



# CityLights

CityMatCH | September 2017



Using Collective Impact

# TO ADDRESS MCH PRIORITIES

# Aligning State and Local Priorities TO ADDRESS MCH OUTCOMES

Working in isolation, health departments can only do so much to impact Maternal & Child Health (MCH) priorities. In our latest cooperative agreement with the Maternal Child Health Bureau (MCHB), we began the Collective Impact Learning Collaborative aimed at aligning state and local priorities to address MCH outcomes. Through this collaborative, local urban health departments have implemented Collective Impact strategies—engaging in multi-level, cross-sector interventions—to address one of their state’s Title V priorities at the local level.



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## Five Conditions of Collective Impact

1. Common agenda
2. Shared measurement systems
3. Mutually reinforcing activities
4. Continuous communication
5. Backbone support

## Phases of Collective Impact

- Assess Readiness
- Initiate Action
- Organize for Impact
- Begin Implementation
- Sustain Action and Impact

We began this process with an environmental scan of our members to identify those who could benefit most from this learning collaborative. In 2016 and 2017, we kicked off cohorts—consisting of 10 local urban health departments—with a 12-month intensive learning collaborative. We have convened face-to-face trainings, provided webinars, and individualized technical assistance for the 20 teams, on the five conditions (common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and backbone support) and phases (assess readiness, initiate action, organize for impact, begin implementation, and sustain action and impact) of Collective Impact. Equity and authentic community engagement are core to CityMatCH and were weaved into the foundation of their Collective Impact work. This looks different in each community; one team may have several community members that participate regularly in their coalition meetings, and another team may get this valuable “lived experience” input

via surveys and regular contact with consumers. However it looks, it is crucial for teams to engage with and make decisions in partnership with their communities. In addition to this technical assistance, we partnered with evaluation experts to provide the teams with an online documentation dashboard, which allows them to enter data, run diagnostics, and track their progress. Based on the work of these cohorts, CityMatCH will develop a promising practice compendium and an evaluation report to cap the project. We are set to launch the third cohort this Fall.

Collaboration is not a new concept, but the method of collaboration matters. Many local coalitions will tell you they are doing Collective Impact. Major improvements in local MCH happen when health professionals, stakeholders and consumers make decisions together. Public health permeates all other sectors: education, policy and government, transportation, housing, faith, and more. When communities realize this, and they engage partners from diverse sectors, they are finally able to make a deeper impact by affecting policies, systems, and the environment. However, shifting the way we do things to work collectively with our communities is a process that takes time and intentionality. When teams in our learning collaborative take the first 12 months to gain a solid foundation in the five conditions and thoughtfully get the right partners to the table, they realize new accomplishments. This, truly, is putting the “public” back into public health.

This issue features the work of some of our local collaboratives, as well as some Healthy Start grantees. As you will read in this issue, many of our teams are finding that when they collaborate with community members and stakeholders from other sectors, they can accomplish much more together. The collaborative has challenged them to do things differently than they have before. As a result, they are cultivating fruitful partnerships with unlikely allies, developing paths to sustainability that do not rely on state or federal dollars, and making impact on their state’s Title V MCH priority.

Cohort 1 Cities:  
San Luis Obispo, CA  
Salt Lake City, UT  
Fort Collins, CO  
Fort Worth, TX  
Milwaukee, WI  
Nashville, TN  
Peoria, IL  
Rhode Island  
Tallahassee, FL  
Little Rock, AR

Cohort 2 Cities:  
Los Angeles, CA  
Portland, OR  
Omaha, NE  
Tulsa, OK  
New Orleans, LA  
Detroit, MI  
Cleveland, OH  
Atlanta, GA  
Bronx, NY  
Clearwater, FL

# The Maternal and Child Health Bureau

## FOCUS ON COLLECTIVE IMPACT



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In recent years, the Maternal and Child Health Bureau (MCHB) has worked to infuse the collective impact framework into grants and cooperative agreements across the Bureau, including the Division of State and Community Health's Partnership for Urban MCH Leadership Community Cooperative Agreement with CityMatCH, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, and the Healthy Start Program.

Over the past decade, many federal, State, and local efforts have been made to translate life course theory into MCH practice.<sup>1</sup> In spite of the increased understanding of the need for broad, early and preemptive, multi-level, cross-sector interventions requiring better coordination and greater integration, much of the work done by MCH still takes place in silos. This siloed approach leads to what Kania and Kramer refer to as isolated impact, which attempts to solve a problem through the work of a single organization.<sup>2</sup> However, as they note, there is little evidence to suggest that isolated initiatives are the optimal approach for solving social problems given the complexities of today's world. Instead, they suggest that significantly greater progress could be achieved in addressing



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challenges of today's society if multiple types of entities work together to create collective impact.<sup>3</sup>

In an effort to promote the translation of life course theory to MCH practice, MCHB has incorporated the promotion of organizations working together across sectors, facilitated by a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and backbone organizations to move from isolated to collective impact.

