

BIRMINGHAM HEALTHY START IMPACT REPORT

Introduction

Birmingham Healthy Start (BHS) is a component of the Jefferson County Department of Health (JCDH), the grantee. Since October 1, 1991, BHS has been on a journey aimed at reducing infant mortality in the city of Birmingham. Initially, during the demonstration phase, twelve inner-city communities, consisting of fifty-six neighborhoods, were designated as the BHS targeted area. Although this made up a large portion of the City of Birmingham, it did not include all of the communities and all of the neighborhoods in the Birmingham area. Together, the communities had an infant mortality rate of 19.2, which was twice that of the nation. By the end of 2000, BHS realized that there were three neighborhoods from two additional communities whose perinatal outcomes were similar to those of the existing targeted area. As a result, for the 2001-2005 grant application, these neighborhoods were added to the BHS targeted area, which gave a total of fifty-nine neighborhoods within fourteen communities. With the additional communities added, the infant mortality rate for the newly proposed area was 15.8 (1996-1998 birth cohort), which was 1.5 times the national infant mortality rate for the same period.

BHS has learned many lessons over the years, and we drew from those lessons in an effort to enhance our program during the extended phases. One of the most valuable lessons learned was the necessity of being an integral part of our parent organization, which has been a continuing effort since its inception. We also realized that reducing infant mortality and eliminating disparities in perinatal health among individuals within the BHS project area required collaborative effort among providers, consumers, and community leaders. We focused our efforts on the needs of mothers, children, families and communities. BHS continued to play a critical role by promoting linkages among community agencies, and providing outreach and tracking directly and through partnership activities. Additionally, education/training and case management services played a vital role.

While outreach/tracking and educational services were provided primarily by BHS, case management services for prenatal clients were provided within JCDH health centers by JCDH case managers until April 30, 2004. For many years, maternity care was provided by JCDH through contractual agreement with nurse midwives from the University of Alabama at Birmingham (UAB) within the JCDH health centers. However, on May 1, 2004, JCDH decided to no longer provide direct care for maternity patients. At this point, the provider of care was changed solely to the UAB, which included employment of all staff. In addition to the direct clinical services being provided by UAB, this also included the case management of the maternity clients. The UAB maternity clinics continued to be housed in the JCDH health centers. Through collaborative efforts of the BHS Administrator and the Director/Administrative staff of the UAB maternity clinics, BHS was able to continue to provide valuable services in conjunction with the clinics for those prenatal clients who resided in the BHS communities. This included a strong working relationship between the CORWs and the UAB maternity case managers.

Collaboration is an essential component of any program geared toward addressing the problems faced by BHS communities. Infant mortality and other poor health outcomes experienced by the communities are affected by varied socioeconomic conditions such as poverty, inadequate housing,

unemployment, violence, racism and other factors. For many low-income pregnant women, personal issues such as substance abuse, youth, and hopelessness often compound these difficult issues. Thus, only a collaborative effort with the community can create long-range strategic plans necessary to combat the problem of infant mortality and eliminating disparities in perinatal health. As previously stated, no singular organization can solve the problem of infant mortality alone.

BHS has had a significant impact on the grantee, JCDH; on many other agencies in the city; and on the people of the BHS area. We are proud to say that we have been successful in establishing valuable partnerships and collaborative linkages with other agencies/organizations providing services to the same population as BHS. This Impact Report will provide a written summary, from our perspective, of the experience and impact of the BHS program. While there may be some references to the previous years, much of the information provided will be reflective of the Calendar Years 2001-2004.

Dr. Richard Sinsky, Epidemiological Analyst from the Division of Quality Improvement at JCDH, has provided BHS with some important information on infant deaths in the BHS area and in Jefferson County. His data show that the Cohort Infant Mortality Rate for the catchment area decreased from 16.2 per 1,000 live births in 2000 to 11.4 in 2004. The County Cohort Rate as a whole went from 12.1 in 2000 to 9.0 deaths per 1,000 live births in 2004. Within the catchment area, the rates for the BHS participants dropped to 9.7 in 2004, compared to non-participants where it dropped to 11.9 deaths per 1,000 live births. While the differences between the rates for participants and non-participants were never significantly different in any given year, they were always less for participants (low difference of 2.2, high difference of 16.7). However, these rates are based on 2 infant deaths in 2000 to 5 infant deaths in 2004 among a relatively small number of participants compared to the non-participant population in the area.

Another indication of the successes of BHS is the progress that has been made towards the 27 objectives developed for the project. There has been marked progress towards 22 of these objectives, including 7 of which the goal was exceeded, and 12 of which the goal has been met. For 3 of the objectives, the goals were nearly met. There were only there 3 objectives in which the goals were not met. Also, for 2 of the objectives, we were unable to obtain data at this time. This report should make it clear that BHS has contributed in many ways to improve the health of families in its targeted communities.

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

The BHS project has continued to serve mostly African-American and Hispanic women residing in 14 communities representing racial and perinatal disparities including high infant mortality rates, low birth weight, teen pregnancy, and adequacy of care. The latest available data, prior to submission of the grant application, was from the 1990 census tract and subsequent years through 1999. The 2000 census tract was not available during that time. The following information was used in making the decision as a point of focus for this project period.

The proposed project area for the competition for this project period was made up of 14 communities within the City of Birmingham. This area covered 82.3 square miles and a population of 220,690 (1990 census data). The BHS project targeted African American and

Hispanic women of childbearing age, 10-44, who lived in BHS communities. According to the 1990 Census, the population of the proposed area's sum total was 220,690 (the original catchment area was 188,597). Its' racial make-up was 60,370 (27.4%) Whites, 159,162 (72.1%) African Americans and 1,158 (0.5%) Others, which includes American Indian, Eskimo, Aleut, Asian/Pacific Islander and Other.

Per the 1990 Census, the total number of women of childbearing age (WBCA) was 62,196. The racial break down was 13,470 (21.7%) Whites; 48,349 (77.7%) African Americans; and 377 (0.6%) Other, the majority of which were Asian/Pacific Islanders. Of the WCBA, 16,002 were teens aged 10-19. Among white WCBA, 2,319 (17.2%) were between the ages of 10 and 19; among African American women, the number was 13,592 (28.1%); and for Other, the number was 91 (24.1%).

Regarding ethnicity, the total Hispanic population in the catchment area was 768 (0.3%) in 1990, and there were 277 (0.4%) WCBA, of which 57 (25.1%) were teens. Since 1996, there has been a dramatic increase in the Hispanic population in Jefferson County, and the 1999 countywide population estimate of 4,587, published by the U.S. Census Bureau, is considered to be a dramatic underestimate by local community leaders. Once the 2000 Census figures are published and obtained, we will have a better idea of both the actual numbers of the Hispanic/Latino population, and where in Jefferson County they are residing.

Since 1993, the BHS Project provided services to the targeted communities that were identified as having high infant mortality rates, and these were designated as the project area. The infant mortality problem in the City of Birmingham was characterized by many of the same issues facing other inner cities across the country. Health status measures showed that the three year infant mortality rate per 1,000 live births, in the currently expanded project area for the total BHS targeted communities, was 15.8 from 1996-1998 and 19.0 in 1999 compared to the county wide rates of 11.5 and 11.8 for the respective time frames. The White infant mortality rate per 1,000 live births in the BHS target area between 1998 and 1999 was 4.4 and 15.2, respectively, compared to the White infant mortality rate for countywide infants overall was 7.2 from 1996-1998 and 6.3 for 1999. The Black infant mortality rate in the expanded BHS Project area per 1,000 live births was 18.0 for 1996-1998 and 19.8 in 1999 compared to the county rates of 16.6 and 17.9 in the two time periods. The Black infant mortality rate in the catchment area was significantly higher than the White rate during the 1996-98 time-period, being 4.4 fold greater. However, in 1999 the dramatic rise in the mortality rate among the White infants made the rates for Blacks and Whites almost comparable, with the Black rate not being significantly larger at only 1.3 times the rate for White infants.

During the period 1996-1998, the largest percentage of infant deaths in the proposed Project Area resulted from prematurity or related low birth weight conditions (39.0%), and 23.2% in 1999. The next most frequent cause of death for 1996-1998 was congenital anomalies at 17%, followed by maternal complications (9.6%) and SIDS (6.9%). In 1999, the second leading cause of infant deaths was maternal complications (16.1%), followed by SIDS (14.3%), then congenital anomalies (12.5%). Neonatal mortality has been associated with several factors, including the adequacy and utilization of prenatal care. The Neonatal Rate per 1,000 live births in Jefferson County for 1996-1998 was 8.0 and in 1999 it was 7.1. Meanwhile, the neonatal rate for the proposed BHS target

area for the same time period 1996-1998 was 10.8 and 10.4 in 1999. The Post-neonatal rate for the target area was 5.0 per 1,000 live births during the 1996-1998 timeframe and was 8.5 in 1999. During the three-year period, the overall infant mortality rate for the proposed target area was 1.4 times the rate for Jefferson County, and 1.6 times the rate in 1999.

The total number of live births within the proposed BHS project area from 1996-1998 was 9,217 or 33.3% of the 27,710 births for Jefferson County during the same time. Among the total number of infants born in the catchment area during this period, 1,355 (14.7%) were White, 7,797 (84.6%) were Black and 65 (0.7%) were listed as Other. During this same three-year period, there were 101 (1.1%) live births to Hispanic women, all of whom were of White race, and this number was 23.2% of all Hispanic births in the county during this time. The number of infants born in the proposed BHS Project area during 1999 was 3,195 which were 34.0% of the county's total births of 9,402. The total number of infants born in the proposed BHS area during this period was 461 (14.6%) White infants, 2,681 (84.9%) Black infants and 17 (0.5%) infants listed as Other. There were 67 (2.1%) Hispanic infants born in the catchment area in 1999, which comprised 28.2% of all Hispanic births in the County for that year.

The number of births in the proposed BHS targeted communities that were < 2,500 grams during the three year period was 1,216 (13.2%) compared against 1,637 (8.9%) for the rest of the county, which excludes BHS numbers, this translates to 10.3 percent of the whole county that was low birth weight. The percentages in 1999 were 12.9, 9.4, and 10.4 for the BHS area, non-BHS area and the county as a whole, respectively. The number of births to women in the BHS area <18 years of age from 1996-1998 was 947 (10.3%) compared to 835 (4.5%) for the rest of the county. For the county as a whole during this time, 6.4% of the births were to women between the ages of 12 and 17. The percentages for 1999 were 8.6% for the BHS area, 3.8% for the non-BHS area and 5.4% for the county as a whole.

Efforts to reduce infant mortality have traditionally been based upon medical care, improved technology, and the regionalization of high-risk infant and maternal services. Birmingham is a good example of this approach. Metropolitan Birmingham houses the University of Alabama at Birmingham (UAB), one of the leading medical centers in the country, where research and technology have received national and worldwide recognition, especially in regard to perinatal issues and problems. We took a closer look at the problem of infant mortality in City of Birmingham and the resources that were available, coupled with the knowledge learned in recent years regarding the importance of behavioral and socio-demographic risk factors, it is clear that, however exemplary the maternity medical system appears, it is not enough. The basics are in place to allow for improvements. However, some vital aspects of the system are either nonexistent or are so limited that the effect is insufficient to realize significant improvement in infant mortality without additional funds to add services and solve systemic problems.

Consistently, data has supported the theory that women and infants living in the City of Birmingham at high socioeconomic risk were not being reached by the existing service delivery system, at maximum level. Health services were available but oftentimes were not accessed due to structural or individual-level barriers. Moreover, communities did not have a very strong coordinated service network, and relationships between agencies serving low-income families were regarded as ad hoc and informal in nature. While the communities had access to a large

number of categorical service agencies, the efforts to coordinate services for individual families were often blocked by “turf issues” or by the independent nature of community agencies of our city. However, some progress has been made over the years.

As the grantee agency, JCDH is recognized as a leader in the city for providing health care services to the general population and targeted populations at-risk for poor health outcomes. Even though a level of interaction existed among service agencies and JCDH prior to the establishment of BHS, oftentimes the delivery of services were uncoordinated, duplicative and fragmented. During the demonstration phase of BHS (1991-1997), the grantee was challenged to re-evaluate how services were provided to low-income populations, populations at-risk for poor pregnancy outcomes, and specific populations such as the homeless, substance abusing women, males and adolescents.

It was realized that we can no longer conduct business in isolation from the community. Instead of waiting for consumers, service agencies, key stakeholders, and political groups to come to our health department doors, we must go to the community to develop an effective plan that would allow us to achieve the desired outcomes. We also realized the importance of community partnerships that included input from consumers in order to develop the strategies and activities that would allow us to address the barriers faced by our clients and problems plaguing our communities. We have continued this journey with our partners to address the elimination of significant disparities in perinatal health indicators for African American and Hispanic women.

The typical client is African American between the ages of 15 and 24, 98% single at the time of delivery based upon birth certificate data, a mother of at least one child, 59% with one child or more, 36% first pregnancy, high risk with 23% previous fetal loss, as high as 10 previous losses. Further, she is usually coping with diverse day-to-day living challenges such as housing, poverty, rising prices, food, clothing and racism; wanting a job, but is without marketable skills, education and experience; suffering from low self-esteem; aware of the poor choices she has made; lacking proper dental care; lacking a support system; lacking transportation; willing to miss health, wellness and social service appointments due to other things that come up, and without insurance before and after the pregnancy. Her children typically lack proper dental care, have outdated immunization records, and do not get appropriate well-child care as schedule.

II. Project Implementation

The overall goal for the BHS project during this time was to address significant disparities in perinatal health indicators for African American and Hispanic women of child bearing age, 10-44, during the prenatal and interconceptional phases. We anticipated reducing the infant mortality rate from 15.8 to 11.8 by 5/31/05, and to address notable disparities among targeted groups within the fourteen BHS communities. The focus was on high risk perinatal clients residing in the BHS communities who were either pregnant, or parenting infants up to 2 years old, and those who had 2 or more risk factors as assessed during prenatal screening. We also paid close attention to women who were in need of or could have benefited from interconceptional care services. This included those who had experienced a poor outcome from a previous pregnancy.

The Cohort Infant Mortality Rate (mortality outcome for the infants born within a given year,

numerators and denominators come from the same population) for the catchment area decreased from 16.2 per 1,000 live births in 2000 to 11.4 in 2004. This indicates that some progress has been made. More detail discussion regarding the IMR is provided in Section VI. Local Evaluation.

Comprehensive services were provided to the participants, which included providing services to her family, during her pregnancy and interconceptional phases, and to the infants up to age two who reside in the proposed BHS area. Some of these services were provided directly by BHS staff such as outreach and tracking, health education, and other supportive services. Other services were provided in conjunction with BHS partners such as JCDH health center maternity clinics and case management staff, UAB Complication Clinics and maternity staff, Oasis Women's Health Center and others. Limited services were provided to males, adolescents and community persons interested in decreasing infant mortality.

Five core interventions, Outreach and Client Recruitment, Case Management, Health Education and Training, Interconceptional Care, and Depression Screening, were implemented to achieve the project's goal and objectives. BHS believed that the strategies and activities from these interventions enhanced the community's existing perinatal service system.

In addition to the five interventions, the four core systems-building efforts, Local Health System Action Plan; Consortium; Collaboration and Coordination with State Title V and Other Agencies; and Sustainability, were also addressed and developed. The following paragraphs will address how BHS identified and implemented each service and system intervention.

A & B. Approach, Rationale, Components of Core Interventions

This section will describe BHS' approach, the rationale for the approach and components of each core intervention.

- **Outreach and Client Recruitment Intervention**

From October 1991 through October 1997, the Demonstration Phase, Birmingham Healthy Start (BHS) operated from a service delivery model that consisted of five components, outreach, education, nursing, nutrition and social services. After the demonstration phase, BHS was only funded for the Outreach and Client Recruitment component. However, there continued to be a demand from the community residents/program participants for "hands-on community-based supportive services" from BHS staff. These services included home visiting, emotional support, one-on-one interventions, educational information, a "shoulder to lean on," and sometimes, in general, someone to talk to. Therefore, BHS continued to see the need to further develop a stronger "advocacy-based" outreach, recruitment and tracking component. This model gained recognition for its unique "personal touch" approach to providing services to its clients, thus adopting the theme "Personal Touch Approach" as its' motto.

The *uniqueness* of the model was demonstrated by a comprehensive service delivery approach that incorporated the skills and experience of BHS, JCDH, contractual staff, and collaborative efforts with other agencies such as Easter Seals of Birmingham, Oasis Women's Health Center, and Aletheia House Residential Treatment Center. The component strategies for BHS' outreach

and tracking model include home visits, phone calls, door-to-door outreach, community canvassing, out stationing activities, health fairs, case review/staffing, home assessments, developmental assessments, depression screenings, hospital visits and documentation of services through tracking forms and a computerized outreach and tracking system.

Outreach has been defined in various ways by different agencies or groups. It is a term often used to describe the activity of active recruitment of program participants. In general, it refers to establishing contact with the target population; maintaining contact until clients are motivated to take advantage of services that are made available to them, and in many cases, following up with later contacts and maintaining communication with clients until they have successfully completed the use of services. The above definition is more consistent than others with the BHS outreach model. However, for the purpose of clarity, we defined outreach more specifically for the BHS project.

To begin, we refer to the model as Outreach, Tracking and Client Recruitment due to its threefold purpose. We define outreach as the act of reaching out, establishing or attempting to establish contact with: (a) consumers (pregnant women, children from infancy to 2 years of age, and women of childbearing age, regardless of pregnancy status) including postpartum and family planning clients, teenagers and males, the family unit and support system; (b) community residents and community organizations who are not participants for the purpose of identifying potential consumers and providers of needed services; (c) social and medical service agencies to develop collaborative efforts and networks in order to expedite services for consumers; and (d) all parties interested and/or involved in achieving the goals of reducing infant mortality and eliminating disparities in perinatal health. Recruitment is defined as the actual enrollment of program participants.

Tracking refers to: (1) monitoring, following, keeping up with, and making contact with a client for a period of time, usually for the duration of the client's eligibility to receive services, and (2) documenting progress. A client is tracked for appointment compliance, compliance with treatment regime, and progress in terms of overcoming barriers.

The purpose of the outreach and tracking intervention is to locate, recruit/enroll and retain clients who are in need and/or will most likely benefit from BHS services.

This includes services provided by those with whom BHS has obtained partnerships. The activities from this intervention are also designed to inform clients and key stakeholders and make them aware of available services. This intervention is important for the reduction of infant mortality and is increasingly important for the long-term success of JCDH in a rapidly evolving managed care environment.

Overview: Outreach and tracking is conducted by: BHS staff, consumers (peer recruiters), others interested in identifying individuals in need of services, those interested in identifying gaps in the health care system, and those interested in identifying community needs.

During outreach activities, consumers and others are informed and encouraged to utilize available services offered through BHS, JCDH health centers, and other service providers. They are educated on the risk factors relating to infant mortality and the problem of infant mortality in the City of Birmingham. They are also educated on ways of increasing community awareness of

existing resources and services to address perinatal health disparities and access to information.

Various activities take place in order to identify, recruit and retain clients in this program. Although all of these activities could be considered case management activities, we note the significant distinction between a case management and an outreach model. Outreach differs from case management in that its primary focus is not on the overall coordination of all services provided to the client, as with case management. Instead, the focus is more on crisis intervention for taking care of the “here and now.” Clients are empowered to take responsibility for their well being and the well being of their children. We provide education to encourage clients to enroll in services that they qualify for including entitlement programs, social services, health care, education, and transportation.

We strengthened the outreach component through establishing partnerships with community agencies that are experienced with serving at-risk populations. These partners have played a key role in targeting and recruiting specific populations including adolescents, males, the homeless and substance abusing pregnant women. Through the year 2000, BHS contracted with these agencies until funding was decreased. This outreach, client recruitment and tracking was primarily aimed at potential program participants and community members, or key players within the identified BHS communities.

Service Component: For this project period, BHS’ outreach component consisted of fifteen staff members. This included nine full-time Community Outreach Workers (CORWs), three part-time CORWs, and two Outreach Supervisors. CORWs were individuals who resided within the BHS communities hired to conduct perinatal outreach services for the program. Many of them have been with the program since the second year of operation. They have received a wide range of training and will continue to receive more throughout the life of the program. A list of training/in-services were developed and coordinated by the Education/Training Coordinator annually. This training enabled them to perform their jobs more effectively, and even enabled them to cope with some of the stresses that they had to experience in their personal lives as they completed their daily work tasks. They worked closely with the case managers, social workers and nurses, and other team members. This included other providers of care serving the same population as BHS. As vital members of the team, they participated in case reviews and had on-going discussions with the care coordinators in regards to the provision of services to clients. BHS’ outreach component was divided into two teams led by the Outreach Supervisors.

- **Case Management Intervention**

Case management has been defined as the coordination of services across providers to the same client, to meet the identified needs of that client. This is done through client assessment, facilitation, referral, monitoring and follow-up on service utilization, as well as client’s completion of those services, conducted with a culturally sensitive approach.

The purpose of the Case Management/Case Coordination intervention is to develop a systematic approach that will ensure coordination of services from multiple providers who are addressing the needs of individual families within the same population. Individualized plans of care with the client’s knowledge and “buy-in” of the planned scope of services were developed by the case

manager. Close working relationship occurred between the case manager and the CORWs. This coordination of services enabled the CORWs to ensure that the client does not “fall through the cracks” or “get lost in the system.” It also provided an opportunity for JCDH, through BHS, to develop enhanced working relationships/partnerships with local hospitals, private physicians, community-based organizations and clinics, and social services agencies.

Important members to this intervention are the 1). Client, 2). Case Manager, 3). Community Outreach Workers (CORW) and 4). other service providers. Care coordination is based upon policies and procedures developed by the Alabama Maternity, Inc. (AMI). AMI serves as the primary contractor in District 5 for the Alabama Medicaid Maternity Care Program. Over 75% of the pregnant women residing in the BHS targeted communities are insured through the Steps Ahead Medicaid Maternity Waiver Program (SAMMWP), which falls under the auspices of AMI. During this reporting period, these individuals actually received prenatal care from one of the JCDH health centers, or one of the subcontractors of the Medicaid program.

The primary focus of care coordination is the organization of services and resources to respond to the health care and psychosocial needs of pregnant women enrolled in the program. These services included recruitment/outreach, assessment, service planning, coordination and referral, follow-up/monitoring, and education/counseling. Through collaborative agreement, BHS provided assistance to AMI with targeted outreach and education in order to promote early and continuous prenatal care among high-risk populations within the City of Birmingham.

Care coordinators could have been either: 1). Licensed Social Worker(s) or license-eligible for Alabama practice with a BSW or MSW from a school accredited by the Council on Social Work Education; 2). Licensed Registered Nurse(s) with a minimum of one year’s obstetrical experience in counseling, accessing resources, and coordinating care with low-income populations; or; 3). Licensed Registered Nurse(s) with no obstetrical or counseling experience, but who have successfully completed a Care Coordinator training course provided by the Primary Contractor and who will be under the supervision of an experienced Care Coordinator for at least six months. Within the JCDH health centers and other perinatal care facilities, case managers are primarily BSW or MSW level Social Workers. Each Care Coordinator had a patient caseload greater than 300 cases at any given time. SAMMWP tracked Care Coordinators’ caseloads for prenatal and postpartum clients to ensure that caseloads did not exceed the requirement.

Overview: As previously stated, Case management/care coordination services were primarily managed by the Social Workers within JCDH health centers and UAB Obstetrical Complications Clinic (OBCC). Care coordinators were also located at delivering hospitals within the county. The Care Coordinator, through the local county health department in the Beneficiary’s county of residence, provided care coordination services, except in Jefferson County. In Jefferson County, the site of prenatal care determined who provided care coordination services. Beneficiaries who received care through JCDH received care coordination by the Care Coordinator with the selected health center.

