

# **SHIELDS FOR FAMILIES, INC.**

## **HEALTHY START IMPACT REPORT Grant Project Period: 7/2001-5/2004 H49 MC 00094**

**September 30, 2005**

**I. Overview of Racial and Ethnic Disparities Focused on by this Project:  
Identify the racial, ethnic or other disparities focused on. Highlight initial  
needs assessment data that led to the decision to focus on the identified  
disparities.**

During the project period of 2001 - 2004, the SHIELDS Healthy Start Program provided a Comprehensive Services Model to pregnant and post partum substance abusing women with children 0-2 within the African-American population in South Central Los Angeles (zip codes: 90002, 90047, 90059, 90061, 90220, 90222). The decision to focus on this population was based on needs assessment data for the community as well as our previous three years of experience providing Outreach services to this target group.

The Watts/Willowbrook community is one of the poorest in Los Angeles County, with 55% of the population dependent upon public assistance. More than 39% of the children less than 18 live below the poverty level and more than 50% live in single parent, female headed households. Based on the data available at the time of the proposal submission, approximately 104,167 women of child bearing age resided in the catchment area, which accounted for an average of 5096 live births annually between 1996 and 1998. For African American women, infant mortality rates were significantly higher than all other populations with an average rate of 15.02 during the same time period in the targeted community.

One of the primary reasons for this high rate was related to substance abuse, with approximately 15% of all African American births at Martin Luther King Hospital/King-Drew Medical Center (the public hospital serving the targeted zipcodes) being substance exposed (approximately 269 births annually) (Department of Health Services, 1999). In addition, substance exposed infants accounted for 50% of all admissions to the Neonatal Intensive Care Unit and 35% of admissions to the Special Care Nursery at King/Drew. Data collected by SHIELDS since 1990 on more than 4,000 substance abusing women enrolled in drug treatment services, indicated that approximately 50% had second trimester

miscarriages and 20% had experienced infant deaths. Approximately 90% of the target population initiated prenatal care after the first trimester and approximately 50% had their first child prior to age 20. Eighty-five percent used more than one drug during their pregnancies and 70% smoked cigarettes throughout the prenatal period. The average number of children was 4.5 of which an average of three were born with prenatal exposure to substances.

Additionally, there were limited resources available that targeted this high risk population. Managed care providers referred pregnant and parenting substance abusing women to high risk care and there was no continuity of care in place to ensure the woman follows through with the referral. High risk infant outreach services in the community specifically excluded substance abusing pregnant women from their programs. Substance abuse treatment resources were limited and there were few providers available that would enroll pregnant and parenting women. These gaps in services resulted in the population that had the highest infant mortality and morbidity rates being eliminated or restricted from accessing the services they needed the most.

For the three years prior to this project, SHIELDS for Families, Inc.'s Healthy Start Program had specifically targeted its outreach model to the pregnant substance abusing population in the Watt's/Willowbrook community (zip codes 90059 and 90222) to begin the attempt to address these gaps in services. During the three year period, 300 high risk substance abusing pregnant women were enrolled in the program, with 100% receiving prenatal care services and approximately 65% enrolling in drug treatment. While this effort greatly assisted in reducing the risk of infant mortality and morbidity rates, the limitations inherent in the model in terms of ongoing monitoring and follow-up with these families inhibited the potential established through our successful outreach efforts.

Therefore, SHIELDS, in collaboration with our Healthy Start Consortium, proposed and was awarded a Healthy Start grant to provide a Comprehensive Services Model that built upon the foundation of our outreach program. The program specifically targeted African American pregnant and post partum substance abusing women with children through two years of age in the Watts/Willowbrook area of South Central Los Angeles. Through the Consortium and our work with the Local and State Maternal Child Health Departments, we also continued to build upon the progress we had made in educating the community and local health providers, implemented our local health plan, and addressed systemic barriers to service provision.

## **II. Project Implementation: Identify how the project implemented each service and system intervention.**

**Healthy Start Core Services:    OUTREACH AND CLIENT RECRUITMENT**

**A. Describe how you decided on your approach and the rationale for your particular approach based upon your community's needs, service system and its challenges and assets.**

SHIELDS believes that outreach is perhaps the most critical function of any service delivery system. With the high risk population of substance abusing women targeted in the SHIELDS Healthy Start Program, we knew it would be the key component utilized to engage women in services. Therefore, we based our approach on the years of experience we had in the community and in providing perinatal treatment services to the population. SHIELDS had been providing successful outreach in the Watts community since 1990 by hiring and training community residents to provide these services. We had found that community residents were more likely to know the community and to access participants who otherwise would have remained isolated. Given that the target population was unlikely to present themselves for services because of fears that included losing their children to child protective services and/or their benefits due to sanctions established through TANF, it was even more critical that our approach used individuals that were non-threatening. Therefore, SHIELDS hired outreach workers who were both residents of the community and who were in recovery from their own substance abuse. It was felt that outreach workers with these qualities would be more likely to know where to find the population, as well as more likely to engage the target population in services.

In addition, our outreach approach targeted three primary subgroups of the target population. They were, as follows:

Substance abusing women who were not linked to any service delivery system and were receiving no services.

- b. Substance abusing women who were identified by existing outreach and/or maternal and child health programs and substance abuse treatment providers and were referred out for prenatal care and related services without any follow-up to ensure access to services and continuity of care.
- c. Substance abusing women who were accessing services but were not identified as substance abusers and therefore were not monitored as high risk pregnancies nor linked to additional services such as substance abuse treatment and were often lost after initial contact.

The rationale for targeting these subgroups was, again, based upon our many years of experience working with the target population. We knew there were individuals who were unlikely to present because of the fears identified previously regarding loss of children and public benefits and therefore were not linked to any service delivery system. We also were aware that the existing high risk infant outreach services in the community specifically excluded substance abusing pregnant women from their programs and there were few substance abuse treatment providers available that would enroll pregnant and parenting women. Therefore, substance abusing pregnant and postpartum women were referred out with no further follow-up. Further, there were substance abusing women who were accessing services, however, because screening for substance abuse was

not conducted, they were not identified and provided with appropriate resources.

**B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.**

***Intervention Components***

Outreach strategies for the targeted population were designed to specifically address the three primary subgroups identified previously. These strategies are presented in conjunction with the subgroup they were identified to target, along with the agencies and entities that agreed to assist with the implementation and provision of each.

(1) Substance abusing pregnant and post partum women who were not linked to any service delivery system and were receiving no services.

Outreach workers distributed program literature, conducted door-to-door canvassing, and targeted local areas known to the community for being frequented by substance abusing women. In addition, based on the input of the Healthy Start Consortium, staff targeted local women's clinics where free pregnancy testing was available. According to the recovering women on the Consortium, these entities are often used by substance abusing women to determine pregnancy, although they do not enroll or access any further services. Through a CSAT grant, SHIELDS was also able to provide outreach through the use of a mobile van that provided HIV, STD and Hepatitis testing throughout the community. In addition, residents in the identified zip codes were targeted for community education services to enhance their knowledge on substance abuse issues affecting healthy birth outcomes. SHIELDS staff linked with local churches, community groups and service organizations to provide community forums on substance abuse and prenatal care. Further, staff participated in local open houses, health fairs, bazaars, cultural events and in the community to familiarize residents with program services and increase the likelihood of their utilization of the Center.

(2) Substance abusing pregnant and post partum women who were identified by existing outreach and/or maternal and child health programs and substance abuse treatment providers and were referred out for prenatal care and related services without any follow-up to ensure access to services and continuity of care.

Healthy Start Outreach staff worked closely with existing outreach and maternal and child health programs to ensure that pregnant women identified with substance abuse problems were linked to appropriate prenatal care and other indicated services. As indicated previously, in the existing pregnancy outreach

programs serving the targeted community, substance abusing women are specifically screened and referred out of the program due to their high risk-- with no mechanism in place to follow-up and determine if the woman accessed services. Both of these entities are represented on the Healthy Start Consortium (REI WIC's Black Infant Health and LA County Department of Health Services' Great Beginnings for Black Babies) and committed to referring identified women to the program to ensure that they were linked to needed care. Further, staff worked closely with the Maternal and Child Health Coordinator for LA Care (the County's managed care system) to outreach to substance abusing a pregnant woman who were referred out of their system of providers to a high risk prenatal care provider in order to ensure that she actually received and accessed that care. Additionally, outreach staff targeted existing community based substance abuse treatment providers who were serving the targeted population but did not have the resources or capability to ensure access and linkage to prenatal and related health care and services.

Staff also utilized SHIELDS existing relationship with King/Drew Medical Center to have access to all women seen at the Prenatal Clinic at Martin Luther King Hospital, the primary public hospital for the targeted community. In addition, direct linkages were established with all local County funded community clinics who provide prenatal care as well as with private providers in the community. Referrals were also accepted from WIC, the Department of Public Social Services, the Department of Children and Family Services, the Juvenile Dependency Courts, medical providers, and other social services organizations, including local hotlines and referral agencies, as well as walk-ins and self-referred.

(3) Substance abusing pregnant and post partum women who were accessing services but are not identified as substance abusers and therefore were not monitored as high risk pregnancies nor linked to additional services such as substance abuse treatment and were often lost after initial contact.

As previously indicated, although many programs have been designed to stress the importance of accessing prenatal care early, they have often failed to identify substance abusing pregnant women. Many medical and social service providers are unaware of or do not screen for substance abuse which limits the care received and often misses a rare opportunity for intervention with the substance abusing woman who may not access the system again. In order to address this concern and increase the identification of substance abusing pregnant and parenting women, staff in collaboration with representatives of the Community Advisory Council(including REI-WIC, LA Care and the Alcohol and Drug Program Administration) provided a minimum of six educational trainings annually to medical and maternal and child health providers.

### **Resources**

Five outreach workers who were residents of the community and in recovery

were hired and trained by SHIELDS to provide outreach services that were ethnically, culturally, and linguistically sensitive to those who were served. Staff received continuous training throughout the course of the project to ensure their ongoing education in substance abuse and its impact upon pregnancy.

Outreach workers carried a maximum caseload of 20 clients/families. Once a client was recruited by the outreach staff and enrolled in the program, they were to a primary case manager. Outreach staff continued to provide intensive outreach services for the first 30 to 60 days, as indicated, to ensure that the client accessed our case management component and enrolled in prenatal care, substance abuse treatment and other indicated services. Outreach staff assisted the client with completion of enrollment forms and transportation as well as in the development of a linkage with her assigned primary case manager. Outreach staff participated in weekly multidisciplinary case conferences and worked with the case manager to provide additional outreach services as needed throughout the client's enrollment in the program. Community education was provided by program staff and representatives of the Healthy Start Consortium (in-kind).

### **Component Changes**

During the course of the project, the only change to this component was the transition of two of the outreach workers to case managers. This change was in response to the growing need for additional case managers as the project progressed and more clients were enrolled in the program, lessening the demand for outreach to new clients.

### **C. Identify any resources or events that facilitated or detracted from successful initiation and implementation of each intervention.**

There was one strategy that we were unable to implement in the Outreach component during the project period. SHIELDS had planned on using the mobile van to provide free pregnancy testing and prenatal care in areas identified as high substance abusing neighborhoods in order to encourage substance abusing women to obtain care and provide the opportunity to inform them of program services. We ran into difficulty obtaining approval from the County Health Department, primarily due to continuing staff changes and cutbacks in Los Angeles County. By the end of the project period, SHIELDS obtained home pregnancy tests that the Outreach Workers utilize in the field.

### **Healthy Start Core Services: CASE MANAGEMENT**

#### **A. Describe how you decided on your approach and the rationale for your particular approach based upon your community's needs, service system and its challenges and assets.**

Substance abusing families generally have multiple problems which require complex solutions; limited or no support systems available; and may be denied

services or assumed to be unsuitable for services. Given these factors, as well as the limited resources available in the community, SHIELDS Healthy Start Program implemented an intensive case management component. Case Management was approached as an interactive, interpersonal process that required a partnership with the family served in order to build trust and rapport with a population that was fearful and often barred from access to resources because of their drug use. The case manager involved the participant in a problem-solving partnership to assist with identifying needs and obtaining services and resources necessary. Participants were monitored closely to ensure that services were obtained and maintained and that children were not at any kind of risk, should a client relapse. This included a minimum of two home visits per month and transportation to services, as needed, to ensure participants accessed necessary services. The implementation of this case management system provided for a systematic approach for mobilizing resources for clients and decreased fragmentation and duplication of services. A standard protocol was utilized to determine risk factors, appropriate level and frequency of interventions, and tasks. This protocol included: intake and assessment; individualized service planning; referral brokerage and linkage with necessary services; standards for home visits and contacts; follow-up on medical care; crisis intervention and emergency availability.

**B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.**

***Intervention Components***

The following interventions were utilized in the Case Management Component:

**Assessment:** A thorough assessment of the family's needs was performed by the case manager. Comprehensive assessments included all of the following areas: *Psychosocial:* including alcohol and drug dependence, patterns of co-dependency, social support system or network, evidence of the past and/or current life endangering behavior, criminal justice history, social isolation, family reunification, child abuse and neglect, battering, and other identified legal needs. *Educational:* including current school status of all children, highest grade completed, literacy level, and/or cognitive or learning deficits which must be addressed. *Physical status and medical care:* including current pregnancy or post-partum care, family planning, sexually transmitted diseases, complete medical history, risk assessment, current source of health care and related services, child health examinations, immunizations and nutritional assessment. *Vocational assessment:* including current learned skills, work experience, employment, vocational training, attitude toward work and special interests. *Social:* including domestic environment, income source, entitlement benefits, emergency aid, food stamps, WIC, transportation, infant/child daycare needs, and housing.

**Development of Family Services Plan:** The assigned case manager had the primary responsibility, in coordination with the client family, of developing and

implementing a Family Services Plan (FSP) based on the completed assessment. The FSP did the following:

1. Defined the family's goals in the program.
2. Identified the services needed to achieve the objectives.
3. Reflected a cooperative planning process with families and staff.
4. Identified services available within program and community.
5. Identified services needed and lacking.
6. Promoted self-sufficiency.

The Family Services Plan was developed within 30 days of program admission and updated every 30 days to indicate family's progress toward established goals and any additional needs that are identified.

**Case Conferences:** FSP's were presented at the weekly multi-disciplinary case conference for review and approval. In order to ensure integration with existing community based programs, the Multidisciplinary Team consisted of Healthy Start staff, representatives from community based service provider agencies and collaborative members. All clients' cases were reviewed a minimum of one time per month at the case conference to ensure progress on identified goals.

**Implementation of Family Services Plan:** All clients/families were contacted by their case manager a minimum of one time weekly. Home visits were provided a minimum of two times per month. Dependent on initial assessment risk factors, home visits increased in order to address the individual client's specific needs. When an infant was born, follow-up ensured that the infant was enrolled in high risk infant follow-up care. Case managers conducted home visits as a team with child development staff dependent upon the nature and the purpose of the home visit in relation to the special objectives and activities identified in the FSP. The case manager assigned to work with the client/family had primary responsibility for ensuring the brokering and coordination of services, as well as the integration with existing programs.

