HEALTHY START IMPACT REPORT - DISPARITIES

I. Overview of Racial and Ethnic Disparity Focused On by Project
In the six-county Enterprise Community (EC) area, covering 2,573 square miles, the estimated 1990 total population was 75,007 (US Census of Population and Housing, 1990). In 1990, more than one-third (38.6%) of children under 18 lived in families whose incomes were at or below the poverty level. Almost 50% of families are below 185% FPL. Over one-fourth (27.6%) of Enterprise Community county residents in 1990 were women of reproductive age (WRA). Of the 20,733 WRA, 58.6% were black and 41.1% were white. The population to be served will be primarily Medicaid insured pregnant women and infants in the six Enterprise Community counties.

For the 1996-1998 average of perinatal statistics across the Enterprise Community, the average infant mortality rate (IMR) was 11.13 (39/3505), with 15.16 (33/2177) for black infants and 4.56 (6/1316) for white infants (Georgia Perinatal Epidemiology Office). The neonatal IMR was 8.56 (30/3505), with 12.86 (28/2177) for black infants and 1.52 (2/1316) for white infants. The post-neonatal IMR was 2.57 (9/3505), with 2.30 (5/2177) for black infants and 3.04 (4/1316) for white infants. The low birth weight rate (LBWR) was 10.90 (382/3505), with 13.64 (297/2177) for black infants and 6.31 (83/1316) for white infants. Live births for 1996-1998 totaled 3505, with 2177 (62.11%) to black women and 1316 (37.55%) to white women. Total live births to teens less than or equal to 18 was 538 (15.35% of total live births), with 421 (78.25%) among black teens and 116 (21.56%) among white teens. Racial disparities in perinatal health among the six Enterprise counties combined reveal about four times the IMR, two times the LBWR, and two and a half times higher the percentage of births to teens less than 18 among black families.

An examination of racial disparities by county in the 1996-1998 averages, excluding Taliaferro County because of small numbers, reveals even greater disparities, with the worst county IMR difference being 0.00 (White) to 20.55 (Black) in McDuffie (9/438) and the worst county LBW difference 4.20 (White) to 14.61 (Black) (1:3.48) (Jefferson). Comparing 1996-1998 to 1993-1995 averages of perinatal statistics, IMR, NIMR, PNMIR, LBW, and VLBW rates among black women all improved slightly in the 1996-1998 averages; however, racial disparities (black/white) ratios increased, some dramatically, in IMR (1.93 to 3.32), NIMR (1.93 to 8.46), LBW (2.06 to 2.16), and VLBW (3.25 to 3.48). The Preterm Delivery Rate in black women jumped from 14.55 in 1993-1995 to 19.66 in 1996-1998. Significant racial disparities continue to exist. Abject poverty and low education levels coupled with fragmented services and the rural isolation of the area contribute to these very poor perinatal outcomes.

The focus of the project was to improve women’s and infant health in order to address the racial disparities among the six Enterprise counties combined which experienced about four times the IMR, two times the LBWR, and two and a half times higher the percentage of births to teens less than 18 among black families. With the combination of the disparities and interconceptional (IC) funding and the federal requirement to incorporate interconceptional health for all women, we focused our services on women with high risk pregnancies and with poor outcomes, including fragile infants.
II. Project Implementation

A. Approach to Each Service and Core Systems-Building Effort

Outreach and Client Recruitment

Approach and Reason: Because our project area is rural and has limited resources, many perinatal and medical services are centralized in metropolitan Augusta; therefore our approach to outreach has been: to create and refine linkages between the tertiary regional perinatal center and local providers through improved exchange of information to identify pregnant women and fragile infants, and enhance service delivery in order to address changes in their health status in a timely manner.

Components: The methodology for this client recruitment and retention approach was to create and maintain a web-based perinatal information system to inform locally based case managers of newly identified pregnant women who were admitted to in- or out-patient care at Medical College of Georgia (MCG) Medical Center, the regional perinatal center. Case managers receive daily queries of newly admitted women with the diagnosis of pregnancy who are residents of the county to which the case manager is located. In addition, to the web-based information system, a staff member was designated as liaison between the other Augusta hospitals and physicians to identify pregnant women from the EC counties, work closely with neonatal intensive care staff, and email and/or phone the contact information to the appropriate case manager.

Another approach was to: improve outreach via contact with health, education, and social service providers and agencies in addition to door-to-door neighborhood contact.

Components: This approach has involved relationship building with local providers and agency staff through a multitude of ways, such as partnering on community events and services, working closely on difficult client situations, and communicating regularly regarding client services and activities. We hired staff from the community to advance relationship building and promote services.

As the program has matured over a total of six years, client recruitment was accomplished primarily through county-based agency referrals, MCG electronic referrals, and word of mouth. Clients and family called our offices to let staff know of potential clients. Staff were visible in the community, making home visits, and identified potential clients and offered services in the traditional outreach manner.

For electronic, phone or fax referrals, we send a letter to each referral, explaining services and then telephone potential clients to initiate the introduction to the program and the screening process. The screening process aids in identifying the highest risk clients.
Our focus has been reaching the highest risk maternal and infant clients and retaining clients for two years postpartum. We have a structured screening process that guides the advocate through gathering information to determine the client’s risks. This screening tool has been refined over the project period (Attachment H).

**Case Management/ Interconceptional Care/Depression Screening and Referral**

**Approach:** Before Enterprise Community Healthy Start (ECHS), the only perinatal case management in the EC communities was health department clinic-based case management that focused primarily on referring and monitoring. If patients came to the clinic, they were assessed and referred to other services, asked about their recent use of services, and provided appropriate education. The goal was a monthly contact, regardless of the complex needs of the patient. There were no private case management businesses or agencies.

Observing the limitations of clinic-based case management services existing in the EC counties, we approached case management with the goal of 1) providing problem-focused case management of varying intensity relative to risks and patient needs aimed at social and medical needs of high risk pregnant women, women experiencing poor outcomes or at risk for subsequent poor outcomes, and high risk infants, particularly neonatal intensive care graduates; and 2) delivering a higher quality of perinatal case management continuity by moving from a clinic-based, single agency model to home visiting and information sharing among health, education, and social service providers.

**Components:** We defined and actualized case management as a continuum of services across the prenatal and two year IC period to include: comprehensive assessment, plan of care, monitoring and promotion of utilization of community services, health education, and disease management. Caseloads were limited to 30 clients per person with oversight for all clients by the Registered Nurse Case Managers. Case management staff included RNs and advocates who are high school graduates. Assessment included depression screening using the Beck Depression Inventory (BDI) and the Edinburgh Depression instrument pre- and post-natally, psychosocial-environment, dietary, medical risk, and literacy level. Women and their infants were case managed from enrollment, which may be prenatally or during the first year of life of the infant, to 2 years of age of the infant. Prenatal enrollment criteria included:

- **Medical Risks** of: any chronic illness, alcohol/drug use, mental health diagnosis, positive depression screen, late or no prenatal care, history of poor pregnancy outcome
- **Dietary Risks**
- **Psychosocial Risks** of: no support system, very unstable living conditions, domestic violence, unsafe behaviors, <18 and >1 pregnancy or < 16 years old, poor parenting skills.

A more detailed explanation of enrollment criteria which is Level III is in Attachment A – Level III of Case Management. Women who were screened but
not enrolled were referred to community resources, such as the less intense case management services of the health department.

The content of prenatal case management included: ongoing assessment, education, service utilization tracking, home visiting, referrals, and problem solving. Individual education regarding prenatal care, nutrition, disease management as needed, women's health, life skills, problem solving, and infant care was provided at appropriate times throughout the prenatal period at each home visit. Service utilization tracking for medical, OB care, WIC, and prenatal classes was monitored. Referrals were made as needed. A home visit was provided at least once per month. See Attachment G, Case Management Flow Chart.

During the interconceptional period, we focused on optimizing utilization of preventive services for the mother and her infant/toddler, promotion of child development, and self-care for control of chronic diseases. For clients enrolled in the interconceptional period, the enrollment criteria were the same as the prenatal period with the addition of infant criteria which included:

- Small for gestational age,
- < 36 weeks gestation,
- Birth weight of <2000 grams,
- Neonatal intensive care unit (NICU) stay of > 4 days
- Genetic conditions
- Serious problems/abnormalities
- Dietary concerns of breastfeeding and infant feeding problems
- Environmental: homeless, soon to be evicted; unsafe dwelling
- Concerns regarding contraception method.

Postpartum/interconceptional home visits were provided or attempted within the first two weeks and again within a month post discharge and at a minimum of once a month. Stable interconceptional dyads could be seen quarterly after the first year. In practice, usually at one year, the family was more stable. The content of the postpartum home visit included the same assessment, education, tracking, and referral format and adds interconceptional care, infant development, infant behavioral responsiveness, infant state modulation topics, and child teaching strategies. Service utilization tracking for medical, GYN/Women's Health, primary care provider services, emergency room/hospitalization, dental, pediatric, well baby visits/immunizations, sick baby visits, subspecialty follow-up clinic visits for NICU graduates, WIC, and kept referrals was integrated into the home visit. Further referrals were made as needed. Additional home visits were made at one-month intervals or more often if needed, again incorporating the assessment, education, tracking, and referral design. Advocate visits were made under the direction of the case manager with the goal of reinforcing the client’s plan of care. Content of the advocate’s visits may have included coordination of services, information gathering, teaching using standardized teaching materials, etc.
The content of postpartum/IC home visiting for PPs included the same assessment, appropriate education, tracking, and referral format with the addition of Ages and Stages Questionnaire (ASQ) and Ages and Stages-Emotional (ASQ-E) tool for assessment of the infant/child and education related to infant development, infant behavioral responsiveness, infant state modulation topics, and child teaching strategies. Service utilization promotion and tracking for women's health, primary care provider services, emergency room/hospitalization, dental, pediatric, well-baby visits/immunizations, sick-baby visits, subspecialty follow-up clinic visits for NICU graduates, WIC, and referrals were integrated into the home visit. Further referrals were made as needed. Advocate activities included coordination of services, information gathering, teaching using teaching guides, etc. During CM contacts, education regarding parenting was structured using Beginnings Parenting Guides.

Interconceptional case management tools were added over the course of the project to include: Life Skills Progression Instrument (LSP), Ages and Stages Questionnaire (ASQ), and mental health promotion activities derived from “Promoting Maternal Mental Health During and After Pregnancy”. The LSP is a clinical outcome tool for low income parents with infants and toddlers to age three years. It includes a rating scale on categories of relationships and supports, education, health and medical care, mental health, basic essentials, and infant/toddler development. The LSP is scored initially after 2-3 visits (whether enrollment is prenatally or interconceptionally) and every 6 months on the maternal and infant PPs. The LSP helps the case manager identify strengths and needs of the parent and infant/toddler and see progress toward goals in a quantifiable manner. It also can be useful in supervision of case managers.

The ASQ is a developmental tool that addresses the infant/toddler’s development in key areas of communication, gross motor, fine motor, problem solving, personal social, social emotional, and regulation. Ages and Stages is administered every 4 months and the items and cut-off scores change with each age increment.

“Promoting Maternal Mental Health During and After Pregnancy” tools include intervention handouts and worksheets presented and discussed in a two-day workshop to the case management staff and other direct providers in the counties. Interventions address the following areas: entering motherhood, connecting with my baby, attachment, relaxation and well-being, honoring the woman in me, making space, and enhancing my baby’s brain. Interventions include approaches to discussing topics with the client, exercises, and coloring/visual tools.

In summary, during the project period, to improve case management services, we:
1) refined and maximized the use of weekly electronic queries that assist the case management and supervisory staff in identifying lag time for screening incoming referrals, time between appointments of enrolled clients, outgoing referrals not completed, clients due depression screening, clients due women’s health visits or child health checks, clients due for Ages and Stages Questionnaire (ASQ), clients due Life Skills Progress, etc.
2) provided staff with training to increase their intervention tools: a) Improving Maternal Mental Health During Pregnancy, b) ASQ, c) Beginnings Pregnancy and Parenting Guides, d) Life Skill Progression Instrument, and Red Cross HIV Starter Facts.

3) implemented use of low literacy Pregnancy and Parenting Beginnings Guides as the curriculum for education of case managed clients

4) implemented use of the ASQ.

5) improved communication with other providers by holding joint case conferences and as we enrolled clients, sending notification to their other providers.

6) began and institutionalized depression screening as a routine of initial and ongoing assessment.

7) emphasized health literacy and its relationship to low reading skills as important to using the healthcare system and making health decisions.

**Depression Screening**

Although depression screening as it was incorporated in the process of enrollment and case management is described above, there is additional information to share.

After the first year of depression screening, we were keenly aware of the high percent of clients who were screening positive for depression and our inability to convince women of their need for mental health services. This triggered:

- HS to alert the EC community to the problem of depression by presenting our findings at consortium meetings which increased the awareness of local providers,
- Consortium members agreed that a focus on depression and anxiety was appropriate for LHSAP projects,
- Consortium member agencies responded with strong proposals to provide mental health services or education messages regarding depression and anxiety in an attempt to promote acknowledgement of depression as a pervasive problem in the community.
- Each county initiated a HS-sponsored project related to depression.
- HS to initiate depression screening at the prenatal clinic at the tertiary center outpatient OB services and for a year facilitated the placement of a psychiatry resident in the OB clinic.
- For one key provider (and a supporter of HS), the only public health nurse in a county with no resident physicians who resisted believing that depression screens were valid, over time she was convinced that depression was a serious problem in her county.
- HS sought direct counseling services acceptable to PPs because clients were resistant to seeking services at the local mental health agency.

**Resources for Outreach/Case Management/Depression Screening:** A significant change was to stop contracting case management services from the health department and instead to hire registered nurses and establish separate offices. Over the course of the four years, we used case management/outreach teams,
comprised of RN case manager(s) and advocate located in Burke, McDuffie, and Hancock County. The Burke and McDuffie offices were stand-alone offices. The McDuffie office staff served McDuffie, Warren, and Taliaferro Counties. The Hancock County staff during part of the project were located in the health department and later were located separately at the administrative building for the school system. Separating from health departments created greater staff accountability to the project, better defined the distinction of goals and approaches of Healthy Start from health department case management approaches, and promoted visibility of Healthy Start to the community at large as a separate entity from the health department without the negative aspects of the health department’s image in the community.

Depression screening provided additional information about the client, but increased our awareness of the need for but lack of mental health services in the area. Further complicating this circumstance was the social stigma of mental illness and the resistance of clients to use counseling services. Described later, we incorporated the need for mental health services into our designated funding for Local Health System Action Plan (LHSAP).

**Web-Based Perinatal Information System.** The web-based perinatal information system was a significant resource that facilitated the ability of the case management and outreach staff to manage outreach/case management services over a large land area and to permit supervision of this process. The original Paradox-based Perinatal Database was no longer adequate due to the requirement of CMs and ORs to document all of their work electronically. We thus contracted with the local computer consulting group of Drayton, Drayton, and Lamar, or DDL, to convert our local server-based database to a web-accessible Oracle version, which was used from October of 2000 until December of 2003. In January of 2004, DDL again upgraded the database from Oracle to MS SQL Server and added a family database to track infants for up to two years, ASQ and LSP pages, and many other minor improvements. We have continued to make minor upgrades as the needs arise; in the mill are JCAHO-compliant record locking and the ability to track letters sent to physicians.