Since its inception, the Partnership for Urban MCH Leadership Community Cooperative Agreement has played a critical role in supporting urban MCH leaders with a strong focus on applying life course theory to solving complex urban MCH challenges. Through the most recent cooperative agreement, MCHB and CityMatCH are working to strengthen the knowledge, skills and abilities of MCH leaders in urban health departments related to achieving and evaluating collective impact. Thus far, to achieve this goal, an environmental scan related to collective impact has been conducted, and two 12-month learning collaboratives



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focused on intensive training on the collective impact model and its application for urban MCH leaders have been conducted.

In addition to MCHB's work with CityMatCH, the collective impact framework is also infused into the work of Healthy Start grantees. To maximize opportunities for community action to address social determinants of health and achieve collective impact, Healthy Start grantees support the coordination, integration, and mutually reinforcing activities among health, social services, and other providers and key leaders in the community at all three levels of the program. The Healthy Start program implements the collective impact framework through Community Action Networks that are mobilized in their community. Healthy Start has also developed peer learning networks, which are used to engage grantees in applying the collective impact framework.

MCHB and CityMatCH will continue to work with our federal, state, and local partners to learn how best to apply collective impact to improve the health and wellbeing of our nation's children and families.

<sup>1</sup> Lu, Michael. (2014). *Improving maternal and child health across the life course: Where do we go from here.* *Maternal and Child Health Journal*, 18, 339-343.

<sup>2</sup> Kania, J. and Kramer, M. (2011). *Collective impact.* *Stanford Social Innovation Review*, 36-41. [http://www.ssireview.org/images/articles/2011\\_WI\\_Feature\\_Kania.pdf](http://www.ssireview.org/images/articles/2011_WI_Feature_Kania.pdf).

<sup>3</sup> Kania, J. and Kramer, M. (2011). *Collective impact.* *Stanford Social Innovation Review*, 36-41. [http://www.ssireview.org/images/articles/2011\\_WI\\_Feature\\_Kania.pdf](http://www.ssireview.org/images/articles/2011_WI_Feature_Kania.pdf).

# NASHVILLE

## Infant Vitality Collaborative

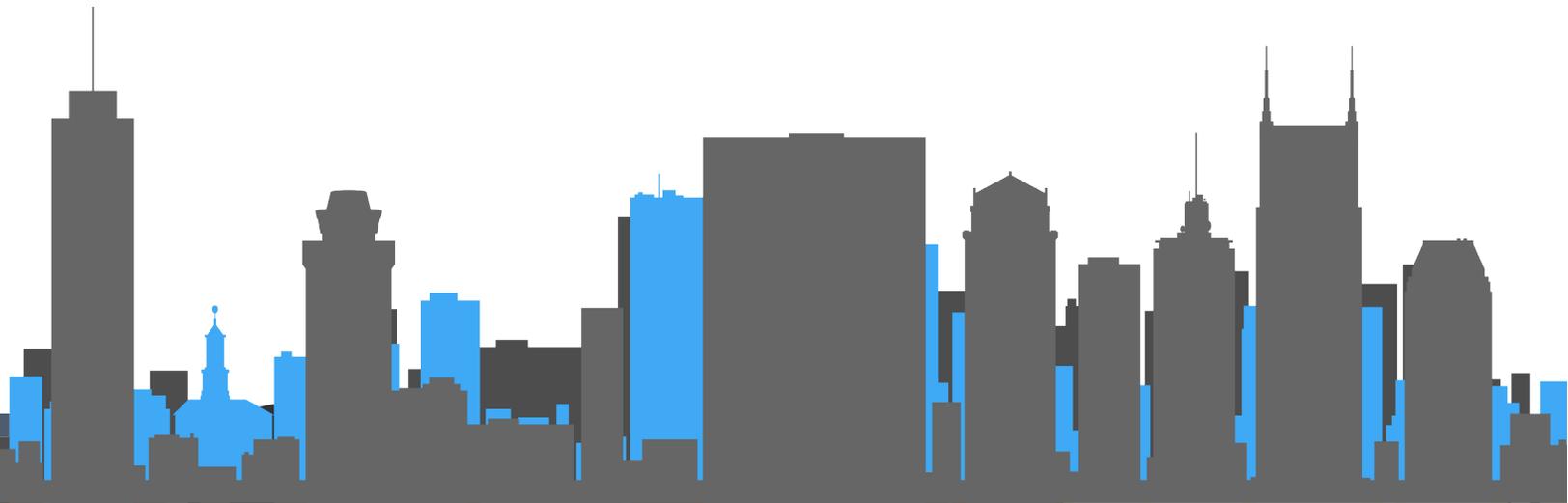
At first glance, it seems routine. Identify a priority issue, look for an opportunity, establish a partnership, and get to work.