**Supportive Services:** Based on needs identified in the FSP, case management staff referred or provided the individual/family necessary on-site and community based resources that provided for a continuum of care from prevention through intervention, including the following: perinatal and related health care services, alcohol and drug treatment services, "survival-related" services (e.g. housing assistance, financial assistance, Women, Infant and Children and supplemental food services), vocational and job skills training, child care, transportation, consumer homemaking training, legal services, psychosocial services, parenting and family services, budgeting and money management training, life skills training, and nutrition. The following supportive services were available directly by SHIELDS and other agencies in the community that provided on-site and/or collaborative services to SHIELDS clients:

Health Care: Participants had access to priority medical, prenatal care, vision and hearing tests, high risk infant care, immunizations, nutrition services, dental and physical examinations, and diagnostic and referral services through an existing agreement with the King/Drew Medical Center.

*Family Support and Parenting Services:* Participants were provided parenting education classes through SHIELDS. Access to child care resources were available through partnership with Crystal Stairs Child Care and Referral Services and all children ages 6 - 18 were eligible for afterschool and day services through SHIELDS' Heros and Sheros programs.

*Child Development:* Healthy Start Child Development and case management staff provided developmental assessments and evaluations for all children 0 - 2 enrolled in the program. The assessment process included a thorough developmental evaluation, a nutritional and environmental assessment, and an interview with each family member who had a direct impact in the parent/child interaction. Once the assessment was completed, an Individual Education Plan (IEP) was developed reflective of the child's programmatic needs. Child Development (Mommy, Daddy and Me) and parenting skills education groups were provided weekly to families by SHIELDS staff.

*Mental Health:* Mental health treatment includes: evaluation and assessment; crisis intervention; hospitalization; medication therapy, and outpatient counseling. On-site evaluation and assessment services were provided by SHIELDS Mental Health staff. Acute care services were accessed through referral with the Los Angeles County Department of Mental Health/Augustus Hawkins Mental Health Center. Outpatient counseling services were provided by referral to SHIELDS Mental Health or other local providers.

*Substance Abuse Treatment Services:* Drug treatment services were available to all participants at one of seven SHIELDS treatment programs or through referral to another community based provider. SHIELDS treatment services include: individual, group and family counseling; educational classes on life skills, parenting, HIV/AIDS, alcohol and drugs, health and nutrition; and therapeutic groups on women's issues, grief and loss and family reunification. On-site child development center and therapeutic nurseries are available at each site as well as afterschool programs for older youth. Additionally, the Healthy Start Program offered an on-site Early Intervention Program for women in the early stages of addiction.

*HIV/AIDS:* AIDS services were available to all participants. In collaboration with the Drew Mobile AIDS project, SHIELDS provided a mobile van that offered general health education; referrals; and screening for HIV, STD's, TB and Hepatitis C, as well as pre and post-test counseling. The van was scheduled to be at the program a minimum of one time per month and served as a mechanism for increasing education regarding the effects of substance abuse and the risks of STD's and HIV/AIDS for pregnant and interconceptional participants. In addition, a 12-week AIDS/HIV Education class was offered in the center weekly and all participants were requested to enroll.

*Domestic Violence:* Individual, couples and group counseling was provided on-site by SHIELDS and through referral to community based providers to address issues of domestic violence.

*Vocational Services:* Employment and vocational training services were provided on-site by Los Angeles and Lynwood Unified School District, the Department of Rehabilitation, Victory High School and SHIELDS Vocational Services Center

(VSC). This included a basic skills and high school class, computer certification courses and job readiness. College courses and certificate programs were offered through the SHIELDS Vocational Services Center.

Food and Clothing: Clothing and food were available on-site and through referral to local agencies. SHIELDS is a Food Bank provider.

Income Support/WIC: Income support services are designed to assist families in obtaining financial assistance through such resources as Temporary Aid for Needy Families (TANF), SSI, Social Security, VA benefits and employment training. These services are provided by the Department of Public Social Services (DPSS) and the Social Security Administration and were facilitated by SHIELDS staff located in the DPSS offices or the Healthy Start case management staff.

Legal: Pro bono legal services were accessed by referral through the Alliance for Children's Rights and Legal Aid to over 350 available attorneys.

Child Care: The program offered an on-site Child Development Center that participants could access while they are attending on-site services. Additionally, child care was provided either in the home or out, i.e., licensed day care, school/campus child care center, or in a relative's home through referral to Crystal Stairs Child Care and Referral Services.

Housing: Access to housing service included: referrals to the Housing Authority of the City of Los Angeles, Beyond Shelter and other community housing agencies for Section 8 Housing application and on-site through SHIELDS 126 units of low-income and transitional housing.

Transportation: Transportation to services was provided through SHIELDS Transportation division, bus passes or tokens, and taxi vouchers.

The case management component also provided special services and activities, in order to enhance the resources participants had available and encourage participation in the program. These included:

Intervention Program: The Intervention Program was targeted to participants who are in the early stages of addiction. They are not appropriate for traditional substance abuse treatment services, but are experiencing the negative consequences of their drug abuse and are in need of intervention in order to alter their path to addiction. The center-based program offered participants on-site services three days a week, three hours a day, in addition to the regular Healthy Start services. Participants participated in group counseling and received extensive education in the effects of substance abuse and the impact on their lives, their role as a mother, and their children.

Mothers' Club: The Mother's Club was developed in partnership with LA Care, the public managed care entity for Los Angeles County. This has resulted in the sponsorship of a support group for consumers and the development of a curriculum designed specifically for the target population. The group met monthly and provided education on relevant topics, supportive group services, and celebrations for births and other accomplishments.

Healthy Start Baby Shower: An Annual Baby Shower was implemented to acknowledge SHIELDS participants and their healthy babies. The event includes

games, activities, food, raffles and educational information. Outside agencies and vendors were invited to offer information about their products and/or services. Participants were recognized for their accomplishments and achievements since enrollment in the program.

*Healthy Start Newsletter.* The Healthy Start Newsletter was distributed monthly and featured articles on pregnancy, nutrition, health, parenting and child development education. Key staff were identified and highlighted each month along with a listing of program services and locations and information on how to enroll. Announcements of births and special participant accomplishments were incorporated in the publication (with consent). The Newsletter was circulated to all participants as well as local service providers and targeted providers.

### **Resources**

Five case managers who were residents of the community were hired and trained by SHIELDS to provide case management services that were ethnically, culturally, and linguistically sensitive to those who were served. Staff received continuous training throughout the course of the project to ensure their ongoing education in substance abuse and its impact upon pregnancy. Case Managers carried a maximum caseload of 20 clients/families. Once a client was recruited by the outreach staff and enrolled in the program, they were assigned to a primary case manager. Case Management staff completed the assessment and FSP with the participant and provided linkage to services.

All other resources for this component, as identified in the previous section, were provided in-kind through linkage to other community and public providers, as well as through SHIELDS programs.

### **Component Changes**

During the course of the project, the only change to this component was the transition of two of the outreach workers to case managers. This change was in response to the growing need for additional case managers as the project progressed and more clients were enrolled in the program, increasing the demand for additional case management services.

### **C. Identify any resources or events that facilitated or detracted from successful initiation and implementation of each intervention.**

During the course of the project, SHIELDS received additional funding from Proposition 10 and CSAT for child development and HIV/AIDS education and outreach services, respectively, which enhanced the resources available to participants in these areas. There were no major events or loss of resources that occurred during the project period that detracted from successful implementation of the case management component.

**Healthy Start Core Services: HEALTH EDUCATION AND TRAINING**

**A. Describe how you decided on your approach and the rationale for your particular approach based upon your community's needs, service system and its challenges and assets.**

Health education and training was a necessary component for the targeted population, as well as for the community and maternal and child health providers who had limited knowledge regarding substance abuse and its impact on infant mortality. Health education services increased awareness of the issues surrounding and impacting the effects of substance abuse on children, prenatally and environmentally, and assisted in changing health behavior for participants and service delivery methods for maternal and child health providers. Health education services included instructional activities and other strategies. Training was provided to all staff, Consortium members and targeted medical and social service providers in order to increase knowledge, awareness and skills in specific targeted topics. In order to ensure that health education and training services were successful, they incorporated activities that targeted the different stages of human learning. As appropriate, a Social Ecological Framework was utilized to promote behavioral change through the targeting of different levels of influence. All education and training was evaluated through the use of pre and post testing and participant feedback.

**B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.**

**Intervention Components**

**Health Education for Clients**

The Healthy Start Program implemented a plan to present ongoing education to participants regarding issues significant to their recovery and the unique concerns of pregnant and parenting women. Educational classes were open to participants' family members and significant others. The education plan incorporated the following activities:

**Health Education:** Educational groups were presented to all participants on health and nutrition, AIDS, drugs and alcohol, as well as family planning. Topics covered included general health education and hygiene (with an emphasis on women's and children's issues, including breastfeeding, and alcohol and drug use during pregnancy), drug and alcohol abuse education, relapse prevention and recovery issues, nutrition, and AIDS education. Educational sessions were offered a minimum of two times per week. All educational modules were offered on ten week cycles in the following four categories: Alcohol and Drug Education; AIDS Education; Nutrition Education; and Health Education. At the completion of each module participants received a certificate of completion. In addition, a Smoking Cessation class was offered to all participants, as indicated, through the American Red Cross. The majority of educational modules were provided by collaborative agreement with community based agencies and consultants such

as the King/Drew AIDS Education Project.

**Life Skills Education:** Life skills training was provided to help develop skills in areas that assisted participants to cope with life problems and situations without the use of alcohol and other drugs. Training was provided in the areas of problem solving, stress reduction, life management (including financial planning and social skills development) and time management. Life skills groups were provided a minimum of one time per week. The Life skills module incorporated a minimum of 20 sessions. Classes were taught by trained program staff and also utilized community-based service providers as guest speakers.

**Child Development Education:** This aspect of the program encompassed center-based and in-home intervention. The center based component was provided onsite at the program. The in-home component serviced all participants with children 0-2. The primary goal of the program was to utilize procedures to promote development of the young child (0-2 years). Each child in the program received an assessment which included a thorough developmental evaluation, a nutritional and environmental assessment, and an interview with each family member who had a direct impact in the parent/child interaction. Once the assessment was completed, a treatment plan was developed reflective of the child's programmatic needs. The plan was discussed with the parent and her support system. The areas of programming included: Perceptual/Fine Motor; Cognitive; Language (expressive/receptive); Socialization; Self-help skills; Nutrition; Gross motor. Evaluation tools included the Denver, Bailey Scale of Development, Michigan/Schaffer Inventory, Caldwell Inventory of Home Stimulation, Nutritional Screen, Direct Observation, Biannual staffing with interdisciplinary team, and periodic written evaluations.

**Parent Education:** The purpose of the Parent Education component was to develop and/or increase appropriate child-rearing skills for the participants through a center and in-home model. The parent training segment proposed to increase positive parent/child interactions, increase participant awareness of child development, train parents in the use of basic behavior management techniques aimed at preventing abuse, foster parent's involvement in their child's stimulation process and to train and monitor parents in providing their children with a safe, healthful, nurturing and stimulating environment. Parent training focused on the following issues: child development, basic behavioral interventions, child/mother interaction and bonding process, safety/emergency aspects during the child rearing process, nutrition and health issues, effects of substance abuse on the child's development, problem solving, decision making techniques, proper use of community ancillary services to ensure the child's welfare, handling of emotional problems, utilization of a peer support group, empowerment issues, child's rights, and abuse and neglect-its consequences for the child/parent relationship. Training was provided at the center-based location and through the in-home model. The group segment addressed issues that were of common concern to all participants. The in-home component was more individually tailored to each particular parent and child needs.

## **Health Education for the Community**

Residents in the identified zip codes were targeted for community education services to enhance their knowledge on substance abuse issues affecting healthy birth outcomes. SHIELDS staff linked with local churches, community groups and service organizations to provide community forums on substance abuse and prenatal care. Community education was provided by program staff and representatives of the Community Advisory Council. A minimum of four community trainings were offered annually through the program. Further, staff participated in local open houses, health fairs, bazaars, cultural events and in the community to familiarize residents with program services.

### **Training for Maternal and Child Health and Social Service Providers**

As previously indicated, although many programs were designed to stress the importance of accessing prenatal care early, they often failed to identify substance abusing pregnant women. Many medical and social service providers are unaware of or do not screen for substance abuse which limits the care received and often misses a rare opportunity for intervention with the substance abusing woman who may not access the system again. In order to address this concern and increase the identification of substance abusing pregnant women, staff in collaboration with representatives of the Healthy Start Consortium (including REI-WIC, LA Care and the Alcohol and Drug Program Administration) provided a minimum of six educational trainings annually to medical, maternal and child health and social service providers.

### **Training for Consortium Members**

Training for the Healthy Start Consortium member was provided on a quarterly basis. The selections of targeted topics were identified through some needs assessment conducted with the Consortium. Through the training subcommittee of the Healthy Start Consortium, trainings were prioritized and community trainers identified. The quarterly trainings included topics such as interagency collaboration, program mission, goals and objectives, teamed building, perinatal substance abuse, dual diagnosis, community resources and asset building, child behavior and development, and cultural competency.

### **Training for Healthy Start Staff**

Healthy Start staffs were provided with monthly in-service training on various topics. The purpose of this training was to increase staff=s general knowledge and skills. This monthly training ranged from ninety minutes to two hours in length depending on the topic. Topics included the following: AIDS/HIV; Tuberculosis; Hepatitis; Child Abuse Reporting; American Disabilities Act; Domestic Violence; Work Place Safety; Cultural Competency; Confidentiality; Alcohol and Drug Issues in the Work Place, Sexual Harassment in the Work Place and Stress Management. Healthy Start staff also had access to outside trainings and conferences as well as participated in planned training specific to staff=s discipline.

### **Resources**

In order to implement the Health Education Component, one full-time health educator was hired to facilitate and/or coordinate the provision of health education groups and trainings. Community based providers and Consortium members, as identified previously in the Intervention section, were utilized to provide educational services at no cost to the project.

### **Component Changes**

There were no changes to this component during the course of the project.

#### **C. Identify any resources or events that facilitated or detracted from successful initiation and implementation of each intervention.**

During the course of the project, SHIELDS received additional funding from Proposition 10 and CSAT for child development and HIV/AIDS education and outreach services, respectively, which enhanced the educational resources available to participants in these areas. There were no major events or loss of resources that occurred during the project period that detracted from successful implementation of this component.

#### **Healthy Start Core Services: INTERCONCEPTIONAL CARE**

##### **A. Describe how you decided on your approach and the rationale for your particular approach based upon your community's needs, service system and its challenges and assets.**

Interconceptional care services were important for the targeted population of substance abusing women in order to ensure two primary goals. The first of these was to ensure a safe and healthy environment for the mother and child. The target population of substance abusing women often have limited parenting and homemaking skills. Program services helped to support the parent while providing education and linkage to resources for her and her child(ren). The second goal was to ensure that participants were healthy prior to any future pregnancy to reduce the risk of poor outcomes for future births. Interconceptional Care services were provided to all participants who were enrolled after the postpartum period and had a child between the ages of 0-2. In addition, participants who were pregnant at enrollment were transitioned into interconceptional care services as they progressed through the program. Significant emphasis was placed on working with the infant/toddler to ensure that they received all necessary services including well-baby, well-child care, immunizations, developmental screening and developmentally appropriate interventions and activities.