The database has been an invaluable aid to both the case management teams and the administrative component of the grant. CM teams can quickly get a complete picture of where each client stands. They also receive weekly a series of queries concerning their active clients that indicate active workload, missing data, and scheduled or due visits, ASQs, LSPs, and depression screens. The administration now has a powerful tool to get an up-to-date “photograph” of the grant’s case management team efforts and to complete federal reports and future grant submissions.

In summary, beneficial changes over the project period were:

- Stand alone offices
- Employed staff instead of contracting with health departments
- Focus on highest risk clients
• Addition of individual counseling services for PPs who screened positive for depression.
• Continued development and enhancement of the electronic perinatal information system.

Continuing the teams’ composition of RNs and advocates promoted daily communication and support for a seamless, integrated approach to outreach and case management.

Influencing events: As the health department lost funding, more and more was expected of contracted staff by the health department. Contracted staff felt conflicting allegiance to their employer and Healthy Start. The solution was to end contracts and hire staff under the supervision of Healthy Start leadership.

Health Education and Training

Approach: Because in the six counties, client and staff education classes were limited, staff education was often confined to the specific sponsoring agencies’ staff and not open to providers outside of that agency, and classes were often located out of the county, our goal was to infuse the community with group educational programs for consumers and providers.

Components: We maintained an education calendar of classes for client education that was regularly distributed to all partners and staff. Initially, the calendar was distributed via email to partners and posted at various sites. Before the end of the project period, our website, www.echealthystart.org, was completed and the calendar posted on the website with regular updates, as well as distributed in hard copy at consortium meetings.

Over the four years, we partnered with other groups and piggybacked sessions with other agency-sponsored sessions, such as schools, health departments, Department of Family and Children’s Services, and prenatal center. In some cases, we became a regular participant in a series of classes sponsored by another agency. For example, we participated regularly in GED classes sponsored by the technical school in difference counties, teaching maternal-child related topics.

We held numerous educational sessions for providers. When we held a staff development session for HS case managers and advocates, we usually invited community agency staff and providers. Examples of Healthy Start sponsorship of conferences were: a) Choices and Changes, which encouraged the provider to examine factors influencing a client’s health care choices and ways to facilitate change, growth, and well-being for the client, b) Adolescent Health conference provided by Emory University, which provided education on physical and psychosocial developments in adolescents. Attendees learned ways to enhance teen health and provide education that will be effective for teens. c) Wise Guys- Male Involvement Training was conducted to train staff on the content of this curriculum. Case managers use the program in a formal setting at county schools and informally
directly with the clients.  

d) Maternal Mental Health training provided by the University of Washington, which provided education on maternal and family readiness for parenting, barriers to emotional health, and risk factors for postpartum depression. Attendees learned ways to assess a woman’s social support during the perinatal period, as well as techniques for working with women who have experienced trauma and loss. 
e) HIV Starter Facts training is a Red Cross program that was taught by a HS staff health educator. Participants received 2 days of training that focused on HIV history, community overview and community education strategies. 
f) Prepared Childbirth Educator training was funded for HS RN Case Managers as well as a group of RN’s from the health departments, schools and prenatal center. The goal was to have prepared childbirth educators available to the counties served by the project.

In addition, ECHS sponsored ECHS RN case managers attendance at a High-Risk Obstetrics or perinatal focused conference usually annually. This conference provided more intense information about the high-risk medical conditions many of the maternal clients experience. Case managers and advocates also attended an outside conference on Home Visitation. This was beneficial because of the opportunity for staff to network with other professionals and learn new ways to be effective during a home visit. Informal training occurred in an ongoing manner in the following ways: distribution of AWHONN Perinatal Depression resources; email of educational information about pediatric care, contraceptive care, obstetrical updates, and breastfeeding information; availability of videotapes on postpartum care, PIH care, etc.; access to maternal-child nursing textbooks, pediatric nursing textbooks, Bright Futures resources, and breastfeeding resources.

Influencing events: Developing a stronger relationship with churches has permitted us to use their transportation and child care services via contract to assist our clients in attending classes and services. As other agencies’ budgets have been cut, we have been helpful in providing training for agency staff, such as CPR for Department of Family and Children Services and Sexually Transmitted Disease sessions for public school faculty.

The strong relationship with school staff that evolved from our visibility and commitment to working intensively with teens contributed to the school systems willingness to permit us to teach in the schools and hold support groups for pregnant and parenting teens at the school or facilitated by the school.

In addition, we sponsor an abstinence education (AE) HRSA-funded project in Burke County, one of the EC counties. This permitted us to co-sponsor events for multiple counties that also have AE funding, thus, broadening our network for agency relationships and work with teens. Teaching STD information to public school staff occurred due to the AE school-based services.

The focus of health education in the counties served essentially remained the same to infuse the community with group educational programs for consumers and
providers. Participant numbers, feedback from participants, newly identified consumer and provider needs all had an impact on changes that occurred in health education provided.

The same factors contributed to the successes and sometimes disappointing outcomes of consumer education activities. Examples include transportation, location, time of day, and perceived value of the offering. Factors that contributed to success or under-achievement of provider education included: staffing of community agencies, location of training, timing of training, perceived need for the training.

**Consortium**

**Approach/Establishment:** The focus of consortium building was to increase the knowledge and skill base of members, build a political constituency to promote maternal and infant health, and gain support for specific community-based perinatal health strategies that would address gaps in the system. Community outreach and consortium events would be used to increase the awareness and knowledge level of perinatal issues in the targeted six counties.

The consortium initially was the CSRA Enterprise Community, Inc., with the Human Development, Health and Public Safety Committee providing advisory input and support to the HS project. In addition, monthly project-wide meetings, focusing on delivery of program components in conjunction with our partner agencies, were instrumental in developing the strong partnerships that now exist between the project and community agencies. This service partnership group continued to expand to include Family Connection coordinators, public health leaders, and some school nurses. The meetings were both educational and programmatic in focus. With agreement of the members of project-wide meetings and key leaders in the CSRA EC, Inc., the HS Consortium became a subcommittee of the Human Development, Health and Public Safety Committee of the CSRA EC, Inc. This change was to allow a more diverse membership than the CSRA EC, Inc., bylaws permitted. From a subcommittee status, the consortium evolved to be a separate consortium and has operated independently of CSRA Enterprise Community, Inc over the last three years of the project.

**Working Structure**

The consortium president with major support of the Outreach Coordinator planned and conducted the quarterly meetings held in McDuffie County, a central location for the six-county group. Although committee structure addressing bylaws, consortium education and training, membership, community needs assessment, and public awareness existed formally, committee member participation was sporadic. Even though committee work was less than desirable, attendance at meetings was consistent with representation from all counties. Because the local system health action planning process described below was also a key collaborative effort of the consortium, this process created more activity and interest among members than the committee structure.
Composition
An analysis of the consortium roster over the life of the project revealed the following:
Race: 58.6 white 41.4 black
Gender: 84.6 female 15.4 male
Consumer 14.3 %
Provider: 44.4
Government: 36.5
Staff are not included in percent, but all staff attended quarterly meetings and key staff presented or participated in various ways to support the success of meetings. When events were at the county level, only the county level staff and an appropriate educator or administrative staff participated.

Activities used to assess needs, identify resources, and establish priorities for allocation, and monitor implementation are discussed under the LHSAP and consumer participation section. We participated in other active collaboratives, including the Family Connection meetings in the six counties, the Burke DFCS collaborative, and subgroups who held initiatives during the project period. Examples of activities supporting other collaboratives were ECHS educator spoke at mother-daughter classes at county sponsored program; ECHS sponsored teen parent support group in conjunction with four school systems; ECHS staff provided education session/activities at county sponsored summer programs and faith-based sponsored programs.

Community strengths
The major strength of the six communities was dedicated leaders, particularly in the health care and social agencies. Agency representation was consistent in the ECHS Consortium and without conflict.

Weakness or Barriers
An emerging barrier to participation has been the shrinking budgets of the agencies participating, resulting in staff having more demands and less time to attend meetings. To counter this, we met only quarterly and often communicated via email.

There were no “lightening rod” leaders who stepped forward to passionately work on issues or “carry the torch”. This could be due to the entrenched problems of poverty and limited resources. This also could be due to the fact that there may not be the combination of a leader with political/financial clout and desire to address issues surrounding poor maternal child outcomes.

Consumer Participation and Input:
Consumer participation was always a challenge, probably due to the large land area of the project, the central location of the consortium meetings, and program participants’ level of poverty and level of need focused on themselves and not the community. Thus, in addition to the quarterly consortium meetings other activities were attempted
primarily to obtain consumer participation of PPs and CPs with activities located in each county. Sessions which were more successful in reaching consumers included Kitchen Table Talks, Women2Women sessions, and Eat While We Meet sessions.

The HS Community Outreach Coordinator organized and facilitated Kitchen Table discussions during 2002-03. The “Kitchen Table Discussion” was a model developed to facilitate the discussion of topics within communities in a setting that is both casual and relaxing. Our first series of Kitchen Table Discussions dealt with domestic violence. Community members were personally invited to attend, either by advocates, case managers, or the outreach coordinator. An attempt was made to include a mix of county residents so that the county was fairly represented. A keynote speaker was identified who discussed the topic, its potential impact on the community, and community resources, a “storyteller” related an anecdote related to the topic, and then attendees discussed the issue over dinner with a facilitator present at each table. The Kitchen Table Discussions were enthusiastically received in Hancock, Jefferson, Taliaferro, Burke, and Warren counties. In addition to supporting the local health action plan of the communities, this strategy was a means of increasing consumer participation and gaining community input related to local health services delivery in the ECHS consortium. Consumers were active in the Kitchen Table Discussions. At the small table discussions, consumers felt more comfortable voicing their concerns and suggestions for addressing domestic violence. Participants also signed up to receive Consortium meeting announcements. In 2004, another strategy was community sessions, entitled ‘Woman 2 Woman’ and held every other month. The purpose was to acclimate and encourage consumers in voicing their opinions and ideas among their peers, hoping that they would be more comfortable to participate in meetings.

“Eat While We Meet” sessions were held with each county Family Connection Collaborative to get their input regarding the use of Healthy Start for community needs. Areas of concern based on input from leaders and consumers were transportation, prevention programs in the middle and high schools for males and females, women’s health issues, transportation, school-based activities, lack of preventive services, lack of mental health services, inadequate nutrition among school age residents, and school based support groups for pregnant and parenting teen students.

Attendance by consumers at consortium meeting was increased, but attendance remained sporadic, even though we offered childcare, travel reimbursement, and/or travel. Food was also provided at each meeting.

**Utilization of Consumer Input:** Consumer education was continued with group classes in each county. Support groups for pregnant and parenting teens were held by ECHS staff and/or partners over the course of the project in Burke, McDuffie, Jefferson, and Warren Counties due to the cooperation of the school systems. Mental health services were addressed via a contract in McDuffie County with Family Connection which provided a credentialed mental health counselor to work with the
young parent support group to focus on mental health issues, primarily anxiety and depression related to pregnancy and parenting. Mental health and teen support needs were also addressed with services by Burke County School system. An age appropriate and culturally sensitive psycho-educational program was utilized to provide education on aspects of depression and specific strategies and coping skills for dealing with depression. Through the use of activities, combined with therapeutic interventions, pregnant and parenting students referred by school counselors and teachers were introduced to activities to combat boredom, career information, family communication skills, and self-esteem building exercises. For the communities of Gough and Midville (very rural areas of Burke County), the school system also conducted 1) a public relations campaign, including dissemination of Power Within information via, church visitation, monthly newsletter, weekly meetings, PSAs in local newspapers, and production and distribution of a Depression Awareness pamphlet and 2) 44 regular instructional sessions to approximately 30 teenagers, using the Power Within curriculum to increase their awareness of depression and their knowledge of strategies to reduce anxiety, stress, and depression among teen participants and improve the lives of families affected by depression. The above strategies in Burke and McDuffie Counties continued over two years (2003-2005) of the project; in addition, other projects were conducted in Warren, Hancock, and Taliaferro. ECHS also contracted with Rape Crisis and Assault Services beginning in March 2004 to provide individual mental health counseling and education services.

**Local Health System Action Plan**

**Approach:** Because we are a multi-county project spanning a large land area, the local county health action plans were developed through a collaborative consortium process, using the Healthy Start (HS) Consortium to build on already existing required reproductive health planning under Title V and existing local county Family Connection Consortia, to address gaps in the perinatal health care system. Perinatal information about each county and collectively for the six counties, gleaned from the needs assessment and disparity eligibility tables, was presented to the consortium. Healthy Start models, planned strategies, and activities were reviewed with the group and individually if necessary. From this information and reports from each county on current Family Connection, DFCS, and public health local initiatives and observations from agency representatives, the consortium determined three to four areas of focus for the health action plan. The areas of focus could relate, for example, to education needs, improvement of linkages among social, mental, and physical health providers; increasing utilization of perinatal services (adequacy of prenatal care is low); access and capacity of family planning services; the quality of case management; the penetration of WIC services; and the scope and quality of interconceptional services.

Family Connection leaders presented the areas of focus for the perinatal health action plan to their local consortia for their determination of strategies relevant to their local resources and needs. Based on what the local group decided as realistic for the county, the group developed local strategies, wrote a plan and budget, and submitted these to the review panel. Funds approved in the Healthy Start budget for
LHSAP contracts were awarded based on the review panel’s decisions. Through this process, many more local individuals, consumers, and providers had input into the health action plan as well as gained knowledge and skills for addressing maternal and infant issues.

**Components:** In summary, from 2003 to 2005, a request for proposal and review process was developed with community partners being eligible to participate. Through partnership grants, projects were designed and implemented by partners. The emphases of the grants included: expanding mental health services and increasing awareness of depression. Contracts for these projects were with: Burke County High School/Burke County Board of Education, Teen Depression Support Group; McDuffie County Partners for Success, Inc., Young Parent Support Group for Depression and Anxiety; Taliaferro County Family Connection Collaborative, Depression Outreach and Referral; Hancock Human Development Center-Hancock County Board of Commissioners, Women and Youth In Training (WAY IT); Burke County Board of Education, Power Within Project—Gough & Midville Communities; and Warren County Family of Families Collaborative, Teen Mentoring Program.

As case management services revealed major client needs of transportation and mental health counseling, which were gaps in services that were critical for case managed clients across all the counties, services contracts were sought from agencies with the needed services. Counseling and mental health education services were obtained from Augusta Rape Crisis and Assault Services, Inc. who had credentialed counselors on staff, and transportation contracts with local churches in 2004 and 2005.

**Influencing factors:** The leadership of partner agencies had to be considered in determining the capacity of the agency to carry out the proposed project. In one case, we had to cancel a contract due to lack of capability after working with the staff intensively to complete prior contracted services. Some partnership project activities were so beneficial that we continued the projects in subsequent years with the consent of the consortium.

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

**Approach:** The four Georgia Healthy Start projects approached the state public health department through our various networks and through these requests to collaborate, Eddie Towson, employee within the Family Health Branch, was assigned as liaison to the GA HS projects by the Director of the Family Health Branch. This approach was very effective and beneficial for collaboration.

