This report represents an overview of the findings for the Health Foundation for Central and Western New York's Maternal and Child Health Initiative (MCH) Evaluation Project conducted by the RED Group between 2011 and 2014.

Contents

Strategy I: Expansion of Midwifery 3
Methods 5
Findings 5
Lessons Learned 7
Recommendations 7
Strategy II: Maternal and Child Health Systems Improvement 9
Findings 10
Technical Assistance 17
Sustainability 18
Use of Data 18
Lessons Learned 19
Recommendations to the Foundation 20
Strategy III: Coordination of Services 21
Methodology 21
Analysis 22
Lessons Learned and Considerations 24
References 26

Introduction

The following overview report documents the evaluation findings for the Health Foundation's Maternal and Child Health (MCH) Initiative in central New York. The Initiative's goal to improve maternal and child health outcomes is part of the HFWCNY's vision to ensure that every child is healthy and prepared to succeed in school. It began by examining multiple determinants of maternal and child health including: access to care, behavior, social and physical environments. Next steps included analysis of data to identify risks, develop intervention strategies, and finally implementation. This preliminary approach (Round 1) to the MCH Initiative in central New York, often referred to as a "*toe in the water,*" is defined by (3) distinct yet interrelated strategies developed to improve maternal and child health outcomes (Table1). This first round provided valuable insight into the complexities of factors influencing maternal and child health care in the region, building a strong base for future Foundation endeavors.

Strategy I: Expansion of Midwifery

Strategy I funded (4) differentiated models of practice which provided a classroom for Foundation learning in the area of midwifery. A success on two levels, this strategy achieved the intended goals of increasing the # of CNM's in CNY and potentially more importantly, providing valuable insight into the challenges facing midwifery practice. These (4) Foundation partners offered new perspectives that would shape future strategic development in the advancement of midwifery. Specifically, previously unknown challenges to midwifery practice were unearthed and examined. These practices continue to be studied as part of the Foundation's strategy to expand and advance midwifery practice.

Key learnings focused on numerous challenges coupled with an environment that frequently offered little support. Most notable: the lengthy and complicated path to independent practice, a health care climate that frequently suppressed midwifery practice and success, and surprising gap in midwifery business acumen and leadership skills needed to address these obstacles. Exacerbating these challenges is the absence of any local support network of practicing midwives. Based on these lessons learned, Foundation strategy has broadened in scope with a continued focus on expanding midwifery practice while supporting currently practicing midwives.

Midwifery Models

Start-up Independent Midwifery Practice This model offers the unique option of home antepartum care as well as traditional outpatient visits. Project focus was centered on the steps necessary to open an independent midwifery practice and provided information into the many obstacles, explicit and implied, related to licensing, hospital privileges,

Established Independent Midwifery Practice This proven model focused on outreach to target population and provided a vision for a successful collaborative model of practice. The project presents information on successful management of an independent midwifery practice, negotiations with collaborating doctors, and contracting with hospitals on behalf of partner OB/GYN practice partners as laborists.

Hospital Based Midwifery Practice This approach is housed and operationally funded by the hospital. Grant funds were invested in the growth and development of the Director to promote this public practice to its fullest

Rural Collaborative OB-GYN Practice *As* the only provider of obstetrics in this county, funding this practice was aimed in the area of midwifery recruitment and retention. Technical assistance provided potential future models of practice.

Table 1. Round 1
Maternal and Child Health

Issues and Opportunities	Strategies	Outcomes Expected	Outcomes Realized	Learnings How did we do?
I. Expansion of Midwifery				Targeted technical assistance to ↑midwifery capacity. Grantees demonstrate ↑ in business, organizational, and clinical knowledge including but not limited to strategic planning, leadership, recruitment, team building, billing and coding, facilitation skills, emotional and situational training, collaboration, advocacy and networking. One-on-one coaching with technical consultant gleaned detailed insight into additional challenges to midwifery including: – lack of reimbursement equity – implications of payer mix – recruitment, rural and urban – readiness and resources
Invest in emerging/expanding Midwifery practice	Support growth of midwifery practice in CNY region	Increased access to prenatal care	√	
	Support development of a Certified Nurse Midwife training program in local nursing or medical schools with planning grants. Demonstrate a commitment to serving uninsured and/or underserved patients	Increase in practicing CNM in CNY	√	
II. Competitive RFP Improving Maternal and Child Health Services in CNY				Health Foundation effort to sustain innovative program in the short term provides long term sustainability. Collaboration with March of Dimes brings innovative program to the larger Navigator Network and becomes the model. Funding Best Practice leads to promising preliminary findings; ↑ in patient satisfaction, ↑ breastfeeding rate within cohort, ↑ in education. Organizational instability diminishes project integrity
Capitalize on strengths in the existing system - provide support to address gaps and needs in those services	Connect low income women to existing care and services	Increased accessibility	√	
	Enhance existing services to improve retention and/or outcomes for low-income woman	Increased service capacity	√	
Invest in innovative approaches to address needs of target population	Address gaps in existing services available to low income women	Increased education	√	
III. Facilitated Coordination				Participants in the facilitated coordination planning exercise gained an increase awareness of neighboring human service providers as well as capacity. The exercise has allowed the Foundation to explore regional dynamics among providers. These findings provide a profile of the culture and the obstacles to coordination of services, notably lack of emergent leadership disconnect between medical and health service community lack of communication lack of "influence-level" administrator present
Partner with local agencies in building a more coordinated integrated service response. Support local stakeholders investing in pursuit of systemic change. Socio-demographic challenges continue; services to address may provide greatest benefit to population	Provide professional facilitation and technical assistance to health and human service providers in Oneida County, to reduce duplication and support better coordination of services for young children and families	Increased sharing, cooperation, and networking	√	
		Enhanced coordination		
		Increased education		

Methods

The evaluation began with a document review, from Foundation-commissioned research to grantee-specific SWOT analysis. As a two phased approach to implementation, each phase included evaluative observation, multiple interviews and site visits (Table 2). Grantee participation in the American College of Nurse-Midwives Benchmarking (ACNM) Project was required and used to measure birth outcome data. The evaluation team continues to follow these grantees as case studies in a longitudinal study of birth outcomes via the ACNM Benchmarking Initiative.

