



Healthy Start Impact Report: 2001-2005

Healthy Birth Initiative II Multnomah County Healthy Start

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Appendix A: Project Data

Appendix B: Local Media

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Publication: *Using Low Birth Weight: An Update of a PDES Analysis for 1998-2003 data for Intensively Case Managed Clients.* (Power point presentation)

For study: Program Evaluation: *Using Low Birth Weight: An Update of a PDES Analysis for 1998-2003 data for Intensively Case Managed Clients.* (Outcome)

Publication: *HBI Focus Group—Reapplication Planning Report*

For study: Program Evaluation: *Conducting Focus Groups with African American Women to Identify Reasons for Low Levels of Participation in Educational Activities.* (Process)

Publication: Untitled and will be completed in 2005.

For study: Program Evaluation: *Conducting Literature Review, Community Focus Groups and Stakeholder Interviews for Shaping Future Perinatal Services for Latinas.* (Formative)

I. Overview of Racial And Ethnic Disparity Focused On By Project

Identify the racial, ethnic or other disparities that your project focused on. Highlight from your initial community needs assessment the data that led to your community's decision to focus on the identified disparities.

The Multnomah County Health Department (MCHD) Healthy Start Eliminating Disparities in Perinatal Health project, locally called Healthy Birth Initiative II (HBI) was developed in response to health disparities; specifically the high rates of infant mortality and low birth weight for African Americans and the high rates of late entry into prenatal care for Hispanic women. The intended population for services were African American and Hispanic families who reside in the project area, and who were either pregnant, planning to become pregnant soon, or who had a child younger than two years old. HBI II offered case management, classes, community outreach, referrals to services, help with child care and transportation, and opportunities for families to socialize with each other. In addition, the program had a emphasis on male involvement activities and family violence screening. The current project focused on:

- Helping women achieve good pregnancy outcomes
- Promoting healthy growth and development of their children
- Promoting maternal health and well-being during the interconceptional phase (i.e. from the end of one pregnancy to the beginning of another or 24 months, whichever comes first)
- Encouraging fathers of young children to deepen their involvement in the lives of their children and to provide various kinds of support to the children and their mothers

The project area was comprised of 17 census tracts in Northeast Portland, which is located within Multnomah County, Oregon. At the time of application (1996-1998), there were a total of 3,070 live births (average 1,023 per year) in the project area, and 26 infant deaths (average 8.7 per year). The infant mortality rate for the project area was 8.5/1,000 live births; **however, the infant mortality rates in the project area for African Americans and Hispanics were much higher in 1996-1998: 15.0/1,000 live births for African Americans and 11.0/1,000 live births for Hispanics. These two groups were the project's target population.**

In 1996-1998, 6.9 % of births in the project area were born with low birth weight; 9.7% were to mothers 18 years of age or younger; 20.4% were to women who began prenatal care after the first trimester; 1.1% were to mothers who received no prenatal care; 1.3% of births were to mothers who used illicit drugs during pregnancy; 2.1% were to mothers who indicated alcohol use during pregnancy; and 16.6% indicated cigarette use during pregnancy. It is apparent from these data that pregnant women in the project area were at high risk for a number of poor pregnancy outcomes.

The percent of births in the project area to women age 18 or less declined from a high of 14% in 1992 to 6% in 1999; however, in 1994-1995, 21% of African American births in the project area were to women age 18 or younger, and 17% of Hispanic births were to women age 18 or younger.

Data reviewed (2000 Census) during the initial community needs assessment showed that the

project area was more ethnically diverse than Multnomah County as a whole, with 64% of the population identifying as Caucasian, 27% African American, 1.4% Native American, 6% Asian, and 2.4% other. Six percent of the population of the project area was Hispanic (all races). At the start of HBI II, 41% percent of all African Americans in Multnomah County resided in the project area. Based on 1996 American Community Survey data, the project area had a total population of 63,540, 10.3% of the total population of Multnomah County. Survey data also showed that 19% of the population of the project area was below poverty level. An additional 21% were between 100-199% of poverty level. Twenty-seven percent of children less than 18 in the project area were below the poverty level. Twenty percent of the population ages 25 and over in the project area has less than a high school education. In addition, birth certificate data from 1996-1998 showed that 26% of births in the project area occurred to women who had less than a high school education.

In a *1992 Regional Drug Initiative Study*, African Americans in Multnomah County expressed concern about the level of substance abuse in their community. Because 41% of all African Americans in Multnomah County lived in the project area, concern among African American residents about substance abuse translates directly to the project area. The study conducted in Portland in 1992 asked the question, "Have you or a family member had a drug abuse problem?" Thirty-five percent of African Americans responding to the survey answered "yes." In this same study, ethnic groups were asked to gauge the seriousness of substance abuse in their community. Eighty-nine percent of African Americans responded that substance abuse was a serious or very serious problem. This was the highest level of concern expressed by any ethnic group. In addition, a disproportionate number of arrests for drug offenses occur in the project area. While 21% of the population of the County resided in the project area, Portland Police data from 1996 showed that 34% of drug arrests occurred in the project area. The countywide 2000 crime rate was 11.64/1000. The project area crime rate is 16.4/1000, significantly higher than the rest of the county.

The *Oregon Prenatal Substance Use Prevalence and Health Service Needs Study* conducted during 1994, reported that the prevalence of prenatal alcohol and illicit drug use in Oregon is much higher than indicated by birth certificate data. This study used meconium samples and in-depth interviews with women to measure prenatal tobacco, alcohol, and other drug use. Almost 19% of interviewed women whose birth records did not show alcohol use, admitted to using alcohol while pregnant. More than ten percent (10.4%) of women whose birth records did not show illicit drug use had positive meconium screens or admitted in interviews that they had used drugs during pregnancy. Based on this statewide data, it is estimated that the prevalence of alcohol use during pregnancy in the project area was 23% (3.6% from birth certificates plus 19% suggested by study) and the prevalence of illicit drug use during pregnancy was 12% (1.5% from birth certificates plus 10.4% suggested by study). In June, 1996 the Multnomah County Health Department Violence Prevention Program published a report, *Faces and Voices of Violence*, reviewing violence in Multnomah County. This report mapped by census tract, the rates of homicide, aggravated assault, and partner violence. It was clear from these maps that all forms of violence, and in particular, partner violence, were higher in the project area than in other sections of the County.

II. Project Implementation

Identify how your Healthy Start Project implemented each service and system intervention.

The Multnomah County Health Department (MCHD) Healthy Start Eliminating Disparities in Perinatal Health project, locally called Healthy Birth Initiative II (HBI), addressed disparities in perinatal health among African American and Hispanic women in Northeast Portland. HBI II was funded for 2001-2005 and was the follow-up program from HBI I, the replication project funded during 1998-2001. HBI I focused on African American women, HBI II retained that focus but was expanded to include Hispanic women as well. MCHD has been recently awarded subsequent funding for HBI 3 (2005-2009). HBI 3 is designed to again focus exclusively on African American women, as the disparities in poor birth outcomes have persisted at a greater rate for African American women than Hispanic women. And as will be described in this report, extensive efforts have been made to gather information from science and stakeholders on the best strategies for both reducing birth outcome disparities for African American women and for ensuring Hispanic women continue to receive culturally appropriate, needed services through MCHD's Early Childhood Services.

For the purpose of this report, when not specified, “HBI” or “the program” refers to HBI II.

HBI II was designed to serve 120 women each year. The scope of the project covered pregnancy and interconceptional phases for women living in the target area through their infants' second year of life. The project also encouraged father involvement in children's health, family planning and other activities that support perinatal health. Project plans included serving 60 males per year. Participants in the HBI II Project can be divided into two groups: *program participants* and *community participants*.

- Program Participants were female clients who were being case managed, children whose mothers were also case managed and for whom direct services were provided, and men who were receiving regular services from the Male Involvement Specialist. The program was designed to provide case management services to 120 women, children of women receiving case management services, and 40 fathers whose partners were enrolled.
- Community Participants were individuals who attend at least one Healthy Start-sponsored event and who were not counted as a program participant. The program was designed to engage at least 20 fathers whose partners were not involved in HBI, African American and Hispanic families in the project area, and providers likely to serve women early in pregnancy.

Outreach and Client Recruitment

a) Approach and Design

The plan for outreach and client recruitment was developed from the lessons learned during the

Multnomah County Health Department's Replication Project: HBI I (1998-2001). The original model had indigenous case managers working together with community health nurses, which was found to be an effective blend of community knowledge and nursing skills.

During the development of HBI II, it was thought that having two positions responsible only for outreach and client recruitment would be a good way to increase the number of women recruited into the program at the earliest stages of pregnancy. It was thought that outreach workers who had years of experience hitting the streets and neighborhoods in the project area would be able to reach the women at the highest risk. The design for HBI II was to have outreach and recruitment services led by the outreach workers and a Male Involvement Specialist to work with the fathers or father figures of the women's children. These outreach workers would be part of case management teams along with case managers, the Health Educator, and a Community Health Nurse.

b) Intervention and Changes

Once the program began, it became clear that the case loads were too large for the three case managers and nurse. Also, women who learned about the program from the outreach workers wanted to continue working with *that* person. As a result, the project was implemented with outreach and case management functions combined so that five case managers and one nurse functioned as outreach workers and case managers. Additionally, the Health Educator position was changed to a Health Promotion Coordinator position and was given primary responsibility for Consortium recruitment. (**See *Health Education and Promotion* section.**) The Male Involvement Specialist position remained the same and continued to have responsibility for the recruitment of male program participants. These changes allowed case management staff the time needed to respond to their clients' needs; however, they also resulted in a decreased capacity for client recruitment and outreach activities.

Recruitment for HBI occurred in a number of ways, including on-going contact with the numerous programs operated by the Multnomah County Health Department, meeting with other agencies' staff and clients, participating in community fairs and events, and providing health education classes to clients' families and community members. The largest source of referrals of prenatal clients to the HBI Project was the Women, Infants, and Children (WIC) nutrition program. In addition, Multnomah County Health Department clinics and school-based health centers as well as community clinics, private providers and social service staff in the community refer clients. Because of its Health Department base of operations and the large role the County plays in serving low-income clients, and because of the duration of the HBI Project, County and other private and public health care and social service providers have learned that HBI is a resource for low-income pregnant minority women in Northeast Portland. In the course of providing outreach and case management, HBI staff became aware of other pregnant women who are not yet connected with referral sources.

Additionally, a number of HBI clients were self-referred, as a result of the outreach activities of the HBI staff and the growing reputation in the community of the value of the Project's services.

c) Events Contributing to or Hindering Implementation

As a result of the decrease in outreach capacity, more emphasis on community outreach efforts and activities shifted to the Consortium and the Health Promotion Coordinator. Because this position was vacant for part of the project, recruitment outreach contacts and client referrals were lower than expected during the first part of the project. During 2003-2005, both the number of individuals contacted during outreach and the number of clients enrolled in case management increased substantially and met program expectations.

Case Management

a) Approach and Design

The program was designed to have a multidisciplinary team available to serve perinatal women and the men and children in their lives. Prior to the development of HBI II, Multnomah County Health Department conducted a series of key informant interviews with individuals and groups representing agencies that provide health services or social services to pregnant women in the Northeast health service area (which is part of the project area). In addition, the Health Department conducted focus groups with African American women from the Northeast service area to examine issues around prenatal care. A strong theme that emerged from this qualitative data was the need for advocacy services. This need was recognized both by users of service, and by service providers. Women wanted advocates who could establish relationships with them, communicate with them, and with whom they could identify (had similar backgrounds and experiences). Women informants also identified the need for transportation services and childcare services.

In the spring of 1995, a joint effort by the Oregon Health Division, Oregon Developmental Disabilities Council, and the Oregon Commission on Children and Families was conducted to involve families as partners in planning. Interviews, discussion groups and surveys were done with 620 low income families from 22 Oregon counties, to identify what works, what does not work, and what was missing from efforts to help Oregon families. While information gained from this process is not specific to Multnomah County or to the project area, it reflected the same themes identified in focus groups conducted by the Health Department. Families identified a "partnership" with those helping them as the most beneficial relationship. Families wanted advocates who supported them, did not give up on them, and were like them (had similar experiences). Families said that a trusting relationship was the critical first step for program effectiveness. Families identified childcare and transportation issues as major barriers for accessing service.

Key informant interviews conducted in 1997, with service providers and clients of the Neighborhood Health Clinic High Risk Pregnancy Program reinforced the need for childcare and transportation services. Clients interviewed universally reported childcare and transportation as major barriers to accessing service. There were no childcare services available at no cost to women.