**Components:**

Linkages and collaboration with State and local Title V MCH and other agencies have included:

- Development and dissemination of 5000 CD-ROMs and executive summary of a maternal-infant health report entitled “Maternal & Child Health in Georgia, Birth Through Age 5: Progress During the 1990s–Planning for the New
“Millennium”, which includes statistics for the nineties, best practices featuring the four Georgia Healthy Start Programs, accomplishments and challenges, issues in infant and child health, etc. (CD-ROM and glossy brochure enclosed). Georgia Healthy Start Programs, the March of Dimes, and the Family Health Branch of GA Division of Public Health funded, statewide maternal and infant health report in CD-ROM format. Healthy Start Directors were on the steering committee for the development of the report and participated in its dissemination. Sandra Pittman participated in the review of proposals and selection of the contractee: ORC Macro and several planning meetings.

- A regional conference in Augusta, in partnership with Augusta-Richmond County Healthy Start, and with participation from state MCH staff as speakers,
- A training workshop on facilitating support group for depressions in collaboration with the Augusta-Richmond County Family Partnership Healthy Start Program and GA Family Health Branch,
- Participation in 5-year needs MCH assessment beginning July 2004,
- Working regularly with local health departments in supporting MCH services to maternal and infant clients,
- Enabling clients to access and receive services at the state-designated, regional perinatal tertiary center, MCG, in order to promote risk-appropriate care,
- Promoting Maternal Mental Health During and After Pregnancy Two-Day Workshop, co-sponsored by the four Healthy Start programs and the state Department of Family Health
- Multiple meetings with Eddie Towson, our state MCH liaison, who also often attended and presented at several consortium meetings. With joint sponsorship from the GA Healthy Start projects, he attended both the Healthy Start Association Meeting in Washington DC, in 2002, and the National Healthy Start Conference in Baltimore, MD in October 2002 and in 2003,
- Family Health Branch provided Georgia Healthy Start sites with information packets and pamphlets as well as several requested data sets.
- Our local training opportunities, such as HIV Facts and quarterly CPR training, which included invitations to health department staff and other perinatal providers,
- Collaborating with the Robert Wood Johnson Covering Kids and Families (CKF) Augusta Pilot site program which promotes Georgia’s SCHIP program, PeachCare by the project director’s participation on the local and state CKF coalition and service as the advocacy committee chairperson, and by regularly including the CKF coordinator on meeting agendas to provide updates to Healthy Start staff and consortium participants,
- Supporting speakers on perinatal topics at the Georgia Perinatal Association Annual Meeting,
- Supporting speakers on a perinatal topic at the Georgia Healthy Mothers Healthy Babies Annual Meeting,
- Incorporating Back to Sleep, breastfeeding, folic acid, and smoking cessation messages in case management education and group education sessions, and
- Receiving a HRSA Community Abstinence Education award for services in Burke County in partnership with the public and private school systems.
• Supporting HS project director’s participation as an officer in state maternal child advocacy organizations and coalitions, including Georgia Perinatal Association, Healthy Mothers Healthy Babies, and RWJ CKF GA Coalition.

• Collaborating with Maternal and Infant Care program at MCG, AWHONN East Georgia chapter to provide Perinatal Potpourri Conference. Education sessions included post partum depression presented by nationally known speaker, care of fragile infants.

• Hosting in conjunction with Center for Breastfeeding a two day conference on strategies to increase breastfeeding rates, and essential breastfeeding information. The training was attended by 40 providers from the 6 counties served and other area counties.

• Providing membership and financial support to regional breastfeeding coalition. Assisted with sponsorship of quarterly breastfeeding education offerings as well as printing and distribution of regional breastfeeding resource information.

• Collaborating with CSRA Breastfeeding Coalition and other Healthy Start project to sponsor professional education conference.

In addition, the program collaborated with many other agencies informally. Examples are classes held at the Wymerly House and social services agency (DFCS), area technical schools in Burke and Thomson, the school systems in Burke, Hancock, Warren, McDuffie, Communities in Schools, Even Start, and churches. The case managers and advocates also related to multiple groups within and outside the project area as they advocate on behalf of clients. A formal contract existed for part of the project period with Hancock and Warren County Boards of Public Health for case management services. Informal relationships existed with the other health departments.

At the local level, collaboration occurred via direct service linkages among HS RN case managers and the health departments to support and facilitate breast-feeding, health screening and immunizations for infants, SIDS awareness and prevention, maternal/family smoking reduction, teen pregnancy reduction, dental care for women, health insurance for infants and children, promotion of case management, risk-appropriate care, pre- and interconceptional interventions to reduce low birth rates, folic acid promotion, WIC promotion, reproductive health planning, provision of a continuum of coordinated services from preconceptional to interconceptional care, etc. MCH health district leaders, including the health officers for the two health districts covered by our six counties, supported this collaboration.

d. Sustainability Components: Our most productive opportunity for sustainability was grant writing. We also explored various strategies for local support, including targeted case management services for at-risk children, new programs related to promoting self-sufficiency among our clients to determine if staff skills and knowledge might offer opportunities for contractual arrangements with social service agencies, jointly funded services with other agencies, and Medicaid billing for CM services. These efforts were not fruitful. We regularly monitored various websites for grant
announcements and requests for proposals. As requests for proposals were announced that dovetailed with our project, we submitted proposals. During CY2003, we were awarded a Community Abstinence Education (CBAE) Grant for $436,000 per year for three years, ending 6/30/06. We submitted a subsequent competing CBAE proposal and await the announcement of awards. We also submitted and received a HRSA award for a two-county disparities grant (Burke and McDuffie with project period 6/1/06-5/31/09) and submitted but were not awarded a four-county HRSA disparities grant.

Resources or Events: We approached our sponsoring agency numerous times, regarding applying for a Medicaid provider number to receive reimbursement for case management and mother-baby assessments in the home. We were unsuccessful in resolving the agency’s issues, such as our record becoming part of the hospital record and the billing process for outpatient services when the hospital is equipped to bill facility not services fees. In summary, we were not permitted to use the hospital FEI number to apply for provider numbers, the initial step in seeking Medicaid reimbursement. Medicaid managed care organizations did not exist during the project period.

Other than additional sources of grant funding (CBAE), potential resources were not identified or developed to continue any HS interventions, except some education services, without HS funding. As a grant funded project under a quasi governmental sponsoring agency, the project is not permitted to raise funds.

Consortium responsibility for sustainability was an advisory, supportive, and collaborative role in the development of new programs as part of the grant writing process and, if funded, then a participatory, partnership role for specifically involved agencies.

III. Project Management and Governance

A. Structure of Project Management

Refer to the attached organizational chart of the project (Attachment C) and the sponsoring agency, MCGHI (Attachment D), for the structure of project management. Refer to the schema of supervision, monitoring, and consulting for visualization of the project management processes (Attachment B).

Sandra M. Pittman, PhD, Project Director (0.9 FTE), assured the project direction and integrity oversight for the project through administrative with the assistance of the key administrative, fiscal, and evaluation staff, consultants, and the ECHS Consortium. She provided oversight and coordination of all administrative activities, facilitated the actual implementation of model services, monitored progress of the project, provided budgetary management, and led monthly staff meetings. She also managed or provided oversight for personnel matters and nurtured and built relationships with key county leaders. She supervised the clinical
services coordinator, the accountant, outreach coordinator, quality assurance assistant, and the data base manager.

Jodi Hudgins, Clinical Services Coordinator, was responsible for case management and education services. She supervised case managers, health educator, and contracted educators. She regularly scheduled and led case conferences, provided feedback on plan of care outlined by case managers as needed, reviewed decisions regarding enrollment and discharge of PPs, and maintained availability via cell phone and email as a resource for RN Case Managers and Patient Advocates as needed on clinical matters. She also maintained the community class schedule, was responsible for curricula, taught classes, and collaborated with existing health care providers to give and receive feedback regarding health education needs and enlistment of support from community businesses and agencies.

Mark Wilkinson, accountant, assured fiscal integrity of the project with the assistance of the project director. He also assisted the Project Director and leadership staff in coordination of activities and project management, handling day-to-day administration and long term managerial planning of support services. He had sole accountability for accurate accounting, contract management, and fiscal reporting, and served as resource person for MCG, MCGHI and Healthy Start fiscal policies and procedures related to grant management. He was responsible for payroll, equipment purchasing, personnel reports, contract payments, and other activities related to grant funds. He also supervised the administrative coordinator.

B. Resources for Fiscal and Program Management
The ECHS Project Director related to Mr. Rich Bias, Vice President of Ambulatory and Network Services on administrative issues and Mr. John Parham, Corporate Accounting, on internal corporate financial matters. The annual Financial Status Report of all project funds and income for each year of funding was produced by Mark Wilkinson, CPA, ECHS Accountant, with review by John Parham, CPA.

MCGHI has all the systems, policies, and procedural structures in place one would expect for a large complex institution. The infrastructure at MCGHI includes Corporate Accounting, Human Resources, Materials Management, Legal Services, and other major departments with management capability to assure proper control and supervision of grant funds and sound management of contracts. These resources were available to the project. MCGHI provided oversight of administrative and fiscal project requirements related to corporate accounting, personnel, and contract review and approval. In addition, an external audit of the ECHS accounting and compliance with financial and programmatic requirements was conducted each year.

C. Changes in Management and Governance
There were no changes in management and governance.
D. Processes to Assure Appropriate Distribution of Funds

The approved budget was used as the guide for expenditures. The accountant and project director conducted periodic reviews of year to date status of expenditures and encumbered funds. At leadership meetings, the status for lines items pertaining to core services and projects were reviewed to assist the staff with programmatic decisions. The HS Accountant monitored accounting processes, including backup documents for payment of expenditures. Contract payments for transportation and counseling occurred if backup service reports were in order and acceptable to the assigned HS coordinator, and the Project Director approved the payment.

E. Additional Non-Healthy Start Resources

The major non-Healthy Start resources were 1) the institutional capacities available, just by being apart of the organization and 2) the various community agency in-kind assistance, such as use of rooms for meeting space. Besides institutional assets related to fiscal and programmatic management, information technology support was always available. Consultation was also available regarding legal matters and HIPAA compliance.

F. Cultural Competency of Staff and Contractors

Culturally diverse and competent staff were employed. Cultural competence was reflected in the staff training and human resource policies. The racial composition of service staff reflected our clients’. Transportation contracts were with African-American churches. Cultural sensitivity was discussed and expected among staff and contractors. Language in contracts expressed the expectation of nondiscrimination and respect.

IV. Project Accomplishments

A. Description of Major Strategies Implemented and Lessons Learned

Strategies and accomplishments are described in Attachment E: Final Report/Implementation Plan, but below are certain accomplishments which deserve highlighting for the years 2002, 2003, and 2004 which are those years covering a full 12 months. Following this quantitative information, are case scenarios composed by the case manager for that specific PP.

Outreach and Case Management Over the course of these years, our enrollment has climbed and our retention rates have increased. This may reflect increased efficiency of staff in recruiting and retaining clients, as well as providing case management services across a large geographic area. In addition, we believe that the prompts provided through quality assurance strategies, such as alerting staff on a weekly basis of multiple CM indicators, assisted them in follow-up on incoming referrals, being in touch with program participants, and maintaining their services, outgoing referral or client service utilization monitoring, and content of care. The increased retention rate also reflects the clients’ trust developed in CM staff and the clients’ value of the services.
Total Clients

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>228</td>
<td>257</td>
<td>332</td>
</tr>
<tr>
<td>Infants</td>
<td>145</td>
<td>215</td>
<td>299</td>
</tr>
<tr>
<td>Total</td>
<td>373</td>
<td>472</td>
<td>631</td>
</tr>
</tbody>
</table>

When the admission numbers for women are broken down into those who were admitted prenatally and those who were admitted post-partally, it is obvious that we admit more women prenatally than post-partally. However, at any particular time, we carry mostly interconceptional women on our rolls.

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal</td>
<td>112</td>
<td>80</td>
<td>89</td>
</tr>
<tr>
<td>Postpartum</td>
<td>26</td>
<td>30</td>
<td>72</td>
</tr>
<tr>
<td>Total</td>
<td>138</td>
<td>110</td>
<td>161</td>
</tr>
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</table>
Retention Times for clients who have had the opportunity to be in the program for 24 months
Retention rates improved in each time period each year.

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Clients</td>
<td>212</td>
<td>230</td>
<td>184</td>
</tr>
<tr>
<td>&gt;12 months</td>
<td>117</td>
<td>156</td>
<td>157</td>
</tr>
<tr>
<td>%</td>
<td>55.2</td>
<td>67.8</td>
<td>85.3</td>
</tr>
<tr>
<td>&gt;18 months</td>
<td>85</td>
<td>118</td>
<td>128</td>
</tr>
<tr>
<td>%</td>
<td>40.1</td>
<td>51.3</td>
<td>69.6</td>
</tr>
<tr>
<td>&gt;=24 months</td>
<td>56</td>
<td>77</td>
<td>84</td>
</tr>
<tr>
<td>%</td>
<td>26.4</td>
<td>33.5</td>
<td>45.7</td>
</tr>
</tbody>
</table>

Medical Home
Ongoing primary care is defined below as a service provider other than the health department. Although the highest percent attained of PPs with an ongoing primary care site is not acceptable, the percent over time reflects improvement each year. The accomplishment is in Georgia, a state where Medicaid for pregnancy extends only to the month in which the sixtieth postpartum day occurs. See Form 9 for medical home based on a non-health department completed visit for family planning or gynecological services.

Patients with a stated ongoing primary care site/primary care provider:

<table>
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<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Clients</td>
<td>228</td>
<td>257</td>
<td>332</td>
</tr>
<tr>
<td>PC Site</td>
<td>67</td>
<td>123</td>
<td>233</td>
</tr>
<tr>
<td>%</td>
<td>29.4</td>
<td>47.9</td>
<td>70.2</td>
</tr>
<tr>
<td>PC Provider</td>
<td>26</td>
<td>66</td>
<td>158</td>
</tr>
<tr>
<td>%</td>
<td>11.4</td>
<td>25.7</td>
<td>47.6</td>
</tr>
</tbody>
</table>
Over the course of the project, 748 unduplicated women were screened for depression, and 38.1 percent (285) were screened positive, either prenatally, postpartally or both. Total women screened more than doubled between 2002 and 2004. Screenings after delivery increased over time. A lesson learned is that it is often much harder to assess women after delivery due to the difficulty finding them, because they often go to a friend or relative’s home from the hospital and their stress with the demands and adjustments created by care of the newborn reduce their responsiveness to CMs contacts for appointment.

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Women Screened Prenatally</td>
<td>64</td>
<td>56</td>
<td>89</td>
</tr>
<tr>
<td>Total Women Screened Postpartally</td>
<td>29</td>
<td>31</td>
<td>127</td>
</tr>
<tr>
<td>Total Screened*</td>
<td>93</td>
<td>84</td>
<td>216</td>
</tr>
</tbody>
</table>

*Note - women who were screened both prenatally and postpartally are counted twice in this table and the accompanying graph.
Infant Developmental Screening
During the project period, 96 unduplicated infants have received developmental ASQ screenings since we began performing them in 2005. 19 unduplicated infants have received two screenings, and 3 infants have received more than two screenings.

Maternal Assessments using the Life Skill Progression Instrument
Case managers have completed LSPs on 50 unduplicated women since we started performing them in 2005. 15 unduplicated women have received two assessments.