“We identified supporting women who had a previous pre-term birth as a priority, and physical environments as an opportunity to make a difference, and we now have a partnership with Nashville’s largest nonprofit that focuses on affordable housing,” said D’Yuanna Allen-Robb, Director, Maternal, Child and Adolescent Health, Metro Public Health Department (MPHD) and CityMatCH Board Member. While still in early development, the vision is the creation of Nashville’s first “Mommy and Me” village – affordable housing specifically for pregnant women and recently delivered families.

Without the ‘we’, it is unlikely, that, “affordable, safe and stable physical environments to optimize infant health,” would have surfaced as a major theme for how to decrease the number of infants that are born pre-term. Without the ‘we’, there would not be community buy-in that, “housing is a critical need and something we can influence with our collective, positive voices.” Without the ‘we’, there would be no, “if ‘we’ do these things ‘we’ will be closer to the positive future ‘we’ envision for Nashville families.”

That ‘we’ is the Nashville Infant Vitality Collaborative (NIVC), a cross-sector collaborative consisting of more than 100 Nashville community members representing various sectors (i.e. business, consumers, health, education, etc.) who are committed to ensuring that, “Nashville is the best place for babies to be born and to thrive.”

It is the, ‘we’ that adds value. It is the, ‘we’ that builds trust. It is the ‘we’ that takes time to establish.



In early 2016, Nashville's Metro Public Health Department signed on as one of 10 local health departments nationwide to participate in cohort one of CityMatCH's Collective Impact Learning Collaborative. Allen-Robb and the health department quickly established a core leadership team consisting of Caroline Young, Executive Director, NashvilleHealth, as well as Dr. Kimberlee Wyche-Etheridge, Associate Professor, Meharry Medical College and former CityMatCH Board Member.

During the first six months the core team worked through the planning phase of the Collective Impact process. They met on a monthly basis and used CityMatCH's Collective Impact toolkit to identify 100 key stakeholders from a variety of community sectors.

"I'll be the first to admit the planning phase felt slow because leaders are trained to act," Allen-Robb said. "I am trained to act. I wanted to choose a priority to work on and get rolling."

Allen-Robb said one of the largest challenges, yet perhaps the most important part with the Collective Impact process, is learning to slow down.

tance calls were a great reminder that it is OK to feel uncomfortable during this phase, because you are being intentional about how to engage your community."

The core team hosted an infant mortality stakeholder meeting in June 2016, where they were able to announce to the community that Nashville would be part of a collaborative to review their infant mortality data. They reconvened in September 2016, to start identifying what organizations were already doing to address infant mortality and identify major drivers around why Nashville was not closing the infant mortality disparity gap soon enough.

In late 2016, Dr. Raquel Qualls-Hampton, Chief Epidemiologist and Epidemiology Division Director, MPH joined the core team to ensure prompt data access and evaluation supports were in place. By April 2017, the group had



*D'Yuanna Allen-Robb*

with one another, but rather we are all on the same page trying to accomplish the same thing. The buy-in and the response from the collaborative would not have been the same, if we didn't follow the conditions and phases of collective impact."

The energy and excitement generating from the NIVC work is being noted.

"We are thrilled for Nashville to host this year's CityMatCH conference and it's fitting because the Nashville Infant Vitality project has done tremendous work in galvanizing stakeholders in businesses, hospitals, education, housing, public health and community around one central goal—to make Nashville the best city for babies to be born and families to thrive," said Kristen Zak, Senior Advisor for Health and Wellness Policy, Mayor's Office. "We're proud and excited about their collective approach toward impacting infant well-being because we know that while quality pre- and post-natal care is critical, social determinants of health also have tremendous impact on a child's and families' ability to thrive."

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"When the core team settled into the realization that we were not going to drive the answers, but that the richness was going to come from the community, that's when we really started to understand the importance of the process," she said. "The monthly technical assis-

identified key themes and values, project aims, and key language changes.

"The April 2017 stakeholders meeting was electric," Allen-Robb said. "There's a trust that those in this collaborative are not competing

# RHODE ISLAND

## Health Equity Zones

With no local or county health departments, Rhode Island Department of Health (RIDOH) has a unique task of safeguarding the health of the nearly one million people who call the nation's smallest state, home. Like many urban cities, the state has adjacent geographical areas that exhibit measurable and documented health disparities, poor health outcomes, and identifiable social and environmental conditions that affect health.

A decade ago, the health department developed a dynamic, comprehensive place-based health strategy that utilizes Health Equity Zones (HEZs)—the geographical areas—to

achieve health equity in urban, suburban and rural communities statewide. The aim was to support communities as they developed a sustainable community-driven infrastructure for addressing social and environmental determinants of health.