True case management entails an array of activities/services designed to meet the client’s needs. Many of these activities included one-on-one interaction with the client both in the health center clinics and in the client’s home. BHS learned that, in order to truly meet the client’s needs and

overcome barriers, it was important to connect with the client both mentally and physically. Sometimes this required meeting the client in other locations such as the food stamp office, rent office, bus stops, community-based agencies, and so forth, or just simply offering emotional support such as listening to her frustrations.

Service Component: Each JCDH health center had one Master Social Worker (MSW) and one Bachelor Social Worker (BSW). The volume of work within the clinic usually did not allow for a great deal of home visiting and/or other client interactions that occurred outside of the health centers. Private physicians who offered perinatal care to the small percentage of clients within the BHS target area provided little or no case management services. Therefore BHS provided supportive services through the CORWs who worked closely with the social workers. The client was the center focus in the case management intervention. Based on information obtained by the case manager during risk assessments, individualized care plans were developed.

One of the major roles CORWs played in the case management intervention was to conduct ongoing client interaction activities on the behalf of the case managers. This included case finding and client follow-up, and in some instances, crisis intervention. BHS had on board one CORW who spoke both English and Spanish fluently. Additional duties for this CORW included providing translation services on behalf of the client and the provider in order to promote effective communication.

Case managers were required to obtain continual education credits. They attended designated perinatal and other health and social related conferences. Additionally, they attended in-services and workshops offered directly by BHS or JCDH at large. The case management intervention enhanced the existing infrastructure to improve case coordination/case management services to clients.

- **Health Education and Training Intervention**

Prior to the onset of BHS, the definition of educational supports, as perceived by consumers, providers, key stakeholders and JCDH was from a traditional service delivery model. The local health care delivery systems have historically provided services to the general population and have included: sexuality classes, childbirth education, home visits, health counseling, grief counseling, and nutrition. Building upon this model and existing systems, BHS developed its health education model/intervention in a manner in which staff was able to provide innovative programming from a broad-based approach which mirrored the needs of the community. Moreover, services have moved from the traditional health care setting to the community. It became evident that it was no longer a viable option to not be in schools, churches, community centers, social services agencies and community based organizations. BHS provided planned education and public information activities that addressed risk factors associated with infant mortality in an effort to improve individual and community health. We realized that we had to provide accessible services which were of high quality, coordinated and comprehensive, and services that went beyond one-shot programming. Funding of this grant application enabled us to move toward a service delivery system that included serial programming, individualized and culturally sensitive education and community-based functions.

The BHS project area is dynamic in the sense that its population— particularly the adolescent and young adult members – are quite mobile. Moreover, it is a young population, with ongoing needs for health education related to reproductive health. Performance indicators for the evaluation of education and training in the target population consisted of the number of individual and community level events sponsored, the number of individuals attending these events, and the extent to which the educational goals set for each affiliated agency were met. As a new evaluation tool, the computerized client outreach and tracking system recorded the number of individual clients recruited into the program as a result of educational events sponsored by the project. The local evaluation team incorporated this source of client contact in the overall assessment of outreach and tracking. As a second new element, the consultation services of an individual with nationally recognized expertise in building on the capacity and strengths that already existed in the community was secured.

The purpose of this intervention is to provide public and community education and information to clients, the public and the community concerning the risk factors that contribute to infant mortality, and strategies to improve individual and community health, improve prenatal health and enhance the delivery of prenatal care. We implemented and participated in programs, services and activities, and disseminated information to providers, consumers and the community at large with the goal of improving the targeted community's knowledge, attitudes, behaviors and practices regarding sound perinatal and infant health. We implemented strategies and activities that targeted the public, consumers/clients and providers regarding health issues and other factors that promoted perinatal health, interconceptional health, mental health, as well as enhance the delivery of such services. Through health education classes and by disseminating pertinent educational information, and enforcing educational messages during home visitation, BHS was able to promote healthier lifestyles, healthier women and infants, and services to both mother and infant through the infant's second year of life. Also, BHS participated in a variety of community awareness events and health fairs. As a result, we believe that these activities enhanced/increased the community's knowledge and involvement in infant mortality reduction efforts would be increased; health knowledge and behaviors among clients/consumers and community members will be improved and knowledge and skills in the health care work force are improved.

BHS believes in the holistic approach in promoting good health, risk reduction and disease prevention strategies for all participants, specifically those at high-risk for complications during pregnancy. The high-risk or at-risk woman fall into varying degrees of risk which range from existing risk factors before conception to ones that may have developed during and after conception. One of the major lessons learned to date includes the realization that, in order for us to address risk factors and behaviors in our community, we can not solely focus on the pregnant teenager or the post-partum female. Rather, we must recognize her social support network, which often includes males, family members and friends. When we are invited into this network, we must welcome and recognize their needs, not our needs.

Education and training activities were conducted on a one-on-one basis, in small groups, classrooms, large group seminars, and community-based health fairs. These activities were provided on a continuous basis including daily, weekly, monthly and as per requested, and by referrals from JCDH and community-based organizations, as well as those recognized by CORWs during ongoing interactions with the client. The targeted population included project

participants, the general public, in-school and out-of-school youth, hard-to-reach individuals, and male participants.

Overview: In the City of Birmingham, the tragedy of infant death is shared by many people, by those who experience it first-hand, those who are providers and by those who are friends and neighbors. From teenagers and pregnant women in focus groups, to women answering questions during earlier telephone surveys, to community residents who attended town meetings, the interest and concern for finding answers to the question, “*Why are babies in our community dying*”, is evident throughout the city. An initial survey showed that, of the teenagers interviewed, 80% knew of someone whose baby had died before its first birthday. Similarly, 56% of a group of GED students knew of someone. Additionally, information from the initial needs assessment showed that there is a lack of information and education. Responses from earlier focus groups included: “*Women need to know that drugs will kill their babies*” and “*We need to help people who cannot read. I had a friend who could not read the formula instructions and could not feed her baby right.*”

Consumers from our communities are affected by many risk factors such as high crime rates, family violence, high unemployment rates, low income, low levels of educational attainment, high substance abuse, high rates of births to adolescents, inadequate prenatal or preconceptional care, lack of transportation, lack of health education and information to enable healthy behaviors or appropriate infant care, and lack of knowledge for making responsible choices. These factors increased the individual’s likelihood of being at risk for poor outcomes.

This initial observation supports the assumption that, not only is there a need for a targeted intervention, but there is also a need to identify successful strategies and barrier reduction activities which support and promote an education and training intervention for the community. The initial demonstration grant allowed the grantee agency to move beyond a traditional service delivery model to a more comprehensive, coordinated and community-based model, which specifically targeted at-risk populations serving them in the community where they live. We continued to build on this model each year. We realized that, in order for us to impact and influence behavior, attitudes, beliefs and practices of consumers, providers, and the community, a strategy had to be developed which supports this concept.

A lack of community awareness of issues around health is a persistent barrier to improving health. BHS’ health education intervention plan continued to be community-driven and involved consumers, providers, and other stakeholders/leaders from the community who were not only knowledgeable about the true needs and concerns of the targeted areas, but were also committed to working in partnership to implement successful health education strategies.

Pregnancy and the prospect of pregnancy provide an opportunity to improve a woman’s health before pregnancy, during pregnancy and after the birth of the child. Therefore, the adoption of a healthier lifestyle either through smoking cessation education, nutritional education, ceasing or reducing alcohol consumption, and ceasing drug use can positively impact the long-term health of women and children. However, it should be recognized that, despite behavioral changes at the individual level, there are structural level issues that had to be recognized and identified. For example, under some circumstances, many women who smoked and engaged in high-risk

behaviors were also surrounded by poverty and violence. Living a healthy lifestyle was not always a priority when compared to day-to-day survival.

Globally, the battle seems unyielding. Our previous experiences showed us that we can participate in the battle. We found our way into schools and developed parenting and human sexuality classes for adolescents. We covered the communities with pamphlets, fliers and newsletters. We organized health fairs and brought them to the community, for the community. We advocated for project goals at city council meetings. We developed media campaigns. We collaborated and coordinated with other community agencies in order to provide comprehensive education and training for consumers, staff, key stakeholders and the community. We educated one another. This model resulted in a more responsive grantee. In light of welfare and healthcare reform, the grantee began to find it necessary to change the way it did business. BHS continued to have significant impact on the way services traditionally had been offered, by being a vehicle in which those who utilized the services could appropriately “have a voice,” expressing the concerns as it relates to service availability, as well as the delivery of services provided. This was done through participation/membership on the BHS Coalition, and through focus groups.

We have learned that one must provide community-based programming that takes into account the cultural mores, norms and language of the target audience in an effort to reach them with vital information that empowers them with knowledge to make informed decisions and choices. This is just another example of how BHS developed and implemented strategies that are culturally sensitive to the population we serve. We involved the consumers in the planning and implementing of special events and campaigns such as the Parenting Conference.

Service Component: The health education component is supported by the BHS staff, in general. It is led by one full-time Education/Training Coordinator, who coordinates all education and training. She is assisted by a part-time Male Involvement Specialist/CORW II, who was once hired as a Public Health Educator (PHE) during the demonstration phase. This individual assists with the provision of Parenting Classes both in group sessions and one-on-one. He also functions as support personnel to male clients providing one-on-one services, when needed. The Prepared Childbirth and Parenting Classes are also conducted by a contractual provider. This individual is a registered nurse and a certified Doula. The funding for this individual is received through non-HRSA funds. Additionally, the health education component is supported by activities such as dissemination of information during home visits, health fairs or other community awareness events by the CORWs and other BHS staff.

The intervention of education and training services included a diverse range of educational programs, curricula, and health promotion and media campaigns. BHS developed and implemented curricula on perinatal service components that included a CORW training manual, childbirth and parenting education curricula, Consortium/Coalition training and consumer empowerment, as well as other training and marketing tools. The curricula can be adapted to meet the specific needs and culture of the community. Some of these services were already available in the community however the BHS project facilitated accessibility to these services or created new ones. For example, due to parenting classes sponsored by the project, parents in the community were exposed to modern strategies for child rearing via highly qualified and respected staff, video tapes, onsite instructors, and so forth. Thus, strong interest and the desire

to become better parents were fostered in participants.

This intervention operated under the auspices of a larger overarching grantee agency that provided services through a traditional public health model. The BHS project demonstrated that there were true differences between the BHS model and the JCDH model. Overall, the BHS education and training model proposed an integrative and collaborative service delivery model inclusive of the individual, family, staff and the community in order to meet the physical, mental and spiritual needs of the participants.

The process of providing health education that is culturally sensitive and specific also incorporates a style of communication, i.e., one that is common to the targeted population. We try as appropriate to utilize the terminology that is familiar to the target audience. We further realized the existence of sub-cultures within a culture, which in itself required further evaluation, pre-testing and revisions of print material to meet the needs of that particular group, i.e., reading levels, age appropriate, gender-appropriate and educationally appropriate.

The health education intervention implemented strategies to increase the community's awareness of infant mortality, its contributing factors, and the strategies to combat it. BHS began this process and continued to do so via activities such as personal testimonies by clients and participants on the radio and in print literature. BHS developed and disseminated information that highlighted not only the services offered by BHS, its partners and JCDH, but also information on infant mortality and common contributing factors, including smoking cessation, information on the prevention, early identification and treatment of HIV and STDs, especially syphilis.

The BHS health education staff received extensive training and education in parenting education, childbirth education, family life education and smoking cessation. These education programs, aimed at reducing infant mortality were provided to BHS participants and the community at the BHS service center, JCDH health centers, local colleges, area high schools, community-based organizations and agencies such as Department of Human Resources (DHR), Project Pride, Eureka Center, and the Adult Learning Center.

BHS sponsored and implemented creative events/seminars such as the annual Baby Reunion Celebration, male involvement activities, welfare reform awareness forum, and other strategies to spread the message of infant mortality reduction. The health education staff worked closely with health center staff on planning and implementing special events. This created closer ties between the health centers and the communities in which they serve. Specific health education programs were provided in the community to facilitate easy access for clients and community members. Some of these educational activities were funded in part by two local foundations: the Community Foundation of Greater Birmingham and the Children's Trust Fund.

- **Interconceptional Care Intervention**

Initially in 2001, BHS submitted an application for Interconceptional Care in collaboration with the UAB Division of Women's Health. The original plan was to provide the interconceptional care through a comprehensive service delivery system through UAB. The grant was approved,

but not funded. Therefore, BHS had to redirect its efforts to provide interconceptional care utilizing its current staff. With this in mind, the focus shifted primarily to pregnant women 19 years of age and younger and those who would have had a poor pregnancy outcome such as miscarriage, or even an infant death.

The goal is to provide these women with supportive services and pertinent information that would encourage them to prolong a repeat pregnancy for at least eighteen months to two years. These services were provided directly by BHS staff in collaboration with the JCDH case managers. Contact was made with clients by way of home visits, phone calls, or meeting the client at the health centers. For the clients who were considered high risk for a short interval repeat pregnancy, i.e., those who would have experienced a loss, contact was made bi-weekly for the first three months, then the client was contacted once a month for the next 12 months.

For those clients who had a positive pregnancy outcome, live birth, but were in the category as described above, CORWs touched base with the mom while monitoring/following up on the infant's well-child visits. During this time, the CORW checked to see if the mother was receiving family planning services, as well as stressed the importance of receiving those services. If she was not receiving family planning services, the CORW dialogued with the client to see what her plan was for prolonging a repeat pregnancy. The goal here was to prevent an unintended or unwanted repeat pregnancy. If the mother stated that she was not receiving family planning services because she intended to get pregnant again, then the CORW provided her with educational and health information that would have better prepared her in making plans for future pregnancies.

As we have all learned, it is important to provide services that can ensure that women are healthy prior to beginning a pregnancy in order to reduce the number of poor pregnancy outcomes. This can be done through interconceptional care or family planning services. Although most facilities do not provide family planning services/healthcare to men, it is also important that health care is available to the male partner as well as their female partner/significant other. Health problems such as STDs that affect the male will also affect his spouse/partner, if not treated. When some medical conditions, poor personal behaviors, and negative environmental conditions are identified, treated, and/or eliminated prior to conception, this decreases the chance of a poor birth outcome.

Service Component: BHS realized the importance of interconceptional health care and other family planning services and its benefits to the clients that we serve. For those women who were enrolled into the interconceptional care component of BHS, the CORWs reinforced health messages and provided interventions through assessments in order to decrease the chances of a repeat pregnancy, within close intervals, and to decrease the likelihood of poor pregnancy outcomes for those who do get pregnant again. In addition to the CORW, pertinent information is also provided by members of the BHS health education component, and JCDH family planning case managers and nursing staff.

- **Depression Screening and Referral Intervention**

Initially in 2001, BHS also submitted an application that was directed specifically at screening

women for depression during and/or around the time of pregnancy and referring for and/or providing some form of treatment. This application was also done in collaboration with the UAB Division of Women's Health. The original plan was to provide follow up and treatment for women who were in need of such services, through a comprehensive service delivery system at UAB. The grant was approved, but not funded. The UAB Complications Clinic (OBCC) would continue to provide prenatal services to women who were experiencing problems during the pregnancy, but would not be able to provide the comprehensive service for those experiencing depression and other mental illness as originally planned. Therefore, BHS had to redirect its efforts to provide depression screening and referral for treatment utilizing its current staff and identifying new partners and resources.

BHS realized that a large percentage of the women that we serve experience a great deal of stressful and emotionally challenging/draining situations on a daily basis. The situations and other life experiences often leave these women in a state of mild to severe/intense feelings of sadness and/or distress or other conditions that affects the woman's ability to function. Sometimes, it can be so severe that it cripples her ability to take care of herself and/or her infant altogether. With this in mind, we knew that we could not ignore this factor.

There are limited resources and treatment services available through referral for the BHS clientele diagnosed with perinatal depression. The perinatal depression screening services are conducted for BHS participants through a collaboration/partnership funded partly by a grant from the Robert Wood Johnson Foundation to the Oasis Women's Counseling Center. Partners with Oasis include BHS, University of Alabama at Birmingham (UAB), Jefferson County Department of Health (JCDH) and Cooper Green Hospital. Other treatment service providers include Amelia Center, Grace Clinic, Jefferson-Blount, St. Clair (JBS) Mental Health Authority, and the Sparks Center.

The BHS staff attended the initial half-day training on postpartum depression and use of the Edinburgh Postnatal Depression Scale Depression on Thursday, November 6, 2003. Subsequent training seminars were conducted on February 6, 2004, June 25, 2004, August 20, 2004, October 29, 2004, November 22, 2004, and April 29, 2005. The training sessions were provided and conducted by the Oasis Women's Counseling Center as part of the partnership BHS established to provide depression screening services to the clients/participants of the BHS Program. The training was conducted by Kathy Kane, Project Director, for the WholeHealth Initiative - Oasis Women's Counseling Center and other Oasis staff members. The agenda included a discussion of signs and symptoms of postnatal depression, identification of risk factors, common indicators, becoming familiar with treatment options, and the screening and referral process.

After a positive screen for depression, the Oasis Women's Counseling Center's WholeHealth Program provides further clinical assessment and diagnosis. Additionally, other service providers and resources are available to meet the mental health needs of the clients that we serve. BHS tracks the status and outcome of referrals made to the mental health providers via monthly reports from Oasis Women's Counseling Center WholeHealth Project and weekly case review/meetings as needed between the BHS Education/Training Coordinator and the Oasis WholeHealth Project Coordinator. The Education/Training Coordinator and the WholeHealth Coordinator are in constant and continuous contact via telephone, e-mail and face-to-face

discussions for reports and updates of clients' scheduled appointments, missed appointments rescheduling of appointments and discussions on possible barriers.

The BHS CORWs conduct the screening using the Edinburgh Postnatal Depression tool with participants during the prenatal period ideally once per trimester and during their six week postpartum period. Additional/subsequent screenings are conducted as needed depending on the woman's previous screening score or as indicated by on going case management. Tracking the status and outcome of referrals is coordinated by BHS' Education/Training Coordinator, assisted by the CORWs and through communication with the WholeHealth staff at Oasis. Since the activity began, BHS staff has screened 432 clients and referred them Oasis.

During 2001 and 2002, the evaluation committee had investigated the possible usage of various screening tools. The actual Edinburgh screening tool was not identified and implemented until 2003. We continued to seek additional providers/agencies or organizations who would be willing or able to provide treatment and/or counseling to women who were identified as either being depressed or were at risk of becoming so during or around the time of pregnancy.

A & B. Approach to Core Systems

This section will describe BHS' approach, the rationale for the approach and components of each core system.

- **Local Health Plan**

BHS' approach to the local health plan was somewhat based on the need to solicit continued support from existing partners. Our approach also included establishing new partnerships with additional partners who could assist with the provision of perinatal health such as prenatal and postpartum care including improving accessibility and availability of healthcare to individuals who reside within these communities. BHS' approach also addressed healthcare needs that were not in place including problems such as depression and/or mental illness experienced by perinatal clients.

A local health plan was initially drafted with the submission of the 2001 competitive grant application. During this time, it was anticipated that BHS would not only be funded for the Eliminating Disparities grant, but would also be funded for the Depression Screening and Interconceptional Care grants. Both of these applications since were submitted in partnership with the University of Alabama at Birmingham (UAB) Division of Women's Health. Although we were approved for the two grants, we were not funded. Therefore, we refocused our efforts of addressing interconceptional care and depression screening. We later fostered a relationship with Oasis Women's Counseling Center to provide training for depression screening and a referral base to their WholeHealth Program for those clients who were in need of further follow-up.

The Director of Oasis Women's Counseling Center and representative from other agencies are members of the BHS Coalition. Although the make-up of the Coalition, in terms of agencies, has remained primarily the same, some of the actual individuals who represent those agencies have

changed. Therefore, the initial local health plan had to be revamped. We are currently revisiting it with input from members of the Coalition including consumers.

The Coalition focused the majority of their efforts on one issue during 2003 thereby achieving a goal of the BHS Local Health System Action Plan, conducting an assessment of available mental health services that address the needs of African American perinatal women to provide staff training on depression screening and referral to implement this service. The Coalition Chair, Dr. Thomas Ellison, along with key staff attended the Healthy Start Technical Assistance Meeting in September 2003 to further gain insight of how other projects were addressing the implementation of core services. In addition, the Project Consultant, Dr. Kimberly Leslie-Patton, presented at the meeting on How to Write A Proposal That Meets Criteria for Funding. Members of the Coalition are active in numerous community efforts that serve the MCH population, and they bring informational resources and experience to the Coalition to help advise the project.

The needs assessment focused on identifying available mental health services. We soon realized that the mental health community is in a major crisis itself for sustainability. There are very limited mental health services for uninsured persons, and the services that are available are geared mostly to the severely mentally challenged persons or persons who are insured. There are even fewer services for the uninsured African American perinatal clients within the community. Some of the agencies that we identified that provide or refer for mental health services include: UAB OBCC, Cooper Green Women's Health Link GYN Clinic, Catholic Family Services, Impact Family Counseling, Aletheia House, Fellowship House, Children Aid Society, Gateway and Oasis.

Some depression screening is conducted through UAB's OBCC/Grace Clinic through the NIH grant. These patients are referred primarily from JCDH where a general mental health assessment is conducted at every visit. Depending on the score, or if the woman reports depression symptoms, she may be considered as being at risk for depression. This woman is then referred to the social worker or nurse practitioner from Grace Clinic who administers the BDI. If the score is 20 or higher, the woman would meet with the psychiatrist. If patient has a history with another psychiatrist or mental health facility, she will be referred back to the provider rather than to the psychiatrist.

Cooper Green Women's Health Link GYN Clinic only conducts mental health screenings if a woman clearly expresses a mental health concern or request counseling. Referrals would be made to Oasis if a woman screens as depressed. Catholic Family Services provides services to enrich individuals, families and community life in order to promote the worth and dignity of every person and family through counseling, foster family care and adoption but does not specifically target any services to African American perinatal women. Impact Family Counseling focused on juvenile delinquents seek to diminish child abuse and neglect, reduce juvenile crimes and delinquency and further meet some of the social and emotional needs of hurting children.

Aletheia House provides residential drug abuse treatment programs to males and females including pregnant women; an outpatient treatment program, an affordable housing program and a prevention program for at-risk children. They do serve African-American women but services

are limited to those experiencing substance abuse challenges. BHS does have a referral process to work with this agency.

Fellowship House provides a dual diagnosis residential treatment program for males and females providing a program of recovery that will enable the individual to become free from addiction and gain their useful place in society. They maintain a waiting list for their services.

Children's Aid Society – Specializes in prevention and intervention services for high-risk children and youth, family preservation and permanency planning and support. All services are home, school or neighborhood-based and reach families in their own communities. However, due to the hard hit of cutbacks in state funding, Family Finders, Family Care, and Foster care programs have been eliminated and funding for other programs dramatically reduced resulting in a loss of 33 staff persons limiting the services they will be able to provide in the near future.

Gateway and The Crisis Center focuses on counseling for adults experiencing personal distress and family discord, assistance for victims of rape and sexual assault, suicide interventions, bereavement counseling, community education and referrals on a sliding scale fee.

Finally, we were able to enhance an existing relationship with one of our Coalition Partners, The Oasis Women's Counseling Center, and a woman's counseling and education center. The Center promotes healing and growth by providing affordable counseling, education programs, and support groups that are uniquely designed for women and children on a sliding scale fee. Oasis is the only women's counseling center in the state, providing services to women throughout the lifespan.