##### **B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.**

### **Intervention Components**

All interconceptional care participants were contacted by their case manager a minimum of one time weekly. Home visits were provided a minimum of two times per month. Dependent on initial assessment risk factors, home visits may have increased in order to address the individual participant's specific needs. The case manager assigned to work with the participant/family had primary responsibility for ensuring the brokering and coordination of services, as well as integration with existing programs. This included the following interconceptional care services:

***Tracking Postpartum Visits:*** Case management staff communicated directly with the treating physician to ensure that a postpartum visit had occurred within the six weeks after delivery. In addition, case management staff provided transportation, child care assistance and enrollment in Medi-Cal and other entitlement programs in order to ensure there were no barriers to accessing or receiving services.

***Tracking Medical Homes:*** The primary case manager had the responsibility of ensuring that all participants assigned were linked with a medical home. Case management staff provided transportation, child care assistance and enrollment in Medi-Cal and other entitlement programs in order to ensure there were no barriers to accessing or receiving services. Through our collaboration with LA CARE, we provided on-site enrollment in medical health plans for women and children if they have no current coverage. This includes resources for undocumented participants. In addition, staff provided advocacy on behalf of the participants and utilized the established linkages with medical clinics and physicians who were responsive to and respectful of the participants enrolled in the program. When a participant established a medical home, the case manager obtained a release of information and communicated directly with the treating physician to ensure the participant received medical services.

***Selecting Family Planning Option:*** Family planning options were discussed with the participant during the assessment process and incorporated as an objective/activity on the Family Service Plan. Case managers assisted participants with selecting a family planning option during one on one session. Women who had difficulty selecting and/or needed more information were linked to our partner, Planned Parenthood, for further individual counseling. Additionally, sessions on family planning options were a part of our regular health education series, provided by Planned Parenthood, that all interconceptional participants received.

Additionally, each child in the program received an assessment which included a thorough developmental evaluation. Once the assessment was completed an individual plan was developed reflective of the child's programmatic needs. Case management services were provided to all children to ensure that they received all necessary services including:

***Newborn Visits:*** Newborn visits were tracked in the mother's chart on our Child Development Checklist form under the well baby care schedule. Case managers confirmed newborn visits through direct communication with the physician or by

confirmation forms completed by the physician and returned to the case manager by the participant.

***Medical Homes:*** The same process utilized to ensure participants linkage to a medical home was used for infants and toddlers enrolled in the program. The primary case manager had the responsibility of ensuring that all children were linked with a medical home. Case management staff provided transportation, child care assistance and enrollment in Medi-Cal and other entitlement programs through our LA Care collaboration in order to ensure there were no barriers to accessing or receiving services. Documentation of the child's medical home was maintained in their mother's chart. Status of services provided were tracked through self report or through direct contact with the child's pediatrician.

***Immunizations:*** Immunization status of children enrolled in the program was tracked in the mother's chart on our Child Development Checklist form under the immunization schedule. Case managers confirmed immunizations through review of immunization records. Copies of records were maintained in the mother's chart. If a child's immunizations were not up to date, the case managers worked to educate the parent on the importance of immunizations, and assisted with any barriers the participant may have been experiencing such as transportation or scheduling appointments.

### **Resources**

The five case managers who were hired and trained by SHIELDS to provide case management services were responsible for the provision of interconceptional care services to identified participants. Staff received continuous training throughout the course of the project to ensure their ongoing education in this area. All other resources for this component, as identified in the case management section, were provided in-kind through linkage to other community and public providers, as well as through SHIELDS programs.

### **Component Changes**

This component was implemented during the last years of the project period. No changes were made to this component since implementation.

## **C. Identify any resources or events that facilitated or detracted from successful initiation and implementation of each intervention.**

During the course of the project, SHIELDS received additional funding from Proposition 10 and CSAT for child development and HIV/AIDS education and outreach services, respectively, which enhanced the resources available to participants in these areas. There were no major events or loss of resources that occurred during the project period that detracted from successful implementation of this component.

## **Healthy Start Core Services: DEPRESSION SCREENING AND REFERRAL**

### **A. Describe how you decided on your approach and the rationale for**

**your particular approach based upon your community's needs, service system and its challenges and assets.**

In the general population, the majority of women experience mild depression during the postpartum period. A small percentage of those women (10%), go on to experience more significant symptoms which may impair their ability to parent their newborn. In the target population of substance abusing women, high rates of depression are already a common phenomenon. When this is combined with the normal depression of the postpartum period, it is not surprising to find that the percentage of participants who suffer from depression is greater than that found in the general population. In our experience, approximately 30% of the participants who were enrolled in the program, upon screening, needed referral for additional evaluation and services. Therefore, SHIELDS implemented an approach that went beyond screening for depression to the provision of on-site mental health services for identified participants.

**B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.**

**Intervention Components**

During the initial assessment, all participants were screened for substance abuse, mental health and domestic violence issues. The Edinburgh Postnatal Depression Scale [EPDS] was administered to pregnant participants once at intake, at one week postpartum, one month postpartum, two months postpartum, and every six months thereafter. The EPDS was administered to interconceptional participants once at intake and every six months thereafter. If the participant presented with any possible mental health issues during the initial assessment or during the EPDS screenings, they were referred to our Mental Health Division for further assessment and to arrange for psychiatric evaluation for medication support, if indicated. As deemed appropriate, the participant was then referred for on-going mental health services at SHIELDS Mental Health services or a community based provider. The case manager assisted the participant with accessing services, including transportation. A release of information was obtained from the participant to allow the case manager to monitor the participant's attendance and progress in mental health services.

Additionally, due to the high percentage of clients identified with mental health needs, mental health groups were added to our educational classes to provide support and assistance to our participants.

**Resources**

Depression screenings were administered by the Healthy Start case management staff. Further assessment and referral for psychiatric evaluation was provided through SHIELDS Mental Health Division. Mental Health Services were provided by SHIELDS Mental Health staff and/or community mental health

providers. Follow-up and monitoring was conducted by the case manager assigned to the case.

### **Component Changes**

Due to the high percentage of clients identified with mental health needs, mental health groups were added to our educational classes to provide support and assistance to our participants.

#### **C. Identify any resources or events that facilitated or detracted from successful initiation and implementation of each intervention.**

SHIELDS is a mental health provider for Los Angeles County which provided access to mental health resources and services and assisted in facilitating the successful initiation of this component. There were no major events or loss of resources that occurred during the project period that detracted from successful implementation of this component.

### **Healthy Start Core System Building Efforts: LOCAL HEALTH SYSTEM ACTION PLAN**

#### **A. Describe how you decided on your approach and the rationale for your particular approach based upon your community's needs, service system and its challenges and assets.**

In order to develop an integrated service delivery system to better serve Healthy Start program participants, the SHIELDS Healthy Start Consortium developed a four-year local health system action plan. This plan was made in conjunction with the local Maternal, Child and Adolescent Health (MCAH) office and other Healthy Start collaborators and complemented the plan developed by the Los Angeles County MCAH (July 1999-June 2004). Based on Los Angeles County's MCAH plan, SHIELDS' Healthy Start Consortium chose to address their priority in regards to the need for increasing the percentage of women with adequate, timely, appropriate prenatal care, specifically as it related to substance abusing women. In order to address this priority, the Consortium committed to assisting MCAH in developing a prenatal risk assessment tool and in developing a system to track pregnant, substance abusing women's entry into prenatal care. In Los Angeles County, there was no uniform tool being used to assess prenatal risk, particularly as it pertains to substance use. In addition, once a pregnant woman has been identified as being at risk due to substance use, there is no mechanism in place to track her entry into prenatal care.

There were multiple reasons for the approach selected for the LHSAP. First, it assisted in establishing the priorities for the Consortium and guided the work they perform for the project period. Second, it was used to inform the local and State MCAH offices regarding the system deficits affecting the target population for the Title V planning and implementation processes. Because of the program's

involvement with the Title V plan, it also enhanced the possibility for establishing the LHSAP's goals as priorities for both the local and State MCAH plans. Thirdly, the LHSAP provided the framework for maintaining collaborative relationships with local providers, consortium member agencies and the Healthy Start program as the plan was developed and implemented.

**B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.**

***Intervention Components***

The Consortium developed subcommittees, each chaired by a Consortium member, to address the system deficits identified and to report back to the entire Consortium on progress and results throughout the project period. These committees, the participants, objective, and tasks, were as follows:

***The Prenatal Risk Assessment Tool Sub-Committee***

Participants: Sub-Committee Chair, Sub-Committee Members, local MCAH representatives

OBJECTIVE: To identify a pre-natal risk assessment tool that will be used uniformly throughout Service Area 6 of Los Angeles, California.

**TASKS:**

Identify and review current assessment tools  
Identify a tool, or Develop a tool  
Evaluate for cultural competency  
Decide what plans are needed to protect participants  
Develop a consensus on reliability and validity of tool  
Develop field test plan  
Field test tool to local high risk clinics, participants  
Present and discuss results of field test  
Agree on necessary revisions  
Revise the tool  
Train providers on the tool  
Distribute the tool  
Implement the tool

***The Prenatal Care Tracking Sub-Committee***

Participants: Sub-Committee Chair, Sub-Committee Members, MCAH representatives, local Public Health Care Providers

OBJECTIVE: To develop a system to track pregnant, substance abusing, womens entry into high risk prenatal care

## TASKS:

Identify the data already collected by clinics  
Develop system for high risk clinics to track all appointments for pregnant, substance abusing woman, at that site.  
Develop a data collection instrument to track appointments  
Identify high risk appointment contacts at local clinics  
Develop a mechanism for the clinic to report back to MCAH on the number of pregnant, substance abusing, women entering and staying in prenatal care, as well as report on birth outcomes.  
Develop a report format for data  
Decide what plans are needed to protect clients  
Pilot test Data Collection  
Present and discuss preliminary findings  
Agree on necessary revisions to system  
If needed, revise the data collection plan  
Implement tracking system

## **Resources**

The resources available for this component included all Consortium representatives, County MCAH staff, local providers, Healthy Start staff and SHIELDS administrative staff

## **Component Changes**

There were no changes to the component interventions, however issues beyond the program's purview occurred that delayed the final implementation of the identified objectives. Please refer to question C. below.

### **C. Identify any resources or events that facilitated or detracted from successful initiation and implementation of each intervention.**

The primary challenge to achieving the LHSAP goals was the ongoing crisis in the health care system in Los Angeles County. Major deficits in the health care funds in the County have caused closure of multiple clinics and hospital departments. This delayed the implementation of the LHSAP objective to implement a tracking system due to an ever changing system of services. As this report is being written, the primary public hospital serving the community, Martin Luther King Hospital, is under imminent threat of closure. The other challenge to LHSAP goal implementation was the impact of HIPPA on sharing of information. During CY 2003, the Consortium piloted the risk assessment tool with local maternal and child health care providers. The regulations on confidentiality created concern with medical providers about referring clients to outside agencies for fear of violating the new privacy laws. Although, the implementation of HIPPA regulations delayed the full implementation of the tool, the Consortium is in the process of revising the risk assessment to assure that no violations of privacy laws will occur. After necessary modifications are made, the tool will be

distributed to all maternal and child health care providers in the target community.

### **Healthy Start Core System Building Efforts: CONSORTIUM**

- A. Describe how you decided on your approach and the rationale for your particular approach based upon your community's needs, service system and its challenges and assets.**

The SHIELDS for Families Healthy Start Consortium was formed in 1998 to focus on the problem of infant mortality in the designated Healthy Start Project area of South Central Los Angeles. Its development was based on the belief that community empowerment is the best method to accomplish and sustain the Healthy Start goals of reducing infant mortality and improving the health of pregnant and post partum substance abusing women and their children in the project area. Community empowerment can best be achieved by fostering collaborations between individuals and organizations within the community, in order to advocate on behalf of community needs and to educate public officials. The primary purpose of the SHIELDS Healthy Start Consortium is to partner with the community to reduce infant mortality amongst the targeted population of substance abusing women. In order to accomplish this task, the Consortium assists SHIELDS Healthy Start program with designing and implementing interventions which address issues impacting the target population.

- B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.**

#### **Intervention Components**

Meetings with the Consortium were conducted monthly during the initial stages of the program, and bi-monthly thereafter. Subcommittees were established to address specific program objectives and activities (By-Laws, Recruitment, Sustainability, and Training and Education). The subcommittees met on a regular basis to initiate activities specific to their particular areas of concern. Specifically, the primary functions of the Consortium included:

1. Designing and implementing interventions which addressed issues such as identifying maternal and child health system deficiencies and alleviating problems of service fragmentation and accessibility.

2. Functioning in an advisory capacity for program planning, operation, monitoring, and evaluation to SHIELDS in application for and implementation of Healthy Start services.
3. Recommending program and Consortium policy needs, including the adherence to conflict of interest policy.
4. Assuring the program's integration with local and state maternal and child health program's and activities.
5. Assisting with securing the sustainability of the project through identification of potential resources and integration possibilities.
6. Educating the community on maternal and child health issues as well as on substance abuse by providing a minimum of four trainings and/or activities annually.
7. Educating maternal and child health and social service providers on issues of screening, identification and referral of target population by providing a minimum of six educational trainings and/or workshops annually.
8. Providing support to the SHIELDS for Families Healthy Start Project in its provision of services to reduce infant mortality through advocacy with public officials, community providers and community residents.
9. Developing and implementing the Local Health Systems Action Plan to enhance the identification and referral of the target population to high risk perinatal care and other needed services.

Additionally, the Consortium worked with SHIELDS for Families in assuring that the ethnic diversity of the Consortium was reflective of the community, that consumers had equal representation on the consortium, that other collaboratives were represented, and the ratio of public to private entities actively involved was equitable.

### **Resources**

The resources for the Consortium included all Consortium members, as well as the agency or community group they represented, and the Healthy Start staff.

### **Component Changes**

There were no changes to this component during the project period.

### **C. Identify any resources or events that facilitated or detracted from successful initiation and implementation of each intervention.**

The skills and resources brought to the Consortium assisted in facilitating the successful implementation of the Consortium and its activities. The only challenge to the Consortium was in the implementation of the Local Health Systems Action Plan as described in the previous section.

### **D. For the Consortium, please address the following additional elements:**

**1. Highlight how the Consortium was established and identify any barriers that emerged in its establishment and how they were addressed.**

The SHIELDS for Families Healthy Start Consortium was formed in 1998 to focus on the problem of infant mortality in the designated Healthy Start Project area of South Central Los Angeles. It was originally developed by SHIELDS as an Advisory Board for perinatal services for substance abusing women in the community in 1991. Through the Advisory Board's recommendations, SHIELDS applied for and received a Healthy Start Planning Grant in 1997 and then a Outreach Healthy Start Grant in 1998. The original Board was made up of primarily representatives from the health field. As the Board transitioned to the Healthy Start Consortium, social service and consumer representatives were added to the group and new roles were established. No major barriers occurred during this transition.

**2. Briefly describe the working structure of the Consortium which was in place for the majority of the implementation, its composition by race, gender and types of representation. Also, please describe the size of the consortium, listing the percent of active participants.**

The SHIELDS Healthy Start Consortium is overseen by an elected Chairperson. Subcommittees are used to address specific program objectives and activities (By-Laws, Recruitment, Sustainability, and Training and Education). The subcommittees met on a regular basis to initiate activities specific to their particular areas of concern. The Consortium is made up of thirty-six (36) members representing individuals from the target population, the medical field and agencies familiar with infant mortality and the target population. The ethnic composition of the existing Consortium is, as follows: 26 (72%) are African American, 6 (17%) are Latino, and 4 (11%) are Caucasian. Eighty five (85%) of the representatives are female, and 15% are male. All Consortium members are representative of and familiar with the targeted community and its resources.