Completed Referrals
We monitored both documentation and completion rates on outgoing referrals to be certain that adequate monitoring by CM/OR staff was occurring. As the percent of completed referrals decreased, we sought an understanding of why, even though we felt that documentation of referrals was adequate. Without analyzing all types of referrals, but selecting those types of referrals most frequently made, the data supports that completed referrals declined due to an increase in mental health referrals triggered by an increase in depression screens and an increase in positive scores. This type of referral is most often not completed by clients, and clients often decline to agree to follow through at initial and subsequent conversations about the need for mental health services. See bar graph below that reflects mental health (MH) referrals compared to others. The graph illustrates the lower completion rate for MH referrals while documentation of MH referrals is high. Documentation across all categories of referrals is high. Documentation refers to the fact that the case management team has determined that the client either completed the referral, failed to complete the referral, or declined the referral.
Top Five Referral Types Over the Project Period (6/1/01-5/31/06)

**Community Education**

The number of attendees at community education classes was sustained at over 1500 each year and increased by over 1000 from 2002 to 2004. Given the percent of the budget allocated for classes, the large land area, and the challenge of transportation for many residents, we believe this is an accomplishment.
Case Scenarios Composed By Case Manager

<table>
<thead>
<tr>
<th>Case Manager:</th>
<th>Client:</th>
<th>Age</th>
<th>Grade Level</th>
<th>Referred by</th>
</tr>
</thead>
<tbody>
<tr>
<td>JoeAnn McGhee R.N.</td>
<td>S. H.</td>
<td>16yo</td>
<td>9th</td>
<td>Local Physician</td>
</tr>
</tbody>
</table>

HS Risk Factors:  
1. Late Prenatal Care  
2. Severe Social Situation  
3. <= 15 at conception  
4. Under 18yo at time of delivery  
5. Preterm Birth<37 weeks  
6. Positive depression screen  

Government services in place:  
1. Medicaid  
2. WIC  
3. Social Security  
4. Local Health Department  
5. Healthy Start

Many may not think this is a success story, but I do. Hopefully, when you look at the odds she is trying to overcome, you will feel the same.

SH is a 16yo student at the Alternative School. She was placed there after an incident involving a knife. She has been there now for several years. She is hopeful she will be returning to the High School next school term. She was referred to us by a local physician. The referral was then followed up with a visit by her aunt. Her aunt at the time of her admission into the program was her legal guardian. Her mother is not in her life at this time because of the mother’s involvement in drugs.

Plan of care includes the following:  
1. Childbirth Education  
2. Breastfeeding/Bottle feeding  
3. Infant care  
4. Parenting Classes  
5. Mental Health Counselor

She delivered shortly after she entered the program. She had a vaginal delivery at 34 weeks gestation. It was arranged for her to remain at the hospital until the baby was discharged home. They both were discharged into the care of her cousin. I was never quite clear as to what the problem was between SH and her aunt that cause her not to return to her home.

I followed her very closely for the next several weeks. Because the baby was 4lbs 12ozs at birth, I did frequent weight checks and visited her every 2 weeks. She was always very anxious to review educational materials and asked many questions. Things went well and she returned to the High School once the new school term started. This was for only a brief time. She was reported to be disrespectful to a teacher and was suspended. She was supposed to be home schooled but that also fell through. She returned to her mother’s and grandfather’s care. This meant within a 3 month period she and her child moved 3 times.

The father of her child, who is older, is not and never has been involved in their lives. He has another child and he has been abusive in the past.
During this period her finances were good. She was receiving a check from social security because her father died in 1997. Her check was in the amount of $770.00 per month. We discussed setting up a saving account on several occasions but she never followed through. We make several deadlines but they came and went. Part of her problem was transportation. Because she was not in school, her check was cut off. She failed to re-certify for Medicaid following her 8 week PP period. I assisted her with paperwork and she was again covered. Her son during this period was always current on Health Checks and Immunizations. She always tried to make sure he was current.

She has continued to live in the home with her mother and was always responsive during my visits. The home was cluttered but safe. Her mother is often missing for weeks at a time which often leaves her home in the care of her mothers’ boyfriend. She has not shared any information that would indicate abuse. She often came by the office to share information with me and other staff members. She would make sure I was aware of any change in her phone numbers or address.

Earlier this year she applied for TANF in the amount of $228.00 per month. Through the help of her case worker, her social security was re-instated but only briefly; this was with the understanding she enroll in a GED program. She did enter a GED program that allowed her to take her son with her and did address her parenting skills. She did as she promised but quit when her mother went missing again for 2 weeks.

SH is a perfect example to the amount of work that goes into trying to get the things she needs when a parent is not in the home to assist her with the things that many of us take for granted. She is a teen mom and one would think surely she has Peach Care or some other form of Medicaid but she doesn’t and there was a short period when her son had no coverage. She has had to overcome multiple obstacles in her life. She has with our help gotten off to a running start. She and her son are covered by Medicaid. She is again looking into a GED program at the local Technical Program and has been looking for a job. I am hopeful that I have been able to change her mindset while stressing responsibility to herself and to her child. To make any change takes time. I am no longer following her because she has graduated from the program but we continue to stay in touch. Her son continues to thrive.

Case Manager: LaSonya Griffin, RN, BSN
Written from the perspective of the client:

I am a 31 year old registered nurse who works in labor and delivery full time. I know the joys of child birth and the pain caused by miscarriage. I know this not only through my professional experience with patients, but I know both sides because of my own personal story. After having a miscarriage I was unsure if I would ever be ready to go through pregnancy again, but I found myself pregnant again.

I knew because I had a previous miscarriage I would need to be cautious with this pregnancy. I thought all was well but one day at only almost 25 weeks I found myself having contractions.
Because I worked labor and delivery I figured I would go to the hospital and would be given medication to stop the contractions. But much to my surprise my labor could not be stopped and I was transferred to MCG.

At MCG I delivered a premature male at 25 weeks gestation. His apgars at birth were 0 at 1 minute, 0 at 5 minutes, 0 at 10 minutes and 4 at 15 minutes. He was intubated after numerous attempts, placed on a ventilator and taken to the Neonatal Intensive Care Unit (NICU). He remained in the NICU from November 8, 2005 to March 12, 2006. I was happy my baby was finally coming home, but I was not prepared for the upcoming challenges I would be faced with at home.

Unlike most mothers, I would not be able to return to work in six to eight weeks because I did not have anyone to help me care for my child. My baby was discharged home with oxygen, apnea monitor, and a feeding tube. Although I was a nurse, I did not know of the many services provided to me with a special needs child. I thought I would have to go this alone only with the support of my family and friends.

When I received a phone call from one of the nurses at Healthy Start, I was willing to join the program because I needed the assistance and I was not turning down any help. When I met with my case manager she informed me of the many services that were available for my son. We began the process to receive private duty nursing. After my son was home for nearly two months, he was approved for private duty nursing and nurses and health care workers from Pediatric Services of America come out daily to help me care for him.

My biggest concern was finally dealt with; my child was receiving nursing services. Because I am a nurse I knew that my child would need therapies to help him along because he was premature. I voiced my concerns with my Healthy Start case manager and she made contact with a program called Early Interventions on our behalf. Within weeks someone was out to my home to begin the initial process and within six weeks my son was receiving physical therapy, occupational therapy, and speech therapy.

My son is now 10 months old and is doing very well. He no longer has the feeding tube. He has been taken off the oxygen and apnea monitor. He is growing and developing well. My son and I are very grateful to Healthy Start for all the help provided to us.
Case Manager: JoeAnn McGhee R.N.
Client: Angela
Age: 28
Family Size: 5
Ages of children: 6 month-old twins, 4 yo, 7 yo
Marital Status: Single at the time of delivery, currently married for 5 months
Family Income: $ 1500.00/month

<table>
<thead>
<tr>
<th>Dates</th>
<th>Risk Factors</th>
<th>Collaborative Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Prenatal Care Visit 12/11/2003</td>
<td>1. Multiple Gestation</td>
<td>1. WIC</td>
</tr>
<tr>
<td>Enrolled Healthy Start 5/24/2004 @ 27 weeks gestation</td>
<td>2. Obesity @ 370lbs</td>
<td>2. DFCS</td>
</tr>
</tbody>
</table>

Angela is a delightful and bright young 28 year old and now a mother of 4 children. Our initial contact with her was the result of her husband coming to our office because he had been told that we helped pregnant women. We explained our program to him and a date and appointment time was made to meet Angela.

The meeting with Angela went well and she was eager to be a part of the program. Consent forms were signed and depression screen administered. The time passed quickly and she and I soon learned that the services we provided were a perfect match for what could be a difficult pregnancy.

Angela was hospitalized twice for pre-term labor and placed on medication to address the problem. She was seen weekly for non stress tests (NSTs) starting at 32 weeks and weekly biophysical fetal profiles (BFPs) starting at 36 weeks. During this time, her weight climbed to 370 pounds. Phone calls and visits were made weekly.

Because she was home on bed rest, but needed to tailor her life to accommodate her children and preserve the health of the twins, we made education the major part of her case plan.

With each visit we review education material that included the Pregnancy Beginnings Guide, which is our core teaching materials. They proved to be very valuable. We also provided her with videos on childbirth and breast feeding topics. She did attend with the approval of her doctor our Childbirth Education Series as well as our Breast feeding class.

The pregnancy progressed and a delivery date was scheduled. She entered the hospital on 8/5/2004 and delivered via of C-Section two healthy babies (Total combined weight was approximately 14 pounds).

Angela was doing well and the breast feeding could not have been going better when on day 6, she developed an elevated temperature of 102. She presented at the local emergency room, was given medication, and sent home with instructions to call her doctor on Monday. She
called me at home to let me know what had happen. I saw her the following morning and she did have a low grade temp. I accompanied her to her doctor’s appointment and the incision was noted to be infected and needed to be opened and drained. This was done in the office and would be done at home by the Healthy Start team daily for 14 days. This was a task that was within the scope of care provided by us. Her doctor was pleased to hear this information. This would prevent him from having to plan additional home health services. The care went well, and her incision healed slowly but without additional problems.

Angela had chosen as a contraceptive method to have a tubal ligation and it was scheduled for 9/16/2004. I accompanied her to the hospital that morning and her husband stayed home with the twins. He would be coming to the hospital later in the afternoon to pick her up. The decision was made by her doctor that because of her weight and the condition of her stomach, he would do her surgery through the same incision he used for her C-Section. She was discharged later that afternoon but did have difficulty and complained of pain at the incision site within two days of her surgery. She was seen by her primary care doctor and eventually the incision again had to be re-opened. This led to the same routine we followed previously with daily dressing changes. Her husband was taught the procedure and did assist in Angela’s care. The incision healed well and Angela has no complaints.

This was a very stressful time for Angela and her family because her six-year-old was hospitalized twice during Angela’s pregnancy. The first time was the day of Angela’s C-section, the next time was the day after Angela’s tubal. Through all of the challenges she has faced she has always been cooperative and pleasant. She has continued to breast feed and attends many of the free classes we offer. She recently attended Infant CPR. The twins are thriving, breast feeding, and now weigh 21 pounds. Angela and the father of her children are now married and she is actively looking for employment as a licensed practical nurse.

<table>
<thead>
<tr>
<th>Case Manager:</th>
<th>Client</th>
<th>Age</th>
<th>Dates</th>
<th>Ages of children</th>
<th>Marital Status</th>
<th>Family Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>JoeAnn McGhee R.N.</td>
<td>D. M.</td>
<td>34</td>
<td>Enrolled by Healthy Start 5/28/2004 Delivery Date 4/14/2004 1st Prenatal Visit 12/1/2003</td>
<td>4 children ages 8 months – 17 years</td>
<td>Married, but separated</td>
<td>$330.00/month from TANF + $470.00 in food stamps. Child Support $0.00 Child Support case pending in New York</td>
</tr>
</tbody>
</table>
Support system includes parents who live next door to Dionne. Mother has several health issues that limit her support. Her father is employed and works 40 hrs per week. D.M.’s two siblings have been very helpful with her children during her illness.

<table>
<thead>
<tr>
<th>Collaborative Team:</th>
<th>Medical Diagnoses:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Healthy Start</td>
<td>1. Hodgkin’s Lymphoma</td>
</tr>
<tr>
<td>2. Department of Family and Children Services (DFCS)</td>
<td>2. Asthma</td>
</tr>
<tr>
<td>4. WIC</td>
<td></td>
</tr>
<tr>
<td>5. LIM (Low Income Medicaid)</td>
<td></td>
</tr>
</tbody>
</table>

D.M. was a working mother of 3 when she found out in March 2004 that, not only was she pregnant, but also battling a malignant disorder that would change the course of her pregnancy, as well as her life. It would also change her view of the structures that are in place to assist her and her family during her illness.

Because of her illness she was forced to stop work as well as begin chemotherapy, which eventually led to the premature delivery of her daughter at 32 weeks. The baby’s weight at the time of delivery was 3 pounds, 2 ounces. She stayed in the hospital three weeks and was finally discharged to home once she was able to feed well. Her daughter has thrived and is doing well. We have monitored the baby, and she is current on all immunizations and health checks. I have watched this beautiful little girl and realized that her mother’s recent hospitalization has been hard on her. She has always been happy and cheerful during my visits, but during her mother’s three weeks in the hospital, she appeared sad and tearful. She was seen by her pediatrician three times during her mother’s hospital stay. She has now returned to her happy and cheerful self. Her current weight at 11 months of age is 19 pounds. She shows no effects of her prematurity.

The health of her mother is hopeful. She has received several dosages of chemotherapy, with each hospitalization leaving her weak and tired. Even in her weakened condition, she was cheerful and always glad to have a visit as well as phone calls of support from the Burke Team members. Because of financial struggles, she applied for a job at the local Wal-Mart and worked as much as possible. She stated that working made a difference in her life and the way she felt about herself. This was very evident. When she was forced to take a leave of absence, our office assisted her with paperwork while she was in the hospital. The Wal-Mart staff appeared to care about her welfare and were very supportive. Our office assisted her with phone calls and paperwork for the following agencies: Child Support Recovery, Social Services, Wal-Mart, DFCS, and SSI (she has been rejected for benefits twice). During her illness, our office, along with the assistance of local churches, provided her children toys for Christmas. She was very appreciative.
The Burke Healthy Start Team has been very supportive of her and her family. During her most recent hospitalization, she underwent a stem cell transplant. Her mother recently told us she does not know what she would have done without our assistance.

Our role is very much about advocacy on behalf of clients and helping them navigate the system with its sometimes rigid and complex rules. In spite of my efforts, Dionne and her family have been put under needless stress by one of the local agencies. Even with her family’s help and my asking the department supervisor for another alternative to her making a personal appearance to re-certify for her food stamps, her food stamps were terminated and she was forced to go into the DFCS office once she was discharged from the hospital. Because her immune system is compromised by chemotherapy and the stem cell transplant, going into public places could possibly jeopardize her recovery.

We are all hopeful that the stem cell transplant has been successful and that with each passing day she will continue to get stronger. Her goal is to return to work so that she can again support her family and terminate her association with the social services here in this area. We will continue her case management until the baby is two years of age.

Case Manager: Erica Mims, RN, BSN

The Healthy Start client is a 25-year-old married mother of two children, a three-year-old daughter and an 18-month-old son. The children had been removed from her and her husband’s custody due to neglect by Department of Family and Children’s Services (DFCS) when I began case managing her 10 months ago. The mother has a history of depression which she is being treated for through Community Mental Health. She participates in the Family Violence Prevention Program and in the Safe and Stable Families program, both sponsored by McDuffie County Partners for Success. She needs help with goal setting as well as life skills which she receives by attending the Family Violence Prevention Program, as well as parenting skills and anticipatory guidance regarding developmental milestones for her children, which she receives by participating in Safe and Stable Families program.