The Oasis Women's Counseling Center received a grant, The WholeHealth Initiative, from The Robert Wood Johnson Foundation and local support from The Community Foundation of Greater Birmingham, The Hugh Kaul Foundation, The Robert R. Meyer Foundation, Protective Life Corporation and the Samuelson Fund for the Promotion of Health, a component fund of the Community Foundation; the outreach staff received the training to implement the depression screening and referral service. In collaboration with the WholeHealth Initiative, BHS was able to address the non-funded mandate to screen and refer for depression despite the fact we were funded for less than 1 million dollars.

The Project Director serves on the Advisory Board for the WholeHealth project and expects to utilize these available resources to further establish new community linkages for mental health and social services. The CORWs screened and served BHS perinatal clients. Prior to the WholeHealth Initiative being funded BHS explored various organizations for and not-for profit seeking resources to refer clients who screen as depressed to. However, after much research and meeting with numerous persons, BHS did not have find any viable avenues for referring perinatal clients who might screen as depressed until the WholeHealth project became a reality in 2003.

In November 2003, the BHS staff attended a training session on perinatal depression and the screening and referral process. The Edinburgh Postnatal Depression Scale is being utilized to screen women and girls in the program during pregnancy and through the first two years postpartum as needed. Women who screen positive for depression will be referred to Oasis for

counseling. This system of ongoing screening will help to ensure that women experiencing emotion distress do not fall through the cracks.

The challenges that we have experienced in developing LHSAP have been the difficulty in recruiting and retaining active on-going consumer participation on the Coalition, and the problem of getting the same Coalition members to meet on a regular basis, i.e., to get all of the major players to sit around the table at the same time. Currently, we are soliciting an alternate scheduling time and even meeting bi-monthly and/or quarterly in order to increase participation. Since a major part of our local health plan must be linked to the State Local Health Plan, we realize that it is imperative that our State Title V Director attends the meetings. Unfortunately, although we maintain on-going communication with him and/or a representative from his office, the State Title V Director has not been able to attend the Coalition meetings. We recently received a commitment from him assuring that he remains interested as well as a part of the Coalition, and that he would make efforts to attend future meetings. Being aware of his busy schedule, we've asked that he sends his assistant in the event that he cannot make it.

We realized that we were faced with the responsibility of addressing the issue of depression screening and interconceptional care, special funding or not. Therefore the Local Health Plan priority was selected by the Coalition and staff identifying the unmet needs of the project, depression screening and referral, and sustainability. Available resources in regards to the other core services were already in place. Once the topics were selected the team went about conducting a mental health needs assessment that included interviews with agency directors and persons who worked within the mental health community to identify opportunities for partnering to secure training and referral sources focused on serving at risk African-American perinatal clients. After numerous attempts to find potential partners to meet our needs we were able to enhance an existing relationship with a coalition member, Eve Laxer the Executive Director of Oasis who was preparing to apply for a grant to provide mental health services both one-on-one and group counseling to women. Through months of meetings and negotiations we were able to sign a Memoranda of Agreement for the proposal and Oasis was funded for the project with BHS as a partner site

- **Consortium**

Details regarding the Consortium are addressed below in D. Consortium

- **Collaboration and Coordination with State Title V and other Agencies**

BHS realized that, in order for the problem of infant mortality in the City of Birmingham to be recognized on a statewide level, it was important for us to establish strong ties with the State Title V Division. BHS Administrative Staff began to meet and have ongoing communication with the State Title V Director, who is located in Montgomery, Alabama. During these meetings, we discussed and planned activities that would address infant mortality and/or poor perinatal health outcome experienced by women who not only lived in the BHS catchment area, but in the state of Alabama period. The collaboration and coordination of activities between BHS and the State Title V actually began in the latter part of the replication phase, and has continued until this present time. In addition to working closely with the State Title V Director, BHS also established

a bond with the only other Healthy Start Project in Alabama, the Mobile Teen Center. Collectively, we worked on projects such as the development of a state-wide FIMR process with both Birmingham Healthy Start and Mobile Teen Center covering the cost of the nurse responsible for coordinating the process. The State Title V Director, the State Director of Vital Statistics both served as members of the BHS Coalition. Further discussion of collaborative activities are detailed in Part V. Project Impact, Section C. Impact on the State.

- **Sustainability**

Details regarding the Sustainability are addressed below in E. Sustainability.

C. Resources or events that either facilitated or detracted from successful initiation and implementation of each intervention.

During the previous phases of Healthy Start, October, 1991-May, 2001, BHS had primarily focused on outreach, health education, and case management. Therefore, the methodology of these interventions had already been defined and implemented. As a result, our previous experience allowed us to enhance the existing models and implement them expeditiously. On the other hand, we had not focused directly on interconceptional care as an intervention, nor had we focused on providing screenings for depression and referral for services to perinatal clients.

As previously stated, we had initially applied for funding both the Interconceptional Care Intervention and the Depression Screening and Referral Intervention. This was a joint venture with the University of Alabama at Birmingham (UAB) Women's Health Center and BHS. The goal was for BHS to obtain the funding and, through contractual agreement, provide the actual services through UAB. Since we never received funding, although we were approved, BHS had to regroup and develop new strategies and activities, as well as find additional partners to provide these services. Although UAB Women's Health Center continued to provide services to prenatal clients through its Obstetrics Complications Clinic (OBCC), it was not in the magnitude that it would have been had BHS obtained the funding. Hence, it was not until the end of the second and the beginning of the third year of funding that we were able to identify other partners, develop a process, train staff, and actual begin to provide ongoing services in regards to interconceptional care and depression screening and referral.

D. Consortium

1. *Highlight of how the Consortium was established.*

During 2001, the BHS Advisory Board met and voted to transition the existing board into a coalition. In the past, the Advisory Board functioned as the re-organized Consortium body. During the last year of the replication phase (2000-2001), the focus of the Advisory Board was to transition the board into a Coalition. During the reporting period, special emphasis was placed on recruitment, sustaining and garnering further support and participation of Board members and potential Coalition members including consumers (women of child bearing age who are receiving services from the project), healthcare providers, State health care policy makers, a political official or designee, clergy, social services providers, local school system

representative, community residents, and a local health care policy makers. These individuals have a strong interest in reducing infant mortality and are sensitive to the needs of the project area, and have a clear understanding of what resources and partnerships are necessary to sustain the project services beyond the project period. Other key stakeholders and policy makers were added, as appropriate, in an effort to sustain project services beyond the project period.

Beginning October 2001, the Advisory Board initiated the process to move toward a community Coalition by mailing letters to more than 52 individuals inviting them to serve on the new BHS Coalition. We received responses from 34 community representatives, healthcare providers, social service providers, consumers, key stakeholders and policy makers who eagerly agreed to serve on the new BHS Coalition. The Advisory Board was able to re-gain the support and participation of key stakeholders to serve on the proposed BHS Consortium such as the Vice President of the United Way of Central Alabama, State Representative Oliver Robinson, marketing representatives from the Baptist Health Systems, and other key community leaders.

An initial meeting for the existing BHS Advisory Board was scheduled for January 2002; however, due to circumstances of illness and health issues of the Board Chair-person and Co-chair-person, the meeting was re-scheduled March 5, 2002. During this meeting, the member voted unanimously for the transition to a Coalition with an initial meeting tentatively scheduled prior to May 31, 2002.

From its onset, the Coalition adopted guidelines for operation and defined a mission statement. The Coalition elected a chairperson and co-chairperson, whose duties were prescribed by the Board. The leadership of the Board shifted from the BHS administration to the elected officials of the Board. The Board's mission is to assist the BHS program in its efforts to reduce the infant mortality rate within the selected project area.

During the first scheduled meeting of the new BHS Coalition, a steering committee of members from the former Advisory Board will make recommendations on the establishment of working groups/subcommittee to assist in defining roles and responsibilities in order to assist the BHS project Administration in monitoring program impact. It has also provided advice regarding program direction and made recommendations as needed. The Coalition continues to assist the project in developing a plan for sustainability and identify potential funding sources for the project's programs, services, and activities when federal funds have ended.

The steering committee also reviewed existing by-laws that currently serve as the guiding principles for managing the member interaction. The existing by-laws contain an article on parliamentary procedures, which follows Robert's Rule of Order established to govern board meetings. The by-laws were reviewed to include a statement that addresses conflict of interest policies to govern the Coalition. The members have been actively involved in the project activities and in working to achieve program goals and objectives. The Coalition continues to serve as a forum in which BHS developed new partnerships/collaborative relationships with other organizations and agencies. The current BHS Coalition has been operational since 2002.

- 2. The working structure of the Consortium which was in place for the majority of the implementation.*

The working structure of the Consortium which has been in place for the majority of the project implementation include an elected chairperson, co-chairperson, secretary and parliamentary. In order to effectively move the Consortium forward during the Demonstration Phase, the meetings were scheduled and facilitated by the BHS Administration. However; the meetings are now scheduled and lead by the elected Coalition body. The current number of members on the BHS Coalition is thirty-five voting members and opened to an unlimited number of members with non-voting privileges. The current composition of the BHS Coalition include consumers, community representative (community resident, school, clergy), State and local health care policy makers, healthcare providers, social services providers, local political official or designee, Project Administrator, Project Training Coordinator and members-at-large. We have developed strategies and activities to increase consumer membership, participation and the membership of non-grantee providers.

The current percentage of BHS' Coalition members represented are follows:

<u>13%</u>	consumers
<u>38%</u>	public agencies or organizations
<u>13%</u>	community-based organizations
<u>3%</u>	private agencies or organizations (not community-based)
<u>3%</u>	providers contracting with the Healthy Start program
<u>13%</u>	other providers
<u>17%</u>	other – (Community Representatives & State Representatives)

The racial and ethnic breakdown of the BHS Coalition is the following:

<u>81%</u>	African-Americans
<u>16%</u>	White
<u>0%</u>	Asian
<u>3%</u>	Hispanic
<u>0%</u>	American Indian

The gender breakdown of the BHS Coalition is the following:

15 males and 20 females

The percentage of consortium members attending the meetings of the Coalition consistently during the reporting period was 55%. The BHS Coalition held meetings which were attended by consumers, providers, community representative and other stakeholders. The meetings provided a forum for both providers and consumers to focus upon relevant infant mortality issues as well as to receive updates on the project's progress.

3. *Activities this collaborative has utilized to assess ongoing needs. Relationship with other consortia/collaborative serving the same population.*

During the project implementation, BHS has learned the importance of collaboration and networking with other establishments with similar interests or goals and/or those who are servicing the same client population. We learned that in order for us to really have an impact on our objectives and to achieve the desired outcomes, we must seek assistance from others.

This must also occur in order to provide a true holistic approach to addressing the clients' needs. Although limited interactions between JCDH and other primary care providers was evident prior to BHS, we have been successful in shifting the focus from an inward directed service delivery model to one of collaborative service integration.

BHS has also been successful in linking and partnering with many service providers in the local perinatal system of care. Prior to transitioning of maternity services to UAB in 2004, JCDH provided the prenatal care for approximately 4,500 women each year. Delivery services and prenatal care for complicated pregnancies is provided in partnership with University of Alabama at Birmingham (UAB) and Cooper Green Hospitals. This is approximately fifty percent of all the pregnancies and births in Jefferson County and about 90% of all deliveries to women with incomes less than 150% of the poverty level. JCDH also provides family planning services and pediatric care through health centers located throughout Jefferson County. Changes in the JCDH system of care should impact many of the women who are at highest risk for a negative pregnancy outcome, therefore strong linkage of JCDH and BHS services is essential.

The private system of perinatal care consists of private obstetricians, private pediatricians and hospitals located throughout the County. Since the end of the Demonstration Phase of the Healthy Start Initiative/Phase I, BHS has been able to identify several providers of perinatal care in which we had developed partnerships. These partners included JCDH health centers, UAB and Cooper Green Hospitals, and Carraway Medical Center. These relationships were established and existed primarily due to the fact that JCDH was once the administrator of Alabama's Steps Ahead Medicaid Maternity Waiver Program (SAMMWP). These organizations were subcontractors of SAMMWP. Prior to BHS, JCDH had not focused a great deal of efforts in terms of networking with private physicians, especially, pediatricians in private practices. BHS has used this linkage to educate physicians about services, and to establish referral systems and strong relationships.

Since much of the target population will be either Medicaid eligible or dependent on Title XXI State Child Health Insurance Program's (CHIP) financing of services, close linkage and coordination with these State and local counterparts is very important.

The BHS Project Administrator attended Regional Perinatal Committee meetings. The purpose of this committee is to coordinate perinatal services and allocate designated perinatal funds to projects within the region. This collaborative relationship continued to build important linkages with JCDH through BHS and has provided such services as client transportation to JCDH health centers. Additionally, during the past four years, BHS served as a co-sponsor of the Annual State Perinatal Conference, held in Birmingham, Alabama.

Additionally, BHS has conducted collaborative activities that have resulted in services that are more culturally, linguistically and gender appropriate. One collaborative activity that has resulted in more culturally and gender appropriate service provision for young males at a local high school's Young Mothers' program. BHS provided parenting and childbirth education to the young males, many of whom were either the partner of a young woman enrolled in the program or enrolled themselves in Woodlawn High School's parenting classes. These classes

were conducted by either a BHS contractual provider of childbirth education or the Male Specialist.

Another collaborative activity that positively influenced culturally appropriate service delivery is the relationship between BHS and the JCDH health centers' social workers, as well as other local health care providers via referrals to BHS' Hispanic CORW. During the reporting period, BHS has provided translation services for more than 185 Hispanic consumers that reside in the targeted areas.

Additionally, BHS sponsored a "Personal Touch" workshop, which served as a forum for consumers and providers to dialogue about the need to modify customer service and service delivery by the local health centers. This workshop was an example of on-going collaborative activities designed to assist health care providers move from the mechanical mode of service delivery to more culturally, linguistically and gender appropriate processes. This was facilitated by the participation of not only female consumers, but male partners/significant others during the panel discussion(s).

As mentioned before BHS is very appreciative of the funds awarded to enhance existing relationships and to foster new ones in the city, county and state perinatal systems. Activities implemented with these funds are as follows:

Folic Acid Campaign: BHS was aware of the importance of folic acid relative to efforts toward preventing birth defects of the brain and spinal cord. As a result we joined the efforts of promoting the use/intake of folic acid prior to becoming pregnant. This was done in conjunction with the family planning clinics and WIC division within the Jefferson Department of Health (JCDH). There are five JCDH health centers located within the twelve BHS communities, at least one in each cluster - North, South, East and West. BHS purchased multi-vitamins, which contains folic acid that was distributed to clients, (prenatal, postpartum, and family planning/preconceptional) who resided within the BHS targeted area.

Population-Based Services (Outreach and Public Education): This partnership activity began during 2000. BHS continued to collaborate with local health department clinics, and other health providers and organizations serving our clientele. The purpose was to educate the community and support the message of "Back to Sleep," while working to dispel the myth prevalent in some socioeconomic groups that "crib death" can be avoided entirely if babies are kept out of cribs. BHS emphasized this message through the distribution of literature (provided through clearing house at no cost to BHS), magnets, infant T-shirts, baby bibs. Additionally, monies were allocated towards other incentives that carried the message of "Back to Sleep" which emphasize putting the infant to sleep on his/her back rather than on the stomach. BHS provided this message to 1850 clients through this activity.

White Ribbon Campaign: During the reporting period, BHS/JCDH served as one of the lead organizations/sponsors of the White Ribbon Campaign for Teen Pregnancy Prevention. This coalition was comprised of various community-based organizations that established a partnership to prevent teen pregnancy in Birmingham, Alabama. These organizations joined forces to reduce teen pregnancy via community-based strategies such as a Teen Pregnancy

Prevention Rally and other school-based programming during the month of May. This partnership activity actually began, utilizing the partnership monies allocated in BY 98/99. BHS joined the Children's Health System (Children's Hospital), and other participating agencies/organizations in promotion of the White Ribbon Campaign, Teen Pregnancy Prevention Rally and Summit for 1999, 2000, 2001 and 2002. Local businesses and merchants provided incentives, food and items for door prizes.

The May 2001 Rally culminated as a joint partnership/collaboration between the Coalition and the city of Birmingham, Community Neighborhood Association. This particular Rally was held at a local park, W.C. Patton Park. What was unique about this collaborative effort is that the Youth Leadership Team for the Teen Coalition spearheaded the Rally. The Rally culminated with performances by local rap groups, step show by youth steppers from local churches, poetry reading, essay and poster contests. The Community Advisory Board/Neighborhood Association sponsored food, refreshments and door prizes for participants.

This activity provided the community institutions the opportunity to increase public awareness of teen pregnancy so that communities will commit to teen pregnancy prevention. The White Ribbon Campaign emphasized the importance of a strong partnership between the community and the family and in helping young people maximize their potential and avoid sexual risk behaviors. This mission was to strengthen existing programs, stimulate community-based activities through concerned parents, business leaders, churches, civic, social and youth groups. HS Funds were allocated to purchase incentives to encourage client participation in the Teen Rally, and to promote the message regarding teen pregnancy prevention. All incentive items were also used to promote the Birmingham Healthy Start project.

BHS has also been successful in impacting and initiating the process for rectifying such concerns as uncoordinated, duplicated, and fragmented interactions among providers through its collaborative agreements with various agencies. For instance, Aletheia House, a residential treatment facility for substance abusing pregnant women, which was once under contract with BHS, continued to provide outreach services to this high-risk population. In addition, they provided the residential treatment and transitional housing to these same clients. Birmingham Health Care, which was also once under contract with BHS, continued to provide outreach to the homeless and indigent population. They also provided case management services to the clients.

Other activities and interventions were implemented to address significant disparities in perinatal health indicators including disparities among African Americans and Hispanics populations, differences occurring by education, income, and disability will be achieved by further enhancing the community's service delivery plan in collaboration with our community partners.

In 2002, the UAB School of Nursing trained CORWs to provide environmental interventions during home visits. Oasis Women's Counseling Center provided perinatal depression services to the same population that was served by BHS. Health service programs also serve susceptible populations. Social service agencies, Head Starts, and churches offer an array of supportive services. The United Way of Central Alabama (UWCA) offers a Community Resource

Directory with over 600 entries for supportive services. This year, UWCA will implement an Internet-based information and referral system to improve access to support services.

The JCDH administrative building with its administrative and program offices, clinical laboratory services, vital records department, and large mainframe computer and Management Information Systems, is located within blocks of the University of Alabama at Birmingham (UAB) Medical Center. Within the main JCDH is the large downtown Central Health Center which offers family planning, maternity services, the STD clinic and related programs. JCDH also operates four additional health centers in the Birmingham area. These clinics all offer maternity services, STD screening, and family planning services, and three of the larger clinics offer an Adult Health Clinic. These clinics are also sites for many other community-based supportive services and health-related programs, such as WIC, BHS, social services, dental health, home care services, and hospice. The health centers are all linked by a computerized patient tracking system that is connected to JCDH's network system, referred to as the Electronic Medical Record (EMR) The network for maternity services called OBAR, also links the maternity services within the health department to UAB Hospital, the Center for Research in Women's Health, Cooper Green Hospital, Children's Hospital, and the UAB Kirklin Clinic.

The private system of perinatal care consists of private obstetricians and private pediatricians and hospitals located throughout the County. Many of these physicians have strong linkages to the Department because they provided prenatal care for Medicaid eligible patients under the Maternity Medicaid Waiver Program called Steps Ahead. Healthy Start has used this linkage to educate physicians about services, establish referral systems and strong relationships.

BHS continued with the established collaborative or cooperative agreements to provide patient tracking services to health providers such as Carraway Clinic, Medical Center East, the UAB's Obstetrical Complication Clinic (OBCC) and Baptist Medical Center-Princeton. We continued to forge working relationships between CORWs and community-based agencies. We further enhanced close working relationship with such agencies as churches, outreach ministries and community childcare providers, i.e. Jefferson County Committee for Economic Opportunity (JCCEO), Birmingham Public School System's Eureka Family and Even Start Centers. We began to work closely with JCCEO's Early Head Start Program.

Throughout the life of the project, BHS has been afforded the opportunity to connect with private organizations/care providers such as the St Vincent Hospital, enhanced relationships with Carraway and UAB, and the establishment of relationships with pediatricians in private practices. BHS was also able to establish a collaborative working relationship with the Easter Seals of Birmingham. The Easter Seals employed staff to train BHS' CORWs on identification of children with potential developmental delays. The CORWs were trained to administer developmental delay assessments during routine home visits with clients.

The UAB Department of Obstetrics and Gynecology and its University-wide Center for Research in Women's Health have a long history of working in close partnership with the major public health care providers in Jefferson County to create a coordinated system for delivery of comprehensive, state-of-the-art prenatal and obstetric care as well as other reproductive health-related services to low-income predominately minority women. Through this partnership, an

integrated system of care has been established that coordinates the appropriate services and level of care based on screening and assessment of risk factors for poor pregnancy outcome. This system includes the use of a computerized medical record that allows patients to be tracked through their first prenatal visit to delivery and postpartum follow-up. The computerized medical record also provides the basis for much of the screening and recruitment for clinical trials research and other studies targeting reproductive age women, as well as providing a clinical and population-based research data base that can be linked to other data bases to support epidemiologic and outcomes-based research studies. The following sections describe the existing system of reproductive health and obstetrical services.

For many years, a program of comprehensive prenatal and obstetrical care services has been provided to low-income pregnant women in Jefferson County through a cooperative public provider network consisting of the Jefferson County Department of Public Health's seven neighborhood primary care centers, the UAB and its OBCC, the UAB Center for Research in Women's Health and its Prematurity Clinic, and Cooper Green Hospital. In 1988, this network was formalized even further under the state's "Steps Ahead" Medicaid Maternity Waiver Program (SAMMWP) which contractually binds them into a more managed care system of services. The UAB Department of OB-GYN Maternal and Fetal Medicine Faculty are responsible for managing all of the deliveries to this population of low-income women and for supervising a team of certified nurse midwives, nurse practitioners and registered nurses who manage the low risk prenatal clinics at the health department clinic sites. In addition to the midwives who are contracted through UAB OB-GYN, the health department staff includes a mix of primary care providers including the primary care RNs, nurse practitioners, social workers, nutritionists, and OB-GYN.

To maintain continuity, consistency and quality of care, the UAB Maternal-Fetal Medicine faculty has written the policy manual that serves as the guidelines for prenatal care and clinical management of women attending the Jefferson County prenatal clinics as well as the UAB high-risk clinics. These clinical policies and management guidelines are updated regularly as new research findings and/or changing population needs dictate. Over 5,000 patients annually received their prenatal care through the Jefferson County obstetrical system. In addition to the Jefferson County prenatal clinic system, the UAB Department of OB-GYN also provides the same prenatal services to the health department clinics in two counties contiguous to Jefferson, Blount County to the north and Shelby County to the south. In addition to regular prenatal clinic sites coordinated through this system, the JCDH is also home to one of the federally funded *Healthy Start Programs*, BHS, which provides services within the community at (i.e., community centers, churches, schools). The major goal of BHS is to reduce infant mortality by reducing the barriers that keep women from obtaining prenatal and infant care.

