, and safety issues. (Completed)
• Implement tracking system to monitor service utilization and missed appointments. (Completed)

Progress: As of May 30, 2005, 1163 women have delivered; of them complete information is available for 1055 women of them 756 have received adequate prenatal care. 72%. (Used Kessner’s Index). (BHSI Program and Clinical data 05)

PROJECT PERIOD OBJECTIVE 3 (CM): By 6/1/05, increase to 95% the number of women who are BHSI participants receiving a 72-hour postpartum home visit by the case management team.
Baseline: 83% of 794 postpartum women who are BHSI participants delivered during baseline period (9/99) received a postpartum visit. (Source: BHSI Program Data)
Project Performance Indicator: The percentage of women who are BHSI participants delivering a baby and who receive a postpartum home visit by a nurse.
Strategy: Close coordination between case manager and hospital and OB/GYN clinic.
Activities:
• Coordinate with midwives/obstetricians to arrange for discharge planning and subsequent home visit within 72 hours of delivery. (Completed)
• Postpartum visit provides parent(s) with information on family planning, maternal depression, and infant/mother care as well as an assessment of services needed/requested by parent(s). (Completed)
• Follow-up care provided by case managers, to ensure that issues identified during visits are addressed and appointments are made with both pediatric and primary care providers. (Completed)
Progress: As of May 30, 2005, out of the 1540 pregnant women 1163 have delivered, and of them 930 (22N/A) have received a 72-hour postpartum home visit by the case management team. Information N/A on 58 women 83.6% (BHSI Program data 05)
PROJECT PERIOD OBJECTIVE 4(CM): By 6/1/05, increase to 75% the percentage of infants (whose mothers are receiving BHSI case management services) who are up-to-date on immunizations and have completed required well child visits.

Baseline: 62.5% of 614 infants received at least 5 pediatric well child visits within the first year of life (FY 00, MIS Clinical Data)

Project Performance Indicator: The percentage of infants receiving appropriate primary care.

Strategy: Intensive care coordination between health care providers, case managers, and support staff. Tracking of infants by case management team from birth to two years.

Activities:
- Conduct home visit (by a nurse) within 72 hours of delivery to assess progress of each newborn and to link families to needed services and supports. (Completed)
- Conduct an additional home visit within the first month following delivery to ensure that both mother and infant are connected to services, that the home environment can support successful parenting, and to provide health education on newborn care. (Completed)
- Case management team members provide a minimum of six home visits during the first two years of infant’s life. (Completed)
- Screen all families and 0-2 year old infants to identify risk, develop care plans, and make referrals to services and support programs; refer families in need of intensive home-based services to healthy Baby/Healthy Child. (Completed)
- Provide education to individuals and groups regarding infant safety, immunizations, care of common childhood illnesses, SIDS, parenting support, and other key infant development issues. (Completed)
- Case Manager coordinates with pediatric provider to ensure ongoing care. (Completed)
- Case manager assists parent(s) reduce barriers that make it difficult to access pediatric care services. (Completed)

Progress: As of May 30, 2005, 1179 live births (including multiple births). Of these infants delivered 1144 were put into the tracking system for a two-year follow-up on well child visits and immunization.
Out of the 1144 infants, there are 876 children who are more than one year old by end of May 2005. Of these infants 617 (information on immunization not available for 94 children more than 1 year old) have the required number of well child visits and immunization. 617/ 876-94=79% (BHSI Program data 05)

HEALTH EDUCATION
As before pre and post tests have been be administered to women attending different educational sessions to determine their increase of knowledge following educational sessions and also to find out what needs, still remain to be addressed. As part of health education services, surveys and questionnaires were used to determine the level of the project’s accomplishment as well as to identify gaps in different health issues, which need to be addressed from the community’s perspective in a culturally appropriate way.
Trainings were done for the providers on an ongoing basis around different MCH issues and also constant trainings as required to enter information into the Access database and to run queries and generate reports.

Focus groups were conducted from time to time, that included both providers, and consumers, to help BHSI identify the problem areas that still remain uncovered. They helped identify topics for which materials needed to be developed.

Brochures were developed with the help of consumers and providers.

PROJECT PERIOD OBJECTIVE 1(ED): By 6/1/05, offer a variety of educational activities which address major infant and family health issues to 75% of Project Area residents.

Baseline: Due to limited funding, current activities are inadequate and do not provide us with good baseline information. The number of PA residents is about 140,000.

Project Performance Indicator: Percentage of Project Area residents reached through educational materials and media activities (attendance at community events, number of educational materials distributed, number of requests for information and support, number of people exposed to media messages)

Strategy: Broad-based media activity, public education campaigns and outreach activities.

Activities:
- Develop PSAs for local radio stations and community newspapers. (PSA’s have been done with one of Boston’s Stations that is geared more towards the Black community around Emergency Contraception, Importance of Partner Health, and Early prenatal care.). Develop monthly informational health columns that can be used in church bulletins, community newspapers, and health center bulletins. (Completed)
- Develop educational materials in multiple languages (i.e. English, Spanish, and Haitian Creole) (Mental Health Brochures have been developed following multiple focus groups that helped us identify the gaps) (Completed)
- Hold monthly consortium meetings and health forums. (Different health topics and issues pertaining to the community have been addressed at the monthly consortium meetings) (Completed)
- Conduct community outreach at health fairs, community ethnic and cultural festivals. (Completed)
- Develop innovative outreach strategies to reach women at churches, grocery stores, nail/beauty salons and community centers with information about health issues and access to health services. The BHSI outreach coordinator has visited different faith based initiatives, salons, community grocery store, health clubs and some shelters) (Completed)

Progress: Objective ongoing As of May 30, 2005, Brochures and fact sheets around various health issues for women and children have been distributed through the various health centers, at churches, salons, grocery stores. Consumers at the consortium meeting have been educated at the first meeting around the importance of attending and being a
part of the Consortium meetings so that they can themselves educate the other members in the community. Health fairs have been done by the agencies. Educational brochures have been distributed to the health agencies by BHSI on an ongoing basis. More than 50% of the BHSI residents have been outreached with educational materials and information.

**Informational workshops:**
14 informational workshops were conducted that were attended by 145 residents for the last 4 years

**Community Organizations:**
About 12 community organizations were outreached and flyers distributed.

**Faith based Initiatives:**
6 Faith based Initiatives have been contacted and fact sheets distributed. The outreach coordinator has reached to about 5000-6000 project area residents each year at the different events, at the churches and at the different housings. Approximately 3012 to 3818 surveys have been conducted each year for the last 4 years. The outreach coordinator has attended 65-87 events each year up to May 30, 05.

**Outreach Information from the 14 BHSI funded Agencies: (these might be duplicated numbers)**
- Number of Outreach Events by the 14 funded BHSI sites= 362-435 events each year
- Number of Pregnant women outreached= 2416 to 3020 women each year
- Number of Postpartum women outreached= 3212 to 3822 women each year.
- Number of consumers outreached= 6266 to 7205 every year for the last 4 years
  (BHSI Program data and BHSI Project Office data 05)

**PROJECT PERIOD OBJECTIVE 2 (ED):** By 6/1/05, 100% of BHSI participants during the inter-conception period will receive family planning counseling and services.

**Baseline:** 67%, 606 out of 980 postpartum women received family planning counseling/education and services CY’2000 (Source: BHSI Program Data).

**Performance Indicator:** The percentage of women who receive family planning counseling and services.

**Strategy:** Identify and recruit postpartum women for family planning counseling and services.

**Activities:**
- Establish a strong linkage with Title X to ensure that family planning services are coordinated with BHSI’s funded agencies. (Established)
- Case manager/nurse will provide family planning counseling in a culturally and linguistically sensitive manner to women and their partners at their postpartum visit and will review information at all patient contacts. (Completed)
- BHSI will provide family planning education at monthly Consortium meetings (Completed)
- Case managers will provide family planning education to women and their partners at the time of their infant’s well baby visits. (Completed)
- Case managers will follow-up women and their partners to ensure they do not miss their scheduled family planning service visits. (Completed)

**Progress:** Objective ongoing.
As of May 30, 2005, out of the 1540 pregnant women who enrolled, there were 1163 deliveries. They were recruited for tracking for two years and all of them have received family planning counseling and intensive follow-up services by the case management team. Of these women 819 women (135 unknown) came for 6 weeks postpartum visit and received Family Planning counseling and services. 79.7 % (BHSI Program data 05) All women coming for the 6 weeks postpartum visit receive Family planning counseling and services.

**PROJECT PERIOD OBJECTIVE 3 (ED):** By 6/1/05, 100% of pregnant and postpartum women who are BHSI participants will be offered health education in a culturally and linguistically sensitive manner.

**Baseline:** 76.9%, 764 out of 994 postpartum women received educational services (nutritional, parenting, family planning, etc.) in FY’2000 (Source: BHSI Program Data).

**Performance Indicator:** Percentage of BHSI participants who received culturally appropriate health education.

**Strategy:** Identify appropriate educational materials for BHSI participants

**Activities:**
- Conduct focus groups with BHSI participants who come from different ethnic/cultural backgrounds to identify/develop materials on the importance of interconception care and how to access health services in Boston including information on free care and publicly funded insurance programs. (Completed)
- Train case managers to provide education workshops to BHSI participants and to work closely with other health educators to develop consistent messages. (Completed)
- Materials will be developed and identified in multiple languages and distributed to all BHSI participants. (Completed)
- Pre and post- tests and focus groups will be conducted to assess the effectiveness of newly developed materials (Completed)
- The curriculum developed by BHSI for women of color called "Moving Mountains" will be used to enhance the physical and mental well being for the women recruited into the program. The curriculum was designed especially for women of color. (Sites use it when required) (Completed)
- BHSI will provide training to the case managers so that they can conduct workshops for their clients. (Completed)

**Progress:** As of May 30, 2005 out of the 1540 pregnant women information available on 1431 (109 Unknown) of these 1286 have received some kind of health education during the time of pregnancy. 90% Some of the topics are around, parenting, breast-feeding, infant care, HIV/AIDS, avoiding substances, smoking during pregnancy etc.

As of May 30, 2005, there have been 1163 deliveries to women enrolled in the BHSI program 84 had no information on education= 1079 of these women 855 received the required educational services especially around family planning issues, depression and parenting. =79% (BHSI Program data 05)

**INTERCONCEPTION CARE**
Our proposed model of care utilizes a case manager to ensure continuity of service for women through 2 years postpartum by assisting women link to primary care. Coordination between primary care/ internal medicine and obstetrical care was facilitated by an internal tracking system and the use at each site of a comprehensive computerized assessment tool which identified the social and health issues of each client.