Membership of the Consortium, by type of representation, is as follows:

**state or local government:** 15%

**program participant:** 50%

**community participant:** 10%

**community-based organizations:** 15%

**private agencies or organizations:** 5%

**providers contracting with the program:** 0% (all resources provided in-kind)

**other providers:** 0%

**other-please specify:** 5%; faith-based organizations

Throughout the project period, approximately 70% of the SHIELDS Healthy Start Consortium were involved as active participants.

**3. Describe the activities this collaborative has utilized to assess ongoing needs; identify resources; establish priorities for allocation of resources; and monitor implementation. Describe your relationship with other consortia/collaboratives serving the same population.**

Meetings with the Consortium have been conducted bi-monthly throughout the project period. Subcommittees were established to address specific program objectives and activities (By-Laws, Recruitment and Hiring, Sustainability, LHSAP Committees, and Training and Education) and continued to meet regularly to initiate activities specific to their particular areas of concern. The Sustainability committee worked with representatives from managed care and the Department of Health Services to identify mechanisms to incorporate program services into existing services and/or utilize Medicaid and/or EPSDT as payment mechanisms for services rendered. In addition, Consortium members continued to network with community providers and agencies to access needed services for program participants, i.e. child care, job training, and educational classes. Members also assisted the program staff in its outreach and client recruitment activities by referring pregnant and postpartum substance abusing women to the program.

Throughout the project period, priorities were identified based on: the local Title V plan; Healthy Start needs assessments; participant input through focus groups and Consortium participation; and the Consortium's experience over the past seven years. Project implementation has continued to be monitored throughout the grant period by regular reports of program activities and presentation of program data and evaluation results at each Consortium meeting. Additionally, Consortium members are actively involved in program activities and utilize their involvement as a component of the monitoring process.

Although there are no other consortia or collaboratives in the community that specifically target substance abusing women, there are collaboratives that focus on the reduction of infant mortality in the general population. Members of these collaboratives are represented on the Healthy Start Consortium and SHIELDS is a member of each of those collaboratives. Additionally, the Consortium has been a vehicle to establish and implement cross trainings, participate in joint health fairs and in community forums with these partner collaboratives. Partnership and TA funds have been utilized to facilitate the cross and joint training with local providers, in particular the REI WIC Black Infant Health Project.

**4. Describe the community's major strengths which have enhanced consortium development.**

The major strength of the community which has enhanced the consortium's development is the willingness of residents, agencies, and organizations to work together to address areas of concern to the community. Historically, the community's passion for joining together has resulted in the development of new

services and resources for the community and has provided the community with political empowerment. Further, the community's emphasis on the importance of families remaining together has served to assist the project and the commitment of the membership to work towards established goals and objectives.

**5. Describe any weaknesses and/or barriers which had to be addressed in order for the consortium to move forward.**

Two barriers have been of concern for our Consortium during the project period. The first has been the conflicting time schedules of key stakeholder members. Because we have been fortunate enough to have high level representation from organizations that represent the MCAH community, they often have had other critical issues or meetings to attend that have limited their time commitment to the Consortium. To the greatest extent possible, they attended our meetings and if unable to attend, they have a designated alternate that can represent their concerns. This has been successful in the past in addressing this challenge and we anticipate it will continue to work as a method of overcoming this barrier. The other barrier that has impacted the Consortium in the past, has been the crisis in the health care system in Los Angeles County. Our community has experienced extensive cuts in health care resulting in the closure of numerous clinics and/or services and is currently threatening to close the only public hospital that serves this community, Martin Luther King Hospital. This has impeded the Consortium's progress on our LHSAP goal of establishing a tracking system for the receipt of prenatal care services for the target population. To address this challenge, the Consortium has continued to participate in planning meetings and community advocacy groups to ensure that our target population's needs are considered in the redesign of the current health care system.

**6. Discuss what activities/strategies were employed to increase resident and consumer participation. How did these change over time?**

Recruitment and training of consumer and resident representatives has remained a priority since the inception of the Consortium. SHIELDS has consistently accessed consumer input through the use of a Consumer Advisory Council. Representatives from this group as well as SHIELDS substance abuse treatment Alumni Association have been recruited to the Consortium. In order to enhance the ability of consumers to participate in Consortium meetings and activities, transportation and child care has been provided. Training offered through the consortium and the ability to provide meaningful input into the program and health care services for substance abusing women has also served as an incentive for consumer and resident representatives to participate. Historically, through this process, our consumer representatives have been selected to serve on the local managed care advisory board and present at local and regional conferences. Additionally, consumer representatives have also been active participants in advocating for the programs to local and state legislators.

**7. How did you utilize consumer input in the decision-making process?**

The role of consumers on the Consortium has been, as with all Consortium members, to provide feedback and advice on: the direction of services and allocation of resources; program activities and interventions; data collection, monitoring and evaluation; and the identification of potential resources for the expansion or continuation the program. In particular, consumer representatives have helped to guide the program and the Consortium in its implementation of services and in ensuring program sensitivity and awareness of issues specific to the target population. Their input has also assisted with increasing professional and provider Consortium member's knowledge of concerns and barriers that confront pregnant and interconceptional substance abusing women as they attempt to access services for themselves and their children. Consumer representatives have also been active participants in advocating for the programs to local and state legislators, as well as through participation in other local boards and consumer groups.

**8. How did you utilize the suggestions made by the consumers?**

A major accomplishment for our Consortium, over the past four years, has been the active involvement of our consumer representatives. As indicated in the previous question, their input has helped to guide the interventions and activities of the program and ensure sensitivity to the needs of the target population. Further, because of their input and advocacy for the program and the needs of the target population, two of our consumer representatives were selected to serve on the local managed care advisory board where they have made recommendations for health service delivery enhancements. In that capacity, they traveled to our State Capitol in Sacramento to testify on behalf of the target population before legislative committees on their concerns, issues and recommendations for change.

**Healthy Start Core System Building Efforts:  
COLLABORATION AND COORDINATION WITH STATE TITLE V AND OTHER  
AGENCIES**

**A. Describe how you decided on your approach and the rationale for your particular approach based upon your community's needs, service system and its challenges and assets.**

This community has limited services and resources for the target population, however the strength of the community is its willingness to join together and work towards mutual goals, as described in the previous question. Therefore, the approach the program has taken to collaborative efforts over the course of the project period has been based on this strength and focused on active involvement, collaboration, and the sharing of resources in all efforts that would

assist in the furtherance of the program's goals.

- B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.**

***Intervention Components***

**Collaboration with State MCAH:** During the course of the project period, SHIELDS Healthy Start has worked closely with other Healthy Start staff from the three other California sites (now two sites), and State MCAH officials. A California statewide plan was developed to focus on the issue of perinatal substance abuse because of its overwhelming impact on negative birth outcomes at the three original Healthy Start sites. The California Healthy Start programs joined with the State and Local MCAH Departments to engage in the implementation of a statewide plan to address this issue and its significant impact on infant mortality rates throughout the State of California. This State collaboration resulted in the sponsorship of a speaker on this issue for the State MCAH Conference and the hiring of a consultant to conduct a statewide needs assessment and best practices guide for MCAH providers working with a pregnant substance abusing population. During the course of the needs assessment, the State's MCAH Directors Association joined with the Healthy Start sites to support our efforts in this arena. The report on the statewide needs assessment was completed in 2002 and was distributed throughout the State to all MCAH Directors, the State Department of Alcohol and Drug Programs and other stakeholders in the area of perinatal substance abuse. This report has continued to generate discussions between State Departments regarding joint efforts to work with this population, including the sponsorship of a conference by the State MCAH Director's Association, specifically on the issue of perinatal substance abuse. SHIELDS presented on both days of the conference on our Healthy Start Program Model as well as the integration of the program with our perinatal substance abuse treatment programs.

**Collaboration with County MCAH:** Locally, our partnership with the local MCAH office has continued to increase significantly since 1998. The MCAH Director for Los Angeles County has taken an active role in our Consortium and has provided continued advocacy for our program. SHIELDS furthered its relationship with the local MCAH program through the implementation of the Local Health Systems Action Plan and increased involvement in MCAH efforts to develop a comprehensive community based system of services. In addition, a SHIELDS Healthy Start representative was appointed by the County Director as a permanent member of the planning committee for the MCAH Local Title V Health Plan. In that role, staff are able to have direct impact on the priorities established for Los Angeles County and assure that the needs of our target population of substance abusing women are addressed. Two additional Healthy Start staff sit on committees that develop activities for addressing specific priority goals for birth outcomes in the five year plan. The local plan becomes a part of

the statewide plan for California and includes the priorities recommended by our Consortium and staff.

**Collaborations with Other Agencies:** Collaborations with the public and private health care entities who have access to the target population and/or needed services have been maintained throughout the project period. These partnerships continued to be utilized to facilitate cross and joint training with local providers, increase referrals and share resources. These linkages across service systems have been essential to ensure that families can access all necessary services to enhance the opportunity for positive birth outcomes. The collaborations that have been maintained throughout the project period include:

*Martin Luther King Hospital:* Through SHIELDS public-private partnership, staff work closely with the Prenatal Clinic and Labor and Delivery to identify and enroll in treatment all women identified with a substance abuse problem.

*Department of Public Social Services (DPSS):* DPSS administers TANF, Medicaid (Medi-Cal) and CalWORKS, California's Welfare-to-Work plan. The Consortium interacts regularly with staff from the Department. Healthy Start Outreach Workers conduct outreach in three local offices that serve the project's zipcodes. In addition, staff interact with DPSS staff on a regular basis to broker and advocate for benefits on behalf of their clients. SHIELDS is an active member of the Substance Abuse Steering Committee for CalWorks in Los Angeles County plan and serves as a provider of substance abuse treatment and mental health services.

*Department of Children and Family Services (DCFS):* DCFS is the Child Protective Services agency in Los Angeles County. SHIELDS has worked in collaboration with the Department for the past ten years to provide Family Preservation and Family Support services to families referred due to child abuse and neglect. Most recently, we are partnering with DCFS to provide Emergency Response Assessments for families where there are allegations of substance abuse and/or mental health. This project has been successful at reducing out-of-home placements and linking families to services immediately. This has assisted in the identification of program participants for Healthy Start, since all newborns with a positive tox screen are referred for family assessment.

*LA Care:* LA Care is the County's managed care program. Staff from LA Care are represented on the Consortium (Chairperson of the Consortium) and they have been an integral part of our work to date. In addition, they have provided educational and training sessions for consortium members, maternal and child health providers and outreach staff and were the original sponsors of our Mother's Club.

*Great Beginnings for Black Babies:* SHIELDS for Families, Inc. and Great Beginnings have worked together for many years in the South Central community sharing resources, referrals, and conducting joint and cross-training. This organization targets the African American community in order to decrease the high rates of low birthweight, infant mortality and perinatal mortality.

*Healthy African American Families (HAAF):* The HAAF program targets African American low-income families in the community to provide training, education and assistance with linkage to health care and related resources. SHIELDS and

HAAF staff have collaborated in the sharing of data, as well as in the exchange of information regarding health care clinics that provide quality services. In addition, SHIELDS staff have attended numerous trainings conducted by HAAF for service providers

*Mother Net:* Mother Net is a community based initiative that targets low-income pregnant women in the community and provides educational and supportive services using a peer model. Mother Net has provided on-site educational classes for our program on child safety issues.

*Planned Parenthood:* Planned Parenthood provides family planning and contraceptive services. They provide a 10 week rotating family planning class for all Healthy Start program participants. Additionally, they provide 1:1 counseling for women who need further assistance with a family planning option. Planned Parenthood also provides staff and Consortium trainings.

*March of Dimes:* The March of Dimes provides on-site classes as a part of their BACK-To-SLEEP and their “Healthy Babies, Healthy Futures: Preventing Prematurity” Campaigns. Additionally, they provide the program with literature, resource materials and training for staff and the Consortium.

### **Resources**

The resources for this component are the Healthy Start staff, the Consortium members, and the agencies we work with and services they provide, as specified above.

### **Component Changes**

There were no significant changes to the approach in this component. However, as the project period progressed, our collaborative efforts with all entities continued to improve and enhance our efforts with accomplishing our program goals.

### **C. Identify any resources or events that facilitated or detracted from**

## **successful initiation and implementation of each intervention.**

Since the inception of the original Healthy Start Planning and Outreach Grant in 1998, SHIELDS has continued to strengthen its ties to the State Maternal and Child Health Department through partnership with the other Healthy Start programs in the state as well as through our individual program involvement with State Initiatives. The efforts made over the past years by the Healthy Start programs in California in collaboration with the State MCAH Office, have been of particular significance to our Consortium and Healthy Start Program. The recognition of the particular needs of our target population have been brought to the forefront of the field and dedicated efforts are now being made to address the issues of this population and the negative impact of substance abuse on infant mortality and morbidity rates in California. Locally, our partnership with the local MCAH office has continued to increase significantly since 1998. The MCAH Director for Los Angeles County has taken an active role in our Consortium and has provided continued advocacy for our program. Further, our close collaboration with our local MCAH has assisted in ensuring that our target population's needs have become a priority locally and has assisted our program and Consortium in the achievement of their goals. It is our hope that this will lead towards integration of MCAH and substance abuse treatment services, as well as blended funding to address the joint concerns of both these fields. More significantly, hopefully the increase in interest will result in more appropriate interventions, cultural sensitivity and respect for this population of women so that they can access services without fear of retribution or discrimination and can receive the assistance they require. Additionally, it is our hope that innovative ideas, such as our model of service delivery, will be adopted throughout the state so that more women have the opportunity to be identified and enrolled in services. Because of the Healthy Start Needs Assessment report and the State's active participation in our local and national Healthy Start activities, we have received numerous calls and visits from providers throughout the state who are interested in replicating this model. Further, our ongoing partnering and resource sharing with other agencies in the community, has resulted in the receipt of additional funding and grants for the target population through successful collaborative grant applications.

### **Healthy Start Core System Building Efforts: SUSTAINABILITY**

#### **A. Describe how you decided on your approach and the rationale for your particular approach based upon your community's needs, service system and its challenges and assets.**

Major responsibilities for the sustainability of the project were vested in the primary resources available to the program - the Consortium and SHIELDS administration. The Consortium has a specific committee to address sustainability of the Healthy Start program. The committee was given the charge of identifying and exploring options available for continued sources of program

revenue in conjunction with identified consortium objectives. SHIELDS for Families has also applied an equal amount of effort to sustain the program after Healthy Start Initiative (HSI) funding ends and to augment the current HSI funding. Potential alternate sources of funding for the program to enhance and sustain services include: (a) medicaid reimbursement for services deemed eligible; (b) applications for local and national funding; (c) corporate or university sponsorship; and (d) fund raising. In addition, evaluation results are utilized to disseminate program results and influence public policy makers in the recognition of the importance of outreach and available services for substance abusing women and their families and in securing fund availability for programs.