Healthy Start through its case management services monitors and promotes improvement in parenting. As her case manager, I also identify health care resources that do not require insurance because she is not eligible for Medicaid due to her husband’s income. As part of Healthy Start case management, I referred her to a county health care provider that provides medical as well as dental services on a sliding scale fee basis.

I participate in case reviews at McDuffie County Partners for Success during which the status of this patient is discussed. Collaboration eliminates duplication of services and helps us maximize education and support to the family. The mother’s caseworker at DFCS also calls me on a regular basis to discuss the mother’s status. Her children were returned to her custody after four months, which I feel is due to her participation in Healthy Start as well as the other community agencies. Through active participation in these programs, she is able to receive care that addresses her as a whole person and allows her to view herself as a responsible individual who is capable of caring for herself as well as her children.
My name is Haniya and I am 23 months old. I was born at 26 weeks gestation to a 21 year old mom. She had a condition known as severe pre-eclampsia. Because of her high Blood Pressure I did not grow as well as I should have and was born at 14 ounces. I was placed on a high frequency ventilator in the NICU because I was unable to breathe by myself. I needed a medication called Surfactant so my lungs would not collapse. I was later unable to wean from the ventilator due to chronic lung disease and received a tracheostomy at 3 months of age. I was sent home with a trachea collar that delivers oxygen and my nurses and mom are able to suction me as needed. My trachea remains in place and I am hoping to have it closed this fall.

Some preemies like me bleed in their heads but I did not. Neurobehaviorally, I did well and continue to. Today I am a happy and exuberant little girl.

At birth I was fed with a tube in my stomach. Today I eat pizza, french fries and everything else I can get my hands into. This month I had a procedure called a fundaplication and a gastrostomy tube inserted. This will ensure that reflux will not damage my trachea any further.

My eyes suffer from a condition called retinopathy of prematurity. This was caused by the exposure to the oxygen I needed at birth and the prematurity of my eyes. Today I wear glasses.

I was finally discharged from the hospital at 4 months of age. Babies like me many times have infections, but my mommy took such good care of me I only went in the hospital one more time. I had nurses who came to my home in a small rural town from the Pediatric Services of America for 9 months. I also received supplies from them. I have a Speech Therapist who is teaching me sign language twice a week. My Occupational Therapist comes once a week and my Physical Therapist comes once a month. My nurse from the Healthy Start program coordinates my care and sees me once a month or as often as needed. I am a big girl and don’t need her as much now as I did when I first came home. My mom has now moved to a town that is a little larger than our original home so we could have decent housing. I continue to receive medical care from a big hospital 1 hour away from my home. I will see a nurse from Children’s Medical Services until I am 3 years old. My mom, grandmom, great grandmom, and I are looking forward to what the remainder of my journey will be.

Lessons Learned
Case Management/Outreach

Education for CM/OR staff: It is important to constantly provide the staff additional tools to address the challenges of working with poor, low literacy women who are facing complex challenges. Promoting Maternal Mental Health During and After Pregnancy two-day workshop, sponsored by NCAST, is an excellent example of education that provides intervention tools for case management.
Hiring case managers instead of contracting for case management services offers the advantages of more effectively setting performance expectations for staff, establishing Healthy Start identity in the community, and reducing any confusion among program participants about who is providing their care.

Electronic CM/OR documentation permits feedback of service delivery prompts that facilitate services and adherence to protocols, performance review communicated in a direct, ongoing manner to providers at multiple sites, and delivery of incoming referrals from a tertiary center.

Although funds for IC were limited, the requirement of CM for two years interconceptionally creates a caseload predominantly of IC clients; however, we enrolled more pregnant women each year.

It is often much harder to assess women after delivery due to the difficulty finding them, because they often go to a friend or relative’s home from the hospital and their stress with the demands and adjustments created by care of the newborn reduce their responsiveness to CMs contacts for appointment.

Education
Piggybacking education with another agencies’ sponsored sessions can increase attendance. For example, HS educator taught health education topics in GED classes at the community technical schools and TANF orientation.

Co-sponsoring education across multiple HS sites requires considerable communication and financial management by one site to minimize mistakes and misunderstanding, but results can be very beneficial. The four HS sites sponsored two Promoting Maternal Mental Health two-day workshops at two sites in Georgia in conjunction with the GA Family Health Branch of Department of Public Health.

LHSAP
The leadership of partner agencies has to be considered in determining the capacity of the agency to carry out the proposed project. In one case, we had to cancel a contract due to lack of capability after working with the staff intensively to complete prior contracted services.

B. Lessons Learned from Other Sites

We did not receive technical assistance or mentoring from another Healthy Start site.

V. Project Impact

A. Systems of Care

1. Approaches to enhance collaboration: Possibly the greatest success in collaborative interaction to improve systems of care has been the work completed by the Augusta Regional Maternal and Infant Program which is a regional entity of the Family Health branch of the GA Public Health and ECHS. Together we have developed a robust and versatile web-based information system to accomplish one of
our original 1999 and 2001 objectives of this Healthy Start program, that is, create and refine linkages between the tertiary regional perinatal center and local providers through improved exchange of information via innovative Web-based electronic perinatal record to identify pregnant women and fragile infants, and enhance service delivery in order to address changes in their health status in a timely manner. The information system permits us to use electronic information from the regional hospital and clinics, including

- All antepartum physician, midwife, and emergency room visits,
- All diagnoses and procedures associated with these visits,
- Postpartum visits,
- All maternal admissions and observation visits and all diagnoses and procedures associated with these admissions,
- Detailed labor and delivery information from the Delivery Log,
- Newborn infant information, to include all diagnoses and procedures for the birth admission,
- All other infant/toddler admissions and observation visits and all diagnoses and procedures associated with these admissions (currently not activated),
- Insurance information, along with Medicaid numbers,
- WIC visits.

The information permits the data base manager to electronically refer clients by creating a query and sending reports to the county specific CM staff identifying information on pregnant women admitted and fragile infants who are admitted or born at the regional center. The CM staff then attempts to contact the families for enrollment in the program or the information serves as an alert to the CM of a change in status of a PP and the birth of the PP’s infant. In addition, those enrolled antepartum clients’ visits can be tracked via the system. Via the system, the M&I staff refers clients to us identified in the clinic with medical risks before the diagnoses are entered in the corporate electronic record. The M&I staff also uses the system to track maternal transports, nutritional consults, and visits in the high risk obstetric clinic.

2. Extent of Structured Changes for System Integration

As described above and in addition ways, the perinatal information system is used by the regional system M&I registered dietician, maternal transport coordinator, director and our case management staff for documentation of case management services. Because M&I and ECHS staff are employees of the MCG Health Systems and the perinatal information system’s security, there is no breach of HIPAA regulations. Because of the perinatal information security levels, the system offers additional systems integration opportunities for many other potential agency users, such as public health, mental health, social services, and obstetric providers.

3. Key Relationships Among Health Service Agencies and Consumers and/or Community Leaders

Agencies Because of the rural character of the ECHS counties, the major health services agencies in the ECHS counties are limited to Department of Family and
Children Services (DFCS), public health, Family Connection, and Mental Health and the local hospitals in Burke and McDuffie Counties. Relationship already existed among these agencies, but Healthy Start education and case management services have been an additional resource among these service agencies. Because we have networked with other agencies and made our project very visible, they are active referral sources. DFCS found our services especially valuable with families under child protective services supervision. In our opinion, this is significant evidence of the agency’s trust and confidence in the quality of our CM staff and services. Refer to certain case summaries. DFCS staff often included many of the free ECHS classes as part of the client’s case plan. In addition to these relationships, ECHS has had a good relationship with the school system as evidenced by the regularly held support groups in Burke and McDuffie counties for pregnant and parenting students. The middle and high schools are also a source of referrals. ECHS is also visible at school health fairs.

Consumers The McDuffie County Family Connection program joined us in developing the focus group for parenting and pregnant student consumers. Their office across the street from the school is the site of support groups. We rotate leadership of the group which meets every other week during the school year. With this agency we also attempted to develop a consumer council at the housing authority, but this effort was not successful. Burke County High School also promoted and facilitated a support group for pregnant and parenting students, permitting us to conduct the group during and at the school.

Relationships with the technical schools in McDuffie, Burke, and Hancock Counties allowed us to reach potential consumers of education and case management who may not have known about our services. We provided health education on such topics as reproductive health and parenting. Via the strategy of teaching health education as an adjunct to GED classes in the technical schools we reached many male and female consumers of reproductive years.

4. Impact on Comprehensiveness of Services
   a. Eligibility and/or intake requirements
   ECHS program eligibility focused on the pregnant or interconceptional woman with risk factors for poor pregnancy outcomes or women with fragile infants because we provided the most comprehensive case management with the only community-based staff dedicated exclusively to prenatal and interconceptional case management. Because the health departments provided office-based case management through 2 months postpartum and did not assign an exclusive team to case management, we referred women not qualifying for our services to the health department. Our model of case management using home visiting has not caused the health departments to change their model, probably due to their limited budgets and staffing.

At consortium meetings whenever there were changes in Medicaid eligibility or other policy changes related to Medicaid, these were announced and written
information provided. We also had Medicaid outstationed workers present changes at consortium meetings and project wide services meetings.

b. Barriers to access and services utilization
Transportation is a major barrier in this community. There is no public transportation service in the area. Medicaid non-emergency transportation and county-sponsored transportation do not meet all the needs, especially of those needing frequent visits. To address this problem, we established transportation contracts with churches. This has been very successful at the churches with dedicated coordinators.

Another barrier is limited access to mental health services and the resistance of consumers to using these services. Given the high number of positive depression screens, to address this barrier we successfully contracted with Augusta Rape Crisis and Assault Services who provided two credentialed counselors supervised by a psychologist. The counselors provided services in the county of residence of the PP at a site agreed upon by the client.

c. Care coordination
To assure continuity of care, all team members routinely had access to the electronic and hard copy record. In addition, weekly reports facilitated continuity by providing information on the following: NICU babies at the MCG Medical Center, active clients, active infants, comparison of first prenatal care date with date of first antepartum visit, ASQs due, list of last infant visits by type, list of scheduled infant visits by type, data “holes”, depression screens due, referrals in to Healthy Start and referrals out and status, non-risk-assessed referrals, last client visits by type, postpartum visits required, undocumented visits (no case management note), and scheduled client visits by type. In addition, the most current weekly report was used during monthly case conferences. An additional case conference among the RNs and the clinical services coordinator focused on the plan of care, progress measured via Life Skill Progression instruments, and challenges with PPs. The quality assurance assistant worked with staff weekly to assure that service utilization and incoming and outgoing referral completion was monitored and documented.

The following description of the CM teams approach to continuity was written by a case manager. Continuity of care was very important in the project and every effort was made to remember that when working with clients. We tried to always work as a team with each team member being introduced at some point to the client. We also kept other team members informed on the activities or problems of our clients so that there will be no lapse in their care should one member not be available. This was done during our bi-weekly office meeting. Contact of incoming referrals was as followed: 1) Phone attempt, 2) Mail, and 3) Home visit. If the mail is returned, we will utilize our community resources in attempting to locate the referral. If this was unsuccessful, a home visit and information pack was taken to the client, informing them of our services and presence in the community.
d. Efficiency of agency records systems and sharing of data across providers
As described earlier, the web-based system permits documentation at multiple sites by multiple simultaneous users, performance review, quality assurance feedback information to CM staff, supervisory oversight, ad hoc queries or information retrieval, quantifying of services for federal and other reports, review of client scores on instruments, etc. The hosting agency maintains backup of files. Electronic sharing of data between the tertiary center and ECHS has been described above. Electronic sharing with other appropriate agencies is possible but has not been accomplished. Because we follow clients for two years after delivery, local agencies we contact for information keep the consent forms as part of their records. This eliminated the need to send consent forms with every request, which can be very time consuming. In addition, we notify prenatal and primary care providers of enrollment of PPs and of positive depression screens.

5. Impact of Client Participation in Evaluation of Services Provision
Provider responsibility in maintaining client participation in the system and provider sensitivity to cultural, linguistic, and gender needs.
ECHS had no contracted provider services, other than mental health counseling, but we monitored PPs service utilization with other agencies. In addition, phone surveys by PPs were conducted to determine satisfaction with ECHS services. Clients were very satisfied with CM and educational services.

Consumer participation in developing assessment and intervention mechanisms and tools. Consumers were not used to develop assessment and intervention strategies, except to suggest education topics for round table discussions at CP sessions. These topics were included in subsequent sessions.

B. Impact to the Community
1. Residents’ Knowledge of Service Availability, Location and How to Access
Through efforts to increase visibility, such as participation in community events, we have successfully alerted consumers of our presence. For example, our Relay for Life banner won second place. In one county, an annual Christmas party with Santa and Easter Egg Hunt create newspaper articles about the program. Both the Christmas and Easter events were well attended. The clients now know that we are in the community and many feel free to stop by the offices to share information as well as their concerns. Having offices separate from the health departments have greatly improved our identity in the community.

2. Consumer Participation in Establishing or Changing Standards and/or Policies of Providers and Governments
Consumer participation did not influence care policies or standards. Consumer satisfaction with ECHS services, based on phone survey was high. Consumer participation did not influence policies of providers and government entities.
ECHS interaction with the community did not involve inter-agency conflict or team building activities across community groups. The resources are limited and agencies are few in these rural counties.

4. Creation of Jobs Within the Community
ECHS provided work experience for TANF recipients assigned to our offices. This program allowed recipients to work in an environment to acquire skills that will make them more marketable. This collaboration with DFCS led to permanent employment with ECHS for the past two years for one TANF recipient. In addition, ECHS contracts with churches provided employment by the churches of coordinators and drivers.

C. Impact on the State
ECHS impact on the state relates to the cooperative projects with the Family Health Branch of the Department of Public Health. See for example the summary brochure and CD-ROM informing the public of maternal and infant information across a ten-year period.

D. Local Government Role
Discussion of local governmental agency interaction has been described in prior sections of this report. Various local entities were very cooperative and we worked together well in sharing resources and facilitating the goals of each on behalf of clients.

A barrier at the local level that impacted project development, negatively effecting case management services was the advent of HIPAA. Many local health departments continue to function under the “release of information” concept instead of understanding that with a business associate agreement information can be shared between the entities for continuity of care. We continue to have difficulty obtaining information related to referrals to the health department. An element of the problem is HIPAA interpretation and possibly resistance due to fear that we will “take clients”. This is obviously unfounded because we are referring and facilitating clients obtaining services from other agencies by referring them and in some cases providing needed transportation.