Table 2. Methodology

Study	Target	Method
Birth Outcomes	Track birth outcome indicators	ACNM Benchmarking
Organizational Readiness	Motivation Resources Staff Attributes Organizational Climate	SWOT Analysis, Interviews, observation,
Technical Assistance	Technical Assistance Requested and applied	Document Review, Site visits
Grantee Case Studies	Lessons Learned	Site visits Interviews Phone interviews Kick-off Meeting

Findings

A success on (2) levels, Strategy I has achieved the intended goals of increasing the # of CNM's in CNY and potentially more importantly, providing valuable insight into the challenges facing Midwifery practice (Table 3), most notably, the recognition of the gap in business acumen and its impact on midwifery practice success. Challenges concerning Insurance reimbursement polices, billing and coding, hospital privileges, and collaborative agreements are further complicated by the lack of tools and skills to effectively address them .Expansion of Midwifery provides critical perspectives to inform strategy as the Foundation continues to adapt and tailor its approach to support midwifery practice.

The Expansion of Midwifery's grant period was divided into two phases. *Phase I* was dedicated to plan development including identification of operational practice model, specific technical assistance needs, suggested revisions to grantee proposals. *Phase II* then utilized the finalized plan developed in Phase I and began implementation. Observations made in Phase I and II have been identified in Table 3. Through continued dialogue, the Foundation addressed emerging needs, tailoring technical assistance in an effort to build capacity while maximizing Foundation investment.

A variety of midwifery models of practice were funded, offering the unique perspectives of each model.

Table 3. Four Studies of Midwifery Practice

	Rural Private	Hospital Based	Start-Up Independent	Established Independent
Phase I: Organizational Readiness [Planning Phase]				
Motivation	High: Keen awareness of the need for strategic planning related to evolving model of practice	High: Personal level of motivation displayed was high, although external factors appeared to have negatively impacted grantee motivation for the time being	High: Grantee displayed consistent and sustained awareness over the grant period	High: Initially grantee did not communicate a real need for change, however emerging need coupled with technical assistant provided motivation for change
**Resources*	Resources appear adequate	Resources adequate for implementation	Resources appear low: may be problematic for start-up	Resources adequate for grant implementation
Staff Attributes	Varying degrees of influence and adaptability while key influencer displayed strong tendency to both influence and adapt	Staff attributes unknown at this time	Highly adaptive with strong problem-solving skills	Perceived sense of competition with fellow grantees
Organizational Climate	Family-owned private practice-related to midwifery	Initially collaborative; opening of clinic revealed new understanding of organizational hierarchy	Strong sense of focus and mission; willingness to collaborate, with high stress potential	Displayed cooperative climate
Phase II: Technical Assistance (TA) [Implementation]				
TA Requested	Site visit: Patient Flow, Practice study, Website Makeover	Executive Coaching & Leadership Training	Consultant Coach and Mentor - monthly calls with prescriptive and practical advice	Marketing Campaign/Practice Retreat
Evidence of TA Application	Moderate evidence of TA Application: Limited changes to Web Page	Limited evidence of application ability to apply skills at this time	High level of application of tailored TA	Moderate evidence of application of TA
Take-Aways to Date				
↑ # CNM/CN	↑2	↑1	↑1	↑1.5
Learnings	- Provided understanding related to challenges in recruiting and retaining midwives in a rural practice. Support for local CNM training was perceived as a possible solution - Physician perspectives related to the emerging change in their model of practice and factors contributing to the perceived need to change. -Advanced the midwifery model in traditional physician practice.	-Provided learnings related to investment in leadership and coaching in order to promote targeted outcomes for change. -Increased understanding of the effect of organizational hierarchy and culture, and the degree to which individualized coaching can create positive outcomes within a larger organization.	-Provided details of the complexity and multiple required steps to independent start-up. -Pending collaboration with fellow grantee promises mutually beneficial advantages	-Provided model of successful independent midwifery practice, specifically the critical networking and alliances necessary and the ability to adapt. -Key observations into motivation and readiness: Grantee must "feel" a need for change.

*Resources originally referred to funding, time, and staff, was redefined to include business skills as a result of Lessons Learned in Round 1.

Lessons Learned

While there were many site- specific findings, there was a common thread of core findings repeated across sites.

- ✓ It has become abundantly clear there is a large and previously unseen gap in skills related to business and leadership. As the key finding in Round 1, many of the additional conclusions are often associated to this root cause
- ✓ Midwives lack professional local networking necessary to advocate for midwifery practice both individually and collectively in challenges faced.
- ✓ Midwifery practices apply limited resources to formal data collection and strategic planning: time is often cited as contributing factor.
- ✓ A strong indicator of midwifery practice success is the degree to which midwives foster and maintain collaborative agreements and approval from partnering physicians.
- ✓ Skilled technical assistance coupled with a driven "change agent" can overcome obstacles and begin the desired shift in organizational culture.
- ✓ A strong "felt gap" or "need" is essential to motivation and project success.