To ensure the importance of this model, BHSI, has provided intense education. The BHSI Office has also provided adequate educational materials and have met with all the providers at the 14 sites and explained the importance of follow-up of women for two years following delivery. To enable this tracking BHSI uses an Access Database that helps the providers to closely monitor the women from pregnancy to two years after delivery. The objectives used for tracking the model are:

**PROJECT PERIOD OBJECTIVE 1(IC):** By 6/1/05, provide appropriate case management services for two years postpartum to 80% of Black women who were enrolled in BHSI during their pregnancy.  
**Baseline:** There is no baseline information available from the current BHSI program.  
**Performance Indicator:** Percentage of women followed for two years.  
**Strategy:** Effective case management, implementation of tracking system, provider training, link to on-line resource directory.  
**Activities:**
- Facilitate meetings with OB/GYN, primary care, social service, and public health providers to ensure a continuum of care for two years after delivery. (CM team does it on an ongoing basis. Site visits of the 14 agencies by BHSI team in 03 ensured that it is in place.) (Completed)
- Develop a coordinated referral system, which will be implemented to support the interconception case management activities. (Established at all the sites)
- Case management/provider training associated with interconception care will continue to be provided. (The BHSI staff also provided Training around interconceptional care and distributed educational materials.) (Completed)
- Monitor the tracking system. (Completed)

**Progress:**
Out of 1163 deliveries 996 women are active and receiving the required case management services till the end of 1st year after delivery on an average 86%. 770 women are active and receiving services till the end of 2nd year after delivery on an average 66% (BHSI Program data 05)

**PROJECT PERIOD OBJECTIVE 2(IC):** By 6/1/05, 70% of BHSI participants during the inter-conception period will receive an annual physical during the first and second year.  
**Baseline:** To be determined by the end of the first year from Medical Record Review.  
**Performance Indicator:** Percentage of the women in the interconception period who will receive an annual physical during the first and second year.  
**Strategy:** Close monitoring and follow-up.  
**Activities:**
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- Case managers will follow-up on identified women in a culturally and linguistically sensitive manner, and make the annual physical medical appointments. (Completed)
- Case managers will ensure women keep their appointments by reminder letters and telephone calls. (Completed)
- Culturally and linguistically appropriate educational sessions have been conducted at the monthly Consortium meetings to raise awareness of the importance of annual physicals and good health. (Completed)
- At the time of postpartum, a culturally and linguistically fact sheet about the importance of annual physicals were handed to all women by the case manager/nurse. (Completed)
- Providers trained at each site in effective use of the assessment tool and cultural competency. (Completed)
- A tracking system developed to identify clients who need appointments and/or who have missed appointments. (Completed)

Progress: As of May 30, 2005, 819 out of 1163 (135 unknown) have received their annual physicals. 79.6%

PROJECT PERIOD OBJECTIVE 3 (IC): By 6/1/05, 100% of BHSI participants during the inter-conception period will receive family planning counseling and services.

Baseline: 67%, 606 out of 980 postpartum women received family planning counseling/education and services CY’2000 (Source: BHSI Program Data).

Performance Indicator: The percentage of women who receive family planning counseling and services.

Strategy: Identify and recruit postpartum women for family planning counseling and services.

Activities:
- Establish a strong linkage with Title X to ensure that family planning services are coordinated with BHSI’s funded agencies. (Established)
- Case manager/nurse provide family planning counseling in a culturally and linguistically sensitive manner to women and their partners at their postpartum visit and will review information at all patient contacts. (Completed)
- BHSI will provide family planning education at monthly Consortium meetings (Completed)
- Case managers will provide family planning education to women and their partners at the time of their infant’s well baby visits. (Completed)
- Case managers will follow-up women and their partners to ensure they do not miss their scheduled family planning service visits. (Completed)

Progress: Objective ongoing.
As of May 30, 2005, there have been 1540 pregnant women who came and there were 1163 deliveries to women enrolled in the BHSI program. They have been recruited for tracking for two years and all of them have received family planning counseling and intense follow-up services by the case management team.
Of these women 819 women (135 unknown) came for 6 weeks postpartum and received Family Planning counseling and services. 79% (BHSI Program data 05)
All women coming for the 6 weeks postpartum visit receive Family planning counseling and services.

**MATERNAL DEPRESSION**
Depression in women is a significant public health problem, often confounded by issues of trauma or interpersonal violence and substance abuse. The BECK-II tool is used to screen all women thrice after entry into the program. The Mental Health task force has been established. The Mental Health Task force had identified the BECK Tool as the Depression screening tool and has been used for screening by all the 14 BHSI sites.

The readings from the BECK Tool were recorded in the Access database created for the case management program data. This was used in analyzing the information and finding how many women are depressed and also detect the exact component of the tool responsible for causing depression in the community. The tool is being administered to all BHSI pregnant women within 90 days of entry into the program.

**Results from the BECK Tool**: The tool began to be administered from August 2002 when we bought the BECK tool and distributed it to all the 14 health centers. A total of 895 pregnant women have been screened since August of 2002 up to May 31, 2005 using the BD-II. Of these women 567, have no or minimal depression. 152 women (17%) were mildly depressed, 101 women (11%) were moderately depressed, and 75 women (8%) were severely depressed. (BHSI Program data 05)

**PROJECT PERIOD OBJECTIVE 1(MD):** By 6/1/05, BHSI will establish and convene a working group of consumers, mental health and maternal and child health providers to develop a screening tool and implement a strong referral and network for treatment of pregnant and postpartum women with depression.

**Baseline:** Health of Women and Infant Working Group (HWIWG) established in 1998. The Boston Public Health Commission has an existing community based collaborative work group that addresses comprehensive health needs of Boston women, from which a committee will be drawn to accomplish the objective’s component parts.

**Project Performance Indicator:** Development of Task Force and screening tool, referral system and advocacy strategies.

**Activities:**
- Identify mental health/MCH providers, and consumers for Task Force.(Completed)
- Establish agenda and timelines. (Completed)
- Review existing screening tools for cultural, linguistic and ethnic appropriateness. (Completed)
- Develop a draft of screening questions. (BDI-II selected)
- Identify deficiencies in local mental health system within the BHSI Project Area. (Completed)
- Develop a uniform referral system for mental health services for BHSI participants. (Completed)
Progress: Objective Activities As of May 31, 2005, the Mental Health task force has been established. It comprises of providers from the different agencies of which there are nurses, licensed social workers, and non-licensed health care providers. The screening tool was selected. All the 14 sites used the tool and reported on a monthly basis and referrals were made to the identified referral system. (BHSI Project Office data)

PROJECT PERIOD OBJECTIVE 2(MD): By 6/1/05, 100% of BHSI participants will routinely be screened for perinatal depression at intake, and will have screenings completed at least twice more. (At intake, 8 weeks after delivery and at the end of the 1st year after delivery)
Baseline: There is no baseline data currently available.
Project Performance Indicator: Percentage of women screened three times for perinatal depression
Strategy: To complete screening for depression at three points for all women who are recruited in the program.
Activities:
• Coordinate a working group of mental health and MCH providers to develop a screening tool. (Completed)
• Facilitate focus groups with consumers and consortium members to present draft of screening tool and include their recommendations. (Completed)
• Train site-providers and case managers in utilizing the screening tool. (Completed)
• Choose five sites to pilot the screening tool. (Completed)
• Implement the screening tool with appropriate changes at all BHSI sites. (Completed)

Progress: Objective ongoing. Activities:
As of May 31, 2005, from the time the BECK started to be administered in August 2002, 1013 pregnant women have been enrolled. Of them, 895 have been screened for depression. 88%.
Minimal or no depression=567
Mild depression=152 (17%)
Moderate depression= 101 (11%)
Severe depression = 75 (8%)
Total=895
(BHSI Program data 05)

Out of 936 women who delivered after August 2002, 745 women were screened for depression at 8 weeks. 80%
Minimal or no depression=577
Mild depression=70 (9%)
Moderate depression= 53 (7%)
Severe depression = 45 (6%)
Total=745(22%)
PROJECT PERIOD OBJECTIVE 3 (MD):  By 6/1/05, all BHSI clients who have been identified with perinatal depression will be linked to appropriate mental health services.

Baseline: 107 women out of the 132 women identified with depression have received a referral (Source BHSI program data CY-02. This was 5 month data information as the Beck was implemented in August of 2002.)

Project Performance Indicator: Development of action plan, final reports, and results of needs assessment at end of grant period.

Strategy: Identify service gaps and develop action plan to realign resources to address current needs.

Activities:
- Establish a system evaluation to document the community action process. (Completed)
- Coordinate meetings with BHSI mental health task force and Consortium for Women in Recovery. (done)
- Develop needs assessment tools to document mental health needs and gaps in service. (Completed)
- Facilitate focus groups with consumers. (Completed)
- Facilitate consortium meetings to prioritize gaps and identify 2 deficiencies. (Completed) The gaps identified are: to enhance the referral system, and provide more education around mental health issues.
- Develop the community action plan. (Completed)
- Coordinate community forums inviting stakeholders such as faith based and community leaders, local public health and political officials, to increase their involvement. (Completed)
- Develop strategies for realigning resources to effectively meet needs of BHSI clients. (Completed)

Progress:

As of May 31, 2005, 261 women during pregnancy have been identified with depression. All of them have been referred for services but 203 were connected for services. 78% (BHSI Program data 05)

As of May 31, 2005, 168 women have been found to be depressed at 8 weeks after delivery. Referral information available for 115 women All of them were referred but 86 of them were connected for services. 75% (BHSI Program data 05)

PROJECT PERIOD OBJECTIVE 4 (MD):  By 6/1/05, BHSI will increase skills and awareness of providers and consumers in the BHSI project area in recognizing and understanding perinatal depression.

Baseline: 10 consortium training and 5 provider trainings were offered around a variety of health topics in FY ‘2000 (Source: BHSI Project Office and Program Data)

Project Performance Indicator: Number of trainings, attendance at trainings, and evidence of increased knowledge (to be determined by a pre and posttest at each training) of participants who attend training; number of residents receiving information about perinatal depression.
Strategy: Provide increased opportunities for providers and residents to better understand perinatal depression

Activities:
- Identify culturally appropriate training materials. (Completed)
- Develop pre and post test for each training session. (Done)
- Coordinate with BHSI agencies and Consortium schedule training. (Completed)
- Identify appropriate trainers/facilitators for each training session. (Done)
- Develop appropriate materials for use in a public education campaign. (Completed)
- Incorporate mental health information into existing BHSI educational materials. (Completed)

Progress:
As of May 31, 2005, a brochure was developed with valuable input from the consumers and providers through multiple focus groups. Also through the focus groups other valuable existing educational materials that would be effective for the community were identified.

Support systems have been established at the different health centers that bring women together and discuss about depression and other issues.
BHISI also made available to the women to attend the Slim down program or the Sister’s Circle a non-traditional support system to address depression. 40 women who were mild or moderately depressed were referred to the program, of them 30 women completed the 6 week Slim down program. The response for the Sister’s Circle was less.

CONSORTIUM
BHISI’s Consortium continues to function as a strong and stable multicultural partnership, which brings together many sectors of the community. A major strength of the Consortium is its focus on consumer involvement and decision-making. Consumers play a key role in BHISI policy development, and are involved in the implementation and evaluation of all activities.

PROJECT PERIOD OBJECTIVE 1(C): Increase the knowledge base for community residents around a variety of critical health topics by June 1, 2005.

Baseline: Four trainings at the Consortium meetings, 1998, with 90% demonstrating an increase in knowledge at the administered post-test. (Source: BHISI Project Office)

Project Performance Indicator: Increased knowledge for community residents (to be determined through post-test).

Strategy: provide opportunities for BHISI residents to attend interactive forums around a variety of health topics that are identified by Consortium members to be of interest/concern to area residents.

Activities:
- Sponsor trainings as part of the Consortium meetings. (Completed)
- Conduct training sessions outside the consortium meetings (for more in depth education, and to facilitate training in small groups) around the new MCH initiatives of interconception care and depression during pregnancy. (Completed)
• Design/purchase public education materials that can be used to support trainings and can be distributed throughout the Project Area. (Completed)
• Design tools to measure effectiveness of workshops, trainings and public education campaigns. (Established)

As of May 31, 2005, 32 Consortium meetings were held. Community residents, consumers and consortium members received trainings around racial disparity, Family Planning, Emergency Contraception, Infectious diseases especially around Sexually Transmitted Infections, Prematurity, Maternal Depression, Partners Health, Undoing Racism, and other MCH issues. (BHSI Project Office Data)

**PROJECT PERIOD OBJECTIVE 2 (C):** Ensure at least a 60% level of community participation and leadership in Healthy Start planning and management activities by June 1, 2005.

**Baseline:** 40% of community participation on the Executive Board in 1996.

**Project Performance Indicator:** Percentage of community participation and leadership in Healthy Start planning and management activities.

**Strategy:** Board and BHSI funded programs will actively invite consumers and create an atmosphere that supports consumers.