The Neighborhood Health Clinic High Risk Pregnancy Program had bus tickets available for women, and had a contract with a local cab company to provide emergency transports. However, women informants said that bus tickets did not solve transportation problems, because traveling by bus with children was too difficult. And aside from the emergency transportation,

there was no other transportation service. These key informant interviews also reflected the themes of partnership, support, and advocacy by workers who are similar to the women served. The feedback was all taken into account in the design of HBI II and resulted in indigenous community health workers serving as case managers as part of a multidisciplinary team. Also, participants would be provided taxi vouchers, childcare, and bus tickets. For Hispanic clients, the community health workers also spoke Spanish and knew the cultural/immigration issues affecting clients.

b) Intervention and Changes

The project was modified from its original model, so that the case managers also provide community-based outreach and recruitment of project participants, provide case management services, and develop and provide support for a service plan tailored to the client's needs. The case management and outreach functions have been merged in order to maintain continuity of relationships and to avoid disrupting the bond of trust that develops between outreach worker and client. The same individual HBI staff members did both case management and community outreach. At the start of the project, the case manager—whether a community health worker or community health nurse—was responsible for conducting the intake and risk screening. During 2004, the program—along with all of the Multnomah County Health Department's Early Childhood Services—experienced a policy change. The initial needs assessment and intake for all clients was performed by a community health nurse. This change was made to ensure that all medical and health risks were identified at intake. For those clients who had identified health risks, the community health nurse would provide case management services. All other clients would be served by community health workers. The community health nurse would be available to provide on-going or as-needed nursing consultation to the community health workers if and when health issues came up with their clients.

In response to a higher demand for services, the program made a shift in 2003 in its enrollment policy resulting in the enrollment of higher risk women and women much later in their pregnancies. Of the women entering the program *and* giving birth in 2003, 22% (7/32) had already recently given birth, 22% (7/32) entered during the third trimester, 34% (11/32) in the second trimester, and 19% (6/32) during the first trimester. In previous years, the majority of clients enrolled during the first trimester. By the start of 2004, the program again shifted back to primarily enrolling women early in pregnancy.

The rationale behind emphasizing first trimester enrollment was to maximize the possible benefits from case management for the entire length of the pregnancy. With the current statewide budget deficits and resulting reductions in wrap-around-services, more women residing in the project area were without needed services. Whether the higher demand is a result of HBI becoming more effective in reaching women who historically missed by human services organizations because they were *too* high risk, or because more women in the project area are being affected by risk factors as a result of service cuts is not known.

The program remained open to enrolling women who were beyond their first trimester on a case-by-case basis. All women seeking services would either receive them from HBI or would be linked to a more appropriate service within the Health Department.

c) Events Contributing or Hindering Implementation

Each case manager was expected to case manage services for 20 clients. During the last two years of the project the average caseload was 18.2. The average caseload was below the expected 20 clients due to case manager positions being vacant for a combined total of 1.0 FTE for 6 months. During 2003, Multnomah County closed programs and clinics and laid off numerous employees due to State budget shortfalls and all new hires were delayed due to the union rules— until all County-wide layoffs and bumping had occurred.

Due to Statewide budget cuts over the last few years, many human services have been eliminated and are no longer readily available. Health care services are often unavailable for interconceptional women without insurance. Additionally, there are very few mental health professionals and services available to clients in the area. Fortunately, the Family Violence Prevention program provides support to HBI clients who are experiencing violence in their homes. In addition to these resource barriers, there are client-based barriers as well. Many of the barriers preventing women from enrolling in HBI prevent those—who do enroll—from accessing services for which they were referred. This is especially seen with chemical addiction treatment. If the client is not ready to enter treatment, then she will not seek treatment. HBI staff advocated for clients who need services that are limited or unavailable. They increased the frequency of contact with the client to help the client stabilize or intensify their search for services. HBI case workers have been hired because of their knowledge of the project area and issues clients face. They are, as a group, quite resourceful and creative. Even with these skills however, some clients went without certain services due to ineligibility or service reductions.

Health Education and Training

a) Approach and Design

HBI's health education and promotion activities were designed to support women and their families by providing training and education addressing factors associated with healthy pregnancies, births, and babies. In addition, health education and promotion messages were aimed at the community to support and reinforce efforts to inform, educate, and mobilize the community around infant mortality, healthy babies and the HBI project.

b) Intervention and Changes

The initial design of the health education component involved a Health Educator who would develop and be responsible for the delivery of health education and promotion activities. In 2003, the Health Educator's position was restructured to a Health Promotion Coordinator's position. This decision was made in order to find a professional who had experience with project coordination and could lead education efforts along with staffing the Consortium.

Educational efforts targeted toward mothers and their families employed multiple educational methods and communication channels depending on the needs and preferences of the mothers and families served. The variety of methods used included training sessions, support groups, and one-on-one training modules provided by case managers.

For example, nutrition topics were covered in one-on-one education sessions with case managers

and reinforced through nutrition classes that were incorporated into women's support group activities. The breadth and flexibility of approach permitted nutrition information to be presented in multiple contexts in culturally appropriate manner. Health Education and Health Promotion strategies targeted toward the broader community included distribution of information at health fairs and other public events. The Consortium wanted to be involved with the community-wide educational activities and begun developing a work plan for a community-wide campaign in 2004. Please see the attached copies of local media stories resulting in Consortium activities in Appendix B. Also in 2004, with carry-over funds, the program provided classes to community members. These class topics were identified by the Consortium and are as follows: English Classes, Child Care Training, Natural Healing (National College of Naturopathic Medicine), Stress Management, Affordable Housing & Displacement (ROOTS Recovering Our Origins Through Struggle), and Cooking Classes. Additionally, the staff teamed with the staff of the Reducing Family Violence program for the annual Men Enriching Neighborhood (MEN) conferences in both 2003 and 2004. In 2003, the program received the Summit Creative Bronze Award for an educational video focusing on culturally relevant issues about domestic violence. A copy of the video has been submitted with the hard copy of this report. In 2004, HBI also received formal recognition from the Multnomah County Domestic Violence Coordinating Council for their efforts working with families experiencing violence.

c) Events Contributing to or Hindering Implementation

The Health Promotion Coordinator position was filled by a temporary employee until hiring freezes were lifted. Because of the challenges the project had in hiring permanent staff in this position, the other team members all participated actively to keep education services on schedule. The case managers, the Male Involvement Specialist, the staff from the Preventing Violence Program, the HBI Program Coordinator, the Program Evaluator, and the Consortium all worked on educational activities to keep the program on track while this position was vacant. All required education topics were covered in classes and the communitywide campaign was begun by the end of the project period.

As part of the evaluation, class participation of case managed participants was tracked. It became evident that Hispanic clients were much more involved in educational activities than the African American participants. Feedback from case managers suggested that the lives of the African American participants in general were far too busy and that it wasn't realistic to expect them to come in for monthly classes in addition to their regular home visits. The Program Evaluator also reported that there was a difference in the response rate for client satisfaction surveys and that when telephone follow-up attempts were made, contacting the African American clients was much more difficult than contacting the Hispanic clients. Staff believed the difference between participation rates was, in part, due to cultural differences between the two groups.

The Hispanic women were less likely to be working outside of the house and in fact were at-risk for being socially isolated. Staff and client feedback from the Hispanic clients indicated that attending monthly classes was a great way to reduce the negative effects of the social isolation. Focus groups with African American clients were conducted in 2004 to explore ways to improve their participation rate. Focus group participants were given a gift certificate of \$25 to attend. Themes emerging from these groups did indeed support the feedback offered by staff. The demands and stressors the women were contending with were barriers. Commonly cited

reasons were the need to work, too many appointments, and too much stress in their lives. The women did also indicate that it would be nice to have the opportunity to meet with other women and talk about stuff and to learn from each other. As a result of this feedback three major changes were made. Each educational group/class now had scheduled time for socializing and the class announcements clearly indicated this. Second, an incentive program was developed for HBI 3, in which women will receive coupons for things like strollers, car seats, etc for participating in all program activities—including classes. Also, now women can be paired with an informal mentor—someone who has either completed the program or who has more experience with pregnancy or parenting. Currently, HBI 3 is exploring how to involve women in the delivery of education as well. The effectiveness of these efforts has not been formally evaluated at the time of this reporting, but will be as part of the on-going program evaluation.

Interconceptional Care

a) Approach and Design

The program was designed to link participants to medical interconceptional care either at the Health Department or at other safety net providers, and to provide non-medical care directly. Additionally, it was intended that health care providers be on the Consortium in effort to encourage relationships and collaborations between private and public providers. This collaboration would then result in improved access to care for the uninsured participants of HBI.

Also, a community-wide provider campaign was to be developed. The purpose of this campaign was to encourage the culturally appropriate screening of risk factors known to contribute to poor health and poor birth outcomes for African American and Hispanic women.

b) Intervention and Changes

Non-medical interconceptional services were provided directly by HBI staff, clinical services were offered through the Health Department's clinics and through other providers. Women received risk assessment, coordination services, health education, counseling, guidance, and family planning services from HBI staff and Health Department clinics. During the two years after delivery participants were seen weekly for the first two weeks after birth and then either monthly or more often as needed. Community health nurses and case workers identified health care needs during the first two visits with clients and continue to assess health care needs along with other service needs on an on-going basis. The Multnomah County Health Department is the largest safety net provider and HBI had the ability to get women seen promptly at the MCHD's Northeast Health Clinic. Unfortunately, whether participants had a source for *on-going primary care* could not be determined.

Part of the challenge was that data were not available for participants receiving their care from other providers. During the last year of HBI II, 80% of the women enrolled in case management had a verifiable source of interconceptional medical care, as defined as having at least one family planning, preventive, or non-pregnancy related visit.

All participants received interconceptional services from program staff if they were enrolled when not pregnant. The Consortium was successful in recruiting a mental health provider from a major health care system, but was not able to recruit primary care providers.

The mental health provider was able to link some clients to emergency funds and services so access to mental health support was improved; however, the same cannot be said for other interconceptional services. The provider campaign also did not get implemented.

c) Events Contributing to or Hindering Implementation

The major challenge to the provider campaign implementation was the vacancy in the Health Promotion Coordinator position. The vacancy was due to two things, difficulty recruiting for the position and then hiring freezes due to union labor procedures. The hiring freeze was a direct result of state budget shortfalls in 2002-2004. Also due to the shortfalls, coverage under Oregon's Medicaid Program, the Oregon Health Plan, has been cut. Many women who are eligible for coverage during pregnancy and the postpartum period were no longer eligible for coverage during the interconceptional phase. In addition, services for mental health services and dental services are even harder to come by for those on the Oregon Health Plan, let alone uninsured. The women who were not eligible for public insurance—even during pregnancy—were seen by the Health Department, but access to preventative, primary care for the uninsured has been increasingly limited due to financial fall out from the Oregon Health Plan reductions and from reductions in general funds supporting the services. HBI II had a direct role in linking uninsured women to prenatal care and some interconceptional care. HBI 3 was designed to improve on this accomplishment by making the securing of medical home for all case managed clients one of the top priorities. In addition, case managers will be encouraged to communicate directly with the health care providers (with client consent and involvement) in order to support their services with the client and to encourage the appropriate utilization of preventive care. The new program also has a Mental Health Specialist. (*See the Depression Screening and Referral section.*) Data collection has been modified so that the name and contact information of the provider will be tracked for all participants—along with the addition of asking participants about their medical home as part of the annual client survey.

Depression Screening and Referral

a) Approach and Design

Depression screening was conducted during the second contact with case manager, and then at regular intervals during each trimester for pregnant participants. The Nine Symptom checklist (PHQ-9) was used for both pregnant and interconceptional clients. The tool was used again at the first postpartum contact and as needed based on individual assessment. This tool was used by MCHD's Early Childhood Services programs and was validated for both English and Spanish speaking women.

b) Intervention and Changes Implementation

Case managers provided feedback that the Spanish-speaking women would answer the screening questions in a way that would indicate that they were not depressed, yet would disclose during conversation that they were down, nervous or stressed. Staff indicated that the questions were too specific and that there were too many questions.

Staff working with African American clients indicated that their clients too would answer the questions in a different way than one would think given the complaints and stressors that would arise in conversation. Case managers expressed that the screening was too pointed and formal.

As a result of these concerns, exploration is currently underway for a shorter screening tool for depression for participants of HBI 3.

During 2003, mental health data on women enrolled in case management services were collected as part of a Preventing Family Violence chart audit. Of the women enrolled in case management services, 59% reported that they were experiencing depression, drug addiction, or another mental health condition. Of these women, only 39% actually completed a referral for mental health services. This is a low completion rate when compared to the 70% completion rate for referrals overall. This low rate of completion is a result of the lack of culturally appropriate and affordable mental health services available in the project area.

c) Events Contributing to or Hindering

In response to this need, HBI 3 was designed to include a Mental Health Specialist who will provide further clinical assessment and diagnosis. If diagnosed with perinatal depression that requires treatment outside the scope of the HBI team, a referral will be made to the County Human Services Department's mental health services, other community mental health providers, and their medical provider. Culturally appropriate mental health services are very limited in the project area and are limited further for uninsured participants. The Mental Health Specialist will also work to identify and nurture resources in the community as well as provide training to mental health providers on culturally issues when working with African American women.

Local Health System Action Plan

a) Approach and Design

The project planning team identified the lack of male involvement as a major deficiency in the current perinatal system. The project staff and Consortium addressed this as part of the Local System Health Action Plan. In the planning phase of HBI II, recommendations were made to develop strategies to gain participation from fathers and other significant males. Focus groups and individual interviews with Consortium members (from HBI I) found that male involvement was low.

Because the Consortium members felt there was not enough male representation on the Consortium or male partner involvement during pregnancy, a focus group with male community leaders was held. The focus group explored ways in which men could be more involved and what the focus group participants, as leaders in the community, could do to assist.