VI. Local Evaluation – See Attachment F

VII. Fetal and Infant Mortality Review (FIMR)
There is no FIMR in the targeted area.

VIII. Products
Enclosed are copies of our brochure developed for the community, both agencies and consumers. In addition, enclosed is the CD, developed in conjunction with the state public health agency, March of Dimes, Healthy Mothers Healthy Babies, and the other three Healthy Start projects in the state. One might also consider the web-based information system a product.
IX. Project Data – See attached Data Forms

Attachment A  Level III of Case Management
Attachment B  Communication and Supervision/Monitoring Among Project Staff, Contractor, and Consortium
Attachment C  Healthy Start Organizational Chart
Attachment D  MCGHI Organizational Chart
Attachment E  Final Report/Implementation Plan
Attachment F  Local Evaluation Reports
Attachment G  Case Management Flow Chart
Attachment H  Ante-partum/Postpartum Risk Assessment Screening Tool

Enclosures: CD and brochure
Attachment A – Level III of Case Management
### Level III of Case Management

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<th>Criteria</th>
<th>Seen Weekly and/or prn based on nursing judgment</th>
<th>NANDA Dx</th>
</tr>
</thead>
</table>
| No support system | 1. Unable to name two supportive persons  
2. No or unreliable relationship with family unit | 1. Family Coping, ineffective: disabling  
2. Family Process, altered |
| Very unstable living situation | 1. Inadequate income to meet basic needs  
2. Homeless, soon to be evicted | 1. Family Coping, ineffective: disabling  
2. Family Process, altered  
3. Coping, individual, ineffective |
| Engages in behaviors that put self or infant’s health at risk | 1. Alcohol and/or street drug use  
2. Noncompliant with care  
3. Poor parenting skills  
4. Unrealistic expectations of children  
5. Noncompliant with children’s health care | 1. Coping, individual, ineffective  
2. Care giver Role Strain, risk for  
3. Parent/Infant/Child Attachment, altered, risk  
4. Parenting, altered, risk for  
5. Family Process, altered: alcoholism  
6. Growth & Development, altered  
7. Noncompliance, [Compliance, altered,] specify |
| Teen | 1. Maternal age ≤ 17 and <12 years education and / or  
2. >2 pregnancies during teens or  
3. <15 at conception | 1. Growth & Development, altered  
2. Coping, individual, ineffective  
3. Care giver Role Strain, risk for  
4. Parent/Infant/Child Attachment, altered, risk  
5. Parenting, altered, risk for |
| Known domestic violence situation | 1. Documented domestic violence or abuse  
2. Hx of abuse or neglect of other children | 1. Violence, risk for, directed at self / others  
2. Trauma, risk for |
| No prenatal care | No prenatal care | 1. Coping, individual, ineffective  
2. Coping, defensive  
3. Decisional Conflict (specify)  
4. Denial, ineffective |
| Mental Health Issues | 1. Under medical care for mental illness during pregnancy  
2. Disability under mental illness Dx  
3. Positive Edinburgh Depression screen with medical diagnosis of depression | 1. Coping, individual, ineffective  
2. Coping, defensive  
3. Decisional Conflict (specify)  
4. Denial, ineffective  
5. Parental Role conflict  
6. Parenting, altered  
7. Violence, risk for, directed at self / others  
8. Trauma, risk for |
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<td>3. HIV</td>
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<td>4. Hx pre-term delivery</td>
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<td>5. Multiple Gestation</td>
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<tr>
<td></td>
<td>6. Hx poor OB outcomes</td>
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<td></td>
<td>7. LBW infant &lt; 2000 Grms</td>
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<td>8. IUGR and/or SGA</td>
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<td>10. Infant with &gt; 4 NICU days stay</td>
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<td></td>
<td>11. genetic condition</td>
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<td>12. serious problems / abnormalities of body systems</td>
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Attachment B – Communication and Supervision/Monitoring Among Project Staff, Contractor, and Consortium
Communication and Supervision/Monitoring Among Project Staff, Contractors, and Consortium

- Community Outreach Services Coordinator (Agency relationships and consortium) (Project Director (S))
- LHSAP Contracts
- RFP developed by program staff
- Proposals reviewed by committee and selection made
- Contracts developed by Program Coordinator, Accountant, and Project Director
- Contracts reviewed by Legal Office, signed by Project Director, signed by Authorizing Official, signed by Service Agency
- Service agency under contract
- Quarterly Report (M) Outreach and Clinical Services Coordinators
- Invoice and backup documents (M) Accountant
- Check request to Corporate by Accountant
- Case Management & Program Participant Outreach Services (Project Director (S))
- Case Managers (Clin Svcs Coord (S))
- Advocates (QA Assistant (S))
- Weekly Queries & Daily Electronic Referrals - Clinical Data Mgr
- Weekly Reviews of Caseload - CMs and Advocates
- Weekly QA Reviews (QA Assistant (S))
- Case Conferences (Adtg. Proj Dir (C), Clin Svcs Coord, QA Assistant, CMs, Advocates)
- CM-Related Expenditures (Clin Svcs Coord & Accountant (M))

- Education Services (Project Director (S))
- Community Education Calendar and Instructor Assignments (Clin Svcs Coord (S&M))
- Conference Planning (Clin Svcs Coord (S&M), OR Coord & Proj Dir (C))
- Educational Partnerships (Clin Svcs Coord (S), Proj Dir (C))
- Educational Expenditures (Accountant (M), Clin Svcs Coord & Proj Dir (C))

LEGEND
C - Consulting
M - Monitoring
S - Supervision
Attachment C – Healthy Start Organizational Chart
Enterprise Community Healthy Start Project
Eliminating Disparities in Perinatal Health and Interconceptional Care for High Risk Women and Their Infants

Org Chart Key:
- Budgeted Personnel
- Contracted Services
- Interconceptional
- Dual Role

SUBCONTRACTORS:
Medical College of Georgia
Drayton, Drayton, and Lamar
Hancock County Health Department

Augusta Perinatal Center

Perinatal Center Director 0.9 FTE

Clinical Data Manager 1.0 FTE

Accountant II 0.8 FTE

Admin Coordinator 0.75 FTE

Community Outreach
- Outreach Coordinator 1.0 FTE

Case Management
- Outcomes Manager 1.0 FTE
- Quality Assurance Assistant 1.0 FTE

Education
- Education Coordinator 0.8 FTE
- Community Liaison 0.5 FTE
- Community Educator 0.75 FTE

Burke County
- RN Case Manager 1.0 FTE
- Patient Advocate 1.0 FTE

Hancock County
- RN Case Manager 0.6 FTE
- Patient Advocate 1.0 FTE

Jefferson County
- RN Case Manager 1.0 FTE
- Quality Assurance Assistant 1.0 FTE

McDuffie County
- RN Case Manager 1.0 FTE
- Patient Advocate 1.0 FTE

Warren/Taliaferro County
- RN Case Manager 1.0 FTE
- Patient Advocate 1.0 FTE

Birth Hospitals
Attachment D – MCGHI Organizational Chart
MCG Health, Inc.

Chairman, Board of Directors, MCGHI, Donald M. Leeburn, Jr.

President/CEO, MCGHI, Don Snell

Senior VP/Chief Financial Officer, Tom Kelly

Director, Corporate Finance, John Parham

Senior VP, Ambulatory & Network Services, Richard Bias

Other Senior VPs and Directors

Fiscal

Administrative

ECHS Accountant and Chief Fiscal Officer, Mark Wilkinson

ECHS Project Director, Sandra Pittman
Attachment E – Final Report/Implementation Plan
## Final Report/Implementation Plan

**Grantee:** Enterprise Community Healthy Start (Disparities and Interconception)

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy</th>
<th>Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 5/31/05, increase and maintain the percentage of consumers in the work of the consortium on program and policy direction for the Health Start Initiative at 33%</td>
<td><strong>Strategy:</strong></td>
<td>Actively involve patient advocates and community leaders in sponsoring consumers</td>
<td>2001 – consumers 2002 – 2003 – Objective 16, Score 9 2004 – Objective 16, Score 10 2005 – Objective 16, Score 14 2006 – Objective 16, Score 0 (Warren only, ending project)</td>
</tr>
<tr>
<td>(Baseline: Score = 0 (there were no consumers in the consortium in 2000))</td>
<td><strong>Activities:</strong></td>
<td>1. Increase consumer and family membership on committees and planning groups for special events 2. Maintain and support consortium committee meetings and activities 3. Meet with consumer members in focus groups as a means of increasing the degree of consumer participation in the work of the consortium on program and policy direction for the Health Start Initiative. 4. Outreach Coordinator will participate in each counties Family Connection meeting (local partner consortia) 5. Continue implementation of Woman 2 Woman discussions in ECHS counties. 6. Include consumers on mail-outs and updates 7. Arrange to share a ride for consumers with HS staff and / or refund consumers for travel 8. Refund consumers for childcare.</td>
<td>Accomplished Activities 3, 4, 5, 6, 7, 8.</td>
</tr>
<tr>
<td>By 5/31/05 increase the cultural competence elements in policies, guidelines, contracts, and training within MCHB supported programs.</td>
<td><strong>Strategy:</strong></td>
<td>Expand health professionals’ awareness of cultural issues and health beliefs. 2. Assist in identifying and addressing systematic and /or institutional barriers to culturally competent care. 3. Support providers in identifying personal prejudice re cultural differences, age, gender, and special needs. 4. Support respectful, ethically sound care that is sensitive to cultural diversity, age, gender, and special needs. 5. Collaborate in designing, negotiating, monitoring, and managing improved access and quality of care.</td>
<td>2003 – Objective 60, Score 53 2004 – Objective 60, Score 50 2005 – Objective 60, Score 54 2006 – Objective 60, Score 39 (Warren only, ending project)</td>
</tr>
<tr>
<td>(Baseline: Score = 16 in 2000)</td>
<td><strong>Activities:</strong></td>
<td>1. Insure consumer and community input re culturally sensitive care issues in program policy development and evaluation methods. 2. Recruit minorities into clinical and leadership positions. 3. Provide education for HS staff re cultural issues and health beliefs, cross cultural communication, and system change as a means to increase awareness of barriers to culturally sensitive, age and gender appropriate care and personal values affecting intuitional and clinical practice.</td>
<td>Accomplished Strategies 1, 2, 3, 4. Accomplished Activities 2, 3.</td>
</tr>
<tr>
<td>There were no FIMRs in the project period</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Calendar Year 4

**Objective:** By 12/31/2004, 90% of enrolled families will be able to provide the name of the pediatrician for their enrolled children ages 0-2.

<table>
<thead>
<tr>
<th>Baseline:</th>
<th>0.00% (there were 0 infants enrolled in long-term case management in 2000)</th>
</tr>
</thead>
</table>

**Strategy:**

1. Increase community awareness of the importance of having a medical home and recommended health screens through:
   - community based infant care / safety classes
   - mass media campaigns
   - civic organization meetings
   - faith community meetings
2. Increase awareness re. Medicaid/PeachCare availability for children through age 18.
   - community based classes
   - mass media campaigns
   - civic organization meetings
   - faith community meetings
3. Provide financial screening and follow-up.
4. Maintain tracking records for all enrolled:
   - track health screening and immunization dates
   - track and refer for lapses in insurance coverage
5. Provide home visit and interconception case management visits for enrolled mother infant dyads as needed and follow for 2 years post delivery.
   - involve family in child’s health and stress need for continued health screening and immunizations
   - encourage strong team linkages Collaborate with Early Intervention. Children 1st (Title V agency staff)
6. Referrals as needed.

**Accomplished Strategy** 1 and 2.

**Accomplished Activities 1, 2, 3, 4, 5.**

---

### Calendar Year 4

**Objective:** By 12/31/2004, 30% (90) of 300 high risk postpartum women will have received recommended women’s health visits at the end of 2 years.

<table>
<thead>
<tr>
<th>Baseline:</th>
<th>There were 0 high-risk postpartum women enrolled in long-term interconceptional case management in 2000.</th>
</tr>
</thead>
</table>

**Strategy:**

1. Increase community awareness of the importance of preconception and interconception care for all women.
2. Provide interconception case management services 2 years post delivery for enrolled prenatal clients.

**Activities:**

1. Increase community awareness of the importance of preconception and interconception counseling for all women through:
   - community based classes
   - mass media campaigns
   - civic organization meetings
   - faith community meetings
2. Interconception appointment tracking and follow up:
   - postpartum appointments, 6, 15,18 and 24 month contraception method and life style review
3. Contact by HS case managers and advocate staff as needed but not less than every month for high risk women (IC_L3) and every three months for high risk step-down (IC_L2).
   - promote health seeking behaviors
   - facilitate positive family support
4. Provide support re. economic self-sufficiency
   - encourage continued career attainment/ remain in school
   - problem solve re child care issues
5. Referrals as needed

---

**Percent of women participants who have an ongoing source of primary care.**

As evidenced by a non-HD Gyn or family planning visit within 12 months of delivery:

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>8.5%</td>
</tr>
<tr>
<td>2002</td>
<td>29.3%</td>
</tr>
<tr>
<td>2003</td>
<td>30.7%</td>
</tr>
<tr>
<td>2004</td>
<td>55.6%</td>
</tr>
<tr>
<td>2005</td>
<td>52.3%</td>
</tr>
<tr>
<td>2006 (Warren)</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

**Accomplished Strategy** 1 and 2.

**Accomplished Activities 1, 2, 3, 4, 5.**
### By 5/31/05, increase the percentage of completed referrals among HS screened and CM women to at least 90%.

**Baseline:** 0.00% (no referrals had been made in 2000).

<table>
<thead>
<tr>
<th>Strategy:</th>
<th>Activities:</th>
<th>2001 – 69.6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive tracking of referrals. Consistent emphasis on tracking by case management coordinator.</td>
<td>• Referral tracking is integrated into the perinatal Database. Missed appointments and posted appointment dates will be queried for follow up by advocate and case management staff.</td>
<td>2002 – 78.8%</td>
</tr>
<tr>
<td></td>
<td>• Educate the client and family re. importance of keeping referral appointments.</td>
<td>2003 – 80.2%</td>
</tr>
<tr>
<td></td>
<td>• Assist with transportation needs.</td>
<td>2004 – 72.4%</td>
</tr>
<tr>
<td></td>
<td>• Encourage family involvement in perinatal care.</td>
<td>2005 – 61.5%</td>
</tr>
<tr>
<td></td>
<td>• Encourage strong team linkages between case management, advocates, physicians, clinics and birth hospitals (June 2001 - May 2005)</td>
<td>2006 (Warren) – 41.9%</td>
</tr>
</tbody>
</table>

Accomplished Strategy 1 and Activities of tracking, education, transportation services, family involvement and linkages.

### By 5/31/05, increase the degree by which Medicaid insured women who are risk appraised medically, psychosocially, and for depression at initial perinatal visit to 100%.

**CHANGE TO:**

By 5/31/05, increase the degree by which EC women who are risk appraised medically, psychosocially, and for depression at initial perinatal visit to 100% of HS and Health Department (HD) after referrals are received.

**Calendar Year 4 Objective:** By 12/31/2003, the score for degree of risk appraisal facilitation will remain at 65.

<table>
<thead>
<tr>
<th>Strategy:</th>
<th>Activities:</th>
<th>2003 – Objective 65, Score 67</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide education and database tool that facilitates assessment and client care tracking with the goal of system change toward more formalized assessment, increased sharing of information among providers, and more comprehensive assessment, including medical, psychosocial, and environmental assessments.</td>
<td>2004 – Objective 65, Score 64</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Systematically meet with local Health Department leaders re. risk appropriate care and referral process to Healthy Stat.</td>
<td>2005 – Objective 65, Score 64</td>
</tr>
<tr>
<td></td>
<td>2. Healthy Start will provide</td>
<td>2006 – Objective 65, Score 64</td>
</tr>
<tr>
<td></td>
<td>• high risk perinatal case management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• high risk interconception case management high risk mother and infant dyads for two years post delivery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• antepartum, postpartum and interconception home visits will be provided.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Healthy Start Staff will provide risk assessment on all women being case managed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Georgia Perinatal Risk Assessment Tool integrated into perinatal database.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Database contains medical, nutritional, psychosocial (to include financial, domestic violence, substance use, and environmental data), depression screening and educational assessment modules.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Strengthen information sharing and referral process – use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Demonstrate use of screening tools and strengthen linkages by referring for significant findings to OB and PC Providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Systematically meet with local physicians re. risk appropriate care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Encourage local physician to use Georgia Perinatal High Risk Guideline</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Encourage local physicians to refer all clients and adopt office protocol that insures High Risk forms reach HS staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Encourage information sharing re. changes in medical and psychosocial status</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Facilitate communication by installing an electronic card file with project wide contact information.</td>
<td></td>
</tr>
</tbody>
</table>

Accomplished Strategy and activities of 1, 2, 3, 4, 5 partially.
By 5/31/05, increase the percentage of Medicaid insured ECHS enrolled pregnant women entering prenatal care in the first trimester to at least 90%.