Ana Novais

“We absolutely rely on these partnerships and local collaborations to be the public health infrastructure at the local level, our local voice,” said

Ana Novais, Executive Director, Rhode Island Department of Health (RIDOH). “It’s critical that we work at the local level with these collaborations to determine what health means to them, what priorities they want to address, and what strategies will get them there.”

In 2014, RIDOH reinvested in this local public health infrastructure, selecting 10 non-profit organizations to lead community collaboratives that focused on addressing the social and environmental conditions of Rhode Island neighborhoods and eliminating health disparities. In 2015, the health department became aware of CityMatCH’s Collective Impact Learning Collaborative and entered into it with aspirations of refining how they support HEZs.

“We wanted to see how we could change ourselves at the state level,” Novais said. “We thought we could be more effective in managing our local investments and in supporting our local partners to better engage their communities.”

Using the collective impact framework and tools, RIDOH reviewed their HEZ management strategy. This included a review of how they were funding the HEZ initiative, as well as a review of internal management structure and external management structure.

With no HEZ-dedicated funding the health department pursued a braided-funding mod-

## Washington (South) County HEZ: Healthy Bodies, Healthy Minds

Washington County—known by locals as South County—is 333 square miles, and it comprised of nine cities and towns. Mostly known for miles of ocean front and affluence, poverty remains largely invisible.

“In general, our county looks pretty good, but there are pockets of poverty that people don’t even know exist,” said Susan Orban, Director of South County Health Bodies, Healthy Minds. “We’ve relied on our partners to provide that neighborhood level data, so we can better understand the neighborhood level health challenges.

South County Health serves as the backbone organization for Healthy Bodies, Healthy Minds —Rhode Island’s largest Health Equity Zone (HEZ). It consists of community partners from nearly all sectors of the community (both local hospitals, five community health centers, all seven school districts, the University of Rhode Island, both YMCAs, a community mental health center, a community action agency, local state representative, local clergy, a major bank, a major insurance company, the Washington County Coalition for Children, and many other agencies and task forces). Orban said collaboration has been unprecedented since beginning the initiative two years ago.

el that wove together resources from various sources. They had to develop new processes and tools to support this model, because their existing grant management infrastructure did not support the braided-funding model.

The internal management structure now includes a policy group of leaders from all funding areas to provide vision and direction; project officers that work closely with each HEZ collaborative and backbone agency as a community liaison; and subject matter experts, who are internal RIDOH staff with expertise in areas that HEZ collaboratives are working on. RIDOH is reinforcing a model where they all collaborate and make decisions collectively. Novais said, “managing by committee is new,” for the health department and that it is allowing them to be more, “proactive than reactive.” HEZ Project officers are working in more of a

liaison capacity between each local HEZ and the health department—as opposed to simply, “overseeing a contract at the community level,”—to better understand the needs of each community.



**Christopher Ausura**

“We are talking about what issues a neighborhood or town are facing, thinking strategically

about what resources we have, and coordinating between programs and grants to bring resources to that community to address their needs more broadly,” said Christopher Ausura, HEZ Project Manager. “As a result, we’ve seen barriers breakdown and we have experienced a willingness of community partners to work with us.”

Externally, RIDOH worked with the 10 non-profit organizations that were selected to lead local HEZ projects, as they developed an infrastructure for their local collaborative using the collective impact framework. The health department established a learning community to provide a community for local partners to share about their work. Finally, the health department developed the Community Health Needs Assessment Group (CHAG) that supports a statewide process for assessment, evaluation, and policy.

“Today there are 10, vibrant Health Equity

“Today there are 10 vibrant Health Equity Zones in Rhode Island—led by 10 backbone organizations—where we are seeing more relationships being forged on the ground,” said Ana Novais, Executive Director of Health, Rhode Island Department of Health. “It’s leading to changes at the neighborhood level and leading to environments that create and support healthy living for all individuals.”

Zones in Rhode Island—led by 10 strong local backbone organizations—where we are seeing more relationships being forged on the ground,” Novais said. “It’s leading to changes at the neighborhood level and leading to environments that create and support healthy living for all of its individuals.”

Novais said that buy-in has been essential throughout the process, and that its critical for long-term sustainability of local HEZ projects. “Shared ownership sustains the work, and that is why true community engagement is so important,” Novais said. “What we are seeing is organic growth happening. People have become advocates for these local efforts, and they are having conversations with legislators in order to maintain their HEZ.”

**Learn more about Rhode Island’s Health Equity work and each of the 10 Health Equity Zones by visiting [www.health.ri.gov/projects/healthequityzones/](http://www.health.ri.gov/projects/healthequityzones/).**

“The only way we are going to see the kind of results we want is by using a collective approach that engages all sectors,” Orban said. “We have two hospitals, 22 miles apart and they have largely competed with each other, they are working collaboratively, which has not happened before. Getting all of these various players to collaborate and work from the same page, speak the same language, work towards the same outcomes, is really necessary if we are going to move the needle.”