**B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.**

***Intervention Components***

A primary means utilized to maximize our Healthy Start grant funds has been through the contribution of in-kind services and training by our collaborative partners, inclusive of community health centers and our local Health Department. All project services provided by our partners were offered in-kind to the grant. This included health education, outreach, and interconceptional care services. Additionally, SHIELDS worked with the Consortium to seek out public and private funding sources for augmentation and sustainability purposes. This included writing proposal for funds from federal, state and local government agencies; contacting private foundations and businesses, managed care organizations, and charities to determine their interest in supporting the project. During the project period, SHIELDS received two major grants that were used to augment and enhance the Healthy Start Program. This included a grant from the Los Angeles County Proposition 10 Commission to enhance child development services and a grant from the Center for Substance Abuse Treatment (a division of SAMHSA) to implement an outreach and case management model for substance abusing women at risk for HIV/AIDS.

SHIELDS for Families is also certified to provide Drug Medi-Cal (Medicaid) services and Short-Doyle Medi-Cal mental health services and utilized these funds to pay for services for eligible participants. In addition, SHIELDS is a Los Angeles County provider of CALWORKS (TANF) mental health and substance abuse treatment and outreach services. Currently, SHIELDS has eight outreach staff in local Department of Public Social Services offices in order to screen TANF clients for substance abuse, mental health and domestic violence. SHIELDS administration has been able to augment Healthy Start services through these or other public funds for eligible Healthy Start Services and/or eligible participants.

***Resources***

The resources available to this component included SHIELDS administration and existing programs and funding sources and the Consortium.

**Component Changes**

No changes were made to this component during the course of the project period.

**C. Identify any resources or events that facilitated or detracted from successful initiation and implementation of each intervention.**

During the course of the project, SHIELDS received two major grants that assisted in the facilitation of the successful implementation of this component. This included a grant from the Los Angeles County Proposition 10 Commission to enhance child development services and a grant from the Center for Substance Abuse Treatment (a division of SAMHSA) to implement an outreach and case management model for substance abusing women at risk for HIV/AIDS. The difficulty experienced with the implementation of this component has been based on our inability to bill Medi-Cal for the majority of Healthy Start services. Since SHIELDS is not a medical provider, many of our services are not eligible for reimbursement under our existing Medicaid certifications. Therefore, we have continued efforts to work with medical providers in order to provide services under their certification.

**E. For sustainability, please address the following additional elements:**

**1. Describe your efforts with managed care organizations and third party billing.**

In order to address the issue of maintaining services beyond the grant period, the SHIELDS Healthy Start Consortium developed a specific committee to address sustainability in 2001. The committee was given the charge of identifying and exploring options available for continued sources of program revenue in conjunction with identified consortium objectives. The Sustainability committee has continued to work with representatives from managed care and the Department of Health Services to identify mechanisms to incorporate program services into existing services and/or utilize Medicaid and/or EPSDT as payment mechanisms for services rendered. Also, SHIELDS has working relationships with both managed care organizations serving the community (Community Health Plan, LA Care) and staff sit on community managed care committees as well as the state committee for drug and alcohol services.

Currently, SHIELDS for Families receives third party reimbursement as a certified Drug Medi-Cal (Medicaid) and Short-Doyle Medi-Cal mental health services provider. SHIELDS administration has augmented Healthy Start services through these funds for eligible Healthy Start Services and/or eligible participants.

**2. Describe major factors associated with the identification and development of resources to continue key components of your interventions without HS funding.**

The services available to the Healthy Start participants through the other programs available at SHIELDS for Families has been a primary factor in the identification and development of resources for sustainability efforts. In addition to the grants received during the project period from CSAT and First Five, SHIELDS has submitted two additional proposals that are currently under review. If funded, these grants would enhance the mental health and housing service available for our Healthy Start program participants. We are also working with USC and the Department of Children and Family Services to apply for a grant from NIMH to evaluate the delivery of services to families referred for child abuse and neglect where substance abuse is involved.

Additionally, the resources available through Consortium member agencies have contributed significantly to our efforts of enhancement and sustainability. Through the Consortium, SHIELDS has participated in two successful grant applications with other Consortium agencies acting as a lead. This has included a grant that focuses on immunizations from the Department of Health Services and another First Five grant that will add two additional case management staff to assist our program efforts.

**3. Describe whether or not you were able to overcome any barriers or to decrease their negative impact.**

As identified previously, the barrier experienced with the this component has been our inability to bill Medi-Cal for the majority of Healthy Start services. Since SHIELDS is not a medical provider, many of our services are not eligible for reimbursement under our existing Medicaid certifications. Therefore, we have continued to work on relationships with medical providers in order to provide services under their certification.

**III. Project Management and Governance**

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

The Executive Director of SHIELDS for Families had direct responsibility for the programmatic and financial oversight of the Healthy Start Project and for reporting the program's status to the Board of Directors. The Executive Director met with the administrative team on a weekly basis to update them on the project and to delegate administrative and fiscal tasks. Additionally, the Executive Director met weekly with the Program Manager and bi-monthly with the Healthy Start Consortium to ensure that the project was being implemented as planned.

The Program Manager had primary responsibility for overseeing the daily operation of the Healthy Start Program. She reported directly to the Executive Director of SHIELDS who served as the Project Director. The Program Manager was responsible for the hiring, training and evaluation of program direct services and support staff. They met with staff a minimum of once a week to encourage their participation in program decision making. The Program Manager also met a minimum of once a month with project collaborators and the Consortium to update them on the status of the program and to solicit input on program operations and evaluation efforts.

The Outreach and Case Management Supervisor and the Program Manager make up the management team for the program. They met on a weekly basis to ensure that the components were providing services consistent with the program objectives and design and made recommendations for changes and/or additions to the program. The team worked with the Program Manager to administer the program and complete required documentation and reports.

Each Supervisor provided supervision to component staff and conducted component staff meetings on a weekly basis. Meetings for the entire Healthy Start staff were held monthly in order to ensure that policies and procedures, and other administrative and programmatic issues were addressed.

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

SHIELDS fiscal and administrative staff were critical resources that were essential for fiscal and program management. They have extensive experience in managing Federal, State, County and private foundation grants and funding. This includes grants from: the Center for Substance Abuse Treatment, HUD, the Administration for Children and Families, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, Los Angeles First Five, United Way, Los Angeles Homeless Services Authority, the Los Angeles County Department of Mental Health, Los Angeles County Department of Children and Family Services, Los Angeles County Alcohol and Drug Program Administration, and the Los Angeles City Community Development Department.

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

There were no changes to the management and governance of the grant over

the project period.

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

Key program and fiscal staff had the primary responsibility for monitoring the program and ensuring that it was complying with all contractual and fiscal requirements. In order to do so, they met weekly during the regularly scheduled SHIELDS management team meeting to review program, fiscal and evaluation data, inclusive of quality assurance reports. The Program Evaluator met with key program and fiscal staff a minimum of one time monthly throughout the report period to provide feedback on the program and recommendations for any modifications.

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

SHIELDS was successful in augmenting all our service components through in-kind resources from our collaborative partners and SHIELDS. Our collaborative partners provided training, technical assistance, educational resources and referrals, as detailed in Section II. As previously indicated, SHIELDS was also able to obtain two grants during the course of the project that enhanced the services provided. This included, a grant from the Los Angeles County Proposition 10 Commission to enhance child development services and a grant from the Center for Substance Abuse Treatment (a division of SAMHSA) to implement an outreach and case management model for substance abusing women at risk for HIV/AIDS. This enabled us to implement the Mobile Van Project to enhance our outreach effort in the community. Through SHIELDS existing resources, we were also able to provide an array of services for our participants. This included: mental health and substance abuse services, vocational services, child care, transportation, housing and community education.

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

SHIELDS has taken pride in its sensitivity to cultural, language and socioeconomic issues often missed by traditional programs by: training staff on the skills necessary for working with persons of color, using ethnic minority staff members as resources for minority issues; providing a coordinated service delivery system; implementing a proactive administrative stance; providing outreach services to ethnic communities and hiring bicultural and bilingual staff

(African-American, Latino). Cultural competence has remained a priority at SHIELDS since its inception. Staff have been actively recruited and hired that are representative of the ethnic, cultural and community backgrounds of the clients they serve. Over 95% of the total SHIELDS staff (250) are ethnic minorities and over 40% are former consumers or residents of the communities we serve. Staff training has been focused on increasing cultural awareness, particularly in regards to the rapidly changing demographics in our community, to ensure that staff take into consideration the needs of the population we serve.

There were no issues of cultural competence identified during the course of the project period.

#### **IV. Project Accomplishments**

**A. Describe each major strategy implemented, with its goals and objectives and accomplishments for this project period. Within the narrative describe in quantitative and qualitative terms the degree of success in achieving the goals and objectives. Describe any barriers that had to be dealt with during implementation and how they were addressed. Summarize all lessons learned.**

In 1998, SHIELDS implemented a Healthy Start Outreach Program that specifically targeted the pregnant substance abusing population in the Watt's/ Willowbrook community to begin to address this issue. In three years of services, over 300 high risk substance abusing pregnant women were enrolled in the program, with 100% receiving prenatal care services and approximately 65% enrolling in drug treatment. In 2001, SHIELDS, in collaboration with our Healthy Start Consortium, applied for and received funding for a comprehensive Healthy Start Program which provides all core components. To date, 691 high risk pregnant and postpartum substance abusing women with children through two years of age have been enrolled and provided comprehensive Healthy Start services, with all performance objectives met or exceeded during the course of the project. Each strategy is presented below with a summary of the accomplishments in each area followed by tables indicating the success made on each project objective during the project period.

##### **Strategy: Outreach**

From 2001-2004, the SHIELDS Healthy Start program has made over 3,044 outreach contacts to the target population. These contacts resulted in the recruitment of seven hundred and twenty-four (724) substance abusing pregnant and postpartum women. Of those women, six hundred and ninety-one (691) were successfully enrolled in program services. Of those enrolled participants, 511 (74%) were African American, 148 (21.4%) were Latina, 24 (3.5%) were Caucasian, 3 (.4%) were Asian/Pacific and 5 (.7%) Other. The age of participants at admission was: 5 (.73%) under age 15, 54 (7.82%) between the

ages of 15 -17; 72 (10.4%) ages 18-19; 168 (24.4%) ages 20-24; 271 (39.23%) ages 25-34; and 121 (17.51%) ages 35-44. The majority of women had never been married (539 or 78%). The educational status of participants upon enrollment was, as follows:

Level of Education	# of Participants	% of Participants
Less than 9 <sup>th</sup> Grade	28	4.05
9 <sup>th</sup> to 11 <sup>th</sup> Grade	255	28.12
High School Graduate/GED	168	24.31
Some College	44	6.37
College Graduate	56	8.10
Unknown	5	0.73

Of the total, 301 participants (43.56%) had no MediCal (Medicaid) at admission and 354 (51.23%) had no food stamps, although all participants were eligible for both types of assistance. Only 350 (56%) participants were receiving WIC upon enrollment and only 443 (71%) were receiving any type of public assistance (TANF, SSI, General Relief). At recruitment, 402 (64%) had received no prenatal or postpartum care prior to enrollment in the Healthy Start program.

Of the 691 participants enrolled, 267 (39%) were prenatal participants and 424 (61%) were interconceptional participants. Of the pregnant participants, 56 (21%) were enrolled in the program during their first trimester, 108 (41%) in the second, and 102 (38%) in the third. However, 155 (58%) of the pregnant women enrolled received prenatal care during their first trimester. Ninety-nine of those clients were identified through maternal and child health providers and referred to the Healthy Start program for ongoing services. Additionally, all pregnant women (100%) were enrolled in prenatal care prior to giving birth. Of the pregnant women enrolled, 183 (69%) had Medicaid, while the remaining 84 (31%) needed assistance with applying. Two hundred and thirty-seven (237) of the postpartum participants had Medicaid at enrollment, the remaining 187 (44%) needed assistance in applying. Cocaine was the primary drug of choice for 36% (225) of participants, while marijuana was the primary drug for 31.89% (199). Two hundred and two (202) or 32% of participants indicated they smoked cigarettes.

At admission, in addition to their substance abuse, participants reported the following areas of need:

Area of Need	# of Participants	% of Participants
Homeless	31	4.5
Illiterate	55	7.96
Lack Family Support	24	3.47
Domestic Violence	11	1.6
Suffered Abuse as Child	9	1.3
Open CPS Case	32	4.64
Suffer from Grief/Loss	14	2.03
Multiple Diagnosis	10	1.45

During the four year period, staff provided presentations at 42 health fairs and conducted fifty-five (55) trainings in the community. A total of one hundred and twenty-five (125) maternal and child health care and social service providers were provided information on the program through staff presentations in order to enhance knowledge regarding the issue, program services and the referral process. Staff also had booths and distributed information on the program at seventy-five (75) open houses, cultural events and bazaars that occurred in the community during the report period. Further, over 75 outreach sites/locations have been targeted in the community for the recruitment process.

**Strategy: Case Management**

For the past four years, SHIELDS has been providing the core service of case management as detailed in the responses provided above. During the course of the project, of the 691 participants enrolled, all (100%) received comprehensive services through the Case Management Component. All Healthy Start participants (100%) completed a Family Assessment and developed a Family Service Plan. Of the 691 participants enrolled, 312 participants were assisted with accessing stable housing; 232 with transportation services; 422 with child care resources; and 691 with linkage to medical care and nutrition education and/or WIC. Over 7,389 doses (service contacts) were provided by case management, totaling 3,116 hours (187,016 minutes).

The following table specifies the type of service contacts and referrals made during home visits and individual sessions with case managers:

Service Contact/Referral#	of Times	Topic Discussed	Total #	Service Minutes	
Adult Education	34	55	330	Child Care	
1853	201	Child Development	219	3787	Clothing
132	1898	Dental Care	39	390	Developmental Assessments
277					
8601	Early Intervention	152	3021	ECE Activity	
143	2576	Education/Training	29	56812	Employment
167	2149	Food Assistance	17	33116	Health Education
42	110,366	Health Services	50	513,099	Housing Assistance
488	10,642	Income Support	208	3809	Legal Services
28	611,051	Mental Health Services	180	4857	Parenting Education
294	7981	Substance Abuse Services	27	35026	Substance Abuse Education
29	95651	Transportation	44	016,062	Vocational Training
136	2181	Other (FSP)	173	255,410	<b>Total Minutes</b>
<b>7389187,016</b>					

During the four year period, pregnant participants received 1,888 prenatal care visits. There were a total of two hundred and eleven (211) live births. One hundred and ninety-eight (94%) were negative for any illicit drugs at birth. Thirteen infants (6%) were born positive for substances. Of those 13, ten were born to mothers who enrolled in the program during the third trimester. Postpartum participants received 213 medical visits during the postpartum period (six weeks after delivery). All (100%) of the perinatal participants (pregnant and postpartum) were provided information and education on breastfeeding, nutrition, family planning, parenting and early childhood education. All (100%) of the 691 substance abusing women enrolled in the program have been linked to a medical home and receive on-going care.