**Activities:**
• Mailings and outreach to Project Area residents to ensure ongoing recruitment of community residents. This is constantly done and the mailing list updated) (Done)
• Applications for Consortium membership are distributed at community events. (Done)
• Ongoing orientation and training for new board members recruited from the consumer membership. (Completed)
• Proving services, which reduce barriers to consumer participation, such as transportation and childcare. (BHSI provides transportation and childcare for the consumers to attend the Consortium meeting. Done)
• Creating and supporting a consumer cluster to allow consumers to work together to develop proposals and strategies for the Consortium board. (Completed)
• Annual elections to the Executive board and sub-committees. (Done in CY 04)
• Maintain adherence to Consortium by-laws regarding consumer participation and leadership. (Done)
• Consortium brochure distributed widely; it includes the actual application, which can be completed during outreach. (Done)

**Progress:**
As of December 31, 2005, 32 consortium meetings have been held. BHSI has a current mailing list for 456 of these 224 are consumers and 181 are community participants. We have about 5 Faith Based Initiatives attached to the Consortium. On an average about 75 consumers and community residents attend the meeting and the 60% level of community participation is maintained. (BHSI Project Office Data)

**PROJECT PERIOD OBJECTIVE 3 (C):** By June 1, 2005, develop a well trained group of at least 26 consumer members of the Consortium with skills in community organizing, advocacy, and leadership to direct the Consortium’s advocacy initiatives.

**Baseline:** 25 consumer members trained (1997).
**Project Performance Indicator:** The number of consumer members of the consortium trained in community organizing, advocacy, and leadership.

**Strategy:** Board and BHSI providers will identify and recruit consumer and offer a series of trainings for interested residents.

**Activities:**
- Community residents will be recruited from the consortium and local outreach events to be enrolled in the Community Health Education Center (CHEC). (Pending)
- Consortium members will identify advocacy issues to improve the delivery of services for Black women. (Done by the members at the consortium meeting in CY 03, especially around Mental Health issues.

**Progress:** Objective ongoing. Activities:
Trainings have been done for community residents on Undoing Racism, 10 consumers have been trained
5 consumers have been trained around Cultural Competency.
10 consumers trained around Advocacy and Legislative activities.
25 consumers attended the Prematurity Summit organized by the March of Dimes. (BHSI Project Office Data)

**PROJECT PERIOD OBJECTIVE 4 (C):** By 6/1/05, 25 men enrolled in the Father Friendly Initiative (FFI) will become members of the BHSI consortium and board, in addition to being trained to develop appropriate consortium agendas that highlight male issues related to parenting.

**Baseline:** Five men from the Father Friendly Initiative are current consortium members (BHSI 2000)

**Project Performance Indicator:** Number of men enrolled in the FFI who are active members of the BHSI consortium.

**Strategy:** Father Friendly Initiative staff, BHSI Board and providers will identify and recruit fathers who are participating in initiative programs.

**Activities:**
- Recruit new and additional board members who are fathers. (Completed)
- Provide introductory trainings as new board members. (Completed)
- Coordinate presentations for consortium meetings directly related to men’s issues such as health, parenting, and employment. (Completed)
- Establish ongoing forum to ensure that men’s issues are addressed throughout consortium activities. (Established)

**Progress:** As of May 31, 2005, Healthy Baby Healthy Child has trained about 100 men around Infant mortality. They have also been trained around anger management, and responsible fatherhood. 4 men from the Father Friendly Initiative have become members of the board. (BHSI Project Office Data)

**PROJECT PERIOD OBJECTIVE 5 (C):** By 6/1/05, increase the ability of the consortium to coordinate efforts across the project area to improve birth outcomes for Black women in the project area by soliciting more involvement in the consortium from business, social service providers, church leaders, and consumers.
Baseline: 125 current Consortium members, with less than 10% members representing businesses, faith-based organizations, and social service agencies (BHSI Project Office Data).

Project Performance Indicator: Increased percentage participation from targeted groups.

Strategy: Targeted outreach to solicit participation from new membership groups.

Activities:
- **Networking among BHSI’s contractors and project area residents.**
  In order to keep members updated and to support a comprehensive model of services the Consortium coordinates a number of activities. One such activity is the scheduled monthly presentations by BHSI contractors at Consortium meetings. One or more programs are highlighted each month, allowing the consortium membership to learn in detail about each program and the variety of services offered through it (e.g., the range of services available not only through the BHSI funded program but its sponsoring agency as well). (Established)
- **Public Information and Education**
  In addition to regular programming on infant mortality issues, the Consortium schedules presentations from the various social service, health, and mental health programs within the BHSI project area. Current prominent public health issues affecting our community receive attention in these forums. Issues such as HIV/AIDS, breast and cervical cancer, substance abuse, and mental health are addressed. (Done)

Progress:
As of May 31, 2005, we established a whole collaborative effort within our Project area that encompasses the mental health services that exist within the Project area. This includes 3 mental health families services program, 4 mental health facilities with inpatient and outpatient services, and 2 child and adolescent social services agencies. Representatives are members of the Consortium as well and attend our Mental Health task Force meeting.

These programs also make frequent presentations at our quarterly provider forums. (BHSI Project Office Data) We developed a curricula targeted towards fathers and included it in our curricula. It has 6 sessions and is done in English and Spanish. We collaborate with the March of Dimes to do presentations for the consumers and community residents at Consortium meetings and at group meetings to enhance education. The schedule for the monthly presentations by BHSI contractors at Consortium meetings continues to happen. And different topics both medical issues and social issues are discussed. Materials are distributed and input is obtained from them to enhance the BHSI services.

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

The Boston Healthy Start Initiative has had a major impact on the way in which services are delivered to women and children in the Project Area. Many individuals and families have been served and continue to utilize the services fed by the program. However, they have also changed the system in fundamentals ways. For example, the community health centers that receive BHSI funding have designed services that address improved perinatal outcomes through care linkages to target communities where high risk Black women live.
Systems change has occurred in a number of ways, including: developing collaborations and linkages between and among agencies; working with agencies and programs to simplify eligibility and intake for health insurance and other public entitlements, expand hours of service allowing for greater access; improving continuity of care; developing mechanisms and opportunities for sharing data across programs; and working with providers to be more culturally sensitive to target population client needs. As a result of BHISI's efforts to impact the system and the way in which services are delivered in the project area, many sustainable relationships have developed between agencies within the community. Many of these relationships have led to enhanced perinatal services, systems and policy changes to address racial disparities and help to ensure that BHISI relationships will remain solid and collaborative. These systems include joint training, combined funding for mutual efforts, meetings, and other linkages.

1. Describe the Approaches utilized to enhance collaboration

BHISI has used a variety of approaches to enhance collaboration. Formal linkages and relationships were developed to establish a solid foundation for ongoing efforts to eliminate disparities and reduce infant mortality. At the same time, maximize opportunities for informal networking, community action, and resource sharing. By pursuing a range of strategies which included many segments of the community, and which cut across traditional institutional boundaries, BHISI succeeded in building a model of collaboration which was unprecedented in the Project Area.

The consortium served as an important arena for collaborative work. Operating with a common goal, consortium members brought a diversity of skills and perspectives to the task of designing, implementing, evaluating, and sustaining the Boston Health Start Initiative. The consortium facilitated interaction among entities not accustomed to working together but united in their purpose. Thus, clients, providers, government officials, and concerned community residents developed an effective collaborative process in the interest of reducing infant mortality in the Project Area. Mandated representation of various groups ensured the ongoing involvement of many sectors and reinforced the development of innovative collaborations.

Collaboration has been a fundamental principle of the Boston Health Start Initiative since its inception. It was built into the organizational structure of the Project, and is evident in all aspects of decision-making, planning, and implementation. Development of the comprehensive plan was a collaborative process undertaken by the Boston Public Health Commission and the Consortium, with extensive input from other relevant agencies, organizations, and groups. Because BHISI is itself a collaborative model, programs applying for funding through the Initiative's RFP process were also encouraged to develop collaborative project designs and activities.

Another significant motivation to collaboration was the acknowledgement of Project Area consumers and residents’ dissatisfaction with the health and social services they received, as well as the persistent infant mortality rates and racial disparities in poor birth outcomes. These concerns became the vocal point for organizing around policy issues, service delivery and systems change. BHISI developed multi-level, collaborations with local, state, and federal agencies which have a role in promoting maternal and child health. In addition, BHISI participated in a number of task forces and commissions which were directed toward policy planning and service coordination in the areas of perinatal health, racial disparity, and infant mortality reduction.
A number of other approaches were utilized by BHSI to enhance collaboration, all of which yielded positive results. These approaches included: developing linkages among providers on a neighborhood basis through the city initiatives for safe communities, property development and clean up of vacant lots, and prevention of youth violence which has funded coalitions of CBO's, churches, and tenant associations in many neighborhoods of the Project Area. Given the impact of so many other issues on BHSI families the program’s collaboration efforts also focused on promoting linkages and coordinated service planning to combat; welfare reform, lack of affordable housing, decrease in health benefits and increase in their cost, and immigration issues. BHSI worked with other like-minded groups, including, among others, Health Care for All, the Massachusetts Committee on Real Welfare Reform, the Consortium of Black Health Center Directors, the Massachusetts Human Services Coalition, the Boston Foundation Persistent Poverty Project, Networking for Life, Massachusetts Law Reform, and the Massachusetts Office on Refugees and Immigrants.

One final note important to mention is that BHSI approached collaboration with the understanding that racial disparity as a public health problem cannot be isolated from the social conditions which give rise to it. BHSI thus assumed a leadership role in developing multifaceted collaborations among health and human service agencies, community based organizations, advocacy groups, issue-oriented initiatives, and local grass roots activists within the Project Area. An important effort in this direction was BHSI's organization of Project Area initiatives to address issues of coordination, linkage, and sustainability. Over the course of this project period, these initiatives participated in a series of meetings with a focus on community building and the improvement of social conditions in the Project Area. The meetings greatly enhanced collaboration among groups which had similar agendas (e.g. mental health, violence prevention, housing, etc.) and were united in their mission to positively impact the BHSI Project area communities and seek solutions to persistent problems.

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

Several structured changes, including procedures and policies, were established for the purpose of system integration. While structural changes tend to be difficult to accomplish, owing to the resistance to change inherent in most systems, BHSI has made some important in-roads. Some examples are the following: forcing the different providers and service departments to work together by establishing a comprehensive case management continuum of care model. BHSI offers a model of service that will support a smooth transition for mother and her baby from prenatal care, to interconceptional care to adult medicine and pediatric care.

Another systematic change was the on-going communication between city and state public health systems. In consultation with BHSI, the Massachusetts Department of Public health (MDPH the state Title V agency) adopted a new process for allocating state maternal/child health funds. The process was reconstructed to disburse funds on a five-year cycle, using the concept of Community Health Networks (CHNAs) in an effort to increase coordination and collaboration among same-area service providers as well as the funders. BHSI held ongoing meetings with MDPH in order to maximize service provision in BHSI Project Area. Programs worked together to avoid any duplication of services within agencies that were being funded by them both. Another outcome
was the development of a reciprocal proposal review process whereby BHSI and MDPH jointly
planned and reviewed proposals. BHSI also worked with MDPH in conducting regular meetings
with Medicaid to share information and better coordinated program and funding decisions. As a
result of these efforts two significant agreements with Medicaid were reached: (1) that
implementation of a managed care system would not preclude the choice of provider by clients
seeking care under the presumptive eligibility clause; and (2) that exemptions for school-aged
clients to use school based clinics would be allowed.

During this project period BHSI also put into place mechanisms to address gaps to access quality
services for mothers and infants.

