

**Louisville/Jefferson County Healthy Start
Impact Report for Past Project Period**

I. Overview

The Louisville Metro Health Department (formerly Jefferson County Health Department) completed a comprehensive needs assessment through a collaboration with the Louisville Metro Human Services. This initiative subdivided Jefferson County using the service boundaries of the eight established Neighborhood Places. After a demographic needs assessment was completed, the Health Department and Human Services deemed the areas of greatest needs. The Ujima, Bridges of Hope, and Northwest Neighborhood Places were designated as the Healthy Start Program areas. The Healthy Start area comprises 36 census tracts that make up these three neighborhood areas known for their poor maternal and child health indicators. Most of the Healthy Start area population families have incomes below poverty.

Louisville/ Jefferson County Metro, Kentucky, (Louisville Metro) unifies two former governments: Jefferson County and the City of Louisville. The Louisville Metro holds a population of 693,604 persons within an area of 397 square miles (land and water). The below chart provides a demographic snap shot of Louisville Metro:

Distribution by Population

Race/Ethnic Group	Population	%	Under 18	%	Over 18	%
Caucasian	536,762	77.0	117,464	17.0	419,257	60.0
African American	130,928	19.0	41,673	6.0	89,255	13.0
Hispanic/Latino	12,370	2.0	3,739	.5	8,631	1.3
Asian	9,640	1.1	2,363	.3	7,277	1.0
American Indiana/Alaska, Native Hawaiian, other	6,483	.9	2,223	.3	4,260	.6

2000 Census Data

As demonstrated in the above table, the African American population is 19% of the total Louisville Metro Population. In the Louisville Metro Healthy Start area, the total population is 90,110, and African Americans represent 66% of that number (59,597), Caucasians 31% (27,746) and Other represents 3%. In the HS area, African American women of child bearing age represents 67% of the total women of child bearing age. 18.5% of children in the HS area are under 18 years of age and live in families with incomes below the federal poverty level (2000 Census).

The initial needs assessment revealed that in 1997 the selected HS area had 1,355 live births of which 68% were African Americans. The infant mortality rate was 11.96 per 1,000 live births and African American infants represented 88% of total infant deaths (birth to 28 days) in the HS area. 80% of the total very low birth weight infants were African American in the HS area. Furthermore, 80% of births to women 17 years and younger were African American.

The needs of the geographic program areas are:

- **High rate of infant mortality**, two times the rate as compared to the rest of Louisville Metro (11.44 vs. 5.81, 1999-2001 average). In Ujima, which is one of the Neighborhood Place sites that falls within the HS area, is predominantly African American (AA) (95.08%) and had an IMR in 2002 of 24.22. In Bridges of Hope, the IMR for Whites was 6.54 compared to 15.77 for AA. Similarly, in the Northwest, the IMR for whites was 6.1 compared to 17.54 in AA. None of these infants that died in 2002 in the HS area were born to mothers that were HS participants.
- **Persisting disparities** in the IMR between Whites and the AA population. IMR in Whites 5.5 compared to 13.7 in AA. Which is twice the rate.
- **High rate of fetal deaths:** 14.9 per 1000 live births and fetal deaths (1999-2001) in the target population as compared to 7 in the entire Louisville Metro.
- **High rate of deaths from SIDS:** 2.14 deaths per 1000 live births in the project area as compared to 0.29 outside of HS area. (1999-2001 average)
- **Lower proportion of African American pregnant women living in the target area who receive early and adequate prenatal care:** only 81.3% AA women in HS area enter prenatal care in the first trimester as compared to 92.5% White women who enter PNC in first trimester. Similarly, only 76% AA received adequate PNC as compared to 85.4% of white women living outside of HS area or 81% of White women living in the HS area.
- **Higher percentage of infants born with Low birth weight (LBW) and very low birth weight (VLBW):** LBW births to AA women in the HS area = 11.5%; LBW births to White women living outside the HS area = 5.7%; VLBW births to AA women in HS area = 2.7%, VLBW births to white women living outside HS area = 1.5%.

The Healthy Start initiative was built upon existing care coordination and case management services provided through the Louisville Metro Health Department and the Neighborhood Place partnership. The project was constructed to develop and provide community based, culturally sensitive prevention and intervention services, with a goal to reduce infant mortality and morbidity in the project area. The original goals included:

- Reduce infant mortality within the project area;
- Increase initiation of prenatal care during the first trimester and improve the attitudes of residents in the project area by raising conscience levels of the importance of prenatal care and healthy life styles;
- Reduce incidence of low birth weight infants while reducing the birth rates and pregnancy rates of girls under the age of 18;
- Provide a basic continuum of care coordination and case management improving the overall health of residents in the area; and
- Enhance current systems of health and social services by full integration of the blended services concept.

In 2002, the beginning of this award period, 89.2% Metro mothers who gave birth began prenatal care in the first trimester compared to 82.8% of the mothers in the HS area. HS African Americans initiated prenatal care in the first trimester less frequently than whites in the area (81.2% vs. 87.0%). A delay in initiation by African American HS population probably

contributes to the lower unadjusted Kotelchuck index (measure of the adequacy of prenatal care) seen in the HS area (80.3% adequate) compared to Metro (89.2% adequate) in 2001.

II. Project Implementation

Healthy Start Initiative was built upon the current systems of care coordination and case management provided through the Louisville Metro Health Department (LMHD) and Neighborhood Place partners. LMHD's approach of case management was about a systematic service continuum of care coordination including 'base' case management services, comprehensive assessments, care planning, service delivery monitoring, follow up and active participation in the 'blended' or 'integrated' services concept. Located within three of the Neighborhood Place sites, the Healthy Start teams have provided direct services in an integrated environment. Not only has this encouraged all partners to utilize the expertise of other providers, it has also ensured that project consumers will receive the 'best' and 'most coordinated' services available within one building.

The five components of our intervention were

- Outreach/Client Recruitment
- Case Management
- Health Education and Training
- Interconceptional Care
- Depression Screening and Referral

Core Services: Outreach

A. Approach & rationale based on community needs. Outreach and client recruitment have been actively pursued in all project areas by the HS team directly or indirectly. The objectives of outreach/resource component is multi focused: 1) reach out to prospective clients in the HS areas, 2) increase name recognition and awareness of HS and benefits to grass roots, clients, prospective clients, family of clients (i.e. parents), social organizations, service/provider agencies, and area professionals, 3) recruit new clients, 4) engage current clients to utilize HS services and community resources, 5) facilitate clients to remain in the care system, 6) educate clients, 7) build client and community relationships, and 8) increase staff expertise.

B. Changes & rationale. HS staff participated in health fairs and neighborhood festivals, visited health care agencies, pursued grassroots organizations, barbershops, grocery stores, churches, and, canvassed door-to-door. In order to increase awareness and name recognition, in 2003 we used billboards, radio spots, bus shelters, brochures, posters and attended many community fairs and events to promote Healthy Start. The program outreach targeted playgrounds, laundromats, nail salons, and other places where women and children are come together: faith-based activities, after-school programs, bible school and summer camp. Every effort will be made to establish eligibility and immediately schedule the first visit. The staff also continuously worked collaboratively with the federally funded Family Health Center Portland and Park DuValle Community Health Center to identify clients appropriate for our program. We

collaboratively sponsored many functions with other community and Neighborhood Place partners to showcase services and identify potential clients.

- Outreach was conducted through radio and television advertising and billboard displays.
- Quarterly newsletters were sent to clients, collaborative partners, local health providers, and community churches
- Bus shelters were part of our advertising and marketing campaign, and were posted strategically in the three targeted neighborhood communities. Posters, public presentations, door hangers, and brochures proved successful outreach tools.
- Healthy Start Baby Shower was a new project that began at the end of FY 2003 and into FY 2004 with a goal of increasing client retention. In coordination with partnering agencies, Healthy Start clients were invited to bring a pregnant friend and attend a baby shower where a professional facilitated a fun event to learn important information and develop skills. Gifts were provided.

Healthy Start management has been instrumental in assisting and encouraging the staff in the processes of outreach activities through daily supervision and weekly meetings. Training regarding safety in the community, confidentiality, methods of referral and follow up, and training on cultural sensitivity continually are being provided. In order to track our progress the evaluator worked with the software designer to improve data collection, retention and processing. Healthy Start designed manual forms to collect data in areas the database is not designed to capture.

The current program evaluator conducts process evaluation of the program on monthly basis. As a result of these evaluations, it was found that 85% of the men in the program were non-case managed clients. Case-managed males are male clients with their partners not enrolled in Healthy Start. Follow-up of the case-managed male partners who were enrolled in the program was also not regular. These issues were brought to the attention of the nurse coordinator that supervised the men resource workers. They explained that it was very difficult for them to engage partners of our Healthy Start women clients since they were not getting any referrals from the female resource workers. The problem was then discussed in a staff meeting where the female resource workers were asked why they were not giving any contact information about the male partners of their clients. They said that the females were not comfortable giving out information about the father of the child that was a Healthy Start client. In view of this, it was recommended by the evaluator to target the outreach activities towards enrollment of men who were fathers and could potentially help in getting the female partners as our clients. But evaluation of these activities regularly suggested that we were not successful in engaging the desired target population for men's services. The young men who became Healthy Start clients frequently required assistance in attaining jobs. The need for a men's program is huge in the area but the target population we could enroll was not in alignment with program requirements. This is when the problem was taken to the level of the Deputy Director and the Director for decisions regarding the continuity of these services in the program. It was decided that since the program needed to target fathers and/or partners of our female clients, the services should be discontinued in the next cycle.

C. Resources or events facilitated or detracted from success or implementation. In the past several years the percentage of clients who did not receive prenatal care or received prenatal care late in pregnancy has declined from 3.69% in 1999 to 1.4% in 2003.

The evaluation finds suggested the project had positive impacts on participant health outcomes, infant mortality and teen births. A challenge was to outreach and serve *more* women and infants in need of services appropriate to their risk status. Data collection tools have been implemented and include IonIdea Case Management data system.

The HS program continued the different outreach activities that included: contacting and enrolling pregnant women referred by Medicaid Managed Care, canvassing the Bridges of Hope, Northwest, and Ujima Neighborhood communities to identify pregnant women, receive referrals from other local federal programs such W.I.C. (Women Infant and Children), maintaining and expanding relationships with providers of pregnancy tests to solicit referrals of pregnant women, distribute a variety of marketing and educational materials to women of childbearing age living in the project area, and educating partner agencies on the availability of Healthy Start services to maintain the flow of referrals.

Core Services: Case Management

A. Approach & rationale based on community needs. Nurse Care Coordinator, staff nurses, resource/outreach workers, social workers and Men's Services staff provided case management with a focus on home visitation. The nurses provided perinatal case management by conducting prenatal and postpartum home visits with the objective to educate and encourage the importance of good perinatal care. Prenatal and postpartum information packets are given to the client and regularly reviewed. The nurse gathered information and determined the level of medical and psychosocial risk through conducting the risk assessment for women and the Intake Evaluation for men. The strategies used were: aggressive identification and case management of pregnant women who were at high risk of delivering a LBA and VLBW baby; identification of women who were at high risk using a uniform assessment tool; provision of services to address high risk behaviors of pregnant women such as inadequate nutrition, harmful effects of tobacco, alcohol and other drugs, and unhealthy lifestyles; provision of intensive prenatal home visitation and referral; monitoring compliance with recommended treatment, referrals and "kept" appointments; collaboration with physicians and other providers to encourage appropriate risk assessment and services.

B. Changes & rationale. The appropriate staff followed up and provided care based on the level of identified by the Risk Matrix Tool. Weekly triage meetings ensured that the plan of care is current in addressing the clients' needs. The cooperative process for ongoing client monitoring is the hallmark of excellent services/care provided by HS staff, which included good documentation and enhancement of communication skills through training and experience.

Seventy-six percent (76%) of the Healthy Start prenatal clients enrolled during their first trimester of pregnancy, 18.9% enrolled during their second trimester and 1.4% enrolled in the Healthy Start program during their third trimester.

Each infant received a care plan that was specific to its individual needs. There were referrals made and education was provided to all parents. The activities used were as follows: refer infants to needed services as identified by plan of care; involve parent/caregiver in development of plan of care and educate about needed referral services; educate staff of appropriate referral/tracking procedures; assist parent/caregiver in obtaining appointments, as appropriate, and provide necessary facilitating services such as transportation; educate clients of importance of rescheduling in advance when unable to keep scheduled appointments. There is collaboration with First Steps and referrals were made to this program for children with special care needs. More efforts need to be made to accomplish this objective and to be able to measure it.

Since Healthy Start database was implemented, there were different data entry personnel involved. This factor might have lead to some missing data and/or underestimated percentage of the up to date immunized children.

C. Resources or events facilitated or detracted from success or implementation. The major barriers that the program faced throughout the project period were population migration, administrative changes, and high employee turnover. Other barriers, which prevented our clients from pursuing recommended services, are the lack of transportation and the unavailability of immediate appointments with the referred providers. By making the referral to recommended services the HS staff were able to relay to the provider the immediate nature of the problem, which helps clients obtain an earlier appointment. HS provides public transportation vouchers to assist with transportation needs. In addition cab services were provided for those with an immediate service requirement.

Other challenges. The Louisville/Jefferson County Metro Health Department and all its programs, including Healthy Start, faced metro-wide challenges during the grant-award period. On January 6, 2003, two governments merged when Louisville and Jefferson County formed the Louisville/Jefferson County Merged Government. As with any merger, new policies and procedures needed to be developed, staffing assessed, and it became imperative to review fiscal conditions under the newly structured government. As a result many changes occurred which were difficult for staff and impeded processes. Furthermore, the Louisville Metro Health Department director position was vacant and filled with interim directors during the search for a permanent leader. The permanent director is in place and his leadership has provided stability. In spite of these barriers, and challenges, the Healthy Start services continued and major programmatic successes were achieved.

100% of enrolled pregnant and postpartum women received education on interconceptional services including family planning. Based on the risk assigned to each client as well as the pregnancy outcomes, an individual health care plan is developed for every infant and mother.

Core Services: Health Education & Training

A. Approach & rationale based on community needs. The HS program conducted participant health education by first assessing the needs of the client and then providing appropriate education. Health Education was provided either one-on-one or in a class setting.

Nursing staff, resource/outreach workers and the health educator were all involved in health education activities. The staffing for health education was as follows:

- One health educator - supervised by the manager
- Three staff nurses - supervised by coordinators
- Nine resources/outreach workers - supervised by coordinators
- Two social workers - supervised by coordinators
- Three Nurse Coordinators - supervised by the manager

Other departmental health educators or outside trainers also provided appropriate training sessions (i.e. parenting classes, breastfeeding classes, car seat safety classes, healthy nutrition classes, tobacco prevention & cessation classes, etc). The nurses provided extensive prenatal and postpartum education; and the resource persons provided additional education during the monthly home visit, using the Growing Great Kids model. Employees of Healthy Start conducted most health education activities; no subcontracts were used. The program's employed staff conducted the proposed community participant health education activities and disseminated health education messages to HS program staff, consortium members, healthcare providers and the general population.

B. Changes & rationale. HS incorporated strategies to meet the multi-faceted needs of the community. Conferences and trainings for professionals, increased awareness of our services, and educated on healthy lifestyles, and risk reduction. Some of the core systems building efforts were:

- Talk Shops
- Parenting Classes
- Baby Store
- Brochures
- Books
- Newsletters
- Breastfeeding Education
- Program/ Partnering collaboration

The Talk Shop Program offered informative parenting education sessions based on the Family Focused Solutions Training model. HS clients and community members were informed of the latest parenting issues, resources within the community, and life skills. Meetings were held within the targeted communities. Transportation, childcare, and healthy snacks were provided as incentives for these sessions.

The program staff provided the following health education topics to the community participants:

- Parenting skills and infant care
- Infant growth and development overview
- Safety concerns including infant car safety, preventing burns, choking hazards and preventing falls
- SIDS and Shaken Baby Syndrome Prevention education
- Immunization and well childcare

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- Smoking cessation and education on the danger of environmental tobacco exposure on child

Talkshop

In 2001, 185 participants attended classes

In 2002, 293 participants attended classes

In 2003, 372 participants attended classes

In 2004, 678 participants attended classes

A committee that included members from the HS team planned the education component. Activities included quarterly newsletter, Baby Store, Books for Baby, Baby Showers, men's and grief conferences, and a video to showcase HS services and educate on healthy life-style choices. Activities are evaluated for effectiveness.

Louisville Metro Healthy Start uses many methods to accomplish the goal of individual and community education including:

- Group sessions
- Public presentations
- Training for health care professionals
- Participation at health fairs, and other events put on by community and faith based organizations
- One on one instruction by the nurse, resource/outreach worker, and social workers
- Written materials supplied by partner agencies (such as American Cancer Society, Heart Association, Family and Children First)
- Written material produced by our program such as the newsletters, brochures, posters, and handouts.
- Power Point Presentation
- Car Safety Seat Training
- Tobacco Prevention & Cessation Program

The Nurturing Parenting Program is based on the Bavolek model that was developed for parents of children, birth to five years of age. To retain and meet client needs, the program has been condensed to six-week sessions. This program builds basic parenting skills such as:

- Identifying parents role
- Forms of discipline
- Time management
- Supervision and safety
- Understanding your child's emotions
- HIV awareness
- Communicating and Cues
- Developing Values in Children
- Importance of a Male Role Model
- Smoking, Pregnancy & Second Hand Smoke
- Health & exercise before and after pregnancy
- Developing an Healthy Relationship

C. Resources or events facilitated or detracted from success or implementation. All education is tailored to the needs of the individual and printed materials provided which were checked to ensure they are culturally sensitive and have an appropriate reading level for the audience. Referrals were made to community resources, as needed, for services beyond the scope of Healthy Start. Outreach efforts and events are critical to the program. It ties the program and employees to the community to offer program ownership to our partners and clients. Outreach services complimented health education, Talk Shops, Men's Services, health fairs and community activities e.g. participation in forums, area schools, churches and community centers.

Core Services: Interconceptional Care

A. Approach & rationale based on community needs. Our target population primarily was low to no income African Americans, pregnant and interconceptional women at risk for a poor perinatal outcome; at risk for developmental delay or special health care needs infants and toddlers; other women of reproductive age; and fathers/male partners.

Enrolled pregnant and postpartum women received education on interconceptional services including family planning. Based on the risk assigned to each client as well as the pregnancy outcomes, an individual health care plan will be developed for every infant and mother.

The LMHD HS program provided the following interconceptional care services to women and infants/toddlers:

- Risk assessment
- Education
- Support and counseling
- Referrals as needed
- Depression screening
- Case Management which includes:
 - In-home nursing risk assessment
 - Mailed information, home visits and telephone calls
 - Individual care plan based upon the delivery outcome
 - Mentoring and encouragement to participate in family planning, as well as, programs to reduce risky behaviors as needed
- Access to the Healthy Start Store and transportation vouchers.
- Encouragement to participate in Talk Shops

B. Changes & rationale. The HS program staff (nurses, and resource persons) made contact with the typical interconceptional program participant monthly during the first year, and more often if requested or deemed necessary by staff. The program tracked whether a woman made a postpartum visit within six weeks of delivery by obtaining information concerning the program participant's six-week visit with her physician, reviewing interconceptional education during the postpartum home visit, recording the nurse's visit, documenting the completion of the postpartum visit in the program participant's chart.

The services that the interconceptional client received included:

- Risk assessment
- Education
- Support and counseling
- Referrals as needed
- Depression screening
- Case Management
- Resource information

C. Resources or events facilitated or detracted from success or implementation. The major barriers that prevented clients from pursuing recommended services were the lack of transportation and the unavailability of immediate appointments with the referred providers. By making the referral to recommended services, the HS staff was able to communicate the immediate nature of the problem, which helped clients obtain an earlier appointment with the provider. HS provided public transportation vouchers to assist with transportation needs. In addition cab services were provided for those with an immediate service requirement.

In attempts to overcome clients barriers all HS nurses, resource/outreach workers, social workers and health education specialist provided health education, promotion and support to the clients monthly throughout the interconceptional period.

Core Services: Depression Screening and Referral

A. Approach & rationale based on community needs. The Edinburgh Postnatal Depression Screen (EPDS) tool was used to screen our postpartum clients for depression. A nurse administered the EPDS at the time of the first postpartum contact or within eight weeks postpartum. With a client EPDS score of ten or greater counseling services were offered. If the client agreed to treatment services the nurse issued a referral to a mental health service provider such as Seven Counties Services, which is a health care organization that provides behavioral, chemical dependency and developmental services within our communities. Other referrals were made to Family Health Center Portland and University of Louisville Hospital Emergency Room. The mental health professional contacts the client with the date and time of the scheduled appointment. The HS nurse followed the outcome and status of the referral. Clients that missed scheduled appointments were urged to reschedule and seek treatment. Postpartum depression signs and symptoms were a component of postpartum education. The resource/outreach workers reinforced mental health issues on subsequent visits with the clients.

In 2003, 219 clients screened prenatally 3 referred

In 2003, 311 clients screened interconceptionally 35 referred

In 2004, 240 clients screened prenatally 8 referred

In 2004, 334 clients screened interconceptionally 12 referred

B. Changes & rationale. A nurse typically administered the EPDS at the time of her first postpartum contact with the client. The first postpartum visit is the only time that the EPDS was given and evaluated.

The nurse care coordinator was assigned to obtain information regarding the status and outcome of the referral made for the client. The referred agency notified the nurse care coordinator of the date and time of any scheduled appointments for the client.

The HS program educated other programs and community participants about the signs and symptoms of perinatal depression at the time of the postpartum home visit. Written materials concerning postpartum depression were reviewed and left with the participants.

C. Resources or events facilitated or detracted from success or implementation. Due to current budget deficits, the Seven Counties Counseling Services accepted only clients who have health insurance with mental health counseling benefits or who received Medicaid. For those clients without insurance a referral was made to Family Health Center Portland or University of Louisville Hospital.

The following formal linkages were developed with local perinatal and mental health providers: Jefferson Alcohol and Drug Addiction Center/Project Link, which provides services to pregnant women who are involved in alcohol or substance abuse or who are at high risk of using substances. An assessment for any client seeking services for alcohol and drug abuse through intervention case management was provided; and Seven Counties Services provided mental health services including counseling, education and prevention programs. High-risk women and infants were linked with primary and specialty systems of care through collaboration with Passport Health Plan, a referral source for the women who live in HS areas. Strong collaborative relationships were in place between HS staff and Neighborhood Place partners; Community Assessment and Planning Project (CAPP); Health Access Nurturing Child Development (HANDS), a statewide family support program based on the Healthy Families America and Resource Persons risk identification model; Family Health Center Portland; and area hospitals. To increase our linkages with providers during the fourth year of our program, we connected with pediatricians and private mental health providers through printed materials and presentations to health field associations and organizations.

Core Systems-Building Efforts: Local Health System Action Plan

A. Approach & rationale based on community needs. The Louisville/Jefferson County Metro Healthy Start Project is a catalyst for improvements and enhancements in the comprehensive system for perinatal care in the target neighborhoods and the community as a whole, as well as for improvements and investment in partnership efforts at the community, local, regional, and state levels to enhance health, education, and social services for vulnerable women and children. A goal of the initiative has been to identify the most cost efficient and effective interventions that can be replicated in other areas to improve perinatal indicators. The Local Health System Action Plan was under review due to changes in the leadership of the health department and the establishment of a new merged government that oversees all the activities of the department.

B. Changes & rationale. PPOR and FIMR have been implemented in Louisville/Jefferson County Metro. By using the PPOR findings, FIMR was targeted to the groups with higher mortality rates. Thus the gaps/problems in the perinatal system could be identified and followed by recommendations for changes. The lack of available resources hindered the process of using PPOR and FIMR. Funding for FIMR from March of Dimes ended, and the program supported this major component without additional resources. The HS program evaluator, who had taken the lead on Jefferson County's PPOR and FIMR activities, left the program for a CDC fellowship. A new HS program evaluator was hired in 2003 and has been continuing the PPOR and FIMR activities.

C. Resources or events facilitated or detracted from success or implementation. There have been many challenges to developing the LHSAP: lack of resources to perform needs assessment; political environment and the continuous change in this environment; turnover at the leadership level. There were delays in implementing some of the plans mentioned in the initial application due not only to the employee turnover but also to the changes in the administrative staff in HS and the Louisville Metro Health Department.

Other challenges to achieving the goals of the LHSAP that were noted were insufficient state/local resources, stakeholders did not take responsibility for implementing goals, goals were too large to be realized within the grant period, political climate (and the continuous changes in the political environment) was not supportive of the efforts, changes in the local health care environment; changes in the national health environment; categorical funding made it difficult to combine resources to reach goals.

Because the mission of the LMHD is "to protect, preserve and promote the health, environment and well-being of the people of Jefferson County principally through health status assessment, policy development and assurance," it is appropriate for this entity to encourage and facilitate perinatal health systems improvements. Also, as a founding partner of Neighborhood Places, it is well positioned to collaborate with other health, education and social service agencies to raise awareness and improve comprehensive systems of care that can improve birth outcomes.

The LMHD HS agreed on two priorities of the local perinatal system that would be addressed: 1) to fully implement Perinatal Periods of Risk/Fetal and Infant Mortality Review analyses and processes, and 2) to assess and intervene when clients disclose use of tobacco, alcohol, and other harmful drugs. Even though PPOR and FIMR were implemented in the metro area enough resources were not available to focus on the Healthy Start area. Furthermore, the HS program evaluator who helped initiate PPOR and FIMR resigned to pursue a CDC fellowship. The current program evaluator is restarting and continuing the work on PPOR and FIMR at the local level.