Building on lessons learned in central New York, the R/E/D Group will continue to document the Foundation's approach to the expanding MCH Initiative, exploring evidence of efficiencies, relevance, acceptance, and utilization related to Foundation resources. From this we will provide considerations for Foundation planning as it expands the Initiative throughout central and western New York State.

Recommendations

Reimbursement: Reimbursement rates for private practice have a higher differential in Rochester and Syracuse than in Buffalo; as much as $20 per visit, resulting in a lack of incentive for the quality of care. Midwifery continues to suffer in the area of equitable reimbursement in relation to their peers and as a result recruitment is difficult. If the opportunity to influence these norms exist, the Foundation might consider applying some of its resources in this area.

Community/Education: Buffalo and to a lesser extent Syracuse are conservative medical models. Midwives entering these arenas must have both the blessing of a senior CNM and agreements with OB to start a practice. MDs are the preferred primary care providers for the community in general. Shortage creates demand and currently there is no shortage of obstetrical care. However, the climate is about to change as the aging population of physicians are on the brink of retirement. In order to

optimize adoption of midwifery model of practice to fill this anticipated provider gap there needs to be an evolution in community attitudes. The Foundation may wish to add an education/marketing component to strength the advancement of midwifery.

Efficiencies in Technical Assistance: Round One of the Maternal and Health Initiative provided post award technical assistance. Building on the lessons learned related to the utility and application of this technical assistance perhaps a more prescriptive and less open-ended approach to technical assistance may be in order; still adaptive but building on what we now know; maximizing access to TA knowledge and skills while building collaboration among midwifery and health service communities.

Strategy II: Maternal and Child Health Systems Improvement

The Health Foundation for Western and Central New York launched its *Improving Maternal and Child Health Outcomes in Central New York* in 2012. The project was designed to support changes or improvements to the current human and health care systems that would lead to the Foundation's established focus on preventative health practices and every child being healthy and ready to succeed in school. The target population was identified as children up to age one and women of child bearing age in poverty in the central New York region, with an emphasis on the identified CNY "hot spot" neighborhoods with high risk of poor maternal and child health outcomes. The Foundation has identified lack of transportation, mental health issues, and lack of education and support as contributing factors.

The goal of this grant strategy was to support sustainable efforts in connecting more low-income women to existing care and services, enhancing existing services to improve retention and outcomes for low-income women, and/or addressing gaps in existing services. To realize this goal the Health Foundation provided grant support and technical assistance to (3) funded projects.

The three case studies discuss the successes, challenges and lessons learned from the grant process. Using qualitative data collected through interviews and site visits, this report details the structure and implementation of the planning process (Phase I), discusses what worked and didn't work as the process unfolded, and provides recommendations for the Foundation to consider when conducting a similar planning process. Key themes include:

- Grantees learned about strategic planning and developed plans to achieve the intended change. Phase I provided grantees with time, resources and guidance to learn about and develop logic models to build connections, and develop understanding and articulate a vision to help support their projects.
- Grantees learned about the need for sustained outcomes, and were provided clear definitions and models to guide sustainability.
- Funders need to receive and provide regular feedback to optimize outcomes. It is important that the Health Foundation require scheduled feedback to support opportunities for learning and to optimize Foundation investment.

Qualitative interview and grantee feedback were obtained from key informants representing funded organizations who participated in Phase I and Phase II, the technical assistant consultants, and Health Foundation Staff responsible for the coordination of the planning and reporting for this project. Originally, (4) projects were funded; however, because of unforeseen circumstances one project no longer had the time and resources needed for implementation, resulting in a total of (3). Document review of grantee logic models and contact sheets supplied by the technical assistant commissioned to support the planning phase were also reviewed. Evaluators attended the August 2012 Kick-off Meeting and January 2013 Sustainability Workshop, and conducted multiple site visits to each of the (3) sites. Survey data were also collected related to grantee perceptions of technical assistance offered and accepted.

Findings

While this was a "toe in the water" approach to Maternal and Child Health in central New York, the Foundation grantees reported that having a funder "partner" willing to support and adapt to emerging needs was a welcome change and enabled them to address unanticipated set-backs and challenges.

Case Study 1: Navigator Program

This innovative navigator program provides direct medical navigation to existing maternal and child health care services for low-income women who are court-involved and are pregnant or parenting a child under the age of one. The program provides three types of services to meet this goal: 1) identifying health care and social service needs through one-on-one consultations, 2) assisting clients in establishing a health care "home," and 3) making referrals to local agencies that deliver maternal and infant health care, education, and free/reduced cost supplies.

Outcomes identified and realized:

The proposal focused on expanding the current program through the pursuit of four short-term outcomes:

1. *Provide direct one-on-one consultations to 150 court-involved clients*
   To date, the program **provided services to 104** women and carried an average caseload of 65 open cases at a time.
2. *Establish a medical home for 75 court-involved clients*
   To date, **25%** of clients (approximately 26) **established a medical home** with the assistance of this program.
3. *Provide appropriate referrals for 100 clients*
   This information is not yet available.
4. *Provide outreach and presentations to five provider organizations*
   To date, the innovative project has forged **partnerships with 17 service providers** and provided **22 community** presentations to community members, professional staff, and community liaisons.

> "Home-grown ideas have the greatest potential for lasting impact because they are far more likely to be sustained after the grant makers' inevitable withdrawal."
> Joel J. Orosz (Gose, 2013)

Challenges:

The greatest challenges facing this project:

1. the limited personnel dedicated to providing services (currently one full-time employee), and
2. the need to establish multiple partnerships with community agencies for acquiring clients and meeting client needs.