**Strategy: Health Education**

For the past four years, SHIELDS has been providing the core service of health education as detailed in the responses provided above. All collaborative partners identified to provide health education for the proposed program, have been providing these service for the past four years. Letters of commitment for their continued participation are included in the Appendix. During the course of the project, twenty-four (24) trainings were provided to the Consortium, fifty-five (55) to the community, and one hundred and twenty-five (125) to maternal and child health providers in order to increase knowledge, awareness and skills in specific targeted topics. Based on our evaluation data, participants showed an average of a 33.25% increase in knowledge based on pre/post tests administered before

and after training sessions. Additionally, over the course of the grant, staff participated in seventy-five (75) local open houses, health fairs, bazaars, and cultural events in the community to familiarize residents with program services. Case managers also provided 7,389 individual health education contacts (referrals, educational activities) to program participants during case management visits. During the course of the program, the following groups/ educational sessions were offered on site to Healthy Start Participants:

<b>Educational Group/Sessions</b>	<b>Total # of Participants</b>	<b>Total # Service Minutes</b>
Health and Nutrition	25825	155
HIV/AIDS Education	33417	800
Life Skills	36232	795
Mommy and Me	48443	560
Parenting Education	49546	144
Mother's Club	35133	416
Family Planning	18216	380
Drug and Alcohol Education	19017	100
Pregnancy and Childbirth	1865	400
Child Safety	1607	740
Smoking Cessation	2029	393
Special Services (guest speakers, health events)		

140

13,569 **Strategy: Interconceptional Care**

SHIELDS has been providing the core service of interconceptional care for the past four years, as detailed in the responses provided above. During the course of the project, total of 424 interconceptional care participants were enrolled in the program. Of those enrolled, 304 (74%) were African American, 99 (23%) were Latina, and 13 (3%) were Caucasian. All 424 (100%) of the interconceptional care participants received outreach and case management services and were linked to a medical home for on-going medical care and family planning services.

There were 421 infants and toddlers who were provided services from 2001-2004. Of those, 272 (65%) were ages 0-12 months and 149 (35%) were ages 12-24 months. Three hundred and twenty (76%) of the children served were African American, 86 (20%) were Latino, 11 (3%) were Caucasian, and 4 (1%) Other. All children (100%) were linked to a medical home and a primary pediatrician. A total of 828 well-baby/well-child care visits were received by children enrolled in the program over the four years. Six hundred and eight (608) Denver II's were administered and 17 referrals were made for further evaluation. Additionally, all 421 (100%) children had a minimum of one developmental screening and an Individual Education Plan (IEP) developed during the time frame.

**Strategy: Depression Screening and Referral**

In the general population, the majority of women experience high rates of mild depression during the postpartum period. A small percentage of those women (10%), go on to experience more significant symptoms which may impair their ability to parent their newborn. In the target population of substance abusing women, high rates of depression are already a common phenomenon. When this is combined with the normal depression of the postpartum period, it is not surprising to find that the percentage of participants who suffer from depression is greater than that found in the general population. In our experience, approximately 30% of the participants who were enrolled in the program, upon screening, needed referral for additional evaluation and services.

Since implementation of the depression screening component, 310 participants have been administered the EPDS. Sixty-one (20%) of the baseline scores indicated an elevated level of depression (score 12 or higher). All 61 participants were referred for further psychological assessment and enrolled in ongoing mental health services. Due to the high percentage of clients identified with mental health needs, mental health groups were added to our educational classes to provide support and assistance to our participants. Further, because of the extensive mental health issues, we are proposing to have a full-time on-site Mental Health Therapist in the proposed program to provide immediate access to staff and participants for consultation, assessment and linkage to mental health services.

**Strategy: Local Health Systems Action Plan**

SHIELDS Healthy Start Consortium developed a Local Health Services Action Plan in 2001, upon receipt of Healthy Start funding for a comprehensive services model. The Consortium committed to developing and implementing: (1) a prenatal risk assessment tool and (2) a system to track pregnant, substance abusing, women's entry into prenatal care. The Consortium developed two subcommittees, each chaired by a Consortium member, to address these deficiencies and to report back to the entire Consortium on progress and results. The subcommittees have continued to meet monthly since LHSAP development to achieve the goals established. During CY 2003, the Consortium piloted the risk assessment tool with local maternal and child health care providers. The implementation of HIPPA regulations has delayed the full implementation of the tool, however the Consortium is in the process of revising the risk assessment to assure that no violations of privacy laws will occur. After necessary modifications are made, the tool will be distributed to all maternal and child health care providers in the target community. Additionally, the Tracking Systems Committee continues to work closely with the local MCAH Department to develop the best plan for implementation of the system.

**Strategy: Consortium**

The SHIELDS Healthy Start Consortium was initiated in 1998. It is made up of thirty-six (36) members representing individuals from the target population, the medical field and agencies familiar with infant mortality and the target population. Current membership includes: nine consumers; the current and former Chief of Maternal and Child Health for Los Angeles County; two representatives from outreach and case management programs serving the targeted community; two representatives from the Maternal and Child Health Services Division for Los Angeles County's managed care organization (LA Care); the Head Nurse from the high risk prenatal clinic from the local public hospital (King Drew Medical Center); and representatives from early intervention programs, social service providers and community based groups, as well as local business. The ethnic composition of the existing Consortium is, as follows: 26 (72%) are African

American, 6 (17%) are Latino, and 4 (11%) are Caucasian. All Consortium members are representative of and familiar with the targeted community and its resources. (Please see the Appendices for the Consortium Roster.)

Meetings with the Consortium have been conducted bi-monthly throughout the project period. Subcommittees established to address specific program objectives and activities (By-Laws, Recruitment and Hiring, Sustainability, LHSAP Committees, and Training and Education) continue to meet regularly to initiate activities specific to their particular areas of concern. The Sustainability committee continues to work with representatives from managed care and the Department of Health Services to identify mechanisms to incorporate program services into existing services and/or utilize Medicaid and/or EPSDT as payment mechanisms for services rendered. In addition, Consortium members have continued to network with community providers and agencies to access needed services for program participants, i.e. child care, job training, and educational classes. Members also assist the program staff in its outreach and client recruitment activities by referring pregnant and postpartum substance abusing women to the program.

The Consortium has served to impact the community where the target population resides. This has included increasing the awareness of the issues surrounding infant mortality; the availability of services for the target population; and working to enhance the system of care available. A major accomplishment for our Consortium, over the past four years, has been the active involvement of our consumer representatives. Because of their input and advocacy for the program and the needs of the target population, two of our consumer representatives were selected to serve on the local managed care advisory board where they have made recommendations for health service delivery enhancements. In that capacity, they traveled to our State Capitol in Sacramento to testify on behalf of the target population before legislative committees on their concerns, issues and recommendations for change.

The Consortium has also made significant progress on the identified priorities for the implementation of the Local Health Systems Action Plan. This includes redefining the existing service delivery system to ensure appropriate referral of the target population to high risk perinatal care services and developing and piloting a risk assessment tool for use by local maternal and child health providers. Further, with the assistance of the Consortium, implementation of the Mobile Van Unit was initiated for use by our Outreach Component. Currently, the van provides outreach; education and referrals; screenings for HIV/AIDS, STDS, and TB; and pre and post-test counseling. Through established Consortium relationships, these services are now expanding to incorporate pregnancy testing as a component of their Outreach. The Consortium continues to monitor the project's progress through the review of evaluation results and program reports provided to all members at quarterly meetings. Further, trainings have continued to be provided to the Consortium on issues affecting the target population and

Consortium members have assisted in the provision of trainings to staff, local providers and the community.

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

The efforts made over the past years by the Healthy Start programs in California in collaboration with the State MCAH Office, have been of particular significance to our Consortium and Healthy Start Program. The recognition of the particular needs of our target population have been brought to the forefront of the field and dedicated efforts are now being made to address the issues of this population and the negative impact of substance abuse on infant mortality and morbidity rates. Further, our close collaboration with our local MCAH has assisted in ensuring that our target population's needs have become a priority locally and has assisted our program and Consortium in the achievement of their goals. It is our hope that this will lead towards integration of MCAH and substance abuse treatment services, as well as blended funding to address the joint concerns of both these fields. More significantly, hopefully the increase in interest will result in more appropriate interventions, cultural sensitivity and respect for this population of women so that they can access services without fear of retribution or discrimination and can receive the assistance they require. Additionally, it is our hope that innovative ideas, such as our model of service delivery, will be adopted throughout the state so that more women have the opportunity to be identified and enrolled in services. Because of the Healthy Start Needs Assessment report and the State's active participation in our local and national Healthy Start activities, we have received numerous calls and visits from providers throughout the state who are interested in replicating this model.

**Strategy: Sustainability**

In order to address the issue of maintaining services beyond the grant period, the SHIELDS Healthy Start Consortium developed a specific committee to address sustainability in 2001. The committee was given the charge of identifying and exploring options available for continued sources of program revenue in conjunction with identified consortium objectives. The Sustainability committee has continued to work with representatives from managed care and the Department of Health Services to identify mechanisms to incorporate program services into existing services and/or utilize Medicaid and/or EPSDT as payment mechanisms for services rendered.

SHIELDS for Families has also continued its efforts to sustain the program after Healthy Start Initiative (HSI) funding ends. In addition to the grants received during the project period from CSAT and First Five, SHIELDS has submitted two additional proposals that are currently under review. If funded, these grants would enhance the mental health and housing service available for our Healthy Start program participants. We are also working with USC and the Department of

Children and Family Services to apply for a grant from NIMH to evaluate the delivery of services to families referred for child abuse and neglect where substance abuse is involved.

Further, we have increased our collaborative efforts in order to enhance in-kind resources available to the families we serve. This includes establishing a partnership with Planned Parenthood for on-site family planning services. Additionally, we have been meeting with UCLA's Postpartum Depression Program staff to determine if collaboration can benefit our program participants.

## **Project Period Objectives and Accomplishments**

### **Objective 1**

**Project Period Objective Strategy and Activities Accomplishments Project Period Objective:** By 6/1/05, increase knowledge of substance abuse and need for prenatal care through the provision of a minimum of four education and training sessions annually in the target community by a minimum of 30% from baseline as measured through pre/post tests.

**Baseline:** Lack of information and education regarding the importance of identification of substance abuse and its impact on enrollment in prenatal care and positive birth outcomes as documented by data from treatment and health care providers and late entry into prenatal care by 70% - 90% of substance abusing pregnant women in target community and as indicated through pre-test results. Data Source: Perinatal Needs Assessment, Los Angeles County Department of Health Services, 1994; Martin Luther King Hospital Data, 1999; SHIELDS treatment data, 2000.

**Project Performance Indicator:** Percentage of Increase in target community's knowledge of substance abuse/prenatal care and infant mortality.

**Strategy:** Increase Program Referrals and knowledge of community through education and training

### Activities:

Develop list of community entities that can serve as a potential source for referrals and/or are in need of education/training on perinatal substance abuse (7/01-9/01)

Identify training need areas for community education in conjunction with Consortium Training and Education subcommittee (8/01-ongoing)

Contact other Healthy Start sites and Healthy Start Resource Center for information on training (8/01-ongoing)

Develop training plan including a minimum of four trainings annually (10/01-11/01)

Identify trainers for specific trainings (10/01-ongoing)

Contract with identified trainers (10/01-ongoing)

Implement training plan (11/01-ongoing)

Conduct pre/post tests of all trainings provided (11/01-ongoing)

As of 5/31/05, fifty-five (55) trainings were provided to community residents. Based on pre/post test results, knowledge of participants on the causes of infant mortality and morbidity increased by 33% as a result of the training.

completed

completed

completed

completed

completed

completed

completed

completed

**Objective 2**

**Project Period Objective Strategy and Activities Accomplishments Project Period Objective:** By 6/1/05, provide comprehensive outreach to a minimum of 700 African-American pregnant and post partum substance abusing pregnant women in the target community.

**Baseline:** 15% of African American births in target community are substance exposed; 50% of infants in NICU and special care at King Drew Medical Center are substance exposed. (Data Source: Martin Luther King Hospital, 1999; SHIELDS, 2000; REI-WIC, 1999; Perinatal Needs Assessment, Los Angeles County Department of Health Services, 1994.

**Project Performance Indicator:** Number of African American substance abusing pregnant and post partum women recruited from the target community.

**Strategy:** Aggressive case finding of pregnant substance abusing women in target community

Activities:

Recruit and hire outreach workers who are representative of the target population (7/01)

Provide training to all outreach staff on program protocols and relevant topics (7/01-ongoing)

Develop all outreach program policies, forms and charts (7/01-9/01)

Develop brochures and flyers for use in recruitment (8/01-9/01)

Develop list of potential sites/sources for recruitment including linkage with Consortium member agencies particularly Black Infant Health, LA Care and WIC (8/01-ongoing)

Implement recruitment plan including door-to-door canvassing, street outreach, and participation in health fairs and other community events/activities (10/01-ongoing)

Link recruited clients to case management component (10/01-ongoing)

Collect intake data on recruited clients for program and evaluation use (10/01-ongoing)

Participate in weekly case conference to review all recruitment activities, new intakes and other relevant information (10/01-ongoing)As of 5/31/05, SHIELDS Healthy Start program made 3,044 outreach contacts to the target population. These contacts resulted in the recruitment of seven hundred and twenty-four (724) substance abusing pregnant and postpartum women. Of those women, six hundred and ninety-one (691) were successfully enrolled in program services.

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### **Objective 3**

**Project Period Objective Strategy and Activities Accomplishments Project Period Objective:** By 6/1/05, provide comprehensive case management, health education and linkage to prenatal care and substance abuse treatment to a minimum of 80% of the 850 African American substance abusing pregnant and post partum women recruited in target community.

**Baseline:** Lack of comprehensive services, enrollment in prenatal care and treatment services for the target population as indicated by the high rates of late entry or no prenatal care (90% of target population). (Data Source: Martin Luther King Hospital, 1999; SHIELDS Healthy Start program data, 2000; REI-WIC, 1998; Perinatal Needs Assessment, Los Angeles County Department of Health Services, 1994.)

**Project Performance Indicator:** Number of African American pregnant and post partum substance abusing women receiving comprehensive case management and health education services. Number of women enrolled in prenatal care and substance abuse treatment.

**Strategy:** Aggressive case management of African American pregnant and postpartum substance abusing women in target community

#### Activities:

Recruit and hire case managers (7/01)

Provide training to all case managers on program protocols and relevant topics (7/01-ongoing)

Develop all case management program policies, forms and charts (7/01-9/01)

Develop list of potential sites/sources for resources including linkage with Consortium member agencies particularly Black Infant Health, LA Care and WIC (8/01-9/01)

Conduct assessments and develop service plans for all enrolled clients (10/01-ongoing)

Implement case management services to recruited clients; link with perinatal care and substance abuse treatment (10/01-ongoing)

Monitor clients participation in resources, conduct in home visits (10/01-ongoing)

Collect intake data on recruited clients for program and evaluation use (10/01-ongoing)

Participate in weekly case conference to review all recruitment activities, new intakes and other relevant information (10/01-ongoing)As of 5/31/05, 691 (100%) of the women recruited into the program were transitioned into comprehensive case management services. A total of 7389 service contacts were made with participants over the project period. Health education services were provided to 100% of enrolled clients. All (100%) of the pregnant women in the program were enrolled in prenatal care.

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**Objective 4**

**Project Period Objective****Strategy and Activities Accomplishments****Project Period Objective:** By 6/1/05, 60% of the targeted population of 850 African American substance abusing pregnant and post partum women who prenatally received Health Start services will enroll in prenatal care in the first trimester.

**Baseline:** Approximately 70-90% of the African American substance abusing pregnant women targeted for services in this proposal do not initiate prenatal care until after the first trimester and more than 40% are in their last trimester or receive no prenatal care at all. (Data Source: SHIELDS Healthy Start data, 2000, Martin Luther King Hospital Data, 1999.)

**Project Performance Indicator:** Percent of African American pregnant and post partum substance abusing women who prenatally received Healthy Start Services and accessed prenatal care in the first trimester.