Core System-Building Efforts: Consortium

A. Approach & rationale based on community needs. The project was constructed to, develop and provide culturally sensitive community based, services that reduce infant mortality and morbidity in the project area. Therefore the Consortium was designed to reflect and foster the implementation of these goals. The main focus of the approach of building the Consortium

was to get endorsement from the community, both residents and professionals. The fundamental aspect of our approach was based upon the existing Neighborhood Place partnership and formed the infrastructure of the Healthy Start Consortium. The consortium has operated with the goal of empowering the community to shape needed services and offset barriers. Comprised of eight public agencies and representatives from the communities, Neighborhood Place has been a systemic network addressing community based needs through a consolidation of blended services and resources. The fact that the NP was already in place and was working well to facilitate comprehensive community change, was a distinct advantage to the HS program. Thus the rationale to locate our programs in the NP sites and start building the Consortium with the existing NP group of dedicated individuals and agencies.

Consequently, there was a substantial reduction in service's duplication; a more efficient client tracking system and the acquisition of new resources and the development of community-generated programming was enhanced. Neighborhood input into the design of programs has enhanced management's decision making processes. Additionally, through the consortia network, Louisville Metro Healthy Start (LMHS) has focused on cultural sensitivity. Individual beliefs, practices and family support (or the lack of) have bore tremendous impact on our project consumer's culture. These in turn have an effect on health-seeking behaviors or "compliance/noncompliance" of families in our communities. Guidance provided through the consortia has assisted Healthy Start in developing and providing in-service sessions to health and social service providers or agencies within the target area.

Other implemented approaches used included 1) recruiting members from the community, 2) conducting meetings, trainings, and events in the community, 3) public awareness in the community through all types of media (radio, TV, billboards, bus stop boards, written material, posters, newsletters, brochures, letters and phone calls).

B. Changes & rationale. The major component to building the Consortium was service providers, community agencies and consumers. The Neighborhood Place partnering agencies involved are: the Louisville Metro Health Department, Louisville Metro Department for Human Services, Jefferson County Public Schools, Kentucky Cabinet for Families and Children Department for Community Based Services Division of Family Support (Medicaid, KCHIP, Food Stamps, TANF, and protective and social services) and Division of Protection and Permanency, Seven Counties Services (regional mental health, developmental disabilities, and chemical dependency agency), and the Louisville Metro Government. These publicly funded organizations have offered resources from the Neighborhood Places. Oversight of the Neighborhood Place Managing Board has facilitated achieving this goal.

Because the scope of the managing board was broader than the Healthy Start Project, a more targeted group of community-based advisors has been developed. The Healthy Start Advocates met periodically since their organizational meeting on September 23, 1999. Partners included representatives of the three community councils, several clients including teens, Neighborhood Place agency partners, community health centers and other primary care centers, providers, hospitals, faith community, neighborhood organizations, youth service organizations, business,

university faculty, and local maternal and child health personnel, the Medicaid managed care partnership, and others.

The Advocates drafted a mission statement and goals and defined the customers and stakeholders to be impacted. These leaders and their teams have worked diligently to develop a dynamic strategic plan. Some of the positive aspects of the process have been the willingness of colleagues to guide and participate in the sessions and the degree of partnership involvement in accepting responsibility to implement defined activities. These partnerships continued throughout the project and are currently still in place and functioning efficiently.

Commitments to work with the Louisville Metro Healthy Start Project have been somewhat fluid. New partners have been frequently identified, and some have chosen to disengage as individual and agency priorities and affiliations changed. Leaders of the advocates represented consumers and providers. Co-chairs have been less involved than before, there was a long standing co-chair vacancy, and the members were reluctant to replace this position, thus requiring a change of responsibilities from some of the Advocates to HS Staff. Thus leading to more projects being implemented, and completed by HS staff, with management taking the lead. Throughout the project the purpose of the Advocates has been two-fold, to work with staff on achieving perinatal system enhancements and sustainability of effective project services, this continues today with almost 100 members.

The Neighborhood Place structure has continued to verbalize and demonstrate commitment to active consumer involvement. Incredible effort has been devoted to making these partnerships work. Residents and providers participated in frequent meetings, activities, and trainings. The project has also benefited from the active, well informed, and influential consumers and consumer representatives served on the Bridges of Hope, Northwest, and Ujima Neighborhood Place Community Councils. These individuals and their constituencies have been involved with the project on a day-to-day basis and provided consistent input to ensure that client and community needs were addressed. The majority of these contacts occurred at the neighborhood and facility levels and typically involved Healthy Start Project staff and/or Neighborhood Place Administrators. However, residents did not hesitate to contact council members in the project communities, the project director, the Director of Community Health Services, or the Director of Health. This level of involvement has strengthened the Healthy Start project and enhanced the consortium.

Neighborhood Place Community Councils met monthly. Neighborhood Place administrators provided staff support. Healthy Start staff, typically the coordinator, often attended these meetings. The project administrator, manager, Director of Community Health Services, and/or Director of Health participated as requested and appropriate.

Because the responsibilities of community councils have been so heavy and complex, Healthy Start business usually could not be considered in detail in these monthly meetings. Each council had a Healthy Start Committee composed of council members and others from the community. In addition, a Healthy Start Advisory Committee was organized which consisted of several representatives of the three community councils. The Northwest Neighborhood Place

Administrator, the project manager, and the three Healthy Start coordinators provide staff support. The committee met as needed to address project business common to the three neighborhoods.

The personnel components of the intervention were as follows: One full-time Community Health Administrator served as project consultant, advisor and provided oversight of the program. The administrator performs the role of administrative oversight and consultation to the program. 100% of the administrator's time was dedicated to this effort for all but the last year of the project, which was 60 % for the last year.

One full-time Community Health Services Manager serves as the Project Director for the last two years, where before that the Administrator served as the Project Director. The Manager was employed through the project to provide project management, assist with evaluation activities, ensure quality client care, and introduce evidence-based strategies through the Coordinators and with consultation from the Administrator.

Three full-time Community Health Services Nurse Coordinators. The Coordinators were responsible for the overall management of the project activities on a day-to-day basis at the individual Neighborhood Place Site (s). The Coordinator's responsibilities included, but are not limited to, planning, directing, and supervising the work of the Healthy Start multi-disciplinary teams. These individuals are RN nurses; approximately one-third of their time was to provide client assessment and case management.

One Office Assistant provided clerical support to the Project Director, as well as support to all Healthy Start locations. The Office Assistant dedicated 100% of her time to the project.

One Management Assistant provided clerical support for all Healthy Start locations, which included proper maintenance of records, scheduling appointments, and other related activities. The Management Assistant will dedicate 100% of her time to the project.

One full-time Community Health Education Specialist coordinated health education activities, provided technical assistance to each of the project staff to ensure that information and training was culturally competent and appropriate as to age and educational-level.

Two full-time Community Health Services Social Workers were budgeted under the project to conduct case management services for clients in all three sites. Under the supervision of the Community Health Service Nurse Coordinators, the social workers developed care plans, linking patients to community resources, and evaluated service delivery.

Nine Community Health Services Assistant II positions conduct outreach, participate in the case management team, and assist in ensuring quality service delivery. They will conduct outreach activities and work with the Healthy Start team with the eliminating disparity module. Each will dedicate 100% of their time to the project.

Three full-time Community Health Nurses. Each will dedicate 100% of their time to the project. The Nurses, who are RNs, will perform case management services, interconceptional care, and quality assurance for all Healthy Start locations. All of the nurses will conduct home visits, serve as a liaison with the patient's physician, and provide perinatal and interconceptional case management services.

C. Resources or events facilitated or detracted from success or implementation. During this project period the LMHS has experienced many changes beyond the program management or staff control that detracted from the implementation and success of the interventions. The major change was merger of two governments. The LMHS project is governed by the Jefferson County Health Department, this governance continued throughout the project (the name changed). The Health Department was already a joint City/County agency but was governed by Jefferson County Government. On January 6, 2003, two governments merged when the City of Louisville and Jefferson County government formed the Louisville/Jefferson County Merged Government, known as Louisville Metro Government. The Louisville/Jefferson County Metro Health Department and all its programs, including Healthy Start, faced metro-wide challenges during the grant-award period. As with any merger, new policies and procedures needed to be developed, staffing assessed, and it became imperative to review fiscal conditions under the newly structured government. As a result many changes occurred both before and after the actual merger date, which were difficult for the staff and impeded processes. Many essential activities were put on hold until new policies could be designed, and implemented, which took months. One example of process difficulties was the changes in the purchasing process. For obtaining approval of vender contracts (i.e. goods and services) the employees were required to resubmit the paper work multiple times as a result of changes in forms, format, process, and chain of command. This prohibited the program from purchasing needed items in a timely manner. Approval for hiring staff suffered the same fate.

Louisville Metro Government implemented several layoffs, salary cuts, benefit reductions, and hiring freezes that led to loss of staff through the layoffs, resignations and retirements. Furthermore, the Louisville Metro Health Department director position was vacant and filled with interim directors during the search for a permanent leader. The permanent director is in place and his leadership has provided stability. In spite of these barriers, and challenges, the Healthy Start services continued and major programmatic successes were achieved. The low moral, fear of job loss, staff shortage, difficulty of securing required resources, changes in responsibilities and work load, management changes (manager and Health Department Director) and systems issues (changes of policies, procedures, forms, and time recording), all contributed to the problems.

The program Evaluator left the agency for another position, and due to hiring freeze the position was vacant for almost a year. A new program evaluator was recruited and hired in October 2003. The commitments from the community members, local agency professionals, and consumers to work with the Louisville Metro Healthy Start Project were somewhat fluid. Leaders of the advocates represented consumers and providers. The Co-chairs have been less involved in the grant project then the one before, there was a long standing co-chair vacancy, and the members were reluctant to replace a non-attending co-chair.

The following events and resources facilitated the successful initiation and implementation of the consortium; 1) NP support and system was already in place, 2) our sites and offices are located in the NP buildings which are located in the communities we serve, 3) determined and dedicated management staff, 4) meeting places in the community, 5) commitment to the program and its goals by the local agencies that the goal of the program.

Core System-Building Efforts: Collaboration Local Agencies and Title V

A. Approach & rationale based on community needs. In Louisville, Kentucky, the Louisville Metro Health Department is the main Title V agency, which address community needs and services in the area of maternal and child health. The department receives support from and is linked to the Kentucky Department of Public Health Maternal and Child Health Bureau. Through this linkage the local HD worked in partnership with the state Title V office to implement appropriate components of the state and local perinatal systems of care. Some Title V employees were members of the Healthy Start Advocates and have participated in the development of that group's strategic plan.

The Kentucky Bureau of Maternal and Child Health and the Louisville/Jefferson County Metro Health Department collaborated to address racial disparities in infant mortality, as well as in poor pregnancy outcomes such as low birthweight and prematurity. Division Director James S. (Steve) Davis, MD serves on the Kentucky Chapter March of Dimes Program Services Committee. Brenda Chandler, Maternal and Child Health administrator, is the state liaison for HS.

The Kentucky Fiscal Year 2001 MCH Services Title V five-year Comprehensive Needs Assessment and Block Grant Plan identifies priority perinatal and early childhood service needs which are pertinent to the Louisville/Jefferson County Metro Healthy Start Initiative. The state's goal is to set Kentucky on the path to achieving economic opportunity and a standard of living above the national average in twenty years. The plan summarizes current status as follows:

To reach the state goal, the Title V plan targets efforts toward the core public health functions (assessment, policy development, and assurance), primary prevention, and reducing health disparities. As Louisville/Jefferson County Metro and the majority of other Kentucky local health department's transition away from the direct provision of health services to population based and infrastructure services, the Department for Public Health (KDPH) provides more flexible funding to encourage communities to assess and address local needs and emphasize primary prevention:

- Increase the percentage of families receiving support services/parenting assistance through home visiting support programs.
- Increase the number of fetal and infant deaths that are reviewed by a multidisciplinary team.
- Increase the percent of coroner case child deaths undergoing multidisciplinary investigation.
- Increase the percent of children with appropriate weight for height.

- Reduce the percent of young people who smoke.
- Decrease the rate of substantiated reports of child abuse, neglect or dependency.
- Increase the percent of primary care providers in KY who are competent and willing to serve as medical homes for children with special health care needs and assure that each Commission enrolled child has a medical home.
- Assure that children with special health care needs enrolled in the Commission receive comprehensive coordinated care.

Besides the collaboration with Title V, the other collaborative efforts on-going in 2003 were:

- Community Assessment and Planning Project (CAPP). Neighborhood Place Partners, Neighborhood Place Community Councils, and other groups participate in this dynamic process.
- Health Access Nurturing Child Development (HANDS), a statewide family support program based on the Healthy Families America and Resource Persons models of risk identification.
- Project Link provides comprehensive services for chemically dependent pregnant women through intervention case management. HS staff uses Project Link as a referral source for alcohol and drug abusing pregnant and postpartum women.
- Faith community and a network of community ministries is a major asset. Churches and linked parishes collaborate with Healthy Start.
- The Kentucky Children's Insurance Program (KCHIP) is a Medicaid expansion program to cover children with family levels up to 200% of poverty levels that works collaboratively with Healthy Start to promote KCHIP enrollment.
- Metro United Way (MUW) is a major community partner in the assessment, planning, and funding of human services. In April 2000, Success by 6 Initiative was undertaken under MUW leadership to ensure that children entering school are prepared to succeed. HS collaborates with MUW to promote services to the children of the community and both programs. In collaboration with MUW, HS was awarded a Dollar General Literacy Foundation Grant in 2002.
- High-risk prenatal care and all deliveries are provided through an agreement with University of Louisville Dept. of Obstetrics and Gynecology and the University Medical Center. UL operates a primary care center in the area used a significant number of project area residents for perinatal services.

B. Changes & rationale. The collaboration of the Healthy Start Initiative will continue with the Kentucky Bureau of Maternal and Child Health. The Louisville Metro Health Department will continue working in partnership with the state Title V office to implement appropriate components of the state and local perinatal systems of care and plans to further strengthen its collaboration with this office. Healthy Start continues to strengthen its collaboration with March of Dimes and has expanded March of Dimes involvement in the Healthy Start Advocates Committee. The Fetal and Infant Mortality Review Project that had been supported by March of Dimes is another example of collaborative efforts between Healthy Start and March of Dimes.

C. Resources or events facilitated or detracted from success or implementation. At state and local levels there is awareness that additional improvements in perinatal health status

indicators will not be achieved by medical interventions alone. Community consortiums that address economic, social, educational, and cultural factors with significant involvement of residents of neighborhoods to be served are in place to be expanded. With Healthy Start funding, the infusion of resources will be reinforced and has the propensity to make a difference in the lives of residents.

From the conception of the Louisville Metro Healthy Start Project, Neighborhood Places (NP) has been, and remains, the Community Based Consortium. The Managing Board of the Neighborhood Place, which includes representation from partnering agencies and from Neighborhood Place Community Councils, is the Consortium under which the original application was made. The Healthy Start Advocates expanded the representation from the larger community and has served as an advisory group to the Neighborhood Place Managing Board. The Neighborhood Place Managing Board has been involved in establishing policies that govern the Neighborhood Places and the Healthy Start Project. Some local decision-making that effect particular service areas has been delegated to the community councils. This was appropriate because the community councils are composed of individuals who are consumers, residents, providers, and business leaders in the neighborhoods. A Community council consists of 15 to 21 people, two thirds being residents and the remaining one third being business or other people invested in the area. At least one third of the total are or have been consumers of services from the partnering agencies. Following the initial recruitment, each council selects its own additional members and also selects one member to represent the council on the managing board. As mentioned before, the decision making body for Neighborhood Place is a Managing Board comprised of one representative of each agency and one representative of each of the Community Councils.

Healthy Start also continued to collaborate with Passport Health Plan, the Medicaid Managed Care Provider that has been a strong referral source for the women in the Healthy Start areas. Strong collaborative relationships that are already in place between the Healthy Start staff and the staff of other Neighborhood Place partners will continue and coordinated services will be provided to empower families.

The Neighborhood Place partnering agencies have been the Louisville Metro Health Department, Louisville Metro Human Services, Jefferson County Public Schools, Kentucky Cabinet for Families and Children Department for Community Based Services Division of Family Support (Medicaid, KCHIP, Food Stamps, TANF, and protective and social services) and Division of Protection and Permanency, Seven Counties Services (regional mental health, developmental disabilities, and chemical dependency agency), and Kentucky Children's Health Insurance Program (KCHIP), Fetal and Infant Mortality Review (FIMR), the Louisville/Jefferson County Primary Care Association, Passport Health Plan (Medicaid managed care), the Community Partnership for the Protection of Children (CPPC), the Jefferson County Childhood Lead Poisoning Prevention Program, and First Steps (the Kentucky Early Intervention System that serves children from birth to age three who have a developmental delay or a particular medical condition that is known to cause a developmental delay). Healthy Start staff participated in the organization of the Metropolitan Asthma Coalition convened by the American Lung Association.

Core System-Building Efforts: Sustainability

A. Approach & rationale based on community needs. The Louisville Metro Healthy Start Project goals are to offer expanded and enhanced service models known to improve perinatal outcomes. Project funds do not duplicate existing resources but enable appropriate services to be provided to more residents of the three project neighborhoods. This has a synergistic effect that enhances the impact of Title V, Title X, Title XIX, Title XXI, state, and local resources. Louisville/Jefferson County Metro Healthy Start has been successful in securing state funding for the HANDS paraprofessional home visitation model and Title XIX reimbursement for perinatal case management and EPSDT Outreach to eligible clients. As a result, critical project services have been sustained, and care can be offered to additional residents in the community. Collaborative efforts with the KCHIP program have ensured that the HS children have adequate medical insurance coverage.

Through collaboration with other Neighborhood Place partners, client families have direct access to an array of social, educational, mental health, and employment benefits as well. This coordinated approach to service delivery enables HS clients to establish goals for themselves and their children designed to achieve optimal health and self-sufficiency.

This approach will enable the partnerships between the community and service providers, the links between the consumer to the referral systems, the agency to agency partnerships, and the connections from the consumers to services to sustain even if HS program was not refunded.

Strategies were developed by the Healthy Start Advocates to improve the data collection, the services offered to community, to better involve all community in the HS process as well to make a plan for future collaborations and project sustainability. Healthy Start Advocates proposed to revise the strategic plan and update the different components of this plan. As a result of this proposal, changes were made in the goals and objectives of the initial strategic plan and it was presented to the Healthy Start Advocates for final review and approval.

B. Changes & rationale. The following interventions components were identified to sustain the HS Project beyond the Project Period:

- To enhance the collaboration with state Title V MCH Administration for the purpose of furthering Healthy Start goals and objectives into a state-wide plan.
- To solicit additional grant opportunities with maternal child health agencies that complement the HS goals and objectives.
- To continue the reestablishment of partnership with the local Medicaid Managed Care provider, Passport Health Plan. Initially, the partnership consists of open dialogue regarding client needs and the possibility of sharing data.
- To enhance the collaboration with the two Family Health Centers in the targeted area. Nursing staff goes to the Family Health Center sites on a weekly basis and recruit and enroll eligible clients for HS program.

In the past Louisville Metro Health Department had a contract with the local Medicaid managed care organization (Passport Health Plan, PHP) performing nursing home visits to the perinatal

population (the Mommy and Me program). The contract with PHP has ended and Health Department has not been able to obtain third party reimbursements. Attempts were made to work with PHP to develop strategies for Healthy Start's access to third party reimbursements for the home visits provided by the nursing and social worker staff members. This was not successful due to cost factors. In FY 2003, another major local change, rational for the inability to move forward in the time planned, was the establishment of a new merged government. The new Metro Government involved a new mayor, a new cabinet system, changes in purchasing procedures, a different system for contract approval, and a different finance/budget system. Furthermore, the Health Department has had several department director changes in the past four years and after having three interim directors, the department has hired a new director, Dr. Troutman. With the stability provided at the new leadership level, Healthy Start is continuing to address the problems surrounding third party reimbursement, bring the decision makers together and working on strategies to seek these sources of revenue for the program.

The Consortium along with Neighborhood Place partnering agencies has a direct role for the sustainability of the HS program. Components for sustainability include: Consortia members have been directly involved in lobbying efforts and have been the voice for HS program. They have met with the congressional members seeking their support for HS and it's continued funding. They also have been active in promoting the program to local legislative representatives and sought new sources of funding for the program. The HS consortia members attend the March regional conference in Atlanta and planed to attend the National Healthy Start Association meeting in Washington D.C. This intervention was changed in that the members were unable to attend the conference due to the Metro Finance prohibiting the payment in advance of travel funds to non-employees. The Consortia members were encouraged and given tools and support to write and phone their representatives in Washington D.C. and to continue advocacy at home.

The Neighborhood Place partner agencies that are all publicly funded organizations, offer services within the N.P. These partners are continuously looking at ways to improve and streamline service delivery and seek new funding sources for sustainability. An ultimate goal is not only to sustain project services but also to replicate effective and efficient modalities in other high need areas of the community to improve perinatal delivery systems and health outcomes. The best practices of Healthy Start and other N.P. initiatives are continuously being reviewed by Neighborhood Places and it's governing body.

Other interventions: the grant monies earmarked for partnership development and support were of value in engaging necessary collaborators and pursuing project goals and activities. Funds used for a share of the cost of a manager on contract to oversee Electronic Public Health Record training and implementation resulted in the initiation of the case management component to record Healthy Start services. This database was necessary as an automated system for capturing and retrieving project data required for reporting and care coordination.

C. Resources or events facilitated or detracted from success or implementation

Detracted:

- Cost to the agency to set up a third party billing system (see more details in B)

Facilitated

- The March of Dimes Prematurity Summit in the Fall of 2004 offered excellent training and awareness for staff, consortium members, consumers, and the community partners. The March of Dimes funded this daylong Conference featuring expert presenters.
- Travel expenses of the Healthy Start Project Manager who participated in a Perinatal Periods of Risk collaborative meeting was paid for by partnership funds.
- Our department has been participating in the CityMatCH Data Use Institute meetings and the Epidemiologist/Evaluator's expenses were paid for by CityMatCH and HS funds.
- Both, PPOR and Data Use Institute collaborative require participation in conference calls, communications with other team members for establishing a network of those working in MCH field. Teleconference telephone and speakers were purchased with the partnership funds that have enabled us to join in with other partners.
- Continued collaboration of our department with Kentucky Department for Public Health has been very important in the implementation of both, PPOR and FIMR. These collaboration activities were supported by Kentucky Department for Public Health funds, which include communicating with the Title V administrator, as well as with the State Vital Statistics Division for getting current state data (birth and death data). A color laser printer was also purchased to help in the production of professional color reports with graphs and color maps. Health Department funds were used for these purchases.
- The Healthy Start Project Administrator, Nazenin Assef, participated in the Kentucky Public Health Leadership Institute (2003-2004) sponsored by the Kentucky Department for Public Health and offered by the University of Kentucky. All travel expenses were paid for by the Kentucky Public Health Leadership Institute. The employee's time was provided by Louisville Metro Health Department.
- The Healthy Start marketing campaign has raised awareness of the initiative throughout the target area. To sustain this level of awareness among prospective clients and community partners and to maintain the engagement of current clients, additional incentive items were needed. These included the very popular canvas tote bags, which has been used by staff as they provide services and interact with the community. Items for infants have also been distributed during home visits to encourage clients to receive staff into their homes. Refrigerator magnets including the Neighborhood Place phone numbers have also been a useful tool for facilitating telephone contacts with workers.
- Another means of sustaining interest in project services has been the branded uniform pieces worn by project staff. The uniform items although purchased with Health Start funds are supported by key community and Health Department funds as they wear the uniforms at community events while their salary and expenses are being paid by other program funds.
- HANDS covered the trainer costs for the training of the LMHS paraprofessional home visitor staff in the Growing Great Kids Curriculum staff
- Metro United Way funds were used for a dual marketing campaign with the Metro United Way Success by Six program targeting the Healthy Start geographic areas. This is an effective client outreach and recruitment method for both programs.

Developmental educational children's books were purchased for HS families for the Literacy Project using Metro United Way funds.

- TARC is the transportation system in the Louisville, Jefferson County area. The Healthy Start consumers use the TARC system for their transportation needs and TARC extended a previously established contract with HS through this grant period to provide TARC tickets to HS consumers as needed.

D Consortium

1) The establishment of the Consortium. The Consortium Model formed the infrastructure of strategies inherent to the Louisville Metro Healthy Start Initiative. Based upon the existing Neighborhood Places partnership, the consortium was established and has operated with the goal of empowering the community to shape needed services and offset barriers.

The Louisville Metro Health Department believes a healthy community can be reached only through agency collaboration. The largest such collaboration is that with the Neighborhood Places. Neighborhood Places offer an array of health, education, employment and human services designed to help families gain and sustain self-sufficiency. Neighborhood Place has succeeded in bringing together four public agencies (Louisville Metro Government, Kentucky Cabinet for Health and Family Services, Jefferson County Public Schools, and Seven Counties Services, Inc.) to create a network of services, not in one central location, but in the communities where families who need Neighborhood Places live. The partner agencies do not operate in a vacuum. Community Councils help guide the decision-making process.

The Neighborhood Places mission is: Neighborhood Places works with communities in Louisville Metro, Kentucky, to provide blended and accessible health, education, employment, and human services that support children and families in their progress toward self-sufficiency.