The collaborative initially identified childhood obesity and mental health as priority areas of focus. They set a common agenda of addressing equity gaps, creating enabling conditions, developing new mindsets within the community, engaging everyone in improving

their own health and that of the larger South County Community. “Mutually reinforcing activities are happening naturally, as partners are drawn into the common agenda,” she said.

Orban said the HEZ learning community, developed by RIDOH has been a vital source of support and information.

“It’s a great space for all 10 HEZs to share our ideas, challenges, and successes,” she said.

**Learn more about the Washington County HEZ: Healthy Bodies, Healthy Minds at [www.bodiesminds.org](http://www.bodiesminds.org)**

# Action Learning Collaborative Approach to COORDINATED INTAKE & REFERRAL

Florida's unique network of community-based Healthy Start Coalitions is providing a foundation for the development of local systems of care with a goal of linking at-risk families with services that best meet their preferences and needs.

The state is leveraging its established universal prenatal and infant screening process to facilitate access to an array of home visiting programs that focus on maternal and child health, prevention of abuse and neglect, and school readiness.

"Healthy Start was the only game in town 25 years ago, but the landscape of service availability has really changed so there was a need for a coordination point," said Carol Brady, Project Director, Florida Maternal Infant & Early Childhood Home Visiting (MIECHV).

The question is, how do you improve coordination and collaboration among programs serving families with children age 0-3, and can it be done in a way that links families to appropriate services?

Florida's universal screening process has been around since the early 1990s, and was primarily used to identify people who might qualify for or need the state Healthy Start program.

"There is a lot of information on that screen that could potentially be used to identify people who are eligible for other programs in the community," Brady said.

In 2016, MIECHV launched a Learning Collaborative working with 10 local Health Start Coalitions to test community approaches for implementing Coordinated Intake & Referral (CI&R) for at-risk families using the state's universal screening process.

The coalitions represented urban, mid-sized, and rural communities. Collectively, they accounted for more than 70,000 of the state's 200,000 annual births. They were given a two-year period to craft local strategies for making home visiting a "hub" of local place-based early childhood systems. The aim being for families to receive the best services for their needs, as well as to minimize duplication of services, ensure effective use of local resources, and collectively track what happens to each family.

"We did not have a goal within the project period of developing a full-scale, fully-operational CI&R at the end of the time," said Lisa Pelle, CI&R Consultant, Florida MIECHV. "This was really about taking the time and resources and encouraging them to start exploring what this would look like at the local level."

Coalitions used an Action Learning Collaborative (ALC) framework to guide the work, which began with a 9-month planning period. Brady and Pelle agreed that the planning period was a challenging, yet a critical phase for all 10 coalitions. It allowed them the opportunity to learn more about CI&R, it gave time to explore what programs and services are available in the community, and it gave them the chance to build or even reestablish relationships with partners.

During the planning period, the coalitions formed community teams, created and tested decision trees, and created transparent pro-

cesses for tracking referrals and enrollment in participating programs.

They incorporated Continuous Quality Improvement by using Plan-Do-Study-Act (PDSA) cycles to do small tests of change. Brady said that the evaluations were important and teams began thinking about how to use data to measure impact. She said it also helped uncover challenges.

"The challenges are helping us improve our capacity for tracking referrals and enrollment within the Healthy Start data system to support CI&R," Brady noted.

As the MIECHV project period ends September 2017, the Florida Department of Health (FDOH), the state Title V agency, will begin incorporating the CI&R within the framework for all of the state's 32 Healthy Start coalitions starting in 2018. Brady said that MIECHV will continue providing some support to the 10 coalitions, and will coordinate with FDOH to help scale the work. The 10 coalitions already engaged in the work will provide peer support for other Healthy Start coalitions.

"The pilot sites did amazing work and demonstrated their value as back-bone organizations for coordinating access to care," Brady said.

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"What we learned is that this can work regardless of the size of your community," said Carol Brady, Project Director, Florida Maternal Infant & Early Childhood Home Visiting (MIECHV). "The coalitions and their effectiveness in bringing partners to the table and commitment to working through inevitable challenges, was key to the success of this effort."

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## Hillsborough County

The Florida MIECHV Coordinated Intake and Referral process provided Hillsborough County with the opportunity to improve their Central Intake Unit (CIU). The process was established 10 years prior to the MIECHV project, when centralized intake for infants took place exclusively in hospitals. In more recent years, prenatal populations have been incorporated into the centralized intake process. One of the most valuable pieces of CI&R has been using PDSA cycles to improve CIU intake.

“The supervision piece has improved... it is now more focused on improving engagement with families,” noted Brenda Breslow, Director of Programs, Healthy Start Coalition of Hillsborough County.