Strategy: Aggressive outreach and case management of African American pregnant substance abusing women in target community

Activities:

Develop and implement recruitment plan specifically targeted at first trimester African American pregnant substance abusing women (10/01-ongoing)

Develop list of high risk prenatal care resources and linkages for pregnant clients including linkage with Consortium member agencies particularly Black Infant Health, LA Care and WIC (8/01-ongoing)

Conduct assessments and develop service plans for all enrolled clients (10/01-ongoing)

Implement case management services to recruited clients; link all first trimester pregnant women with perinatal care (10/01-ongoing)

Monitor clients participation in prenatal care, arrange for transportation, conduct in home visits (10/01-ongoing)

Collect intake data on recruited clients for program and evaluation use (10/01-ongoing)

Participate in weekly case conference to review all recruitment activities, new intakes and other relevant information (10/01-ongoing)

As of 5/31/05, a total of two hundred and sixty-seven (267) were pregnant at recruitment into the program. Of those, 155 (58%) of the pregnant clients received prenatal care in their first trimester. Ninety-nine of those clients were receiving prenatal care prior to enrollment in Healthy Start and were recruited through our linkages with maternal and child health providers. The remaining fifty-six clients who enrolled in Healthy Start services during their first trimester received prenatal care in their first trimester (100%). Further, all clients (100%) were enrolled in prenatal care prior to delivery.

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**Objective 5**

**Project Period Objective Strategy and Activities Accomplishments Project Period Objective:** By 6/1/05, 80% of the targeted population of 850 African American substance abusing pregnant and postpartum women who prenatally received Health Start services will deliver at full term.

**Baseline:** Approximately 70-90% of the African American substance abusing pregnant women targeted for services in this proposal do not initiate prenatal care until after the first trimester; more than 26.2% of all African American women have preterm births in the targeted area. (Data Source: SHIELDS Healthy Start data, 2000; Los Angeles County Department of Health Services, Vital Statistics and Records, 1999; Martin Luther King Hospital Data, 1999.)

**Project Performance Indicator:** Percent of African American pregnant and post partum substance abusing women who prenatally received Healthy Start Services and delivered at full term.

**Strategy:** Aggressive case management of African American pregnant substance abusing women in target community

Activities:

Develop list of high risk prenatal care resources and linkages for pregnant clients including linkage with Consortium member agencies particularly Black Infant Health, LA Care and WIC (8/01-ongoing)

Conduct assessments and develop service plans for all enrolled clients (10/01-ongoing)

Implement case management services to recruited clients; link all pregnant women with perinatal care, substance abuse treatment and risk reduction activities (10/01-ongoing)

Monitor clients participation in prenatal care, arrange for transportation, conduct in home visits (10/01-ongoing)

Collect intake data on recruited clients for program and evaluation use (10/01-ongoing)

Participate in weekly case conference to review all client progress, new intakes and other relevant information (10/01-ongoing)

Of the 211 women who gave birth by 5/31/05, 87% delivered full term infants. One hundred and ninety-eight (94%) were negative for any illicit drugs at birth. Thirteen infants (8%) were born positive for substances. Of those 13, ten were born to mothers who enrolled in the program during the third trimester. Postpartum participants received 213 medical visits during the postpartum period (six weeks after delivery).

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**Objective 6**

**Project Period Objective Strategy and Activities Accomplishments Project Period Objective:** By 6/1/05, 80% of the two year olds who received Health Start services will have received the full schedule of immunizations.

**Baseline:** Approximately 90% of the infants of African American substance abusing pregnant women targeted for services in this proposal do not receive the full schedule of immunizations; 75% of all African American two year olds in the targeted area receive the full schedule of immunizations. (Data Source: SHIELDS data, 2000; Los Angeles County Department of Health Services, Vital Statistics and Records, 1999; Martin Luther King Hospital Data, 1999.)

**Project Performance Indicator:** Percent of two year olds who are enrolled in Healthy Start Services and receive the full schedule of immunizations.

Strategy: Aggressive case management of African American infants born to substance abusing women in target community

Activities:

Develop list of high risk infant follow-up care resources and linkages for infants including linkage with Consortium member agencies particularly Black Infant Health, LA Care and WIC (8/01-ongoing)

Conduct assessments and develop service plans for all enrolled clients (10/01-ongoing)

Implement case management services to recruited clients; link all infants with high risk infant follow up (10/01-ongoing)

Monitor infants participation in high risk infant care and immunization schedule, arrange for transportation, conduct in home visits (10/01-ongoing)

Collect intake data on infants immunization compliance for program and evaluation use (10/01-ongoing)

Participate in weekly case conference to review all progress, new intakes and other relevant information (10/01-ongoing)

By 5/31/05, of the 421 children (0 - 2) who received Healthy Start services, 80% (337) had received the full schedule of immunizations to date.

All children (100%) were linked to a medical home and a primary pediatrician. A total of 828 well-baby/well-child care visits were received by children enrolled in the program over the four years. Six hundred and eight (608) Denver II's were administered and 17 referrals were made for further evaluation. Additionally, all 421 (100%) children had a minimum of one developmental screening and

an Individual Education Plan (IEP) developed during the time frame.

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#### **Objective 7**

**Project Period Objective/Strategy and Activities/Accomplishments** **Project Period Objective:** By 6/1/05, the Healthy Start Consortium will have implemented the local health system plan: (1) To identify and implement a pre-natal risk assessment tool that will be used uniformly throughout Service Area 6 of Los Angeles, California; and (2) To develop a system to track pregnant, substance abusing, women's entry into high risk prenatal care

**Baseline:** Currently, there is no common pre-natal risk assessment tool that is used uniformly throughout Service Area 6 of Los Angeles, California; and no system to track pregnant, substance abusing, women's entry into high risk prenatal care. (Data Source: Los Angeles County Department of Health Services Maternal and Child Health Plan, 1999.)

**Project Performance Indicator:** Implementation of the local health system plan: (1) Implementation of a pre-natal risk assessment tool that is used uniformly throughout Service Area 6 of Los Angeles, California; and (2) Implementation of a system to track pregnant, substance abusing, women's entry into high risk prenatal care.

**Strategy:** Develop subcommittee of Consortia members to oversee development and implementation of plan for (1) Perinatal Risk Assessment; (2) Tracking System

#### **Activities:**

Develop subcommittees (7/01)

##### **(1) Perinatal Risk Assessment**

Identify and review current tools, (12/31/01)

Identify a tool, or Develop a tool (3/31/02)

Develop a consensus on reliability and validity of tool (5/31/02)

Develop field test plan (06/30/02)

Field test tool (8/31/02)

Discuss results of field test (11/30/02)

Revise the tool (12/31/02)

Train providers on the tool (12/31/02 - ongoing)

Distribute the tool (6/31/03-ongoing)

Revise tool for HIPPA (5/31/04)

Implement the tool (06/04-Ongoing)

##### **(2) Tracking System (under review)**

Identify the data already collected (12/30/01)

Develop system for high risk clinics to track all appointments for pregnant substance abusing women (8/31/02)

Develop a data collection instrument to track appointments (12/30/02)

Identify high risk appointment contacts at clinics (3/31/03)

Develop a mechanism for the clinic to report to MCH on the number of pregnant substance abusing women in prenatal care (6/30/03)

Develop a report format for data (11/30/03)

Pilot test Data Collection (1/31/04)

Present and discuss preliminary findings (5/31/04)

Implement tracking system (12/31/04)

As of 5/31/05, the Healthy Start Consortium and Healthy Start staff had trained a total of 28 maternal and child health providers on the risk assessment tool. The tool was distributed to local clinic's and doctor's The tool is being revised to ensure its compliance with HIPPA.. Development of the tracking system and data collection plan has been delayed due to the crisis in Los Angeles County. Alternative goals are being considered

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**Objective 8**

**Project Period Objective/Strategy and Activities/Accomplishments/Project Period Objective:** By 6/1/05, improve the capacity of maternal and child health and social service providers to identify and provide services and referrals for the targeted population by increasing their knowledge by 45% from baseline measure of the impact of substance abuse on infant mortality and related issues through the provision of a minimum of six trainings and educational sessions annually.

**Baseline:** Healthy Start findings from prior cohorts of programs; consortium identification of providers need for training; lack of prenatal identification of substance abuse; pretests of providers. (Data Source: Healthy Start reports and findings; Consortium data, 2000; Los Angeles County Department of Health Services Maternal and Child Health Plan, 1999.)

**Project Performance Indicator:** Improvement in the capacity of maternal and child health and social service providers to identify and provide services and referrals for the targeted population.

**Strategy:** Increase Program Referrals and knowledge of providers through education and training

**Activities:**

Develop list of provider entities that can serve as a potential source for referrals and/or are in need of education/training on perinatal substance abuse (7/01-ongoing)

Identify training need areas for provider education in conjunction Consortium Training and Education subcommittee (8/01-ongoing)

Contact other Healthy Start sites and Healthy Start Resource Center for information on training (8/01-ongoing)

Develop training plan including a minimum of six trainings annually (10/01-11/01)

Identify trainers for specific trainings (10/01-ongoing)

Contract with identified trainers (10/01-ongoing)

Implement training plan (11/01-ongoing)

Conduct pre/post tests of all trainings provided (11/01-ongoing)

As of 5/31/05, 125 (125) trainings were provided to maternal and child health and social service providers. Based on pre/post test results, knowledge of participants was increased by 41% as a result of the training.

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**Objective 9**

**Project Period Objective/Strategy and Activities/Accomplishments/Project Period Objective:** By 6/1/05, ensure active and consistent participation of consumers in the Consortium by having membership that is a minimum of 50% consumers (a minimum of fifteen active members on an ongoing basis).

**Baseline:** Currently, 70% of the Consortia membership are representatives of agencies familiar with infant mortality and with the target population. (Data Source: Consortium roster; Consortium sign-in sheets.)

**Project Performance Indicator:** Number of Healthy Start consumers on the Healthy Start Consortium members who actively and consistently participate in Consortium meetings and activities.

**Strategy:** Aggressive recruitment of new Consortia consumer members

**Activities:**

Develop Recruitment subcommittee of Consortia members (7/01-9/01)

Develop list of potential consumers and/or entities that can recommend consumers for recruitment that reflect the cultural diversity of the target population (9/01-ongoing)

Develop recruitment plan (9/01-11/01)

Implement recruitment plan (12/01-ongoing)

Orient new members to Consortium (12/01-ongoing)

Continue recruitment as needed (1/02-ongoing)As of 5/31/05, a total of seventeen (17) consumer representatives (49%) had been recruited to the Healthy Start Consortium.

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**Objective 10**

**Project Period Objective**Strategy and ActivitiesAccomplishments**Project Period Objective:** By 6/1/05, improve the capacity of consortium members to participate in the consortium by increasing their knowledge of infant mortality, substance abuse and related issues a minimum of 45% from baseline measure.

**Baseline:** Healthy Start findings from prior cohorts of programs; consortium identification of need for training; pre-tests of consortium member's knowledge on infant mortality and related issues; pretest results. (Data Source: Program records, meeting minutes, Healthy Start reports and findings.)

**Project Performance Indicator:** Increase in Consortium members capacity to participate in Consortium through an increase in knowledge on infant mortality and related issues.

**Strategy:** Active engagement of Consortium members in all activities

**Activities:**

Develop Training and Education subcommittee (7/01)

Identify training need areas for Consortium members (8/01-ongoing)

Contact other Healthy Start sites and Healthy Start Resource Center for information on training for Consortium (10/01-ongoing)

Develop training plan for consortium including a minimum of three trainings per year (10/01-11/01)

Identify trainers for specific trainings (10/01-ongoing)

Contract with identified trainers (10/01-ongoing)

Implement training plan (11/01-ongoing)

Conduct pre/post tests of all trainings provided (11/01-ongoing)As of 5/31/05, twenty-four (24) trainings were provided to the Consortium. Based on pre/post test results, knowledge of participants was increased by 40% as a result of the training.

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

Not applicable.

**V. Project Impact**

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

- 1. Describe the approaches utilized to enhance collaboration.**

The approach the program has taken to collaborative efforts over the course of the project period has been based on the community's strengths and willingness to work together and have focused on active involvement,

coordination of services, and the sharing of resources in all efforts that would assist in the furtherance of the program's goals. Collaborations with the public and private health care entities who have access to the target population and/or needed services have been maintained throughout the project period. These partnerships continued to be utilized to facilitate cross and joint trainings, resources, joint funding applications, and representation on committees and boards that support or enhance the program. These linkages across service systems have been essential to ensure that families can access all necessary services to enhance the opportunity for positive birth outcomes. For example, a SHIELDS Healthy Start representative was appointed by the County MCAH Director as a permanent member of the planning committee for the MCAH Local Title V Health Plan. In that role, staff are able to have direct impact on the priorities established for Los Angeles County and assure that the needs of our target population of substance abusing women are addressed. Two additional Healthy Start staff sit on committees that develop activities for addressing specific priority goals for birth outcomes in the five year plan.

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

The Consortium recognized that one of the major problems in the community was the lack of system integration for substance abusing women. When a pregnant woman was identified as being at risk due to substance use, there was no mechanism in place to track her entry into prenatal care. The SHIELDS= Health Start Consortium chose to address this need and assist the Los Angeles County MCAH in developing a prenatal risk assessment tool and a system to track pregnant, substance abusing women=s entry into prenatal care. Although these changes have not been fully incorporated into the service system, there is a commitment from the providers and Los Angeles County=s MCAH to continue efforts towards their full implementation.

The primary challenge to achieving these goals was the ongoing crisis in the health care system in Los Angeles County. Major deficits in the health care funds in the County have caused closure of multiple clinics and hospital departments. This delayed the implementation of a tracking system due to an ever changing system of services. As this report is being written, the primary public hospital serving the community, Martin Luther King Hospital, is under imminent threat of closure. The other challenge to LHSAP goal implementation was the impact of HIPPA on sharing of information. During CY 2003, the Consortium piloted the risk assessment tool with local maternal and child health care providers. The regulations on confidentiality created concern with medical providers about referring clients to outside agencies for fear of violating the new privacy laws.

Although, the implementation of HIPPA regulations delayed the full implementation of the tool, the Consortium is in the process of revising the risk assessment to assure that no violations of privacy laws will occur. After necessary modifications are made, the tool will be distributed to all maternal and child health care providers in the target community.

**3. Describe key relationships that have developed as a result of efforts covering the following areas:**

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

The relationships that have been established and maintained throughout the project period include:

*Martin Luther King Hospital:* Through SHIELDS public-private partnership, staff work closely with the Prenatal Clinic and Labor and Delivery to identify and enroll in treatment all women identified with a substance abuse problem.

*Department of Public Social Services (DPSS):* DPSS administers TANF, Medicaid (Medi-Cal) and CalWORKS, California's Welfare-to-Work plan. The Consortium interacts regularly with staff from the Department. Healthy Start Outreach Workers conduct outreach in three local offices that serve the project's zipcodes. In addition, staff interact with DPSS staff on a regular basis to broker and advocate for benefits on behalf of their clients. SHIELDS is an active member of the Substance Abuse Steering Committee for CalWorks in Los Angeles County plan and serves as a provider of substance abuse treatment and mental health services.