The following are services offered at the Neighborhood Places:

- Alcoholics Anonymous and Narcotics Anonymous meetings
- Child Care Eligibility
- Child Protective Services
- Communicable Disease and Blood Pressure Screenings
- Community Outreach
- Community Partnership for Protecting Children
- COP Program
- Domestic Violence Information Sessions
- Emergency Financial Assistance
- Family Assessment
- Family Case Management Services
- Family Planning
- Food Stamps
- Head Lice Checks
- Health Clinic; Primary care and preventive services
- Healthy Start Initiative

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- HIV Testing
- Immunizations
- Information and Referral: School Social Services and Truancy Referrals
- Juvenile Delinquency Prevention Program
- Kentucky Temporary Assistance Program
- Lead Tests
- Legal Aid: Concerning Spouse Abuse and Domestic Violence Information
- Linkage with Employment/Training
- Mediations
- Mental Health Counseling And Referral
- Neighborhood Youth Board
- Perinatal Case Management
- Pregnancy Tests
- Sexually Transmitted Disease Tests
- T. B. Skin Tests
- Women, Infants and Children Nutrition Program (WIC)

Comprised of four public agencies and representatives from the communities, Neighborhood Places has been a systemic network addressing community based needs through a consolidation of blended services and resources. Consequently, there was a substantial reduction in service's duplication; a more efficient client tracking system and the acquisition of new resources and the development of community-generated programming was enhanced. Neighborhood input into the design of programs has encouraged management and decision-making processes to be enhanced, using funds that provide avenues for innovated prenatal and family services. Additionally, through the consortia network, Louisville Metro Healthy Start (LMHS) has focused on cultural sensitivity. Individual beliefs, practices and family support (or the lack of) have bore tremendous impact on our project consumer's culture. These in turn have an effect on health-seeking behaviors or "compliance/noncompliance" of families in our communities. Guidance provided through the consortia has assisted Healthy Start in developing and providing in-service sessions to health and social service providers or agencies within the target area.

Barriers. The major barriers for clients' involvement in the consortium are the clients' stressful day-to-day lives cause them to forget or miss meetings, the many responsibilities of work, school, family, lack of transportation, lack of child care, lack of confidence in ability to perform in the business or meeting environment, other issues such as substance abuse, absent partner and/or father of child, difficult relationships with partner and/or father of the child, domestic violence, partners (or friends/family) do not want the clients to be involved in a program, unstable housing, distrust of the 'system', lack of interest, and a high percentage of the target population change their residence frequently. If the client moves from the service area, the client becomes ineligible for our program. Some clients are so involved in the system that they already have too many activities and appointments to manage. Fears of the system, fear of being judged, lack of interest and lack of time have all been reported by clients as their concerns.

Other barriers to consortium activities are: limited Healthy Start resources; irregular attendance by key members of the Advocates group meetings; a changing political environment as a result

of the establishment of a newly merged government; changing health department directors with different visions; and State limitations to support the consortium goals.

Barriers addressed. Staff and consortium member dialogue, discussion groups, focus groups, and client surveys addressed the listed barriers. Solutions implemented were to provide an increase in the diversity of incentive items, transportation, meals for the clients and their children, reminder letters, and reminder phone calls. As another service to our clients and to overcome the barrier of lack of confidence/skill/experience, we provided training sessions and open discussions on advocacy, professionalism, and personal and professional development at each meeting. During these sessions transportation, meals and childcare were provided.

Other solutions included networking with area agencies and businesses, brochures, posters, billboards and bus shelter signs, radio advertisement; staff attended area health fairs, festivals, and community and agency events. Making contacts with and client referrals to Neighborhood Places services enabled staff to support and encourage the clients' involvement in the consortium and recruit professionals and community members. Many barriers were overcome through: 1) education and information about the program and consortium, 2) staff encouragement and support of consortium members and activities.

2) The Working Structure of the Consortium. The Consortium size over the four years has been 80 to 110 members; at the end of program year four there were 100 members. The working structure includes members from all segments of the community as described in detail below, two leaders as co-chairs and clerical support from HS staff.

The consortium members represent the following categories:

- State or local government (G): Public agencies or organizations: 34%
- Program participant (PP): Consumers: 14%
- Community Participant (CP): 18%
- Community-based organizations (CBO): 1%
- Private agencies or organizations (not community-based) (PAO): 1%
- Providers contracting with the Healthy Start program (PC): 0%
- Other providers (OP): 24%
- Other-regional/service area consortium: 29%

(See Attachment H for list of Consortium Members)

The Louisville Metro Healthy Start program (LMHS) consortium racial/ethnic breakdown and by percentage is as follows: 41% White and 59% African American.

70% of the Healthy Start consortium members attend the monthly or quarterly meetings. The Healthy Start consortium composition by gender at the end of this grant cycle is female 67%, male 33%. The LMHS program worked to ensure that the membership on the consortium is culturally representative for both providers and consumers by selecting members who are:

- Representatives from each Neighborhood Place Community Council;
- Administrators of each partner agency of Neighborhood Places from each targeted area;
- Actively involved in collaborating with local community ministries network;

- Culturally representative of both providers and consumers; and
- Either a resident of Neighborhood Place or is a service provider who works within that community.

3) Activities of the collaborative. The strong collaborative relationships that have been in place with the Neighborhood Place partners, who are Consortium Members, have enabled the three Healthy Start sites to use a standardized screening and assessment process for identifying families in need of support and community resources. Families served at all three sites have assisted in the development of individual family support plans to guide their service involvement. Once risk factors and family needs were identified through the screening and assessment process, families were assigned to a specific case manager.

Resources were identified in the community through regular monthly and annual meetings/trainings. Over 600 people attend the Annual Neighborhood Places Conference where relationships are strengthened through skill building, problem solving, networking and showcasing of area resources

The Neighborhood Places (NP) structure has continued to verbalize and demonstrate commitment to active consumer involvement and needs assessment. Incredible effort has been devoted to making these partnerships work. Residents and providers participated in frequent meetings, activities, and trainings. The project has benefited from the active, well informed, and influential consumers and consumer representatives that served on the Bridges of Hope, Northwest, and Ujima Neighborhood Place Community Councils. These individuals and the constituencies have been involved with the project on a day-to-day basis and provided consistent input to access and ensure that client and community needs were addressed. The majority of these activities occurred at the neighborhood and facility levels and typically involved Healthy Start Project staff and/or Neighborhood Place Administrators. This level of involvement has strengthened the Healthy Start project and enhanced the consortium.

All agencies at the three Neighborhood Places sites have been utilizing a common form for consent for services and release of information. This standardization of family consent has allowed for information exchange among providers of the Neighborhood Place. While this policy of sharing information is a major testament to the effort and mutual trust that had to occur for this standardization to be a reality.

All three sites have been using a standardized screening and assessment process to identify families in need of resources and support. Screenings were conducted to determine need for further assessment of risk factors. Through Family Team meetings conducted at the NP all the agencies including HS meet with the family and work together to establish an individual family support plan to delineate family goals. This plan serves as a guide to identify and utilize community resources for the family to access to achieve their goals. This process involves needs assessment, identify resources, establishing priorities for allocation of resources, and monitor's implementation of the family's plan and the program's goals.

The Consortium is part of the implementation monitoring team for the project along with the staff. Three full-time Community Health Services Coordinators, who were responsible for the day-to-day overall management of the project activities at the individual sites, serve as a liaison to the Consortium and the respective community councils.

The program Consortium has been involved in the following specific activities: outreach, advocacy, outreach event planning and participation (i.e., holiday celebrations, program participant graduations, baby showers, mother's day out, walking club, etc.). The Consortium has also been involved in the HS program marketing efforts, and meet quarterly. The meetings included the advocates and consumers. In addition the consumers had their own subcommittee meeting monthly then on a quarterly basis.

The HS program consortium, in collaboration with Neighborhood Place partnering agencies, had a direct role in identifying resources and establishing priorities for allocation resources. The consortium members were directly involved in the lobbying efforts and served as a voice for HS program. The Consortium networked with the congressional members and enlisted their support for the HS program, and its continued funding. The consortium was active in promoting the program to local legislative representatives and worked to discover new sources of funding for the program.

The HS consortium members attended the HS conferences. The Neighborhood Place (NP) partner agencies, that are all publicly-funded organizations, offer services within the N.P. These partners and consortium members continuously reviewed ways to improve and streamline service delivery and seek new funding sources. An ultimate goal is not only to sustain the program services but also to replicate effective and efficient modalities in other high need areas of the community to improve perinatal delivery systems and health outcomes.

4) Community's major strengths, which have enhanced consortium development. A major strength of the Louisville Metro community is its willingness to collaborate and build from its strengths. The Neighborhood Places are an example of such collaboration. The Neighborhood Places concept developed from many meetings among representatives from the Jefferson County Government, the City of Louisville, the Jefferson County Public School System, and the State of Kentucky. These entities set aside political concerns and strived to build for the well-being of underserved community members who faced a multitude of barriers. Another example of collaboration is the Association of Community Ministries. These agencies are a collaborative group that stretches throughout Jefferson County providing services to the community and are represented in the work of the Neighborhood Places. Other examples of major strengths include:

The Family Health Centers, Inc. (FHC) is a 501© (3) non-profit corporation established by the Louisville-Jefferson County Board of Health "to ensure that the citizens of Louisville and Jefferson County have access to high quality, affordable primary care services regardless of the ability to pay." Currently comprised of five primary care delivery sites, FHC provides health care services a health care "safety net" to many of the community's neediest citizens.

The clinics operated by Family Health Centers, Inc. are fully licensed by the State of Kentucky as Primary Care Centers. A team of physicians and nurse practitioners provides primary care services. They provide acute episodic medical care, management of chronic illnesses, well child/adult exams, and family planning services at each site. The mix of physician specialties includes: Family Practice, Pediatrics, Obstetrics/Gynecology, Internal Medicine and General Practice. Nurse practitioners and physician assistants operate under protocols and primarily provide Family Planning, Prenatal Care, GYN services and Well Child Exams. Nursing staff assist each provider and provide triage services and pre- and post-counseling of patients when required.

Park DuValle Community Health Center is a suburban neighborhood Community Health Center developed around the framework of new urbanism, that is a design and planning technique used to prevent the displacement of existing residents in a gentrifying neighborhood. The neighborhood must have the appropriate balance of low-income and market-rate units. Park DuValle Community Health Center is basically a primary care center with services available for specialty care, prenatal care, family planning, plus adult and well childcare. Park DuValle has strategically placed two other sites in areas of special need. They are Newburg Primary Care on Hikes Lane and Cityview at 10th and Chestnut Streets.

Some of the other community strengths are: the three HS project areas are adjacent, have public transportation, and are old, long established communities with a strong connection to local neighborhood churches. The NPs in the three HS Areas have been in place over 10 years and while they adapt and change services as the clients needs change the location and a majority of the staff, community counsel members, and services remain constant.

5) Weaknesses and barriers. The major barriers for clients' involvement in the consortium are the clients' stressful day-to-day lives cause them to forget or miss meetings, the many responsibilities of work, school, family, lack of transportation, lack of child care, lack of confidence in ability to perform in the business or meeting environment, other issues such as substance abuse, absent partner and/or father of child, difficult relationships with partner and/or father of the child, domestic violence, partners (or friends/family) do not want the clients to be involved in a program, unstable housing, distrust of the 'system", lack of interest, and a high percentage of the target population change their residence frequently. If the client moves from the service area, the client becomes ineligible for our program Clients have reported fear of the system, fear of being judged, lack of interest and lack of time.

Other weaknesses and barriers include: limited Healthy Start resources including staff time to dedicate to the consortium efforts; irregular attendance by key members of the Advocates group meetings; a changing political environment as a result of the establishment of a newly merged government; changing health department directors with different visions; and State limitations to support the consortium goals.

6) Activities/strategies to increase consumer participation. As a part of the Neighborhood Places, the HS program is strategically poised to be involved in integration of services and collaboration with other social service providers. Increase consumer involvement in the consortium and the HS program as a whole. The HS program has also been involved in cultural competence trainings that are part of the annual requirements of the department.

The HS Consortium establishment of strong partnerships in the Men's Services Program by the Men's Task Force increased consumer participation in HS decision-making and supported the establishment of the consumer subcommittee. The HS program provided workshops and participated in different training forums for providers and the community-at-large to increase awareness and reinforce the importance of consumer participation in the consortium

This major Consortium activity of the birth of the HS Men's Task Force had a positive impact of many parts of the program, Consortia, consumers and the community. The HS Consortia has been very involved in the restart of the HS Men's Services Program and has provided leadership and guidance throughout the project in the implementation of this important component of the program. The HS Men's Task Force includes individuals from faith-based community, partner agencies and other social service providers. The following are some of the major activities of HS Men's Services Program:

- On October 16, 2003 HS Men's Services in collaboration with Northwest N.P. partners, sponsored an event to promote HS Men's Services program and to increase the referrals to the program from the community. The Neighborhood Place agency partners set up informational booths and invited male clients to attend this function. The total number of participants in this event was over 150. This was a successful event that has resulted in a continuous flow of referrals to the Men's Services program.
- On October 31, 2003 HS Men's Services in partnership with the Task Force presented the first Men's Conference with the theme of identifying gaps in services for men. A panel of speakers included representatives from health delivery, transitional programs for the paroled, male community mentors and job-training counselors. In attendance were 78 participants that included clients, service providers and area business leaders. This conference was successful in bringing a wide variety of service providers together in an effort to provide a cohesiveness of service delivery for the men in our community.
- Healthy Start Men's Services offered numerous support group sessions on the third Tuesday of every month on topics such as child support, parenting 101, domestic violence, family relations, financial planning and expunging records. Task Force members conducted most of these sessions and there was a consistent increase in client attendance.
- On November 19, 2003 Men's Services sponsored a workshop entitled Men's Involvement in their Homes and Community. Neighborhood place partners i.e. Department of Human Services, Food Stamps, Child Protection Services, Daycare program, in cooperation with our task force members provided booths and information on

their individual programs. Individual Task Force members along with HS male resource workers participated in a panel discussion with 64 families from the HS service area. Some of these families were already enrolled in the program, but many attended the event and were referred by other partner agencies. This workshop provided an excellent opportunity for providers and clients to understand the needs of the community and for clients to learn about the availability of current services.

- Men's Services Program in collaboration with Ujima Neighborhood Place held a Child Safety and Child Protection workshop in April 2004.
- Men's Services Program is sponsored a Men's Health Conference on May 12, 2004 for the male service providers target audience.
- In February 2005, Men's Services Program, in collaboration with Jefferson County Public Schools' Head Start/Early Head Start Fatherhood/Male Initiative Program, presented the "Building Blocks for Father Involvement". This two-day training included:
 - Information on identifying the needs of fathers in the community and what activities and services they might find most useful.
 - The need the recruit community partners, as both a means to broaden and strengthen services and to reach out to underserved fathers in the community.
 - Help the fathers overcome barriers that might keep them from being involved in their children's lives, whether legal, emotional, physical, relationship, or driven by fear or a lack of understanding, confidence, or time.
 - Ways to improve the father's understanding of the unique and vital role he can play in the life of his/child, helping him understand that no one else can take his place.
- In May 2005, the Men's Services Program in collaboration with Men's Task Force and the Jefferson County Public Schools Head Start/Early Head Start Fatherhood/Male Initiative Program sponsored a Fathers and Families Conference offered to the community that focused on:
 - Healthy Lifestyles
 - Financial Health
 - Healthy Relationships

7) How did you obtain consumer input in decision-making process? Consumers participated in the decision-making process through multiple outlets. The HS program actively solicited participation and feedback from the following venues:

- Client surveys
- Focus Groups
- Consumer sub committee
- Consumer's attendance in monthly, quarterly, and annual meetings
- Suggestion box
- Comment cards mailed or left with the consumer at a home visit
- Staff reports of consumers verbal input to their case worker, nurse or resource worker

- Consumer involvement in planning and implementing HS activities such as baby store, baby shower, community fairs, etc.

8) Utilization of Consumers Suggestions. In order to utilize consumer suggestions the program evaluator compiled the results and presented the outcome to the consortium and staff in meeting/training sessions. Through this process a plan was designed to immediately implement some of the suggestions that could be easily accomplished, such as calling consumers or sending post cards to remind the consumer of an appointment or having an event in a different location due to parking. Committees were formed to further study the feasibility and plan for the more complicated suggestions. Some suggestions were assigned to individual staff or standing committees to complete. The results of both the original consumer suggestions and the implementation were presented to the community and consumers in meetings and in the LMHS newsletter. Suggestions were brought from the consumer through the resources person to Case Management Meetings and were utilized and then reported out to the larger group of staff and Consortium as appropriate.

E. Sustainability

As a result of HS Men's Program activities, many new partnerships have formed to work toward sustainability. The following is a list of active partners in the Men's Program: Jefferson County Public Schools Male Initiative Program, Metro Louisville Probation & Parole, Metro Louisville Police Department, Louisville Community Center, and Our Father's House treatment facility. Representatives from various agencies continue to join and partner with the Healthy Start Program to build upon and expand on the current level of resources.

The HS program Consortium, in collaboration with Neighborhood Place partnering agencies, have had a direct role in working towards ensuring sustainability of the HS program. The Consortium members were directly involved in lobbying efforts and served as a voice for the HS program. The Consortium met with Congressional members and sought their support for the HS program and its continued funding. The Consortium was active in promoting the program to local legislative representatives and assisted in seeking new sources of funding for the program.

The LMHD HS program works with State and local government funding agencies by:

- Collaborating with state Title V MCH Administration for the purpose of furthering Healthy Start goals and objectives into a state-wide plan.
- Soliciting for additional grant opportunities with maternal child health agencies that complement the HS goals and objectives.
- Continuing to re-establish the partnership with the local Medicaid Managed Care provider, Passport Health Plan. Initially, the partnership consists of open dialogue regarding program participant needs and plans to share data.

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- Enhancing the collaboration with the two Family Health Centers in the targeted area. The HS program nursing staff will go to the Family Health Centers sites on a weekly basis to recruit and enroll eligible program participants for HS program.

The Healthy Start program benefited from various Louisville Metro Health Department services. Furthermore, the LMHD HS program partnered with Community Health Centers and Health Departments to:

- Provide a variety of health care delivery sites to program participants for prenatal and infant care from public health agencies to private physician's offices and the downtown medical center area.
- Provide access to the Family Health Center-Portland, a federally-qualified health center (FQHC) for prenatal care.
- Provide access to Park DuValle Community Health Center, another FQHC within the service area near the Ujima Neighborhood Place, which provide prenatal services.
- Provide access to the Family Health Center-Portland and Park Duvalle Community Health Center. Both Community Health Centers offer a wide array of prenatal services including on-site WIC and extensive case management in conjunction with the local health department.
- Provide high-risk prenatal care and all deliveries through a linkage agreement with the University of Louisville's Obstetrics and Gynecology residency program and the University Medical Center, the management consortium that operates the University of Louisville Hospital. The University of Louisville School of Medicine operates a primary care center in the downtown medical center area. A significant number of project area residents receive perinatal services from these providers. Limited perinatal care services also will be provided near the Bridges of Hope NP through two private primary care clinics.

The HS program has had continual meetings and discussions to determine ways to use third party billing. We continue these efforts and continue to seek out public/private funding sources.

The LMHD is in the process of establishing a 501(c)(3) Foundation that will allow the department to seek donations from charities, industry/businesses. The money raised could be utilized for different programs, including Healthy Start.

The LMHD HS program and the Consortium have:

- Sought funds from the Passport Health Plan (PHP), the Medicaid managed care organization for the region.
- Continued its efforts in seeking third party reimbursements for the home visitation services provided by HS.

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- Pursued special appropriations and Federal Appropriation Funds.
- Asked for funds from the Metro United Way. This organization helped fund the literacy project and provided books that Healthy Start and HANDS workers distribute to the families to promote reading and nurturing.
- Applied for funds from the March of Dimes.

In the past, the Louisville Metro Health Department had a contract with the local Medicaid managed care organization (PHP) to perform nursing home visits to the perinatal population (the Mommy and Me program). The contract with PHP ended in 2001, and the Health Department has not been able to obtain third party reimbursements. Plans are under way to convene a meeting with PHP to develop strategies for Healthy Start's access to third party reimbursements for home visits provided by the nursing and social worker staff.

The HS program consortium, in collaboration with Neighborhood Place partnering agencies, had a direct role in ensuring sustainability of the HS program. The consortium members were directly involved in the lobbying efforts and serve as a voice for HS program. The Consortium met with congressional members to seek their support for the HS program, and it's continued funding. The consortium was active in promoting the program to local legislative representatives to seek new sources of funding for the program.

The collaboration of the Healthy Start Initiative will continue with the Kentucky Bureau of Maternal and Child Health. In Louisville, the Louisville Metro Health Department is the main Title V agency, which address community needs and services in the area of maternal and child health. Through this linkage, the local Health Department has worked in partnership with the state **Title V** office to implement appropriate components of the state and local perinatal systems of care. Some **Title V** staff members are members of the Healthy Start Advocates and have participated in the development of the group's original strategic plan. In recognition of these facts, the Kentucky Bureau of Maternal and Child Health and the Louisville Metro Health Department are collaborating to address racial disparities in infant mortality, as well as in poor pregnancy outcomes such as low birth weight and prematurity.

A Division Director and the HS program administrator serve on the Kentucky Chapter March of Dimes Program Services Committee. The state HANDS program administrator serves as a liaison to HS program and attends the annual HS conference as the state MCH representative. In the future, the HS program will focus its efforts in obtaining a greater allocation of the Title V funds for perinatal services.

The Kentucky Bureau of Maternal and Child Health established a FIMR program and the FIMR program coordinator works closely with Louisville/Healthy Start FIMR program, led by the HS program evaluator. The HS program has been the lead program in implementing Perinatal Periods of Risk (PPOR), and the program continues to seek partnership with the state to obtain more funding for sustaining its efforts in this area.

III. Project Management and Governance

A. Structure of project management

The structure of the LMHS project management that was in place for the majority of the project implementation was as follows:

- One full-time **Community Health Administrator** serves as project consultant, advisor and provides oversight of the program. Nazenin Assef, administrator, performs the role of administrative oversight and consultation to the program. Ms. Assef dedicated 100% of her time to this effort.
- One full-time **Community Health Services Manager** serves as the Project Director and is employed through the project to provide project management, assist with evaluation activities, ensure quality client care, and introduce evidence-based strategies through the Coordinators and with consultation from the Administrator. There were two different Community Health Services Managers over the course of the project, Paula Staley, and Ginger Dereksen, each dedicated 100% of her time this effort.
- Three full-time **Community Health Services Nurse Coordinators**, Barbara Reck, Gency (Atieh) Fowler, Donna Dooley. The Coordinators are responsible for the overall management of the project activities on a day-to-day basis at the individual Neighborhood Place Site (s). The Coordinator's responsibilities include, but are not limited to, planning, directing, and supervising the work of the Healthy Start multi-disciplinary teams. These individuals are RN nurses; approximately two-thirds of their time was devoted to program site management and supervision.
- One full-time **Epidemiologist** was employed to collect, evaluate and analyze data. The Epidemiologist has been involved in the development of pre- and post-surveys, monitoring project progress, and compiling reports and analyzing data.

B. Recourses available

We accessed Neighborhood Place partners for client referrals. The staff works collaboratively with the federally funded Family Health Center Portland and Park DuValle Community Health Centers to identify clients appropriate for our program. Throughout the project, we collaboratively sponsored many functions with other community and Neighborhood Place partners to showcase services and identify potential clients.

The Medical Society provides a system and resources to address the gaps in routine screenings and skilled assessment for depression during and around the time of pregnancy. Local providers include mental health treatment center, Seven Counties Services and Central State Hospital.

PPOR and FIMR have been implemented in Louisville/Jefferson County Metro. By using the PPOR findings, FIMR was targeted to the groups with higher mortality rates. Thus the gaps/problems in the perinatal system could be identified and followed by recommendations for

changes. The lack of available resources hindered the process of using PPOR and FIMR. Funding for FIMR from March of Dimes ended, and the program supported this major component without additional resources. The HS program evaluator, who had taken the lead on Jefferson County's PPOR and FIMR activities, left the program for a CDC fellowship. A new HS program evaluator was hired in 2003 and has been continuing the PPOR and FIMR activities. HS involved some of the Consortium members as members of the FIMR Community Action Team.

The Neighborhood Places partners entered into an innovative partnership governed by a Managing Board, made up of representatives from each Neighborhood Place Community Council and administrators of each partner agency. Neighborhood Places improve citizen access to services; influences major policy decisions, involves line staff and residents in creatively restructuring services and demonstrates outcomes that indicate success. In each area there is active collaboration with the local Community Ministries network. To our knowledge, no one else in the country has embarked on such an ambitious journey of bringing together in a common site a diverse group of staff and community members systematically to present a rich mix of health, education, and human services to families in need of assistance. Membership on the consortium is culturally representative of both providers and consumers, since one of the criteria of being a consortium member is to either be a resident of the Neighborhood Places area or be a service provider and work within that community.

As resources allow, additional services are streamlined to the specific needs of the disparate communities. Therefore some services are unique to their sites. For example, because one of Bridges of Hope's (BOH) sites is located within a Louisville Metro Housing Authority building, the Wiggins Family Investment Center, its clients have access to Housing Authority programs, including, a self-sufficiency program for housing development residents, GED classes (offered by the Jefferson County Public Schools), computer classes, and financial skills workshops for adults and for teens. This site also has a drop-in childcare center, so parents can leave their children in a safe environment while meeting with Neighborhood Places staff. Two staff members of Community Coordinated ChildCare (4C's) are housed at BOH. This agency contracts with the state to provide subsidized childcare. BOH has had a "Targeted Assessor" assigned through the Cabinet for Health and Family Services. This social worker conducts intensive assessments for clients who may have substance abuse or mental problems or be victims of domestic violence or have learning disabilities. A Family Advocate, housed at Bridges of Hope, recruits and supports foster and adoptive families. This position is funded by the Family to Family Initiative through the Annie E. Casey Foundation. A Jefferson County Alcohol Drug Abuse Center (JADAC) counselor is housed at Bridges of Hope to assess and provide substance abuse counseling services to clients.