The project lacked internal resources to design and implement change related to data gathering. Although attempts were made to support efforts to implement change, staff lacked the resources for follow through.

In November 2013, the program coordinator became ill, went out on a Leave of Absence and eventually resigned her position with the program. In March 2014 a replacement was found and has since continued the work in the areas of outreach and referrals.

Looking Forward:

Recently, changes in the judicial system provided new opportunities for the program. Jamesville Correctional Center has made accommodations for pregnant inmates to keep their newborn babies while incarcerated. Public Health Nursing (PHN) and Community Health Workers (CHW) services are offered to all pregnant women incarcerated at the county jail (Justice Center). The program coordinator created a relationship with the PHNs, obtained the required correctional facility privileges, and currently accompanies the PHN on visits.

A second opportunity recently provided by the City involves the installation of a new Human Trafficking Court. The new court, established late last fall, takes a new approach to reduce prostitution by treating those arrested as victims, rather than criminals. In lieu of jail time, defendants are offered a plea deal that provides six months of counseling and social services. Again, this program established a relationship with those appointed to coordinating the plea deal arrangements. As this population tend to be young mothers and/or pregnant, high risk and hard to reach, the court coordinator provides a unique opportunity. As a result of these new connections the client demographic is changing, and as a result so too are the service needs. On three separate occasions over the last two months women called upon release from jail needing immediate housing for themselves and their newborn baby. The Director characterized these new clients as "*women in crisis,*" who are among the hardest to reach of the target population and a perfect fit for Foundation funding.

In addition to these changing demographics a new partnership with March of Dimes offers a plan for sustainability. This partnership brings the navigator program into a larger network of like programs. Recent communications indicate the chosen model for the network will be that of the Foundation's innovative navigator program grantee.

In summary, the Foundation's funding of this innovative program has proven to be a great success and is one example of the Foundation's ability to work with an emerging innovative program, and using a variety of skills and connections, nurture a sustainable, replicable model.

Case Study 2: Health Services Program

The second grantee is a comprehensive family support program that provides assistance and mentoring to new families including home visiting services initiated prenatally or in the baby's first three months through age five. These services make an important contribution to the community by connecting needy families to relevant resources and providing the home visiting program when appropriate. The program goals revolve around preventing child abuse, promoting child health and development, and enhancing parental self-sufficiency.

The intent of the proposal to the Foundation was "to connect more low-income women to existing care and services by addressing the high client refusal rates for services." The planned intervention included working with a consultant to develop, test, implement, and evaluate new strategies to increase the enrollment rate for home visiting services. The 18-month goal was to double the rate (from 15% to 30%) of families that agree to participate in formal assessments.

The grantee engaged in several activities related to organizational improvement. However, much of the work was at best indirectly focused on the actual intent and proposed plan of the project. A number of personnel and organizational adjustments further complicated the project. This particular case study provides an example of what began with a clear need and a defined problem, over time became less than expected and promised.

Although, there was a fair amount of work done that may have a positive effect on the agency, for the most part the project tackled issues not necessarily related to the project intent.

***Outcomes identified and realized**:*

The activities which are directly involved with the grant proposal are those making changes to improving the quality of the screen and improving the quality of the referrals from the other agencies:

- changing the screening form,
- developing up to date handouts for the partnering agencies,
- clarifying who qualifies for services, and
- freeing up personnel work load to make time for face to face contact.

Activities less aligned with project goals include agency expectations for conduct and performance. Recent organization changes have produced a need to shore up personnel practices. The consultant recommended a review of roles and responsibilities and new job descriptions. Training and curriculum are also issues in discussion. These may be beneficial to the overall program but will not directly affect the increase in screens to assessments, which is the focus of the funding.

There has been a challenge on the part of the evaluation team in receiving responses to requests for data. In June 2014, the Program Director was laid off but had yet to provide the requested data; Total Births, Families Screened, Positive Screens, Assessments, Positive Assessments, and Enrollments. Although there was a verbal report by the former director that the numbers have improved, recent communication with the current director reveals a different story:

Table 4. Health Services Data

	2011	2012	2013
Total Births (live)	2689	2614	N/A
Families Screened	1602	1633	1487
Positive Screens	843	875	850
Positive Assessments	103	106	88
Enrollments	55	57	46

During the period 2011-2013 positive assessment rate decreased by 2%. The 18-month goal was to double the rate (from 15% to 30%) of families that agree to participate in formal assessments was not achieved.

Finally, visitations were made to successful programs in Madison County, Binghamton, and Buffalo by consultant, manager, and /or director. They report getting good advice from Madison related to their assumptions in designing the referral form and in the content/vocabulary of the early interviews of clients.

Challenges:

In its report to the Foundation, the grantee cites a “large number of structural and personnel changes” complicating implementation as originally planned. Also cited were key modifications to the originally stated

hypothesis of core challenges. Intervention targets were altered and now recognized as structural issues, requiring policy-level changes rather than performance-based. Whether to characterize this as "scope creep" or simply not keeping a focus on the problem and proposed solution is difficult to say.

In order to gain understanding as to why families were reluctant to sign up for services, a central proposed activity of this project was to interview these families hoping to gain some knowledge that might be generalizable to other settings. These interviews were not initiated due to lack of IRB permission as stated by the consultant commissioned by the grantee to facilitate project activities. Although the evaluation team attempted to assist in this issue from the beginning, i.e., resolving its lack of necessity, the program staff and consultant persisted in seeking State approval. As a result, families who did not agree to meet the health care worker for assessment have not been interviewed as to their reasons for refusal.