Among many other things, they recommended having educational topics at the Consortium meetings that are pertinent to male involvement during pregnancy, to implement project outreach and educational components directed at male involvement, to conduct an educational campaign, and to get male organizations to support the program and individual participants.

b) Intervention and Changes

As a result of this feedback, the HBI II project planning team identified the lack of male involvement as a major deficiency in the current perinatal system. The project staff and Consortium would address this as part of the Local System Health Action Plan.

A Male Involvement Specialist was hired to work with 60 men each year with the goal of increasing the involvement of fathers or father figures in perinatal health, parenting, and family planning. This component had some success particularly with Hispanic participants, but had major challenges engaging African American men.

Throughout the project period, 62 men were involved with on-going program services. The male involvement component was unable to enroll the projected 60 men a year and had difficulties engaging African American men in on-going activities. Results from focus groups conducted during 2004 with African American women enrolled in case management revealed that women involved in the focus groups did not want their male partners included in program activities. As a result of this feedback from focus groups and the limited ability to engage men, for HBI 3 (which focuses only on African American families), the Male Involvement Specialist position was eliminated, along with the provision of male-specific groups; however, men are encouraged to participate in program activities including the Consortium.

c) Events Contributing to or Hindering Implementation

One major success was the partnership with the Preventing Family Violence Project, the Men's Network, and Desarrollo Integral De La Familia (DIF). This partnership resulted in the development of the Men Enriching Neighborhood conference in both 2003 and 2004. Each year approximately 150 individuals attended the conference. Approximately half of those attending were men; and the overwhelming majority of attendees were staff of local social service agencies, health programs and schools. The partners have all shown interest in continuing this conference and highlighting the need for services for men and their families. Additionally, the Male Involvement component was able to recruit for the Consortium, representation from Umoja Inc, a non profit group serving exclusively young men affected by gangs. Unfortunately this organization closed its doors in late 2004 but the representative continues to participate on the HBI Consortium. Increasingly, the Consortium members from agencies and faith organizations are male and there is a renewed energy in developing male-inclusive community education messages; in an attempt to better support the men who in turn, can better support the women and babies in their lives.

The program was quite successful engaging Hispanic men who were husbands/partners of women enrolled in case management services. There were 12 Male Involvement classes during 2004 alone, covering topics such as financial planning, acupuncture and herbal medicine, arrival of new babies, domestic violence, STD and HIV, and emotions. Additionally, English as a Second Language (ESL) classes were held and men comprised slightly more than half of the participants in the 23 sessions. As HBI II came to a close and the Male Involvement component was phased out, the men coming to classes decided to stay in contact with one another and were offered a meeting space and involvement with another social service agency.

Consortium (including required additional elements 1-8 per instructions)

a) Approach to Design and Establishment

The Healthy Birth Initiative II Consortium was designed based on the lessons learned from Portland's earlier HBI I. Similar to the first program's Consortium design, HBI II was to have a

Consortium comprised of community members, program participants, agency staff, and others with an interest in promoting healthy birth outcomes in the project area. It was understood that community collaboration is essential because the problem of infant mortality is affected by a myriad of conditions in the community. Only a collaborative effort within the community can develop long-term strategies necessary to impact the problem. The role, structure, and operations of the Consortium reflect the importance and value of the community participation in the project.

At the time HBI II was being planned, the existing Consortium (1998-2001) was evolving and was to be operationally based in Multnomah County Health Department's Community Health Council (CHC). The CHC is the governing body for MCHD's Section 330 Community Health Centers. The Consortium was to be operated as a committee of the CHC under the bylaws of the CHC. This would allow the Consortium to utilize the important strengths of the CHC, including its longevity, structure and procedures, involvement in maternal and child health activities in the project area, consumer involvement, and community and governmental credibility.

Some of the strengths that would be gained from this change of the HBI Consortium also became barriers at the beginning of HBI II project implementation. Since the Consortium was to be under the umbrella of the Health Department's Community Health Council, some members were unclear about whether it was truly a community Consortium or a Health Department Consortium.

The combination of HBI I transitioning into HBI II, the transitioning of the Consortium being part of the CHC, and the changing of the staffing within the program ultimately proved to be too much change. It began to appear that the Consortium was more of an advisory group than a governing body since much of the program was designed during HBI and the grant applying stages so several agency representatives were disappointed, felt it was not addressing their issues, and dropped out. The roles and responsibilities of the Consortium's workgroups were not clarified so members were unsure what they could influence. Finally, as a result of the Consortium's meeting times (during regular work hours), consumers found it difficult to participate. As a result, community membership declined.

b) Interventions, Structure, Composition, Consumer Participation, and Changes

Several changes were made to amend the situation during HBI II. A Consortium chair was elected from the membership to give the Consortium more of a community feel. The meeting time was changed to after-work hours. This helped increase the consumer membership but further reduced agency representative membership.

A consultant was hired to help clarify roles and responsibilities of the Consortium and its workgroups and develop leadership skills among the membership. The plan for connection with the CHC was modified so that at least one member of the Consortium would also sit on the CHC, but that the Consortium would remain a separate group. During 2002 and 2003, the Consortium began to meet more regularly, the consultant was contracted to provide leadership to the group until the Health Promotion Coordinator position could be hired.

This hiring was delayed due to countywide hiring freezes as described in the *Interconceptional Care section*. When it started meeting regularly again, it was primarily a consumer group whose focus was education of members on perinatal health issues and now is a fully functioning Consortium with a blend of service providers and consumers, which is championing a community-wide education campaign—much like the original intent.

As HBI II transitioned to HBI 3, the Health Promotion Coordinator was actively staffing the Consortium, the Health Educator position is being hired to provide technical assistance pertaining to health education information and methods, and the Project Director was participating as a member. Two consumers, one current and one previous program participant serve as co-chairs. The current Consortium is comprised of community members, program participants, and service providers. The HBI Consortium has taken a more active role in the past two years by prioritizing the health education activities. The group is taking lead in the designing and implementing of a community-wide education campaign. Additionally, one member of the Consortium, the manager of the Preventing Family Violence Project, is contracting with community-based organization to provide training on African American and Hispanic cultural issues and family violence for staff, Consortium members, and other agencies.

There are currently 24 members on the Consortium. During 2005, another nine members will be recruited; four additional consumers, and five service providers. The addition of these members will enhance the group and build the program's capability to link program participants with mental health services, employment services, and substance abuse treatment. The providers will be from the Morrison Center Mental Health Services, Steps to Success, Project Network, Insights Teen Parenting Program, and The African American Health Coalition. The anticipated percentage of the Consortium membership is as follows: 12% state or local government; 18% program participant; 18% community participant; 43% community-based organizations; and 9% other providers.

Of the 24 current members; 54% are African American; 17% are Hispanic; and 29% are White. In order to maintain a Consortium that is culturally, racially, and socio-economically reflective of the project area and clientele; program and community participants will continue to be actively encouraged to participate in the Consortium. Transportation and childcare will continue to be provided to facilitate their participation.

The Consortium began the design of a three-part, community-wide campaign designed to accomplish three goals: 1) increase awareness of the disparity African Americans experience when compared to Whites, in infant mortality and low birth weight; 2) educate community members about the risk factors contributing to poor birth outcomes, such as drug use, smoking, insufficient folic acid, delayed prenatal care, and unexpected pregnancy; and 3) recruit program participants and community participants for HBI. In addition to the community campaign and

participation in community educational activities, including health fairs, the Consortium is responsible for the following oversight/sustainability activities:

- Recruit members in the community for any vacant staff positions as well as to join the Consortium.
- Identify education topics for both adult participants and children. They will continue to provide this guidance. Additionally, members will be asked to help identify service providers to contract with for childcare and other services.
- Provide feedback in the design of client satisfaction surveys.

In addition to the community campaign and the program oversight duties, the group will also continue to identify and participate in community health fairs such as the African American Wellness Village, during which at least 500 individual community members attend each year. The Consortium will help identify class topics for educational activities and activities for child care services.

c) Events Contributing to or Hindering Implementation, Community Strengths, and Future Steps to Reduce Barriers

Because the program has experience with developing and maintaining a Consortium, the staff and program has improved its ability to identify stakeholders and make their involvement meaningful. The project area and the African American community include a relatively small population with strong social ties to family, community and faith organizations. The largest barriers have been providing staffing to shepherd the Consortium and then providing them with opportunities to truly become active in meaningful ways to positively influence the larger community. Potential barriers to participation by community members are their comfort levels interacting in a professional meeting, availability to meet during the day, and a meaningful way to participate.

In an effort to prevent these barriers and to ensure consumers involved will be comfortable and effective, they will receive leadership training and meeting times will be scheduled with everyone's availability in mind. Potential barriers for agency participation is the need to have a clear role and collaboration defined in order to make it worth the time it will take to participate in the Consortium.

Membership attendance has been fairly consistent, with an average of half of participants attending each monthly meeting during the last year. The Consortium has not historically had any difficulties with unstable relationships between members, competing agendas of member organizations, poor histories of collaborative effort, or challenging political environments.

In order to ensure continuity of the group and the projects for which it will be responsible, at least half of the membership will need to be retained throughout the project. Ideally, all members will be engaged to such a degree that most members will remain active; however, history has shown that community members may drop out due to life demands and service providers may drop out if their agency has conflicting priorities. In order to retain members, the meeting times and the priorities of the group will be identified by the group. Members will be surveyed to measure satisfaction levels and suggestions for improvement.

Consumers will serve as full members on the Consortium. The full participation of consumers on the Consortium is supported through leadership development, mentoring, providing transportation and child care, and conducting Consortium meetings at convenient times and locations. From the experiences of the first HBI, we learned that in order to ensure meaningful consumer involvement, certain supports needed to be in place. To ensure meaningful advisory and governance functions for the Consortium, we also learned from our previous experience that, in addition to consumer involvement, a full range of individuals and groups also needed to be included for their expertise and resources. However, this wide range of representation presents challenges, particularly with regard to real and perceived differences in power among individuals. In our experience, it is not reasonable to simply seat a group of people who are diverse in race/ethnicity, class, educational background and life experiences around a table, and expect to obtain meaningful participation in advisory and governance activities. Therefore, HBI 3 will employ the following strategies to ensure the continued growth and effectiveness of the Consortium:

- Staff support for the Consortium to ensure that all members have the basic knowledge and skills necessary to participate. This would be done through a “board development” approach - e.g., creating clear role expectations for members, promoting adoption of a code of conduct, and providing training on facilitation and group process, as well as on the subject matter that the Committee will address. Where appropriate, services of consultants based in the project area will be utilized to provide training and facilitation.
- The Committee would provide opportunities for consumer members and other members (e.g., community-based organizations and clinical service providers) to form interest groups or working groups within the consortium. These groups would allow members to participate in ways that may be more effective and more comfortable than taking part in larger meetings.
- Even with these approaches, it may not be possible to overcome all of the differentials among members. Therefore, the Committee would employ additional methods to ensure consumer input. These would include ongoing service consumer focus groups and interviews, and representation and support by the project’s case managers.

Collaboration

a) Approach and Design

For seventy-five years, the Multnomah County Health Department (MCHD) has supported families and their children through various public health programs. The goal of these programs is the same today as it was in 1926; i.e., preventing health problems and promoting healthy families in safe and prosperous communities including eliminating disparities in the health of ethnic and racial groups. The MCHD believes that “A healthy community is one that supports its people in achieving a complete sense of physical, mental and social well being” (World Health Organization, 1978, Ottawa Charter 1986).

The staff also believes that partnerships strengthen our services and improve our outcomes, and that flexibility and creativity are essential to successful outcomes. This belief grew out of a long history of being present in and working with the community. Because of this presence, MCHD benefits from a community perspective as one of the major partners in the provision of early child care services in collaboration with the community, schools, other health care systems,

community-based organizations, other county groups and statewide programs.

HBI sits organizationally within Early Childhood Services (ECS) in the Health Department. ECS goals are to 1) improve health during pregnancy and 2) promote healthy child development. The primary service interventions are home visits and classes. Within ECS are a variety of population-based programs that address specific MCH population needs. HBI is one component of the continuum. These services are funded by a combination of state general funds, Title V funds, Medicaid fee for service reimbursement, and contracts. Referrals for pregnant women and infants are received at a central referral intake and depending on family needs are assigned to a specific program or geographic team. Contracts with community based agencies for teen parents, first-time parents, and crisis relief nurseries are also managed by ECS and a resource for families served by ECS staff.

Early Childhood Services consists of community health nurses, community health workers, mental health consultants, office assistants, field team managers and program-specific staff. Staff members are located in community-based, geographically designated teams or are out-stationed in various community based locations such as Early Head Start programs and the Oregon Department of Human Services (child protection) offices as members of multidisciplinary, interagency teams. These staff utilizes a variety of methods to contribute to the health and well being of individuals, families, groups and communities. These methods include assessment, advocacy, health screening, counseling, teaching and case finding. Field Services staff is also experts at community building, mediating between communities and systems and linking people to services. To accomplish these tasks, staff members collaborate with other agencies, providing leadership in community improvement activities and acting as a health resource to the community. The recent addition of community health workers who are from the African- American, Latino/Latina, Russian and Asian/Pacific Islander communities has enhanced our ability to interact with our community members in a culturally significant manner.

Current Early Childhood Services programs are designed to build on the strengths of specific populations, promote healthier mothers, babies and families thereby improving the health of the community. All of the programs are built around partnerships with other community agencies and organizations that multiply its impact on the community and assure culturally relevant supports and resources exist. Early Childhood staff rely heavily on their long-term community partnerships for assisting in case finding, referring individuals and families and providing community-based resources.