Bridges of Hope also has WIC Nutrition services at both sites. Service providers from Truancy Court, a collaborative prevention program of the Department for Juvenile Justice, the Department for Human Services, and Jefferson County Public Schools, are located in a BOH area school. Referrals to Healthy Start, 4C's and other NP services continue to be offered. A new program, through the Community Action Partnership, provides an employment counselor on

site for clients. Bridges of Hope continues to promote Children's Sabbath, a project of the Children's Defense Fund to service area churches.

Bridges of Hope received a small grant and began a program for high school students, male and female that included prevention of risky behaviors, financial responsibility, sexual responsibility, and opportunities for community service. HS has worked in collaboration with the other NP partners in the development of this prevention program. BOH also worked with the Commission for Children with Special Needs, Kentucky SPIN, and Seven Counties Services on a Supporting Transition Resource and Opportunities in Neighborhood Grant (STRONG) planning grant. This was an attempt to identify and provide referral services to families who have children with disabilities. The intent was to place STRONG resource staff in each of three NPs (including BOH and Ujima). BOH Administrator is on the Managing Board of Project FIND, a project of the Council on Mental Retardation that helps families navigate the school system for appropriate classes and services for children with disabilities and offers trainings for parent and volunteers to assure education on and access to services for families with disabled children.

Bridges of Hope each summer holds a Back to School Safety and Health Festival, offering immunizations and school supplies to area children. Numerous health and social service agencies, police and fire departments, area Family Resource Center/Youth Service Centers cooperate in this effort that serves approximately 300 families.

Bridges of Hope, Ujima, and Northwest staff and Community Councils have continued their collaboration on a cardiovascular project that targets African American families (through the Health Dept.) and a prostate cancer-screening program (through the University of Louisville School of Nursing).

Northwest Neighborhood Place moved to its newly renovated offices within Shawnee High School in April 2002. This expansion accommodated all of the Neighborhood Place agency partners moving in their respective staff, and as of this writing the following staff are located on-site:

- The Healthy Start staff as assigned.
- Protection and Permanency Staff of the Kentucky Department for Health and Family Services, Family Support Staff (Food Stamps, Medical Assistance, Temporary Assistance Program, eligibility and case management services) of the Kentucky Department for Health and Family Services.
- Community Coordinated Child Care staff, under contract to the Kentucky Department for Health and Family Services.
- HANDS Staff under contract with the Department of Health.
- Family Services of the Louisville Metro Department of Human Services.
- School Social Workers of the Jefferson County Public Schools.
- Seven Counties Services: JADAC/Project Link services to serve pregnant woman or women of infants who are involved in alcohol or substance abuse or who are at high risk of being involved and to provide assessment for any client seeking services for alcohol, substance, and drug abuse. Seven Counties Services also has another part-time staff that

works with staff and community to develop alcohol, substance, and drug abuse education and prevention programs.

- A Community Liaison funded by Family to Family Initiative through the Annie Casey Foundation is also housed at Neighborhood Place Northwest. The role of the Community Liaison is to recruit and support foster and adoptive families. This is another program of the Kentucky Department for Health and Family Services.

Along with Neighborhood Place, the Shawnee complex has several excellent partners located within the immediate area of its suites of offices:

- The Jefferson County Public Schools Early Childhood Education Program (serving over 120 children).
- The Intergenerational Program sponsored by Jefferson County Public Schools and Louisville Metro Human Services.
- The Family Education of Jefferson County Public Schools.
- Within the building are the Community School Program, and post-secondary classes and Adult Education classes.

With the support and encouragement of the Northwest Community Council, the Northwest staff assumed a major role in the establishment of a Coalition to Prevent Childhood Lead Poisoning. During the 2003-04 FY the three communities within the Northwest service area brought together its two Coalitions under one banner, and by this writing have created the Louisville Lead Safe Coalition. Neighborhood Place Northwest has also been active in the efforts of the Kentucky Department for Health and Family Services to re-tool its child protective services in a partnership with the community. In addition, foster parents and local non-profits representation on Northwest Community Council has increased.

Through collaboration with other Neighborhood Place partners, client families have direct access to an array of social, educational, mental health, and employment benefits as well. This coordinated approach to service delivery enables HS clients to establish goals for themselves and their children designed to achieve optimal health and self-sufficiency.

C. Changes in Management

The Louisville/Jefferson County Metro Health Department and all its programs, including Healthy Start, faced metro-wide challenges during the last three years of the project period. On January 6, 2003, two governments merged when Louisville and Jefferson County formed the Louisville/Jefferson County Merged Government. As with any merger, new policies and procedures needed to be developed, staffing assessed, and it became imperative to review fiscal conditions under the newly structured government. As a result many changes occurred which were difficult for staff and impeded processes. Furthermore, the Metro Health Department director position was vacant and filled with interim directors during the search for a permanent leader. The director is in place and his leadership has provided stability.

Other challenges include: Changes in the roles and responsibilities of the project central office and direct services staff are as follows: Project Manager duties previously held by the

Administrator changed to the Manager; the Administrator provides programmatic oversight. During the FY 04 budget process, Louisville/Jefferson County Metro Government reviewed staffing and issued layoffs based on seniority. As a result, the previous Healthy Start Manager moved to another position. Ginger Dereksen filled the vacant Healthy Start Manager position on July 1, 2003. The program Evaluator left the agency for another position, and due to hiring freeze the position was vacant for almost a year. A new program evaluator was recruited and hired in October 2003 (Dr. Sarojini Kanotra).

D. Process to assure appropriate distribution of funds

The LMHD HS program’s key program, fiscal, and evaluation staff worked together on a regular, on-going basis. While program, fiscal, and evaluation functions are located in the same agency, additional fiscal oversight is located in the Louisville Metro Finance Department, Grants Management. The finance department monitors each grant awarded to ensure fiscal compliance, appropriate distribution of funds, and communicate with grant-funded program administrators and metro agency business managers. The key health department program, fiscal, and evaluation staff members are located in close proximity, communicate face-to-face, by phone and e-mail. This staff team disseminates information in work groups, meetings, and collaborative reports. Each area provides technical expertise to team members, program staff, and community participants and advisors. Specialty experts monitor functions under their purview and report outcomes. Together, team members monitor the comprehensive program, which provides functional cohesiveness. The Louisville Metro Health Department's lead business manager provides fiscal oversight of all health department programs including those grant-funded.

The LMHD HS program did not use contracts with agencies or individuals to provide Core Services to the program participants. As contracts relate to purchasing good and services, such as office supplies and printing, the HS program under the direction of Louisville Metro Government, and therefore abides by the Louisville Metro Finance and Administration policies and procedures. The following table outlines the procedures for soliciting and awarding purchasing contracts.

Type of Service/Item	Procedure
Metro (Price) and State Contracts to buy goods or services.	Call the Business Office, if there is no contract, follow the steps below.
<u>For Items Under \$10,000</u>	
From \$500.00 - \$2,499.00	3 quotes on letterhead. At least one quote should be from a minority owned business. The Division Director signs the purchase order before ordering.
\$2,500 – 10,000.00	3 quotes on letterhead. At least one quote should be from a minority owned business. Send to the Business Office to set up a requisition and call Purchasing. Purchasing takes care of bids, winning quote, and set-up the purchase order. For professionals, the Program completes the “Intent to

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Type of Service/Item	Procedure
	Purchase Services Form.”
<u>Over \$10,000.00</u>	
Competitive Sealed Bids	Decide what it is that you want to buy. Call the Business Office. Decisions will be made by Metro Purchasing
Non-competitive Negotiation: professional services, single source, and emergencies	Call Purchasing. Complete the “Contract Data Sheet” and “Written Findings Form.”
Professional: Attorney, Physician, Psychiatrist, Psychologist, Certified Public Accountant, RN or Education Specialist	Call the Business Office. Complete the “Contract Data Sheet” and “Written Findings Form” and send them to the Deputy Director of Support Services.

The Program Manager, LMHD Business Office, and Louisville Metro Government Finance Department provided fiscal monitoring. The Louisville/Jefferson County Metro Government A-133 annual audit for fiscal year ended June 30, 2003 revealed that Louisville Metro Government expended \$89,837,006 in cash from 15 federal agencies during FY 2003. The Louisville Metro Health Department federal awards, inclusive of Healthy Start funds, were a part of the Schedule of Expenditures of Federal Awards. The Louisville Metro Health Department manages state and federal funds (approximately \$12,500,000), which comprises approximately one-half of its annual budget. The total budget managed by Louisville Metro Government is over \$400,000,000.

On January 6, 2003, the City of Louisville and Jefferson County merged and began the task of blending agencies from two government entities with minimal interruption of agency services to the public. During this merger, financial controls and structures were evaluated for effectiveness and efficiencies. As the fiscal agent of federal awards, the Louisville/Metro Government maintained a fiscal structure where each agency assumes grant program, fiscal, and evaluation responsibilities. The Louisville Metro Finance Department Grants Management Division provides oversight and charges accountability to the agency that assures compliance with executed grant agreements. Prior to January 6, 2003, the City of Louisville and Jefferson County were represented on the Board of Health with Jefferson County holding fiscal responsibility for the health department.

E. Quality assurance, program monitoring, service utilization, technical assistance

The Louisville Metro Health Department Quality Assurance/Quality Improvement team conducts regular quality assurance audits and provides technical assistance to the Healthy Start Management Team on program and compliance issues. Information Technology (IT) implementation, development, assessment and technical assistance are provided by the LMHD IT Department. In order to ensure HIPPA Compliance, the LMHD HIPPA Compliance Officer provided assessments, technical assistance and training to all HS staff. The LMHD HS program

did not use any contracts with agencies or individuals to provide Core Services to the program participants.

F. Cultural competency

All HS staff received training on cultural competency. Staff shadows other outreach workers who have a wide array of field experience. New Nurse Care Coordinators/nurses shadow an experienced nurse until ready to work alone and are supported with ongoing supervision and monitoring. Nurse Care Coordinators/nurses receive prenatal/postpartum training conducted by qualified nurse practitioners and academic educators. Additional training is offered in accordance with staff's request. LMHD continuously offers trainings that all HS staff can participate in. The LMHD HS program has not used any contracts with agencies or individuals to provide Core Services to the program participants.

The program also adapted its screening process to account for **cultural diversity** among the program participants. The HS program: 1) provided services that reflect culturally-specific values and norms; 2) disseminated information in terms and materials that are appropriate for various cultures; and 3) used channels of communication or points of entry deemed credible by the program participants.

The HS Outreach and Marketing Committees staff represents all three sites, and staff members have developed culturally sensitive material for brochures, manuals, billboards and media blitzes and organizing several events. The Marketing Committee developed, designed, and completed the layout of the publication of the Healthy Start Newsletter quarterly. The newsletter is reviewed to insure culturally sensitive material. The newsletter provides program information and education to the clients, partners, community, and Consortium.

IV. PROJECT ACCOMPLISHMENTS

See Attachment A

V. PROJECT IMPACT

A. Systems of Care

1). Collaboration. The Louisville Metro Health Department was the local Title V agency. As such it partnered with the Kentucky Division of Maternal and Child Health to advocate for local needs, implement the objectives of the approved Title V block grant, and achieve health status improvements. Through this linkage the local health department worked in partnership with the state Title V office to implement appropriate components of the state and local perinatal systems of care. Some of the State Title V staff were members of the Healthy Start Advocates and have participated actively in the development of the group's strategic plan.

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The needs of the geographic program areas stated in the overview prompted the Kentucky Bureau of Maternal and Child Health and the Louisville Metro Health Department to address racial disparities in infant mortality, as well as in poor pregnancy outcomes such as low birthweight and prematurity. Deputy Director of Kentucky Department of Health, James Steve Davis, MD, and Healthy Start project administrator, serve on the Kentucky Chapter March of Dimes Program Services Committee. In collaboration with March of Dimes and Kentucky Department of Health, Healthy Start provided a Prematurity Summit in fall of 2004. The second annual Prematurity Summit will be held in November 2005.

Certainly collaborations with major partners have raised community awareness of services for women, children, and families, decreased barriers to access, and increased utilization. Much of the orientation and training of project personnel has addressed assessing family needs and coordinating care. Because staff has been very aware of services and other community resources available within the health department and from other partners, they have been able to respond to a variety of client needs. Every effort has been made for service delivery to be as seamless as possible to clients irrespective of the payment source. Locating Healthy Start teams in Neighborhood Places where other major public providers can immediately respond to provide appropriate services has supported this goal.

As resources have allowed, additional services were streamlined to the specific needs of the disparate communities. Therefore some services were unique to their sites. For example, because one of the Bridge's of Hope's sites has been located within a Housing Authority of Louisville building, its clients have had access to Housing Authority programs, including Youth activities, a self-sufficiency program for housing development residents, parenting education programs, GED classes (offered by the Jefferson County Public Schools), computer classes and financial skills workshops for adults and for teens. This site also has a drop-in childcare center, so parents can leave their children in a safe environment while meeting with Neighborhood Place staff. Two staff members of Community Coordinated ChildCare (4C's) are also housed at BOH. This agency contracts with the state to provide subsidized childcare. BOH also has had a "Targeted Assessor" assigned through the Cabinet for Health and Family Services. This social worker conducts intensive assessments for clients who may have substance abuse or mental problems or be victims of domestic violence or have learning disabilities. A family Advocate, housed at BOH, recruits and supports foster and adoptive families. This position is funded by the Family to Family Initiative through the Annie E. Casey Foundation. A JADAC counselor is also housed at HOH to assess and provide substance abuse counseling services to clients. Bridges of Hope also has had WIC Nutrition services at both sites.

Project Women, which is a collaborative organization that provides housing to single mothers who are experiencing homelessness and supports them in obtaining a baccalaureate degree, enables women to break the cycle of poverty. Support and assistance is provided for women entering the program (i.e., housing based on family size).

Service Providers from Truancy Court, a collaborative prevention program of the Department for Juvenile Justice, the Department for Human Services, and Jefferson County Public Schools, are located in a BOH area school. Referrals to Healthy Start, 4C's and other NP services continue to

be offered. A new program, through the Community Action Partnership, provides an employment counselor on site for clients. Bridges of Hope continues to promote Children's Sabbath, a project of the Children's Defense Fund to service area churches. Bridges of Hope also received a small grant and began a program for high school students, male and female including prevention of risky behaviors, financial responsibility, sexual responsibility, and opportunities for community service. HS worked in collaboration with the other NP partners in the development of this prevention program. BOH also worked with the Commission for Children with Special Needs, Kentucky SPIN, and Seven Counties Services on a Supporting Transition Resource and Opportunities in Neighborhood Grant (STRONG) planning grant. This was an attempt to identify and provide referral services to families who have children with disabilities.

2 and 3) Structured Changes and Key Relationships. Bridges of Hope each summer holds a Back to School Safety and Health Festival, offering immunizations and school supplies to area children. Numerous health and social service agencies, police and fire departments, area Family Resource Center/Youth Service Centers cooperate in this effort that serves approximately 300 families. Over the years, this popular activity has developed key relationships that enhance collaborative interaction between consumers and community leaders who are not employed by the partner agencies.

Bridges of Hope, Ujima and Northwest staff and Community Council members have collaborated on a cardiovascular project that targets African American families (through the Health Department) and a prostate cancer-screening program (through the University of Louisville School of Nursing).

Talkshops has been a program at Bridges of Hope funded by a grant from Prevent Child Abuse-Kentucky to provide parent education and support for persons rearing children, with a special emphasis on foster parents and grandparents. This collaboration included two churches and the Neighborhood Place partner agencies.

Northwest Neighborhood Place, housed at Shawnee High School has had the resources of that school and its three-year-old Community School. Northwest has three Truancy Courts at elementary schools. Important structured changes at Northwest included: Northwest expanding its newly renovated office space within the school in April 2002 and has additional staff housed at this location. For the purpose of system integration, with the support of the Northwest Community Council, the Northwest staff assumed a major role in the establishment of a Coalition to Prevent Childhood Lead Poisoning.

Ujima has been the site for the development of the practice models of the Community Partnership for Protecting Children that is being rolled out to other Neighborhood Place sites. This has been an eight-year effort that has involved all of the Neighborhood Place partners and their staff, the Community Council, public and private community organizations, and many residents. Four strategic models of service delivery have been extended to all Neighborhood Place sites, and they continue to impact the protection of children statewide. Ujima has been

located within a school facility, DuValle Education Center, and developed many opportunities to partner with the school and its early childhood and adult education components.

Another community collaboration enhancing the Health Start's ability to eliminate disparities was through the FIND initiative of the Council for Retarded Citizen's. FIND of Louisville addresses the need to enhance the knowledge and skills of parents of children with disabilities, to ensure their effective participation in decisions regarding education, health, and related services. FIND's targeted outreach includes low income, racial/ethnic minorities, and immigrants in geographic areas as the three Healthy Start sites. Project FIND expands on existing parent outreach programs to provide targeted information, training, referrals, and parent-to-parent support that engages parents in making decisions for their children. BOH Administrator is on the Managing Board of Project FIND.

Louisville Metro Healthy Start and other community partners have recognized the increasing diversity within the county and have been formulating and implementing initiatives to better engage and serve all residents. Translation and interpreter services have been enhanced, and marketing and health education materials have been available in an increasing number of languages.

Healthy Start team members have participated in cultural diversity training, and training in this area has been ongoing. At this time the three project neighborhoods have been composed almost exclusively of African American and white residents, who were born in this area and speak English. Therefore the need for interpretation services has been limited. Healthy Start has key relationships with Catholic Charities for interpretation services if needed. Staff often have related easily to clients because many have been residents of the communities as well.

As has been reported in the **Consortium** section, each of these organizations has representatives who are on the Healthy Start Advocates Committee and has participated actively in the development and implementation of the project's strategic plan. It is appropriate that these agencies coordinate their efforts so closely as they engage other diverse community partners to achieve maternal and child health goals.

The current Healthy Start Evaluator, Dr. Sarojini Kanotra, joined the project in October 2003. Dr. Kanotra is a graduate from the Rollin's School of Public Health from Emory University, Atlanta, Georgia. She received training in conducting utilization-focused evaluation as a Collaborative Evaluation Fellow of the American Cancer Society. Further she has over a year's experience in conducting evaluation as a guest researcher with the Pregnancy Risk Assessment and Monitoring System (PRAMS) team of the Applied Science Branch at the Centers for Disease Control and Prevention (CDC). PRAMS is CDC's flagship surveillance system serving over thirty-two states. She has also worked with state Program Consultants and Analysts on development of process evaluation plan (consistent with Branch Evaluation Framework) in the Division of Public Health, Georgia. Dr Kanotra has strong skills in research design and strategic planning. She has extensive experience working with community coalitions both here in the US and in India. Her passion for maternal and child health and data applications to practice in order to achieve better health outcomes, offered valuable technical assistance and support to the local

Healthy Start project. She has demonstrated initiative to strengthen and foster the key relationships and collaboration among different MCH projects and among different agencies/partners with the same goal of reducing infant mortality and racial disparities by improving the birth outcomes. Dr. Kanotra's highly sought after presentations have been part of Health Start's structured changes established for the purpose of system integration and community understanding of the project.

She is also one of the Perinatal Periods of Risk Practice Collaborative (PPOR-PC) team leaders and is working closely with the State Infant Mortality Program coordinator on the FIMR project. In fact, due to the local PPOR analysis work, Kentucky Department of Public Health approached Dr. Kanotra and asked for her expertise in implementing a state FIMR project and utilizing Louisville as the pilot site. Louisville was one of the 14 cities accepted in this collaborative that was another CityMatCH/CDC initiative having MOD and HRSA as partners. The Perinatal Periods of Risk Approach is being used to ascertain the most compelling factors contributing to negative pregnancy outcomes in the Healthy Start and other areas. The findings of the analysis have been shared with local partners to determine which interventions are likely to be most successful in achieving improvements. The PPOR approach as well as the local data are described in the evaluation reports.

The examination of a large number of infant deaths by the Jefferson County Child Fatality Review Team and the Kentucky Child Fatality Review team has revealed that **bed sharing may represent a risk factor in sudden infant death** as the result of unintentional asphyxia by compression (external airway obstruction) and suffocation. Various mechanisms for deaths occurring while **bed sharing** has been postulated, including accidental overlay and re-breathing of carbon dioxide. The hypothesis is that unsafe practices of bed sharing with adults and or children (including a twin) may be a risk factor for unexpected infant death. Other major risk factors for unexpected infant deaths include prone sleeping and smoking by anyone in the house.

As a result of these concerns, a Safe to Sleep Workgroup was established during FY03 and several members of the Healthy Start team, including project evaluator, have been active participants of this workgroup. The workgroup's goal was to develop a "Co-Sleeping" educational awareness campaign to be piloted in Jefferson County with the understanding that it could be expanded in counties throughout Kentucky. The following, along with LMHS and the Health Department are the community partners involved in this group: Cabinet for Families & Children, Louisville Metro Office of Youth Development, Office of Child Advocacy-KCH, Louisville Metro Health Department (including Healthy Start), CPPC, Medical Examiners Office, SIDS Network of Kentucky, Metro United Way, and Preventing Child Abuse in Kentucky.

The following are the current outcomes from the work of this group: 1) Development of Safe to Sleep brochures (100,000) in Spanish and English, 2) Infant T-shirts with Safe to Sleep message printed on them (these will be distributed in the community and HS contributed towards the printing of these T-shirts), 3) Planning a big press release to promote the Safe to Sleep practice.

There are several other more recent active changes that promoted collaborations. With the high rates of smoking reported by women who give birth in the Healthy Start communities, staff has joined a diverse group of organizations and individuals to reduce smoking rates throughout the community and exposure to second-hand smoke. The Jefferson County Medical Society organized the Jefferson County Smoke-free Coalition. As Tobacco Settlement funds became available and the Jefferson County Health Department had increased resources to address this major health issue, the department expanded and assumed a more active role in the coalition. Healthy Start's implementation of the Make Yours a Fresh Start Family intervention is an example of an initiative for the special populations of pregnant women and families with young children.

Metro United Way was a major community partner in the assessment, planning, and funding of human services. In April 2000 Metro United Way began a Success by Six Initiative. This community-wide initiative targets the needs of children from conception to six years of age. The vision for the program is to ensure that every young child in the community is healthy, safe, nurtured, and enters school ready to succeed. The Jefferson County Healthy Start project has been collaborating closely with Metro United Way to promote services to the children of the community and has continued a literacy project. The purpose of this project is to: 1) educate parents/families about the development of language and literacy skills when young children are read to on a daily basis; 2) show parents how to use reading as an activity to nurture young children and 3) increase the frequency of reading aloud that occurs between a parent and child.

4) Impact on Comprehensive Services. The major client enrollment barriers are: clients' stressful day-to-day lives cause them to forget or miss appointments, trust issues in the community with clients and the provider's in the service areas, substance abuse, absent partner and/or father of child, difficult relationships with partner and/or father of the child, domestic violence, partner (or friends/family) do not want the client to be involved in a program, unstable housing, and a high percentage of the target population change their residence frequently. If the client moves from the service area, the client becomes ineligible for our program. Some clients are concerned about how their home and lifestyle will be judged. Some clients are so involved in the system they already have too many "programs" and appointments to manage. Fear of the "man," "the system," and fear of being judged lacking causing "them to take my baby away" are reported as client concerns. In the next project year we plan to conduct a study to discover the major barriers and install a procedure to overcome these barriers. Other barriers include not enough nursing staff to enroll new clients in an expedient manner and a very transient population. Through filling our vacant positions we anticipate nursing staff issues to be resolved. The barriers are the same for pregnant clients and interconceptional clients.

If transportation was a problem, staff arranged door-to-door transportation for clients to health care appointments and project activities. Through an arrangement with the local transportation authority, a vehicle can pick up clients at their homes or other location, take them to appointments, and return to provide round-trip service. Although many clients identified transportation as a need and a barrier to service utilization, few have taken advantage of this service.

Unfortunately many children living in the project area have elevated blood lead levels. HS staff assists with lead poisoning prevention as they work in the community. They refer children who have not been screened to health centers for testing. They may also assist nurses in locating children referred for lead case management.

Barriers were overcome through: 1) education and information about available services, staff encouragement and support of clients positive choices, 2) Healthy Start provides transportation through local bus system passes or cab fare for more pressing needs, 3) Referral, awareness and coordination with area partners can often facilitate appointment availability.

By making the referral to recommended services the HS staff is able to converse to the provider the immediate nature of the problem, which helps clients obtain an earlier appointment. HS provides public transportation vouchers to assist with transportation needs. In addition cab services are provided for those with an immediate service requirement.

The nurse or resource/outreach worker help eliminate fears of medical care by reviewing expectations with the client. HS staff provides services such as referrals, transportation assistance and translation services. If clients do not have a medical home, they are referred to a provider followed up by the resource/outreach workers to confirm. Medicaid eligible clients are referred to Passport Health Plan for provider selection.

As members of the Neighborhood Place teams, Neighborhood Place partners provide a source of client referrals. HS staff work with community partners to identify clients eligible for the program. Staff regularly visits clinics and delivering hospitals to obtain referrals for client enrollment. Resource/outreach workers canvas door-to-door, visiting businesses, agencies, grassroots organizations, grocery stores, Laundromats, beauty/barber shops, churches and other groups. Staff also participates in health fairs and similar events sponsored by partner agencies to promote client enrollment.