There was a challenge expressed regarding positive relations with the County Health Department. The director of the project (grantee) came to understand that the Department was concerned with the amount of time between referral (by HD) and the assessment. With WIC now a "strong referring source" for the program, the relationship, as reported by the project director, has improved.

The challenges of personnel changes and role revisions have persisted throughout the project time frame. Currently some of this has been alleviated by freeing the program manager from much data entry and allowing more time spent with referring agencies.

On a positive note, the goals for screening, assessment, and enrollment are now posted on the wall in the HFOC office as a reminder. However, overall there is little actual evidence of the link between institutional changes and anticipated changes in numbers served.

Looking Forward:

Although there were a number activities engaged in that may over time have a positive effect on the agency, particularly in the definition of personnel roles and responsibilities, there is little evidence that these will directly affect the targeted area.
During the period that specific activities were enacted, the actual numbers of families accepting target services actually went down. Before giving up on what was purposed, however, two further steps might be worth pursuing:

1. Interview non-respondents as to their reasons for reluctance. This was the action with the most potential in the original proposal, yet was not implemented.
2. Act upon the findings rather than simply gathering data, solution strategies might be planned and piloted to test the value of the data.

Case Study 3: Centering Pregnancy

The Health Foundation funded a local hospital in their implementation of the CenteringPregnancy™ model. The Centering Pregnancy model was one of the interventions recommended in the Chapin Hall report and is suggested as an evidence-based practice well suited for women in urban areas. This evaluation focused on the period of transition from a traditional model of care to a group model. CenteringPregnancy™ defines this as the System

Redesign Phase and provides prescriptive training and a checklist of protocols intended to provide a map for successful implementation. At the end of the System Redesign Phase, Centering Healthcare Institute (CHI) conducts a site review and determines the site accredited.

This case study offers a unique first-hand perspective of the shift in prenatal care paradigms, from the traditional, individual model to a group model of care. Insight into the challenges faced at the individual, program and organizational levels, and how these challenges impact implementation, will inform future replication sites.

Outcomes Identified and realized:

In the original grant proposal the Prenatal Care Clinic identified (3) short term goals through implementation of Centering Pregnancy:

1. Individual/family level: Improvements in "hotspot" birth weight, preterm birth, birth spacing, visit compliance, tobacco/substance use, feelings of isolation, and education and support (Table 5.)

Table 5. Birth Outcomes Centering Pregnancy

June 2013 marked the beginning of CenteringPregnancy™ at the Prenatal Clinic, with this first group to deliver in December. Since then a total of 39 women have entered the program, 22 of whom have given birth. Still very early in implementation, birth outcome data are limited:

Unit	Measure		2012 Birth Outcomes by Quarter				2013 Birth Outcomes by Quarter				1st Quarter 2014
Clinic	Total # of prenatal visits (Avg. # kept)		82%	82%	81%	81%	80%	81%	76%	84%	82%
Centering Clinic	Total # of Centering sessions (Avg. kept.)		-	-	-	-	-	67%	90%	80%	71%
Clinic	**Timing of entry into care (**Avg. # weeks gestational age at first OB visit	First Trimester	64%	59%	72%	72%	83%	83%	79%	77%	60%
		Second Trimester	32%	38%	27%	27%	9%	8%	16%	12%	37%
		Third Trimester	4%	3%	1%	1%	8%	9%	6%	11%	3%
Hospital	% Vaginal Delivery		81%	71.5%	77%	83%	83%	82%	78%	77%	81%
	% Primary C/S Delivery		8%	14.5%	8%	11%	9%	8%	16%	12%	8%
	% Repeat C/S Delivery		11%	14%	15%	6%	8%	9%	6%	11%	11%
Clinic	Gestational age at delivery (%<37 weeks)		-	-	-	-	14%	9%	3%	7.28	14%
Centering Clinic							-	-	-	33%	15%
Hospital	**Infant birth weight** %<2500 grams (5lbs. 8 oz)		92%	95%	96%	97%	92%	96%	98%	96%	95%
Hospital	**Breastfeeding at discharge** (% yes)		71%	70%	67%	67%	68%	64%	71%	68%	68%
Clinic	**Breastfeeding at post-partum (PP) visit**		-	-	-	-	12%	12%	29%	41%	25%
Centering Clinic			-	-	-	-	-	-	-	-	50%
Hospital	**% NICU admission**		2%	3%	4%	2%	25	5%	2%	4%	2%
Clinic	**% Attendance at post-partum visit**		-	-	-	-	-	76%	76%	67%	80%
Centering Clinic								-	-	-	92%

2. Provider level: Short-term improvements and enhancements of prenatal care delivery.

Promising indications found in the first quarter of 2014 - The first Centering cohort had a 92% attendance rate at their first post-partum visit, compared to the Clinic's 80% attendance rate. Also encouraging were breastfeeding rates. At the post-partum visit, **50% of the Centering cohort were breastfeeding compared to 25% of their clinic counterparts.**

Patient survey data indicates 100% felt the group care model was a positive and comfortable experience, while 92% reported feeling prepared for labor, birth and parenting. When asked if they plan to keep in touch with the other group members, 82% were unsure and 18% planned to keep in touch.

3. System level: short-term improvements in coordination of postpartum education and support services.

Centering's monthly group session provides an educational component covering a variety of topics. Patient survey indicates the majority of participants perceived the educational discussions to be very helpful. Table 5 provides identification of topics and the degree to which each topic's discussion was perceived as helpful.