**Baseline:** Of 509 Medicaid insured ECHS women who entered prenatal care in 2000, 356 (69.9%) entered prenatal care in the first trimester.

**Strategy:**
Aggressive case finding of pregnant women in first trimester.

**Activities:**
- Increase community awareness re. perinatal issues and need for early perinatal care through, civic organization meetings, and faith community meetings. (June 2001 - May 2005)
- Partner with Family Connection re. case finding among FC participants. (June 2001 - May 2005)
- ECHS Staff will work with local agencies re. consumer teaching needs and opportunities, case finding and referral for HS services through systematic contact to health care provider sites, health centers, birth hospitals, school nurses, Dept. of Children and Family Services (June 2001 - May 2005)

**Very low birth weight**
Baseline: 3.5 (2000)

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>3.8%</td>
</tr>
<tr>
<td>2002</td>
<td>5.4%</td>
</tr>
<tr>
<td>2003</td>
<td>0.0%</td>
</tr>
<tr>
<td>2004</td>
<td>1.4%</td>
</tr>
<tr>
<td>2005</td>
<td>0.0%</td>
</tr>
<tr>
<td>2006</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total grant period</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

**Low birth weight**
Baseline: 11.3 (2000)

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>9.2%</td>
</tr>
<tr>
<td>2002</td>
<td>23.4%</td>
</tr>
<tr>
<td>2003</td>
<td>11.8%</td>
</tr>
<tr>
<td>2004</td>
<td>11.6%</td>
</tr>
<tr>
<td>2005</td>
<td>1.9%</td>
</tr>
<tr>
<td>2006</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total grant period</td>
<td>12.9%</td>
</tr>
</tbody>
</table>

**Infant mortality rate**

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>0.0</td>
</tr>
<tr>
<td>2002</td>
<td>8.3</td>
</tr>
<tr>
<td>2003</td>
<td>0.0</td>
</tr>
<tr>
<td>2004</td>
<td>12.3</td>
</tr>
<tr>
<td>2005</td>
<td>0.0</td>
</tr>
<tr>
<td>2006</td>
<td>0.0</td>
</tr>
<tr>
<td>Total grant period</td>
<td>4.3</td>
</tr>
</tbody>
</table>

**Post-neonatal infant mortality rate**
Baseline: 1.6 (2000)

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>0.0</td>
</tr>
<tr>
<td>2002</td>
<td>0.0</td>
</tr>
<tr>
<td>2003</td>
<td>0.0</td>
</tr>
<tr>
<td>2004</td>
<td>0.0</td>
</tr>
<tr>
<td>2005</td>
<td>0.0</td>
</tr>
<tr>
<td>2006</td>
<td>0.0</td>
</tr>
<tr>
<td>Total grant period</td>
<td>0.0</td>
</tr>
</tbody>
</table>

**Active clients (not just Medicaid insured):**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>61.2%</td>
</tr>
<tr>
<td>2002</td>
<td>61.2%</td>
</tr>
<tr>
<td>2003</td>
<td>69.2%</td>
</tr>
<tr>
<td>2004</td>
<td>66.7%</td>
</tr>
<tr>
<td>2005</td>
<td>79.3%</td>
</tr>
<tr>
<td>2006</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total grant period</td>
<td>65.8%</td>
</tr>
</tbody>
</table>

**Accomplished strategies.**

Small denominators create erratic rates.
Attachment F – Local Evaluation Reports
HEALTHY START LOCAL EVALUATION REPORT

PROJECT NAME: Enterprise Community Healthy Start (ECHS)

TITLE OF REPORT: Comparison of Enterprise Community Healthy Start Clients versus Non- Clients in Select Cohorts Selected from Georgia Vital Statistics Record of Births, 1997-2002

AUTHORS: Lauren B. Zapata, Ph.D., MSPH

Section I. INTRODUCTION

Local Evaluation Component

A. The impetus of the local evaluation was to determine the impact of the ECHS program on select birth outcomes. The design for the local evaluation was the result of collaboration between the ECHS project director, Dr. Sandra Pittman, the ECHS data manager, Dr. Don Sutherland, and the contracted evaluator, Lauren B. Zapata.

B. This was the first evaluation study completed on the ECHS project. Prior to this study, required MCHB performance and outcome measures were completed annually. This study revealed that vital statistics data as a comparison had limited medical risks. Another data set with risk factors is available from hospital data compiled for submission to the National Perinatal Information Center. An additional component of the evaluation could be an analysis of an outcome of interconceptional care, for example, subsequent pregnancies in 6, 12, 18 and 24 months, using CDC’s GA longitudinal linked maternal data set. Another possible additional evaluation is an analysis of outcomes for women with and without positive depression screens.

C. The study is a retrospective cohort outcome evaluation study comparing ECHS clients with non-clients from three separate comparison groups derived from Georgia vital statistics record of births, 1997-2001.

Key Questions/Hypotheses

1. Does the ECHS program positively impact select maternal behaviors during pregnancy?
   a. Hypothesis: The ECHS program positively impacts select maternal behaviors during pregnancy.

2. Does the ECHS program positively impact select birth outcomes?
   a. Hypothesis: The ECHS program positively impacts select birth
outcomes.

3. What characteristics of women describe the segment of the population the EHS program has the most potential to benefit?
   a. Hypothesis: The ECHS program will most benefit young, unmarried and lower educated women.

4. Does length of prenatal program exposure improve birth outcomes?
   a. Hypothesis: ECHS program clients exposed to the program for longer periods of time will have better birth outcomes than ECHS program clients exposed for shorter periods of time and non-program clients.

Section II. PROCESS

A. Secondary analysis of Georgia birth certificate data for 1997-2002 were conducted to assess differences between Enterprise Community Healthy Start (ECHS) clients with the following subgroups of women: (a) non-ECHS clients residing in the same project area counties; (b) non-ECHS clients residing in non-ECHS counties in Georgia; and (c) non-ECHS clients residing outside of the project area but in similar counties in Georgia matched on population characteristics using census data. ECHS clients were compared with the abovementioned subgroups of women related to month mother began prenatal care, maternal tobacco use during pregnancy, weeks gestation of the infant, infant birth weight, and infant Apgar scores at one and five minutes. Multivariate regression models were developed for each outcome variable to control for potential confounders including maternal age, maternal race, maternal education, maternal marital status, parity, plurality, maternal history of previous fetal death, timing of initiation into prenatal care, maternal use of tobacco during pregnancy, and weeks gestation (select models).

B. Data sources included (1) programmatic data maintained by ECHS project staff; and (2) Georgia vital statistics record of births, 1997-2001.

C. No instrumentation was employed. All variables included in multivariate modeling were available in secondary data sources.

Section III. FINDINGS/DISCUSSION

1. No positive associations between ECHS client status and maternal behaviors during pregnancy were statistically detected.

2. No positive associations between ECHS client status and select birth outcomes were statistically detected.
3. The ECHS program was found to most benefit women with less than a high school education, women pregnant with multiple infants (twins), and non-primaparous women.
   - Comparing ECHS clients with non-clients residing in the project area, the ECHS program had a more beneficial impact on *infant gestational age* among women with less than a high school education \( (b=0.92431, t=1.98, p<.05) \).
   - Comparing ECHS clients with non-clients residing in the project area, the ECHS program had a more beneficial impact on *infant apgar score at five minutes* among women pregnant with multiple infants \( (b=1.32052, t=3.89, p<.0001) \).
   - Comparing ECHS clients with non-clients residing outside of the project area in similar counties in Georgia, the ECHS program had a more beneficial impact on *infant gestational age* among women with less than a high school education \( (b=1.07507, t=2.13, p<.05) \).
   - Comparing ECHS clients with non-clients residing outside of the project area in similar counties in Georgia, the ECHS program had a more beneficial impact on *LBW* among non-primaparous women \( (OR=0.315, CI=0.105, 0.943, p<.05) \).

4. Length of prenatal exposure to the ECHS program significantly impacted (1) weeks gestation; and (2) infant classification as preterm (<37 weeks gestation).
   - More specifically, the longer the client was exposed to the EHS program during the prenatal period, the greater the weeks gestation of the infant. This was true for comparison cohort 1, ECHS clients versus non-clients residing in the project area, \( (b=0.00847, t=2.04, p<.05) \); and for comparison cohort 3, ECHS clients versus non-clients residing outside of the project area in similar counties in Georgia \( (b=0.00861, t=2.02, p<.05) \).
   - Furthermore, the longer the client was exposed to the EHS program, the less likely the infant was classified as preterm. This was true for comparison cohort 1, ECHS clients versus non-clients residing in the project area \( (OR=0.992, CI=0.985, 0.999), p<.05 \); and for comparison cohort 3, ECHS clients versus non-clients residing outside of the project area in similar counties in Georgia \( (OR=0.993, CI=0.986, 0.999), p<.05 \).

Methodological limitations of the evaluation included limited availability of variables via secondary data sources to include in multivariate regression models. For example, high risk characteristics of ECHS clients include diabetes, high blood pressure, and pre-pregnancy weight; none of which were available in Georgia vital statistics, 1997-2001.

Section IV.  RECOMMENDATIONS

A. Because the ECHS program was found to have a more beneficial impact for women with less than a high school education, women pregnant with multiple infants (twins), and non-primaparous women, it is recommended that these subgroups of women be further targeted for future program implementation.

B. Because length of prenatal exposure was found to positively impact weeks gestation of the infant and decrease the likelihood of infant classification as preterm, it is
recommended to increase outreach efforts of the program to engage pregnant women into the program as early as possible in the prenatal period.

C. Further evaluation of the ECHS program is recommended to consider a broader range of high risk characteristics including medical complications such as diabetes and hypertension, to more adequately assess the direct impact of program exposure.

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

A. ECHS staff will stress with partners, especially those at perinatal access points, the importance of receiving incoming referrals as early as possible. Primary access points include health departments, physicians’ offices, and ‘Right From the Start’ offices where women seek presumptive eligibility Medicaid. The study emphasized to the community the significance of the project to improvement of outcomes, the need to support ECHS services, and that the project sought self-evaluation to determine changes that might improve program strategies.

B. Because of the public health focus of the program, enrollment will not be limited to early in the pregnancy or only to certain high risk groups, although management has considered this change. Program staff will stress to partners the significance of early referrals.

Section VI. PUBLICATIONS

No manuscripts have yet to be developed and submitted for publication.
HEALTHY START LOCAL EVALUATION REPORT

PROJECT NAME: Enterprise Community Healthy Start (ECHS)

TITLE OF REPORT: Impact of Prenatal Exposure to the Enterprise Community Healthy Start Program on Select Birth Outcomes, 2001-2005

AUTHORS: Lauren B. Zapata, Ph.D., MSPH

Section I. INTRODUCTION

Local Evaluation Component

A. The impetus of this local evaluation was to determine the impact of prenatal exposure to the ECHS program on select birth outcomes, controlling for medical risk factors. A previous local evaluation conducted a similar study, but was limited in its ability to include a host of medical risk factors such as hypertension and diabetes in a multivariable model due to data limitations. The design for this local evaluation was the result of collaboration between the ECHS project director, Dr. Sandra Pittman, the ECHS data manager, Dr. Don Sutherland, and the contracted evaluator, Lauren B. Zapata.

B. This was the second evaluation study completed on the ECHS project. As mentioned above, this local evaluation was intended to build upon results from the first local evaluation that also investigated the impact of the ECHS on select birth outcomes, but was limited in the independent variables that were available for inclusion in a multivariable model.

C. The study is a retrospective cohort outcome evaluation study comparing prenatal ECHS clients with non-prenatal ECHS clients and non-clients residing in the same project area, during the project period 2001-2005.

Key Questions/Hypotheses

5. Does prenatal exposure to the ECHS program positively impact select birth outcomes?
   a. Hypothesis: Prenatal exposure to the ECHS program positively impacts select birth outcomes.

6. What characteristics of women describe the segment of the population that the EHS program has the most potential to benefit?
   a. Hypothesis: The ECHS program will most benefit young, unmarried and lower educated women.
7. Does length of prenatal program exposure improve birth outcomes?
   a. Hypothesis: Prenatal ECHS program clients exposed to the program for longer periods of time will have better birth outcomes than ECHS program clients exposed for shorter periods of time or no program exposure at all.

Section II. PROCESS

B. Secondary analysis was conducted. Data from the National Perinatal Information Center (NPIC) representing deliveries at the MCG Medical Center to women residing in the ECHS project area were linked to programmatic data maintained by ECHS project staff to determine the type of ECHS program exposure. Classifications included: (1) no exposure; (2) prenatal exposure; and (3) postnatal exposure. Analyses were limited to deliveries occurring during the project period, 2001-2005. SAS statistical software was used to assess any differences between prenatal ECHS clients with non-prenatal ECHS clients and non-clients residing in the same project area. Dependent variables investigated included weeks of infant gestation, infant weight in grams, infant apgar at one minute, infant apgar at five minutes, hospital length of stay, infant classification as preterm (<37 weeks), infant classification as VLBW (<1500 grams) and infant classification as LBW (<2500 grams). Multivariable regression models (OLS and logistic) were developed for each outcome variable to control for potential confounders including maternal race, maternal marital status, plurality, and maternal medical risk factors that were determined based on ICD-9 codes from NPIC data. Due to the complexity of ICD-9 codings, only ICD-9 codes representing complications related to pregnancy were analyzed as “risk factors” in this study. The following “risk” variables were created to include as independent variables in multivariate modeling (women were either classified as experiencing the complication or not).
   a. Hemorrhage in Early Pregnancy / Antepartum Hemorrhage, Abruptio Placentae, and Placenta Previa (640.0 – 641.9)
   b. Hypertension Complicating Pregnancy, Childbirth, and the Puerperium (642.0 – 642.9)
   c. Infectious and Parasitic Conditions in the Mother Complicating Pregnancy, Childbirth, or the Puerperium (647.0 – 647.9)
   d. Diabetes Mellitus or Abnormal Glucose Tolerance (648.0 or 648.8)
   e. Other Current Conditions in the Mother Complicating Pregnancy, Childbirth, or the Puerperium (i.e., Thyroid dysfunction, anemia, drug dependence, mental disorders, cardiovascular disease, bone/joint disorders) (648.1 – 648.7 and 648.9)

C. Data sources included (1) programmatic data maintained by ECHS project staff; and (2) data from the National Perinatal Information Center (NPIC) representing deliveries to women residing in the ECHS project area.
D. No instrumentation was employed. All variables included in multivariable modeling were available in secondary data sources.

Section III. FINDINGS/DISCUSSION

5. Prenatal ECHS clients were identified as being at much higher risk than non-prenatal ECHS clients/non-clients related to both demographic and medical risk factors.