The three Healthy Start Stores have been a client incentive program serving families in the three target areas and have proven to increase the community's awareness of services. Located in the three Neighborhood Place sites, the stores stock a variety of items such as baby clothing, bottles, diapers, diaper bags, strollers, swings and educational items. Clients earn coupons after keeping appointments for health care, WIC, and educational sessions. This collaborative effort involves retail stores, consignment shops, churches, community groups and community health centers. One goal of this program is to increase self-esteem self-sufficiency and responsibility by using a coupon earning system. The stores also increase awareness and utilization of services that will lead to healthy babies and a reduction in infant mortality. The popularity of the store among Healthy Start clients and the "word of mouth" publicity they have given the program has made the stores a substantial recruiting tool resulting in significant referrals.

Healthy Start outreach staff has provided grief counseling to families who experienced pregnancy loss or infant death. A team member contacts the grieving family to offer support as

well as assistance with funeral and burial arrangements if necessary. Agreements have been negotiated with four funeral homes that will serve indigent families at no charge. As clients work through their grief, staff can help them assess the need for health and related services and facilitate referrals.

Collaborations have continued with the community-at-large through Neighborhood Place councils, all Neighborhood Place partners and neighborhood community-based organizations. The faith community and its human service network of community ministries have been integral to continuing validation of Healthy Start.

Another collaborative effort has been the provision of parenting classes in each of the three neighborhoods. Trained staff offered the Nurturing Parenting Program developed by Stephen J. Bavolek, Ph.D. This program promotes nurturing parenting attitudes and skills that contribute to child abuse prevention. The project's health educator coordinates scheduling, arrangements, and publicity. Staff members offer classes at different times of day and different days of the week to make the service accessible to a majority of participants. Childcare and transportation assistance are provided if needed, and nutritious foods are offered. Community schools, agencies, and the courts all work with staff to promote parenting education and to refer clients.

At the Ujima Neighborhood Place Healthy Start has collaborated with the Community Partnership for Protecting Children to offer "Talkshops". This service strengthens parenting skills and enhances family values through short, informal sessions. Facilitators are recruited to discuss a variety of topics that support positive parenting.

Men's services have been coordinated with the Men's Task Force. The task force has been a valuable resource for the assistance of Healthy Start fathers. Staff made referrals for assistance in the areas of employment, services to incarcerated fathers, reintegration of fathers into society from penal institutions, grief services, and other needed support. Fathers have also referred to Healthy Start and other parenting classes.

Healthy Start outreach and other Neighborhood Place staff collaborated to attract additional clients for Healthy Start and the Neighborhood Places as a whole. Healthy Start Coordinators worked closely with Neighborhood Place Administrators to provide support and coordinate training. Team members included the Jefferson County Public School social workers; the Jefferson County Department of Human Services providing emergency financial assistance; Seven Counties Services, the local mental health/developmental disabilities/alcohol and other drug services agency; and the Kentucky Department for Community Based Services, which provides protective services and eligibility determination for Medical Assistance, Food Stamps, and TANF.

These team members acted as community case finders referring pregnant women and other potential clients to the Healthy Start staff. The outreach staff also worked closely with the Neighborhood Place Community Councils in distributing information to neighborhood residents. Other health department preventive health services such as WIC and prenatal providers located at the project sites and other health department clinic locations have referred clients who met the target population for outreach.

Staff of the Northwest and Ujima Neighborhood Places worked closely with the community health centers in their areas that serve many clients in the Healthy Start target population. The Family Health Center-Portland and Park DuValle Community Health Center received project personnel each week to facilitate engagement with newly identified pregnant women. Healthy Start staff was on-site to advise parents of project services and enroll them. In this way new prenatal visits were identified early in pregnancy for the initiation of case management and other services often weeks or months before referrals were received from the Medicaid managed care organization. In addition, one of the HS social workers visits the local birthing hospitals on a weekly basis and recruits and enrolls new mothers into the project. This has been an effective method of engaging interconceptional clients into the program.

The Louisville Metro Health Department Healthy Start staff has conducted presentations on the project to many non-profit community based agencies, many of which become a consistent source of referrals. The outreach team also attends community health fairs to display the program and obtain referrals.

Healthy Start Project has had articles in many different community publications. Included are monthly articles for a newsletter distributed by a local Community Health Center, neighborhood newspapers, *The Courier-Journal* and a Neighborhood Place newsletter, the "Communiqué" that is distributed to 2,500 service agencies and individuals in Jefferson County. The quarterly Healthy Start newsletter has been another successful publication that the project staff works on. This newsletter is distributed to clients, partners, consortia members, local providers and other community members. Public service announcements have also been broadcast over local radio stations.

The project's marketing campaign has continued to publicize project services. Brochures and inserts with specific information on the three sites and service components have been distributed to prospective clients and displayed on pamphlet racks throughout the area. Coordinated door hangers have been used during door-to-door outreach when no one answers or when clients were not home to receive staff.

Bus shelters and billboards also have spread the Healthy Start message. In addition to publicizing the project they have enhanced the safety and security of uniformed field staff by making sure the visitors are identified with these valued services.

The Community Partnership for Protecting Children, funded by the Edna McConnell Clark Foundation to reduce child abuse and neglect in the Healthy Start Project area, has been working with the Healthy Start outreach workers to refer women that they identify who are pregnant and may or may not be receiving health care. A community resource team visits a family who has been reported for child abuse but is considered not serious enough for a full-scale investigation. If any young children or pregnant women are in the family, a referral will be made to Healthy Start. The Department for Community Based Services has shown a direct, sustained flow of referrals as a result of educational efforts and staff participation in the Integrated Services teams.

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In addition to being responsible for activities designed to identify and recruit new clients, HS staff help maintain in care those who were enrolled. If other team members or partners lost clients to follow-up, they made referrals to HS staff who attempted to locate and re-engage participants.

The following table summarizes the care coordination/case management and outreach programs currently in existence including the current number of providers and their client capacity to serve the population targeted under Healthy Start program.

HANDS (Health Access Nurturing Development Services)	Provides an intensive, home visitation program that assists first time parents at critical points during their child's first 2 years of life.
First Steps	Provides services to children from birth to age 3 who have a developmental delay or a diagnosis that is known to cause a developmental delay.
Healthy Child Care	Provides health, safety, and nutritional training at day care centers throughout the community.
Neighborhood Place	Refers program participants to HS and other services; provides community education, and coordination of community activities and services.
Passport Health Plan	Provides case assessments, referral, high-risk referrals for HS program participants. Since 1997, served more than 132,579 clients.
Project Link	Provides comprehensive services for chemically dependent pregnant women through intervention case management. The HS program staff uses Project Link as a referral source for alcohol and drug abusing pregnant and postpartum women.
Family Health Center – Portland and Park DuValle Community Health Centers	These federally-qualified health centers initiate prenatal care for approximately 800 patients yearly.
Family and Children's First	Provides case management services for HANDS. HS refers first time Mothers to HANDS. Family and Children's First refers all non-first time Moms to HS.

The HS staff's role as a resource to clients has required that they keep abreast of services and educational programs offered to low-income mothers to help them become stable proactive decision makers in their own lives. HS provided information about such opportunities to clients on a regular basis. In the event that a client loses employment, housing, utilities, childcare, or does not have food, or is the victim of violence, the worker provides the client with resource information on appropriate crisis intervention services. Furthermore, staff has provided avenues for employment to project area residents and clients.

Team members from each location have participated in special initiatives each summer before school started to ensure that students met requirements for immunizations and physicals. Although these efforts target children older than the Healthy Start population, they nevertheless serve as an effective outreach intervention for the project. They raise awareness of the importance of age-appropriate immunizations and well child screenings. As parents bring infants to the service sites, these younger children can receive immunizations. Children

presenting for six grade physicals/immunizations are counseled about risk reduction related to sex, tobacco, alcohol and other drugs, violence, preventable injuries, etc. Clients are advised of Healthy Start services and are given the opportunity to enroll.

Case conferences are conducted at each of the three sites once a week. The Nurse Care Coordinator conducts the conferences during the triage meetings attended by nurses, social workers, resource/outreach workers and support staff. During the triage meetings each worker has the opportunity to give a case update and recommend changes in the client's plan of care. Our Healthy Start program uses the case conferences as a training /supervisory tool; the employees pose questions, learn from each other's skill, knowledge and experience. These weekly meetings enhance communication by giving the team member an avenue to discuss their issues, identify resources and share experiences with partners to increase collaboration. By working together the team uses this opportunity to foster quality improvement. The Nurse Care Coordinator may discuss quality improvement as it relates to documentation and client charts. The Nurse Care Coordinator reviews one-third of the client records.

Nurse Care Coordinators/nurses assess clients' physical, mental and environmental status. If the client is prenatal, health education is provided to cover such points as fetal development, normal symptoms of pregnancy, sign and symptoms of preterm labor, how substance abuse affects pregnancy. If the client is postpartum, infant care and normal development, self care of breasts and episiotomies are reviewed. During regular home visits, the resource/outreach workers reinforce the importance of timely immunizations, nutrition and correct positioning. After the nurse has an opportunity to sit with the client/family and evaluate their plan of care, the case is assigned to a resource mother/father for monthly home visits to provide health education, support and referrals.

Nurse Care Coordinators are the case managers and coordinate the client's total care. During the weekly triage meetings the Nurse Care Coordinators designates the appropriate plan of care to the resource/outreach staff that will provide follow up case management care for that client.

By making the referral to recommended services the HS staff is able to converse to the provider the immediate nature of the problem, which helps clients obtain an earlier appointment. HS provides public transportation vouchers to assist with transportation needs. In addition cab services are provided for those with an immediate service requirement.

The strong collaborative relationships that have been in place between Healthy Start staff and the staff of the other Neighborhood Place partners have enabled the three Healthy Start sites to use a standardized screening and assessment process for identifying families in need of support and community resources. Families served at all three sites have assisted in the development of individual family support plans to guide their service involvement. Once risk factors and family needs were identified through the screening and assessment process, families were assigned to a specific case manager. The site coordinator and staff have been determining case manager assignment during triage sessions, based on the family's needs.

All agencies at the three Neighborhood Place sites have been utilizing a common form for consent for services and release of information. This standardization of family consent has allowed for information exchange among providers of the Neighborhood Place. While this policy of sharing information may seem insignificant, a great deal of effort and mutual trust must occur for this standardization to be a reality.

Each family works with staff to establish an individual family support plan to delineate family goals. This plan serves as a guide to identify and utilize community resources that the family can access to achieve their goals.

Healthy Start services have made positive differences in the lives of clients. Staff assisted clients to specify goals and facilitate referrals for services such as housing, transportation, education, domestic violence, training and employment, child care items, etc. Several developmentally delayed infants have been referred to First Steps and are making good progress.

An electronic web-based data system was implemented in the Healthy Start Project in 2002. Previous data collection tools including a Microsoft Access database and the Electronic Public Health Record System used by the health department were abandoned in favor of a case management data system purchased from IonIdea, Inc., using HS funds. All HS staff was trained and has been entering their own information in the data base system. All sites have adopted a consistent integrated health record in which all team members document. This has facilitated service coordination, data collection and retrieval, improved efficiency of agency record systems, sharing of data across providers and reduced the need for repetition.

In order to achieve project goals it has been important that orientation training and continuing education be well planned and coordinated. This has encompassed offerings provided by Neighborhood Place, Louisville Metro Health Department, state MCH programs, University of Louisville, and other community continuing education and service providers. All staff has received training on cultural sensitivity, team building, identifying community resources and referral systems, and personal safety when working in the field. Nurse case managers received extensive prenatal and postpartum training conducted by qualified nurse practitioners and academic educators.

During new employee orientation, Neighborhood Place staff attends a one-day workshop entitled Focus on Clients Through Unified Services (FOCUS). This training is designed to build a sense of community, orient staff to the concepts of the Neighborhood Place, to develop an understanding of the benefits of collaborative efforts for families and recognition of knowledge and skills among experienced staff. In each Neighborhood Place guest speakers provide information on community resources and collaborative presentations during regular staff meetings. This forum also allows project staff to inform and update colleagues on Healthy Start activities. Additional training for the staff includes: Using Community Resources, Working with Fathers, Developmental screening- Ages and Stages; Safety in the Home; Stress and Time Management and Professional Boundaries. All HS case management staff has attended smoking cessation training programs to prepare them in assisting preconceptional/prenatal postpartum

clients to stop smoking and increase their awareness of the danger of environmental tobacco exposure for themselves and their children.

The Health Education and Promotion Unit of the Louisville Metro Health Department has a history of collaboration with community agencies that provide education and training for professional as well as nonprofessionals. The health department is the recipient of funds from the Tobacco Master Settlement Monies that are used to address smoking prevention and cessation. A countywide Smoke Free Coalition has been established as a partnership with the Jefferson County Medical Society.

This relationship allows the health department to work with the medical society to identify professional training needs and develop appropriate CME programs that educate and train the provider. The health department is a provider for continuing education units for nurses. The Health Education Unit also has a programmable satellite that provides a live/interactive down link site for national training opportunities for the community and professionals, as well as its own staff. Each professional training activity has measurable objectives and a pre- and post-test determines how well those objectives were met. Healthy Start staff has also taken advantage of the webcast training sessions offered by HRSA in the past couple years.

Training of staff has followed the outreach, perinatal case management, and HANDS models for staff training and development. Given the educational level of clients, staff was trained in delivering education on a level in which clients could comprehend, therefore it was necessary for staff to evaluate the client's ability to understand and comprehend the information. Staff was trained in how to develop or choose educational materials for different levels of reading and comprehension abilities.

The Healthy Start Advocates met periodically since their organizational meeting on September 23, 1999. Their major task was the development of a strategic plan to guide efforts to achieve perinatal system improvements and sustain effective Healthy Start services. Advocates drafted a mission statement, goals and defined the customers and stakeholders to be impacted. These leaders and their teams worked diligently to develop a dynamic strategic plan. Leaders of the advocates represent consumers and providers. Co-chairs of Healthy Start Advocates were originally Ms. Deborah Stallworth, Ujima Neighborhood Place Community Council and Dr. Simmons, the Chief Medical Officer of the Medicaid managed care administrative organization. Ms. Stallworth resigned from her position and the project has been trying to recruit a consumer for this co-chair position. The purpose of the Advocates has been two-fold, to work with staff on achieving perinatal system enhancements and sustainability of effective project services. Efforts were also made to recruit additional consumer members to Healthy Start Advocates. A consumer subcommittee was established and several of the members of this subcommittee participate in the quarterly advocates meeting.

Neighborhood Place is an award winning collaboration among public agencies, including the Kentucky Cabinet for Health and Family Services. While this partnership is consistently working toward improving their systems one of the greatest challenges is using technology to communicate and to share data for common planning. Because of the existing cooperation and

hard work over the past few years, serious consideration has been giving to the Neighborhood Place as a pilot site for data sharing. This is a beginning of working together to use technology as a tool to benefit the residents of Kentucky. By allowing a meaningful overlay of data the Neighborhood Place will be able to have a better plan and resource allocation that is more effective and efficient. Baselines and outcomes are more reliably collected and reported. Preparing grants and reporting to funders is more efficient and accurate. Correlations between problem areas are more readily identifiable. Also by having a common tool, partnership in working with families is strengthened. Client accessibility to services is enhanced, which with improved access, families achieve goals more readily.

5. The impact on enhancing client participation in evaluation of service provision. All staff members receive training on cultural sensitivity, identifying community resources and referral systems, and personal safety when working in the field. Healthy Start also provided local training to local providers and community leaders that were cultural sensitivity such as Grief Counseling, Workshop and multiple Men's Service events. Men's Services events included: support group sessions covering Domestic Violence, Financial Management, Record Expungement, Parenting 101. Men's Services hosted a training conference on October 31, 2003 that included clients and multidisciplinary service providers.

A major Consortium activity has been the birth of the HS Men's Task Force. The HS Consortia has been very involved in the restart of the HS Men's Services Program and has provided leadership and guidance throughout year 2 in the implementation of this important component of the program. The HS Men's Task Force includes individuals from faith-based community, partner agencies and other social service providers. The following are some of the major activities of HS Men's Services Program:

On October 31, 2003, HS Men's Services in partnership with the Task Force presented the first Men's Conference with the theme of identifying gaps in services for men. A panel of speakers included representatives from health delivery, transitional programs for the paroled, male community mentors and job-training counselors. In attendance were 78 participants that included clients, service providers and area business leaders. This conference was successful in bringing a wide variety of service providers together in an effort to provide a cohesiveness of service delivery for the men in our community.

Annual client satisfaction surveys were conducted during 2003 and 2004 to evaluate the services provided by the Healthy Start staff. The results of these surveys indicated that 87% of the clients rated the Healthy Start Program as "very good" and 13% rated it as "good". The table below is reflective of the satisfaction of the clients with program,

Table. Results of the Client Satisfaction Survey (2003-2004)

Statement	Strongly	Agree	Disagree	Strongly
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	Agree			Disagree
The Healthy Start program benefits my Community	77.0%	22.8%	-	-
I trust the Healthy Start person who came to my home	84.2%	15.8%	-	-
I have recommended the program to other people	80.4%	19.6%	-	-
The resource person has a genuine interest in me and my family	78.6%	19.6%	1.8%	-
I learned about some new resources from the Healthy Start person	70.2%	26.3%	3.5%	-
The Healthy Start program has benefited me and my family	80.7%	17.5%	1.8%	-
The staff treats me with respect and dignity	84.2%	15.8%	-	-
I felt comfortable with the nurse who came to my home	83.9%	14.3%	1.8%	-

Besides the annual surveys conducted by the program, the neighborhood place administrators conduct regular satisfaction surveys and disseminates the reports to the program staff.

Consumer input is continually sought during the sub-committee meetings conducted by the Healthy Start staff. In addition to this, a focus group was conducted with Healthy Start participants to gain an insight on what they needed from the program versus what we want to provide through the program. A Health Department educator who is not part of the Healthy Start staff facilitated the group and the program evaluator was present in that group as an observer. This helped the evaluator do a content analysis of the focus group. The participants were asked how they felt about the program and they expressed that they found the program to be supportive, provides different services and they liked the coupon incentive they received. They were asked to describe an ideal home visit. To this question they replied that it should be fun and exciting and bring in lots of information. The best time for a home visit was suggested to be evening by some and flexible by others. They were asked what they expected from a home visitor. To this the major theme that emerged was dependable and easy to talk to. The participants expressed that they needed more visits both by the nurses and their caseworkers. In response to how we should encourage women to enter our program the participants said,

“...Tell them about the support system i.e. the transportation provided”

“...Tell them about all the services provided by Healthy Start.”

Suggestions were also asked from the participants regarding how to promote the program, these were their replies,

“...place information at TAPP...”

“...Expand to other counties such as Newburg, open up another clinic”

“...Place information at middle and high schools.”

These suggestions were used to plan strategies for doing outreach and promoting the program for the competitive grant application for Healthy Start. The participants had expressed concerns

about access to care in one of the major birthing hospitals in the community and these concerns were communicated to the Director of Resource Planning at the hospital.

B. Impact to the Community

1) Developing and empowering Residents increase knowledge of resource/service availability, location and how to access services

From the work of the Edna McConnell Clark Foundation supported CPPC at Neighborhood Place Ujima, several recommended strategies have been rolling out to other Neighborhood Place sites, including the Healthy Start sites. One of these was the Family Solutions Casework Training provided by staff from the University of Louisville under contract with Community Partnership. To date all of the Healthy Start staff has participated in this training that aids them as they work in partnership with families and other service providers.

Certainly these collaborations with major partners have raised community awareness of services for women, children, and families, decreased barriers to access, and increased utilization. Much of the orientation and training of project personnel has addressed assessing family needs and coordinating care. Because staff has been very aware of services and other community resources available within the health department and from other partners, they have been able to respond to a variety of client needs. Every effort has been made for service delivery to be as seamless as possible to clients irrespective of the payment source. Locating Healthy Start teams in Neighborhood Places where other major public providers can immediately respond to provide appropriate services has supported this goal.

As resources have allowed, additional services were streamlined to the specific needs of the disparate communities. Therefore some services were unique to their sites. For example, because one of the Bridge's of Hope's sites has been located within a Housing Authority of Louisville building, its clients have had access to Housing Authority programs, including Youth activities, a self-sufficiency program for housing development residents, parenting education programs, GED classes (offered by the Jefferson County Public Schools), computer classes, Manpower Services, an employment agency. This site also has a drop-in childcare center, so parents can leave their children in a safe environment while meeting with Neighborhood Place staff. Two staff members of Community Coordinated ChildCare Program provided subsidized childcare at this site. Bridges of Hope also has had WIC Nutrition services at both sites.

Advocates meet quarterly; the group is comprised of agencies that represent services in the HS areas. The Neighborhood Place partners have a monthly Integrated Team Meeting, which provides linkage and coordination of services. Ujima Nurse Care Coordinator participates with Park DuValle Community Health Center in providing perinatal educational classes to clinic clients. We collaborate with the Louisville Metro WIC to identify prospective clients and Bridges of Hope Neighborhood Place that sponsors a Back To School event.

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

The Neighborhood Place structure has continued to verbalize and demonstrate commitment to active consumer involvement. Residents and providers participated in frequent meetings, activities, and

trainings. The project has also benefited from the active, well informed, and influential consumers and consumer representatives served on the Bridges of Hope, Northwest, and Ujima Neighborhood Place Community Councils. This level of involvement has strengthened the Healthy Start project and enhanced the consortium.

The Edna McConnell Clark Foundation's initiative, Community Partnerships for Child Protection, is assisting St. Louis, Missouri, Cedar Rapids, Iowa, Jacksonville, Florida and Louisville, Kentucky to develop new approaches to child protection. The goals of the initiative are:

- To assure that children in the neighborhoods targeted by the initiative will be less likely to be abused and or neglected;
- To assure that children who come to the attention of child protective services will be less likely to be re-abused and / or neglected;
- To reduce serious injuries to children in the targeted neighborhoods due to abuse and neglect.

The Family Team Meeting is a group decision-making approach that works with families to define goals, services and resources with the ultimate goal of promoting family safety, stability, and self-sufficiency. One of the critical strategies for accomplishing these goals is employing and individualized course of action with each family served. An individualized course of action is an approach to helping and serving families which includes the following characteristics: strength based, focused on the underlying needs of the family, highly individualized and heavily reliant on assistance from the family, the family's natural helping system and formal and informal community stakeholders. These contributors make up a family team, which supports and assists the family in ongoing problem solving. The Family Team Conference is often the forum in which the child and family team come together to help the family craft, implement or change the individualized course of action. The team that comes together provides an alliance of support for the family and facilitates the family's participation in decision-making regarding safety, permanence and well being for their children. Family Team Conferencing is a solution focused method that draws on the family's history of solving problems, determines times when the family is currently able to solve the problem and develops the family's vision for a preferred future. Family Team Conferencing can work to strengthen families in a way that they can find immediate solutions to needs and provide long term solution for issues related to safety, permanence and well being.

3) Community experience in working with divergent opinions, resolving conflicts, and team building activities. Healthy Start as a project supports working with divergent opinions and resolving conflicts and team building efforts through the Family Team Meeting process (as described above), the N.P. annual conference, monthly N.P. staff meetings, quarterly HS advocates meetings, HS consumer subcommittee meetings, monthly N.P. supervisory meetings, monthly HS staff meetings and different HS committee meetings (i.e. marketing committee, store committee, etc). At every level, HS Neighborhood Place sites encourage team building and the N.P. collaborative is based on team building efforts. The N.P. annual conference, held every fall, is a major team building day long conference that brings staff, community members, and

partner agency administrative members together. HS staff and consortia members participate in this annual team building conference.

The HS system is designed to immediately address any situation of conflict. Whenever divergent opinions cause negative impact on the project, team-building activities are utilized and an experienced professional facilitates this process.

4) Creation of jobs within the community. Healthy Start has been instrumental in creation of jobs within the HS community. Most of the project staff is from the community and specific attention was given to recruit and hire individuals from the HS areas. In addition, the project has worked closely with different agencies and businesses in Louisville area and successfully linked HS clients with vacant positions. Thus, even though the program didn't create any new jobs, except for the 23 HS positions, it was instrumental in linking HS participants to available jobs within the local business community. In addition, during the past two years, HS has had a good job retention rate among the case management and clerical staff members.

C. Impact on the State

Public health efforts to reduce maternal complications and poor pregnancy outcomes encompass a wide array of approaches, including close attention to the system of perinatal health care, particularly its organization and financing. A coordinated system of care is necessary, including clinical services, system connections, and payment for perinatal services, mechanisms to fund infrastructure, providers' education, structures and processes for program accountability. The identified five essential public health functions for pregnant women and infants are: *promoting access to or provision of services to clients, promoting collaborations and partnerships, policy formation, ensuring the capacity and competency of the perinatal health workforce, and informing and educating the public.* These five elements should be leading the perinatal system development.

Healthy Start Initiative's main goal is to enhance the community's perinatal service system and thus to improve the pregnancy outcomes, the health of women and children living in different communities. Healthy Start Initiative was considered a catalyst between public health services and providers' offices.

Two other projects were implemented in Louisville and Jefferson County: Perinatal Periods of Risk (PPOR) and Fetal and Infant Mortality Review (FIMR). By using the PPOR findings, FIMR was targeted to the groups with higher mortality rates. Thus, the gaps/problems in the perinatal system could be identified and followed by recommendations for changes. The lack of available resources hindered the process of using PPOR and FIMR for a short period. Funding for FIMR from March of Dimes ended and the program supported this major component without additional resources.