Table 6. Patient Survey Centering Pregnancy

Patient Response to Centering Educational Component

Please indicate how helpful the discussions of each of these topics were for you:	Not Helpful	Somewhat Helpful	Very Helpful	Not Discussed
Common changes in pregnancy	**0**	**8%**	**92%**	**0**
Nutrition	**0**	**17%**	**83%**	**0**
Exercise and relaxation	**0**	**25%**	**75%**	**0**
Pregnancy problems	**0**	**8%**	**9%**	**1**
Breastfeeding and infant feeding	**0**	**33%**	**67%**	**0**
Sexuality and family planning	**0**	**33%**	**67%**	**0**
Family relationships	**0**	**33%**	**67%**	**0**
Family violence and abuse	**9%**	**18%**	**64%**	**9%**
Labor and birth	**0**	**8%**	**92%**	**0**
Baby care and parenting	**0**	**8%**	**92%**	**0**
Postpartum care	**0**	**8%**	**92%**	**0**
Emotional changes and depression	**0**	**17%**	**83%**	**0**

Challenges:

The greatest challenge faced is patient acceptance of group prenatal care. Previously each new patient received education on both tradition and group prenatal care and was then offered a choice. This approach was proved ineffective in reaching target class size (8-12). As class size continues to be less than optimal, ranging from 4-7 participants, combining classes was a necessary consequence but still has not produced desired target. The director of the clinic is currently seeking advice of neighboring programs to assist in recruitment. Reasons cited for

patient reluctance to participate in the group care model continue to be lack of childcare, work schedule, and perceived lack of privacy.

Looking forward:

The Hospital's goal to deliver healthy babies to healthy mothers and reduce C-section rates has earned top ranking in the state according to Consumer Reports. The hospital's mission and vision aligned to CenteringPregnancy and the Foundation's goals provide strong support for the challenges common to transition from a traditional to a group model of care. The program director has continued to seek advice from neighboring Centering programs to address challenges and tailor the model to meet the needs of the patient.

Technical Assistance

In Strategy II's RFP the Foundation defines *Technical Assistant* as "an expert identified by the Foundation who will work with each grantee to provide guidance and feedback on project goals, activities, and measurement, including the development of a logic model that would describe how each proposed project intended to achieve specific outcomes". The expert advisor was to assist in the identification of specific objectives and measurement tools; as well as selection of evidence-based models and planned data collection approaches to guide project implementation.

In Phase I, the technical assistant provided logic model training, which was a sound idea conceptually, but resulted in limited usefulness. The training was inadequate and required more follow-through and support for successful completion. However, the real issue is neither the level of adequate training nor follow-up, but rather the intended outcome. What was the purpose of the logic model? It may be that the logic model was intended to serve as a work plan or it may be the intention was to provide the Foundation insights into how the grantee viewed the cause and effect relationships within their project. Regardless of the exercise's original intent, its utility was limited due to inexplicit expectations and inadequate adaptation to grantee capacity.

Sustainability

In January 2013, the Foundation offered grantees a Learning Session facilitated by Scott Thomas, PhD. This session centered on *Sustaining Improved Outcomes: A Toolkit*, a framework developed by Thomas to address the maintaining and continuing improved outcomes and programs. The session focused on (12) factors related to sustainability:

- perceived value
- Monitoring /Feedback
- Leadership
- Staff
- Shared Models
- Organizational Infrastructure
- Organization fit
- Community fit
- Partners
- Spread
- Funding
- Government/
- Institutional Policy

These factors were discussed and rated by project staff as to their current strength, ability to influence, and importance. Finally, the facilitator led the group in outlining activities to strengthen the factors chosen in their own work. Grantees gave favorable feedback during the hands-on activities, stating they added clarity to a subject that can be difficult to define.

The workshop appeared to broaden grantee perceptions of sustainability beyond the funding and into a framework that included sustaining ideas, relationships and outcomes. Participant evaluations revealed an increase in confidence and ability to address issues of sustainability as well as an increased likelihood of formally assessing the sustainability of their projects. Workshop features cited as most useful included:

"The framework and the time allowed to practice,"
"How to incorporate sustainability into the work of the project,"
"The assessment and planning worksheet complimented each other very well," and
"Breaking down sustainability into smaller parts - this makes it manageable."

The sustainability workshop was an effective use of Foundation and grantee time and resources. The technical consultant was well received and able to translate concepts that can be difficult to communicate into pragmatic, useful program activities.

Use of Data

By all accounts the collection and use of data are an essential component in successful healthcare programs. It is critical to grant funding and plays a central role in strategic planning, benchmarking, and best practice identification. However, key personnel across all (3) projects reported data collection as one of their biggest challenges to the implementation. Reasons varied from lack of time, skill, and inability to delegate. Some lack the infrastructure needed to build a data collection framework from scratch. Frequently grantees did not feel justified adding another task to their staff's workload and yet were unable to keep sufficiently accurate records themselves.

Lessons Learned

Analysis of qualitative including site visits, interviews, and survey data revealed several common themes. As a result the following lessons emerged and may inform others seeking to replicate a similar process to support systems improvement.