The basic strategies for collaboration for HBI include advocacy and coordination of care by case managers; a continued outreach campaign to "get the word out" about the project; contracting with community-based providers for day care assistance and transportation services; maintaining an active Consortium made up of representatives from community based agencies, social service agencies, medical providers, local/state government, faith communities, consumers, and others interested in the problems of maternal/infant health; and intensifying efforts to recruit consumers and community members to the Consortium.

b) Intervention and Changes

HBI, as part of the Multnomah County Health Department's Early Childhood Services had a rich network of collaborative efforts and agencies that supported the project goals and objectives.

Major collaborations involved:

- **Oregon MothersCare Initiative:** The program supplies a variety of outreach and marketing tools to participating agencies, such as MCHD. They also provide incentives directly to clients when they return a postcard indicating that they have initiated prenatal care.
- **Babies First:** A statewide program with a goal to improve the physical, developmental and emotional health of high risk infants through early identification and assistance to access appropriate and culturally relevant community resources specific to their infant's needs.
- **Family Centers (Parent Child Development Centers – PCDCs):** A community health nurse is part of a multi-disciplinary team at each of the seven family centers run by non-profit agencies that serve a unique geographic area of the County. All families with newborns in the service areas are contacted, often through a home visit.
- **Project Network:** Participants at Project Network, a community residential drug and alcohol provider specializing in services for women of color use educational classes offered through HBI as part of their treatment program, and more than 100 spots in these classes are filled with Project Network residents each year. Case managers can access beds at Project Network for HBI program participants needing residential drug and alcohol treatment.

In addition to these collaborations, the Consortium was comprised of community partners such as the March of Dimes, Nursing Mothers Counsel of Oregon, the state's Title V Program, Planned Parenthood, Umoja Inc, Albina Early Head Start, Self Enhancement Incorporated, churches, and Portland Community College, Department of Human Services, and Legacy Health System.

These members are working with HBI to increase awareness of the importance of prenatal care and ensure access to care. Two years into the project, MCHD received HRSA funding for the Preventing Family Violence Program resulting in an instrumental collaboration. This collaboration resulted in violence screening and a violence disclosure rate of 32% for women enrolled in HBI case management services.

The manager of the Preventing Family Violence Project served as an active member of the Consortium and was instrumental in the training of program participants in leadership skills in preparation for them to become comfortable participating alongside agency staff as active Consortium members.

Additionally, the collaboration led to the development of the MEN's conference as described in the ***Local Health System Action Plan section***. Also, this collaboration involved HBI co-sponsoring the technical assistance training conducted by the San Francisco-based Violence Prevention Fund that was attended by more than 159 individuals participants representing social service agencies, health care facilities, corrections, schools, and community groups.

c) Events Contributing or Hindering Implementation

There are two types of collaborations between the Healthy Start Project and the existing perinatal system. Both of these linkages contributed to the design and subsequent implementation of HBI II. One linkage involves analysis, planning and policy development. The other involves coordination of service delivery. The Oregon Department of Human Services, Office of Family Health (OFH) is the state's Title V Agency, and has MCH analysis and planning responsibilities for the state as a whole. Under Oregon law, most local public health service delivery and associated planning activity is delegated to counties. MCHD, where HBI is located, is the local provider of Title V funded services. Periodic review of county MCH activities is a routine feature of the agreement which delegates MCH service responsibility to the County. MCHD staff members participate on the MCH Committee of the Conference of Local Health Officials that acts in an advisory capacity on program and policy issues to OFH. A MCHD staff member is on the Perinatal Technical Advisory Committee that advises the state on clinical issues.

The State Title V MCH Plan sets the context for the project's objectives. The current Plan's Needs Assessment identified five key public health issues, three of which are directly linked to proposed project: Promoting Optimal Prenatal Care for Healthy Birth Outcomes, Prevention of Child Abuse and Neglect, and Preventing Intimate Partner Violence. The key service delivery issues identified were early enrollment and use of prenatal care, and addressing logistical barriers to needed services. Improving the percentage of babies born at a healthy birth weight, and decreasing infant mortality were seen as major outcomes, with emphasis on tobacco cessation for pregnant women.

Identified child abuse prevention strategies included increasing parent support service, public health nurse home visits, and culturally appropriate services. Strategies for reducing partner violence focused on increasing and improving health care providers' screening and referral abilities.

Sustainability (including required additional elements 1-3 per instructions)

a) Approach and Design

The Health Department has well-established relationships with State and Local government funding agencies. The Health Department receives a wide range of State and Local funds including state funding for 32 programs through the State Health Division, including WIC, Babies First, Title X Family Planning, Title V Maternal and Child Health Grant, HIV Prevention, Breast and Cervical Cancer Prevention and State Support for Public Health.

On a local level, the Health Department receives funding from Multnomah County and the City of Portland for Early Childhood Services. The Early Childhood Services manager and the HBI

Project Directors have shared responsibility for maintaining good working relationships with these programs and funding agencies, particularly the State Maternal Child Health Program. The Health Department's grant writing office has the primary responsibility for identifying funding opportunities and securing new program resources. The Health Department's Business and Quality Services group is responsible for billing State and Local agencies and tracking State and Local funds. The Project Director has primary responsibility for maintaining relationships with programs, such as Early Head Start, that support the Healthy Start effort but do not provide funds to the program or Health Department. Many of these types of agencies are represented on the Consortium.

Multnomah County Health Department's capacity for sustainability is demonstrated through long-standing as well as recent efforts in the area of infant mortality and related concerns; through a proven track record of developing and maintaining meaningful partnerships with clients, community leaders and state and local agencies; through the effective use of evaluation to illustrate program effectiveness; and through our past record of securing other funding sources to continue proven services. The Health Department has developed meaningful partnerships with consumers, community leaders, and state and local agencies through a variety of forums. The Community Health Council, composed of consumers and providers of health care, has been in place since 1980 and acts in advisory, advocacy and governance roles for the Health Department. The Council meets monthly, guiding department policy, reviewing department budget proposals, advocating for services with funders and raising concerns with the Department.

In addition, Health Department management and staff represent the Health Department on a number of local and state organizations including the County Commission on Children and Families, the Leaders' Roundtable, local Caring Communities organizations, the African American Birth Outcomes Task Force, the regional Healthy Communities Council the State Conference of Local Health Officials (CLHO) and the CLHO Maternal and Child Health Committee.

A significant development on the Oregon health care scene is an organization comprised of major public and private health care systems in the Portland area, known as Oregon Health Systems in Collaboration (OHSIC). OHSIC is committed to strengthening public/private partnerships to improve the health of Oregonians.

Its members include Blue Cross/Blue Shield; Clackamas, Multnomah and Washington County Health Departments; Kaiser Permanente; Legacy Health Systems; Oregon Health Sciences University; and Providence Health System. Currently, OHSIC committees are working on health care access, data sharing issues, teen pregnancy, and domestic violence prevention. Multnomah County Health Department, as a partner in this organization, has the opportunity to educate and advocate with members of OHSIC to promote HBI activities and address issues of sustainability. OHSIC representation the Consortium has the potential to create strong linkages between these two organizations.

MCHD is committed to using evaluation to analyze program effectiveness, design program improvements and convey information to the broader community, community leaders and potential funders about the impact of the program on the lives of women and children in

North/Northeast Portland. The state of Oregon and Multnomah County have identified key Benchmarks for the health and well being of individuals and communities. The Benchmarks are qualitative indicators that are widely used to both measure how Oregon communities improve quality of life for their residents and guide program and resource development. For example, there are Maternal and Child Health related Benchmarks that measure percentage of babies born at a healthy birth weight, adequacy of prenatal care, and immunization rates.

b) Intervention and Changes

HBI has a lead grant writer assigned to the project. The lead grant writer works with the Project Director, project staff, the Consortium, the Evaluation Team and community partners through the four-year project period to identify funding needs and grant opportunities. Needs assessment will be done on a periodic basis through client surveys, Consortium meetings, staff input, and community focus groups. Towards the end of the third year of the project, a formal sustainability plan is developed. This plan identifies specific strategies and action steps for sustaining successful project component beyond the project period. The lead grant writer and Project Director have the primary responsibility for sustaining the project. The efforts of the lead grant writer are an in-kind contribution to the project.

The Health Department has a strong commitment to meeting the needs of populations served through pilot projects and grant-funded programs. HBI II served both Latinas and African American women. The Hispanic population is Multnomah County's fastest growing ethnic group—this population increased by 188% between 1990 and 2000. Spanish-speakers now represent about 44% (14,435 patients) of the Health Department's primary care clients. In response to the tremendous increase of Hispanic clients, the Health Department's Early Childhood Services (ECS) has recently developed Hispanic specialty teams who have the linguistic and culturally sensitivity to work with pregnant Latinas and their families.

During the past year, the Healthy Birth Initiative Project Director has worked with the ECS manager to explore the possibility of high-risk pregnant Latinas being served through the regular ECS system. This was explored because the birth outcomes for Latinas in the project area had improved while the African American birth outcomes had not made as many gains. ECS has agreed to transition the Latina HBI clients into the ECS Latina specialty teams. These teams were not in existence four years ago. This transition will enable the continuing Healthy Start project to focus more resources in the African American community. This is also a solid example of the Health Department's ability to sustain program components. During the next project period, 2005 – 2009, HBI and ECS will collaborate to explore the possibility of developing African American maternal child health specialty teams.

c) Events Contributing or Hindering Implementation

Multnomah County Health Department demonstrates its capacity for sustainability through our record of securing other funding sources to continue proven services, such as billing for traditional maternity case management.

A key to our success in sustaining grant-funded programs is in integrating those services within the existing system of care and building community support and collaboration. An example is

the Community Integrated Services Systems Program, funded from 1993 through 1996. This program funded a neighborhood-based health team of Community Health Nurses and Family Health Workers in outer Southeast Portland, co-located at a Family Center that provided an array of social services. Home visits were made to women and families with children from birth to age 5 and other health services including WIC, well-child care, and prenatal care were provided at the Family Center. MCHD is known nationally as an innovative county health department that provides quality health care service to the citizens of the county. With the support of the Healthy Start Consortium and community providers, we will develop a framework for sustaining the service delivery system established by this project.

d) Managed Care and Third Party Billing, Identifying New Resources, and Overcoming Barriers

The Health Department has a successful history providing cost-effective and high quality primary care, health education, and disease prevention in collaboration with multiple community partners. The Department has met 330 Primary Health Care Grant requirements and demonstrated excellence in quality improvement endeavors for over 25 years, and the Health Department has successfully billed Medicaid and other third parties during this period. The Health Department's Business and Quality Services group has a well-established third party billing system which was used by HBI.

All HBI case management was conducted under the supervision of a community health nurse. This practice maximized the number of billable encounters and the subsequent program income. The project recordkeeping supported this practice. Program income was used to support the following costs: office and educational supplies, contracted child care and transportation services, office space, staff education and training, computer usage fees, postage and mailing, printing, space for Consortium meetings, client incentives, nutritional snacks, and other items associated with service delivery.

No barrier were experienced working with managed care or third party billing.

The Health Department recognizes that low-income residents are in an unstable position regarding access to health care, and that there is a need to provide alternatives to care through the establishment of a network of high quality, culturally competent community health centers. In partnership with neighboring Clackamas and Washington Counties, the Health Department received a "Communities in Charge" grant from the Robert Wood Johnson Foundation to investigate the safety net as a system of health care for the uninsured. This project resulted in a set of recommendations to enhance the safety net system.

During December 2003, the Health Department was awarded funding through the Healthy Community Access Program to establish the Safety Net Enterprise, a nonprofit entity that is responsible for improving access to health care through coordination, technical assistance, capacity building and outreach.

The Health Department and other area community health centers are active members of the Safety Net Enterprise. The Safety Net Enterprise is a hub for collaborative efforts. The Health Department grant writing staff periodically works with the Safety Net Enterprise staff to develop resources in conjunction with other Community Health Centers. Grant writing staff identify potential funding opportunities and share those opportunities with Community Health Centers and/or other local partners via email. If there is interest in pursuing a grant opportunity, the

interested parties engage in a planning process that may result in a collaborative project.

III. Project Management and Governance

A) Briefly describe the structure of the project management which was in place for the majority of the project's implementation.

Organizationally, the HBI Project was part of Early Childhood Services, under the Community Health Services group of Multnomah County Health Department. The Project Director oversees all program activities and budget. All HBI staff except the program evaluators report to the Project Director. The Coordinator reports to the Program Manager of Early Childhood Services, who also has the role of Project Director of HBI. The Project Director has oversight responsibility, but all project management is the responsibility of the Project Director. In order to ensure objectivity and avoid any conflicts of interest, the Program Evaluation Team reports to Manager of Community Health Programs.

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

Several essential resources were available to the project. Firstly, Business Services of MCHD played a crucial role in assisting the Project Director follow the budget and stay on track. Secondly, the Evaluation Team provided important feedback throughout the life of the project and assisted the HBI Team in making changes and modifications to the project in order to reach its goals. Finally, partnerships with local community-based organizations to provide childcare, transportation and translation services were critical in enabling HBI to provide services to clients.

C) What changes in management and governance occurred over time and what prompted these changes?