In addition to BHS, the existing system of obstetrical care services provides assistance to women who have transportation needs and other needs such as medicines and medical support through the State Health Department's Perinatal Advisory Committee Fund. This coordinated system of care has in essence become a medical home for Medicaid and low-income uninsured women in their childbearing years. The continuum of maternity care services provided through this system included the following:

- General Range of Services
- Coordinated Maternity Services
- Coordinated Low and High Risk Prenatal Care (including psychosocial and physiologic risk assessment, coordination with WIC and social services, risk management, treatment and risk factor reduction interventions, OB ultrasound and other antenatal testing)
- STD screening, treatment and counseling (including specialized AIDS care and counseling for pregnant women)
- Substance Abuse Treatment and Counseling
- Abuse Assessment Screening and Linkage to Community Services
- Genetics Screening and Counseling
- Home Visits
- Inpatient Antepartum Care
- Labor and Delivery Services
- Emergency Care
- Postpartum Care and Follow-up
- Family Planning Services
- Social Services (including case coordination, home visits, transportation and childcare coordination)

The project experienced numerous successes and accomplishments during the reporting period that included hosting two conferences, submitting two grant applications, conducting BHS Spa, creating Self Esteem Videos of consumer testimonials, conducting a Clothing Drive, and disseminated Holiday Baskets to consumers.

The BHS Project and Consortium sponsored a Community Awareness & Holiday Safety observance on December 10, 2003 for participants enrolled in the BHS Program in which Holiday Safety Tips were provided for parents by BHS contractual provider Beverly Brown, R.N. The event was also marked by the distribution of developmental toys and games to the infant and children present for the event. Each infant or child attending had their picture taken with Santa's elves and helpers upon receipt of their individual gift. The celebration was further marked by the dissemination of literature on holiday safety tips. There were 80 participants in attendance.

This was the second annual celebration held to thank participants for not only enrolling in the BHS program, but also for continuing to receive healthcare for themselves and their children at one of the JCDH Health Centers. Not only was this event a time of celebration for our clients, but also an expression of true teamwork by all BHS staff and the Coalition. BHS staff volunteered to prepare and serve the light refreshments.

In addition to sponsoring the Annual BHS Christmas Holiday Safety Event, Healthy Start also co-sponsored the Christmas Tree Lighting Ceremony held at two of JCDH's Western and Chris McNair Health Centers. BHS provided the refreshments for the celebration at Western Health Center, and refreshments and developmental toys and games for the celebration at Chris McNair Health Center. The Chris McNair Health Center's celebration was held on December 12, 2003 where pictures were taken with Santa as he passed out the toys and games. The

Western Health Center's event was held on December 11, 2003, where entertainment included singing by Ruben Studdard, Sr., (the father of the 2003 American Idol winner), Rufus Hill, Traymon Williams, and Patrick Thomas. Each of the health center's Christmas Tree Lighting Ceremony was well attended totaling over 400 attendees combined. We look forward to the continued teamwork, collaboration and partnership with the community.

Childbirth/Parenting classes with two local high schools (Woodlawn Young Mothers' Program and Ensley High Young Mothers' Program). These classes are conducted by BHS contractual provider. Parenting classes are provided for participants at community-based organizations such as DHR, UAB, JCCEO, and local faith based institutions.

4. *The community's major strengths which have enhance consortium development.*

The new BHS Coalition continues to serve as a conduit for feedback from consumers/clients to the project and grantee. It provides an avenue for active participation of clients/consumers in the healthcare delivery system, as well as input into the project's direction. In past meetings, consumers voiced their desire to serve in Advisory Board activities provided the Board's activities had a 'purpose' for meetings held. Consumers also shared that they were willing to participate if 1.) their voices were heard, 2.) suggestions and recommendations were "listened to," and 3.) they were kept well informed of the project's progress.

Another strategy to facilitate participation of consumers on the Coalition involved recruitment through varied activities such as BHS health fairs, childbirth/parenting classes, outreach and canvassing, home visits, clinic visits and other activities. During this time, consumers or potential program participants are informed of BHS, the importance of their involvement in the program and in our attempts to address health disparities, and to identify barriers to care. They are also encouraged to become participants of the Coalition and/or BHS consumer focus groups.

The availability and involvement of all major local area hospitals including UAB, CGH, Baptist Health System (Princeton and Montclair), St. Vincent's, Carraway and Medical Center East are also major community strengths that enhanced Coalition development.

BHS also partnered with other providers to sponsor and/or co-sponsor local campaigns such as the Folic Acid campaign, Lead Prevention (with CLEPP), the White Ribbon campaign, and Male Involvement activities (JCCEO, DHR, UAB, Boyz to Men, Children's Aid Society).

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

Barriers included consistent and continuous consumer participation in attending the meetings. Consumers are involved in activities; however, BHS realized the need to increase their participation in all aspects of program implementation, even in an advisory nature. Challenges to the effectiveness of the consortium included additional staffing support, including clerical and other staff, to assist in Consortium (Coalition) implementation.

Another challenge involved competing agendas of member organizations. Many members of

the coalition are actively involved in their jobs and other community activities where their responsibilities may force them to prioritize their commitment. This can result in their inability to attend some coalition activities. BHS addressed this challenge by initiating the bi-monthly meetings that helped to increase opportunities for all members to become involved.

During the reporting period, BHS identified the need for additional consumer involvement. BHS worked toward recruiting consumers by restructuring the coalition to include a separate committee with representatives that report directly to the Coalition body. Additional stakeholders were recruited from those areas that are under-represented on the existing coalition.

6. *Activities/strategies were employed to increase resident and consumer participation.*

The new BHS Coalition continues to serve as a conduit for feedback from consumers/clients to the project and grantee. It provides an avenue for active participation of clients/consumers in the healthcare delivery system, as well as input into the project's direction. In past meetings, consumers voiced their desire to serve in Advisory Board activities provided the Board's activities had a 'purpose' for meetings held. Consumers also shared that they are willing to participate if 1.) their voices were heard, 2.) their suggestions and recommendations "listened to," and 3.) they were kept well informed of the project's progress.

Another strategy to facilitate participation of consumers on the Coalition (Consortium) involved encouraging them to become coalition members during attendance at BHS activities such as childbirth/parenting classes, outreach and canvassing, home visits, clinic visits and other activities.

Consumers continue to assist in planning for project implementation. They work together to review demographic data on the county and determine approaches to reach high-risk families in targeted communities. Consumers participate in grant application development by aiding in the process of identifying new and innovative projects for community development. For example, consumers and clients participated in the development and implementation of the BHS Christmas Holiday Safety Workshop in December 2003.

BHS project consumers play an important role in the program activities and strategies. BHS understands the importance of consumer participation not only in JCDH and BHS services, but also on the Coalition. Their presence is vital, their voices and active participation are needed as we continue in the fight to reduce infant deaths and assist in eliminating disparities in health care in the BHS project area. We encourage a continued partnership with consumers and other agencies/organizations that share a common goal of healthier pregnancy outcomes and improved access to quality health care in the city of Birmingham.

Consumers served as advocates for others in such activities as focus groups, peer-to-peer parenting support groups, marketing committee, and special events (Baby Reunion Celebrations, Parenting Conference). Consumers have played an active role in the marketing of health promotion and awareness activities/events either sponsored or co-sponsored by BHS. These include radio spots highlighting personal testimonies on the importance of receiving early

prenatal care, adequate health care and the benefit they gained from participating in BHS services.

Consumers participate in identifying community locations for *focus groups* to conduct pilot tests of new materials. They also recruit collaborative partners to assist with program planning and implementation efforts. A Teen Recruiter and Parenting Instructor work at a local high school to identify recruit and enroll new clients/consumers into prenatal care and the coalition.

Coalition members continue to provide Input into developing the scope of services BHS offers. Two BHS Coalition members, Dr. Tom Ellison, Chair and Kevin Ware, both attended the National Healthy Start Grantee Meeting in 2003 to learn more about the process involved in developing the scope of services for BHS. Upon their return, they presented information to the Coalition body and served on a subcommittee to give input and advice to the Project Administrator on developing the implementation plan for the program.

Coalition consumers also assist with communication/media efforts. Two former male participants, who are now staff members with the Male Involvement Program, were showcased in a BHS video by providing personal testimonials about their involvement with Healthy Start, the classes and other services. Clips of this video were viewed during the Male Involvement presentation by Rick Green, BHS Project Administrator during the Healthy Start Grantee Meeting. Furthermore, consumers participate in identifying community locations for *focus groups* to conduct pilot tests of new materials. They also recruit collaborative partners to assist with program planning and implementation efforts. One consumer developed a plan for hosting consumer activities and events for training and empowering the consumer voiced and presented the plan to the Coalition in 2004 and the beginning of 2005. We plan to identify funds to carry out these activities during 2005.

BHS further recognizes the need for regular training for the Coalition members, particularly, consumers. On-going education and training sessions were provided including stress management, Childbirth and Parenting education, child safety, nutrition information, environmental issues/factors in the home, factors that contribute to infant mortality, importance of early and continuous prenatal care, and board development training.

Another role of the consumer on the Coalition is to create trusting relationships between “customers” and “providers.” This occurs through the facilitation of effective dialogue among all board members. We realize that dialogue, strategies and activities that will work and make a difference require “trust” in order to be effective. It is when this trust has been established that different individuals or groups can find themselves on common grounds, “organizing working partnerships.”

The Coalition was also challenged to create activities and strategies to utilize Coalition budget to facilitate progress in Coalition objectives, i.e., increase the participation among Board members, increase community awareness of the problem of infant mortality, the need for community involvement, identification of gaps in services, and the reduction in fragmentation of services.

7. *Process for obtaining Consumer input*

Consumer input in the decision-making process was obtained via focus group sessions, training sessions, surveys, questionnaires administered during childbirth/parenting classes, and special activities and events.

Verbal and written requests for modification of services, e.g., request by consumers for additional parenting and childbirth classes and the need for an additional service station to provide transportation assistance more conveniently and expeditiously are examples of feedback that consumers provide and the project addresses their concerns.

8. *Utilization of the suggestions made by the consumers*

In 2001, the Coalition (Advisory Board) made the recommendation for change directed toward re-modification of the Local Evaluation process. During an Advisory Board meeting, members raised several questions regarding the goals and objectives of BHS and the process for program evaluation. The consumers made the recommendation to establish activities that will more effectively assess and evaluate community-based programs. BHS modified the evaluation process which was formerly coordinated via contractual provider Joseph Telfair, Dr.PH, UAB. Local evaluation is now coordinated via JCDH Perinatal Epidemiologist, Richard Sinsky.

During the project period, Coalition members continue to make recommendations regarding staffing patterns and contractual providers. BHS instituted a consortium model that assisted in building community capacity and infrastructure for provider and consumer participation in establishing/building needs and focus on cultural competence and values.

Additionally, BHS utilized consumers input during the planning and implementation of community based activities and educational/training needs. Also, one very active consumer that participated on the Advisory Board became an employee of BHS. Consumer participants continue to make recommendations regarding convenient times, dates and locations for prepared childbirth/parenting classes, male involvement activities, focus group sessions, community-based events, and the need for more convenient gas/service stations for transportation assistance.

E. Sustainability

1. Efforts with managed care organizations and third party billing.

BHS has not been involved with any managed care organizations for activities such as outreach and health education. BHS has not sought third party reimbursement for the supportive and enabling services by the project. However we were able to receive additional funding the Children's Trust Fund and the Community Foundation of Greater Birmingham to support educational activities such as Prepared Childbirth and Parenting Classes, and male involvement activities. These services met the community need for community based educational services. Additionally, JCDH, the grantee, does receive third party reimbursement for the traditional public health services provided to the participants (i.e. immunizations, well-baby check-ups,

family planning, dental care, etc.)

2. *Major factors associated with the identification and development of resources to continue key components.*

BHS realizes the importance of identifying resources to sustain and enhance key components of the program. In order to achieve lasting sustainability, BHS acknowledge a need to align services with the standards necessary for third party reimbursement. Some factors associated with identifying and developing resources to continue key components include the following:

Consortium	Education	Outreach	Public Awareness
Reach out to Sororities and Fraternities	Corporate Partners	Network with Entitlement Providers	Radio/TV PSAs
Social Service Agencies	County Commissioner	Social Service Agencies	Print Media
Faith Community	State Legislators	Faith Community	Involve former clients
Medical Providers	City Government	Housing Authority	Speakers Bureau
Present and Former Clients	Philanthropic Agencies	Local Schools	
	Program Activity Partners		

3. *-Barriers overcome and efforts to decrease negative impact.*

One of the biggest lessons learned for BHS is the importance of establishing a firm foundation and network based upon community and professional support. This must be initiated at the onset of any community based, community driven program. In the beginning, BHS spent a great deal of time trying to overcome the past and the long-lasting impact of the program (on the program) as a result of what happened initially, i.e., the tumultuous situation that ensued with community conflict with JCDH management. The establishment of BHS was JCDH’s first involvement with a program that had a great deal of community input in planning, implementation, involvement, and ownership.

The initial tempestuous and angry community relations lasted for 3-4 years which interfered with program implementation and progress, thus causing negative relationships and/or perceptions with other community-based organizations and agencies. As a result, BHS had to spend additional time re-establishing vital and essential community partnerships. We were able to overcome this barrier by garnering and establishing working relationships and partnerships with community based agencies such as Easter Seals, Children Can Soar, Aletheia House, JCCEO, UAB, Cooper Green Hospital, St. Vincent’s Hospital, Princeton Hospital, and Birmingham Health Care for the Homeless.

We continued to network with crucial stakeholders in building bridges to resources. We engaged and involved the State Title V Director, the State Director of Vital Statistics, and the Medicaid agency as partners. As previously mentioned, we collaborated on state wide campaigns such as the ‘Back to Sleep’ Campaign, Shaken Baby Campaign. BHS staff and the State Medicaid agency partnered and networked for joint staff training for the Medicaid/ALLKIDS application process. The BHS outreach staff was trained to assist applicants in completing Medicaid and ALLKIDS applications.

During outreach activities, CORWs distributed Steps Ahead Maternity Medicaid Waiver (SAMMWP), ALLKIDS and entitlement program applications and assisting clients with the

completion and submissions of the applications. Additionally, they disseminated information through pamphlets and other enrollment packets in regards to the availability and eligibility of these entitlement programs. BHS served and continues to serve as a point of distribution of literature and enrollment packets for ALLKIDS and Medicaid. In an effort to reestablish partnership with Alabama Medicaid Inc (AMI), BHS staff met with the new manager of the SAMMWP. Members of the BHS leadership team attended a one-day training and update session on March 4, 2005 with the SAMMWP Care Coordinator.

III. Project Management and Governance

A. Structure of the Project Management

The administration and management of the BHS project remained the same throughout this project period with a few exceptions. The administration and management plan supported the same staffing pattern as originally budgeted. There were changes in the organizational structure within JCDH under the leadership of a new Health Officer, Dr. Michael Fleenor, who was the former Deputy Health Officer. Due to some restructuring, in addition to his responsibility as BHS Project Administrator, he (Rick Green) took on the responsibility and oversight of two JCDH centers, Chris McNair and Eastern as Health Center Administrator (HCA). These are two of the five JCDH health clinics that are located in the BHS targeted area. As of March 2002, in line with the vision and new direction for JCDH in general, BHS was moved from under the umbrella of the Bureau of Public Health Nursing with the Project Administrator reporting to the Director of that Division, Flora Blackledge, to reporting to Gwen Veras, the Director of Finance and Administration. All HCAs, as well as the Administrator of the newly developed Case Management Division, reported to Ms. Veras. This move allowed the BHS Project Administrator and the other HCAs better communication/collaboration and enabled a smoother integration of the attributes of the BHS concept into the overall JCDH environment. In May, 2004, Health Center Administration, which included BHS, was moved to the Division of Clinical Services, of which Dr. Stephen Mallard is the Division Director. JCDH has a six member executive management team. Each member assigned to designated division/areas within JCDH. Dr. Claude Ouimet, Deputy Health Officer is assigned to BHS, and has on-going communication with the BHS Administrator regarding the program.

Another notable change during 2002 was the death of the longtime Chairman of the BHS Advisory Board/Coalition, Rev. Rufus McGhee, who was replaced by Dr. Thomas Ellison, Director of Project HELP (Health Education Linkages Program). Both men have served on the Board since its inception. Also during this time period, new officers were elected as follows: Chairperson, Dr. Thomas Ellison, Co-Chairperson, Ms. Leona Payne (President of the Southwest Community), and Secretary, Loretta Myricks (BHS Education/Training Coordinator).

The Project Administrator continued to be responsible for the programmatic administration/oversight/monitoring of BHS service delivery activities, and reviewed/approved all fiscal activities, although the grantee has a staff person assigned 20% to assist with fiscal issues. The BHS Organizational Chart denotes the Project Administrator as having the oversight/administrative responsibilities for the project during this reporting period. Other members of the BHS Leadership Team were assigned additional responsibilities as the Project

Administrator took on additional responsibilities within JCDH. The BHS Leadership Team consisted of the Project Administrator, Administrative Assistant III/Clerical Supervisor, Education/Training Coordinator, and two Outreach Coordinators. The Administrative Assistant III/Clerical Supervisor continued to be responsible for supervising all clerical staff; coordinated and provided training and technical assistance on record maintenance and data entry; developed administrative policies and procedures pertaining to client registration, filing systems, communications and property management; assisted the Administrator in the development of program tools and activities; worked closely with the MIS division; and assumed some fiscal management responsibilities of the Administrator in his absence. This position reported directly to the Project Administrator.

The Education/Training Coordinator became more active in the day to day operation and site coordination of the BHS service center. In addition, she continued to be responsible for staff development; coordination of staff training/in-services and the health education component; assisted the Project Administrator in the development/implementation of the Advisory Board/Coalition; assisted in contract management activities; conducted/coordinated focus groups and needs assessment activities; developed flyers and other printed material about the program; assisted with the coordination of all media releases; radio/TV announcements and interviews for outreach purposes; assumed administrative responsibility and program oversight in the absence of the Administrator. This position reported directly to the Project Administrator.

The two Outreach Coordinators maintained the supervisory responsibility of assigned Community Outreach Workers (CORWs). Also, they assisted the Administrator with the coordination and implementation of all outreach and tracking activities, and were solely responsible for evening and weekend outreach activities. This position reported directly to the Project Administrator.

Service staff included one full-time Administrative Assistant I, who was responsible for client registration, data entry of client encounters, issuing client transportation assistance, establishing positive relations with community and program personnel, served as the central communication point for all site activities, and provided clerical support for designated outreach activities. She received some assistance from the part-time staff. This position reported directly to the Administrative Assistant III/Clerical Supervisor.

Core staff included nine full-time and three part-time CORWs who conducted a wide range of activities. These activities included identifying, recruiting, and retaining women in need of prenatal care, infants in need of health care and other BHS services. The CORWs referred clients for additional services according to the need. They made phone calls, home visits, canvassed the community and went door-to-door, set up outstation activities for outreach purposes, identifying women in high risk categories. They utilized community resources for outreach and referral purposes, followed up on prenatal and postpartum clients, as well as infants identified as delinquent for medical care. CORWs also distributed information and educated potential clients and community agencies about BHS and participated in health fairs and community awareness events, maintained daily logs/weekly reports of work activities and client contacts to demonstrate productivity, worked closely with JCDH health center staff, and reported directly to the CORW II/Outreach Coordinators. The part-time CORWs reported directly to the Administrative

Assistant III.

There were two part-time CORW II/Male Outreach Specialists. One was responsible for providing specialized outreach and supportive services to male partners of pregnant women who were program participants. The other assisted the Administrator with the development, implementation and coordination of male involvement activities, and provided one on one supportive services, when requested/needed and parenting instructions, through classes, to program participants. These individuals reported directly to the Education/Training Coordinator.

The majority of the BHS staff has 10 years of experience providing outreach services to the maternal and child health population. Therefore, the existing staff was provided, and continues to receive, on-going training to expand their understanding and capacity to address disparities in perinatal health indicators and interconceptional care services. Contractual providers, JCDH staff and local agency staff were also invited to attend these sessions. BHS staff also attended training sponsored by local services agencies.

The decision making and communication process included weekly meetings with the BHS Leadership Team to assess status of program activities, and bi-weekly general staff meetings with all staff. These meetings were conducted by the Project Administrator to provide updates of project status, disseminate information, voice concerns and allow for staff interactions. Minutes, agendas and sign-in sheets were maintained in order to document attendance and discussions. The administrator met periodically with the Technical Assistance Consultant regarding program issues. The BHS administrator also received feedback from the BHS Coalition during quarterly meetings. More frequent communication took place between the Administrator and the Coalition Chairperson. Also the Project Administrator met monthly with the Director of Finance and Administration, Health Center Administrators (HCA), other JCDH department heads, and the representative for the Health Officer, during which time he would update them on BHS progress, concerns, barriers, upcoming events and activities.

B. Resources for Fiscal and Program Management

The resources available to the project are demonstrated in JCDH's ability to receive and administer funds, and the ability to assume direct fiduciary responsibility. JCDH is the largest local health department in the State, with an annual budget in excess of \$60 million. For years JCDH has managed millions of dollars in federal grants. JCDH has established accounting controls to receive, administer, and assume direct fiduciary responsibility for all funds. The internal controls are compliant with Office of Management and Budget (OMB) standards, and annual audits are conducted by independent auditors and the State of Alabama Office of Public Examiners. As a component of JCDH, BHS works very closely with the department's management team and department of finance. BHS receives assistance in fiscal management from Susan Nail, a Sr. Accountant within JCDH's Department of Finance. Ms. Nail devotes approximately 20% of her time to BHS.

Each grant award is separately budgeted to insure no over-expenditures, and monthly reports are generated to show all revenues and expenditures that have been posted for each program. All reports are reviewed by the program managers and by the accounting office. Salaries are

calculated for employees, using a time and attendance electronic system that documents time spent on a particular budget area, and the accounts payable system has several levels of approval to assure no improper payments are made. Finally, the purchasing system follows all state and federal bid law practices.

C. Changes in Management and Governance

Changes in management and governance are described above in *Section A. Structure of Project Management*.

D. Process for Distribution of Funds

The process for the distribution of funds is described in *Section B. Resources for fiscal and program management*.

E. Non-HS Resources for QA/Program Monitoring, Service Utilization, and Technical Support

The BHS Administrator developed a quality assurance process and team which consisted of members of the BHS Leadership staff and contractual provider. The salaries for all of these individuals were paid through BHS funds. However, BHS received substantial support from the JCDH Perinatal Epidemiologist, who provided and analyzed data for program monitoring and service utilization. Much of this individual's time was in-kind services.

F. Cultural competency of contractors and of project staff

During the initial years of the Demonstration Phase, BHS had to work hard to triumph beyond the history between the old dissonant community consortium including blame and distrust of the Grantee, JCDH. This was a tremendous hurdle. BHS learned to develop strategies to encourage internal JCDH stakeholder support in an effort to enhance team building. The years of crisis intervention training, team building workshops, resulted in BHS staff and Coalition member being well prepared, trained and experienced in working with divergent opinions, resolving conflicts and how to build working teams

IV. Project Accomplishments

The BHS project had a great deal of accomplishments during this reporting period. As previously stated, the program has had a great impact on the grantee agency, the existing perinatal system of care, the community at large, and the clients we served. The staff remained focused and was able to stay on track as we put forth efforts to achieve the project's goal. The overall goal for the project during this time was to address significant disparities in perinatal health indicators for African American and Hispanic women of child bearing age, 10-44, during the prenatal and interconceptional phases.

We expected to reduce the infant mortality rate from 15.8 to 11.8 by 5/31/05, and to address notable disparities among targeted groups within the fourteen BHS communities. As of December

31, 2004, the overall cohort infant mortality rate was 11.4. For the program participants, the rate was 9.7. For the non-program participants, the infant mortality rate was 11.9. This indicates some progress towards program goals.

The focus was on high risk perinatal clients residing in the BHS communities who were either pregnant, or parenting infants up to 2 years old, and those who had 2 or more risk factors as assessed during prenatal screening. We also paid close attention to women who were in need of or could have benefited from interconceptional care services. This included women who had experienced a poor outcome from a previous pregnancy.