Challenges

- **Staff turnover**
- **Alignment of technical assistance with grantee readiness**
- **Capturing programmatic utility in appropriate measures for success**
- **Lack of data**

- **Capturing evidence that shows a direct correlation between personalized case management and better maternal**
- **Lack of organizational infrastructure inhibits preparation to maximize funding opportunity outcomes**

What Worked

- **Providing adequate time and funding for planning and reassessment of grant priorities**
- **Flexibility to ask questions of funders and resubmit grant application**
- **Interim grantee reporting to identify challenges in real-time and provide opportunity for correction**

- **Professional development in the area of sustainability provided insight on how to incorporate sustainability into the work of the project**
- **A strong "felt gap" or "need" is primary to project success**

Recommendations to the Foundation

Early assessment of data collection capabilities: There is a question of imposing data collection responsibilities on grantees versus building grantee capacity for data collection within the grantee organization. The challenge is to find a balanced approach that will encourage organizational growth for the grantee while recognizing their limited resources.

Planning phase contracts include periodic progress reports: As part of the monitoring process, it may be important to choose an achievable short-term goal to enhance the possibility of early success and establish a "backbone" for continued activities. Also important is the dissemination of these results to stakeholders to continue to build support for the project. Explicit articulation of these expectations in future RFP's may assist in a structured approach to a continuous improvement "learning loop" between funder and grantee.

Capacity Building Opportunities: The Sustainability Workshop was favorably received by the participants and appeared to broaden perspectives related to how grantees thought about their work. Participants reported a lack of opportunity for professional development and capacity building in today's healthcare environment.

Coaching allows for differentiation: Because not everyone begins the process at the same level of interest, exposure, and understanding, the one-on-one component of this coaching model allows the consultant to provide each grantee with the specific detailed strategies needed to move forward. However, cost of this tailored approach must be considered relative to potential return.

Use of Data: Across all (3) projects, data collection was one of the biggest challenges to project implementation. Reasons varied from lack of time, skill, and inability to delegate. Some lack the infrastructure and needed to build a data collection framework from scratch. Frequently key staff members did not feel justified adding another task to their staff's workload and yet were unable to keep sufficiently accurate records themselves.

Strategy III: Coordination of Services

Whereas the eight projects (later seven) funded by the Foundation to address Strategies I and II supported individuals or individual agencies, Strategy III focuses on multiple agencies working toward the same ends: decrease in infant mortality, increase in rate of breast feeding, increase in rate of post-partum visits, and decrease in rate of low birth rates. The Foundation believed by organizing and implementing a well-coordinated set of services, eliminating duplication of services, and creating appropriate service matches, previously underserved or unserved populations could be integrated successfully into the system. Over time, it was hoped, such an approach would positively impact the serious issue being addressed.

The Foundation selected a perinatal network center as the point unit for the initiative and a local consultant group to serve as facilitators for building the new community of coordinated services. In July 2012, a six-person Leadership Team met with the facilitators and with Kara Williams representing the Foundation related to the newly formed "Healthy Babies Initiative." At that meeting, goals, roles and responsibilities, and general work plan were established. The plan called for facilitation activities with the Leadership Team and the Network group in four major areas:

- Setting Goals
- Identifying Needs and Developing a Service Map
- Finalizing Indicators/Action Plan
- Implementation

Methodology

The objective is to see what can be learned from an attempt to establish and implement a community-based approach to increasing maternal health services through coordination (and perhaps collaboration) of cross-agency services. The evaluation focuses on two factors in Jacobs's Five-Tiered Approach to Program Evaluation (1988), specifically:

- **Tier 2: Monitoring and Accountability** – Gathering and analyzing data to determine the degree of fidelity between the proposed and enacted processes for establishing the Network; to describe the program as it emerges; and to provide a groundwork for later evaluation activities.
- **Tier 3: Quality Review and Program Clarification** – Gathering and analyzing data to expand on the picture of the work and the program; to assess the quality and consistency of the approach taken (in this case, the establishing of a viable Network); to compare the process to standards and expectations; and to understand the elements of mid-course correction as part of continuous improvement.

The evaluation team used the framework provided by the consulting group that focused on the goal of an established and viable Network of coordinated services. Data were gathered through attendance at

meetings of the Leadership Team and the full Network; phone interviews with consultants and Network coordinator; review of all documents used and resulting from the facilitation meetings; analysis of field notes and research literature related to effective organizational coordination/collaboration; and interviews with key personnel and successful or less successful attempts at service coordination.

Analysis

In reviewing the project activities we used the following three lenses:

1. **Core Fidelity** – To what degree did the actual process align with the intended? Where/why were mid-course corrections made? Where do the project's achievements currently stand in relation to the intended outputs and outcomes?
2. **Drivers and Barriers** – From evaluator viewpoint, what has moved the project to its current state and what has proven problematic?
3. **Researched Practices and Standards** – How does the current process align with criteria from the professional and research literature, as well as current practice, on planning and establishing effective organizational coordination and/or collaboration to meet targeted social needs?

Core Fidelity

During the July through September 2012 Setting Goals period, the facilitators completed tasks described in their Strategic Planning Timeline. This included defining the goal and the vision for the work, describing the roles and responsibilities of consultants and leadership team, and preparing an agenda and work plan for the large group session. The major activity for the September through November 2012 Needs and Services period was the kick-off meeting with the full network. Activities included polling the participants on the types of services they provide to meet specific lient needs, and then attempting to plot the results into a master list. A second activity asked participants (as homework to be sent to consultants) to identify issues they saw as important and that they were interested in working on. The consultants also assessed the satisfaction of the participants with the agencies represented and the activities themselves. Although the plan was to place participants in work groups during this session, this was moved to subsequent activities.