During the first year of HBI II, a temporary Project Coordinator, Tricia Tillman was hired to assist the Project Director with day-to-day management along with provide leadership to the Consortium. She remained in place for six months. In the second year, the Project Coordinator position was filled permanently by Sharon Smith.

The original Project Director, Shirley Orr relinquished all aspects of management to Sharon Smith, who became the Project Director. Ms. Orr retired in 2003. The Project Coordinator position was eliminated. The Health Department re-organized and the HBI Project became part of the Early Childhood Services under the direction of Jan Wallinder. Although there was a leadership change, the responsibilities remained the same.

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

MCHD's Business Services assisted the Project Director with developing the annual budget. The Project Director reviewed monthly expenditure reports, provided by Business Services, which outlined, by budget category where the money was spent and the amount remaining in the budget. The same process was in place for all of MCHD and therefore, remained the same over time.

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

The Project relied on the same services and processes that were already in place with MCHD and the Oregon Department of Human Resources. The revenue generated by the project was budgeted for specific line items in the annual projections.

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

Cultural competency was not an issue given that the HBI Project was based in the community, and therefore represented the community and HBI clients. The HBI staff was hired from the community. All contracts to provide services were with community-based agencies.

IV. Project Accomplishments

A) Describe each major strategy implemented, with its goals and objectives and accomplishments for this project period. Within the narrative describe in quantitative and qualitative terms the degree of success in achieving the objectives. Describe any barriers and how they were addressed.

During the four years, there were no infant deaths and very few babies born with very low birth weight. There were 197 births, including two sets of twins. The following table highlights some of the mothers' demographic characteristics and birth outcomes for their infants. Each program objective and strategy is described in detail following Table 1.

Table 1: HBI II Singleton Births

	2001 n= 44	2002 n=63	2003 n= 411	2004 n=452	HBI II N=193	Year 4 Goal
Race/Ethnicity						
African American	70.5% (31)	44.4% (28)	68% (28)	62% (28)	60%(115)	66% ³
Hispanic	27.2 (12)	50.8% (32)	32% (13)	38% (17)	38% (74)	34%
Other	2.3% (1)	4.8% (3)	0	0	2% (4)	0
Birth Weight and Infant Mortality						
Low Birth Weight <2500g (inclusive of VLBW)	6.8% (3)	7.9% (5)	17% (7)	8.8% (4)	9.8% (19)	6.9%
Very LBW <1500g	0	1.6%(1)	4.9% (2)	0	1.5% (3)	--
African American LBW	6.5% (2)	10.7% (3)	17.9% (5)	14.3% (4)	12% (14/115)	12.7%
Hispanic LBW	8.3% (1)	6.3% (2)	15.4% (2)	0	6.8% (5/74)	--
Infant Mortality	0	0	0	0	0	0
Prenatal Care						
Mother had first trimester care	88.6% (39)	74.6% (47)	61% (25)	80% (36)	76% (147)	95%
Mother had inadequate care	6.8% (3)	3.2% (2)	14.6% (6)	0	5.7% (11)	--
First trimester care for Hispanics	100% (12)	65.6% (21)	53.8% (7)	76% (13)	72% (53)	90%
First trimester care for African Americans	87% (27)	86% (24)	64% (18)	75% (21)	78% (90)	--
Potential Risks						
Mother had less than high school Ed.	46% (20)	59% (37)	51% (21)	49% (23)	52% (101)	--
Mom Younger than 18	18.2% (8)	6.3% (4)	9.8% (4)	12.8% (6)	11.4% (22)	--
Mother had Previous Loss of child/pregnancy	40.9% (18)	31.7% (20)	31.7% (13)	28.9% (13)	33% (64)	--
Behavioral Risks						
Tobacco use by mother	25% (11)	21% (13)	14.6% (6)	12.8% (6)	20.2% (36)	10%
Drug use by mother	2.3% (1)	1.6% (1)	2.4% (1)	6.4% (3)	3.1% (6)	--
Alcohol use by mother	0	0	2.4% (1)	0	<1% (1)	--

Source: Birth records provided by Oregon Department of Human Services, Center for Health Statistics

1 Singleton births only, omitting one set of twins.

2 Singleton births only, omitting one set of twins.

3 Based on project-area population at onset of grant; African American population is twice the size of Hispanic population at the start of the project.

Project Objective 1: To operate a community-based Healthy Birth Initiative II Consortium that is comprised of at least 50% consumers by 5/31/05.

Baseline: 52% of the 2001 Consortium members were consumers as indicated by the 2001 Consortium Roster.

Strategy: To have the Consortium identified as a community based group serving the community.

Activities:

- Hold ten Executive Committee and full Consortium meetings with part of each meeting covering a pre-determined educational topic requested by Consortium members. **(Annually)**
- Organize and facilitate committees. **(On-going)**
- Clarify the purpose of consortium and workgroups, clarifying the roles of consortium and workgroup members, revisit the structure of the consortium and workgroups, how to involve community members and consumers, how to mentor new members. **(On-going)**

Accomplishments/Barriers:

- In December 2004, 70% of the Consortium participants were consumers. By **May 2005**, the Consortium was comprised of 62% community agencies, 25% HBI clients, and 12% HBI staff. The decline in consumer participation was a result of the program not enrolling new clients in program services (including the Consortium) when openings occurred and transitioning clients to other programs in anticipation of the funding cycle coming to a close. The Consortium was lead by two co-chairs who have been consumers of HBI services.
- **During 2003, 2004, and 2005**, the Consortium continued to meet as one large group, but formed ad-hoc groups to work on prioritizing class topics, staffing health fairs, and writing a press release about the disparities in birth outcomes.
- **During 2003 and 2004**, the Consortium met on average 8 times a year, and had an average number of 10 participants of members per meeting. The group has met six times during the first half of **2005**, with an average attendance of 8 members. During the project period, Multnomah County closed programs and clinics and laid off numerous employees due to State budget shortfalls and all new hires were on hold until all County-wide layoffs and bumping had occurred. As a result of hiring freezes, the position responsible for leading the Consortium was vacant for more than a year. In spite of the vacancy, project staff were involved in moving the Consortium forward along with their other responsibilities, but were not able to conduct the goal of 10 meetings per year.
- **In 2003 and 2004**, the Consortium reviewed its charge and modified its work plan. In **2005**, the group was trained on the new evaluation protocol for the newly funded HBI 3 and begun making a training manual/work plan for members.

Project Objective 2: To operate a community-based Healthy Birth Initiative II Consortium whose

consumer membership reflects the race/ethnic diversity of the project enrollment and whose general membership reflects the race/ethnic diversity of the project service area by 5/31/05.

Baseline: 2001/2002 project enrollment data indicated that clients were 62% African Americans, 24% Hispanics, 9% Asians and 5% Whites. The project area includes 21% African Americans, 10% Hispanics, 6% Asians, and 61% Whites.

Strategy: Increase Consortium members' effectiveness in influencing project direction so that it addresses community concerns and issues by having a membership that is reflective of the community.

Activities:

- Conduct culturally appropriate outreach to project participants and community members. **(On-going)**
- Provide orientation and ongoing training to Consortium members. **(December 2003)**

Accomplishments/Barriers:

- By **May 2005**, 50% of Consortium members were African American, 17% were Hispanic and the remaining third were White or did not provide this information.
- **During 2004**, the Consortium developed and distributed a press release designed to a) generate interest in the community about the poor birth outcomes African American and Hispanics were experiencing in the project area along with b) recruit new community members for the Consortium. Two newspaper articles resulted from this effort. Copies can be found in Appendix B.
- **Each year**, the Consortium was provided an overview of grant expectations and the health disparities the program was designed to address. Additionally, consumers were provided with leadership training in **2003**; in **2004**, Consortium members were trained on family violence intervention, stress reduction, and HBI program services; and in **2004** and **2005** the Consortium was provided with training on evaluation activities. All Consortium members were encouraged to participate in the **MEN 2003 and 2004** conferences that were developed by HBI and the related Preventing Family Violence Project.

Project Objective 3: By 5/31/05, 90% of Consortium members indicate that their participation in

Consortium activities have influenced the Healthy Birth Initiative II Project.

Baseline: A Consortium Member Survey was conducted in May 2005.

Strategy: Survey Consortium members annually asking their perceptions of effectiveness in influencing project direction and incorporate feedback into future strategies.

Activities:

- Provide Consortium opportunities to influence project activities. **(On-going)**
- Conduct Consortium Survey. **(Annually)**

Accomplishments/Barriers:

- **By May 2005**, 50% of the respondents of the Consortium survey, felt that the Consortium activities had influenced the project; the other half couldn't say one way or another. Factors that could help explain this response include the under-representation of clients in the survey response and the fact that the Consortium hit its stride after the program was well established—making it difficult to involve the Consortium in the development of project activities.
- The Consortium began to develop a community health campaign to increase the awareness of the racial/ethnic disparities in adverse birth outcomes. Additionally, members promoted HBI at events such as the African American Wellness Village.
- The Consortium was able to contribute to the project by identifying and prioritizing the education classes to be provided to community participants and identifying and prioritizing topics that they wanted their children to be taught while in childcare.
- The Consortium agreed to continue efforts to improve birth outcomes in the project area whether or not additional funding was secured to ensure the continuance of HBI.
- The Consortium is engaged in evaluation activities and has requested semi-annual evaluation updates on *health education and outreach activities*, *case management*, and *community mobilization activities* and will provide recommendations for improvements as needed.

Project Objective 4: By 5/31/05, the rate of low birth weight (<2500 g) live births among project clients will be 10% lower than the rate in the project area population for 1999.

Baseline: 8.0% (83/1037) of the 1999 births in the project area were low birth weight (<2500g). Source: Birth certificate data (Center for Health Statistics, Oregon Health Services).

Strategy: Conduct aggressive outreach in Northeast Portland to recruit women in first trimester. Case Management Team provides intensive case management services to Healthy Birth Initiative clients.

Activities:

- Outreach to service providers will focus on enrolling women in their first trimester of pregnancy. Therefore, Case Management Team will concentrate on agencies that are more likely to see women early in their pregnancy. **(On-going)**
- Continue intensive case management, which includes systematic client tracking and follow up, through delivery of the infant and two years postpartum. **(On-going)**
- Case managers and health educator will provide culturally appropriate parenting education to clients. **(On-going)**
- Collaborate with other organizations to develop a male support circle project in order to enhance the project's capacity to involve the male partners of our clients. **(On-going)**

Accomplishments/Barriers:

- By **May 2005**, the low birth weight rate for program participants enrolled during 2001-2005 was 9.8%. The program did not make its goal in part due to its shift to enrolling high-risk women who were well into pregnancy prior to enrollment.
- During **2003** the program made a shift in its enrollment policy and outreach efforts resulting in the enrollment of higher risk women and women much later in their pregnancies. Of the women entering the program *and* giving birth in **2003**, 22% had already recently given birth, 22% entered during the third trimester, 34% in the second trimester, and 19% during the first trimester. In previous years, the majority of clients enrolled during the first trimester. The rationale behind emphasizing first trimester enrollment was to maximize the possible benefits from case management for the entire length of the pregnancy. With the current statewide budget deficits and resulting reductions in wrap-around-services, more women residing in the project area were without needed services.
- Staff case managed women who gave birth to 197 babies during **2001-2004** and tracked whether postpartum visits were received. Approximately half of these women had verifiable postpartum visits from a Multnomah County Health Clinic. **During 2004**, 80% of the case-managed women received interconceptional medical care from the Health Department. Also in **2004**, 85% of interconceptional clients received services from their case managers
- All women were provided with health education information during home visits and approximately half of the case managed women also attended at least one education class.

- In **2003 and 2004** the program collaborated with the Preventing Family Violence Program and other community partners to develop the “Men Enriching Neighborhood Conference,” 150 individuals attended the conference each year.
- Approximately half of those attending the conference were men; and the overwhelming majority of attendees were staff of local social service agencies, health programs and schools. Throughout the project period, 62 men were involved with on-going program services. The male involvement component was unable to enroll the projected 60 men a year and had difficulties engaging African American men in on-going activities. Results from focus groups conducted during **2004** with African American women enrolled in case management revealed that women involved in the program did not want their male partners included. It is not known to what extent this reluctance played in the challenges faced in enrolling men.

Project Objective 5: By the 5/31/05, the rate of low birth weight (<2500 g) live births among African American project clients, will be 10% lower than the rate in the project area's African American population for 1999.

Baseline: 14.8% (35/236) of the 1999 births and 12.5% (32/257) of the 2000 births in the project area were low birth weight (<2500g). Source: Birth certificate data (Center for Health Statistics, Oregon Health Services).

Strategy: Conduct aggressive outreach in Northeast Portland to recruit women in first trimester. Case Management Team provides intensive case management services to Healthy Birth Initiative clients.

Activities:

- Outreach to service providers will focus on enrolling women in their first trimester of pregnancy. Therefore, efforts will concentrate on reaching agencies that are more likely to see women early in their pregnancy. **(On-going)**
- Educate community on issues related to infant mortality and healthy birth outcomes, to raise awareness of project program, and to educate perinatal providers about working with women experiencing domestic violence, drug treatment, or other risk factors. **(On-going)**
- Continue intensive case management, which includes systematic client tracking and follow up, through delivery of the infant and one year postpartum. Case managers and health educator will provide culturally appropriate parenting education to clients. **(On-going)**
- Collaborate with other organizations to develop a male support circle project in order to enhance the project's capacity to involve the male partners of our clients. **(On-going)**

Accomplishments/Barriers:

- During the project period the percent of African American babies born with low birth weight **(during 2001-2004)** has decreased to 12%—exceeding the goal for year four of 12.7%.
- Refer to the accomplishment/barrier information provided for **Objective 4**.