PPOR and FIMR recommendation for an interconceptional health care plan was considered when the Healthy Start services were re-shaped and adapted to the new funding cycle models. A risk assessment tool as well as an interconceptional health care plan were developed and began

to be implemented in the Healthy Start area with the hope of being expanded to the entire Louisville and Jefferson County area.

This is just an example of a MCH partnership that brings evidence-based findings as well as more insights and understanding of the maternal and child health issues. As a consequence, more targeted and more effective prevention strategies could be developed to improve the health of the women and children living in Louisville and Jefferson County, in the State of Kentucky.

This partnership also strengthens our collaboration with the State Department for Public Health, and especially with Title V. It took time to happen and we consider it just a beginning of more partnership and collaboration not just among different MCH program, but also among different organizations such as the local and state Public Health Departments.

At state and local levels there is appreciation of the fact that additional improvements in perinatal health status indicators will not be achieved by medical interventions alone. Community consortiums that address economic, social, educational, and cultural factors with significant involvement of residents of neighborhoods to be served have been expanded. With Healthy Start funding, this infusion of resources has been reinforcing and has been making a difference in the lives of residents.

Another good example of collaborative relationships is the collaboration between HS team and the case management team of Passport Health Plan (PHP), the Medicaid Managed Care provider in Louisville/Jefferson County. In an effort to avoid duplication of services to the perinatal patients, a referral process was established, where the PHP nursing staff refers the pregnant and postpartum patients in the HS area to HS. This has been a win-win situation for both partners and as a result of the established process, the number of referrals to HS has increased significantly.

Because the mission of the LMHD is “to protect, preserve and promote the health, environment and well-being of the people of Jefferson County principally through health status assessment, policy development and assurance,” it is appropriate for this entity to encourage and facilitate perinatal health systems improvements. Also, as a founding partner of Neighborhood Places, it is well positioned to collaborate with other health, education and social service agencies to raise awareness and improve comprehensive systems of care that can improve birth outcomes. The department’s role has been changing from that of a major provider of medical care to that of assurance. In this way caregivers in both the public and private sectors should see it as a more neutral partner that is not competing for the business of diminishing numbers of patients with insurance coverage.

D Local Government Role

The Louisville Metro Health Department has continued to work in partnership with the state Title V office to implement appropriate components of the state and local perinatal systems of

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care and plans to further strengthen its collaboration with this office. The department receives support from and is linked to the Kentucky Department of Public Health Maternal and Child Health Bureau. Some Title V employees are members of the Healthy Start Advocates group. Dr. Steve Davis, Deputy Director of Kentucky Department of Health, is directly involved with FIMR and Brenda Chandler, Maternal and Child Health Administrator, is the state liaison for HS. Healthy Start has continued to strengthen its collaboration with March of Dimes and HS administrator is an active member of the Kentucky Chapter March of Dimes Program Services Committee. The Fetal and Infant Mortality Review Project was originally supported by March of Dimes and this is another example of collaborative efforts between Healthy Start and March of Dimes.

Healthy Start collaborated with Passport Health Plan, the Medicaid Managed Care Provider that has been a strong referral source for the women in the Healthy Start areas. Since November 1997, the department had a contractual arrangement with Passport Health Plan (PHP), the Medicaid managed care provider for Jefferson County and 15 other counties of Kentucky. This agreement required department nurses, including JCHS staff, to provide perinatal case management services to Medicaid recipients. The arrangement identified Medicaid prenatal clients and placed them in a care management system. This contractual arrangement ended March 2002 and Healthy Start currently collaborates with Passport Health Plan by obtaining referrals for the women in the Healthy Start areas. The Healthy Start nursing staff provides perinatal case management services following the model designed by Healthy Start project. The health department works closely with Passport Health Plan to improve the accuracy of referral information including names, addresses, and phone numbers (when available), and to offer incentives for clients to participate.

Because it was necessary to begin the nursing interventions early in pregnancy to improve outcomes, Healthy Start staff worked to identify eligible clients around the time of pregnancy diagnosis or shortly thereafter. Medicaid and non-Medicaid prenatal referrals were generated by the outreach staff and through agreement with the two public primary health care providers (Park DuValle Community Health Center and the Family Health Center) in the Healthy Start area. Project personnel were assigned to each primary care center weekly to advise new prenatal patients of Healthy Start services and to enroll them. Staff has been working to develop similar referral arrangements with private physicians who care for women in the project area. Healthy Start nurses have begun the process of visiting physician offices to introduce the perinatal case management services and enlist their assistance to identify and refer new prenatal patients to the HS program. Strong collaborative relationships that were already in place between the Healthy Start staff and the staff of other NP partners continued and coordinated services were provided to empower families.

The Kentucky Fiscal Year 2001 MCH Services Title V five-year Comprehensive Needs Assessment and Block Grant Plan identifies priority perinatal and early childhood service needs which are pertinent to the Louisville Metro Healthy Start Initiative. The state's goal is to set Kentucky on the path to achieving economic opportunity and a standard of living above the national average in twenty years. The plan summarizes current status as follows:

Sadly, the overview of the maternal and child health population demonstrated that compared to other states, children are growing up poorer, dropping out of school and not working when they do drop out and if they are living at home, their parents do not have full time year round employment. Too many teens are involved in accidents, smoke and have low birth weight babies. White adults in Kentucky lead the nation in having less than a high school education, view their health as fair or poor, are obese and current smokers. All of these findings demonstrate the aggressive efforts that must be targeted to improve outcomes for women, children and children with special health care needs to bring Kentucky above the national average within 20 years.

To reach the state goal the Title V plan targets efforts toward the core public health functions (assessment, policy development, and assurance), primary prevention, and reducing health disparities. As Louisville/Jefferson County Metro and the majority of other Kentucky local health departments transition away from the direct provision of health services to population based and infrastructure services, the Kentucky Department for Public Health (KDPH) provides more flexible funding to encourage communities to assess and address local needs and emphasize primary prevention:

- Increase the percentage of families receiving support services/parenting assistance through home visiting support programs.
- Increase the number of fetal and infant deaths that are reviewed by a multidisciplinary team.
- Increase the percent of coroner case child deaths undergoing multidisciplinary investigation.
- Increase the percent of children with appropriate weight for height.
- Reduce the percent of young people who smoke.
- Decrease the rate of substantiated reports of child abuse, neglect or dependency.
- Increase the percent of primary care providers in KY who are competent and willing to serve as medical homes for children with special health care needs and assure that each Commission enrolled child has a medical home.
- Assure that children with special health care needs enrolled in the Commission receive comprehensive coordinated care.

Each of these priorities is directly or indirectly related to goals and interventions of the Louisville Metro Healthy Start Initiative:

- Increase the percent of women of childbearing age taking folic acid regularly. Frequency of State funding allows the Louisville Metro Health Department and its contracting providers of Title X family planning services to counsel women about prevention of neural tube defects and supply them with supplements containing 400 mcg. of folic acid. This service has been expanded to WIC and other health department patients with reproductive potential. Prenatal patients receive vitamin tablets containing 800 mcg. of folic acid.
- Increase the percentage of families receiving support services/parenting assistance through home visitation.
- Increase the number of fetal and infant deaths that are reviewed by a multidisciplinary team.

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- Increase the percent of coroner case child deaths undergoing multidisciplinary investigation. The Jefferson County FIMR includes case review and community action teams that consider individual outcomes and mortality trends. The Jefferson County Child Review Team investigates all fatalities of children up to the age of 18 and shares these findings with departmental staff to support affected families and stress indicated prevention strategies.
- Increase the percent of children with appropriate weight for height. Appropriate weight for height among young females can affect prenatal risk and birth outcomes. This indicator is assessed during education and service delivery associated with well child, WIC, family planning, and other care.
- Reduce the percent of young people who smoke. Released CDC State Tobacco Control Highlights reports KY ranks near the top of all states in smoking and smoking-related deaths; it ranks comparatively low in spending to reduce tobacco use. A Prenatal Tobacco Cessation Workgroup has been organized under Jefferson County Smoke Free Coalition's Professional Education Task Group and is staffed by HD Tobacco Prevention and Cessation staff. Tobacco Settlement funds to the Health Department expand the work of the Smoke free Coalition originated by the Jefferson County Medical Society. Youth and pregnant women are among populations identified. HS team members implemented education and counseling to support smoking cessation and exposure.
- Decrease the rate of substantiated reports of child abuse, neglect or dependency. The HS Project leads child abuse and neglect prevention efforts. Edna McConnell Clark Foundation initiative, Community Partnership for Protecting Children, was implemented in the Healthy Start service area and has been expanded metro wide.
- Increase the percent of primary care providers in Kentucky who are competent and willing to serve as medical homes for children with special health care needs and assure that each Commission enrolled child has a medical home.
- Assure that children with special health care needs enrolled in the Commission receive comprehensive coordinated care. Outreach and education for the provider community is vital to continue and expand access to the comprehensive, coordinated care that best meets needs of infants/children with chronic illnesses and disabilities. Infants and toddlers with identified developmental delays are referred to the First Steps Program for case management services.

Besides the collaboration with Title V, the other collaborative efforts on-going in 2003 were:

- Community Assessment and Planning Project (CAPP). Neighborhood Place Partners, Neighborhood Place Community Councils, and other groups participate in this dynamic process.
- Health Access Nurturing Child Development (HANDS), a statewide family support program based on the Healthy Families America and Resource Persons models of risk identification.
- Project Link provides comprehensive services for chemically dependent pregnant women through intervention case management. HS staff uses Project Link as a referral source for alcohol and drug abusing pregnant and postpartum women.
- Faith community and a network of community ministries is a major asset. Churches and linked parishes collaborate with Healthy Start.

- The Kentucky Children's Insurance Program (KCHIP) is a Medicaid expansion program to cover children with family levels up to 200% of poverty levels that works collaboratively with Healthy Start to promote KCHIP enrollment.
- Metro United Way (MUW) is a major community partner in the assessment, planning, and funding of human services. In April 2000, Success by 6 Initiative was undertaken under MUW leadership to ensure that children entering school are prepared to succeed. HS collaborates with MUW to promote services to the children of the community and both programs. In collaboration with MUW, HS was awarded a Dollar General Literacy Foundation Grant in 2002. MUW has continued providing books to Healthy Start clients as an incentive to promote reading to children, despite the discontinuation of this grant.
- High-risk prenatal care and all deliveries are provided through an agreement with University of Louisville Dept. of Obstetrics and Gynecology and the University Medical Center. UL operates a primary care center in the area used a significant number of project area residents for perinatal services.

The collaboration of the Healthy Start Initiative will continue with the Kentucky Bureau of Maternal and Child Health. Louisville Metro Health Department will continue working in partnership with the state Title V office to implement appropriate components of the state and local perinatal systems of care and plans to further strengthen its collaboration with this office. Healthy Start continues to strengthen its collaboration with March of Dimes and has expanded March of Dimes involvement in the Healthy Start Advocates Committee. The Fetal and Infant Mortality Review Project that had originally been supported by March of Dimes is another example of collaborative efforts between Healthy Start and March of Dimes.

Healthy Start also continues to collaborate with Passport Health Plan, the Medicaid Managed Care Provider that has been a strong referral source for the women in the Healthy Start areas. Strong collaborative relationships that are already in place between the Healthy Start staff and the staff of other Neighborhood Place partners will continue and coordinated services will be provided to empower families.

D. Lessons Learned

The lessons learned related to project implementation process that included the hiring of Healthy Start employees and offering of services, helped us better understand that the Healthy Start project does not stand alone and we need to concentrate our efforts on building a strong MCH partnership that would lead to improved pregnancy outcomes. Some of the lessons learned are: prematurity/VLBW is a complex association of different factors and more research is necessary; need to redefine the content of prenatal care and its adequacy or inadequacy;

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preconceptional/interconceptional health is a priority and needs to be carefully addressed; improving the existing data system and/or developing other data sets as necessary (better data for better information); PPOR integration into the existing community initiatives enhances the MCH/women's health capacity and efforts; working as a team and building partnerships, in other words "collaborate"; being flexible and adjusting the system by using the evidence-based findings; the need for right stakeholders and having the political will to be successful.

VI. Local Evaluation

HEALTHY START LOCAL EVALAUTION REPORT

PROJECT NAME: _Louisville Metro/ Jefferson County Healthy Start_____

TITLE OF REPORT: _Healthy Start Initiative Evaluation 2005, Louisville, KY_____

AUTHOR: _Sarojini Kanotra, PhD, MPH, CHES_____

Section I: Introduction

Louisville Metro experienced a 40 percent decrease in its infant mortality rate (IMR) between 1993-2001. In 2002 the IMR showed a distinct rise from 5.9 to 8.9 infant deaths per 1000 live births. Louisville Metro is divided into 10 Neighborhood Place areas. There are certain neighborhood place areas in the western part of Louisville that have very poor birth outcomes. The Healthy Start project serves three of these neighborhood places: Bridges of Hope, Northwest and Ujima. Some other areas are also beginning to exhibit similar trends in birth outcomes. These areas show a high prevalence of minority communities and there have been persisting disparities in between the white and African American population in IMR, fetal deaths, deaths from SIDS, adequacy of prenatal care and low birth-weight births. In order to specify and prioritize the need in our community, the Healthy Start Program Evaluator used PPOR (Perinatal Periods of Risk) and GIS (Geographic Information System) as tools, to

- Assess fetto-infant mortality rates in Louisville Metro using Perinatal Periods of Risk approach.
- Identify the strategic areas in perinatal health for community-based intervention using GIS mapping
- Translate data into information for policy and program planning

The Healthy Start project has been serving women in the three neighborhood place target areas since 1999. Part of the local evaluation to assess the impact of this project by analyzing the birth outcomes of women receiving Healthy Start services and compare them with the women who reside in the target area but are not Healthy Start clients, and to women living outside of Healthy Start area (fig 1).

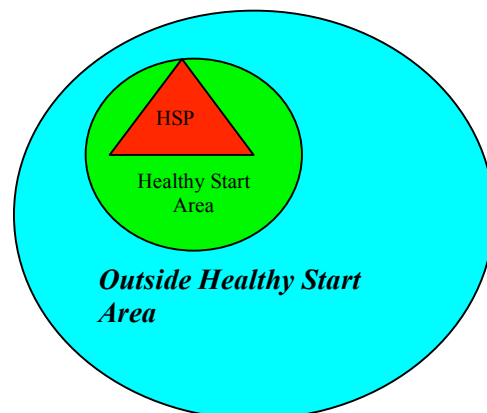


Figure 1. Depiction of Evaluation Plan, HSP=Healthy Start Participants

Key Questions/Hypotheses

- Does living in the Healthy Start area make you more or less likely to have good pregnancy outcomes as compared to women living outside the healthy Start area than by chance alone?
- Does being a Healthy Start participant as compared to a non-participant living in the Healthy Start area make you more or less likely to have good pregnancy outcomes than by chance alone?

Program outcome evaluation was focused on changes in five health outcomes for the Healthy Start (HS) participants at the three Neighborhood Place locations:

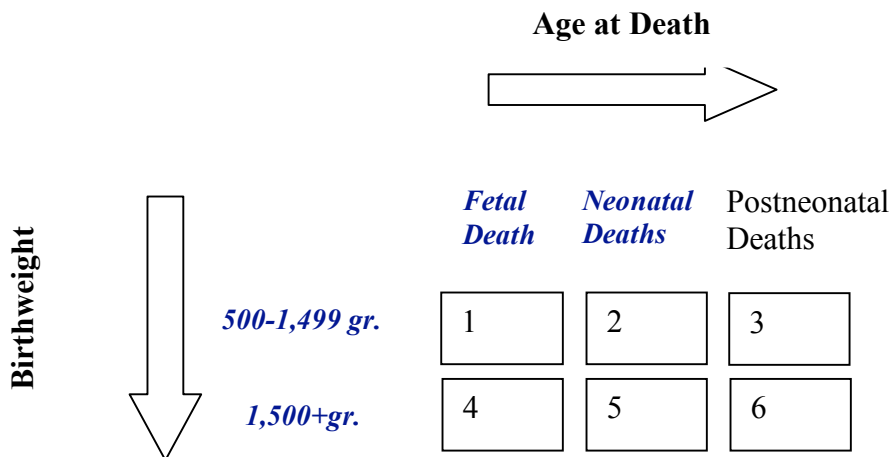
1. Changes in infant mortality in the Healthy Start project area;
2. Changes in initiation of prenatal care during the first trimester;
3. Changes in adequacy of prenatal care during pregnancy;
4. Changes in the percent of preterm births to mothers; and
5. Incidence of low birth weight and very low birth weight babies.

Section II: Process

Needs Assessment of the Community using PPOR and GIS as tools

The Office of Policy, Planning and Evaluation in the Louisville Metro Health Department is responsible for developing a specific statement of need. The Healthy Start program evaluator is part of this office. She uses both Perinatal Periods of Risk (PPOR) and Geographic Information System (GIS) as tools to develop this statement of need in the area of Maternal and Child Health in the community. The PPOR methodology differs from conventional measures of analyzing infant mortality because it is based on a linked birth-death cohort, plus selected fetal records. By including the fetal deaths with infant deaths in a single combined outcome measure, PPOR takes into account all events occurring around the time of birth and provides more information about adverse pregnancy outcomes. Data from linked birth and death files were used to create the categorizations by age at death of the fetus/ infant and its birth-weight.

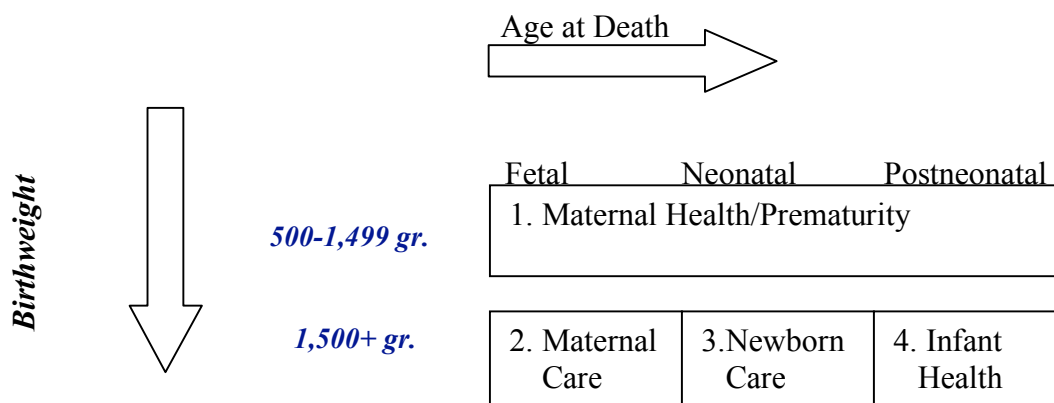
Combining age at death and birthweight yields the two-dimensional map of feto-infant mortality. The three categories for age at death are: (1) fetal deaths, (2) neonatal deaths (first month of life), and (3) postneonatal deaths (remainder of the first year). These time periods are hypothesized to be associated with different causes of death. Birthweight can be divided into two major birthweight categories: those less than 1,500 grams (very low birthweight--VLBW) and those 1,500 grams or more (higher birthweight--HBW) based on the findings that much of the mortality impact of low birthweight can be captured in the VLBW group and it is similar for those 1,500 grams and over. Combining these two dimensions provides a 2 by 3 matrix of 6 cells.



It is important to note that this matrix uses two clearly defined cutoffs. First, fetal deaths are limited to fetal deaths with gestational ages of 24 weeks or more. Second, fetal deaths and live births are limited to birthweights of 500 grams or more. These criteria are important because situations not meeting these criteria often are not reported. For an added benefit, these cutoffs generally limit pregnancy events to those that are physically viable, assuming no underlying congenital defect or medical condition.

The PPOR approach clusters these six cells into four primary groups. First, the VLBW (500-1499g) fetal, neonatal, and postneonatal deaths becomes one group. The other three are the higher birthweight (1500+ g) cells form the three remaining groups.

In the PPOR approach, these four groups are given labels that suggest the primary preventive strategy for reducing deaths for that group. VLBW-related deaths can best be prevented by addressing maternal health issues and by preventing and treating prematurity. For HBW-related deaths the best prevention is adequate maternal care; neonatal deaths, it is providing newborn care; and for postneonatal deaths, it is improving infant health.



These labels were designed to suggest preventive action:

(1) For Maternal Health and Prematurity (VLBW deaths) it is hypothesized that prevention may need to focus on preconceptional health, unintended pregnancy, smoking, drug abuse, and specialized perinatal care.

(2) For Maternal Care (Stillbirths) it is hypothesized that prevention may need to focus on early continuous prenatal care, referral of high-risk pregnancies and good medical management of diabetes, seizures, postmaturity or other medical problems.

(3) For Newborn Care (Newborn Deaths) it is hypothesized that prevention may need to focus on advanced neonatal care and treatment of congenital anomalies.

(4) For Infant Health (Infant deaths) it is hypothesized that communities may need to focus on SIDS prevention activities such as sleep position education or breast-feeding promotion, access to medical homes and injury prevention.

Trend analysis compared the status of infant mortality from 1997-2002 in the four perinatal periods of risk categories: Maternal Health/Prematurity, Maternal Care, Newborn Care and Infant Care. Both external and internal reference groups were used to calculate excess mortality in the county as a whole and by race. Kitagawa analysis was used to estimate the amount of excess mortality due to Very Low Birth Weight (VLBW) births versus the amount due to birth weight specific mortality rates.

Simultaneously, all addresses of women delivering a live birth and all infant deaths from the vital statistics records were geocoded. Maps depicting rates and birth outcomes by neighborhood place areas were created. The results of this analysis were presented at different venues such as the March of Dimes Prematurity Summit, Health Status Assessment Committee, Healthy Start Advocates meetings, Medical Examiners' Office and Community Partnership for Protecting Children initiative (CPPC) in an effort to build collaborative partnerships with the responsive stakeholders.

For conducting Impact Evaluation, 2003 and 2004 preliminary State Vital Statistics birth and death files were used to compare the Healthy Start participants with non-Healthy Start women. Information about the Healthy Start clients is captured in Outreach Case Management database maintained by the Healthy Start evaluator. Social Security numbers (SSN) were used to match the Healthy Start (HS) database to the preliminary birth file. The birth and death files were initially geocoded using ArcGIS software. SPSS software was then utilized for matching and data analysis. Throughout this report, missing and incorrect data from the preliminary Vital Statistics files were treated as missing data. A case-control study design was used to compare the pregnancy outcomes of the Healthy Start clients with Non participants and those outside the Healthy Start area. The normal birth weight infants were considered as control group. The experimental design simulated the Static group comparison design (Russell and Bernard, 1995). Statistical analysis using chi-square tests was done and p-values were calculated to determine if birth outcomes of Healthy Start participants and non-participants living in the target area differed significantly from each other. Since the number of participants was much smaller compared to the non-participants the evaluator also did independent sample tests. The impact evaluation was done only for years 2003 and 2004 since the evaluator did not have information about the Healthy Start participants for years 2001 and 2002. The Outreach Case Management database

system was implemented in 2003 and modified in 2004. Risk factors that may affect the pregnancy outcomes were also assessed and compared between Healthy Start Clients and non-participants. In 2004 the birth file was changed to include several additional data fields that aid assessment of risk factors.

The outcome evaluation focused on a trend analysis (1999-2002) comparing birth outcomes in women living in Healthy Start Area versus those living outside of Healthy Start area.

Section III: Findings/Discussion

Results

PPOR and GIS mapping to assess strategic areas in Perinatal Health for community-based intervention

There was a decline over time in fetio-infant mortality in the Maternal Care and Newborn Care group, but a slight increase in infant mortality in the Maternal Health/Prematurity group (Figure 2).

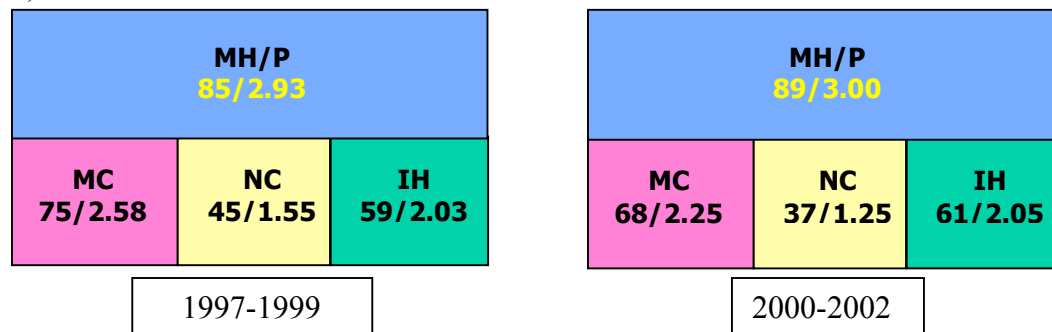


Figure 2. Feto-Infant Mortality maps, 1997-2002.

The Maternal Care and Infant Health groups had larger gaps when compared to external reference groups, 2000-2002 (Table 1). But, Maternal Health/ Prematurity showed the

Table1. Excess fetio-infant mortality rates, 2000-2002

2000-2002	Rate All Races	Internal Reference	External Reference	Difference Internal	Difference External
MH/P	2.92	1.43	2.2	1.49	0.72
MC	2.25	1.79	1.5	0.46	0.75
NC	1.21	1.07	1.0	0.14	0.21
IH	1.78	0.86	1.2	0.92	0.58

highest gap when compared to an internal reference group. The largest racial disparities between African American and Whites existed in Infant Health followed by Maternal Health/ Prematurity (Table 2).