*Department of Children and Family Services (DCFS):* DCFS is the Child Protective Services agency in Los Angeles County. SHIELDS has worked in collaboration with the Department for the past ten years to provide Family Preservation and Family Support services to families referred due to child abuse and neglect. Most recently, we are partnering with DCFS to provide Emergency Response Assessments for families where there are allegations of substance abuse and/or mental health. This project has been successful at reducing out-of-home placements and linking families to services immediately. This has assisted in the identification of program participants for Healthy Start, since all newborns with a positive tox screen are referred for family assessment.

*LA Care:* LA Care is the County's managed care program. Staff from LA Care are represented on the Consortium (Chairperson of the Consortium) and they have been an integral part of our work to date. In addition, they have provided educational and training sessions for consortium members, maternal and child health

providers and outreach staff and were the original sponsors of our Mother's Club.

Great Beginnings for Black Babies: SHIELDS for Families, Inc. and Great Beginnings have worked together for many years in the South Central community sharing resources, referrals, and conducting joint and cross-training. This organization targets the African American community in order to decrease the high rates of low birthweight, infant mortality and perinatal mortality.

Healthy African American Families (HAAF): The HAAF program targets African American low-income families in the community to provide training, education and assistance with linkage to health care and related resources. SHIELDS and HAAF staff have collaborated in the sharing of data, as well as in the exchange of information regarding health care clinics that provide quality services. In addition, SHIELDS staff have attended numerous trainings conducted by HAAF for service providers

Mother Net: Mother Net is a community based initiative that targets low-income pregnant women in the community and provides educational and supportive services using a peer model. Mother Net has provided on-site educational classes for our program on child safety issues.

Planned Parenthood: Planned Parenthood provides family planning and contraceptive services. They provide a 10 week rotating family planning class for all Healthy Start program participants. Additi

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March of Dimes: The March of Dimes provides on-site classes as a part of their BACK-To-SLEEP and their “Healthy Babies, Healthy Futures: Preventing Prematurity” Campaigns. Additionally, they provide the program with literature, resource materials and training for staff and the Consortium.

- b. Relationships that focus on involvement of consumers and/or community leaders with any of the agencies/ organizations listed above or any additional organizations.**

Involvement of consumer and resident representatives has remained a priority for SHIELDS throughout the project period.

SHIELDS has consistently accessed consumer input through the use of a Consumer Advisory Council. Representatives from this group as well as SHIELDS substance abuse treatment Alumni Association have been recruited to the Consortium and provided input to the Healthy Start program that assisted in guiding its activities and interventions. Because of their input and advocacy for the program and the needs of the target population, two of our consumer representatives were selected to serve on the local managed care advisory boards where they have made recommendations for health service delivery enhancements. In that capacity, they traveled to our State Capitol in Sacramento to testify on behalf of the target population before legislative committees on their concerns, issues and recommendations for change.

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

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

Prior to the implementation of Healthy Start services, substance abusing pregnant and post partum women were often referred out when they requested medical and social services because they were felt to be too high risk for the providers. Because of the advocacy of the Healthy Start Consortium and staff, perinatal substance abuse is now a priority issue for MCAH providers. Staff have developed linkages with medical clinics, physicians and social service providers who have now altered their eligibility and intake requirements in order to provide priority prenatal and related services to substance abusing women to increase the chances of positive outcomes for mother and child. The success of the impact is identified in our outcomes where medical providers referred 154 pregnant substance abusing women to the project who were in the first trimester of their pregnancy.

**b. Barriers to access and service utilization and community awareness of services;**

Medical and social services that do exist in the community have often been inaccessible due to lack of transportation, child care or the long waiting periods for appointments. It is not unusual, therefore, for a pregnant woman to only be seen by her physician three times during her pregnancy because of the number of patients served in Medi-Cal and/or public funded medical clinics/hospitals. Systemic barriers have been another fundamental cause

of the low rates of service usage for the targeted population. Staffing with a lack of sensitivity to the community and judgmental attitudes toward the population served were identified as primary factors in non-compliance with perinatal care in a needs assessment conducted in Los Angeles County by the Department of Health Services. In addition, disregard for scheduled appointment times, making women and children wait for hours to be seen was also cited as a prime hindrance to utilization of available services. Cultural and linguistic incompetence found in community providers also impedes the use of services.

As indicated above, staff have advocated on behalf of the participants and developed linkages with medical clinics and service providers who are responsive to and respectful of the participants enrolled in the program and provide priority service to our families. In addition to these efforts, staff have utilized the mobile van funded by a grant from the Center for Substance Abuse Treatment to assist with participant identification and engagement. The van provides general health education; referrals; and screening for HIV, STD's, TB and Hepatitis C. We believe the van is of invaluable assistance in identifying and outreaching to the target population and serves as a mechanism for increasing linkage to prenatal care and education regarding the effects of substance abuse and the risks of STD's and HIV/AIDS.

Additionally, all of the outreach activities to program and community participants have assisted in increasing awareness and name recognition of the Healthy Start Program in the community. Over 75 outreach sites/locations were identified and targeted for the recruitment process. During the course of the project, fifty-five (55) trainings were provided to the community and one hundred and twenty-five (125) to maternal and child health providers in order to increase knowledge, awareness and skills in specific targeted topics. Based on our evaluation data, participants showed an average of a 33.25% increase in knowledge based on pre/post tests administered before and after training sessions. Additionally, over the course of the grant, staff participated in seventy-five (75) local open houses, health fairs, bazaars, and cultural events in the community to familiarize residents with program services.

**c. Care coordination including descriptions of mechanisms implemented to assure continuity of care, quality improvement and follow up system(s) for client referrals;**

Fragmentation and the lack of integration of supportive services is

another prime barrier to perinatal care. The majority of women targeted for this project are engaged in multiple social service systems which often function independently of one another due to categorical funding and/or isolative procedures. Multiple assessments, appointments and criteria for eligibility can be overwhelming to a mother already victimized by her environment and life situation. Historically, efforts which support the integration of prenatal care and community services and focus on the reduction of infant mortality and low birth weights have been limited.

The SHIELDS' Healthy Start program was in a unique position to address these care coordination issues in that SHIELDS provides substance abuse and mental health treatment, transportation, child care, housing and case management services and was linked to health care in all project sites. This facilitated the access to services for participants enrolled in Healthy Start. The majority of participants were transitioned to substance abuse treatment in one of the SHIELDS' programs. The case management component monitored and tracked all participants to ensure they remained in services. Additionally, because of the relationships established through the Consortium, staff have developed a system to work with LA Care and the Black Infant Health program to assist with referral and service linkage for women identified as high risk due to substance abuse.

In order to ensure that referrals to that program were monitored and tracked, referrals of participants to the program were made directly to the Outreach Component of the program. Staff contacted the referral entity/individual to obtain the necessary releases and contact information for the potential participant. Upon contacting the individual, staff completed the enrollment process and informed the referent of the successful outcome. If staff was unable to locate the potential participant or they were unwilling to enroll in services, staff informed the referent of the outcome and continued to work with them to engage the woman in services. All referrals received by the program were also tracked by the evaluation component to verify completion of the referral process.

To verify that referrals to services were successful for participants, referrals made by Case Management were verified through three primary mechanisms. The first was through direct communication with the service provider by the case manager to ensure the participant had connected and received the services designated. Second, was through the use of referral forms taken by the participant to the referred provider. These forms were signed by the

service provider when services were completed and returned to the case manager. The third mechanism to verify completion of referrals was through self-report by the participant with some form of documentation to ensure the services were rendered (e.g. prescription received). All referrals to services by the program were also tracked by the evaluation component to verify completion of the referral process.

**d. Efficiency of agency records systems and sharing of data across providers to reduce the need for repetition.**

In order to reduce the need for repetition and share data across providers, SHIELDS ensured that all participant's pertinent information (with signed consent), was given to other providers involved in their care. Likewise, providers were asked to share information and participate in joint case conferences in order to eliminate the possibility of repeat processes and service duplication for the participant.

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

**a. Provider responsibility in maintaining client participation in the system and provider sensitivity to cultural, linguistic and gender needs of the community;**

Consumer representatives have helped to guide the program and the Consortium in its implementation of services and in ensuring program sensitivity and awareness of issues specific to the target population. Their input has also assisted with increasing professional and provider Consortium member's knowledge of concerns and barriers that confront pregnant and interconceptional substance abusing women as they attempt to access services for themselves and their children. This has had a significant impact on provider sensitivity to the cultural, linguistic and gender needs of the target population. Consumer representatives have also been advocates for services to local and state legislators, as well as active participants in other local boards and consumer groups, where they have identified barriers to service and made recommendations for change.

**b. Consumer participation in developing assessment and intervention mechanisms and tools to serve perinatal women and/or infants, and the extent of implementation**

**and utilization of these tools or mechanisms.**

With the input of consumers, service interventions were altered in the program to incorporate the use of a mobile van for outreach and the targeting of clinics where abortions were preformed. Based on their own personal experiences, they were able to identify these mechanisms as having the ability to reach substance abusing women that were not currently accessing services. According to the participants, many women abusing substances were concerned about whether or not they were pregnant and would access abortion clinics or mobile units to determine their pregnancy status because they would not have to be concerned about identification of their substance abuse or any follow up services. These interventions has been extremely successful in the Healthy Start Program, assisting with the identification of a large number of participants due to their implementation. Additionally, consumers were actively involved in the development of a uniform perinatal risk assessment tool through the identification of questions that would assist in the identification of substance abuse. This tool has been piloted with local and maternal child health providers and is targeted for implementation in the near future.

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

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

All of the outreach activities to program and community participants have assisted in increasing awareness of services and how to access them in the community. A total of fifty-five (55) trainings were provided to the community and one hundred and twenty-five (125) to maternal and child health providers in order to increase knowledge, awareness and skills in specific targeted topics. Additionally, over the course of the grant, staff participated in seventy-five (75) local open houses, health fairs, bazaars, and cultural events in the community to familiarize residents with program services. Healthy Start staff were also active participants on local health councils and committees, as well as other collaborative groups, which assisted in increasing the awareness of our services in the community.

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

As previously indicated, because of their input and advocacy for the program and the needs of the target population, two of our consumer representatives were selected to serve on the local managed care advisory boards where they have made recommendations for health service delivery enhancements. In that capacity, they traveled to our State Capitol in Sacramento to testify on behalf of the target population before legislative committees on their concerns, issues and recommendations for changes in services and service delivery that impact the target population.

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

This community has limited services and resources for the target population, however the strength of the community is its willingness to join together and work towards mutual goals, as described previously. The Healthy Start program assisted with this process by providing a forum where consumers, residents and professionals could work together to gain a better understanding of the issues impacting the target population, learn to resolve conflicts and work towards building a team to address the presenting problem. The success of this process is evidenced in the number of joint grant applications that have been submitted by Consortium members to target areas of concern in the perinatal health care system in the community. Each one has identified a different lead agency and included the other agencies as a part of the collaborative. Two of these applications have already been funded and will serve to support the efforts of the Healthy Start program and assist with the accomplishment of our identified objectives.

**4. Creation of jobs within the community.**

Over 90% of the Healthy Start program staff are former consumers and/or residents of the community we serve. Additionally, because of the role the consumers have played on the Consortium, many have been hired over the years to work at one of the agencies represented on the Consortium, including LA Care and Drew Child Development Corporation. Further, because of the educational and vocational services available through the program, our consumers are now able to participate in the job market and fill positions available in the community.

**C. Impact on the State: Over the past four years Healthy Start has supported activities to strengthen and develop relationships with the State Title V program. In some states where there was more than one HS project, the Division of Healthy Start and Perinatal Services encouraged coordinated activities across these sites. Describe the activities and impact that this approach has had on your relationship**

**to the State Title V Agency, State Children with Special Health Care Needs Program, your state Medicaid and SCHIP programs, your State Early Intervention Program and other state programs. Highlight any benefits and lessons learned from these relationships.**

Since the inception of the original Healthy Start Planning and Outreach Grant in 1998, SHIELDS has continued to strengthen its ties to the State Maternal and Child Health Department through partnership with the other Healthy Start programs in the state as well as through our individual program involvement with State Initiatives. During the course of the project period, SHIELDS Healthy Start has worked closely with other Healthy Start staff from the three other California sites (now two sites), and State MCAH officials. A California statewide plan was developed to focus on the issue of perinatal substance abuse because of its overwhelming impact on negative birth outcomes at the three original Healthy Start sites. The California Healthy Start programs joined with the State and Local MCAH Departments to engage in the implementation of a statewide plan to address this issue and its significant impact on infant mortality rates throughout the State of California. This State collaboration resulted in the sponsorship of a speaker on this issue for the State MCAH Conference and the hiring of a consultant to conduct a statewide needs assessment and best practices guide for MCAH providers working with a pregnant substance abusing population. During the course of the needs assessment, the State's MCAH Directors Association joined with the Healthy Start sites to support our efforts in this arena. The report on the statewide needs assessment was completed in 2002 and was distributed throughout the State to all MCAH Directors, the State Department of Alcohol and Drug Programs and other stakeholders in the area of perinatal substance abuse. This report has continued to generate discussions between State Departments regarding joint efforts to work with this population, including the sponsorship of a conference by the State MCAH Director's Association, specifically on the issue of perinatal substance abuse. SHIELDS presented on both days of the conference on our Healthy Start Program Model as well as the integration of the program with our perinatal substance abuse treatment programs.

The efforts made over the past years by the Healthy Start programs in California in collaboration with the State MCAH Office, have been of particular significance to our Consortium and Healthy Start Program. The recognition of the particular needs of our target population have been brought to the forefront of the field and dedicated efforts are now being made to address the issues of this population and the negative impact of substance abuse on infant mortality and morbidity rates in California. Because of the Healthy Start Needs Assessment report and the State's active participation in our local and national Healthy Start activities, we have received numerous calls and visits from providers throughout the state who are interested in replicating this model. It is our hope that innovative ideas, such as our model of service delivery, will be adopted throughout the state so that more women have the opportunity to be identified and enrolled in services.

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

Locally, our partnership with the local MCAH office has continued to increase significantly since 1998. The MCAH Director for Los Angeles County has taken an active role in our Consortium and has provided continued advocacy for our program. SHIELDS furthered its relationship with the local MCAH program through the implementation of the Local Health Systems Action Plan and increased involvement in MCAH efforts to develop a comprehensive community based system of services. In addition, a SHIELDS Healthy Start representative was appointed by the County Director as a permanent member of the planning committee for the MCAH Local Title V Health Plan. In that role, staff are able to have direct impact on the priorities established for Los Angeles County and assure that the needs of our target population of substance abusing women are addressed. Two additional Healthy Start staff sit on committees that develop activities for addressing specific priority goals for birth outcomes in the five year plan. The local plan becomes a part of the statewide plan for California and includes the priorities recommended by our Consortium and staff.

Our close collaboration with our local MCAH has assisted in ensuring that our target population's needs have become a priority locally and has assisted our program and Consortium in the achievement of their goals. It is our hope that this will lead towards integration of MCAH and substance abuse treatment services, as well as blended funding to address the joint concerns of both these fields. More significantly, hopefully the increase in interest will result in more appropriate interventions, cultural sensitivity and respect for this population of women so that they can access services without fear of retribution or discrimination and can receive the assistance they require.

**VI. Local Evaluation**

Please see attached.

**VII. Fetal and Infant Mortality Review**

Not applicable

**VIII. Products**

Please see Attachments.

**IX. Project Data**

Please see electronic submissions.