Supervisors monitor calls to observe the message delivery style and referral patterns of each intake specialist. With this information, supervisors have designed individual and group training sessions with topics such as motivational interviewing. Within 2 months of this review process, referrals have increased by at least 50 percent. The Hillsborough team now better understands the importance of quality improvement and engaging in the feedback loop by communicating with partners. Additionally, there has been a positive shift in staff motivation. Previously, staff focused on volume, making sure they referred the maximum number of clients. Now, the central intake specialists are more concerned with the connection of appropriate services and longevity of the family.

The CI&R pilot also served as an opportunity to create a mobile app. Once the group came to consensus, the team began reaching out to developers. A common concern amongst staff and community members was that it was difficult to remember the requirements for each agency. Thus, Parent Connection, a home visitation referral service mobile app, was created.

Hillsborough County (Continued on page 13)

## Manatee County

The Healthy Start (HS) Coalition of Manatee serves 2,400 clients per year. Four agencies provide home visitation services within the county, and seven programs that provide home visitation services (prenatal to age five).

Prior to joining the CI&R pilot, the Coalition was already a part of the county’s Home Visitation Coalition. “Everyone was 100 percent onboard and in the right mindset to work on CI&R,” Lauren Blenker, Community Relations Manager. “We were ready to give it the time, and ready to change our processes to make it work.”

Together, the group developed decision trees and tested them by working first with a small population. “Once we were comfortable with the process, we expanded to include first time moms and targeted ZIP codes based on high-need and high-risk,” said Marissa Bressi, CI&R Project Coordinator. “Our goal is to scale CI&R to include the entire county between now and July 18.”

Blenker and Bressi said the CI&R work is crucial for linking families to services they need. Together, the group zeroed in on process flow from screen entry to assignment as a means of making that happen. “It’s about refining the communication to really paint a picture about what families can expect out of services,” Bressi said. “It helps them make more informed choices about how to better address their needs.”

“Throughout the planning process we have been conscious of each program’s deliverables and requirements, and have taken those factors into account before adopting a new element within the system,” Blenker said. “The ultimate goal is better service to families. If an agency receives an inappropriate referral, for example, that takes away time they could be focusing on engaging another family that may be eligible for services.”

## Jefferson, Madison, Taylor

The Healthy Start Coalition of Jefferson, Madison, and Taylor (JMT) serves three rural contiguous counties in north Florida. There are 550 to 600 births a year within these three counties, and the coalition intake is approximately 35 to 45 participants a month. While there are some safety net services provided through the local county health departments, there are no obstetric services and no birthing centers within these three counties. Until recently, the counties had only one home visiting program [Healthy Start], but now more than 12 agencies provide home visiting.

“What makes CI&R work for us is that we are some of the most underserved communities in Florida, and therefore the agencies are highly motivated to change outcomes for our families,” said Donna Hagan, Executive Director, Healthy Start Coalition of JMT. “If we don’t work together intentionally, we will be reaching out to the same people and no one will get into services.”

Hagan said that one of the greatest challenges has involved maintaining the referral infrastructure. “The folks that we are serving are going outside of our county for services [to Leon County],” she said. “It challenges us to work with that community to keep our referral structure.”

Hagan said that because home visitors cover a large geographical area that is sparsely populated, high engagement rates are crucial. “All agencies are looking at months worth of engagement rate data, and we are using a driver diagram to see if we can identify trends or commonality that we can address,” she said.



Florida  
Maternal  
Infant &  
Early  
Childhood  
Home  
Visiting  
Initiative

# HEALTHY START



The Healthy Start EPIC Center (EPIC Center) is responsible for providing technical assistance to Healthy Start grantees to support capacity building of the program. In 2014, the Healthy Start competitive funding announcement introduced Collective Impact (CI) as one of the programs five approaches. Knowing that for many grantees CI was a new framework—even though all Healthy Start grantees have much experience with community collaboration—the EPIC Center knew it would need to focus efforts on increasing grantees’ knowledge of and confidence in applying CI. In 2015, the EPIC Center partnered with the Tamarack Institute, an organization internationally recognized for their expertise in CI, to create a virtual peer learning series called the Collective Impact Peer Learning Networks (CI-PLNs). The CI-PLNs were designed to provide a dedicated forum for grantees to share their experiences with applying CI within the Healthy Start context. A key feature of the CI-PLN structure was, each CI-PLN was co-facilitated by a grantee paired with an EPIC center staff member or paid consultant. This pairing helped balance the context and content experience. Using a CI Implementation Tool Kit developed by Tamarack, the co-facilitators planned monthly calls that focused on a pre-condition or condition of CI while highlighting useful tools that could help grantees apply the condition within their own CI initiative. The initial CI-PLN series consisted of six different groups that met monthly for eight sessions. In 2016, the EPIC Center hosted a second CI-PLN series consisting of three groups that drove a bit deeper into specific topics related to Collective Impact. The majority of Healthy Start grantees participated in at least one of the two CI-PLN series. These peer learning networks and the tool kit laid the foundation for many grantees as they began to more formally incorporate CI as an approach to more effectively address the complex issues their communities face.