<table>
<thead>
<tr>
<th></th>
<th>Non-Prenatal Clients or Non-Clients (n=4176)</th>
<th>Prenatal Clients (n=830)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Black</td>
<td>1381</td>
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</tr>
<tr>
<td>Hispanic</td>
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<td>1.42</td>
</tr>
<tr>
<td>Non-Married</td>
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<td>76.55</td>
</tr>
<tr>
<td>Multiple Birth</td>
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<td>1.47</td>
</tr>
<tr>
<td>Hemorrhage</td>
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<td>15.46</td>
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<tr>
<td>Hypertension</td>
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<td>24.52</td>
</tr>
<tr>
<td>Infectious/Parasitic Conditions</td>
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<td>12.78</td>
</tr>
<tr>
<td>Diabetes</td>
<td>131</td>
<td>7.15</td>
</tr>
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<td>Other</td>
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<td>24.27</td>
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<tr>
<td>Preterm Birth</td>
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<tr>
<td>VLBW</td>
<td>63</td>
<td>2.86</td>
</tr>
<tr>
<td>LBW</td>
<td>251</td>
<td>13.80</td>
</tr>
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</table>

- Prenatal ECHS clients were 2.92 times more likely than non-prenatal clients/non-clients residing in the same project area to be Black (OR=2.92, CI=2.05, 4.15, p<.0001).
- Prenatal ECHS clients were 1.42 times more likely than non-prenatal clients/non-clients residing in the same project area to be unmarried (OR=1.42, CI=1.06, 1.89, p<.05).
- Prenatal ECHS clients were 2.37 times more likely than non-prenatal clients/non-clients residing in the same project area to have had a multiple birth (OR=2.37, CI=1.21, 4.63, p<.005).
- Prenatal ECHS clients were 1.41 times more likely than non-prenatal clients/non-clients residing in the same project area to have had hemorrhaging (OR=1.41, CI=1.06, 1.87, p<.05).
- Prenatal ECHS clients were 1.60 times more likely than non-prenatal clients/non-clients residing in the same project area to have had hypertension (OR=1.60, CI=1.26, 2.03, p<.0001).
- Prenatal ECHS clients 3.63 times more likely than non-prenatal clients/non-clients residing in the same project area to have had diabetes (OR=3.63, CI=2.68, 4.90, p<.0001).
- Prenatal ECHS clients were 1.86 times more likely than non-prenatal clients/non-clients residing in the same project area to have had some “other” high risk pregnancy ICD-coding (OR=1.86, CI=1.48, 2.35).
- Prenatal ECHS clients were 2.03 times more likely than non-prenatal
clients/non-clients residing in the same project area to have had a preterm infant (OR=2.03, CI=1.56, 2.65, p<.0001).

- Prenatal ECHS clients were 1.43 times more likely than non-prenatal clients/non-clients residing in the same project area to have had a LBW baby (OR=1.43, CI=1.07, 1.92, p<.05).

6. No positive associations between prenatal ECHS program exposure and select birth outcomes were statistically detected.

7. No positive associations between length of prenatal ECHS program exposure and select birth outcomes were statistically detected.

8. Prenatal exposure to the ECHS program was found to most benefit unmarried mothers, mothers that did not have an infectious or parasitic condition affecting pregnancy, mothers pregnant with multiple births, and Black mothers.

- Prenatal exposure to the ECHS program had a more beneficial impact on infant weight among unmarried mothers, as compared to married mothers.
- Prenatal exposure to the ECHS program had a more beneficial impact on infant weight among mothers that did not have an infectious or parasitic condition affecting pregnancy.
- Prenatal exposure to the ECHS program had a more beneficial impact on gestational age of the infant among mothers that did not have an infectious or parasitic condition affecting pregnancy.
- Prenatal exposure to the ECHS program had a more beneficial impact on hospital length of stay among mothers pregnant with multiple births.
  i. For example, among mothers pregnant with multiples, those with prenatal exposure to the ECHS program had a lower mean number of days spent in the hospital (mean=3.31, SD=6.22), as compared to those without prenatal exposure to the ECHS program (mean=6.81, SD=8.36).
- Prenatal exposure to the ECHS program had a more beneficial impact on infant LBW among unmarried mothers.
- Prenatal exposure to the ECHS program had a more beneficial impact on infant LBW among mothers that did not have an infectious or parasitic condition affecting pregnancy.
- Prenatal exposure to the ECHS program had a more beneficial impact on preterm birth among Black mothers.
  i. For example, among Black mothers, those with prenatal exposure to the ECHS program were 1.67 times more likely than those without prenatal exposure to have had a preterm baby.
  ii. In contrast, among White mothers, those with prenatal exposure to the ECHS program were 5.68 times more likely than those without prenatal exposure to have had a preterm baby.
- Prenatal exposure to the ECHS program had a more beneficial impact on preterm birth among mothers that did not have an infectious or parasitic condition affecting pregnancy.
9. Length of prenatal exposure to the ECHS program was found to most benefit unmarried mothers, mothers that did not have an infectious or parasitic condition affecting pregnancy, mothers pregnant with multiple births, Black mothers, and mothers with hypertension.

- Length of prenatal exposure to the ECHS program had a more beneficial impact on *infant weight* among unmarried mothers, as compared to married mothers.
  i. For example, among married mothers, length of prenatal exposure to the ECHS program was associated with a decrease in infant weight in grams.
  ii. Among unmarried mothers however, as length of prenatal exposure to the ECHS program increased, infant birth weight increased.

- Length of prenatal exposure to the ECHS program had a more beneficial impact on *gestational age of the infant* among Black mothers as compared to White mothers.

- Length of prenatal exposure to the ECHS program had a more beneficial impact on *gestational age of the infant* among mothers that did not have an infectious or parasitic condition affecting pregnancy.

- Length of prenatal exposure to the ECHS program had a more beneficial impact on *hospital length of stay* among Black mothers.

- Length of prenatal exposure to the ECHS program had a more beneficial impact on *hospital length of stay* among mothers pregnant with multiple infants.

- Length of prenatal exposure to the ECHS program had a more beneficial impact on *infant LBW* among unmarried mothers.
  i. For example, among unmarried mothers, those with greater prenatal exposure to the ECHS program were 0.99 times less likely than those without prenatal exposure to have had a LBW baby.
  ii. In contrast, among married mothers, those with greater prenatal exposure to the ECHS program were 1.01 times more likely than those without prenatal exposure to have had a LBW baby.

- Length of prenatal exposure to the ECHS program had a more beneficial impact on *infant LBW* among mothers experiencing hypertension.
  i. For example, among mothers with hypertension, those with greater exposure to the ECHS program were 0.99 times less likely than those without prenatal exposure to have had a LBW baby.
  ii. In contrast, among mothers without hypertension, those with greater exposure to the ECHS program were 1.01 times more likely than those without prenatal exposure to have had a LBW baby.

Methodological limitations of the evaluation included limitations in the availability of sociodemographic variables such as maternal age and maternal education via secondary data sources to include in multivariate regression models.

Section IV. RECOMMENDATIONS
D. Because prenatal exposure to the ECHS program was found to have a more beneficial impact for unmarried women, women pregnant with multiple infants (twins), Black mothers, mothers with hypertension, and mothers that did not have an infectious or parasitic condition affecting pregnancy, it is recommended that these subgroups of women be further targeted for future program implementation/outreach.

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

A. ECHS staff will stress with partners, especially those at perinatal access points, the importance of receiving incoming referrals as early as possible. Primary access points include health departments, physicians’ offices, and ‘Right From the Start’ offices where women seek presumptive eligibility Medicaid. The study emphasized to the community the significance of the project to improvement of outcomes, the need to support ECHS services, and that the project sought self-evaluation to determine changes that might improve program strategies.

B. Because of the public health focus of the program, enrollment will not be limited to early in the pregnancy or only to certain high risk groups, although management has considered this change. Program staff will stress to partners the significance of early referrals.

Section VI. PUBLICATIONS

No manuscripts have yet to be developed and submitted for publication.
Attachment G – Case Management Flow Chart
Attachment H - Ante-partum/Postpartum Risk Assessment Screening Tool
The Enterprise Community Healthy Start Initiative
Ante-partum/Postpartum Risk Assessment Screen
(Circle appropriate time period)

Client MR #________________________ Date of screen ____________________________
Name ______________________________ DOB ______________________________
Medicaid # ________________________ Patient contact phone ______________________
Address ________________________________________________________________________

Date of delivery or Due date __________________________
Sex [ ] male [ ] female Birth weight ____________
Delivery hospital ________________________________
Mother’s doctor ________________________________ Baby’s doctor ____________________
Doctor when not pregnant _________________________
Mother’s Dentist ________________________________

General Questions: (to be asked of all clients)

How many grades of school have you completed? ______________
What is your household income level? ______________
Do you have any health problems? Yes [ ] No [ ] If so, what are they ________________________________

Do you have a health history of any of the following:
(During this pregnancy, or when not pregnant)

* Asthma Yes [ ] No [ ]
* Diabetes (insulin used?) Yes [ ] No [ ]
* High blood pressure (when not pregnant) Yes [ ] No [ ]
* High Cholesterol Yes [ ] No [ ]
Cancer Yes [ ] No [ ]

Toxemia/Pre-eclampsia (high blood pressure during pregnancy) Yes [ ] No [ ]
Preterm labor Yes [ ] No [ ]
*Preterm delivery (delivery of baby before 37wks) Yes [ ] No [ ]
Abortions or miscarriages (how many? ____________) Yes [ ] No [ ]
Previous stillbirth Yes [ ] No [ ]
Sickle cell anemia (trait or disease) Yes [ ] No [ ]
Depression Yes [ ] No [ ]
Mental disorder( specify) [Yes ] No [ ] *Dental problems (cavities, gums bleeding) [Yes ] No [ ] *Infections [Yes ] No [ ] If yes, what kind of infection did you have? Urine [ ] STD [ ] Other [ ] *Have you been screened for HIV in the last 3-6 months? [Yes ] No [ ] Do you know the results of the screen [Yes ] No [ ] *Do you have a family history of breast cancer (mother, sister)? [Yes ] No [ ] Have you been in the hospital for anything other than childbirth? [Yes ] No [ ] If yes, why were you in the hospital? ____________________________________________________________________________________________ ____________________________ ____________________________ ____________________________ Are you on any regular medications? _______________________________________________________________ Are you taking any over the counter medicines? ___________________ Vitamins, Herbs? ___________________ If so what are they? _______________________________________________________________ ____________________________ ____________________________ ____________________________ How far along were you in this pregnancy when you first went to the doctor? __________________________ Have you ever been pregnant before? Yes [ ] No [ ] G _____ P _____ L _____ A _____; Preterm: ______ Did you have any problems during your last pregnancy? [Yes ] No [ ] If yes, what were they? __________________________ ____________________________ ____________________________ ____________________________ ____________________________ *What is your weight and height (prepregnancy or now if IC)? ___________________ Weight ___________________ Height *Do you normally exercise regularly? [Yes ] No [ ] If yes, please describe ____________________________________________________________________________ ____________________________ ____________________________ ____________________________ ____________________________ How much physical activity do you get or do at home and/or at work? __________________________ ____________________________ ____________________________ ____________________________ ____________________________ ____________________________ ____________________________ ____________________________ ____________________________ ____________________________ Do you receive any of the following services? [ ] WIC Location [ ] Case Worker [ ] TANF [ ] Other ____________________________ [ ] Food Stamps [ ] Medicaid (LIM or RSM) [ ] Transportation [ ] Car Seat from Health Department [ ] Counseling (for any reason) [ ] GED Program
Living Situation:
Who are you living with? ________________________________________________________

How long have you been living in this location? _______________________________________

How do you feel about your living arrangements for you and your baby?
______________________________________________________________________________

Who will help you with the baby? ___________________________________________________

Is the father of the baby involved? _________________________________________________

How does he help you? ____________________________________________________________

Will you be going back to school/work? Yes [ ] No [ ] If yes, when?____________________

Who will take care of your baby when you are at school/work? ___________________________

Environmental Assessment:
Working utilities (water, heat, telephone) Yes [ ] No [ ]

Do you have adequate space for you and your baby to sleep? Yes [ ] No [ ]

Are you homeless or do you think you may soon become homeless? Yes [ ] No [ ]

Are you having any major financial problems? Yes [ ] No [ ]

Is this a change happening in the last 6 mos? Yes [ ] No [ ]

Do you feel safe in your home? Yes [ ] No [ ]

Behavioral Assessment:
Do you or did you feel good about your pregnancy? Yes [ ] No [ ]

*Do you smoke cigarettes, marijuana, cocaine, or do you use any other drugs? Yes [ ] No [ ]

*Do people living with you smoke? Yes [ ] No [ ]

*Do you drink alcohol? Yes [ ] No [ ]

*Do others living with you drink or use drugs regularly? Yes [ ] No [ ]

Have you ever felt like you wanted to harm yourself in any way? Yes [ ] No [ ]

Are you afraid of any of the people you live with? Yes [ ] No [ ]

If yes, who?_____________________________________________________________________

*Family Planning:
What will you /or are you using for birth control? ________________________________

Where do you go for your birth control?____________________________________________

Antepartum Specific Screening Questions:

How are you planning to feed your baby? Breast [ ] Bottle [ ]
Have you been in the hospital at any time during this pregnancy or with a previous pregnancy?  Yes [ ] No [ ]
If so, what was the reason? ______________________________________

When is your next appointment with your doctor? ________________________

Do you have any problems keeping your appointments?____________________

Have you had any problems during your pregnancy that I have not asked you?
________________________________________________________________________________________

Postpartum Specific Screening Questions:

Did you have a vaginal delivery or c-section? ______________________________

How long were you in the hospital? (If >3 days, ask why was your discharge delayed)
________________________________________________________________________________________

How are you and the baby doing? __________________________________________________________

Did the baby have any problems after delivery?  Yes [ ] No [ ] If so, what were they?
________________________________________________________________________________________

Does the baby have any problems now? Yes [ ] No [ ] If yes, what are they? ______________________

Did the baby come home from the hospital with you? Yes [ ] No [ ]
If no, when did the baby come home? ______________________________

Does the baby need any kind of special treatment? Yes [ ] No [ ] If yes, what kind? ________________

Is your baby being seen by more than one doctor; if so who ______________________________

Have you had your postpartum appointment or when are you scheduled for your postpartum appointment?
________________________________________________________________________________________

Will you be able to get to that appointment?  Yes [ ] No [ ]

Depression Screen

“Many women have some problems with feeling sad during or after their pregnancies. We would like to mail you a depression screening survey for you to complete and mail back to the Healthy Start office. We will mail you a stamped envelope to mail it in. We will also be mailing you a consent form that we would like you to sign and send back with your depression survey. The consent form gives us permission to arrange for assistance for you if you require the type of help Healthy Start can provide at any point over the next two years. Not all women qualify for Healthy Start services, but your consent form will allow us to provide services for you if you need and qualify for them. When you have completed and mailed your depression survey, we will mail or bring you a baby gift as a thank you for participating in the Healthy Start risk assessment program”.

Patient Advocate Signature

________________________________________________________________________________________
Meets HS criteria Yes [ ] No [ ] or needs further evaluation Yes [ ] No [ ] If yes, CMr scheduled date for pick up__________

Case Manager Signature

_________________________________________________________ Date reviewed

Date depression screen and consent mailed _____________________________

*Mailout indicated—list below pamphlet and date mailed:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