In collaboration with other agencies/partners, comprehensive services were provided to the participants that included providing services to her family during her pregnancy and interconceptional phases, and to the infants up to age two who resided in the proposed BHS area. Limited services were also provided to males, adolescents and community persons interested in decreasing infant mortality.

As previously stated, five core interventions were implemented to achieve the project's goal and objectives. The five core interventions were Outreach and Client Recruitment, Case Management, Health Education and Training, Interconceptional Care, and Depression Screening and Referral. In addition to the goal of reducing the infant mortality rate, 27 objectives were identified and used as the means/tools for measuring/monitoring desirable outcomes/endpoints.

Another indication of the successes of BHS is the progress that has been made towards the 27 objectives developed as described below: This following section will outline the objectives that were developed and the progress and/or status as of December 31, 2005. Although the project period object was set to have been met by 05/31/05, Calendar Year 2004 data was the latest that we could obtain, at this time.

Objectives 1 through 16 were general objectives for the project. While they were supported by activities of all intervention, these were more applicable to the Outreach and Case Management Intervention. Following is a listing of those objectives and the status/accomplishment as of 12/31/05.

OR/CM Objective #1: By 05/31/05, increase the percentage of women, residing in the BHS targeted areas, (and were program participants), who receive adequate prenatal care as defined by the Adequacy of Prenatal Care Utilization (APNCU) Index to at least 78.0%.

Status: For CY 2004: 76.0% participants compared to 74.2% non participants received adequate prenatal care as defined by the APNCU. Goal nearly met.

For CY 2001: 68.3% participants compared to 68.3% non participants received adequate prenatal care as defined by the APNCU.

As of 12/31/04, this objective was nearly met indicating significant progress. There is also significance difference when looking at the data for 2001 as compared to 2004. In this case, it appears that significant progress has been made.

OR/CM Objective #2: By 05/31/05, increase the percentage of women, residing in the BHS targeted areas (and were program participants), who enter into prenatal care in the first trimester to at least 80.0%.

Status: For CY 2004: 86.9% participants compared to 80.7% non-participants entered into prenatal care in the first trimester. Goal exceeded.

For CY 2001: 64.5% participants compared to 69.4% non-participants entered into prenatal care in the first trimester.

As of 12/31/04, this objective had exceeded it's goal indicating that much progress has been made. This is also seen when comparing CY 2001 data to CY 2004.

OR/CM Objective #3: By 05/31/05, decrease the percentage of women, residing in the BHS targeted areas, who received no prenatal care, while pregnant, to 1.0%. In 2001, this goal was modified and reset to 1.4%. By the end of CY 2001, the percentage of women receiving no prenatal care was 1.8.

Status: For CY 2004: 1.4% of the pregnant women residing in the BHS targeted area received no prenatal care while pregnant. Goal met.

OR/CM Objective #4: By 05/31/05, decrease the percentage of preterm births (births occurring prior to attaining 37 weeks of gestational age) to women residing in the BHS targeted areas, (and were program participants) to 10.0%.

Status: For CY 2004: 14.6% participants compared to 15.3% non participants decreased the percentage of preterm births. Goal not met.

Although this goal was not met by the end of 2004, this data indicates that the program participants had better outcomes than those who were not participants.

OR/CM Objective #5: By 05/31/05, decrease the percentage of Low Birth Weight (< 2,500 grams) babies born to women residing in the BHS communities, (and were program participants), to no more than 10.0%

Status: For CY 2004: 12.9% participants compared to 13.9% non participants decreased the percentage of LBW babies. Goal nearly met.

By 12/31/04, BHS came close to meeting its goal with the belief that this goal could be met by the end of 2005. However, in comparing the participants to non-participants, it appears that the participants had better outcomes than those who were not participants.

OR/CM Objective #6: By 05/31/05, decrease the percentage of Very Low Birth Weight (< 1,500 grams) babies born to women residing in the BHS communities, (and were program participants), to no more than 2.0 %

Status: For CY 2004: 2.3% participants compared to 2.7% non participants decreased the percentage of VLBW babies. Goal nearly met.

By 12/31/04, this goal was nearly met, indicating that the goal could be met by 5/31/05. There does not appear to be a significant difference between the status of the program participants and the non-participants.

OR/CM Objective #7: By 05/31/05, increase to at least 72.0% the percentage of infants residing within the targeted area who receive appropriate health service/care.

Status: as of Calendar year 2004: Unable to obtain data.

OR/CM Objective #8: By 05/31/05, increase the percentage of 2 year olds who have received the full scheduled of age-appropriate immunizations, to at least 80.0%

Status: as of Calendar year 2004: 79.8% CI₉₅: (83.9, 65.7). Goal nearly met.

OR/CM Objective #9: Increase the annual number of male partners who are actively involved in the pregnancy of the woman who reside in the target area and were program participants of the HS Initiative to 500 annually by 05/31/05. This objective was modified in 2002 to reflect the number of male participants who were recruited and became program participants annually by outreach staff and through other collaborative efforts. The purpose here was to increase the number of males who became actively involved in the pregnancy status of his significant others, and the upbringing of the child.

Status: For CY 2004: 510 male participants were actively involved in the pregnancy stage and the upbringing of the child as indicated by BHS encounter forms and education class participation rosters and information obtained from birth certificates. Goal exceeded.

OR/CM Objective #10: By 05/31/05, at least 85% of the pregnant women, who reside in the targeted area and were contacted by BHS staff, will have completed a Medicaid application.

Status: For CY 2004: 88.0% of the pregnant women who were contacted by BHS staff had completed a Medicaid application. Goal exceeded.

OR/CM Objective #11: By 05/31/05, decrease the proportion of births to teens who reside in the BHS targeted areas from 22.14 (1999) to 19.5.

Status: Calendar year 2004: 19.91. Goal nearly met.

OR/CM Objective #12: By 05/31/05, increase percentage of women who receive appropriate family planning service to at least 15.5%.

Status: Unable to obtain data.

OR/CM Objective #13: By 05/31/05, increase the percentage of women, who live in the BHS targeted area who, by self-report, (birth certificate) abstain from alcohol use during pregnancy to 99.8%

Status: as of CY 2004, 99.5%. Goal met.

OR/CM Objective #14: By 05/31/05, 99.5% of women who live in the BHS targeted area who, by self-report, (birth certificate), would have abstained from drug use during the pregnancy

Status: as of CY 2004, 99.3. Goal met.

OR/CM Objective #15: By 05/31/05, 96% of women who live in the BHS targeted area who, by self-report, (birth certificate) would have abstained from tobacco use during the pregnancy.

Status: as of CY 2004, 93.2. Goal nearly met.

The following is a list of objectives that were unique to the Health Education Intervention. The status/accomplishment as of 12/31/04 is also included.

HE Objective #1: By 12/31/05, the BHS staff will be participating in at least twelve (12) health fairs/community awareness events, reaching **3,200** individuals, annually.

Status: For CY 2004, BHS staff participate in 16 health fairs/community events, reaching 3,810 community residents. Goal Exceeded.

HE Objective #2: By 12/31/05, BHS staff will have provided fifteen (15) presentations to Community Based Organizations (CBOs) and agencies about eliminating health disparities and the services offered by Birmingham Healthy Start.

Status: as of 12/31/04 BHS had provided 13 presentations to CBOs. From this we believe that this will be met by 12-31-05. Goal met.

HE Objective #3: By 12/31/05, BHS health education staff conduct 34 childbirth/parenting classes reaching 175 participants, annually.

Status: During CY 2004 BHS conducted 42 classes to 210 individuals. Goal Exceeded.

HE Objective #4: By 12/31/05, the BHS Health Education staff will increase the number of clients who serve on the Teen Advisory Board to 16.

Status: Goal not completed. This goal was not completed as written, however, BHS obtained valuable information from teens enrolled in the Young Mother's Program during Prepared Childbirth Classes conducted at the two high schools. Since this seems to be the best approach of obtaining information from the students, this objective will be modified.

HE Objective #5: By 12/31/05, the BHS Male Involvement staff will coordinate and conduct on-

going male involvement activities reaching 450 males, annually.

Status: For CY 2004, 510 males were reached through Male Involvement Activities. Goal Exceeded.

HE Objective #6: By 12/31/05, the BHS Health Education staff will produce and distribute quarterly newsletters and BHS Fact Sheets describing BHS services and activities to 1,200 individuals in the BHS target area, annually.

Status: For CY2004, 1800 fact sheets were distributed. Goal Exceeded.

The following is a list of objectives that were unique to the Depression Screening Intervention. The status/accomplishment as of 12/31/04 is also included.

PD Project Period Objective #1: By 05/31/05 2005, the BHS staff would have identified maintained on-going relationship with its partners.

Status: By the end of CY 2004, BHS had established and maintained an on-going partnership with Oasis. Goal met

PD Project Period Objective #2: By May 31, 2005, BHS staff will have begun the use of the screening tool.

Status: By the end of CY 2004, BHS staff had begun the use of the Edinburgh Postnatal Depression Scale Depression screening tool. Goal met

PD Project Period Objective #3: By May 31, 2005, all BHS staff will have received training on the signs and symptoms of perinatal depression.

Status: On November 6, 2003, February 6, 2004, June 25, 2004, August 20, 2004, October 29, 2004, and November 22, 2004, BHS staff attended in services in which they learned of the signs and symptoms of perinatal depression. Goal met

PD Project Period Objective #4: By May 31, BHS staff would have begun to screen at least 250 clients for perinatal depression, with an increase of 50 annually.

Status: For Calendar Year 2004, 245 clients were screened for depression. Goal Met.

The following is a list of objectives that were unique to the Interconceptional Care Intervention. The status/accomplishment as of 12/31/04 is also included.

IC Project Period Objective #1: By 5/31/05, BHS would have identified a process for follow-up to interconceptional care clients.

Status: The process for conducting interconceptional care activities/services was developed and implemented by December 31, 2002. Goal Met

IC Project Period Objective #2: By 12/31/05, BHS would have begun to identify and provide services to 200 interconceptional care clients, annually.

Status: For CY 2004, BHS had provided interconceptional care services to 375 clients. **Goal Met.**

Indeed, it is apparent that in order to achieve the project's goal and objectives, there had to be a game plan, or a plan of action. This game plan consisted of strategies and activities aimed at accomplishing these goals and objectives. The following section will outline the strategies developed and the activities employed in our efforts to achieve our goal and objectives.

- ***Strategies***

Strategy 1: Recruiting and maintaining pregnant women in prenatal care.

This strategy included locating pregnant women who have not had a prenatal visit. The CORW made sure that a visit was scheduled and kept. For women in care, this strategy focused on follow-up to see that the woman had kept the appointment. If the appointment was missed, the CORW assisted the woman in identifying reasons for missing it, scheduled a new appointment, and assured that appointment was kept. They also discussed ways to prevent missed appointments in the future.

Strategy 2: Assisting pregnant women in complying with the recommendations of the provider(s) of prenatal care.

This strategy included working with pregnant women and their families to make sure that they understood what to do and/or not to do during the pregnancy and locating the resources that may be necessary for their compliance with the recommendations. CORWs worked very closely with the healthcare providers to ensure that clients understand the messages that providers were delivering and provided proper follow-up to the client to ensure the provider's instructions were carried out.

Strategy 3: Assisting mothers/guardians of infants in initiating and maintaining well-child Supervision.

This strategy included locating/identifying new mothers who had not initiated a well-child visit for the newborn. CORWs made sure that the infant had a medical home and that an appointment was scheduled. They made future contact to ensure appointments were kept and/or rescheduled, if missed. They also assisted the parents in discovering ways of preventing missed appointments in the future. CORWs worked closely with JCDH health centers and other health care providers to assure that clients were enrolled in a timely manner and that they received appropriate services.

Strategy 4: Assist women in complying with recommendations of providers of well child Supervision.

This strategy involved working with parents and/or guardians of infants and their families to make sure that they understood the importance of well child supervision and to identify any barriers to receiving medical care. This strategy also included locating/identifying new mothers who had not initiated a well-child visit for the newborn. CORWs made sure that the infant had a medical home and that an appointment is scheduled. They maintained contact to ensure appointments were kept and/or rescheduled, if missed. They also assisted the parents in discovering ways of preventing missed appointments in the future. CORWs worked closely with JCDH health centers and other health care providers to assure that clients were enrolled in a timely manner and that they received appropriate services.

Strategy 5: Recruiting male spouses/partners and getting them involved in the pregnancy and parenting of the infant.

This strategy had a two-fold purpose: 1) to identify male spouse/partners of prenatal clients, and 2) to recruit and encourage participation in the pregnancy stage and child rearing of the infant.

Strategy 6: Assist women in completing applications for needed assistance in entitlement programs.

This strategy included identifying women who were eligible for Medicaid coverage and other entitlement programs, but had not completed the application process. CORWs assisted the client in completing the forms as well as obtaining verifiable information needed for the application

Strategy 7: Preventing unintended pregnancies.

This strategy included the prevention of pregnancies that are unwanted by the woman, the prevention of pregnancies in females under the age of 19, increasing pregnancy intervals to two to three years, and the delay of pregnancies in those with medical, social, or behavioral problems until these problems are solved or ameliorated.

Strategy 8: Recruiting women in need of postpartum or family planning services.

This strategy included locating women who had delivered, but had not received postpartum services, and in some cases, had not even scheduled an appointment, and women who have been referred by medical providers because of missed appointments. CORWs assisted the client in scheduling an appointment and provided follow-up to see that the appointment is kept.

They also made contact with women who were in need of family planning services and reinforced family planning messages upon client contact. These messages focused on on-going health promotion strategies highlighting adequate intervals between pregnancies, as well as following up on provider recommended regiment. CORWs worked closely with JCDH health center case managers to assure that clients were enrolled in a timely manner and that they receive appropriate services.

Strategy 9: Assist women in overcoming barriers to obtaining care.

From past experience, clients have identified roadblocks that hinder them from obtaining needed medical and/or social services. These roadblocks include lack of adequate transportation, inadequate or no childcare services, “daily life stressors,” tobacco, alcohol and drug use, and sometimes depression during or around the time of pregnancy. This strategy included assisting clients in obtaining needed supportive services in order to obtain proper medical care and social services for herself and/or the infant.

- ***Outreach and Client Recruitment Activities***

Targeted Outreach Activities: This included door-to-door outreach and community canvassing. Community Outreach Workers (CORWs) identified clients by going door-to-door and canvassing communities in the BHS areas. Priority was placed on areas that continued to have high infant mortality rates and/or poor health outcomes. Identified clients were referred to appropriate service providers. The CORW followed up on the referral to see if the client made it to the appropriate location and received services. ***During this Project Period a total of 340 new perinatal clients were identified.***

New Prenatal List/Referral List: Since 1996, BHS had been able to identify prenatal clients through a computerized printout of clients who had their first prenatal visit in one of the maternity clinics located in a JCDH health centers. We continued to use this process of identifying prenatal clients. Clients from the list were assigned to a CORW. These clients were contacted by way of home visits and/or phone calls at least three times during the pregnancy depending on risk-level and support needed as identified in the initial assessment. CORWs provided emotional support to many of these clients throughout their pregnancy, they were the only support system in some cases. This list provided the staff with the client’s name, address, phone, contact name and number, date-of-birth, estimated due date, community, health center and next appointment date. ***During this Project Period , 4,023 pregnant women were identified from this list. Of that number, 3,657 were contacted at least once and 3,234 actually became program participants, having three or more interactions with BHS staff.***

Out Stationing Activities: CORWs conducted outreach activities in local grocery stores, community centers and other community-based areas. They rotated throughout the JCDH health centers and spent two hours per day, four days per week within specified health centers and worked closely with the clinic Social Workers/Case Managers. ***During this Project Period , a total of 278 new perinatal clients were identified, of which 143 were pregnant woman.***

Home Visits to Perinatal Clients: CORWs made home visits to prenatal and postpartum clients, and to the parents/guardians of infants. They completed home/environmental assessment tools during each home visit, and provided emotional support, as needed, which has proven to be a very valuable service. The CORWs also provided educational information stressing the importance of prenatal and postpartum care and well child supervision.

In addition, while conducting home assessments, CORWs identified clients with possible drug, alcohol and tobacco use. This information was obtained through self-report. The home/environmental assessment tool included culturally appropriate screening questions regarding the prevalence of drugs, alcohol and tobacco use in the home. They also provided

pertinent information regarding the ill effects of these behaviors as it relates to desired health outcomes. Clients with identified problems are referred to appropriate providers. CORWs follow up to assure that clients made it to the designated locations. They worked very closely with service providers and case-managers. ***During this Project Period, a total of 6,877 perinatal clients were visited in their homes by the CORWs. Of that number, 3,657 were pregnant women.***

Appointment Reminder Phone Calls: This activity began in 1997-2001 during the replication phase at which time they made reminder phone calls to all clients with prenatal, postpartum and well-child appointments. However in 2001, JCDH clinics changed it protocol from pre-scheduled appointments to open access/same day appointments, with the exception of maternity clients. For those who had scheduled appointments, CORWs made phone calls to clients and reminded them of the appointment. They checked to see if the client would be able keep the appointment. If the client identified barriers to keeping the appointment such as transportation, the CORW assisted the client in addressing the barrier. When the client insisted that the appointment could not be kept, then the CORW encouraged the client to call and reschedule the appointment. ***During this Project Period, total of 21,786 appointment reminder calls were made to 4,737 perinatal clients. Of those clients that were actually contacted 85% kept their appointments.***

Missed Appointment Follow-up: CORWs were notified by the case manager when a prenatal client missed an appointment and had not rescheduled another one, or had missed others prior to this one. The CORW made contact with the client, obtained another appointment, and monitored to assure that appointment was kept. They provided educational information and reinforced messages about the importance of prenatal care. They notified the provider of the results of this follow-up. ***During this Project Period a total of 673 clients were referred for missed appointment follow up. Of those referred, 606 were actually located and contacted and received rescheduled appointments. The remainder appeared to have been lost to follow up.***

Health Fairs: BHS staff participated in health fairs and other community events hosted in community-based facilities such as local churches and community colleges. This activity allowed staff to reach out to the community at large. ***During this Project Period, a total of 14,450 individuals were reached during this time.***

Translation Services: BHS has on board at least one CORW who spoke both English and Spanish fluently. In addition, all CORWs worked closely with the Language Interpreters in the health centers. ***During this Project Period, a total of 315 clients received translation service and/or other supportive services from BHS staff along or in conjunction with JDCH staff.***

Hospital visits to new mothers before discharge from the hospital: This activity stemmed from the CORWs' belief in their philosophy of practicing love and care. The outreach and tracking procedure in place allowed the CORWs to be reminded to make contact with the prenatal client two weeks prior to the Estimated Date of Delivery (EDD). At that time the CORW made a "special home visit" to the expectant mother to review, in detail, the essentials for a smooth transition from home to the hospital, and from the hospital to home. Problems and/or concerns detected at these visits were reported/referred to the health center Case Managers via the BHS Communication Log. The CORW provided the client with a personal information check off card

listing items needed for hospital admission and discharge. This card also included the CORWs' name and contact number. The CORWs encouraged the client or family member/support person to contact them shortly after delivery, preferably within 12 hours.

The CORW visited the new mother before discharge from the hospital. They provided needed support and checked to see if the mother was prepared for discharge, made sure that the mother had adequate transportation home from the hospital, proper car seat to transport the newborn, and clothing for both the baby and herself. The CORW also made sure that the mother had selected a medical home for the infant as well as a scheduled an appointment for the infant's two-week check-up. The CORW checked to see if the mother completed the proper documentation/applications, i.e., birth certificate with correct spelling of infant's name, and social security card application for the infant. The CORWs reminded the mother that the newborn may not receive WIC services until after the infant's two-week examination and encouraged them to use the formula received from the hospital according to recommendations. They made sure that the postpartum appointment was scheduled. To assure appointments were kept, an incentive package for keeping the newborn's two-week appointment and the mother's post partum appointment was provided at the time of the visit

BHS had considered dropping this activity since clients are being visited by other providers while in the hospital. However, during a client focus group, in which clients were given the opportunity to have actual input in the provision of services, clients insisted that BHS continue this activity. ***A total of 2,563 new mothers were visited before discharged from the hospital during this project period.***

Immunization tracking for up to 2 years of age. CORWs made home visits to parents/guardians of infants up to 2 years of age to make sure that immunizations were up to date. For those who were *delinquent*, appointments were made and follow up was done to assure that the appointments are kept. The CORW stressed the importance of making and keeping well-child appointment visits. ***During this Project Period, a total of 1,115 clients were home visited for monitoring of well child check ups.. Of that number, 216 were delinquent in immunizations and were referred to the appropriate provider***

Describing BHS services to individuals and other agencies that might refer clients, developing a referral system and maintaining contact: BHS staff continued to meet with other medical and social service agencies, and encouraged them to utilize available services through BHS. We informed the providers of the services that were available through BHS and the benefits of using such services. We utilized a referral mechanism that allowed for inter-agency referrals. Once received, referrals were assigned to CORWs within 24 hours. The referrals were logged and monitored for completeness by the Outreach Coordinators. The Coordinators also provided a follow-up report/feedback to the originator of the referral with status update within 72 hours. ***During this project period, a total of 132 clients were referred to us from other agencies.*** Of those referred, ***111*** were actually contacted. The remaining 21 were considered to be "lost to follow-up" due to the difficulty to locate, after several attempts.

Follow-up on delinquent WIC status. Many clients, who were delinquent in their pick-up for WIC vouchers and/or were at risk of losing this service, were referred by JCDH WIC staff to the

CORW. The CORW made contact to help get the client back on schedule. The CORW reinforced messages and provided educational information regarding the importance of proper nutrition during this time. ***During this project period, a total of 532 clients were contacted by the CORW regarding the delinquent status of their WIC.***

Transportation assistance: During this project period, a total of 3,627 gas vouchers and 3,650 bus tokens were provided to clients for transportation assistance for prenatal, well-child and WIC appointments.

Assisting women with obtaining and the completion of applications for eligible entitlement programs: The CORWs assisted women in obtaining the applications for entitlement programs in which they were eligible for services such as SOBRA Medicaid (Medicaid for pregnant women), and Food Stamp Applications and CHIPS (Children Health Insurance Programs)/All-Kids. Not only did they obtain the applications, they also assisted the client in filling it out, as well as obtaining and copying needed proofs. Additionally, the CORW monitored and obtained the status of the application when the client had not received feedback for a period of time. ***During this Project Period, a total of 3,200 women were contacted and were assisted the completion of applications and enrollment for entitlement programs. This included checking on the status, when the client had completed the application but was not aware of the status of the application.*** There is a Medicaid Worker housed in each of the JCDH health centers. There some of the centers, there are two workers. The CORWs checked the status of the application, often through this workers who were able to look them up in the system. They would let the CORWs know when additional information was needed to order for the application to be completed. Afterwards, the CORWs worked with the client to get application completed.

Male Involvement/Enrollment: CORWs encouraged the prenatal client to identify the male partner, and obtained permission to make contact with him. After permission had been obtained, the male partner was contacted and encouraged to become an active participant in the pregnancy by attending prenatal appointments, Prepared Childbirth and Parenting Classes, well-child appointments and male involvement activities. BHS worked closely with other agencies that provided specialized services, such as job referrals, job placement, and GED to link males to support services.

The Male Involvement Specialist, formally a JCDH/BHS Public Health Educator, facilitated the parenting skills classes and co-facilitated the prepared childbirth classes. The presence of this person helped to encourage male partners who were reluctant to participate in the sessions to take an active role. The male partners that attended classes maintained communications with the male involvement program for emotional support, and advice on personal situations that involved their infant, their relationship with their partner, and employment assistance.