- First, the project initiated a series of meetings with managed care providers to share the
  comprehensive case management model and suggest ways that it could be adapted and
  implemented in the context of managed care.
- Secondly they collaborated with the Boston Public Health Commission in taking the
  lead on implementing a local partnership using the National Perinatal Periods of Risk
  Practice (PPOR) Advancement Collaborative, working with the March of Dimes. The
  ultimate goal of the PPOR is to improve the health of women and infants in
  participating cities through effective use of the PPOR approach, as a systems changing
tool.
- Another collaborative was with the local SIDS program, Boston University, and the 3
  major birthing hospitals in the city to establish a Fetal and Infant Mortality Review
  community action team, (FIMR-CAT). In the fall of 2003 they began a depth study to
critically examine the reasons for racial disparities in fetal and infant mortality.
- BHSI also partners with the state’s Maternal and Child Health FIRST Link program to
  promote in-hospital identification of women in need of case management, and match
  these women with appropriate services. The goal is to make sure that no woman who
could benefit from case management services is overlooked, and to see that case
management programs are well coordinated so as to maximize their effectiveness.
- During this phase of the project Healthy Start has partnered with Title X working
closely with family planning agencies in project area and BHSI contractors to ensure
that access to these services are available ongoing beginning in prenatal care and
followed through to post partum and during the interconceptional period, given the
large amount of women who have experienced unplanned pregnancies.
- BHSI in collaboration with the Commission’s Emergency Contraception Task force has
  launched a major campaign designed by our community Consortium members and
  focus groups held throughout our project area, to inform project area women on what is
  and how to access emergency contraception. Included in this campaign are PSA’s on
  the radio and the distribution of health education materials chosen by community
  participants.

3. Describe key Relationships that have developed as a result of Healthy start efforts covering
the following areas:

  a. Relationships among health service agencies, and between health and social service
     agencies; and community-based organizations

  During the project period BHSI developed many key relationships some were long-term
  collaborations others time-limited based on activities. The collaborations are extensive in
scope, and fall into ten categories; private non-profit, federal agencies, state agencies, city agencies, city health programs, advocacy organizations, public middle and high schools, local colleges and universities, hospitals, and churches. The collaborations cover the areas of prenatal care, pediatric care, smoking cessation, domestic violence intervention, substance abuse treatment, school based health and social services, homelessness, HIV services, and legal services across a spectrum of public, private, non-profit, academic, faith-based, and mental health organizations.

Collaborations not only included linkages for comprehensive services to support the BHSI women and their families but also involved the sharing of information and resources, referrals for services, technical assistance, and funding opportunities. One of the most successful strategies that were used to develop relationships and collaborations between agencies was the establishment of the mental health task force the networking monthly provider meetings were coordinated by BHSI to ensure that services were offered in a culturally appropriate manner to Black pregnant and postpartum women within the Project Area. The task force worked with BHSI consumers to identify appropriate mental health information materials, and assessment tools. They also established a screening process and referral system that would be used to screen all BHSI women for material depression.

Given the high association between substance abuse and depression BHSI funded programs within the perinatal substance abuse system and became closely linked with a range of services that support clients' recovery in an integrated fashion. In fact, all of the programs developed direct linkages with the perinatal health care system and continue to work closely with the OB clinics at the community health centers and hospitals in the BHSI Project Area. At the level of service delivery, BHSI's quality assurance manager and program monitors played a key role in promoting collaboration between BHSI service providers and other organizations.

During this project period as in the past BHSI maintained an extensive network of collaborations which have been established and refined through multi-year processes of dialogue and negotiation. Collaborative relationships—with state and local governmental human service agencies were an important strategy since many of the BHSI families have a need for family services like in early childhood development, or they may have older children that could benefit from therapy. Other family support may include the need for affordable housing, or temporary shelter due to domestic violence, or displacement.

BHSI has worked to development these collaborations and linkages to ensure that women have the support to address their concerns especially those that may create stress and or medical complications that may directly impact their risk for a poor birth outcome. The program has put great emphasis on partnering with programs such has the Department of social services, child-protection, housing advocates, child care, vocational training and GED programs and broad based community coalitions that promote healthy families and communities.

b. Relationships that focus on involvement of consumers/community leaders with any of the above agencies or any additional agencies.
In the area access to prenatal care, a large collaboration between community health centers and other providers has developed, using the Consortium, the Infant Morality Review (IMR), Working Groups, and neighborhood meetings as vehicles. Both the Consortium and other BHSI consumers provided vital input to the collaborative efforts of the program. Consumers were utilized in the development of health education materials, for the March of Dimes, and mental health information brochures for a social service group targeting Black families in the BHSI Project Area.

A number of BHSI contracted sites provided consumers to review videos and materials about substance abuse, domestic violence, and acting-out children. The social services agencies were targeting communities where English is their second language. Programs involved included the Haitian Multi-Service Center, Project sway a program for pregnant substance abusing women, Alianza a Latina service organization. These collaborations have had a broad impact on the health of the community, and have developed and fortified structures to promote ongoing services. The cultural diversity of BHSI organizations ensures that access to prenatal care is promoted for different ethnic, cultural, and linguistic groups among Black women within the Project Area.

BHSI facilitated many other collaborations which focused on the involvement of consumers, residents, and community leaders. Extensive collaborations developed through BHSI's relationships with the social service agencies, and coalitions were important in integrating the work of BHSI's Consortium with other local initiatives and organizations designed to promote community empowerment through consumer involvement and leadership.

Consumers also worked closely with the city and state public health departments, reviewing health education materials, for behavioral change in smoking, use of condoms, family planning services, and participation in research projects. Community residents from the BHSI Project Area were also involved in RFP reviews and data reports that specifically focused on Black women living in Massachusetts.

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

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

The most major impact in this area was BHSI’s efforts to establish common intake and assessment tools that could be utilized across service agencies. The WHQ has been institutionalized in 14 community health centers both in prenatal and adult medicine departments. And in the cities’ home visiting public health nurses program. The idea of screening women for material depression is also being replicated across many health agencies across the state; some have been implemented in conjunction with pediatric services, others in WIC programs, and one with women who attend support groups for mothers with children who have a disability. BHSI has also been working with the Mass Department of Public Health to develop common fact sheets that talk about maternal depression, and a number of diverse brochures that will approach the issue of mental health and depression from different cultural perspectives.
Several other BHSI initiatives involving multiple providers have had an important impact on simplifying eligibility and intake requirements for programs. Some examples include enrollment for Mass Health insurance coverage, free health care, or the State healthy Start insurance program to ensure the women can be covered for her health care throughout her pregnancy and up to 6 weeks postpartum. Another example is the collaborative relationships that have developed between community health centers and health programs in the public school system. Through relationship-building, streamlined intake and referral processes, and shared information, teens who receive a positive pregnancy test at any site then receive follow-up through the programs funded at the public schools.

Active outreach programs at the schools facilitated referral and intake to community health center prenatal care clinics. In addition access to prenatal care has been enhanced through expanded evening and weekend clinic hours at five community health centers. In the past, there were few connections between schools, school-health clinics, outreach programs, and community health centers. These systems are now working together to ensure that pregnant teens do no fall through the cracks.

Another example is the streamlined intake work that BHSI and project case managers have done with the WIC program. In response to consumer concerns that they have to make two or three trips to the WIC office because they do not know what information they need to apply for WIC, BHSI staff have worked with WIC to develop a fact sheet and checklist for WIC eligibility. These materials are distributed to pregnant women by both WIC and community health center staff in order to facilitate the application process.

b. Barriers to access and service utilization and community awareness of services
Many of BHSI's activities have focused on increasing community awareness and decreasing barriers to access. The impact of these activities has been far-reaching, and included a heightened level of knowledge and awareness among providers, community residents and BHSI consumers about racial disparities in perinatal health. BHSI public information efforts established a vast expansion of knowledge in the community informing them about available health care resources and support on how to access health care coverage especially for poor and under insured. The program developed linkages and direct relationships with public assistance programs to ensure that staff is aware of the specific issues creating barriers for BHSI women and the community residents that live within the BHSI Project Area. Public awareness efforts were also implemented to increase the recruitment and leadership development of Project Area residents and potential consumers and to expand involvement of new community leaders in many different capacities throughout the project. During this project period BHSI continued to conduct activities that would promote community empowerment and enhance sense of community responsibility for addressing many of the issues associated with supporting healthy families and reduce infant mortality.

A major contribution to increasing service access and utilization, as well as community awareness of service, has been BHSI's multicultural, multilingual outreach and education
efforts. BHSI has maintained a resource center that provides an array of educational materials in a variety of formats and languages, conducted outreach and programming targeted to specific communities, and aired PSAs and educational programs in Spanish, Haitian, and Cape Verdean Creole via the community cable access channels.

Limited access to prevention services is a major barrier for BHSI’s clients the current budget cuts have limited most agencies capacity to provide outreach, health education, smoking cessation and parenting and nutritional support services. BHSI’s approach to address this barrier is to coordinate supportive services among contracted agencies this was accomplished by monthly provider forums where they have the opportunity to network and formalize collaborations. BHSI’s Quality Assurance Manager oversees these collaborations and offers training and other needed support. The BHSI interagency collaborations have enhanced the project’s capacity to provide mental health services, and enhance consumers’ access to financial entitlements, transportation, and interpreter services. BHSI also successfully partnered with community –based agencies to develop health education materials in multiple languages and designed materials that are available in different reading levels to ensure that all in the Project area have appropriate reading materials.

c. Care coordination descriptions of mechanisms implemented to assure continuity of care, quality improvement, and follow-up systems for client referrals

Care coordination has been improved throughout the BHSI Project Area. This coordination has been improved both within and among agencies in several ways. Examples include improved communication systems within and between health centers, hospitals, and community-based agencies internally and externally. The main issue for many of the BHSI women was the lack of consistent health care consequently many of them experienced poor birth health outcomes. This pattern of utilization impacted the infant as well. One of the problems in the past was that prenatal and adult medicine providers at the community health center might not know when a mother delivered her baby, and might not be alerted to the fact that the mother or child needed immediate follow-up care. When case management was introduced as a service, this problem did not go away immediately. Now health centers have adopted improved communication systems, both internally and with hospitals, to ensure that all mothers and their newborns receive prompt follow-up care, including a 24 hour home visit after birth. The newborn risk assessment that has been developed at the MDPH also serves as a tool to notify providers of families that need immediate postnatal attention, and will help ensure that high risk newborns do no fall through the cracks.

BHSI’s new model of service ensures a continuum of care for pregnant and postpartum women and their infants for two years after delivery. The services include outreach, health education, and care coordination, home visiting, psychosocial support, interconceptional care, screening for maternal depression and follow-up for pediatric care. The Boston Healthy Start Initiative case management model is designed to support women and their infants in obtaining a medical home. For those clients who require public assistance case mangers work
with MassHealth and Children’s Medical Security Plan (CMSP) to secure health care coverage beyond pregnancy for mother and infant. BHSI contracting sites offer enabling services such as childcare, transportation assistance, and translation services to support the woman in consistent use of important health and social services.

BHSI case managers follow pregnant women from OB/GYN after post partum to primary care to ensure that the case management team is well informed about client’s needs and that the services provided are complementary. The case management team consists of a nurse, social worker, outreach worker, health educator and case manager.

BHSI designed their model to provide services in a coordinated approach to prevent consumers from becoming overwhelmed. Case conferences are conducted with the whole case management team and are usually held on a quarterly basis, exceptions may be when a client has a multiple of agencies involved and there is a need to coordinate and monitor services more frequently. BHSI are used to fine-tune client care plans and to address gaps in client services.

Case management supervisors also utilize case conferences to assess how well case managers and clients are connecting. In difficult complex cases a case conference with all stakeholders can offer guidance and suggestions to case managers. Other incidents that may require more frequent case conferences is when the case manger is not able to access the service a client may need and it requires that the supervisor or someone else from the team to intercede.

To ensure consumer satisfaction and quality improvement BHSI clients are involved in the development of their own service plan. All clients fill out the Women’s Health Questionnaire the responses from this assessment is the foundation of their service plan. The tool is totally self-administrated and information from the Woman’s Health Questionnaire is scanned by computer and compiled into two reports one for the woman and another report for the provider. The provider reports serve as guidance for the medical provider and case manager in identifying the major concerns of the woman. The second report highlights what the woman is doing well and suggests areas where she could improve. During the assessment process, the case manager also provides one-on one health education based on the woman’s responses.