Table 2. Excess feto-infant mortality rates by race, 2000-2002

2000-2002	White	AA	Difference
MH/P	1.95	4.93	2.98
MC	2.32	2.33	0.01
NC	1.07	1.92	0.85
IH	1.06	4.79	3.73

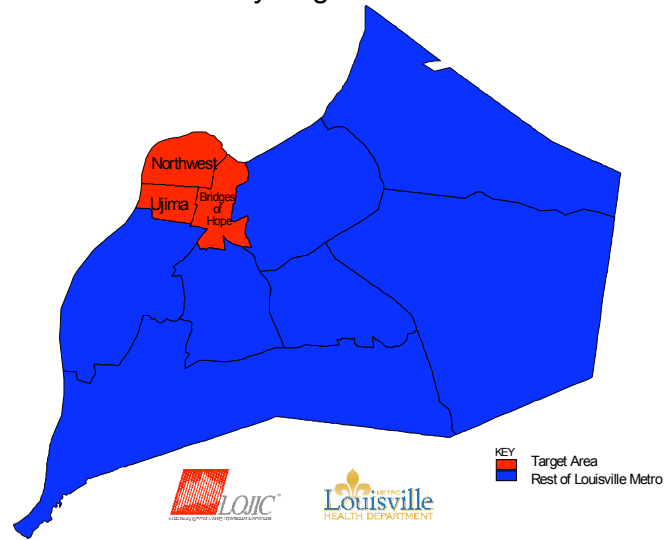
These gaps have increased in 2000-2002 as compared to 1997-1999. Results of kitagawa analysis (Table 3) indicated that birthweight specific mortality contributes 53.5% and birthweight distribution contributes 46.5% to the overall excess mortality when one is looking at the total excess that includes all birth weight categories. Looking at only Maternal Health/ Prematurity, the excess is 83% in infants under 1500 gram birthweight was due to birthweight distribution.

Table 3 Excess Mortality - Effects of the Birthweight Distribution and of the Birthweight-Specific Mortality

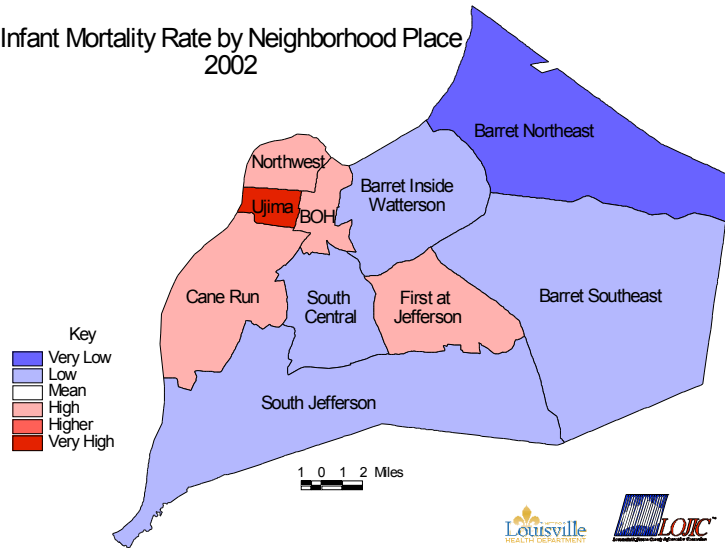
	Actual Contribution to the Difference in Excess Mortality Rates			Percentage Contribution to the Difference in Excess Mortality Rates		
	Birthweight Distribution	Feto-Infant Mortality Rates	Total	Birthweight Distribution	Feto-Infant Mortality Rates	Total
500-749	1.1	0.4	1.5	12.3%	4.3%	16.7%
750-999	1.2	0.6	1.8	13.5%	6.5%	20.0%
1,000-1,249	0.4	-0.3	0.1	5.0%	-3.4%	1.5%
1,250-1,499	0.6	0.0	0.6	6.3%	0.3%	6.6%
1,500-1,999	0.6	0.0	0.6	6.7%	0.0%	6.6%
2,000-2,499	0.6	0.3	1.0	7.2%	3.8%	11.0%
2,500-6,499	-0.4	3.7	3.3	-4.5%	42.1%	37.5%
Total	4.1	4.7	8.8	46.5%	53.5%	100.0%
MH / Prem.	3.3	0.7	3.9	37.1%	7.7%	44.9%

Maps created using GIS clearly depicted three neighborhood place areas that had very poor birth outcomes. These were Ujima, Northwest and Bridges of Hope, also known collectively as the Healthy Start area. When a map showing the prevalence of African Americans in Louisville Metro was layered over the NP area maps, it became very clear that the three Healthy Start NP areas had a very high prevalence of the minority population. Another NP area was identified, First at Jefferson, also has a high African American population.

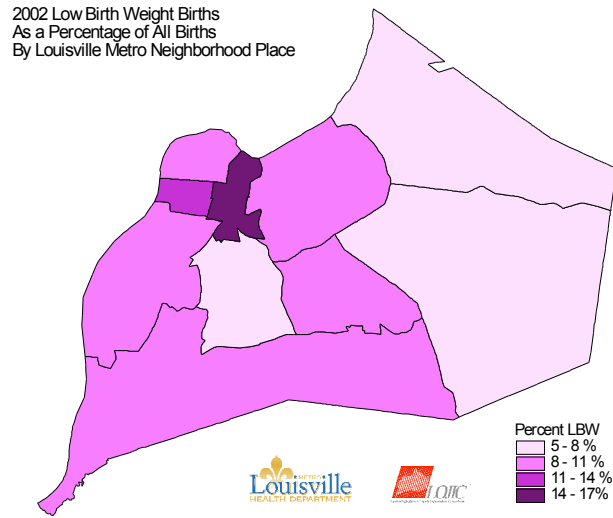
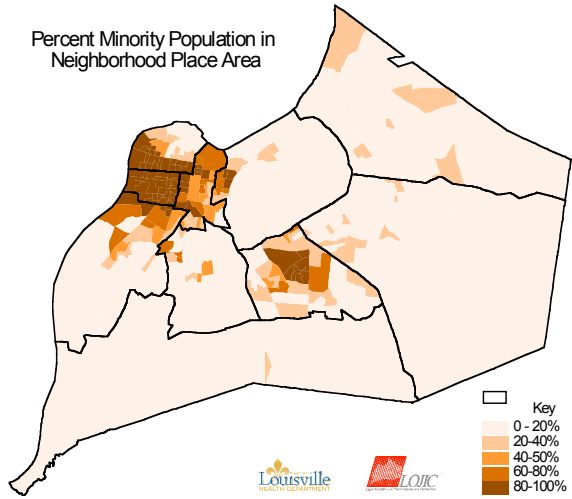
Louisville Metro by Neighborhood Place Areas



Infant Mortality Rate by Neighborhood Place
2002

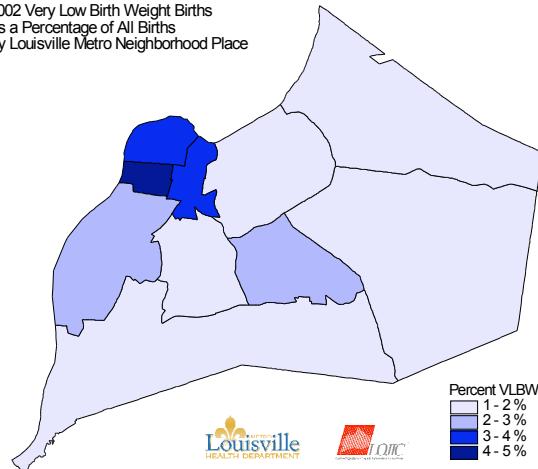


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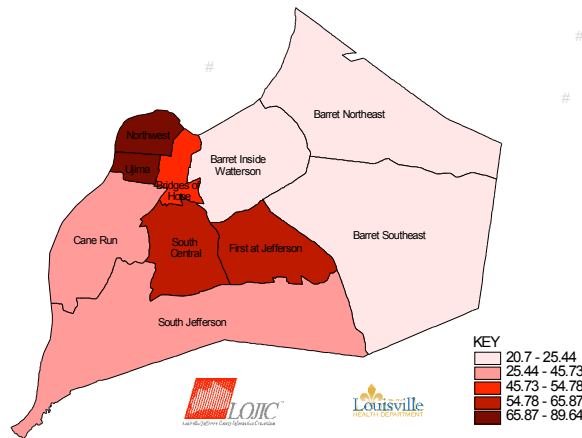


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2002 Very Low Birth Weight Births
As a Percentage of All Births
By Louisville Metro Neighborhood Place



2002 TEEN BIRTH RATES BY NP



The maps shown above clearly show that areas with poor birth outcomes are located in the Healthy Start target area and other areas that also have a high percentage of African American population.

2003 Impact Evaluation Results

Birth Outcomes of Women Living in the Healthy Start area compared to those living outside Healthy Start Area:

Two variables were tested for significant differences- Low birth-weight births and entry into prenatal care. There are significant differences in low birth-weight births to women living in the Healthy Start area as compared to those living outside the Healthy Start area. Similarly entry into prenatal care was significantly different in the two populations. Women entered prenatal care earlier if they lived outside the Healthy Start area.

Table 4 LBW Birth in HS Area versus Outside Healthy Start Area Cross tabulation

		Healthy Start Area	Outside Healthy Start	
Less than 2500 grams	Observed Count	105	413	518
	Expected Count	74.3	443.7	518.0
Greater than or equal to 2500 grams	Observed Count	734	4598	5332
	Expected Count	764.7	4567.3	5332.0
	Count	839	5011	5850
	Total	839.0	5011.0	5850.0

* Chi-square P value <0.001

Table5 Trimester Care Began versus In Healthy Start Area Crosstabulation

		Healthy Start Area	Not in Healthy Start Area	
First trimester	Count	690	4482	5172
	Expected Count	735.0	4437.0	5172.0
Second Trimester	Count	113	364	477
	Expected Count	67.8	409.2	477.0
Third trimester	Count	19	116	135
	Expected Count	19.2	115.8	135.0
	Total	822.0	4962.0	5784.0

* Chi-square P value <0.001

The data support that living in the Healthy Start area make you more likely to have poor pregnancy outcomes.

Birth Outcomes of Women who are Healthy Start participants compared with non- participants living in the target area:

The variables tested in this instance included the birth-weight of the infant born to these women, low birth-weight birth, preterm birth, entry into prenatal care and adequacy of prenatal care.

Table 6 Independent T Test of Birthweight, 2003

	HSPART	N	Mean	Std. Deviation	Std. Error Mean
GRAMS	Yes	143	3219.8703	491.46762	41.09859
	No	1149	3065.1370	714.54244	21.07987

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* Independent T test assuming unequal variances P value=0.001

Infants' birth-weight in grams was found to be significantly higher for Healthy Start participants (HSPART) compared to non-participants in the area.

Table 7 HSPART * LBW Crosstabulation

			LBW		Total
			Yes	No	
HSPART	Yes	Count	10	133	143
		Expected Count	19.6	123.4	143.0
	No	Count	167	981	1148
		Expected Count	157.4	990.6	1148.0
Total		Count	177	1114	1291

Chi-square P value <0.05

The expected count of the number of low birth-weight births to Healthy Start participants was approximately 20 but the observed low birth-weight births were only 10. The number of low birth-weight births to Healthy Start participants was significantly lower as compared to non-participants in the area.

For preterm births to healthy start participants the expected number was 23 preterm births but the observed preterm births were 17. However, the chi-square results did not give a significant difference between the preterm births to healthy start participants versus non-participants.

Table 8 HSPART * Preterm Birth Crosstabulation

			Preterm Birth		Total
			Yes	No	
HSPART	Yes	Count	17	126	143
		Expected Count	22.7	120.3	143.0
	No	Count	188	961	1149
		Expected Count	182.3	966.7	1149.0
Total		Count	205	1087	1292
		Expected Count	205.0	1087.0	1292.0

* Chi Square P-value = 0.167

Table 9 HSPART * PNC IN First Trimester Crosstabulation

			PNC IN First Trimester	Total

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			Yes	No	
HSPART	Yes	Count	123	20	143
		Expected Count	119.4	23.6	143.0
	No	Count	956	193	1149
		Expected Count	959.6	189.4	1149.0
Total		Count	1079	213	1292

Although the observed number of Healthy Start clients that entered prenatal care in the first trimester was higher than the expected the difference between the Healthy Start clients versus non-participants entering prenatal care in the first trimester was not significant (Chi-square P value was equal to 0.393). A similar pattern was observed for adequacy of prenatal care between the two comparison groups.

Table 10 HSPART * Adequate PNC Crosstabulation

			Adequate PNC	Inadequate	Total
HSPART	Yes	Count	119	23	142
		Expected Count	110.9	31.1	142.0
	No	Count	886	259	1145
		Expected Count	894.1	250.9	1145.0
Total		Count	1005	282	1287
		Expected Count	1005.0	282.0	1287.0

* Chi-square P value= 0.081

Of all the variables tested birth-weight of the infant in grams and low birth weight births were the only two variables that were significantly related when comparing between the Healthy start participants and non-participants. Hence, being a Healthy Start participant as compared to a non-participant living in the Healthy Start area was significantly related to not having a low birthweight birth.

2004 Impact Evaluation Results

The 2004 State Vital records are preliminary and we could match only a small number of births to Healthy Start participants in these files. The file structure of 2004 vital records has been changed to include several risk factors that may help us understand the poor birth outcomes in women living in the Healthy Start area.

Birth Outcomes of Women Living in the Healthy Start area compared to those living outside Healthy Start Area:

Table 11 LBW * In Healthy Start Area Crosstabulation

			Not in Healthy Start Area	In Healthy Start Area	
LBW	Less than 2500 grams	Count	715	191	906
		Expected Count	787.0	119.0	906.0
	More than 2500 grams	Count	7676	1078	8754
		Expected Count	7604.0	1150.0	8754.0
Total		Count	8391	1269	9660

*Chi-Square P value<0.001

Low birthweight births were tested for significant differences between the two populations. It was seen that there are significant differences in low birth-weight births to women living in the Healthy Start area as compared to those living outside the Healthy Start area. There is sufficient evidence to say that living in the Healthy Start area makes you more likely to have poor pregnancy outcome such as low birth-weight birth.

Birth Outcomes of Women who are Healthy Start participants compared with non- participants living in the target area:

The variables tested included the birth-weight of the infant born to these women, low birth-weight birth and preterm birth.

Table 12 Group Statistics Birthweight, 2004

	HS Participant	N	Mean	Std. Deviation	Std. Error Mean
GRAMS	Yes	110	3025.88	680.792	64.911
	No	1159	3031.60	714.083	20.975

* Independent T test assuming unequal variances gave a P value=0.936

Infants' birth-weight in grams was not significantly higher for Healthy Start participants compared to non-participants.

Table 13 LBW * HS Participant Crosstabulation

			HS Participant		Total
			Yes	No	

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LBW	Less than 2500 grams	Count	16	175	191
		Expected Count	16.6	174.4	191.0
	More than 2500 grams	Count	94	984	1078
		Expected Count	93.4	984.6	1078.0
Total		Count	110	1159	1269

* Chi-square P value= 0.877

Table 14 PRETERM * HS Participant Crosstabulation

		HS Participant		Total
		Count	Yes	No
PRETERM	Preterm	20	186	206
		Expected Count	17.9	188.1
	Normal	90	973	1063
		Expected Count	92.1	970.9
Total		Count	110	1159
		Expected Count	110.0	1159.0

* Chi-square P value= 0.562

There is not a significant relationship between Healthy Start participants and non-participants in the area. The file structures of 2003 and 2004 vital statistics files are very different so it was not feasible to compare them at this time.

Risk factors of healthy start participants who gave birth in 2004 were compared with all women who gave birth lived in the healthy start area and those who lived outside the healthy start area. The following table shows the different social and medical risk factors that could have an effect on the pregnancy outcomes of these women.

Looking at Table 15 we can see that majority of the women living in the Healthy Start area are Medicaid recipients, are African American, have lower level of education, and are un-married. These women smoke at a higher rate compared to women living outside the healthy start area. None of the Healthy Start participants reported drinking alcohol during pregnancy.

Examining the medical risk factors associated with the current pregnancy of all women that were Healthy Start clients, shows that the program is targeting very high-risk women.

Table 15 2004 Risk Factor Analysis

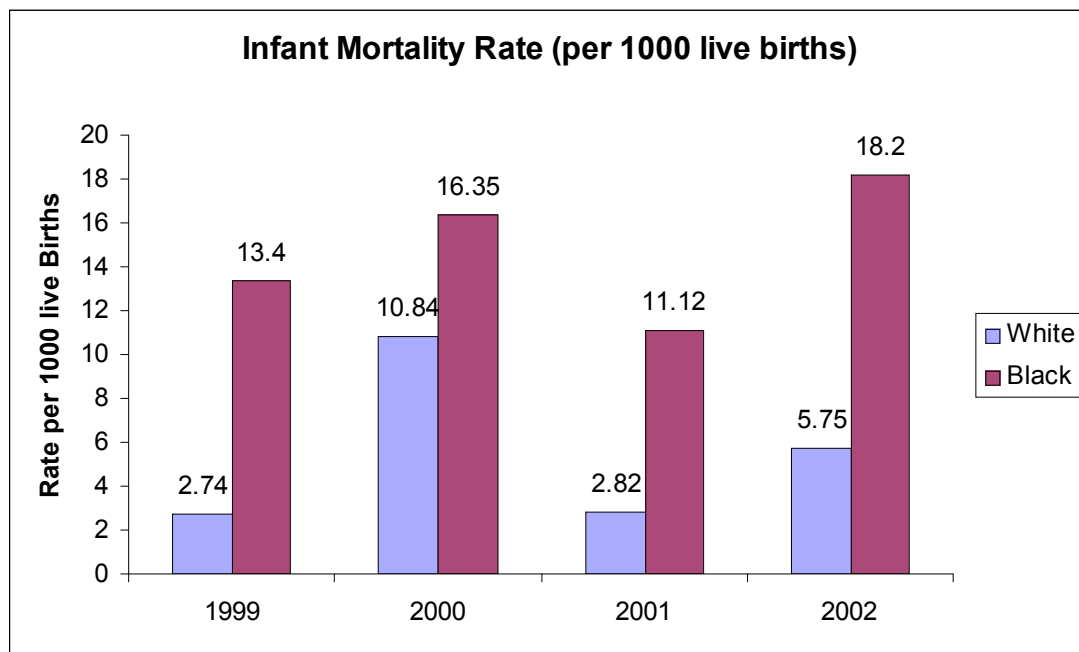
2004 Risk factors Analysis	Louisville Metro	Outside Healthy Start Area	Inside Healthy Start Area	Healthy Start Participants
Social Risk Factor				
Marital Status	44.1%	38.5%	81.4%	82.4%
Education (<HS Grad)	19.1%	16.6%	35.9%	34.4%
Hispanic Origin	5.3%	5.8%	2.2%	0.0%
Race (AA)	24.9%	17.6%	73.5%	87.4%
Income (Medicaid)	30.5%	25.8%	61.2%	73.1%
Smoking	22.4%	21.6%	28.0%	27.7%
Alcohol Use	1.1%	1.1%	1.3%	0.0%
Medical Risk Factors				
Previous Children Dead	3.3%	2.8%	7.2%	10.1%
Prepregnancy Diabetes	0.7%	0.7%	0.5%	1.7%
Gestational Diabetes	6.6%	6.9%	4.6%	5.0%
Prepregnancy Hypertension	0.0%	0.0%	0.0%	0.0%
Gestational Hypertension	0.3%	0.3%	0.4%	0.0%
Previous Preterm Birth	2.6%	2.2%	5.7%	8.4%
Previous Poor Pregnancy Outcome	2.2%	2.0%	3.6%	3.4%
Uterine Bleeding Prior to Labor	1.5%	1.4%	2.2%	1.7%
Pregnancy Result of Infertility Treatment	1.2%	1.4%	0.0%	0.0%
Previous Cesarean Delivery	10.2%	10.3%	9.9%	9.2%
Gonorrhea Present During Pregnancy	0.6%	0.4%	1.9%	0.0%
Syphilis Present During Pregnancy	0.1%	0.1%	0.5%	0.0%

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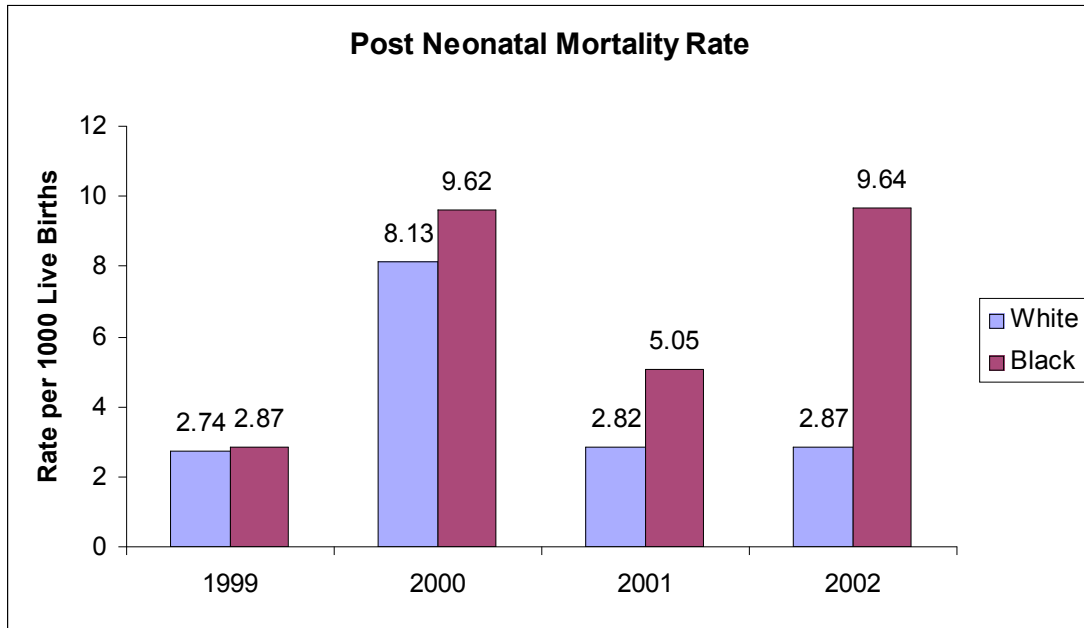
Herpes SV Present During Pregnancy	2.1%	2.0%	2.8%	6.7%
Chlamydia SV Present During Pregnancy	2.3%	1.7%	6.8%	8.4%
Hepatitis B Present During Pregnancy	0.1%	0.1%	0.0%	0.0%
Hepatitis C Present During Pregnancy	0.0%	0.0%	0.0%	0.0%

Outcome Evaluation

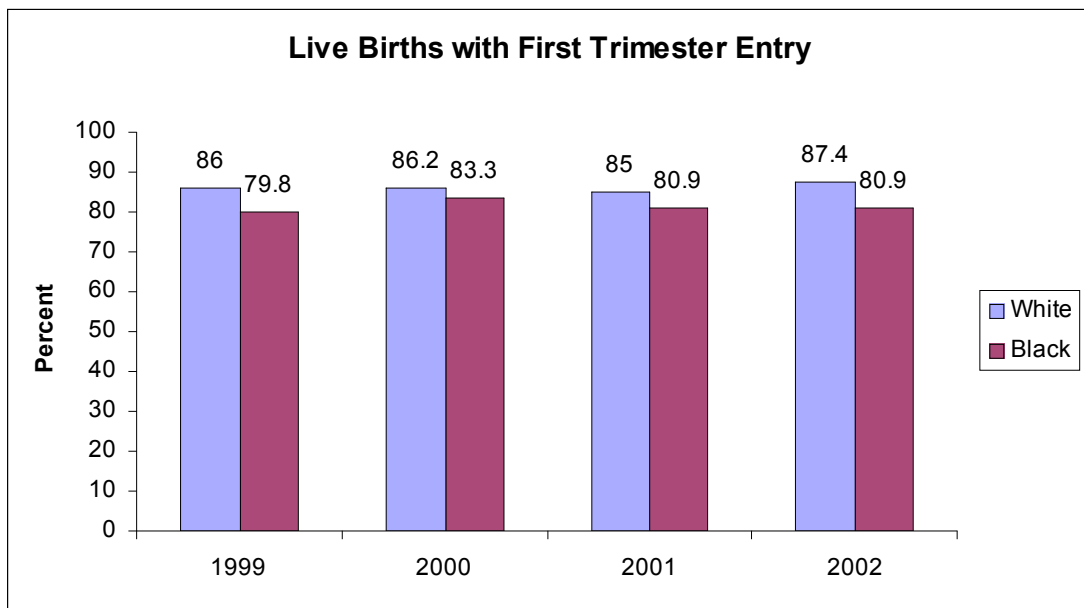
Trend analysis was conducted to see changes in infant mortality, low and very low birth-weight births, entry into prenatal care, adequacy of prenatal care, and preterm births in the Healthy Start area. The following graphs illustrate the changes observed in birth outcomes between white and black women living in the Healthy Start area from 1999-2002.