The other Male Involvement Specialist conducted targeted outreach in an attempt to identify and recruit potential program participants. He also provided one-one information on the importance of the male figure in the life of his child, and/or other children in the community who may look up to him.

The BHS male involvement program has taken the lead in the development of a network of

services throughout the target area to better serve the needs of the male parents and parents-to-be in this community. Meetings were scheduled by the groups based on the availability of the participants. We believe that the involvement of the father or concerned male figure plays a vital role in the well-being of the child, physically, mentally and emotionally. ***During this Project Period, a total of 1,985 males received services from BHS.***

Educating CORWs/Assessing for domestic violence during home visits: CORWs make home visits to many prenatal clients during any given year. They are entering homes where clients may be experiencing multiple problems ranging from drug and alcohol use to physical, emotional and mental abuse. In some instances, the CORW may find himself/herself walking into a dangerous or potentially dangerous situation. Therefore, it is imperative that CORWs are aware of the signs and symptoms of domestic violence and drug/alcohol use. Training and education regarding this subject helps prepare the CORWs to recognize a potentially dangerous environment and act accordingly, not only for the benefit of the client, but also for the safety of the CORW.

BHS staff has received extensive training on the signs and symptoms of domestic violence through the Young Men Christian Association (YMCA) and Project HELP. During the home visit or any other contact, if the client acknowledges the presence of domestic violence, the CORW will inform her that this is not his/her area of expertise, however, the CORW will provide her with the 1-800 domestic violence number and the number to the Crisis Center. The CORW will also encourage the client to inform her case manager of the situation, as well as provide written documentation of the client's issue to the case manager via the BHS Communication Log. As stated earlier ***during this Project Period, a total of 6,877 perinatal clients were visited in their homes by the CORWs. Of that number, only 180 were identified as having problems of domestic violence in the home.***

- ***Case Management Activities***

Pre-Delivery Encounter: Prenatal clients received a pre-delivery encounter between 30 - 34 weeks gestation by the Care Coordinator. The encounter may be face-to-face or by telephone, depending upon the patient's risk status and service plan. During this project period, 99% of the prenatal clients who were program participants of BHS received pre-delivery encounters. These were all clients who received care at one of the maternity clinics located within one of the JCDH health centers.

Face-to-Face Encounters to High Risk Clients: Case managers are required to have a minimum of two face-to-face encounters with clients that are considered to be high risk due to medical and/or psychosocial conditions. These clients were referred for on-going follow-up/close monitoring by BHS staff, as needed. ***During this project period, 99% of the prenatal clients who were program participants of BHS received pre-delivery encounters.*** These were all clients who received care at one of the JCDH maternity clinics, and all had their social security numbers. ***The remaining 1% either received care elsewhere or had not obtained a social security number prior to delivery.***

- ***Health Education Activities***

Recruitment and Information Dissemination: This activity will occur during the health fairs and community awareness events, which are joint efforts by the Training Coordinator and CORWs to ensure client enrollment and participation in BHS and JCDH services. ***During this project period, BHS staff participated in 68 health fairs, community awareness activities and special events within the project area to increase awareness of services provided by BHS.***

Presentations: BHS provided presentations to and collaborate with community-based organizations and agencies and their participants about infant mortality issues, eliminating health disparities, and the availability of services through BHS/JCDH. The presentations were joint efforts by the Training Coordinator and CORWs to ensure enrollment and participation in the health education classes.

Enrolling Participants into Parenting and Prepared Childbirth Classes and Conducting a series of Parenting and Prepared Childbirth Classes to program participants: The BHS Childbirth Educators (contractual provider) and Male Involvement Specialist provided childbirth, parenting and smoking cessation classes in the project area. These classes were held at the BHS service center, two local high schools, and other community bases organizations as requested by DHR, group homes, local middle and high schools, faith-based institutions and Jefferson County Commission on Economic Opportunity (JCCEO). Students in each class session enroll on a Site Session Registration Form for classes. Health education classes for the hard-to-reach, at-risk out of school dropout youths will be provided at community-based organizations in order to increase attendance of youths most at risk for poor health outcomes. Currently, BHS offers augmented childbirth/parenting education classes at two area high schools' Young Mothers' Programs. The educational sessions included topic such as anatomy, labor and delivery, tools for labor, signs of labor, newborn care, parenting skills, putting the baby on the back to sleep, smoking cessation, avoidance of alcohol consumption and illicit drug use, unsafe sexual practices, HIV and STD prevention and other risk behaviors.

During the provision of health education classes, specifically, childbirth education, family life education, and parenting education, the BHS Contractual provider and Male Involvement Specialists stress the importance of early and continuous prenatal care, the importance of routine, scheduled immunization for infants, smoking cessation, HIV and STD prevention and basic nutrition information. Clients and/or participants are also assisted with making healthy choices regarding risk factors in relation to interconceptional care. Also, one-on-one counseling is provided. In addition to smoking cessation, the Childbirth/Parenting Instructor also discusses the risk associated with alcohol consumption and illicit drug use.

During the reporting period (2001-May 31, 2005), BHS educators provided 246 classes on Prepared Childbirth and Parenting education with 1,943 participants in attendance at the BHS service center and two local high schools (Woodlawn and Ensley High School Young Mother's Programs). The Educators have been able to provide a more personalized service to our most at-risk clients by active coaching and support during the labor process. The educators provided intensive customized parenting classes for the DHR and Family Court referrals. Our Educators have provided one-on-one telephone consultation with expectant and new parents to address the emergent concerns.

The Childbirth Instructor conducted 248 individual one-on-one sessions that involved coaching the pregnant women at various hospitals. Additional parenting education was provided for 572 individuals off-site. A large percentage of participants are low-income women and adolescents from the BHS target area. However, our classes are offered to any pregnant woman in Jefferson County. Because some of the participants are pregnant adolescents from the Woodlawn Young Mothers Program, BHS staff rallied together to donate funds for refreshments in that the young women travel directly from school in order to attend the two hour sessions each week.

BHS, through funds from the CFGF, provided incentives to the pregnant women and also the support person to encourage attendance, participation and completion of the series on Prepared Childbirth and Parenting. The last class of each series is called ‘Graduation’ where we present a Certificate of Completion to those clients and support persons who attend the six (6) classes. The class attendance has grown due in part to word of mouth communication by the class participants. We also attribute growth in the classes to a teen mother who serves as a teen recruiter for BHS, along with her mother, who refer other pregnant women to the classes.

Health promotion and prevention education was further enhanced by the distribution of female condoms during the childbirth/parenting classes on-site at BHS. This activity was the result of a collaborative partnership between BHS/JCDH, the State Department of Public Health and UAB. The condoms, with appropriate lubricant and educational materials were provided, by the State, via a grant with UAB. BHS education staff attended training sessions, while receiving electronic updates by the UAB Division of Infectious Diseases. ***During this project period, 6,250 female condoms were distributed.***

Special Events: Annually, BHS staff sponsored four (4) special events to encourage consumer participation in planning and implementation of community based activities. Such special events included the Breast-feeding Seminar, Postpartum Depression Awareness, Parenting Conference with special emphasis on the Role of Father, Male Family Planning Workshop. BHS staff continues to initiate other activities and special events such as partnering with the Teen Pregnant Prevention Coalition of Alabama (TPPCA) White Ribbon Campaign on adolescent pregnant prevention, youth rallies, and male involvement activities, along with the distribution of brochures, booklets, fliers, and media messages to encourage early entry into prenatal care, access to services, and the availability of services offered by BHS and JCDH. Development of the BHS newsletters was also initiated during the reporting period; however, production and dissemination was delayed due to budget limitations. It is anticipated that we will be able to continue production and dissemination during the fourth quarter of this budget period.

Training: As a comprehensive program that focuses on the many needs of low-income families, BHS is committed to providing a well-rounded agenda of educational activities to improve consumers’ abilities to care for themselves. Education and training occurred in the consumers’ homes or in group settings. Topics for instruction included nutrition, family planning, Sexually Transmitted Diseases (specifically syphilis), HIV/AIDS prevention – Update and Current Trend, smoking cessation, adolescent sexuality and Postpartum Depression Screening, Personal Safety, Customer Service, Domestic Violence: Identifying Signs & Risk Factors, Child Abuse and Neglect, CPR, Health Education Outreach Update, BHS Project Update, How to Deal With Difficult People, Conflict Resolution, Internal Policies, Stress Management, and Time

Management.

The project provided continuing education and training for BHS staff, provider, contractors and administrators so that they may effectively implement program strategies and remain up-to-date in receiving specialized training in the area of risk prevention and risk reduction modalities. We provided 14 staff training sessions/workshops/conferences, annually during the project period.

Male Involvement Activities such as a male conference, family life education specifically for males, BHS male rally, violence prevention education, and parenting education will be provided on an on-going basis. The purpose was to provide health education and health promotion with male issues as the focal point. These activities addressed the particular needs, roles, responsibilities, situations, etc. of males as related to pregnancy, parenting and infant mortality. ***As a result of male involvement activities in the BHS service center, area middle and high schools and other community-based sites, the Male Involvement Specialists successfully to reached 813 males during this Project Period.***

- ***Depression Screening Activities***

The following activities have already been discussed in detail under the section entitled “Outreach Activities.”

- Home Visits to Perinatal Clients
- Training and in-services
- Establishing a Referral Source
- Follow-up on Referrals
- Providing Emotional Support
- Assessing for Barriers to care
- Providing transportation assistance

- ***Interconceptional Care Activities***

The following activities have already been discussed in detail under the section entitled “Outreach Activities.”

- Home Visiting
- Establishing a Referral Source
- Follow-up on Missed Appointments
- Providing Emotional Support
- Assessing for Barriers to care
- Providing transportation assistance
- Reinforcing messages regarding importance of family planning services
- Hospital Visits
- Follow-up for Well-Child Appointments
- Follow-up for Immunizations Compliance

The focus was primarily on women 19 years of age and younger, or those who had a poor pregnancy outcome and/or otherwise considered “at-risk.” These clients were followed

extensively by the BHS Intensive Outreach Home Visiting Team. They were assisted by the BHS Tracking Team who conducted on-going monitoring of clients' compliance with appointments.

V. Project Impact

Based on a review of all of your projects HS grant submissions during the project period, and the services and strategies implemented, describe the impact of Healthy Start on your Project Area and community. Please organize your description using the outline below.

As noted in the Introduction, Birmingham Healthy Start has had a significant impact on the grantee (the Jefferson County Health Department), and on many other agencies in the city, as well as on the residents of the BHS area. This section will provide a description of the impact that BHS has had on our parent organization, the targeted communities and the clients to whom we have served.

A. Systems of Care

BHS has enhanced collaborative interaction between the JCDH and other community organizations involved in promoting maternal and infant health and in providing social support services. The following paragraphs describe how the BHS has enhanced collaborative interaction among community organizations and services involved in promoting maternal and infant health and social support services

1. Approaches utilized to enhance collaboration.

BHS continued linkages both at the state and local levels through the BHS Advisory Board (hereafter known as the BHS Coalition) membership, and other linkages through formal and informal agreements. Members of the Coalition included consumers, representatives of the Alabama Department of Public Health (ADPH), JCDH (grantee), Department of Human Resources (DHR), Black Nurses Association, Enterprise Community, Cooper Green Hospital (CGH), Project HELP, Neighborhood Associations, University of Alabama at Birmingham (UAB) School of Public Health, Birmingham Health Care, Work Force Investment Board, Even Start, Birmingham City Schools, Jefferson County Commission for Economic Opportunity (JCCEO) Head Start, faith-based and other community-based organizations.

Ongoing coordination with the State Title V is evident through membership/participation on the BHS Coalition where Dr. Thomas M. Miller, Alabama State Title V Director, and Dr. Albert Woolbright, Alabama State Health Statistics Division Director, both served. An example of another collaboration is BHS and the UAB School of Nursing with Dr. Ann Turner-Hinson, who provided BHS staff with training on Environmental Risk factors. This was similar to the collaboration with BHS and The Easter Seals of Birmingham, in which BHS staff was trained to conduct interview assessments that provided early detection of developmental delays.

Through a grant from the Community Foundation of Greater Birmingham (CFGB), BHS has been instrumental in filling a gap in the availability of quality health education classes based within the community. BHS provided prepared childbirth and parenting health education classes targeted at expecting moms and fathers and continued with supportive services after delivery.

Due to limited resources and decreases in JCDH funding to support community education, few classes, if any, were available to at-risk families, prior to this grant. BHS also worked closely with DHR to make these classes available to their clients who were mandated by family court to receive parenting education classes. Other collaborations included joint training with other organizations such as Aids Alabama, United Way of Central Alabama, and Alabama Department of Public Health.

BHS maintained on-going communications with the State Title V Director and the Mobile Teen Center for joint planning of statewide activities. These activities were related to issues that impacted the MCH populations served by both projects. The two project directors maintained open lines of communication and sharing of information.

JCDH had an internal MCH Team of which the BHS Project Administrator is a member. Other members included Assistant Directors for Maternity and Family Planning Clinical Services, the Administrator for Case Management Services, the Coordinator of Health Promotion, JCDH Perinatal Epidemiologist Analyst, Coordinator for JCDH WIC services, the Director of Clinical Services and the Director of Public Health Nursing. The MCH team met quarterly and submitted annual reports to the State Bureau of Family and Child Services.

Other MCH programs and activities that BHS partnered with during this Project Period included the Alabama State Perinatal Outreach Division in which the entire BHS staff supported and attended the Annual Perinatal Conference, annually. Staff from BHS were members of and supported the activities of the White Ribbon Teen Pregnancy Prevention Campaign. BHS also worked with the JCDH WIC program to follow-up on missed WIC appointments, and Plan First to track clients for appointment/program compliance.

BHS established partnership with the Oasis Women Counseling Center, who submitted a proposal, which was funded by the Robert Wood Johnson Foundation. This collaboration provided a process for perinatal clients in the targeted area to be screened for perinatal depression and to receive counseling if needed. Oasis served as a referral source for follow-up and provided training to BHS that would enable CORWs to conduct screening.

The overall project contributed to the comprehensive system of care by establishing partnerships with various agencies. Some of the activities were done directly through BHS and others were done through other components of JCDH such as the Community Access Program (CAP) Grant, in which joint eligibility and other shared information was established.

Other programs in the comprehensive system of care that BHS has collaborated/partnered with in terms of financial support and/or provided outreach services included Plan First, Tobacco Prevention Programs, Teen Pregnancy Prevention Program, Alabama Unwed Pregnancy Prevention Program, WIC, Back to Sleep Campaign, Folic Acid Campaign, Child Death Review, and the Fetal and Infant Mortality Review.

BHS collaborated with the State of Alabama, Title V Program in working on such project and/or campaigns as, Shaken Baby Syndrome Campaign, and the Back-To-Sleep Campaign. BHS also collaborated with the State Title V Program, JCDH, local clinics and other MCH

providers and community-based organizations serving our clientele, on various other projects.

BHS staff and the State CHIP Coordinator established a partnership and cooperative working relationship marked by an initiative for outreach activities including the distribution of ALLKIDS applications, as well as BHS' commitment to assist clients/consumers with completing the applications as appropriate. BHS Staff later attended the CHIP satellite training on how to complete the ALLKIDS application.

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

The BHS Project Administrator and the management team reviews policies and procedures to evaluation and compare them to the current practices for service provision in order to determine if changes are needed. This process allows for further opportunities for collaboration and networking within JCDH and external stakeholders. During the reporting period, modifications were made to both JCDH and BHS procedures and policies to enhance and ensure that the necessary infrastructure to further integrate and communicate with vital external stakeholders for quality service delivery. As a result of these changes, BHS established working relationships and collaborations with programs such as WIC, RAPP, Steps Ahead Maternity Care, CAP grant, local health centers, Community Health Promotion.

BHS has also been successful in implementing the process for rectifying such problems as uncoordinated, duplicated and fragmented interactions among providers through our contractual and collaborative agreements with community-based organizations and agencies. One such example is the working relationship with Aletheia House, a residential treatment facility for substance abusing pregnant women. Currently, BHS does not have a contract with Aletheia House (a former contractor); however, they continue to provide outreach services to this high-risk population. Additionally, they also provide the residential treatment to these clients at no cost to BHS.

While Birmingham Health Care for the Homeless (BHCFH) was under contract to provide outreach services to the homeless population, they also provided case management services to the clients at no cost to BHS. Both of these agencies continued to provide these important outreach and case management services to the clients even after the contractual relationships ended. We plan to further intensify our efforts by establishing partnerships with other agencies that serve the same population.

Other factors impacting infant mortality in which BHS staff and contractual providers have received training/in-services and have incorporated into outreach activities include stress management/depression awareness and lead poisoning. On-going staff in-services are conducted by and/or facilitated by BHS' Training Coordinator. Clients are assessed and informed and the risk factors associated with SIDS, stress/depression and lead poisoning during home visits using the encounter/assessment form. Referrals are made to the appropriate agency utilizing the BHS Referral Form.

3. Describe key relationships that have developed as a result of Healthy Start efforts covering

the following areas:

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

BHS reached out to many community-based organizations. We promoted educational efforts in churches in the targeted neighborhoods. We worked with the Jefferson County Committee on Economic Opportunity in relation to employment. During the first 2 years of the project period, we worked with Intercession Ministries, an organization that formerly was known primarily for its anti-gang activities, of which BHS had contracted with in previous years. The organization provided education to assist young men and women to pass the GED examination and counseling in regards to employment. In addition to education and employment counseling, largely for males, Intercession Ministries identified pregnant women and encouraged them to seek prenatal care and worked with males around issues of responsible parenting.

• *Collaboration with Other Organizations*

During the reporting period, BHS' Administrator, Training Coordinator and Male Specialist all served on various Advisory Boards and Steering Committees. This included groups supporting cancer awareness and prevention, male services and United Way's Healthy Families Working Group, which is part of the Jefferson County Covering Kids Initiative. This is a national health access initiative for low-income, uninsured children, funded by the Robert Wood Johnson Foundation. Its purpose is to assure that all children in the State of Alabama are enrolled in some kind of insurance plan. BHS is negotiating on further training for CORWs who can enroll individuals in CHIP, Medicaid, and other entitlement programs. CORWs assisted clients with the completion of entitlement applications, including Medicaid and ALLKIDS after they received proper training.

Because we understood and realize the benefits of early detection of developmental delays, BHS established a partnership with the Director of Children Services at the Easter Seals of Birmingham. This partnership actually started during the Replication phase of Healthy Start and continued through the first two years of this Project period. Easter Seals Foundation conducted a training program for BHS staff via UAB Civitan. Afterwards the CORWs was able to conduct the screenings for infants and children. The CORWs forwarded their findings to the Early Interventionists of Easter Seals of Birmingham. BHS staff and the Director of Children Services conducted ongoing weekly staff meetings to discuss clients identified and screened. BHS continued this worthwhile collaborative effort with the Easter Seals Foundation until they had a change in administration and the funding decreased for assessing the screens provided by CORWs.

BHS continued the established collaborative & cooperative agreements to provide patient tracking services to healthcare providers such as Cooper Green Hospital, Carraway Clinic, University of Alabama at Birmingham (UAB) Obstetrical Complication Clinic (OBCC), Medical Center East and Baptist Medical Center Princeton.

BHS continued to forge cooperative working relationships and partnerships with such community-based organizations including: Jefferson Committee for Economic Opportunity (JCCEO), Birmingham Public School System's Young Mother's Program (YMP), a program designed to keep pregnant teens in school, at Ensley and Woodlawn High Schools, and the Eureka and Even Start Centers, churches, outreach ministries, and community-based childcare providers.

BHS instituted and maintained a collaborative relationship with JCCEO's Early Head Start Program, which resulted in BHS serving as a point of mass distribution of literature and information to consumers on the services available through the Head Start Program. We also established a partnership with a local private hospital, St. Vincent's Hospital via our Advisory Board (Coalition). A staff member with the St. Vincent Hospital's Maternal-Child Division served on the Coalition prior to her becoming ill.

We began the process for collaboration with youth-servicing community-based organizations to develop more youth-focused activities such as pregnancy prevention, gang involvement prevention and HIV/AIDS/STD prevention strategies. We started to network/collaborate with such agencies as the City of Birmingham's Youth Division Program, and local media, including KISS/JAMZ radio stations.

The City of Birmingham has ninety-nine neighborhood associations with individual presidents. Many of those neighborhood association presidents were involved in the BHS, through participation on the Coalition and community events. They also helped with dissemination of information on BHS to those communities. The mayor's office of the City of Birmingham has a representative who serves on the BHS Coalition Board.

BHS garnered further support by establishing a partnership with the Alpha Sigma Zeta Chapter of Zeta Phi Beta Sorority, Inc. Stork's Nest Program. The purpose of the Stork's Nest was to provide to pregnant mothers needed items for the care of their infants. The Stork's Nest served not only as a referral source, but also as a sponsor of an incentive package for those pregnant women who completed a six-class series of Prepared Childbirth and Parenting Classes. Because of the lack of available funds to fully implement these services, this partnership served as the venture to fill this gap in service delivery support services.

There continue to be limited resources and treatment services available through referral for the BHS clientele diagnosed with perinatal depression. The perinatal depression screening services were conducted for Birmingham Healthy Start participants through a collaboration/partnership funded partly by a grant from the Robert Wood Johnson Foundation to the Oasis Women's Counseling Center. Other partners with Oasis included, University of Alabama at Birmingham, Jefferson County Department of Health and Cooper Green Hospital. Other treatment service providers include the University of Alabama at Birmingham (UAB), the Amelia Center, Grace Clinic, Jefferson-Blount, St. Clair (JBS) Mental Health Authority, and the Sparks Center.

The BHS Staff attended the initial half-day training on postpartum depression and use of the Edinburgh Postnatal Depression Scale Depression on Thursday, November 6, 2003.

Subsequent training seminars were conducted on February 6, 2004, June 25, 2004, August 20, 2004, October 29, 2004, November 22, 2004, and April 29, 2005. The training sessions were provided and conducted by the Oasis Women's Counseling Center as part of the partnership BHS established to provide depression screening services to the clients/participants of the Healthy Start Program. The training was conducted by Kathy Kane, Project Director, for the WholeHealth Initiative - Oasis Women's Counseling Center and other Oasis staff members. The agenda included a discussion of signs and symptoms of postnatal depression, identification of risk factors, common indicators, becoming familiar with treatment options, and the screening and referral process.

After a positive screen for depression, the Oasis Women's Counseling Center's WholeHealth Program provides further clinical assessment and diagnosis. Additionally, other service providers and resources are available to meet the mental health needs of the clients that we serve. BHS tracks the status and outcome of referrals made to the mental health providers via monthly reports from Oasis Women's Counseling Center (WholeHealth Project) and weekly case review/meetings between the BHS Education/Training Coordinator and the Oasis WholeHealth Project Coordinator. The Education/Training Coordinator and the WholeHealth Coordinator are in constant and continuous contact via telephone, e-mail and face-to-face discussions for reports and updates of clients' scheduled appointments, missed appointments rescheduling of appointments and discussions on possible barriers.

The BHS CORWs conduct the screening tool with participants during the prenatal period ideally once per trimester and during their six-week postpartum period. Additional/subsequent screenings for women in the BHS service are conducted as needed depending on the woman's previous screening score or as indicated by on going case management. Tracking the status and outcome of referrals is coordinated by the Education/Training Coordinator, assisted by the CORWs and through communication with the WholeHealth staff at Oasis.