BHSI Case managers have a set of assessments they must follow for all clients, during pregnancy, postpartum, and the interconceptional period. They include (1) Women Health Questionnaire WHQ three times (2) BECK depression screening tool for maternal depression screening three times (3) 9 home visits including 24 hr home visit after hospital discharge (4) Child immunizations bi-monthly (4) Family planning monthly (may vary depending on method).
The project has established a plan to verify completion of referrals through the BHSI racking system where all case managers must report monthly on a referral log that includes information of type of referral, date, and resolution. This information is entered into an access database and we can track every referral from each agency and case manager. We can also match referrals that relate to medical, pediatric, and or mental health by linking clients medical records and program data because each BHSI client has a unique identifier number.

d.  Efficiency of agency records systems and sharing of data across providers to reduce the need for repetition.
BHSI has developed methods to assure client confidentiality when sharing data and information. In planning, agencies discuss trends rather than individuals, and in case management meetings to organize services for an individual, all parties sign a release to share information.

Implementation of the BHSI data system significantly improved the efficiency of agency records systems and the sharing of data across providers. Each agency funded by BHSI received its own computer and executable programs which allowed the generation of agency-specific reports. Providers were able to create their own versions of reports which allowed them to maximize the use of data which they had been collecting. All confidential information remains at the sites. Furthermore, BHSI developed the capability to ensure the non-duplication of records - i.e., if a client was receiving services at more than one site, that individual would be counted once; however, records from the two(or more) sites could be combined to create one complete record for the individual client.

BHSI collaborations with the city's public health programs also enhanced record keeping efficiency and the sharing of data. For example, the data collected by public health nurses through the Healthy Baby/Healthy Child program could be matched with BHSI data to see if the same clients were being seen and followed, this enabling the programs to coordinate their services for each client. Similarly, immunization records tracked by the city could be matched with BHSI's program data.

BHSI also partners with the state’s Maternal and Child Health FIRST Link program to promote in-hospital identification of women in need of case management, and match these women with appropriate services. Our goal is to make sure that no woman who could benefit from case management services is overlooked, and to see that case management programs are well coordinated so as to maximize their effectiveness.

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

a. Provider responsibility in maintaining client participation in the system and provider sensitivity to cultural, linguistic, and gender needs of the community.
All contracting sites had to qualify as having expertise in working with the Black communities within the Project Area. Therefore BHSI has had a major impact in this area during this project.
period. The ability to maintain consumer participation and offer culturally appropriate providers has been one of the major strengths of this program. From the onset the project community residents and later as the program moved passed implementation, the consumers guided every aspect of the BHSI program. With every new phase from the demonstration period to its current phase, all service providers receive training and skill building workshops to enhance their ability to maintain client participation and to respond to the cultural, linguistic, and gender needs of the community.

Ongoing efforts during this project period included: training of outreach workers and case managers to enhance cultural competence, and develop skills related to the needs of specific target populations. Consumer participation in the evaluation of services through the Consortium. The new model of service came into being as a result of consumer input, conducted focus groups aimed at developing and refining the services most needed by the Black community. BHSI efforts provided opportunities for networking, resource sharing, training, and peer support. BHSI's focus on “undoing racism for providers and consumers have also had a significant impact, not only in terms of cultural competency in the delivery of services, but also in raising overall community awareness of institutional racism and its impact on health disparities.

Technical assistance was consistently provided to BHSI subcontractors to help them develop tools and mechanisms for consumer input. BHSI exemplified consumer input in service evaluation, and technical assistance to providers reflected the consumer/client involvement, alongside providers, in evaluating educational strategies and materials. For example, monthly, "preview sessions," (which were a forum for examining, evaluating, and discussing various educational materials) were conducted through BHSI's public information and education component.

BHSI's training and education program has extended technical assistance to a large number of other agencies to help them design and implement their own efforts to eliminate racial disparities in health using the innovative approaches built up in the BHSI project. For example, the March of Dimes was helped to develop culturally appropriate brochures for reducing birth defects, and both the National Sudden Infant Death Syndrome Foundation and the Child Injury and Prevention Center used consumers from BHSI to design their educational materials.

Annual consumer focus groups and client satisfaction surveys have been a major source for BHSI program development. The idea to support services for fathers was a direct result of these activities. The Father Friendly Initiative (FFI) grew from the personal requests of BHSI mothers who stated that their partner needed to find employment, enhance their ability to parent and be supportive during the pregnancy. BHSI conducted a needs assessment within the Project Area for existing male services. The findings indicated that there was a clear gap in health and social services for men, and even fewer that focused on fathers. As a result FFI was implemented offering case management services to fathers assisting them in becoming responsible and supportive. Currently the FFI program has become an independent program and services over 350 fathers annually.
As part of the BHSI evaluation, consumer satisfaction surveys are conducted at each BHSI site. The goal of the satisfaction survey is to identify clients' perceived level of involvement in BHSI funded programs, their assessment of information available through the program, their evaluation of staff's impact on their learning and development, and finally, their satisfaction with the major core services they received in health, social services, and parenting and child development areas. The survey represents a major attempt to involve clients in the evaluation of services, and to elicit information which is critical to BHSI's forward movement as a community empowerment project. Not only have the results been important in determining the quality and responsiveness of services, but the survey serves as a framework which may be applied or adapted in future evaluation efforts.

b. Consumer participation in developing assessment and intervention mechanisms and tools, and extent of implementation and utilization of these tools or mechanisms

BHSI consumers participated in a number of program and city-wide efforts in developing assessments, and intervention approaches. Consumers have been involved in the development of assessment and intervention mechanisms and tools in a variety of ways, but especially through the Consortium subcommittees. Through the Evaluation Committee consumers have provided input into program design and approach to implementation of services including the development of the WHQ assessment, outreach community surveys, and the screening tool for maternal depression.

During this project period the Consortium, BHSI Executive Committee, and consumers consistently guided the development of all assessment tools currently being utilized. The most recent is the screening and referral process for identifying pregnant and postpartum women facing depression. Consumers worked with the mental health task force reviewing and field testing screening tools. In addition to identifying the BECK tool the established a formal screening protocol and were involved in the establishment of the BHSI provider mental health referral system.

BHSI consumers are continuously working on plans to investigate alternative approaches for those women who screened mild to moderate using the BECK screening tool and who are not interested in mental health services. Women of color who have an extremely narrow perspective of mental illness may need to have an intermediate service prior to becoming willing to participate in counseling or other mental health services for depression. Some of the alternatives being considered include acupuncture, quilting or sewing women groups, peer coaching, and spiritual sister groups.

B. Impact to the community: Describe the impact the project has had on developing and empowering the community, at a minimum in the following areas:

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

BHSI has had a tremendous impact on residents' knowledge of resource and service availability, location, and access. This was accomplished in a number of ways, most notably through:

• Intensive and continuous outreach;
• Public information and educational campaigns;
• Consistence in program presence at substantial annual community events;
• Wide distribution of community-oriented publications in multiple languages
• Media publicity and informational programming (in local ethnic newspapers, and radio)
• Extensive resident involvement in all BHSI activities, especially the Consortium.

The importance of resident involvement in the planning and execution of all these activities cannot be underestimated. In any community, personal networks and "word-of-mouth" are the most effective and reliable means of circulating information. The extensive participation of community residents in the Boston Healthy Start Initiative, from initial design to evaluation and sustainability planning, has ensured that its services are well known throughout the Project Area.

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

Throughout the life of BHSI, consumers and project area residents have been active participants in shaping policies and standards of care, and in advocating for needed changes. They have done this through their participation in the Consortium and its committees, the Working Groups, focus groups, and public forums such as the Infant Mortality Summit and various city-wide conferences.

Consumers, members of the consortium have played a crucial role in advising the Consortium and BHSI administrative staff on the barriers faced by project area pregnant and parenting women in accessing health and social services, and the problems they have confronted in using some of the services. Based on their experience, they developed recommendations which could be translated to new or revised standards and policies. The impact of residents/consumers' input was evident in many areas. For example, consumer recommendations led to changes in the provision of family planning services, standards of cultural competency, involvement of male partners in perinatal services and support, extension of clinic hours, and the development of risk assessment protocols.

Consumers participated in empowerment workshops sponsored by the Consortium and held at various locations in the Project Area. These focused on health issues affecting the community, and the development of programmatic and political strategies to address these issues. Residents were educated on the issues surrounding infant mortality, and they received ongoing training related to their role as activists in the area of health policy.

Leadership development was promoted through the Consortium, and this too has had an important impact on resident's involvement in setting standards and policies. At Consortium meetings, agenda items pertaining to health care reform, managed care, welfare reform, and impending hospital mergers were introduced and discussed. In addition, collaboration was developed with Health Care for All (HCFA), a consumer based advocacy organization that works for health care reform and maintenance of a public health agenda in the state. HCFA provided training for Consortium members around some of the key health policy issues in the city and state, including the reconstruction of state and local health departments, managed care,
and welfare reform. These trainings increased community residents' knowledge of major issues and enabled them to play an advocacy role as decisions were being made at the city and state level.

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

BHSI has struggled over the years to establish collective expectations, and reach agreement on the responsibilities of Consortium members, grantee staff, service providers, and consumers. With large numbers of dollars and the health of the community at stake, different constituencies were not always able to agree on priorities, or evaluate the interests of their own organization in relation to a larger goal. While the strength of the Consortium has been the racial and ethnic diversity of its membership, and the diversity across membership groups such as consumers and providers, that strength has not come without conflict.

In any community, differences of opinion which are emotionally charged can easily escalate to a level of conflict where positions are fixed and decision-making is paralyzed. For the Consortium, the challenging ideal posed by diversity was to establish a safe environment where everyone could feel welcome, free to express their opinions, and confident that disagreements would be handled constructively. Through experience, the community has made a lot of progress in learning to work with divergent opinions, resolve conflicts, and build consensus.

Out of this experience, several lessons emerged. Certain strategies were helpful in negotiating conflict and creating positive forums. Some of the approaches which BHSI found to be important in this regard were the following:

*The development of clear structures for decision-making,* with agreements placed in writing. BHSI found in its early stages that many disputes arose over conflicts of interest and power sharing. These were eventually resolved through negotiation, and became codified in two major documents: a Memorandum of Agreement between the Consortium and the grantee, and the Consortium’s By-laws. These documents have served as a foundation for decision-making. They delineate specific roles and responsibilities, so that confusion and conflict around power is minimized.

*A facilitated process for conflict resolution*

At times it was important to engage the assistance of an outside facilitator, to help the group move through especially difficult of complex decisions. This enabled the group to focus on content, as opposed to process, and ensured that all voices were heard and respected.

*Community leadership development*

Leadership development has been a major component of BHSI’s work to achieve consensus and establish collective expectations. Leadership development activities were organized with three goals in mind: (1) the development of individuals’ leadership skills; (2) education as to the environment in which the Consortium operates, and major public policy issues related to the Consortium’s mission; and (3) identification of
practical avenues for taking action. These activities, we found, are essential to building an empowered community, in possession of the skills and tools needed to make sound decisions and resolve conflicts.

4. Creation of jobs within the community

In terms of job creation, BHSI has had significant impact on the community. By the end of the Project's second year, approximately 50 jobs had been created through BHSI funded activities. BHSI has continued to support community economic development through its hiring practices and through their linkages with programs that provide job training and career development to BHSI’s targeted communities. In addition, BHSI has established numerous collaborations academic institutions that offer community residents the opportunity to obtain a GED, computer training, or attend community college.

In brief, BHSI has supported job creation in the community through the following means; Community members were hired to fill BHSI staff positions. Contracting sites are encouraged to prioritize the hiring of people from the targeted communities. BHSI collaborates with the Mass Union of Public Housing Tenants to train and hire public housing tenants as health outreach workers, who staffed health stations at various sites in the community. Community residents were hired as outreach workers to conduct Public Information/Education and Consortium activities.

Linkages were established with job development initiatives, such as Boston's Enhanced Enterprise Community (EEC), and the Enterprise Zone Project. Collaborations were established with existing job training programs, including the health careers training programs at Dimock Community Health Center and Boston Medical Center.