Project Objective 6: By 5/31/05, 95% of project participants will receive first trimester prenatal

care.

Baseline: Baseline: 79% (820/1037) of mothers in the project area in 1999 and 82% (869/1061) of mothers in the project area in 2000 received first trimester prenatal care. Source: Birth certificate data (Center for Health Statistics, Oregon Health Services).

Strategy: Conduct aggressive outreach in Northeast Portland to recruit women in first trimester. Case Management Team provides intensive case management services to Healthy Birth Initiative clients.

Activities:

- Outreach to service providers will focus on enrolling women in their first trimester of pregnancy. Therefore, Case Management Team will concentrate on reaching agencies that are more likely to see women early in their pregnancy. **(On-going)**
- Recruit Planned Parenthood representative for consortium. **(By 2003)**
- Continue intensive case management, which includes systematic client tracking and follow up, through delivery of the infant and two years postpartum. **(On-going)**

Accomplishments/Barriers:

- During the project period 76% of women giving birth during **2001-2004** received first trimester prenatal care. The project did not reach its goal of 95% in part due to the enrollment of women who were already past their first trimester of pregnancy. This decision was made in order to serve the women who were at the highest risk for poor birth outcomes and in order to be responsive to the community and the individuals seeking services.
- Refer to the accomplishment/barrier information provided for **Objective 4.**
- The Consortium was successful in recruiting a representative from Planned Parenthood to participate on the Consortium, but was unable to do so until **2004**; part of the difficulty was due to reluctance of non-profit agencies to commit staff resources outside their organization during challenging economic times.

Project Objective 7: By 5/31/05, 90% of Hispanic project participants will receive first trimester prenatal care.

Baseline: 65% (124/190) of Hispanic mothers in the project area in 1999 and 71% (118/166) of Hispanic mothers in the project area in 2000 received first trimester prenatal care. Source: Birth certificate data (Center for Health Statistics, Oregon Health Services).

Strategy: Conduct aggressive outreach in Northeast Portland to recruit women in first trimester. Case Management Team provides intensive case management services to Healthy Birth Initiative clients.

Activities:

- Outreach to service providers will focus on reaching women in their first trimester of pregnancy. Therefore, Case Management Team will concentrate on reaching agencies that are more likely to see women early in their pregnancy. **(On-going)**
- Continue intensive case management, which includes systematic client tracking and follow up, through delivery of the infant and two years postpartum. **(On-going)**

Accomplishments/Barriers:

- During the project period 72% of women giving birth during **2001-2004** received first trimester prenatal care. The project did not reach its goal of 90% in part due to the enrollment of women who were already past their first trimester of pregnancy. This decision was made in order to serve the women who were at the highest risk for poor birth outcomes and in order to be responsive to the community and the individuals seeking services.
- Refer to the accomplishment/barrier information provided for **Objective 4**.

Project Objective 8: By 5/31/05, reduce the percent of project participants who smoked during their pregnancy to 10%.

Baseline: In CY 1999 and CY 2000, 11% (114/1037 and 121/1061) of mothers in the project area smoked during their pregnancies. Source: Birth certificate data (Center for Health Statistics, Oregon Health Services)

Strategy: Conduct aggressive outreach in North and Northeast Portland to recruit women in first trimester. Case Management Team provides intensive case management services to Healthy Birth Initiative clients.

Activities:

- Provide tobacco use assessments for all participants. **(On-going)**
- Clients will be referred to smoking cessation classes that are currently available in the community. **(On-going)**
- The Health Promotion Coordinator will conduct a survey with clients to determine whether the program should provide any additional classes or groups to work on smoking cessation and relapse prevention. **(December 2003)**
- An improved intake questionnaire will obtain consistent information about client's smoking status. **(By July 2002)**
- Provide clients with tobacco education materials and smoking cessation support. **(On-going)**

Accomplishments/Barriers:

- The percent of women giving birth, who used tobacco, has decreased over the last three years from 25% to 12.8%; however, of the women giving birth during **2001-2004**, 20.2% still used tobacco.
- During **2001-2005**, no client successfully completed a tobacco cessation program. Incentives for clients participating and completing cessation programs might have improved the cessation rate.
- Program charts showed a consistently lower rate of tobacco use during than pregnancy than did the self-reported data on birth records. It is probable that screening for tobacco use was not done consistently during program activities. Staff could have benefited by motivational interviewing training and new procedures involving care coordination with medical providers.
- Case managers indicated that although they educated their clients about the negative impact of smoking, serious referrals to cessation services were not provided unless the client was contemplating quitting. Closer coordination with health care providers should have been emphasized to help motivate clients to quit tobacco use.
- In **2003**, An HBI education class on tobacco and pregnancy was attended by nine program and community participants.

Project Objective 9: To have 80% of clients report that education and training sessions assist in adopting healthier behaviors or increase knowledge regarding healthy pregnancies and infant health by 5/31/05.

Baseline: In CY 1999, 74% of clients surveyed reported that education and training sessions helped them adopt healthier behaviors or increased their knowledge regarding healthy pregnancies or infant health. Source: Client Survey

Strategy: Provide information and education to support women and families in having a healthy pregnancy and baby. Support and enhance existing efforts to inform, educate, and mobilize the community around infant mortality/healthy babies and the Healthy Birth Initiative Program.

Activities:

- Conduct support groups for clients that will include educational activities. **(Monthly)**
- Use Home Visiting Guide developed by Florida State University Center for Prevention and Early Intervention Policy as a tool for perinatal case management for both CHW and CHN. **(On-going)**
- Case managers attend continuing education classes related to perinatal health. **(On-going)**
- Provide health promotion workshops for clients to learn about SIDS, Childproofing the Home, First Aid, Car Seats, Poison, and Food Safety. **(Annually)**

Accomplishments/Barriers:

- During the fall of **2003**, 70% of HBI clients responding to a survey reported that HBI education and training increased their knowledge regarding healthy pregnancies and infant health; 86% reported that these services helped them adopt healthier behaviors. A client satisfaction survey was conducted during the fall of 2003 with the clients of the Healthy Birth Initiative (HBI). Of the 84 surveys sent, 37 were completed—a 44% response rate. Most of the women responding to the survey were satisfied with HBI, with 78% saying that they were “very satisfied” with the program overall.
- HBI sponsored five community classes during the spring of **2004**. The topics were selected by the HBI Consortium in the fall of 2004 and were paid for with carry-over funds from the previous year. All classes were open to the community. There were 83 participants attending these classes; 28 of these attended the English as a Second Language (ESL) classes and were not given an evaluation form (so these participants are not included in the response rate). Sixty-two percent of the individuals participating in the classes completed an evaluation form; 76% of the respondents indicated that they would definitely want to participate in additional classes about the same topic as the class they attended.
- **During 2003 and 2004**, all of the grant-required topics were covered *directly* during HBI conducted classes or were available either from the Northeast Health Clinic housed in the same building or the free statewide QuitLine.
- There were 67 class sessions offered during 2004, similar to the number in 2003. There were 12 Male Involvement classes during 2004, covering topics such as financial planning, acupuncture and herbal medicine, arrival of new babies, domestic violence,

STD and HIV, and emotions. Additionally, ESL classes were held and men comprised slightly more than half of the participants in the 23 sessions.

- During **2004**, HBI classes were attended by more participants than in **2003**, with 830 participants compared to 614; in 2004, 414 were community participants and 416 were female and male program participants.
- In both **2003 and 2004** fifty-three percent of the female case-managed clients participated in the HBI classes. This is the same rate as in **2003**. Of the female clients attending classes, the median number of sessions attended was three. One client attended 21 separate class sessions.
- All women enrolled during **2001-2005** in case management services, received one-on-one education from the Home Visiting Guide developed by Florida State University Center for Prevention and Early Intervention Policy.
- All program staff are employees of the Multnomah County Health Department. Employees of the Health Department have access to all trainings offered by Multnomah County. Additionally, individual staff members access numerous outside training opportunities. Training opportunities are available on an on-going basis. Training topics cover a wide array of areas including drug and alcohol use, family planning, violence intervention, charting, child development and accessing local services. Early Childhood Services offer trainings on a monthly basis and program staff are required to attend these technical in-services.

Project Objective 10: By 5/31/05, to have 80% of women clients report that their knowledge regarding healthy pregnancies and infant health has increased between intake and termination of services.

Baseline: Baseline: In CY 1999, 74% of clients surveyed reported that education and training

sessions helped them adopt healthier behaviors or increased their knowledge regarding healthy pregnancies or infant health. Source: Client Survey

Strategy: Provide information and education to support women and families in having a healthy pregnancy and baby. Support and enhance existing efforts to inform, educate, and mobilize the community around infant mortality/healthy babies and the Healthy Birth Initiative Program

Activities:

- Monthly Consortium meetings as an educational forum for clients and community members. **(On-going)**
- Educate community on issues related to healthy birth outcomes, including resources available to pregnant and postpartum women in the community. **(Start campaign by 2002.)**
- Conduct support groups for clients that will include activities as well as an education component. **(Monthly)**
- Continue intensive case management, which includes systematic client tracking and follow up, through delivery of the infant and two years postpartum. Case management includes education about and referral services to community resources. **(On-going)**
- Project newsletter produced quarterly and distributed to project area service agencies, businesses, providers and residences. **(By September 2002)**

Accomplishments/Barriers:

- Most of the women responding to the **2003** client satisfaction survey (70%) reported that the information and support they received from staff helped them “very much” with learning about healthy pregnancy and child development. Additionally, 86% the women said that the program helped them adopt healthier behaviors.
- During **2003**, the Consortium was responsible for identifying and prioritizing the education classes to be provided to community participants. Additionally, they were involved in identifying and prioritizing topics that they wanted their children to be taught while in childcare. Starting in **2004**, the Consortium began launching a three-part community-wide campaign designed to accomplish three goals: 1) increase awareness of the disparities that African Americans experience when compared to Whites, in infant mortality and low birth weight; 2) educate community members about the risk factors contributing to poor birth outcomes, such as drug use, smoking, insufficient folic acid, delayed prenatal care, and unexpected pregnancy; and 3) recruit program participants and community participants for HBI. As part of this campaign, members will be speaking with local media as well as designing all campaign materials with the Health Department’s Public Affairs Office.
- Both program and community participants are encouraged to attend educational activities. Similar to **2003**, all of the grant-required topics were covered *directly* during HBI conducted classes or were available either from the Northeast Health Clinic housed in the same building or the free statewide QuitLine. There were 67 class sessions offered during **2004**, similar to the number in **2003**. During **2004**, HBI classes were attended by more participants than in **2003**, with 830 participants compared to 614; in **2004**, 414 were community participants and 416 were female and male program participants. Fifty-three

percent of the female case-managed clients participated in the HBI classes. This is the same rate as in **2003**. Of the female clients attending classes, the median number of sessions attended was three. One client attended 21 separate class sessions. In the first six months of **2005**, 16 classes were provided to 291 participants.

- In **2003**, community outreach efforts reached 880 providers, consumers and community members. During **2004**, program staff had direct contact with 1460, most of whom were middle school students attending Intel's science fair. This opportunity allowed HBI to teach about birth control, health disparities, and healthy pregnancy. However, contacts for women of childbearing ages and social service providers were down from last year's level. Included in these numbers are the individuals participating in the HBI-sponsored "Men Enriching Neighborhood Conference," 150 individuals attended the conference in both 2003 and 2004. Approximately half of those attending were men; and the overwhelming majority of attendees were staff of local social service agencies, health programs and schools. The collaboration with the Reducing Family Violence Program was instrumental in the development of this conference.
- Case managers provided intensive case management to 409 perinatal women throughout the project period. All women in case management received education based on the Home Visiting Guide developed by Florida State University Center for Prevention and Early Intervention Policy as a tool for perinatal case management
- During **2004**, staff made 365 referrals to services in an effort to reduce or eliminate risk factors. Of the referrals made, clients completed 80% of these referrals. (Data collection on referral completion was improved during **2003-2004**. Data for earlier years is not complete.) In **2005**, the project developed a referral card, which clients bring back with verification of referral completion and then is kept in chart. Clients receive incentives for returning completed cards (and thus completing referrals).
- The newsletter was not developed due to vacant positions and limited staff resources. See Objective 1 for information about hiring difficulties. In addition, the Consortium decided that word of mouth and mass media would be better methods for reaching the community.

Project Objective 11: To reduce by 80% between intake and termination of services the proportion of women who report that transportation is a barrier to attending prenatal or well child medical appointments by 5/31/05.

Baseline: A January 2003 survey of program participants indicated that 47% (17/36) of program participants had been unable to get to doctors' appointments for themselves or their children prior to participating in HBI.

Strategy: Provide transportation services for women enrolled in the program for any activity that case managers decide is related to improving health outcomes for families, e.g. health care appointments, social service appointments, grocery shopping, personal appointments, and recreational activities.