In addition to the CI-PLNs, the EPIC Center provides individualized Technical Assistance to grantees that request assistance. This TA is customized and specific to the needs of the grantee making the request. The tools in the CI Implementation Tool Kit, which are also on the EPIC website, have served as a tremendous resource when attempting to bridge the gap between the theory of CI and the application of the approach.

# Collective Impact Infused Into the Work of Healthy Start Grantees

## Center for Black Women's Wellness Inc./Atlanta Healthy Start

"While we have worked collaboratively with multiple agencies for a number of years, this new funding cycle of Healthy Start 3.0 has made us more intentional about collective impact," said Jamea Dorsey, CEO Center for Black Women's Wellness, Inc. "Some of the key factors of success have been having shared leadership and ownership, having team building imbedded into every meeting to help build trust among agencies, and finding opportunities to support each agency at the table."

The Atlanta Healthy Start Initiative (ASHI) worked diligently to achieve collective impact through their AHSI Consortium/CAN. They developed impact focus groups (maternal mental health, early learning literacy, and breast feeding) in an effort to engage members and strengthen partnerships. The impact focus groups support the AHSI-CAN Common Agenda. Each CAN partner had the opportunity to assist the CAN backbone support with 1) managing meetings (registrations, evaluations, dissemination of information, etc.); 2) recruitment and retention activities (inviting target partners to attend CAN meetings, maintaining communications with CAN members, etc.); 3) community collaborative activities (identifying community needs and opportunities for CAN participation, sharing this information with CAN and determining strategies for implementation and/or involvement); 4) marketing and community outreach (disseminating CAN information beyond the parameters of the general CAN to inform other community stakeholders (not currently at the table) of CAN initiatives; 5) evaluations and outcomes (CAN members consistently provide feedback of CAN meetings and activities to determine areas of growth and improvement). These internal strategies parallel the CI implementation phases, resulting in more efficient meetings, more engaged partners, producing specific deliverables, identifying shared measurement objectives and mutually reinforcing activities. The AHSI/CAN embraces CI and supports its Common Agenda. It works cooperatively and collaboratively to achieve collective impact for families and communities in the service area. The CAN partners met throughout the year to develop the shared measurement instrument and mutually reinforcing activities. This was the first attempt to collect data for a shared measurement system.

"The work is important because it provides the opportunity to address common issues through teamwork, the pooling of resources, creativity and vision, which allows a "win-win" situation for the agencies involved and more importantly, the women, children, families and communities we serve," Natasha Worthy, Atlanta Healthy Start Program Manager/AHSI Consortium/CAN, Co-Facilitator.

## REACHUP/Central Hillsborough Healthy Start (CHHS)

REACHUP/Central Hillsborough Healthy Start (CHHS) has been successful in establishing strong reciprocal relationships with partners to mobilize assets, leverage resources, and achieve meaningful change for East Tampa, FL families.

By incorporating Collective Impact to formalize their Home Visitation Advisory Board, they are less siloed in their work, they have a stronger focus on program evaluation, they have been able to strengthen relationships, and they are utilizing data to identify areas of focus. Because of these changes, they can address emerging issues because of established partners, processes, and shared data. They are poised to decide who gets funding locally.

"When there is a funding opportunity, people bring it to the table and go before the board and decisions are made on who should apply," Estrellita "Lo" Berry, President/CEO REACHUP, Inc., and Project Director/Principle Investigator of Central Hillsborough Healthy Start.

CHHS realized that a standardized index was needed to quantify collective impact among healthy start programs. They convened a scientific group comprising of MCH experts and methodologists. They have developed the first standardized method of measuring Collective Impact, the CII. The index represents a potential tool for evaluating and comparing the Collective Impact of HS programs, locally, regionally, and nationally regarding progress made towards targeted objectives and goals.

"Simply put, Collective Impact is combined intellect," Berry said.

## CityMatCH's New At-Large Region Board Member

Olivia Quiroz, a Senior Policy Specialist at Multnomah County Health Department, is one of CityMatCH's newest board members. Driven by her personal experiences growing up as an uninsured, undocumented immigrant from 8 years old until the age of eleven, Olivia finds her passion in public health and social justice work. At this intersection, she works towards addressing and advocating on behalf of communities that do not have a voice or involvement in planning processes. Through her work at Multnomah County Health Department she focuses on raising awareness of and addressing issues surrounding underserved and immigrant communities given our political climate. She strives to capture the story behind these communities and ensure awareness of their contribution to the health of her community as a whole. Her social equity lens stems from her cultural background and historical context, as well as her natural big systems thinking and aptitude for questioning policies and outcomes. She expressed the importance of doing work that is through the values of and in partnership with community-based organizations that are on the ground.