- b. *Relationships that focus on involvement of consumers and/or community leaders (who are not employed by a health or social service agency) with any of the agencies/organizations listed above or any additional agencies.*

BHS established and maintained key relationships with community leaders and consumers as well as other stakeholders with an increase in the goals and objectives of the project. Such relationships included partnerships with Project HELP where we were able to have our outreach staff conducted on-going sessions on such topics as "Male Responsibility" for the adolescent male and female workers. Our male involvement outreach staff also provided on-site sessions with Project HELP's summer interns and 21st Century youth. This partnership began in June 2002 and continues today. Another community leader made a sizeable donation to BHS to be used as incentives for Prepared Childbirth and Parenting Classes. The donated funds were used to purchase essential items for the consumers and their babies. This activity took place in December 2002.

To ensure that each Advisory member has the ability to provide responsible advice regarding the needs and problems that exist in the community and to suggest or recommend strategies

for implementation we provide a board orientation to Advisory Board members at the beginning of the project year. Consumers were also be provided additional training regarding board service, Roberts Rules of Order, developing By-Laws, an overview of the grant, and issues regarding Infant Mortality risks and prevention strategies. Consumers will also develop leadership skills through Advisory Board/Consortium participation. They focused on developing skills to become “spokespersons” on the issue of Infant Mortality, for themselves and peers as well. The goal was for them to become “true advocates” of health care promotion. During consumer focus group sessions held in Phase II, a need assessment identified the following topics that they would like specific training. As a result, the following training topics were proposed and provided this project reporting period:

- Empowerment and Self-Esteem Building
- Cultural Competency
- Job Readiness (How to Build a Job Bank)
- Entitlement Programs (New Changes, New Process)
- Stress Management
- How to deal with long waiting times in the clinic
- Taking Care of Me: Tips to help a new Mom find time for “pampering” herself
- Sexually Transmitted Diseases
- HIV/AIDS and Women
- Housing (Home Ownership)

BHS has also continued to provide consumers with empowerment training and social skills and assertiveness training. This process was initiated during the annual 3rd Baby Reunion Celebration, with the keynote address focusing on empowerment and self-sufficiency. Also, we conducted a male involvement focus group/needs assessment session during the Celebration as a venue to motivate male participation in the efforts to reduce infant mortality in the project area and to encourage the male partner to become a more active participant in encouraging a healthier pregnancy outcome.

Additionally, a very active consumer, RayShon Murdock-Williams, attended the National Healthy Start Association Annual Conference in 2004. She actively participated in discussion groups and was able to bring vital information back to the Coalition to share with other consumers and the Coalition body as a whole. She submitted a proposal to the Project Administrator that outlined strategies to involve more consumers in order to have them be empowered to be more actively involved in program activities, as well as goal(s) and objective(s) attainment.

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

BHS has not changed the eligibility or intake requirements of agencies operating in the area, but it has made it much easier for consumers to determine their eligibility and make use of services for which they are eligible. For example, CORWs have received training from agency staff in how to complete application forms for food stamps, Medicaid, birth

certificates, social security cards and payments, and housing assistance. This training has enabled the workers to assist their clients. In addition, applications for Medicaid had been facilitated by out stationing a Medicaid Worker at two of the BHS centers. As a result, of these services not only are applications processed faster, but clients do not need to go to multiple sites to obtain the information that they need, an approach to one-stop shopping.

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

For years clients in the project area experienced many barriers to the use of the service provided by JCDH and other agencies. These included problems with transportation, inappropriate clinic times or places, child care problems, forgetting appointments, perceptions of unfriendliness of staff, ignorance of the availability of services, and long waiting periods in the facilities. Prior to the implementation of BHS, attempts were made to address some of these problems. BHS has attempted to enhance the efforts of addressing these problems through our unique approaches and activities. Although BHS has had a significant impact on most these barriers, we have not been able to completely resolve all. Following is brief discussions of the barriers identified and BHS' efforts to resolve them.

- *Transportation*

For those women who stated they were unable to keep their appointments, BHS issued gasoline vouchers and bus tokens to them in order for them to bring themselves or their children for services to one of the JCDH Health Centers or to other health or social service agencies.

- *Forgetting Appointments*

Several prenatal clients identified "forgetting their appointments" as a barrier to care. While most other appointments. The CORWs received lists of scheduled appointments from the JCDH Health Centers. They contacted the clients and make certain that they remember their appointments. Often they help resolve a problem with transportation or child care so that the client is able to attend. The CORWs also receive lists of "missed" appointments. Women who miss an appointment for prenatal or postpartum care, or for family planning or well child services often are too busy to remember to schedule a new appointment. The CORWs contacted these women, help resolve the problems that may have caused them to miss appointments, assisted with rescheduling, and followed up to assure that the appointment was kept.

- *Staff Unfriendliness*

This problem has been addressed in relationship to the family planning clinics that operate during evening hours and on weekends in two of the Health Centers. CORWs have been stationed at those Health Centers to serve as Clinic Ambassadors during these evening and weekend sessions. The CORWs greet clients, keep them company while they wait to be seen, assist them as needed, and encourage them to complete a Customer Service Survey card. Apparently, this has not only made the visit more pleasant, but has also led to the perception

the waiting period is shorter. Comments on Customer Service Survey cards also suggest greater consumer satisfaction. As a result, two Health Center administrators have reported an increase in family planning clinic show-rates, 12% at one Center and 14% at another, while the rate is decreasing at the other JCDH family planning clinics.

- *Unawareness of Availability of Services*

BHS has made consumers aware of many services whose availability had been previously unknown or which had previously not been available. Newsletters, health fairs, radio announcements, and, perhaps most important, talks with CORWs and Health Educators, Resource Mothers, workers from Intercession Ministries and Birmingham Health Care for the Homeless have informed clients of eligibility for WIC, Medicaid, SSI, and other benefit programs. They have also learned about child care and transportation opportunities and about special family planning clinics. Clients have also been urged to seek assistance from the state Department of Human Resources and from Intercession Ministries.

- *Long Waiting Period at Facilities*

BHS has been unable to help the Health Centers overcome this barrier, but it has increased awareness of this problem among Health Center administrators, who are now working on the problem.

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

BHS has been able to improve the coordination of care offered to clients through several mechanisms. This process is described in the following paragraphs.

- *Network with Community Outreach Workers*

BHS CORW worked closely with the case managers, rotating through JCDH Health Centers that served BHS neighborhoods. The CORWs followed up on missed appointments and thus improved continuity of care. Clinicians also discussed with the CORWs specific instructions that they would have given clients and ask the CORWs to determined whether the clients understood the instructions and to follow up to ensure that the instructions were followed.

- *Infant Mortality Review*

The process actually began during the demonstration phase of Healthy Start and was enhanced to include more partners. The Infant Mortality Review process was under the direction of the same JCDH staff member who is responsible for the health department's quality assurance program. She developed the system whereby JCDH nurses and social workers attend the meetings of the Infant Mortality Review's Technical Review Team and learn about women who have experienced a recent death. Many of them would not have been followed up by the appropriate clinic or have refused additional services. The Technical Review Team assigned one of the JCDH clinical staff to follow-up and to report at the next meeting about progress.

This mechanism brought several high-risk, high-need women into care who previously had not received it. It improved the quality of their care. This process was continued until the retirement of the individual overseeing the process. By the end of the project period, BHS was in the process of revisiting how this activity could be revamped and carried out.

- a. Efficiency of agency records systems and sharing of data across providers (within the confines of confidentiality rules) to reduce the need for repetition.

For many years, the JCDH has maintained an extensive, computerized Management Information System (MIS). The MIS, however, was primarily used to track appointments, immunizations, and other essential services and for billing purposes. It was linked to the Obstetrical Automated Medical Record System maintained by the JCDH and the University of Alabama at Birmingham's Department of Obstetrics and Gynecology. It was not linked to the JCDH's vital record system (births and deaths). BHS staff developed an Encounter Form, which went through several revisions. MIS entered the material from the forms into its computerized system.

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

- a. Provider responsibility in maintaining client participation in the system and provider sensitivity to cultural, linguistic and gender (especially male) needs of the community;

The Education/Training Coordinator developed a plan of action that included working with the Spanish speaking CORWs to encourage more participation by Hispanic consumers in the consortium. During the project period, BHS hired (2) Hispanic consumers who also served on the consortium. The Education/Training Coordinator, JCDH's interpreter and BHS' bilingual CORW conducted an in-service for staff and selected consumers on March 24, 2000. The topic of the training was "Cultural Competency."

BHS continued to address the issue of cultural differences. BHS made further gains in our efforts to reach and enhance access for non-English speaking clients. Advancement toward accomplishment of this strategy included training/in-service activities for the BHS staff during regularly scheduled staff meetings. The Education/Training Coordinator coordinates mini-courses that are provided by BHS' Hispanic CORW on such simple phrases that most CORWs encounter during interaction with their non-English speaking clients.

We addressed the challenge faced by existing staff in working with Hispanic consumers/clients through the hiring of the bi-lingual CORWs. During service delivery activities in the BHS project area that is most populated by Hispanic clients, BHS' Hispanic CORW provided translation services at one of the JCDH health centers, local hospitals and Family Court. Additional translation services for clients in the BHS project areas are provided by other JCDH translators as available. Also, JCDH now offers Spanish classes for interested providers at the health centers. The BHS Education/Training Coordinator continues to work with the translator at JCDH to translate printed materials specific to BHS. This process began in October 1999. We continued to make this activity an integral part of service delivery.

During this project period, members of the Coalition met and discussed the application, evaluated and approved each objective. The members also made recommendations as to the staffing pattern and contractual providers. As we strive to continue to increase consumer and community participation on the Coalition, BHS implemented training activities such as Board development, team building, strategic planning, cultural competence and infant mortality (risk factors).

- *Male Involvement*

During the past project period, BHS Male Involvement Component has conducted several activities. Initially the program planned to make contact for the First Fathers Club through the use of contact information gathered by the CORWs during their interaction with their female clients. This method has proven to have several different barriers. From 123 contact cards, 16 successful contacts have been made. There have been problems with incomplete contact information, incorrect phone numbers, non-response to messages, and unavailability of the person being called.

The Male Involvement Component has formed a 12 member advisory committee from community focus groups of concerned males. Representatives from the BHS Male Involvement Component have participated in activities with other community agencies. Presentations and group activities have included topics on male responsibility, family involvement, community involvement, pregnancy prevention, good health habits, goal setting, and disease prevention. These activities have outreached and provided services to approximately 750 adolescent males and 470 adult males during the reporting period.

The BHS Male Involvement Component has collaborated with the following agencies in a variety of activities such as Father-Child Breakfast, Male Health Fair:

- Jefferson County Department of Human Resources
- Birmingham Division of Youth Services
- Birmingham City Schools
- Jefferson County Schools
- United Way of Central Alabama
- Children's Aid Society
- Project Dads
- Proud Papas

In the past, BHS' CORWs were comprised of African Americans, with one Hispanic. BHS hired four additional male CORWs as we continued to encourage the involvement of the male partner in the lives of the mother and infant.

- 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.

We had limited activities that incorporated consumer participation in developing assessment tools. However, consumers participated in focus group sessions during the planning phase of the integration of depression screening and counseling as a specific service. The focus group session assessed the participating consumers' input into the design of the poster for publicity and the type of education information useful for disseminating to the consumer population. The consumers also provided vital information regarding the need for a support group for those consumers that screened positive for depression. The CORWs also administered questionnaires to the consumers during home visits in order to gain helpful and useful information on the topics for discussion, meeting times and locations for the support group sessions. Additionally, our CORW staff includes over 4 workers who were once clients and they are involved routinely with review of forms, tools and processes as we conducted routine quality assurance reviews.

B. Impact to the Community

1. Impact on Residents' knowledge of service availability

BHS conducted a number of activities that developed and empowered the community in relations to knowledge of resources and available services, including locations and how the services and resources are accessed. These activities included health fairs, Radio public service announcements (PSA's), Remotes, Interviews, Newspaper articles, church bulletins, word of mouth, community awareness events, distribution of fliers and handouts, one-on-one visits and communications, telephone visits, homes visits, hospital visits and community collaborations in hosting events and sites for disseminating information.

2. Consumer participation in changing standards and/or policies

Consumers have been actively involved in changing policies of participating service providers and BHS since the inception of this project. BHS was instrumental in providing the forum for consumer voices to be heard. Consumers identified the need for after-hour clinics during focus groups and surveys. We were able to partner with the JCDH to provide 3 days of after hour clinics at 3 locations. However, with the decrease in funding over the project period and despite the increasing show rate of clients during after-hour clinics we were unable to maintain the clinic support thereby closing. These clinics were a direct result of client input in identifying an unmet need.

Consumers were very vocal about their need for educational services despite the fact that both JCDH and BHS experienced decreases in funding for education. As a result of decreased funding from the Maternal Child Health Bureau, National Healthy Start, BHS no longer received funds for any health education activities. In an effort to meet the enormous void that resulted from this lack of funding source, the need for health education services for low-income clients, the numerous telephone calls and visits by clients, BHS submitted a proposal to the Community Foundation of Greater Birmingham (CFGB) to fund childbirth and parenting classes and received funding of \$25,000 a year for three years.

BHS was able to provide Prepared Childbirth and Parenting Classes, funded in part by CFGB

despite the decrease in funding. Since March 1999, BHS hired, on a part-time basis, a Childbirth Educator/Trainer who is a Registered Nurse, certified by ICEA in childbirth education and is one of only two certified Doula in Jefferson County. The certified RN provided the childbirth education while the parenting skills education was provided by the BHS' part-time Male Outreach Specialist (CORW) who is also a former Health Educator for BHS/JCDH. Classes were further enhanced by the on-going partnership with a local high school to provide childbirth education and parenting skills for consumers in the project area. As a result, five consumers that attended these sessions joined the Advisory Board. BHS was also able to recruit more male partners and participants in not only the classes, but the Advisory Board as well.

Each series of classes consisted of six consecutive sessions. The pregnant women that attended were encouraged to bring spouses/partners and/or a support person to the classes. BHS received a tremendous amount of gratitude and appreciation from clients and family members/support persons, many who would not otherwise be afforded an opportunity to attend the Prepared Childbirth and Parenting classes. BHS is one of very few agencies in the city that provided these services free to the consumer.

During the reporting period (2001-May 31, 2005), BHS educators have provided 246 classes on Prepared Childbirth and Parenting education with 1943 participants in attendance at the BHS service center and two local high schools (Woodlawn and Ensley High School Young Mother's Programs). The Educators have been able to provide a more personalized service to our most at-risk clients by active coaching and support during the labor process. The educators provided intensive customized parenting classes for the DHR and Family Court referrals. Our Educators have provided one-on-one telephone consultation with expectant and new parents to address the emergent concerns.

The Childbirth Instructor conducted 248 individual one-on-one sessions that involved coaching the pregnant women at various hospitals. Additional parenting education was provided for 572 individuals off-site. A large percentage of participants are low-income women and adolescents from the BHS target area. However, our classes are offered to any pregnant woman in Jefferson County. Because some of the participants are pregnant adolescents from the Woodlawn Young Mothers Program, BHS staff rallied together to donate funds for refreshments in that the young women travel directly from school in order to attend the two hour sessions each week.

BHS, through funds from the CFGB, provided incentives to the pregnant women and also the support person to encourage attendance, participation and completion of the series on Prepared Childbirth and Parenting. The last class of each series is called "Graduation" where we present a Certificate of Completion to those clients and support persons who attend the six (6) classes. The class attendance has grown due in part to word of mouth communication by the class participants. We also attribute growth in the classes to a teen mother who serves as a teen recruiter for BHS, along with her mother, who refer other pregnant women to the classes.

These are just a few examples of how consumer input can enhance opportunities to meet their identified needs despite challenges in decreased funding for both BHS and JCDH.

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

During the initial years of the Demonstration Phase, BHS had to work hard to triumph beyond the history between the old dissonant community consortium including blame and distrust of the Grantee, JCDH. This was a tremendous hurdle. BHS learned to develop strategies to encourage internal JCDH stakeholder support in an effort to enhance team building. The years of crisis intervention training, team building workshops, resulted in BHS staff and Coalition member being well prepared, trained and experienced in working with divergent opinions, resolving conflicts and how to build working teams.

BHS stayed focused on the mission to impact infant mortality and eliminate disparities in health care by working to build partnerships within JCDH and with external stakeholders. We worked to build community stakeholder participation and true consumer input and knowledge of maternal and child health issues. Encouraging community residents and consumers by providing information on how they could impact their own futures to have health infants and a healthier community was a routine task.

4. Creation of jobs within the community.

The BHS program has maintained a process of hiring, training and retaining community outreach workers reflective of the communities and residents from the communities that we serve. In addition, the contractual staff during this reporting period, were members of the community reflective of the communities served, primarily African-American and Hispanic. Thus, limited creation of jobs resulted from the project's hiring process.

Due to the reduction in funding over time and the limited new funding received, limited resources were available to invest in job creation.

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 (DHSPS) 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(s), your state Medicaid and SCHIP programs, your State Early Intervention Program and other state programs. Highlight any benefits and lessons learned from these relationships.

BHS continued to work collaboratively with the State of Alabama Title V Program on other projects/campaigns such as the Shaken Baby Syndrome Campaign, the Back-To-Sleep Campaign, and the Folic Acid Campaign. Additionally, BHS collaborated with JCDH, local clinics and other MCH providers and community-based organizations serving our clientele.

BHS established further collaboration with the State Title V Perinatal System and local perinatal

system via the payment for one nurse to provide program planning for the Infant Mortality Review Process in the local target area.

BHS staff and the State CHIP Coordinator established a partnership and cooperative working relationship marked by an initiative for outreach activities including the distribution of ALLKIDS applications, as well as BHS' commitment to assist clients/consumers with completing the applications as appropriate. BHS Staff later attended the CHIP satellite training on how to complete the ALLKIDS application. BHS continues to collaborate with the State of Alabama, Title V Program, Shaken Baby Syndrome Campaign and the Back-To-Sleep Campaign. BHS collaborated with the State Title V Program, JCDH, local clinics and other MCH providers and community-based organizations serving our clientele.

BHS established and maintained close linkages with state and local agencies targeting the Medicaid eligible. Families with children 0-18 years of age eligible for SCHIP and other entitlement programs were also targeted. BHS continued to co-locate Community Outreach Workers (CORWs) at Central, Chris McNair, Eastern, Northern, and Western Health Centers where clients were assisted with BHS' "Personal Touch" supportive services that included assistance in completing entitlement program applications such as SCHIP, Medicaid, housing, and Head Start, along with other services while consumers waited for appointments within the health centers. BHS participated in joint health fairs and community awareness events with other agencies where BHS staff distributed information/applications for State Child Health Insurance Program/ALL Kids and assisted community residents with completion of applications, as needed.

D. Local Government Role

The activities/relationships at the state and local level that facilitate project development are discussed in Section V. Project Impact A. Systems of Care (Collaboration), and also is further discussed in C. Impact on the State.

The Project Administration, Rick Green, and a consultant to the project, Dr. Kimberly Leslie-Patton, both serve on newly developed Health Action Plan Committee, with the JCDH.

E. Lessons Learned

Throughout each section of this report, BHS noted lessons learned beginning with the Introduction. In addition to the lessons learned in previous sections of this paper, BHS also notes the following:

- Services and any printed materials need to be culturally and linguistically appropriate for the targeted audience.
- Representatives from the targeted audience should be involved in the planning and decision making phases.
- Health education is important as part of the process and strategy for behavior modification in health related issues.

The following pages display the suggested format for the Final Report/Implementation Plan. Objectives, strategies and activities are described in detail in the previous sections.

Final Report/Implementation Plan

Grantee: Birmingham Healthy Start (BHS)

Intervention: Outreach, Tracking & Client Recruitment and Case Management

Project Period Objective	Strategies and Activities	Accomplishments
<p><i>By 05/31/05:</i></p> <p><i>OR/CM #1: increase % of adequate prenatal care to at least 78.0%.</i></p> <p><i>OR/CM #2: increase % prenatal care in the first trimester to at least 80.0%.</i></p> <p><i>OR/CM #3: decrease % of women receiving no prenatal care to 1.4%.</i></p> <p><i>OR/CM #4: decrease % preterm births to 10.0%.</i></p> <p><i>OR/CM #5: decrease the percentage of LBW to more than 10.0%</i></p> <p><i>OR/CM #6: decrease % VLBW to no more than 2.0 %</i></p> <p><i>OR/CM #7: increase % infants receiving appropriate healthcare services to at least 72.0%.</i></p> <p><i>OR/CM #8: increase % of 2 year olds full schedule of age-appropriate immunizations to at least 80.0%</i></p>	<ul style="list-style-type: none"> • <i>Outreach and Case Management Strategies</i> <p><i>Strategy 1: Recruiting and maintaining pregnant women in prenatal care.</i></p> <p><i>Strategy 2: Assisting pregnant women in complying with the recommendations of the provider(s) of prenatal care.</i></p> <p><i>Strategy 3: Assisting mothers/guardians of infants in initiating and maintaining well-child Supervision.</i></p> <p><i>Strategy 4: Assist women in complying with recommendations of providers of well child Supervision.</i></p> <p><i>Strategy 5: Recruiting male spouses/partners and getting them involved in the pregnancy and parenting of the infant.</i></p> <p><i>Strategy 6: Assist women in completing applications for needed assistance in entitlement programs.</i></p> <p><i>Strategy 7: Preventing unintended pregnancies.</i></p> <p><i>Strategy 8: Recruiting women in need of postpartum or family planning services.</i></p> <p><i>Strategy 9: Assist women in overcoming barriers to obtaining care.</i></p>	<p><i>Goal Nearly Met</i></p> <p><i>Goal Exceeded</i></p> <p><i>Goal Met</i></p> <p><i>Goal Not Met</i></p> <p><i>Goal Nearly Met</i></p> <p><i>Goal Nearly Met</i></p> <p><i>Unable to obtain data</i></p> <p><i>Goal Nearly Met</i></p>

Final Report/Implementation Plan

Grantee: Birmingham Healthy Start (BHS)

Intervention: Outreach, Tracking & Client Recruitment and Case Management

Project Period Objective	Strategies and Activities	Accomplishments
<p>By 05/31/05:</p> <p><i>OR/CM #9: increase # of male partners actively involved in the pregnancy of the woman to 500 annually</i></p> <p><i>OR/CM #10: at least 85% of the pregnant women will have completed a Medicaid application.</i></p> <p><i>OR/CM #11: decrease the proportion of births to teens from 22.14 (1999) to 19.5.</i></p> <p><i>OR/CM #12: increase % of women receiving appropriate family planning service to at least 15.5%.</i></p> <p><i>OR/CM #13: increase % of pregnant women by self-report abstain from alcohol use to 99.8%</i></p> <p><i>OR/CM #14: increase % of pregnant women who by self-report abstain from drug use to 99.5%.</i></p> <p><i>OR/CM #15: increase % of pregnant women who by self-report abstain from tobacco use to 96.0%.</i></p>	<p>Outreach and Case Management Activities</p> <ul style="list-style-type: none"> • <i>Targeted Outreach</i> <u>340</u> new perinatal clients identified • <i>New Prenatal/Referral List</i> <u>4,023</u> pregnant women identified <u>3,657</u> contacted at least once <u>3,234</u> became program participants w/≥3 contacts • <i>Out Stationing Activities</i> <u>278</u> new prenatal clients identified <u>143</u> were pregnant women • <i>Home Visits to Perinatal Clients</i> <u>6,877</u> perinatal clients visited in their homes by CORWs <u>3,657</u> were pregnant women • <i>Appointment Reminder Phone Calls</i> <u>21,786</u> reminder ph calls made to <u>4,737</u> perinatal clients <u>85%</u> of the clients contacted actually kept their appts • <i>Missed Appointment Follow-up</i> <u>673</u> clients were referred for missed appointment f/u-up <u>606</u> clients located, contacted, received rescheduled appt <u>67</u> clients were lost to follow-up • <i>Health Fairs</i> <u>14,450</u> individuals reached through community events • <i>Translation Services</i> <u>315</u> clients received translation services • <i>Hospital Visits to new mothers before discharge</i> <u>2,563</u> new mothers were visited before discharge • <i>Immunization Tracking for up to 2 years of age</i> <u>1,115</u> clients were home visited <u>216</u> clients were delinquent/referred appropriately • <i>Describing BHS services to individuals & other agencies who might refer/establishing referral system</i> <u>132</u> clients were referred to us from other agencies <u>111</u> clients were actually contacted • <i>Follow-up on delinquent WIC status</i> <u>532</u> clients were contacted re delinquent WIC status • <i>Transportation Assistance</i> <u>3,627</u> gas vouchers were issued to clients for transp. <u>3,650</u> bus tokens were issued to clients for transp. • <i>Assisting women with completion of entitlement appl.</i> <u>3,200</u> assisted with completion of entitlement appl. • <i>Male Involvement/Enrollment</i> <u>1,985</u> males received services from BHS • <i>Assessing for Domestic Violence/Educating CORWs</i> <u>6,877</u> perinatal clients assessed <u>180</u> identified as having a problem • <i>Pre-Delivery Encounter with Case Manager</i> <u>99%</u> received pre-delivery encounters w/CM • <i>Face-to-Face Encounter to High Risk Clients</i> <u>99%</u> received face-to-face encounter w/CM 	<p><i>Goal Exceeded</i></p> <p><i>Goal Exceeded</i></p> <p><i>Goal Nearly Met</i></p> <p><i>Unable to obtain data</i></p> <p><i>Goal Met</i></p> <p><i>Goal Met</i></p> <p><i>Goal Nearly Met</i></p>