Activities:

- Cab and bus transports will continue to be provided on an as-needed basis. **(On-going)**
- Further investigation into community supported transportation for clients. **(On-going)**
- Contract with a local town car company to provide transportation services for HBI clients.**(By September 2001)**

Accomplishments/Barriers:

- Of the clients receiving case management services in **2003 and 2004**, 70% received bus tickets or town car rides. Of the new clients completing an intake survey during the same time period, 66% reported that they have had problems getting to appointments because of transportation—indication that the percentage of clients receiving transportation services was somewhat higher than the percentage of the clients who were experiencing barriers resulting from lack of transportation. The use of an intake client survey was initiated in **June 2003** and will allow for better evaluation of this objective.
- During **2003**, HBI provided 2,385 bus tickets and 540 town car rides to the case-managed clients and their families in order to reduce the effects of transportation barriers. In **2004**, HBI provided 2,868 bus tickets and 756 town car rides to program participants and their families.
- More of these tickets and rides were for social service appointments, school, and job searches than in earlier years. The average number of rides per client increased from 4.5 to 6 and the number of bus tickets from 20 to 22 between **2003 and 2004**.
- A contract was finalized in **2002** with a local town car/taxi company in order to provide transportation services. Additional funds were received from the Northwest Health foundation to augment transportation resources budgeted in grant.

Project Objective 12: To reduce by 80% between intake and termination of services the proportion of women who report that childcare is a barrier to attending prenatal or well child medical appointments by 5/31/05.

Baseline: A January 2003 survey of clients indicated that 28% (10/36) of program participants said that before participating in the HBI project, lack of or problems with childcare prevented them from getting to doctor's appointments for themselves or their children.

Strategy: Provide child care services for women enrolled in the program for any activity that case managers decide is related to improving health outcomes for families, e.g. health care appointments, social service appointments, grocery shopping, personal appointments, and recreational activities.

Activities:

- Provide childcare through contracted services.

Accomplishments/Barriers:

- During **2004**, 2028 hours of in-home respite care were provided for program participants. This number of hours is comparable to **2003**. Additionally, childcare was provided to 50 children so their parents could attend the Consortium meetings and for 469 children so their parents could attend an HBI class.
- A contract was finalized in **2002** with a child care company in order to provide services. Additional funds were received from the Northwest Health foundation to augment transportation resources budgeted in the grant.
- Focus groups conducted in **2004** highlighted concerns program participants had with the childcare services provided during activities. The most common concern was that they didn't know the providers and would have preferred if program staff provided the care for their children. As a result of this concern, child care training for family members, program participants and community members was developed.
- With carry over funds, the program provided child care training in **June 2005** that resulted in certification for 20 community members. Those who completed the certification program were eligible to apply for work as a child care provider with the contractor and other agencies.

Project Objective 13: By 5/31/05, the rate of involvement in perinatal health, parenting, and family planning by fathers and other significant males who are partnered with female participants will increase by 30%.

Baseline: In a January 2003 survey, 72% (26/36) of participants indicated that their child's father or a male father figure was very involved in emotionally supporting their pregnancy, or their child's life and health care. Source: Client Survey

Strategy: To give individualized services to the young fathers (or prospective fathers) and their

families; to assist with goal setting; to discuss health/nutritional needs of the pregnant mothers, babies, and children; to provide informal counseling; and to help the fathers provide a safe and nurturing environment for their young children.

Activities:

- Recruit 40 fathers or other significant males who are partnered with female participants to participate in project activities. **(On-going)**
- Conduct weekly Health Education and Support Groups. Support group activities include: group discussions on topics related to fatherhood, parenting and other topics chosen by the group members; problem solving; age appropriate father/child structured play time; information sharing about current resources such as employment, housing, day care, etc.; and nutritional support. **(On-going)**
- Provide information and referral and assistance with crisis resolution. **(On-going)**
- Recruit five male participants to become part of the Consortium. **(By December 2002)**

Accomplishments/Barriers:

- On average, over the project period, 18 men were active in program activities each year. Hiring challenges (See Objective 1) delayed the hiring of the Male Involvement Specialist, until November 2003. During **2003 and 2004**, approximately 150 individuals attended each year's MEN's conference developed in collaboration between HBI, the Preventing Family Violence Program and the Men's Network. Half of these attendees were male community members and service providers. This conference focused on the health of men and their role in supporting healthy families and communities.
- There were 12 Male Involvement classes during **2004**. Additionally, ESL classes were held and men comprised more than half of the participants in the 23 sessions.
- Focus groups held in **2004** with African American program participants highlighted some issues possibly affecting the engagement of African American men. There was considerable discussion that male partners were not interested in participating. In addition there was agreement that they did not want to engage them in the program. This feedback was taken into account in the redesign of HBI 3. And although men will be welcomed to participate, there will not be a position responsible for involving them.

Project Objective 14: By 5/31/05, 80% of the project participants will receive interconceptional care, such as health services, family planning services and exposure to informational educational messages on the importance of interconceptional care.

Baseline: In CY 2001, 83% (64/91) of HBI clients received interconceptional care. These clients received a total of 446 visits. Source: MCHD Health Information System

Strategy: To provide interconceptional care information and referral to all project participants.

Activities:

- Conduct risk assessment of participants using the Contraceptive Health History tool.

(On-going)

- Complete the Health Seeking Behaviors Regarding Family Planning survey with each participant. **(On-going)**
- Provide interconceptional care education, including Folic Acid information. **(On-going)**
- Provide interventions, as appropriate, such as family planning. **(On-going)**

Accomplishments/Barriers:

- During **2004**, 80% of the women enrolled in case management services received interconceptional health care from the Multnomah County Health Department. During **2003**, 63% received interconceptional care from a medical provider. These percentages include only those women receiving health care from the health department and exclude those receiving care from other providers.
- Case managers followed Early Childhood Service protocol in charting and used appropriate tools.
- Education on both folic acid and family planning were offered in group sessions each of the project years as well as through one-on-one home visits.

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

HBI did not receive any technical assistance or mentoring from another site.

V. Project Impact

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

1. Describe the approaches utilized to enhance collaboration.

The existing perinatal system in the project area is a loosely integrated system comprising three major subsystems: 1) assessment and planning, 2) clinical service delivery and financing, and 3) wrap-around/service coordination services. These elements must be thought of in the context of a local health care services delivery system that is dominated by managed care, both in the public (Medicaid) and private sectors.

Multnomah County Health Department (MCHD) operates a Section 330 Community Health Center in the Project Area (Northeast Health Center). MCHD provides translation services for any client needing translation. The majority of clients needing translation services speak Spanish. MCHD also operates three school-based health centers located in or very near the Project Area high schools. These clinics do not provide prenatal services, but do provide family planning and acute and chronic primary care.

HBI's primary strategy for enhancing collaboration has been and continues to be its connection to the community. Collaboration occurs through referrals to and from project services, through case manager advocacy services, through contracting project services at community based agencies, and through the operation of the HBI Consortium.

The Willamette North Early Childhood Services (ECS) Team, located at the North Portland Health Center, provides in-home visits in the Project Area. The primary role of ECS teams is to provide services to families with pregnant and parenting women. Maternity case management services are provided for pregnant and postpartum women, with an emphasis on case management for women on Medicaid. Medicaid reimburses maternity case management visits, covering both the prenatal and postnatal period. Willamette North ECS Team members reported an unmet need in the area for intensive case management services, which HBI helped to address.

The HBI II Project addressed the gaps in the perinatal service system identified in the original HBI needs assessment. The HBI case management model improved the comprehensiveness of services by increasing the number of women/ families who received intensive case management services. In addition, the services follow women over a longer period of time, (through the prenatal and interconceptional periods, and until the infant's second birthday), to insure the ability to address multiple risk factors.

Unlike many service settings, case management services at the HBI II Project were provided by indigenous case managers who are culturally similar to the women with whom they work. The project provided a resource to other service providers (both medical and social service) who serve high-risk women.

In addition, the male involvement program was added to the HBI II Project to bridge the gap in addressing the needs of fathers and significant male figures in the lives of the project's women clients and their children. Prior to the HBI project, there were no resources for child care, and limited resources for transportation and translation services for high-risk women and their families. With the addition of the HBI facilitating services model, child care, transportation, and translation services are available to all project high-risk women and their families.

The project impacted the perinatal service system by enhancing collaboration and facilitating linkages among service providers. The Oregon MothersCare program was working with primary care clinics to increase access to early prenatal care. The MothersCare coordinator received referrals from the SafeNet hotline and worked with the HBI and ECS Teams. The MothersCare Coordinator assisted clients with Medicaid, Children's Health Insurance Program, and Family Health Assistance Program, and improved HBI clients' access to perinatal health services.

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

System integration is an important element to enhancing perinatal services in the project area and has brought significant changes to some of the procedures and policies within the system. The HBI and MCHD's Willamette North ECS Teams are integrated because of the Health Department's structure. They are an integral part of the ECS organization with the same manager and are considered to be part of the Community Health Services Group. MCHD adapted the Tallahassee home visiting system and documentation to fit the specific needs of HBI and the MCHD case managers in general. In addition, the referral system was modified so that clients would be directed to the appropriate team. The MothersCare representative became an HBI nurse instead of the general ECS team nurse.

Another change occurred when case managers learned that housing was a significant barrier to healthy pregnancies for the HBI clients. HBI staff had to work closely with the community organizations that assisted with housing and in several cases had to co-case manage clients because of the housing requirement that anyone receiving assistance had to be case managed by that organization. HBI case managers advocated for their clients and HBI was listed as an agency whose clients qualified for "Severe Housing" and was given priority when housing became available. Additionally, HBI staff became certified trainers to teach classes for potential renters, allowing them the opportunity to become "ready to rent" certified and eligible for public housing.

3. Describe key relationships that have developed as a result of Healthy Start efforts covering health service agencies and community members.

Because HBI was a part of MCHD, it benefited from the connections and relationships with health service providers previously developed by the Health Department. Relationships with the following were very important to the program: primary care clinics, three local hospitals (Emanuel, Providence and OHSU), the Urban League of Portland, Adult and Family Services, Child Services, Project Network, Albina Ministerial Alliance, Housing Authority of Portland, Oregon Community Warehouse and countless other social service agencies.

HBI also had relationships that focus on involvement of consumers and/or community. Examples include; Bishop Wells, a local minister and political figure, who supported HBI and helped to recruit other community leaders. He led the effort when the Consortium was trying to bring more agency representatives, community leaders, and service providers to the table by representing HBI in a media campaign. Representatives from the March of Dimes, Morrison Center, Self Enhancement Institute, MCHD Family Violence Program, Head Start and Project Network supported HBI by attending Consortium meetings.

4. Describe the impact that your HS project has had on the comprehensiveness of services particularly in eligibility/intake for social services, barriers to access, service utilization, and community awareness of services; care coordination, continuity of care, quality improvement and follow up system(s) for client referrals; and efficiency of agency records systems and sharing of data across providers.

A significant impact of the HBI Project on the comprehensiveness of services was the ability of

HBI case managers to stay involved with families more intensively and for a longer period of time. The consistency helped case managers bridge gaps for clients who previously would have fallen out of the system, or would have received inadequate care because they were not eligible for existing services. This level of involvement helped clients build confidence in their own abilities while the duration of intervention allowed the Health Department to truly serve high risk families. Prior to HBI, the Health Department was not in a position to assist the chronically high risk because of the limited amount of time case managers could spend with clients.

Unlike many service settings, HBI case management services were provided by indigenous case managers, who were culturally similar to the women with whom they partnered. The HBI project provides a resource to other service providers (both medical and social service) for referring high-risk women who previously might have fallen out of the system, or who would have received inadequate care, because they were not appropriate for existing services. The project also added two services that were consistently missing in the perinatal system for high-risk women: advocacy and care coordination among multiple service providers.

Following are some examples of how HBI case managers helped clients break through barriers to service. HBI encouraged clients to start prenatal care in their first trimester, so case managers worked with the Health Department's primary care clinics to ensure access to their clients. In addition, HBI case managers encouraged clients to use the services, helped them understand their rights and would even attend appointments with clients.

Also, given the housing shortage in Portland, HBI worked closely with housing agencies to help them understand the special needs of the HBI families. This collaboration resulted in many HBI clients receiving housing during the last two years of the program. Case managers also worked with community agencies to help clients overcome the barriers to obtaining food by providing regular weekly food boxes for clients in need. Aside from the services related to case management, HBI also promoted access to perinatal health care by providing transportation and child care services, which were two significant barriers initially described by women in the North and Northeast communities prior to the HBI Project.

Most of the mechanisms related to continuity of care, quality improvement and follow up systems were already in place prior to the HBI Project. Since HBI was a part of the MCHD ECS Team, it was able to benefit from the current system. The biggest impact HBI had on care coordination was in changing MCHD's system of case management. HBI demonstrated the benefits of coordinating case management between community health workers and community health nurses. The nurses were able to focus more on medical issues while the community health workers (CHW's) helped clients with connections to social service agencies and advocacy. This type of case management encouraged communication between the case management team. Also, such collaboration between the CHW's and CHN's coupled with the extended length of involvement with the families helped to assure there was continuity of care and more reliable follow up mechanisms.

Because HBI was a part of the Health Department, it followed the department's rule and regulations regarding sharing data. It was possible to share information within the department but special written permission was required to do so with agencies and providers outside of the

department.