C. Impact on the state: Over the past four years the DPSWH has provided funds to strengthen and develop relationships with the State Title V program. Describe the activities and impact that this approach has had on your relationship.

During this project period BHSI continued to work closely with the Massachusetts Department of Public Health Bureau of Family and Community Health, the State’s Title V agency, to collaborate and coordinate planning, program development and service support to reduce eliminate racial disparities in perinatal health, and decrease infant mortality in the Project Area. Regular meetings were held to develop a coordinated plan to eliminate disparities in perinatal health. Representatives from Title V are members of the Consortium and the Executive Committee. Current joint efforts include:

- The coordination of funds contacted to mutual agencies to ensure that funding provided by BHSI and MCH is non-duplicative and complementary.
- Program development and coordination with the New England Healthy Start projects in Worcester, and New Haven Connecticut to share lessons learned and partner in projects.
- Improved access for Project Area residents to state insurance programs by training BHSI front line staff to ensure that all women and their children without health insurance apply for coverage.
- Combining primary care, perinatal and pediatric programs. The provision of comprehensive primary care to pregnant women and infants in community health centers and primary care sites is supported through joint initiatives. Title V funding
supports clinical services and outreach, BHSI funds support case management, social work, and health education.

- Develop a state-wide plan to eliminate racial disparities in maternal and child health by developing an action plan that could be replicated across the state.
- Develop public awareness materials for diverse populations about maternal depression, including brochures and fact sheets in other languages.

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

The major lesson learned was that the Healthy Start model is progressive and the program’s expectations regarding systems change were unrealistic, given that systems are by nature conservative. The program quickly learned that in order for systems to change, there needed to be substantial interaction between and across different levels and systems of care. Again the program was confronted with the element of time which was so critical because the systems change that BHSI planned to confront was institutional racism and it was not likely to be accomplished in the short term. Never the less BHSI moved forward on this agenda and experienced some success.

During this project period the political environment remained challenging, however BHSI successfully brought issues of racial disparities, maternal depression, interconception care and women’s health to the forefront of health policy discussions in Boston and Massachusetts. This was evidenced by the elimination of health disparities conference conducted in Boston. The work done by BHSI formed the bedrock of the conference which highlighted the issues and examined hospital and health plan administrators, community health center representatives, physicians, government officials, community advocates, and consumers. BHSI played a key role in shaping policy recommendations which merged from the conference.

BHSI’s emphasis on collaborative process also produced results. Despite the many barriers to collaboration, BHSI made persistent efforts to build inclusive and cooperative relationships based on recognition of mutual goals. As noted earlier, a major problem was the difficulty inherent in bringing institutions and agencies together when they have been adversaries in the past. These adversarial postures were nowhere more obvious than in the dealings between the city and various community-based initiatives as well as the varied agendas of the medical specialist.

BHSI took the unprecedented step in mandating that different components of healthcare communicate with each other, in order to develop a continuum of care. Although the idea of closing the gap in services between perinatal care and adult medicine to address the problem of fragmented health care was well accepted there still remained a problem of “turf issues”. The effect was a gradual shift in the willingness of others to engage in collaborations which they perceived to have mutual benefits, and to broaden their view of sustainability.

Another barrier BHSI faced was the assumption, on the part of institutions such as the Public Health Commission and the local birthing hospitals that it would be simply disappear at the end of four years, even though the program has survived way beyond the demonstration phase. This attitude continued to plague the project even ten years later. This presented a particular hurdle which BHSI has had to overcome in negotiations relating to the Healthy Start as a whole.
Throughout this experience it has become evident that much of the minimizing of BHSI’s impact and ability to continue services is rooted in institutional racism, operating under the assumption that a true community–driven model led by Blacks and other people of color would not have the skill and ability to survive. Much of the “Undoing Racism training confronted this systematic thinking and paved the way for a much more receptive system willing to examine its weaknesses.

During this project period the program’s eliminating disparities work has been a great success and challenge for BHSI and its grantee the Boston Public Health Commission. The city has state-of-the-art hospitals, an outstanding community health center system and innovative community-oriented public health campaigns. Yet, in the midst of this wealth of services, within the shadow of our most distinguished institutions, are significant sectors of the Boston population who have not equally shared in the benefits of the health advancements. In the last 4 years BHSI’s program data and vital statistics has demonstrated the enormous gap in health status, medical treatment and outcome between White, and Black, citizens.

In response a number of efforts have been undertaken to address these disparities in Boston, including several that have been led by Mayor Thomas M. Menino, numerous health care leaders and community-based coalitions. Three of these efforts have had a major impact on health systems in the city. The first was the establishment of a hospital working group whose primary focus was to identify service gaps and in data collection processes that limited the facilities ability to determine the quality of service provided to the different racial groups they serviced. The second was to produce two reports one from the Hospital working group the other from the city’s data collection systems. The final effort involved funding activities that would address some of the issues identified through these efforts.

More than a year ago the Mayor began the two groups – a Mayor’s Task Force on Racial and Ethnic Health Care Disparities and the Citywide Hospital Working Group. After extensive work and numerous meetings, these groups released reports to be used in conjunction with the data analysis report. They provided a more thorough consideration of the nature of the issue and, most importantly, a series of concrete and achievable action steps. The hope is that the data report, when used in conjunction with the other documents, will promote a coordinated movement to eliminate unacceptable inequities in health service provision.

The data report, presented the most recent data from a wide variety of sources. The emphasis was on Boston-specific information although, at times, they drew upon national information to help inform and enlighten the analysis. To assist in a fuller understanding of the challenges the report also highlighted likely socio-economic factors that contribute to the inequalities – such as the persistence of racism, the burden of poverty and the declining availability of affordable health insurance. The report was prepared and released as part of a major citywide initiative led by the Mayor and the Boston Public Health Commission programs that work on eliminating disparities, the BHSI Consortium and REACH 2010 coalitions.
Despite the difficulties that BHSI had to struggle with during this project period the one of the major lessons learned through the barriers discussed is the value of developing and maintaining collaborations, and despite entrenched resistance to collaborative process, it is important to keep collaboration as a goal and even when it is difficult adversaries must be invited to participate. In order for progress to happen, one needs to constantly nurture networking and communication. It is important to insist that funders use their power to get everyone at the table and require projects to demonstrate collaboration. Funders play a major role in determining the success or failure of any project or initiative. Their mandates must be matched with accountability, not just on the part of the grant recipient but the funder as well. By demanding that funders use their power constructively, to facilitate collaboration, we have been able to proceed in that direction.

E. Lessons Learned

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

Many lessons were learned during this project period. These are compiled below, under the categories of financial management, quality assurance, program empowerment model, Consortium, and evaluation. Organizational structure, sustainability, and other large lessons.

1. Financial Management

A sound working relationship needs to be in place with the institution that serves as the fiscal conduit for the grant.

Because BHSI operations model is different than other BPHC programs (a community-driven Board with governance power) the program and the grantee had to adjust their systems. Considerable planning, strategizing, and negotiating were required on the part of the BHSI Project Director to serve as a liaison between the two groups. Assisting the grantee to understand the community perspective and convincing the community /Consortium that the commission was not always out to get them and procedures and restrictions were set in place for good reason and not just to make their lives difficult. To avoid conflicts and to ensure a "timely flow of paper" in-house work needs to be done, or in place, well ahead of time so as to minimize the time lag that may be produced by a large fiscal system like the Boston Public Health Commission.

2. Quality Assurance

Programmatic and budgetary matters go hand in hand

BHSI's Financial Manager and Quality Assurance Manager developed a close working relationship which supported the inter-relatedness of budget and programming. This has been critical to the smooth functioning of BHSI as a whole as well as the subcontracted programs. It's important to keep in the forefront the need for communication and joint planning with regard to both programming and budget. Under the rubric of Quality Assurance, both "monitoring" and "compliance" are necessary operational concepts. Compliance connotes the fulfillment of contractual obligations. Monitoring is more subjective and implies a working relationship with programs to ensure that they are running well, and fulfilling their goals and objectives. Both monitoring and compliance should be viewed as aspects of quality assurance and certainly include consumer satisfaction measurements.

3. Program-Empowerment model

For the "empowerment model" to work, resources must be in place to support consumer and community involvement throughout the life of the project
Adequate time, staff, and funding must be available to provide technical assistance, consistency, and continuity. There is a definite need to develop a decision-making mechanism which is accountable and fair. Key issues of board development which must receive attention are: (1) recruitment, (2) training (3) decision-making process and 4) clear define roles that distribute power evenly. An effective infrastructure is needed for working with grass-roots organizations, community residents and program consumers, and local government systems.

The "lessons learned" in this area continue to grow and change with each phase of the program. BHSI has tried to provide both a critical assessment and suggestions for the future. Throughout the project there was always a genuine desire to see the community-driven approach of the program to succeed, however what that truly means did look different for the groups involved. For example the Commission saw the BHSI Consortium as an advisory group, and the Consortium saw the Commission as only the financial conduit when in fact both groups’ roles overlapped in these areas. The By-laws of the Executive Consortium Board and the Memorandum of agreement between the Consortium and the Commission was the saving grace of these conflicts. These documents served as a foundation and guidance that needed to be revisited periodically especially during times of program changes, funding issues, or new leadership at the Commission.

4. **Consortium**

*To substantiate true community/consumer involvement ongoing there must be ongoing efforts.*

The following are a number of suggested lessons learned:

- Board development needs to happen early on, and continue through the life of the project to ensure that the consortium has the capacity to address current political environment
- People need to be educated in their role as board members and become political advocates
- Structures need to be in place to assist new members, as they cultivate skills of effective decision-making.
- Decentralization is an effective means of mobilizing the consortium.
- Conducting meetings in the Project Area neighborhoods is a way to bring in people from the community.
- Participation has increased greatly since the meeting site has remained at the same site, date, and time.
- Focus groups were good, and should be maintained. Focus groups are a way to get people involved, to receive valuable input, and recognize the knowledge which is held in the community.
- Outreach has been extensive and effective in building the Consortium.

In order for the Consortium to be the "voice of the community" outreach must be constantly underway, and conducted in all sectors of the community/BHSI Project area.

5. **Evaluation**

*The evaluator should be part of the program staff*

Evaluation must be program driven not based on the current research interest, not based on the grantees agenda, or on an academic institutes’ requirement for frequent publications. The major lesson learned for BHSI was not to contract out the major evaluation components the results were always disastrous because all too often others’ agendas and interests took precedent over BHSI’s interest.
The programs ability to track a woman’s progress throughout her entire participation in the program is due to the data collection program developed and implemented by BHSI’s evaluator a full-time staff on the project. The evaluator needs to work on-going with program staff and should be involved from the onset of program development and implementation. The objectives and outcomes need to be based on the core services and goal of the project. When evaluations are outsourced even within the same agency there is no guarantee that staff and allocated resources will not be utilized for activities other than the healthy Start program.

All data collection process should be controlled by the program
One of the most recent lessons learned during this project period was to establish a back-up system when program data is inputted into to a larger system not specifically designed for Healthy Start. The last four years have been very frustrating in terms of the programs’ ability to collect and report on clinical data extracted from medical records. BHSI developed a comprehensive program data collection process that has been very successful in tracking client services, referrals and follow-up. However BHSI did make a major error in depending on the Commission’s data base (Sophia) for their clinical data consequently the system has failed to meet the program’s expectation and the evaluator has had to hand tab much of the results.

VI. Local Evaluation

Section I. INTRODUCTION

Local Evaluation Component
A. The impetus for the local evaluation was to find out whether the intervention made by Healthy Start can reduce the high infant mortality among the black babies in Boston and thus reduce the disparity between the black and white babies in certain areas of Boston with the highest infant mortality rates.

It was designed based on a needs assessment that was conducted prior to the beginning of this phase through consumer and provider focus groups. It was also based on the results from prior evaluation.

Project staffs were involved in designing and conducting the local evaluation. A contract has also been set up with the Boston University School of Public Health to address certain special components of the evaluation.