Final Report/Implementation Plan

Grantee: Birmingham Healthy Start (BHS)
Intervention: Health Education

Project Period Objective	Strategies and Activities	Accomplishments
<p><i>By 05/31/05,</i></p> <p><i>HE #1: BHS staff participate in 16 health fairs/community awareness events reaching 4810 community residents</i></p> <p><i>HE #2: staff provided 13 presentations to CB0s/agencies about eliminating health disparities and BHS services</i></p> <p><i>HE #3: HE staff conducted 42 childbirth/parenting classes with 210 participants</i></p> <p><i>HE #4: HE staff will increase the # of clients who serve on the Teen Advisory Board to 16.</i></p> <p><i>HE #5: BHS Male Involvement reached 510 male participants during activities..</i></p> <p><i>HE #6: HE staff will produced and distributed quarterly newsletters and BHS Fact Sheets 1,800 individuals</i></p>	<p><i>Strategy #2: Assisting pregnant women in complying with the recommendations of the provider(s) of prenatal care.</i></p> <p><i>Strategy #5: Recruiting male spouses/partners and getting them involved in the pregnancy and parenting of the infant.</i></p> <ul style="list-style-type: none"> • <i>Health Education Activities</i> • <i><u>Recruitment and Information Dissemination: 1,800 fact sheets distributed</u></i> • <i><u>Health Fairs</u></i> <i>16 health fairs reaching 4,810 community residents</i> • <i><u>Presentations:</u></i> <i>13 presentations</i> • <i><u>Enrolling Participants into Parenting and Prepared Childbirth Classes and</u></i> <i>246 classes on Prepared Childbirth and Parenting education</i> <i>1,943 participants in YMP @ two local high schools</i> • <i><u>Conducting a series of Parenting and Prepared Childbirth Classes</u></i> <i>248 individual received complete one-on-one sessions of class instruction</i> <i>572 individuals received complete sessions of class instruction off-site</i> • <i>Distribution of Female Condoms</i> <i>6,250 female condoms were distributed during these classes</i> • <i><u>Male Involvement Activities</u></i> <i>813 males during BHS male involvement activities</i> 	<p><i>Goal Exceeded</i></p> <p><i>Goal Met</i></p> <p><i>Goal Exceeded</i></p> <p><i>Goal Not Completed</i></p> <p><i>Goal Exceeded</i></p> <p><i>Goal Exceeded</i></p>

Final Report/Implementation Plan

Grantee: Birmingham Healthy Start (BHS)

Intervention: Depression Screening & Referral and Interconceptional Care

Project Period Objective	Strategies and Activities	Accomplishments
<p><i>PD #1: By 05/31/05 2005, the BHS staff would have identified maintained on-going relationship with its partners.</i></p>	<p><i>The Strategies for the Depression Screening and Interconceptional Care Interventions are pretty much the same as Outreach and have already been discussed in detail under the section entitled "Outreach/Case Management Activities."</i></p>	<p><i>Goal Met</i></p>
<p><i>PD #2: By May 31, 2005, BHS staff will have begun the use of the screening tool.</i></p>	<p><i>The Activities for the Depression Screening and Interconceptional Care Interventions are pretty much the same as Outreach and have already been discussed in detail under the section entitled "Outreach/Case Management Activities."</i></p>	<p><i>Goal Met</i></p>
<p><i>PD #3: By May 31, 2005, all BHS staff will have received training on the signs and symptoms of perinatal depression.</i></p>	<ul style="list-style-type: none"> • <i>Depression Screening Activities</i> <ul style="list-style-type: none"> ➤ <i>Home Visits to Perinatal Clients</i> ➤ <i>Training and in-services</i> ➤ <i>Establishing a Referral Source</i> ➤ <i>Follow-up on Referrals</i> ➤ <i>Providing Emotional Support</i> ➤ <i>Assessing for Barriers to care</i> ➤ <i>Providing transportation assistance</i> 	<p><i>Goal Met</i></p>
<p><i>PD #4: By May 31, BHS staff would have begun to screen at least 250 clients for perinatal depression, with an increase of 50 annually.</i></p>	<ul style="list-style-type: none"> • <i>Interconceptional Care Activities</i> <ul style="list-style-type: none"> ➤ <i>Home Visiting</i> ➤ <i>Establishing a Referral Source</i> ➤ <i>Follow-up on Missed Appointments</i> ➤ <i>Providing Emotional Support</i> ➤ <i>Assessing for Barriers to care</i> ➤ <i>Providing transportation assistance</i> ➤ <i>Reinforcing messages regarding importance of family planning services</i> ➤ <i>Hospital Visits</i> ➤ <i>Follow-up for Well-Child Appointments</i> ➤ <i>Follow-up for Immunizations</i> <p><i>Compliance</i></p>	<p><i>Goal Met</i></p>
<p><i>IC #1: By 5/31/05, BHS would have identified a process for follow-up to interconceptional care clients.</i></p>	<ul style="list-style-type: none"> • <i>Interconceptional Care Activities</i> <ul style="list-style-type: none"> ➤ <i>Home Visiting</i> ➤ <i>Establishing a Referral Source</i> ➤ <i>Follow-up on Missed Appointments</i> ➤ <i>Providing Emotional Support</i> ➤ <i>Assessing for Barriers to care</i> ➤ <i>Providing transportation assistance</i> ➤ <i>Reinforcing messages regarding importance of family planning services</i> ➤ <i>Hospital Visits</i> ➤ <i>Follow-up for Well-Child Appointments</i> ➤ <i>Follow-up for Immunizations</i> <p><i>Compliance</i></p>	<p><i>Goal Met</i></p>
<p><i>IC #2: By 12/31/05, BHS would have begun to identify and provide services to 200 interconceptional care clients, annually.</i></p>	<ul style="list-style-type: none"> • <i>Interconceptional Care Activities</i> <ul style="list-style-type: none"> ➤ <i>Home Visiting</i> ➤ <i>Establishing a Referral Source</i> ➤ <i>Follow-up on Missed Appointments</i> ➤ <i>Providing Emotional Support</i> ➤ <i>Assessing for Barriers to care</i> ➤ <i>Providing transportation assistance</i> ➤ <i>Reinforcing messages regarding importance of family planning services</i> ➤ <i>Hospital Visits</i> ➤ <i>Follow-up for Well-Child Appointments</i> ➤ <i>Follow-up for Immunizations</i> <p><i>Compliance</i></p>	<p><i>Goal Met</i></p>

VI. Local Evaluation

PROJECT NAME: BIRMINGHAM HEALTHY START

TITLE OF REPORT: Evaluation of Selected Birth Outcome for Women Residing Within the Birmingham Healthy Start Project Area

AUTHOR: Richard J. Sinsky, M.S., Dr. P.H., Epidemiological Analyst,
Jefferson County Department of Health

Section I: Introduction

Local Evaluation Component: The local evaluation for Birmingham Healthy Start (BHS) looks at specific birth outcomes, comparing the outcomes of women classified as participants (three or more service contacts during the pregnancy) to all others within the BHS catchment/targeted area. This evaluation is based on outcomes that were targeted during the original development of the BHS Program as a Demonstration project, and to serve as indicators of improvement in access to and quality of care. The evaluation process is driven by the ability to access birth certificate data for those individuals within the project area that we served and compare against those we did not serve.

Hypothesis: The hypothesis for this evaluation is that the services and support provided by BHS will lead to better outcomes. In this evaluation, mortality is evaluated for a specific cohort rather than as the usual annual rate to better reflect the mortality experience of the infants born during a specified timeframe. This also coincides with the other measures (maternal age, birth weight, gestational age at delivery, and adequacy of care).

Section II: Process

The local evaluation of pregnancy outcomes in the BHS project area is based on linking the participant status of the women who delivered in the area to the data from the linked birth/death certificates for the event. Death certificates are linked to the birth certificates prior to downloading the data, via the linkage number that the State appends to the death records as they are filed. Participant status is determined by the date of receipt of services from BHS. A woman must have received at least three service contacts during the pregnancy to be considered a participant for that pregnancy. Linkage of the birth and death certificates is accomplished through the Access database in which the records normally reside, and data is exported in a text file to SAS[®]. This provides us with the ability to do cohort mortality analysis based on specific risk factors (maternal age, birth weight, marital status, etc.). Encounter dates are abstracted from a mainframe database, in a text format and also exported to SAS[®]. These two data sets are merged and participant status is calculated from the pertinent dates provided by the two sets. This process required developing a means for identifying data entry errors within the BHS Databases, which could occur in either the patient master system or the encounter system. Audit reports were developed to compare various key elements (date of birth and contact, maternal age, gender, pregnancy status) in an attempt to detect errors, such as an individual with gender marked male being listed as pregnant on their encounter form. Negative ages also indicated data entry errors. An audit was also created to flag

“underage” pregnancies (pregnancy at age less than twelve) for verification. This audit report was developed specifically for the current evaluation and has now been formalized into the weekly reporting to management, clerical and outreach staff for immediate corrections.

This linkage between the two data sets allows stratification of all of the deliveries within the catchment area into three groups: participant (three or more service contacts), minimal contact (one or two service contacts), or no contact. The last two groups are collapsed to create the comparison group against which the BHS participants are compared.

Section III: Findings/Discussion

Infant Mortality: The **Cohort Infant Mortality Rate (mortality outcome for the infants born within a given year, numerators and denominators come from the same population)** for the catchment area decreased from 16.2 per 1,000 live births in 2000 to 11.4 in 2004. The **County Cohort Rate** as a whole went from 12.1 in 2000 to 9.0 deaths per 1,000 live births in 2004. Within the catchment area, the rates for the BHS participants dropped from 11.6 in 2000 to 5.7 in 2002 and then rose to 9.7 in 2004, compared to Non-Participants going from 16.5 to 11.9 deaths per 1,000 live births. While the differences between the rates for participants and non-participants were never significantly different in any given year, they were always less for participants (low difference of 2.2, high difference of 16.7). However, these rates are based on from 2 (2000) to 5 (2004) infant deaths among a relatively small number of participants compared to the non-participant population in the area.

Neonatal Mortality: Neonatal Mortality for the catchment area Cohort dropped steadily from 12.3 deaths per 1,000 live births in 2000 to 8.7 in 2004 while for the County as a whole the rate dropped from 8.5 to 6.0. BHS participants began the timeframe with a rate of 5.8 and dropped steadily to 1.6, but jumped in 2004 up to 7.8 deaths per 1,000 live births. At the same time, the non-participants rate started at 12.7 raising to 13.3 in 2003, and then dropping in 2004 to 8.9. Only in 2003 was there a significant difference between participants and non-participants.

Post neonatal Mortality: Post neonatal Mortality for the Cohorts in the BHS area rose during the first year from 3.9 to 7.0 and then steadily decreased to 2.8 per 1,000 live births in 2004. The County as a whole started out at 3.7 and gradually came down to 3.0 at the end point. Participants started out with a rate of 5.8 and trended down to 1.9 in 2004. The non-participants started off the period with a lower mortality rate of 3.8 but jumped to 7.6 in 2003 and 6.6 in 2003 then returned to a lower rate of 3.0 in 2004. At no point was there any statistical difference between the two populations. In all but 2003 there was only one post neonatal death in the Participant Cohort. In 2003 there were 3 deaths, and this was the only year that the rate exceeded that of the non-participants.

Teen births: Objective #11 targeted a decrease in the **percentage** of births to teens who reside in the BHS targeted areas. One of the problems with using this particular indicator is that if the number of adults who give birth rose or fell at a different rate, the proportion of teen births among all of the births could rise or fall regardless of what happened to the number of teen births. If the number of teen births stays the same and the number of adult births rises, there would be an apparent improvement in teen pregnancy. On the other hand, if there was a reduction in the

numbers for both the teens and adults, depending on the relative rate of reduction there could appear to be an improvement, no change, or a worsening of the situation. In fact, numbers did decrease for both groups leading to a reduction in the proportion of teen births from 21.4% in 2000 to 19.9% in 2004 which was not significantly different. However, if the number of births was compared, there was a 16.4% reduction in the number of births to adults 2,429 in 2000; 2,030 in 2004), and a 23.5% reduction in teen births (660 down to 505). Both reductions are significant from their starting points. A significantly larger proportion of the Participants in the program were teens in each year, starting at 31.2% in 2000, and ending up at 28.3% in 2004. At the same time, teens made up 20.8% of the births to Non-Participants and dropping to 17.8% in 2004%

Low Birth Weight (<2,500 grams): The proportion of women who delivered Low Birth Weight (LBW) infants in the BHS area stayed relatively constant from 2000 to 2004 starting at 13.5%, fluctuating slightly and ending at 13.9% in 2004. At the same time, the overall rate for the county rose gradually from 10.5% to 11.3%. The rates for participants were consistently lower than those for non-participants, starting at 8.7% and 13.8% (difference of 5.1%) respectively, and follows the countywide trend of gradually increasing proportions. The gap between the two BHS area populations decreased through 2004 with a rate of 12.9% for participants and 14.1 for non-participants (difference of 1.2). There were no significant differences between the participants and non-participants.

Very Low Birth Weight (<1,500 grams): The proportion of live birth deliveries in the catchment area that were Very Low Birth Weight (VLBW) rose slightly over three years from 3.07% in 2000 to 3.88% in 2003 then dropped to a ten year low of 2.6%. This mirrored the County's experience in the same time period, rising from 2.3% to 2.8% in 2003 then dropping to 2.1%, which matched the County's ten year low. Participants started off the time period with a low of 0.58% in 2000, which due to the discrepancy in population size, was not significantly different than the 3.22% for the non-participants. Both populations saw increasing proportions through 2002 (2.7% participants and 4.0% for non-participants). In 2003, the proportion for participants dropped to 1.7% while for non-participants the rate continued to rise to a high of 4.6%. This was the only year that there was a statistical difference in the two rates. In 2004 the rates were essentially the same for both populations; 2.3% for Participants and 2.7% for Non-Participants.

Preterm deliveries: The proportion of preterm deliveries in the project area rose from 15.4% in 2000 to 17.3% in 2002 then dropped back to 15.1% in 2004. For the County as a whole, the rate gradually increased from 12.7% to 13.9% in 2002, then dropped to 13.7% in 2004. Participants started off at 9.8% preterm births. This was not significantly different from the 15.8% proportion for non-participants. The proportions increased for both populations through 2002 to 12.7% for participants and 18.5% for non-participants. In both 2001 and 2002, the proportions for the participants were significantly less than for the non-participants. In 2003 the proportions dropped slightly for both populations (participants: 12.4%; non-participants: 16.9%) and were still significantly different. In 2004, the rate continued to fall for non-participants (15.3%) but rose again for participants (14.6%). While the proportion for participants was still less than that for non-participants, it was no longer significantly so.

First trimester entry into care and adequacy of care: These two indicators are best compared together, or more appropriately against each other. While early entry into care has always been an

important goal in any maternal care program, it can truly “stand alone”. It has to be understood that although someone may enter care early in the pregnancy, they may not necessarily get adequate care over the course of the pregnancy. The Adequacy of care measure used was the Adequacy of Prenatal Care Utilization (APNCU) Index, also referred to as the Kotelchuck Index.

The proportion of women in the project area who entered care in the first trimester rose from 73.8% to 82.7% in 2004 and in the County as a whole it went from 82.9% in 2000 to 87.4% in 2004. Within the project area 70.5% of participants and 73.9% of non- participants entered care early. These were not significantly different from each other. The proportions dropped for both populations during 2001 through 2003 (participants 64-68%; non-participants 69-75%) with participants’ proportions being significantly less in 2002 and 2003. In 2004, the rates jumped to 80.7% for non-participants and participants having a significantly larger proportion at 86.9%.

The proportion of women who received adequate prenatal care, regardless when a woman entered care was 69.8% within the project area in 2004 and rose steadily to 74.5% in 2004. In the County overall the proportion was 82.9 in 2000 and dropped in 2001 to 80.5% and then began to climb again, reaching 87.4% in 2004. In the catchment area the proportion of participants with adequate care began at 64.2% in 2000 and rose 76.0% in 2004. Non-Participants started at 70.2% and mirrored the County’s drop and rise, recovering to 74.2% with adequate care. The differences were not significant in any of the years.

Among the women who began care early, 85.0% of the women in the project area and 85.5% of the women in the county actually receive adequate prenatal care. This proportion rose to a high of 88.7% in 2003 for the project area and 90.9% in 2002 for the County overall. For the BHS area, the proportion dropped to 83.7% in 2004 and the County dropped to 88.8%. A total of 79.3% of the participants who began care early received adequate care throughout their pregnancy in 2000, rising to approximately 88% in 2002 and 2003. In 2004, the proportion dropped to 80.9%. For the non-participants, the proportion rose steadily from 85.3% in 2000 to 89.0% in 2003, then dropped to below where it started to 84.5%.

Discussion: Over the course of the four years of the program evaluated, the Cohort Infant Mortality Rate in the catchment area dropped from a starting point in 2000 of 16.2 deaths per 1,000 live births to 11.4 in 2004. Had the rate stayed the same during that time we would have expected to see 41 deaths rather than 29. **Comparing the current project area Cohort rate to the rate of 21.3 in 1993, the first year that BHS provided services in the community, a rate of 11.4 deaths per 1,000 live births represents a 53.5 % reduction in the overall Infant Mortality in the project area, which was statistically significant ($p < 0.0001$). Had the Mortality Rate remained the same as in 1993, we would have expected to see 54 infant deaths, or 25 more than actually experienced.** While the differences in the rates are not statistically significant over the time frame of 2000 to 2004, to the 12 families that potentially would have lost a child this is quite significant. Although the gains from year to year to year have been small there has been a continuing trend for improvement. The County Cohort rate was 12.0 in 1993, 12.1 in 2000 and dropped to 9.0 in 2004 (a 25.0% reduction from 1993). Cohort Mortality in the project area is approaching that of the county as a whole.

Teen pregnancy has shown an improvement in the BHS project area though it would not appear so

by looking simply at the proportions. For the project area, the number of births dropped by 17.9% from 3,090 in 2000 to 2,537 in 2004. The adult delivery population decreased by 16.4%, while the teen delivery population dropped by a larger percent of 23.5%. As a targeted group for services teens made up a significantly larger proportion of the Participants in each of the years evaluated. This shows that BHS is reaching a high-risk group and providing services to the, and keeping them in the program. As the number of teens delivering infants decreases the overall outcomes for deliveries should also improve in terms of birth weights and mortality. However, we still will be unable to determine if the number of *pregnancies* actually decrease without the specific population numbers need to do the calculations, which are not available at the community level. Steadily decreasing **pregnancy rates** in the county as a whole, for both white and Black teens, given the reduction of live births in the area, would indicate that teen pregnancies are also decreasing.

The low and very low birth weight rates in the project area while higher than County rates have mirrored the rise and fall seen in the county and the State, indicating that there is an overall problem that needs to be addressed. Issues that appear to be impacting this indicator overall is the increasing age of mothers, increasing smoking among pregnant women and a gradual increase in the number of multiple births in the cohorts.

Until 2004, the proportion of the women that were entering care early was staying low, but since many of the women who enter the program do so after starting prenatal care, this is not unexpected. The key point is that once they enter into care and BHS begins to provide them with their services and support, the women have a better chance of getting adequate care.

Limitations of findings: Relatively small numbers of participants in relation to the area population, makes it difficult to show statistical significance. However, a consistent difference in an outcome either above or below that of the comparison population should still indicate if there is some benefit in receiving services and support from BHS. An additional hazard or the small population to work with is that in some of the characterizations (such as mortality), a fluctuation of only 1 or 2 events and cause large changes in rates. The timeframe for this report cycle is too short (four years) to calculate something more appropriate, such as three year running rates, which would “smooth out the bumps” and better visualize any trends, or the lack there of.

As previously noted the problem of proportion of births to teen is not just a function of the number of teens that deliver, but tied directly to the number of adults who gave birth. Evaluating the change in number provides a better measure of “what is happening” regarding teen births. Better measures would be the fertility and pregnancy rates among teen woman. Unfortunately, population data for the age and race categories are only available at the county level in the years between the censuses, as are the abortion data needed for the estimated pregnancy numbers. Without the appropriate estimates at the census tract level, these preferred measures cannot be calculated.

Comparisons of Racial and Ethnic differences are also hampered by small numbers of White (approximately 400 per year project wide) and Hispanic (85 increasing to 156 in 2004) women in the delivery population. The criteria of three service contacts restricts the numbers to less than twenty (range 1 to 16) for Whites and from 0 to 2 for Hispanics in any given year. Comparing proportions and rates for these populations would not be appropriate at this time. However, as the Hispanic population continues to grow, particularly among the delivery population (approximately

6% of the county wide resident deliveries in 2004, up from 3.1 % in 2000), it may become possible to conduct meaningful evaluations in the coming years.

Section IV: Recommendations

BHS would like to do further evaluation before making recommendations for policy change. In terms of program and practice, a major recommendation would be to further enhance the project's quality assurance activities since the completion and expedience submission of the encounter form plays a vital role in data entry.

Section V: Impact

The impact in the perinatal system is described in detail in Section V. Project Impact.

Section VI: Publications

None.

VII. Fetal and Infant Mortality Review (FIMR)

- *Infant Mortality Review*

The process actually began during the demonstration phase of Birmingham Healthy Start (BHS) and was enhanced to include more partners. The Infant Mortality Review process was under the direction of the same JCDH staff member who is responsible for the health department's quality assurance program. She has developed the system whereby JCDH nurses and social workers attend the meetings of the Infant Mortality Review's Technical Review Team and learn about women who have experienced a recent death. Many of them have not been followed up by the appropriate clinic or have refused additional services. The Technical Review Team assigned one of the JCDH clinical staff to follow-up and to report at the next meeting about progress. This mechanism brought several high-risk, high-need women into care who previously had not received it. It improved the quality of their care. This process was continued until the retirement (2003) of the individual overseeing the process. By the end of the project period, BHS was in the process of revisiting how this activity could be revamped and carried out

VIII. Products

IX. Project Data

This information can be found in Tables A, B, C and Forms 1, 5 and 9.