5. Describe the impact made on the project by encouraging client participation in evaluation activities. Include impacts on client participation in care, provider sensitivity as well as assessment, intervention and tools used.

At the design phase of HBI II, stakeholders (who were consumers, providers, and community members) provided information that resulted in the final design. Specifically, the Male Involvement Specialist component, having indigenous community health workers, the provision of taxi rides rather than only bus tickets, and ensuring that services and materials were developed in English and Spanish were some of the major impacts of this feedback.

Over the course of HBI II, clients provided feedback through class evaluations, conference evaluations, satisfaction surveys, intake surveys, and through focus group participation. Some of the changes made to HBI II as a result of the information provided by clients includes the addition of socializing time at each group activity, the use of incentives for referral completion, the provision of childcare training certification to community members, the provision of English as a Second Language (ESL) classes, the provision of “ready to rent” certification classes, and the ability to link women with public housing. Whether the implementation of socializing time or referral incentives improves participation has not been measured yet, but will be as part of the formal program evaluation for HBI 3.

Feedback received from conversations with staff and participants about the satisfaction survey, the depression screening tool, and the violence screening tool used has resulted in investigation of shorter tools. This process is currently underway, and involves a literature review, conversations with stakeholders and ultimately a short-term pilot run with the new tools prior to any official adoption of new tools. HBI 3 will benefit from feedback regarding the need for culturally sensitive mental health services, through the addition of a Mental Health Specialist who has experience working with African American women and their unique stressors.

As part of the final evaluation of HBI II and the planning process for HBI 3, a broad cross-section of stakeholders from the target population was engaged in several activities. Focus groups were held with African American women enrolled in the current project to identify satisfaction levels with the current services and suggestions for improvements. The HBI Consortium was asked for input on unmet needs, possible collaborations not yet explored, service design, health education activities, and outreach activities.

Current staff of the program participated in a Strengths, Weakness, Opportunities and Threats (SWOT) analysis, during which they identified strengths, weaknesses, opportunities and threats to the current design. An additional SWOT process was conducted with field staff of other early childhood service programs serving the project area. Feedback received as part of these activities was used throughout the design of the current proposal. Whenever this feedback is used, it is referenced as coming from one of these activities. As a result of these activities, the following issues were highlighted as needs that the current program could address in a different manner. Table 2 highlights the feedback/suggestions made during this process and *the impact of each on HBI 3's design*.

Table 2: Identified Needs and Responses

NEED	RESPONSE
The Consortium wanted the program to develop a resource guide to increase community members' knowledge on how to access services already in existence.	HBI 3 will distribute an existing directory with additions/modifications specific to HBI clients.
The Consortium wanted to emphasize education/promotion about breast feeding.	HBI 3 will offer a class on the importance of breastfeeding and will collaborate with WIC and Oregon Mothers Nursing Council.
The Consortium wanted the program to continue to enroll women in HBI even if they are past the first trimester.	HBI 3 will enroll women up until the 4 th month, and will link other women to other services through Early Childhood Services
Staff wanted to have improved access to mental health services, especially the addition of an on-site Mental Health Specialist.	HBI 3 has a 0.8FTE Mental Health Specialist on staff.
Staff wanted to develop a referral tracking card with incentives to improve referral completion.	HBI 3 has implemented a referral card along with an incentive program to encourage the completion of referrals. The Program Evaluator will formally evaluate this process.
NEED	RESPONSE
Staff wanted to build opportunities in for program participants to co-teach classes and develop leadership skills.	(HBI 3 will have opportunities for clients to either teach, lead or mentor other women in the program under the direction of the Health Educator.)
Staff wanted a designated staff position responsible for group health education activities.	HBI 3 has a 0.8FTE Health Educator position on staff responsible for all group education activities and for training providers on culturally competent screening and service delivery.
Women wanted child care that they were familiar enough with to be comfortable when leaving their children.	HBI 3, like HBI II, will provide opportunities for program participants, their families, and community members to become certified providers. The program will contract with a community-based child care provider and encourage this contractor

	to hire the best candidates from this certification class.
Women want to have opportunities to meet, socialize, and learn from other clients/women.	HBI 3 like HBI II will have a time for socializing at the start of each group activity.
Women wanted activities held from 1-3pm rather than in the evening.	HBI 3 will provide classes at varying times to accommodate different needs.
Women wanted help finding affordable housing.	HBI 3, like HBI II both will offer “ready to rent” classes and linkage to public housing.
Women wanted advocates to help them take steps toward their goals.	HBI 3 has a formal objective that involves participants and case managers identifying personal goals and action steps. Case managers will undergo motivational training and clients will receive incentives for successfully completing actions toward reaching their goals.
Women wanted the program to be for them, not the men in their lives.	HBI 3 no longer has a Male Involvement Specialist position.
Women wanted education activities to include topics for them as women, not just as mothers.	HBI 3 will offer classes and recreational activities focusing on stress reduction, financial planning, and life planning.

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

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

The Consortium began the design of a three-part, community-wide campaign designed to accomplish three goals: 1) increase awareness of the disparities that African Americans experience when compared to Whites, in infant mortality and low birth weight; 2) educate community members about the risk factors contributing to poor birth outcomes, such as drug use, smoking, insufficient folic acid, delayed prenatal care, and unexpected pregnancy; and 3) recruit program participants and community participants for HBI.

Without this intervention spearheaded by the Consortium, there would not be any public campaign influencing awareness of poor birth outcomes nor resources available.

Two local newspapers, the *Skanner* and the *Portland Observer* both ran articles about the infant mortality rates and the programs efforts to reduce poor birth outcomes for African Americans. Copies of these articles are can be found in Appendix B.

2. Consumer participation in establishing or changing standards and/or policies of

participating service providers and local governments, that affect the health or welfare of the community, and have an impact on infant mortality reduction.

Feedback from participants resulted in the design of HBI II and the subsequent HBI3. The designs of these programs were made to improve participation in the program and the quality of the intervention. Both the participation rates and the quality will affect the health of program participants and ultimately the welfare of community participants and the community as a whole. *See the response to A5* for a description of the consumer participation resulting in these program/policy changes.

Perhaps the most important policy change resulting from consumer feedback is the refocusing of HBI to serve African American participants exclusively and to transfer Hispanic clients to other programs provided through other Early Childhood Services. Many discussions occurred with stakeholders—both in the community and in the Health Department. These conversations focused on the growing demand for services for Hispanics as they are the fastest growing ethnic population in Multnomah County. *(See the Sustainability section for more information on this trend.* In response to the tremendous increase of Hispanic clients, the Health Department’s Early Childhood Services (ECS) has recently developed Hispanic specialty teams who have the linguistic and culturally sensitivity to work with pregnant Latinas and their families. During the past year, the HBI Project Director has worked with the ECS manager to explore the possibility of high-risk pregnant Latinas being served through the regular ECS system. This was explored because the birth outcomes for Latinas in the project area have improved while improvements in birth outcomes for African Americans have been more modest. ECS has agreed to transition the Latina HBI clients into the ECS Latina specialty teams. These teams were not in existence four years ago. This transition will enable the continuing HBI project to focus more resources in the African American community.

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

During HBI II there were few opportunities to resolve conflicts because there were very few conflicts. There were a couple of misunderstandings that were dealt with before they could grow into conflicts. These misunderstandings were around the Consortium being part of the Community Health Council verses maintain its own identity and the confusion about the Consortium having oversight responsibility over the day-to-day operations of the program verses being charged with the development of health education activities. Both of these issues were dealt with in the early phases of HBI and slowed the establishment of the new HBI Consortium, but due to the sensitive leadership provided by the program management and the Health Promotion Coordinator, both issues were overcome. *(See the Consortium section for more information.)*

One conflict that did occur was around the development of the Preventing Family Violence Project, also funded by HRSA. This project offered HBI the opportunity to increase its screening and service for participants experiencing family violence. By the last two years of HBI, these two projects were fully integrated with the Manager of the Preventing Family Violence being instrumental to the success of the HBI Consortium; however, at the start of the violence project, there was some conflict. The conflict was a result of poor communication

between the staff working directly with HBI clients and the initial management of the violence project. HBI staff members have expertise addressing domestic violence and specifically dealing with it in the context of African American and Hispanic families.

Staff felt that this expertise was not fully appreciated when the violence project was conceived. Communication during the development and initial implementation of the violence project could have been better and could have prevented staff from feeling devalued. And although this perceived oversight was not intentional and conversations were held during the development, the HBI staff members were not included to the level they felt was necessary. As a result of this initial conflict, staff did not see the added value of the violence program until the new violence project manager was hired in 2003. This manager, Julie Goodrich, had credibility with staff as she had worked as a community health worker for many years and was able to demonstrate that she truly valued the experience and skills of the HBI community health workers. HBI staff did participate fully in the violence project's screening of their participants and collaborated with the project's MEN's conferences in both 2003 and 2004.

4. Creation of jobs within the community.

The program employed five indigenous case managers, a Male Involvement Specialist, a Community Health Nurse, and a Health Promotion Coordinator from the community. Additionally, leadership training was provided to community members participating as Consortium members. At the date of this reporting, two of the participants receiving leadership training were able to secure full-time jobs utilizing some of the skills learned. Also because of the opportunities provided for program participants, their families, and community members to become certified child care providers; at least 20 participants are prepared to apply for childcare positions.

Lastly, ESL classes were provided for Spanish speaking participants. There were 23 sessions during 2004 alone. These classes were the only free ESL classes in the project area and were by far the most attended of any other activity in the program. Limited English ability was cited by both female and male Spanish-speaking participants as the main barrier to employment.

C) Impact on the State: Over the past four years Healthy Start has supported activities to strengthen and develop relationships with the State Title V program. Describe the activities and impact that this approach has had on your relationship to the State Title V Agency, State Children with Special Health Care Needs Program(s), your state Medicaid and SCHIP programs, your State Early Intervention Program and other state programs. Highlight any benefits and lessons learned from these relationships.

The Oregon Department of Human Services, Health Services Section, is the State's Title V agency, and has MCH analysis and planning responsibilities for the state as a whole. Under Oregon law, most local public health service delivery and associated planning activity is delegated to counties. Periodic review of county MCH activities is a routine feature of the agreement which delegates MCH service responsibility to the county.

Prior to the HBI grant, there was close coordination between MCHD and DHS MCH staff. This coordination continued throughout the HBI project. MCHD staff participate on the MCH Committee Conference of Local Health Officials which acts in an advisory capacity on program and policy issues

to DHS. A MCHD staff member is on the Perinatal Technical Advisory Committee which advises the state on clinical issues. MCHD has an MCH representative on the Planning and Development team. The HBI project objectives were related to the needs identified in the State MCH Plan. The state Title V coordinator strongly supported the HBI project.

Because the relationship between the State and the MCHD already existed prior to HBI, the importance of working together in collaboration was already clear. The biggest benefit is for clients since this type of collaboration enhances the State and County's ability to provide services to clients.

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

As noted earlier, HBI partnered with the State to implement Oregon MothersCare. The program, built on a long-time relationship between MCHD and the State, helped to improve the perinatal system of care by connecting pregnancy testing to prenatal care providers. As a result of the long-term relationship between both parties, there were no real barriers to working together.

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

Some of these lessons learned may have been discussed already; however, they are important enough to be included again.

- The relationship with the State helps the clients as well as reduces duplication of services.
- Representation from the community served is critical to the program. The representatives should have responsibilities in determining program direction. This ensures the program is truly meeting the community's need.
- Be responsive to community feedback. Make changes accordingly and in a timely manner.
- The staff needs to reflect the diversity of the community. The role of the indigenous case manager is fundamental to success. Education degrees are not as important as life experiences. Sometimes sharing one's life experience can make more of a positive impact than anything else.
- Case management teams with both nurses and paraprofessionals better serve clients.
- Management must value evaluation in order for the team and community to value it.

VI. Local Evaluation

During HBI II there were three separate evaluation studies one studying outcomes, process and formative. Each of the following Local Evaluation Reports is included as a separate report in Appendix C.

1. Program Evaluation: *Using Low Birth Weight: An Update of a PDES Analysis for 1998-2003 data for Intensively Case Managed Clients.* **(Outcome)**
2. Program Evaluation: *Conducting Focus Groups with African American Women to Identify Reasons for Low Levels of Participation in Educational Activities.* **(Process)**
3. Program Evaluation: *Conducting Literature Review, Community Focus Groups and Stakeholder Interviews for Shaping Future Perinatal Services for Latinas.* **(Formative)**

VII. Fetal and Infant Mortality Review (FIMR)

The Multnomah County Health Department and the Healthy Birth Initiative does not participate in the FIMR.

VIII. Products

Copies of *Growing Health Families*, the Healthy Birth Initiative brochure and *Domestic Violence (Version for Mothers)*, the award-winning Healthy Birth Initiative education video are included with the hard copy of this report.

IX. Project Data

Please find the following required forms illustrating data for the project period in Appendix A.

Table A: Characteristics of Program Participants

Table B: Risk Reduction/Prevention Services

Table C: Healthy Start Major Service Table

Form 1: MCHB Project Budget Details (Jodi)

Form 5: Number of Individuals Served (Unduplicated) Program Participants

Form 9: Tracking Discretionary Grant Healthy Start-Specific Performance Measures