B. The primary goal of BHSI still continues to be reducing infant mortality in Boston by decreasing racial disparities in the perinatal system of care. This was done using a strong case management model that encompass besides the regular case management care, outreach and client recruitment, health education and training, screening for depression and referrals, and providing interconception care to the Black women in the Project Area.

The case management begins with the women being recruited into the program as early in pregnancy as possible through intense outreach. Once in service a care
plan is developed following the intake process, where all women are screened for depression and other risks identified. Depending on the results women are connected to the necessary services and referrals are made which are closely followed. The women are provided with educational services throughout pregnancy and also after delivery. Finally the women and their children are followed for 2 years after delivery to ensure their connectedness to primary care for themselves and their child.

Each of the components were evaluated using data collected on an ongoing basis, through focus groups with providers and consumers, surveys also with providers and clients, pre and post tests, Beck Depression Inventory and women’s health assessment tool. For all BHSI women enrolled in the program. None of the components were dropped from the study. Some special studies were done the findings of which were presented to the community and also at National conferences.

C. Type of Study: The proposed plan for local BHSI evaluation encompasses a number of steps and builds upon the knowledge gained from previous evaluation exercise. The evaluation includes a formative evaluation, process evaluation, outcome evaluation.

1. Formative evaluation was conducted at the start of the project period for the mental health component of the model. The setting of the mental health task force, the suggestions of providers and consumers helped BHSI to decide on the required tool and how it should be implemented. The surveys and focus groups done at the onset of the project period also helped us to decide on the logistics of the case management model and how best it can be implemented.

2. Process evaluation looked at the intermediate objectives and was done on an ongoing basis to assess whether the changes intended were taking place and contributing towards an improved delivery of services. It was used as a diagnostic tool to identify problems if any that needed to be addressed. It looked at how many clients were served by each component (i.e. case management including mental health and interconception care, health education, outreach, and consortium) and their characteristics.

This component of evaluation examined client utilization patterns of services including keeping appointments, tracking of missed appointments, checking if all women received the risk assessment (WHQ) and the Beck tool, and if not, why and what can be done to increase compliance. Included in the process evaluation was a review of the number of women who completed satisfaction surveys. This process was also used to monitor the number of women who delivered their infants to see if they were connected to care. It examined to what extent the program and its components were implemented as planned and if it deviated from the proposed plan. The number of men and women receiving training and education and their satisfaction level were also gauged. Focus groups conducted
determined the level of satisfaction and the appropriateness of the materials both culturally and linguistically.

In addition, it examined questions regarding the nature and extent of community empowerment, the effectiveness of the Executive Committee in identifying and prioritizing relevant policy issues and how community awareness and participation is fostered. How the program is staffed and its adequacy in terms of training, expertise and FTE was examined. Finally, it explores the highlights of the project.

3. **Outcome Evaluation** was conducted in two phases: (1) A midterm evaluation and (2) The final outcome evaluation that examined both BHSI’s performance measures and the project period objectives. The purpose was to answer the primary question of what measurable changes are detected as a result of the program and the degree of success in attaining the stated goals and objectives of the project and to learn lessons for the future sustainability of the gains from the project.

Outcomes measured include increase in client connection with health services as a result of case management and increased knowledge of health risks among women. Improvements in physical and mental health of women examined by analyzing indicators like adequacy of prenatal care, women entering care in 1st trimester before and after the program. However the primary focus is still to see the reduction in infant mortality, rate of low birth weight, and rate of prematurity in the project area as well as any reductions in racial disparity in such measures.

Special studies are currently being conducted using this project period data. These studies will generate a refined understanding of the biological and social epidemiology of infant mortality and its associated risks in the BHSI Project Area (PA).

Studies have been conducted to ascertain the extent of depression among the BHSI women to determine whether case management made a difference. Similar studies using the risk tool have been done to capture a wide array of issues responsible for poor birth outcomes. A special study is under way to do a comparison between the project area residents receiving services versus those not receiving services to determine the importance of the Healthy Start intervention. It will also be used to examine whether the gap between the Black and White infant mortality and maternal indicators have been reduced at the end of the 4 years.

The providers, consumers and the community were involved in each step of the evaluation to find out what was needed and what needed to be done differently. The findings of the intermediate outcomes were shared at the Consortium meetings who helped us with valuable input that has made the process of evaluation so effective. The evaluation is based on the voice of the community,
the need that they perceive that should be addressed and also how it should be addressed.

Key Questions/Hypotheses

a. Process Questions:
The process evaluation answers the following basic questions, what was done? What were the activities? What were the problems? Were the identified problems rectified?

1. How many clients were served by each component (i.e. case management, health education, outreach, Consortium) and what were their characteristics?
2. To what extent was the program and its components implemented as planned? How, if at all did the program deviate from the proposed plan and why?
3. What were the barriers or challenges in implementing the program? Was it rectified and when?
4. To what extent were the participants satisfied with the case management program?
5. How the program was staffed and was the staffing adequate, in terms of training, and expertise?
6. What were the highlights of the project?

b. Outcome Questions:.
A major part however is the Impact Evaluation. This is demonstrated through the changes achieved in the targeted community using the BHSI holistic case management model. Outcomes measured are: (a) Evaluating relationships and capacity, using the client satisfaction surveys and provider surveys. (b) Assess the quality of care, also using the satisfaction surveys. (c) the effectiveness of services by measuring the outcomes achieved. These will be done using the various calendar period objectives and the final project period objectives proposed by the Project as well as by using the various Common and Performance measures.

The evaluation will primarily utilize data collected as part of the reporting activity. The outcome evaluation will answer the primary question what measurable change is detected as a result of the program?

1. To what extent did the case management services increase client connection with health services?
2. Was there increase in knowledge among the participants following the different educational sessions?
3. To what extent did participating in the Consortium enhance advocacy techniques and increase awareness of available resources?
4. To what extent did the infant mortality rate among the Black women change between before and after the 4 year period? Low birth weight rate? Rate of prematurity?
5. To what extent did some of the maternal indicators of health change over the 4 year period? Adequacy of prenatal care? Women entering care in 1st trimester/
6. To what extent did the disparity in infant mortality between Black women and white women change over the four year period?

Section II PROCESS
A. Procedure: The evaluation was done with the help of BHSI staff, staff from the Research division at the Boston Public Health commission and with the help of outside evaluators from the Boston University School of Public Health. It was established on the strong grounds of a needs assessment done prior to the beginning of the phase that helped us identify the gaps in services and plans that needed to be rectified and implemented. It was also based on the results from the prior evaluation results and also from the rich experience and input of the staff and the providers of the 14 BHSI funded sites and through the valuable contribution from BHSI clients and consumers.

Methodology:

A major part of the evaluation was based on clinical data and BHSI Program data. Individual data and not aggregate data were collected in this Phase, to ensure unduplicated count of clients, which is especially important for the interconception service for monitoring and close follow-up of the high-risk clients and their infants for two years postpartum. This was a cohort study of individuals followed from the point of entry into the program and for 2 years after delivery, a period of 2.9 years, using reports from the 14 BHSI funded sites.

BDI-II done at three points: at intake, end of 8 weeks post partum and at the end of 1 year after delivery to see the improvements in the woman’s level of depression symptoms identified at 1st intake.
Women’s Health Questionnaire (WHQ) a risk assessment tool also done at 3 points to see whether problems identified at intake improves over time with the case management services.

As before pre and post tests were administered to women attending different educational sessions to determine their increase of knowledge following educational sessions and also to find out what needs, still remain to be addressed. As part of health education services, surveys and questionnaires were used to determine the level of the project’s accomplishment as well as to identify gaps in different health issues, which need to be addressed from the community’s perspective in a culturally appropriate way.

The focus groups conducted from time to time, that included both providers, and consumers, helped identify the problem areas that still remain uncovered. They helped to identify topics for which materials need to be developed, or stress the need for more distribution of certain materials. The focus groups were used to do a comparison study between clinical and nonclinical sites what works and what does not. Outreach surveys were done on an ongoing basis to identify gaps in services and in the system of care.
In addition, preview sessions were held where consumers view educational materials and help identify the materials to be purchased and distributed. This helps in identifying the gaps in knowledge that BHSI still needs to address.

B. Data Sources: Collection of appropriate and timely data is crucial for successful evaluation of a program. BHSI has most of the data collection instruments in place and only minor adjustment will be made by adding a few variables to the already existing data system.

1. Clinical MIS Data: The data collection procedure for the MIS Clinical data will use Oracle for its data collection and analysis. It involves extraction of information from the client’s medical records at the 14 BHSI funded sites. A Client Intake Form is always completed for the mother at the point of entry into the program. Prenatal Progress record, labor & Delivery Record and Six Weeks Postpartum visit record are all abstracted from medical records. Infant Health Record and Pediatric Visit Record are obtained from medical chart review on a quarterly basis by trained medical record abstractors.

Quality Assurance MIS: The team makes frequent logical checks and range checks on the quality of the data. The staffs have been trained about medical terminologies and random checks of client records are done by the BHSI staff at the time of site visit.

2. BHSI-Program Data: This is an MS ACCESS database that is submitted by each program monthly and maintained in a database at the BHSI Office. This will capture, besides the usual demographics, important non-clinical aspects of the BHSI component. Depression and especially the interconception aspects will be captured by this data.

Quality Assurance BHSI Program Data: Monthly reports are obtained on an ongoing basis from funded sites and are checked by BHSI case managers for the validity of the data. Any overdue reports are followed-up first by a phone call, and then by a letter. Funded sites are constantly provided with technical assistance to obtain quality data.

3. Women’s Health Questionnaire (WHQ): This is an access database that has 63 questions about the heath and social well being of the participant woman. The data is collected at intake, end of 1st year, and 2nd year after delivery. It is a self administered questionnaire and the information is collected from the sites on a quarterly basis.

4. Beck Inventory: This is a self administered tool and the information is obtained from each woman three times. The data is inputted into the BHSI access database.

5. Client Satisfaction surveys: These are completed by each woman at the end of pregnancy, 1st year, and 2nd year after delivery. They are received monthly from the 14 funded sites and are tabulated by the BHSI staff.

6. BHSI Project Office Data: This will be maintained in a database by the BHSI office staff and include the Consortium member list, the different
trainings organized, the pre and post-test results, minutes from different meetings, focus group surveys, and outreach survey results.

C. Measures and Instruments:
The BHSI Program data was created in an Access database to ensure the reporting of unduplicated data. Intense trainings were provided to all the case managers from time to time and the quality was checked based on the monthly reports that were submitted on a regular basis.

The BDI-II was used to identify the symptoms of depression. This tool was selected based on the recommendations of the Mental Health Task Force that consisted of BHSI case managers, mental health providers and the consumers. It was presented at the consortium where it was finalized.

The Women’s Health Questionnaire is another risk assessment tool that was developed to assess the social, mental and medical issues in a woman. It was done three times to see whether the problems identified at the time of intake improved with case management.

Section III. FINDINGS/DISCUSSION

The findings of the local evaluation is as reported in”
   a) Project Period Objectives (in accomplishment section)
   b) WHQ results - Women's Health Questionnaire (WHQ)

The Women's Health Questionnaire is a major tool that has been incorporated into the BHSI case management model, to enhance not only the self-esteem of the women but also to make her aware of her health needs and ways to improve it.

This is a self-administered tool that is being administered to all BHSI pregnant women. The case managers have been trained to help the women complete this health assessment questionnaire. This tool is being administered thrice. Once at the time of intake or more appropriately within 60 days of entry into the BHSI program, once at the end of the first year and once at the end of the second interconceptional period.