During the December 2012 through February 2013 Needs and Services period, less of what was in the initial work plan was addressed. Little attention was placed on identifying and quantifying key indicators of success in the zip code areas, nor on finalizing a Service Map for implementer use. A "final working document" was not part of this period's activity. Instead, the leadership team meetings and the large group session in February focused primarily on discussing if the right people were at the table, how to bring others on board, and planning/implementing the major activity of four facilitated work groups aimed at giving definition to the coordination initiative. The March through May 2013 Finalizing Indicators/ Action Plan period was spent with little attention to the activities of the Strategic Planning Timeline. Since the leadership and the network teams were putting primary effort into the four work groups, concluding with the decision to focus on the Model Development component at the May session, there was not a readiness for the activities as originally planned. The April leadership team meeting resulted in the decision to make the model development "exploration" the central activity of

the May meeting. The May meeting did seem to come closer to identifying factors to include in a coordination model, and although much of the discussion went in many directions, there were more pragmatic matters considered – although not agreed upon – than in prior meetings.

Drivers and Barriers

The most important driving forces, i.e., those integral to moving the initiative forward revolve around the people involved: participants, facilitators, Foundation staff. The participants, whether on the leadership team or the general network population, seem sincerely concerned about the issues being addressed, motivated to work toward a solution based on some sort of service coordination and/or collaboration, and willing to harness their energies toward getting something done. There is a general understanding (one that has been part of the initiative from the start) that providers do communicate with each other but there is a lack of coordination and poor follow-up on referrals to each other. The providers also agree that there is a certain duplication of effort among them. Both leadership team members and general provider representatives do seem to agree on the general vision of moving toward getting each family the right level of intervention, ensuring that the right referrals are made by outside organizations and among each other, and avoiding duplication. The consultants are experienced in the basics of effective facilitation, as well as of logic model and strategic planning. They are facile at creating a positive working relationship with both leadership and general populations, and very focused on providing participants with open opportunities for expressing their ideas and considerations. The Foundation staff, as with each of the Strategies, has been hands-on at the start, and attentive to what has transpired throughout, including meeting with the consultants and with the evaluation team during the early spring period.

We (the evaluation team) have perceived certain factors as standing in the way of moving forward toward development and implementation of a working system of coordination focused on a clearly identified population. These issues may be useful in regard to the Foundation's interest in similar endeavors down the road.

Document review and observation of activities revealed a certain degree of lack of continuity, of a loose coupling of parts, in the process as enacted. Although these activities were built on a clear strategic plan and timeline, and later employed a solid project logic model demonstrating an intent at continuity – in practice it seems more disjointed.

As stated earlier, relationship-building is a strength of the consultants. At the same time, creating an "open forum" allows individuals to build their own threads of interest yet disallows the facilitation to stay consistently on point relative to the targeted plan. This responsiveness to participant interests and concerns is a positive, yet risks creating a process that spins in many directions, that is more about discussion than action, and that results in hasty "group think" when the time comes for necessary decisions.

Lessons Learned and Considerations

We engaged in considerable study of the factors that are most closely aligned with successful community service coordination efforts *versus* others that were well-intended but unrealized. Through review of professional and research literature as well as interviews with practitioners of successful and less successful attempts, we are able to delineate quite clearly multiple factors that can be used as standards – hence, criteria – for examining the facilitated coordination activity (Woodland & Hutton, 2012). The following elements are consistent throughout our reviews and raise what might be helpful questions as the Foundation studies the coordination of services.

The Readiness: Successful community coalitions are most often designed and conducted by individuals and community organizations with a readiness for change from "business as usual." Where there is some history of trust (or at the least neutrality) among participants based on prior working relationships, there is a better chance of overcoming the "me-first" attitude that dooms many attempts. If this history takes place at the executive level, the initiative has a great advantage. If it is among those on the ground providing service, it can bubble up if the members can navigate the way to those who make policy and provide resources. Question: What is the history of interagency coordination and collaboration in the catchment area? How ready are the key constituents for this initiative? What can be built on from prior activity in the region?

The Need: Successful community coordination/collaborations evolve from *pressing social needs.* The provider community shares and articulates a strong imperative to solve a community problem that no one agency can solve alone. In most cases the need is articulated as goals and objectives focused on real gaps in real data, i.e., here is what we are achieving with an identified population, here is where we want to be (moving the needle). Question: Do the current participants have a clear, articulated, data-defined sense of the problem to be solved and what success would look like from the consumer view?

The People and the Resources: Successful community service coordination programs begin with a core group of stakeholders who are interested in and able to drive early planning, and whose involvement is crucial to success. Often these are chief executives or trusted deputies who can influence executives. They can run the range from agencies to United Way to school superintendents to senior city officials, community foundations and the like. Question: Are the right people at the table? Do the participants have the authority or the ear to authorities to get things done? Does the leader of the group have the clout and/or neutrality to serve effectively? If not, how can they address these issues? Successful service coordination/collaborations trust that key providers have the intent and the authority to cross service lines, to share resources of time, energy, talent, and to actively assist in addressing appropriate factors for sustainability. Question: Do the current agencies and players have the history and the ability to commit or to secure the necessary resources to get the project off the ground and to maintain its growth?

The Framework: Successful program frameworks are designed first to directly address the most critical client needs and then secondarily to formalize new structures. They often begin with coordination of a few services among a few agencies to meet a few needs. Later, coordination would include "the regulation of diverse elements into an integrated and harmonious operation." Question: Is the framework being developed (Model Development, Assessment, Communication, Evaluation) one that will serve the participants well in getting to a pilot ready for implementation in a timely fashion? How is the important balance between form (written reports/products) and function (people serving and being served) being facilitated?

References

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