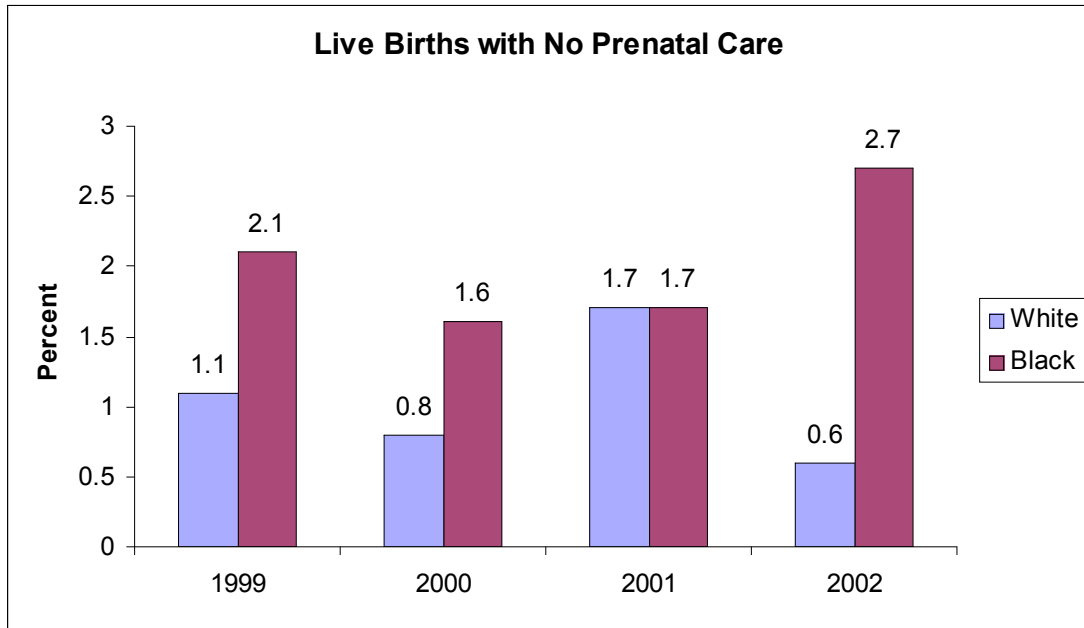
The graph above showing the infant mortality by race from 1999-2002 it is clear that not only has the IMR increased for African American infants but the gap between the African American and white population has increased through these years. This trend mirrors the national trend for IMR between black and white population.



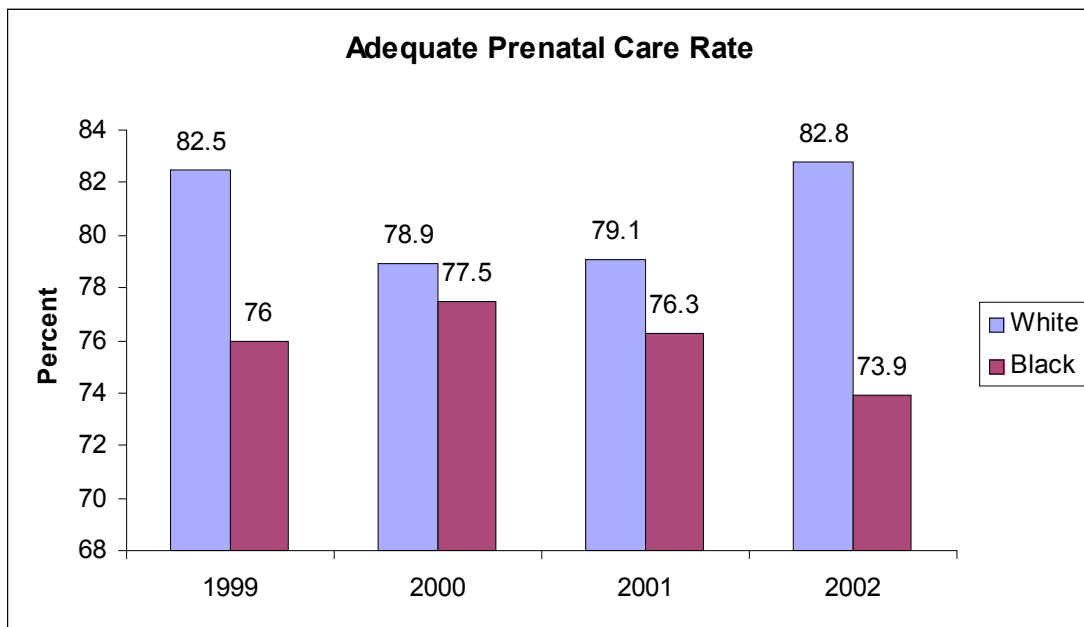
The graph above shows that over time the postneonatal mortality rate for African Americans has increased in the Healthy Start area.



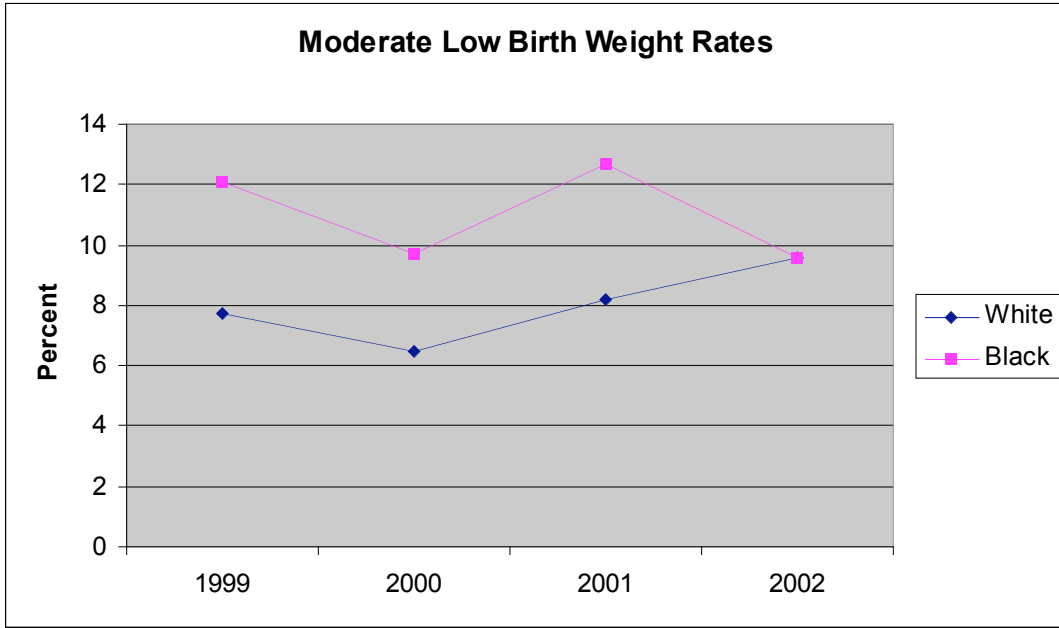
In the graph above shows a slight increase in African American women entering prenatal care in the first trimester but the percent is still lower than White women entering prenatal care in the target area.



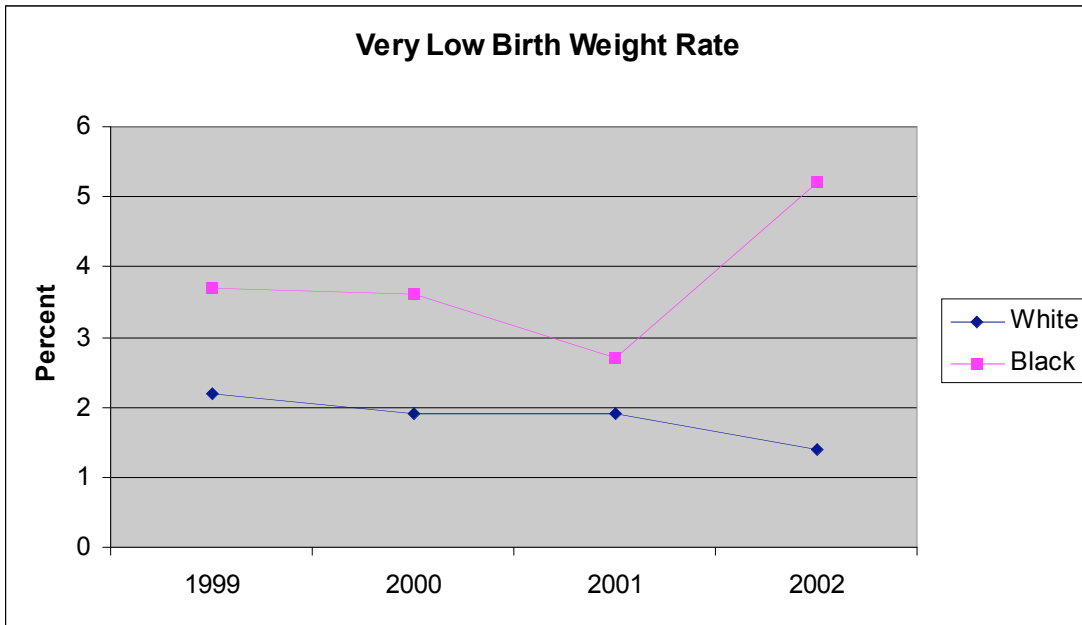
The results shown in the graph above are dramatic for 2002. Almost 3% of the African American women had no prenatal care in compared to only 0.6% for white women.



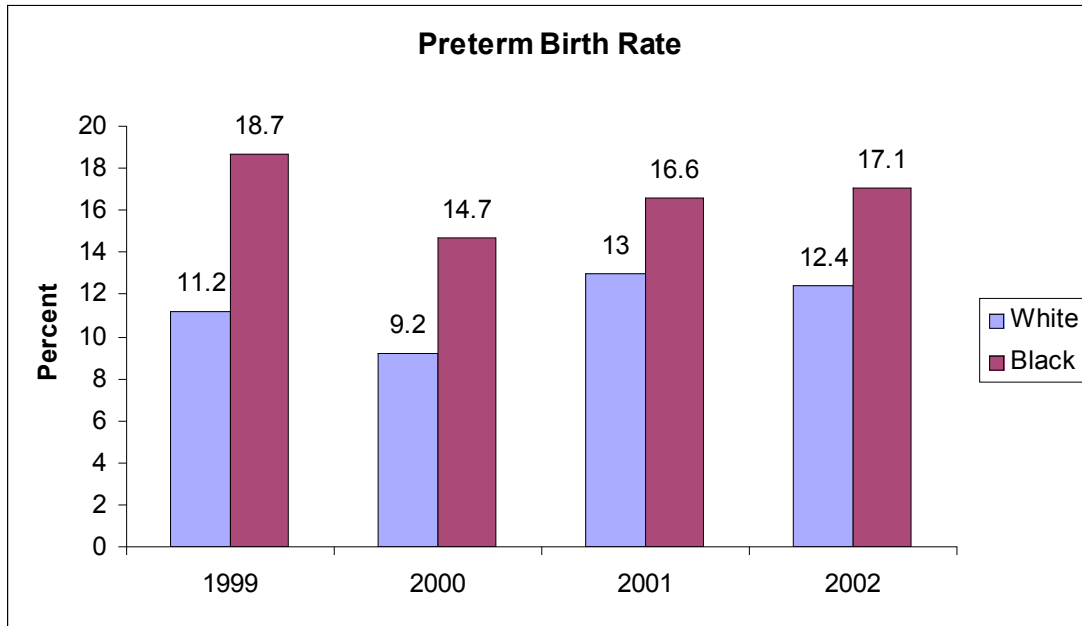
Adequacy of prenatal care is again lower for African American women compared to white women.



Low birth-weight births have decreased in African American women and increased in white women.



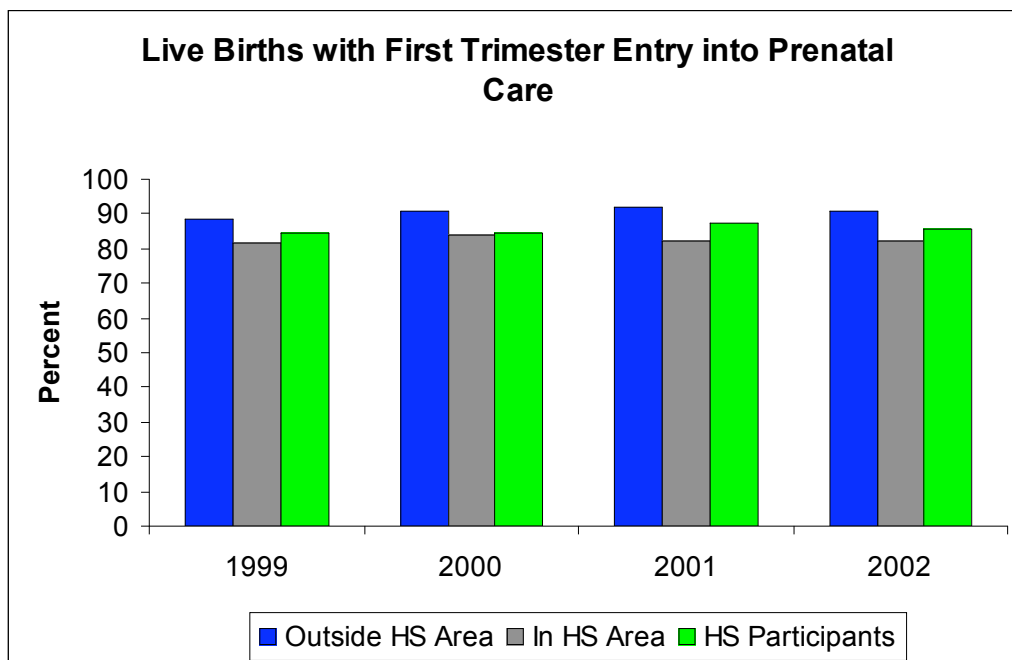
An opposite trend is seen for the two races for very low birth-weight births.



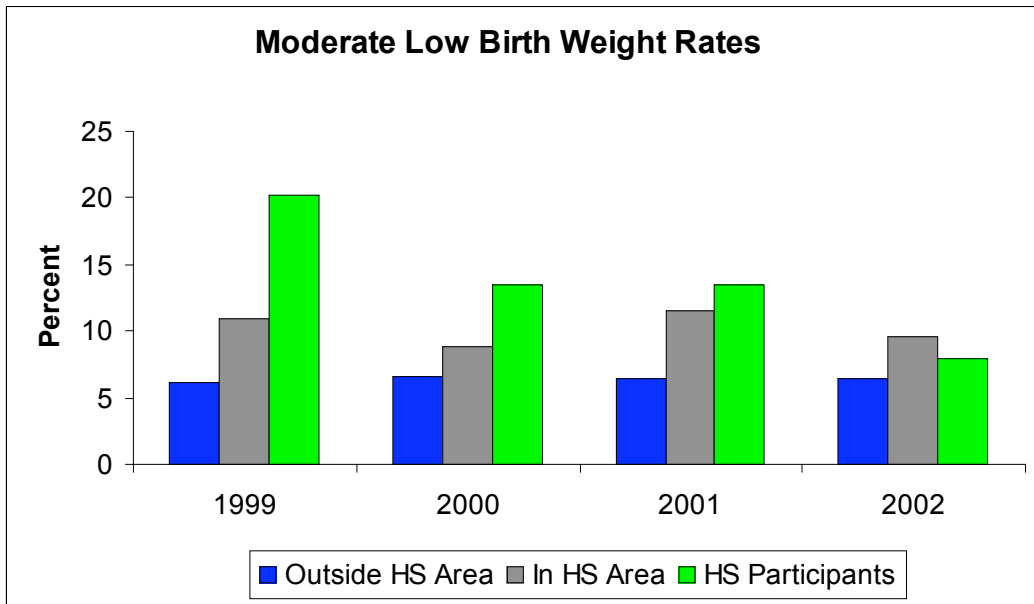
The preterm birth rate seems to be increasing in African American women since 2000, although it did show a decrease in 2000 as compared to 1999.

Comparison In Birth Outcomes Among Healthy Start Participants, Women Living In Healthy Start Area And Those Living Outside The Target Area

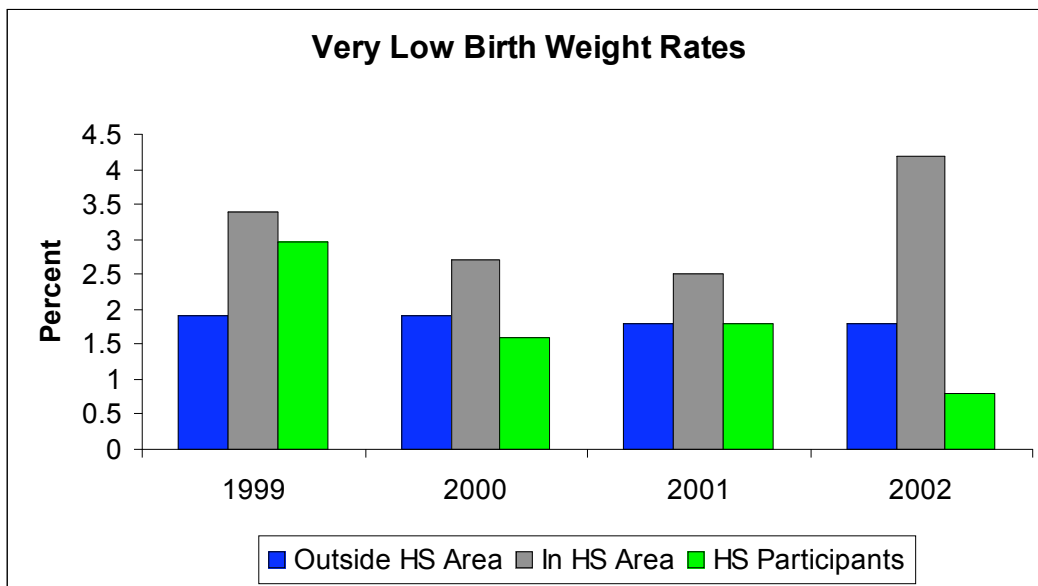
The following graphs show a comparison in the birth outcomes to Healthy Start Participants, women living in the Healthy Start area and women living outside Healthy Start area during the period 1999-2002.



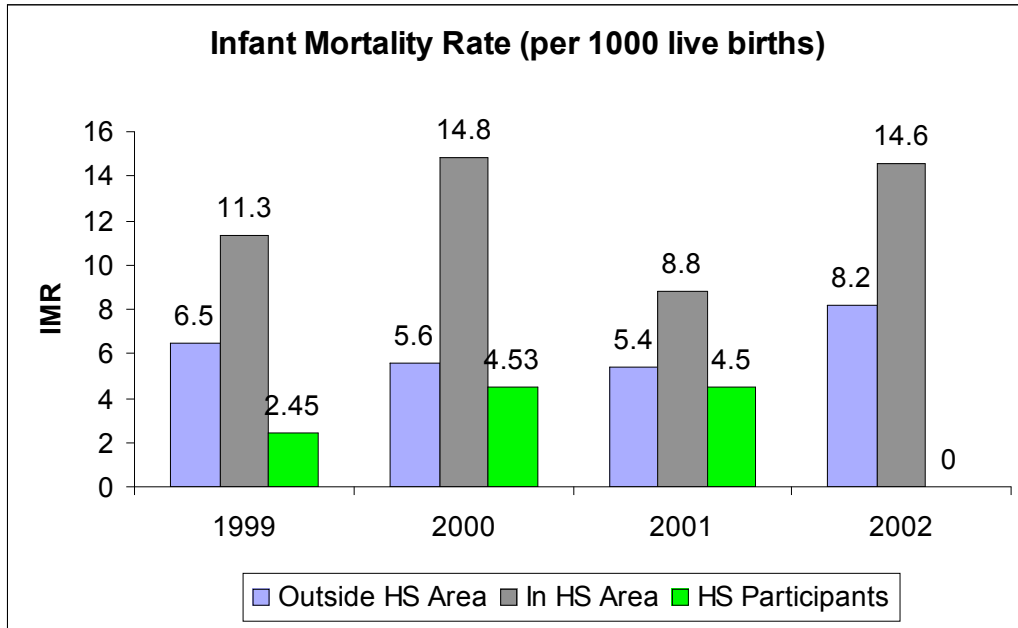
The graph above shows that Healthy Start participants entered prenatal care earlier than the non-participant women living in the Healthy Start area.



The moderate low birth weight rate shows a steady decline for healthy start participants, in fact in 2002 it was lower than the women living in the healthy start area.



The very low birth weight rate also shows a decreasing trend for Healthy Start participants. In 2002, this rate was lowest for the participants as compared to both women living in the healthy start area and outside healthy start area.



In 2002, the IMR increased in both the healthy start area as well as outside the Healthy Start area but there was zero infant death noted for healthy start participants.

Discussion:

When examining the needs assessment, impact and outcome evaluation data for the Healthy Start initiative, it becomes apparent that the target area is in great need of a program that provides interventions to reduce the disparities in poor birth outcomes between the resident African American and white women. The Healthy Start program has made a positive impact in lowering the low birth weight births and infant mortality rate in the participants who receive healthy start services. The evaluation results point to the need to focus preventive efforts on preconceptional health of women living in the area and prevention of postneonatal deaths. The community in Louisville has come together to address the latter issue by starting a Safe Sleep and Crib for Kids campaign. The community now needs to focus on preconceptional health of women.

Limitations:

One major limitation is an inability to obtain the most current data on birth and death files from the state. This inhibits the evaluation process of matching cases with the birth and death files. The file structure for the 2004 birth file was changed tremendously making it difficult to merge the 2003 and 2004 birth files for statistical comparisons. The current evaluator did not have information about the clients in 2001 and 2002 so statistical tests could not be run for all years 2001-2004 to obtain a more comprehensive complete picture.

Section IV Recommendations

- Local evaluation reveals the need to of focus preventive efforts in the area of preconceptional health of women, to target women before they become pregnant.

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- The program needs to examine why women are not entering prenatal care earlier during their pregnancy.
- The program needs to develop linkages with the health care providers, especially the physicians in an effort to research the reason why the entry into prenatal care is lower in the target area.
- The program needs to seek advice and help from the consortia in terms of volunteer hours. It needs to use consumers to do outreach and assist in answering the questions regarding entry into prenatal care.

Further evaluation will include examining the reasons for lower rates of entry into prenatal care by conducting focus groups and/ or interviewing agencies that provide prenatal care.

Section V Impact

A major impact of the needs assessment and local evaluation was seen when crucial stakeholders such as the State Department of Public Health focused their attention to reduction of feto-infant mortality in Kentucky. The State Public Health Deputy Director contacted the Louisville Metro Health Department to collaborate in starting Fetal Infant Mortality Review (FIMR) in Louisville Metro as a pilot project with the vision of making it a statewide initiative. The State is applying for the Pregnancy Risk Assessment and Monitoring System (PRAMS) grant. It is CDC's flagship surveillance system of women and infants, serving over 32 states. The evaluator is assisting the State in the application process. The Health Department is doing a MAPP process for the community and the evaluator is a part of the data assessment team.

Maps showing that the areas with poor birth outcomes are concentrated in the western part of Louisville Metro also made an impact with the stakeholders. The new Director of the Health Department has made reduction of persisting disparities in infant mortality part of the strategic plan of the department. Dr Troutman received monies from the Mayor of Louisville to open a Center for Eliminating Health Disparities.

Ongoing communication of these results to the Deputy Director of the Health Department, Janita Perry and the Director of the Office of Policy, Planning and Evaluation, Sheila Andersen, has resulted in the development of a Women's Health Task Force. This task force will specifically focus on preconceptional health issues in the community and how we can resolve the problems through changes in policy, access to services, and education.

Section VI Publications

1. **Kanotra S**, Troutman A, Andersen S and Assef N. 2005. Using Perinatal Periods of Risk (PPOR) and Geographic Information System (GIS) to assess feto-infant mortality rates and to identify strategic areas for community-based intervention in Louisville. Submitted to CityMatCH. Selected for oral presentation during the 15th Annual City MatCH Urban Maternal and Child Health Leadership conference (September 10-13, 2005) in Fort Worth, TX

2. **Kanotra S**, Troutman A, and Andersen S. 2005. Assessing feto-infant mortality rates using Perinatal Periods of Risk (PPOR) approach to identify strategic areas for community-based intervention Submitted to American Public Health Association. Selected for Poster presentation during the 133rd Annual Meeting (November 5-9, 2005) in New Orleans, LA.

VII. Fetal and Infant Mortality Review (FIMR)

The program had a FIMR project implemented in Jefferson County in 2001 that was funded by the Kentucky Chapter of the March of Dimes. The previous Healthy Start Evaluator, Dr Violanda Grigorescu, was the FIMR Project Coordinator. She was instrumental in engaging partners and implementing FIMR project in Louisville Metro/ Jefferson County. She developed a Case Review Team composed of physicians and nurses from the community that met twice during that year to review cases that had been identified using Perinatal Periods of Risk approach. This project was not staffed to lead case investigation for all fetal and infant deaths that occurred in Jefferson County. Therefore, the PPOR findings were used to target the FIMR efforts, to analyze only those deaths from the groups identified as having gaps/higher rates when compared to reference groups. Dr. Grigorescu left the program in second year of the grant cycle and this brought the FIMR project to a stand still.

The current evaluator joined the program in October 2003 and she picked up the threads where the previous evaluator had left off. She started from the process of analyzing the fetal-infant deaths using PPOR as a tool. The Human Subject Committee approval for the FIMR project had expired in March 2003 so she could not continue reviewing cases with the CRT team. But, with continuous presentations to powerful stakeholders regarding the status of fetal-infant mortality the present evaluator re-generated the interest of the community towards this issue. The State Public Health Deputy Director contacted the Louisville Metro Health Department to collaborate in re-starting Fetal Infant Mortality Review (FIMR) in Louisville Metro as a pilot project with the vision of making it a statewide initiative.

At present the evaluator is in the process of getting the Human Subjects Approval from the University of Louisville. She is working closely with the State Infant Mortality Program Coordinator Carolyn Robbins to develop a Community Action Team. She plans to use the previous members of the Case Review Team and has requested those members to participate. It is hopeful that the FIMR process will be fully functional during the CY 2005. In addition to federal funding for this project, additional financial and political support is being sought from the State and local Legislators and the State Department of Public Health. Thus, PPOR and FIMR will be used an-on-going fetal and infant mortality surveillance in Louisville Metro/Jefferson County.

FIMR Model