Results of the Women’s Health Questionnaire Analysis:
As of May 30 2005, 675 women during pregnancy have been administered the WHQ. There were some interesting findings. The results of the WHQ analysis is attached in the Appendix. Some of the highlights are:
   • More than ½ the population are born abroad.
   • Only 52% have English as their primary language.
   • 87% of the women have been tested for PAP smear.
   • 82% have been tested for HIV
   • High Blood Pressure, Asthma, Overweight, repeated vaginal infection were found to me some of the major medical concerns.
   • 50% of the women have some housing problem.
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- 12% of the women have been ever hurt by someone.
- 20% of the women have problems getting along with their partner.
- Chlamydia is the most prevalent STI.
- More than 17% of the women have problem paying for transportation to appointments.
- By ethnicity African American have the highest depression, followed by the Latinas, with the lowest amongst the Haitians.
- Haitians have the lowest level of STI, with the highest amongst the African Americans.
- Smoking, Drug use is also highest among the African American followed by the Latinas and lowest among the Haitian.

c. BDI-II results
Prevalence of Significant Depressive Symptoms among Minority Women Participating in the Boston Healthy Start Initiative During Pregnancy to 12 Months Postpartum (Attached)

d. Outreach surveys
BHSI does not fund any of its 14 sites for outreach. But due to major state budget cuts many outreach components have suffered a setback. BHSI has therefore strengthened its own outreach component through its outreach coordinator to outreach to project area residents and also to the providers at health centers, faith based initiatives and other community organizations.

Outreach Surveys:
Surveys were filled out at the outreach events, by the Outreach Co-coordinator to assess the success of BHSI's educational campaign and also to find the barriers if any that might be preventing our clients from accessing health care. These surveys were conducted at the different health fairs, ethnic festivals, at the different housing events, and any other major events in the Project Area. The outreach co-coordinator did 3012 surveys.

Informational workshops:
14 informational workshops were conducted that were attended by 104 residents.

Community Organizations:
About 8 community organizations were outreached and flyers distributed.

Faith based Initiatives:
6 Faith based Initiatives have been contacted
The outreach coordinator reaches to about 5000 to 6000 residents in the BHSI Project Area every year at the different events, at the churches and at the different housings. Approximately 3000 to 4000 surveys have been conducted every year and the outreach coordinator attends about 65 to 85 events every year.

Outreach Information from the 14 BHSI funded Agencies: (these might be duplicated numbers)
Number of Outreach Events=362-435 events are held each year by the 14 BHSI funded sites.
Number of Pregnant women outreached= 2800-3020 every year at the various events and through outreach.
Number of Postpartum women outreached= 3212-3822 every year at the various events and through outreach.
Number of consumers outreached= 6266-7205 at the different health centers every year.

e. Client satisfaction surveys

Protocol: Client satisfaction surveys regarding the case management services are done thrice; once at the end of delivery, then at the end of the first year, and finally at the end of second year of follow-up, after delivery. This help us ascertain whether the interventions were successful and whether it was useful for the client. The satisfaction surveys were used by all the BHSI sites. The surveys are sealed and returned to BHSI Office to ensure confidentiality of the client's response.

The satisfaction survey was also translated in Spanish and distributed to all the sites.

Satisfaction Survey Results:
To date we have about 302 surveys done at the end of pregnancy. Most of the clients have greatly appreciated the support received through BHSI’s holistic case management model. Most surveys have very positive feedbacks.

BHSI Client Answers
What has been the most helpful to you about BHSI case management services so far?
• “Assisting me with transportation, moral support and clothing. I feel my case manager have gone beyond the call of duty.”
• “Information about my pregnancy.”
• “Finding a homeless shelter for me”
• “Helped me with bus tokens and clothes for my baby and much support from my case manager”
• “Helped me with transportation; very loving and emotionally supportive. Got clothing for my baby.”
• “I like all the program. Helped with bus tokens, cab vouchers to go to see my doctor.”
• “Everything, (BHSI case manager) was very caring and resourceful.”
• “Helped me with medical appointments and transportation.”
• “Home visits were very helpful, and the clothing and pampers I received for my baby.”
• “All the referral and resources that the case manager helped me get.”
• “She was there when I needed to get to doctor’s appointments with tokens, pampers, and wipes. Very helpful information. Helped me with a referral to a therapist and programs and just being there to talk.”
• “Ella siempre esta pendiente de mi, si me puede ayudar lo hace y se preocupa por mis necesidades. Me ha ayudado a ser mas paciente y..."
como controlar el estrés.” (“She always is attentive to my needs, if she can help me, and she is attentive to my needs. She has helped me be more patient and how to control stress”).

- “The program will always help me to remember a very important time in my life. This time would be a time of growth independence. A time in my family’s life of transition and support. Health Care for the Homeless has blessed me with several female staff in different times of my life. I’ve utilized their case mgmt, counseling, nursing and nutritionist services to name a few. Even though closing this case is a sad moment to myself and my family; and a closing in our lives it’s an accomplishment in our hearts.”

- “They helped providing me with Head Start.”

- “Nurse visits were very helpful”

- “She (case manager) has helped me with my boyfriend, with housing, clothes, food and when needed a taxi cab to the hospital. Get me a winter coat for the winter because I’m very big. I hope she stays with me for a long time. She is very nice.

- “Finding housing. I would like to get more home visits. She helped a lot with parenting classes.”

- “She helped me in every way she could. She assisted me with housing, looking for jobs, safety stuff, keeping me up, not stressed and keeps my head on tight.” I learned how to take care of my own health, keeping appointments and about child safety.

- “She helped me with staying in school. She made sure that I had safety things for my new apartment.”

- “She helped me get things done with the landlord to clean the air vents for my son’s breathing problems. She helped me graduate from high school and get daycare for my baby.”

- “They taught me how to discipline my child, and how to take care of myself while taking care of my child.”

- “I had someone to talk to about how I was really feeling after giving birth. It helped me out a lot because I really didn’t feel alone, I felt like someone was on my side. All the help I received was beyond the call of duty. I learned how to be patient with my children.”

- “It helped me a lot because I was a first time mom”

f. FIMR Results:
The Boston Public Health Commission is also assessing the health and health care experience of women who have suffered a late fetal or infant loss through analysis of the Women's Health Questionnaire (used also by BHSI clients and their case managers) in the Healthy Baby/Healthy Child program. A particular focus of this assessment is hope of better understanding women’s health issues and experiences that may contribute to the excess preterm and low birthweight risks of Boston's black residents.”

g. Performance measures (see attachments)
h. Special Studies:

1) Comparison of CBA and CHC.

*Highlights*

- Community-based agencies (CBAs) offer added instrumental supports that may reflect a slight difference in the demographics and needs of the clients served by the CBAs compared with the community health centers (CHCs);
- Both CBA and CHC clients experience barriers to depression services, including patient non-compliance with appointments, patient denial for need of services, difficulty getting insurance coverage, long waiting time, difficulty getting transportation, few mental health professionals that speak Spanish, and lack of childcare for counseling sessions;
- CBAs do more active recruitment activities than do CHCs who rely solely on their client base;
- CHC case managers might have more administrative responsibilities than CBA case managers, which may prevent CHC case managers from developing more intimate relationships with their clients and being more attentive to their needs;
- CHCs might have fewer barriers than CBAs to coordinating services for clients since all or the majority of the services are contained within the CHC;
- There is a disproportionate dissatisfaction among CBA clients compared with CHC clients regarding the patient-provider and patient-staff relationship at clinical sites;
- CBA clients experience more cultural and linguistic barriers to care;
- Both CBA and CHC clients would like more involvement of the male partner in care;
- According to CBA and CHC clients and providers, transportation, affordable childcare, and better insurance coverage would help facilitate the implementation of the BHSI case management model at both sites.

2) Depression among BHSI women (see attachment)

3) Health Status of BHSI pregnant women (see attachment)

*Discussion of limitations:*

- The data was checked on an ongoing basis for quality and completeness.
- The response to the surveys was mostly complete and very informative.
- Valuable information has been gathered through these tools and surveys. The only problem encountered is the WHQ or BECK was not done on those who were lost to follow up at the end of 1st and 2nd year of services. So also some of the immunization information could not be completed due to loss to follow up.
The Beck Inventory was begun in August of 2002 so all those clients recruited before this period did not receive the tool at intake.

The WHQ also had some limitations. The length of the tool was intimidating for both the providers and consumers but it was slowly done in a few sessions which improved its completion rate also clients completing it received some kind of incentive which further boosted the response rates. The data also had some problems as it was created in Access 97 and with the switch to Access 2000 there were technical problems across both this data as well the BHSI program data that needed to be taken care of.

There was also a problem with the clinical data as it was being transferred from Foxpro into an Oracle database. This resulted in us relying more on the Massachusetts vitals record for reporting on the clinical indicators. The Vitals in Massachusetts is 2 years behind that also creates problems as recent information on the present clients are not available. The problem has however been rectified and the data is being used for reporting in this final phase.

Section IV. RECOMMENDATION
A. The recommendations that stemmed from the local evaluation are:
   i) The importance of screening women for identifying the symptoms of depression, as it has been found that case management definitely helps lower the prevalence of depression.
   ii) The use of the BDI-II instead of the other tools as found from the formative evaluation of the mental health task force records.
   iii) To train all case managers about the importance of educating women around family planning to increase the interconception period, as it was found that many women were getting pregnant in a year after delivery.
   iv) To encourage women to use condoms even during pregnancy to lower the risk of sexually transmitted infections.
   v) To have case managers gain the confidence of the women before doing tools and surveys to identify the problems rightly and also to keep them connected to care. It has been found from an analysis that non clinical site women are connected to care more than in a health center setting.
   vi) To listen to the needs of the community and always to present the findings to the community to get a true and valuable input and recommendation for any changes that are appropriate and timely.
   vii) To make concrete efforts to include consumers in the development of any possible exploratory evaluation especially if the outcomes reflect making changes in behavior.
   viii) There needs to be flexibility in defining outcomes for very high risk groups such as those with substance abuse issues or those who are homeless especially measures like women and children with permanent medical home.
viii) The evaluator needs to be part of the program to understand the needs of the community and develop a community participatory research.

B) The local evaluation results have been presented to the PPOR group so that other programs across the country can replicate the model of service. It is also used by the Boston Public Health Commission where a Mental Health division is being established and the results of the local evaluation have been extremely beneficial. Studies will be done in depth in the current phase to see the causes that precipitate depression among the Black women and what more can be done. Also a case by case evaluation of each infant death will be done to see what was responsible and what needs to be done to correct it.

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

A. Describe changes in the perinatal system

1. Based on the results of the local evaluation which showed the importance of recognizing the symptoms of depression early in pregnancy, the mental Health Task Force came up with the plan of screening all pregnant women early in the pregnancy and then ensuring that the women received the services.

Also the referral system was strengthened and ways were found to address the long waiting time for an appointment. This was done by hiring part-time consultants, taking the women into the walk in clinics and also collaborating with the local health agencies which have a mental health component at their sites.

Focus groups were held with both the providers and consumers and it was found that depression is considered to be a taboo in some cultures. It was also found that women do not consider themselves to be depressed even when scoring high with the Beck tool.

2. The evaluation process also identified the disconnect between primary care and Ob/Gyn. This resulted in the women falling through the cracks. BHSI mandated that all their women be connected to primary care after delivery. This was done my doing trainings for all the BHSI providers, and also working closely with the physicians and other health care providers in both the departments to ensure a continuum of care for the women. BHSI mandates the contracted sites to ensure that their women receive their physical and their other identified medical problems be take care of to ensure a healthy pregnancy in future.
It was also recommended that case managers work closely with the pediatrics department to not only ensure that kids complete their immunization but also to look for women who are lost to follow up. It has been found that women mostly care to complete the kids requirements but neglects their own.

B. Describe changes project implantation

1. Based on the formative evaluation done at the beginning of the project it was decided that the BDI-II would be used and should be done 3 times.

2. Focus groups conducted helped us identify the need for the women with mental health issues to have a support group, and therefore BHSI implemented the Sisters Circle to provide support to these women who are depressed through non traditional ways and just not a regular mental health referral.

3. It was also learnt from surveys that men were important to be around when the women were pregnant and also in the interconception period. BHSI mandated all the health centers to refer the partner to the Father Friendly Initiative.

Section VI: PUBLICATIONS

Reports have been developed for publication on the results of the WHQ and based on the results of the depression screening tool. They are attached in the appendix.