As a new member of the CityMatCH board, Olivia is drawn to the opportunity to gear her work towards interventions addressing the life-course approach, knowing that maternal and child health it is such a critical point as a determinant of a lot of health outcomes. While partnering at the national level, she is excited to learn from other communities and bridge connections between communities of color, their experiences, and solutions at a national level. She hopes to elevate the policy conversation with the equity lens at the forefront.



**Olivia Quiroz**

"The state of Oregon is at the forefront nationally in addressing social determinants of health, with upstream policies," said Olivia Quiroz, Senior Policy Specialist at Multnomah County Health Department. "I am excited to share about our work, and to learn from other communities nationwide."

## CityMatCH's New South East Region Board Member

Marilyn Johnson is the state Title V Director for Mississippi at the Mississippi State Department of Health (MSDH). She has more than 10 years' experience in public health with specific experience in areas of policy and evaluation, grant writing, management, professional development, quality improvement, and maternal and child health. In addition, she serves as the Pregnancy Risk Assessment Monitoring System (PRAMS) Program Manager and the State Systems Development Initiative (SSDI) program manager.

Johnson grew up in poverty in a small rural town in southern Mississippi. She said that she learned early on in her life that poverty is a, 'state-of-mind,' and that taught her to dream big and work hard. She admits that growing up she didn't know she was living in poverty until she was much older because her family was always full of love and her mother often worked two jobs to support her and other family members. She earned a Master's in Business Administration and focused her efforts in training and development. Johnson admits she had no idea that training and development would set her career course. Johnson's first role at the MSDH was in the field of training and development within human resources.

"I was fortunate to meet a lot of people in my first job as training coordinator. I worked with people in our public health districts and central office employees and that afforded me the opportunity to build relationships all over the agency. These relationships proved to be beneficial in the years to come". Johnson stated. "I fell in love with the people and I fell in love with the idea and possibilities of doing something different, in public health."

Johnson said there is tremendous need and opportunity within the field of public health for youth and women who aspire to leadership. She is Chair of the Young Professionals Special Interest Group (YP SIG) of Mississippi Public Health Association (MPHA). The group works to connect young professionals across the state with each other and with mentors within the public health field. Johnson credits her own personal mentorship as being instrumental in where she's at today, and encourages those with aspirations of leadership to be proactive.

"Kathy Burk, our Director of Health Services at MSDH, has been the best mentor. She is a leader who makes it a priority to help people produce GREAT results by making sure people know their goals, making people feel good about the work they do and doing everything possible to support, encourage, and coach people to achieve their goals," she said.



**Marilyn Johnson**

Johnson's background has been helpful as she's worked to establish a culture of communication across programs within the Office of Health Services/Maternal and Child Health. She believes that focusing on individual and team leadership development is foundational for engaging in organizational and systems level change needed to advance Maternal and Child Health. She believes that life is truly what you make of it and if we focus more on seeing opportunity instead of obligation we will not only make a difference but we will "be" the difference.

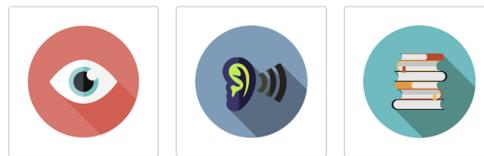
# CityMatCH Learning Portal

This learning portal provides access to online resources developed to augment CityMatCH projects, which are grounded in the philosophy that all children and families deserve to be healthy and achieve their optimal growth and development. Children and families in urban areas have unique needs and deserve special attention. Check out CityMatCH's newest learning modules: the *Local MCH Responds to Zika* and the *Well-Woman Project*.

Access the learning portal at <https://www.citymatchlearning.org>.

## Local MCH Responds to Zika

The Zika virus infection (ZVI) has emerged as a public health threat, with specific implications to the MCH community, that "requires the public, public health professionals, and governments to find effective responses to mitigate the current crisis and prevent recurrence."



- Look**
  - Review information, resources, and advocacy efforts from the MCH community
  - Access information about Zika via the CDC Zika Portal
- Listen**
  - Check out 5-minute segments from the CityMatCH Zika webinar
  - Provide feedback about other topics you'd like to hear about
- Learn**
  - Find the most current evidence-informed research from the field
  - See what social media is saying about Zika

Spread by daytime-active mosquitoes, the virus often causes only mild symptoms but can spread from a pregnant woman to her fetus, resulting in microcephaly, severe brain malformations, and other birth defects. In adults, there has been evidence that ZVI can rarely result in Guillain-Barré syndrome.

There has been much written, presented, and aggregated on the topic. This MCH mini-module does not seek to be comprehensive, but provides learners access to (1) critical federal information, (2) webinar podcasts outlining how two health departments have worked to communicate about, prevent and mitigate the effects of, and used data to develop impactful programs related to Zika, and (3) current-awareness mechanisms to find the latest evidence-informed information as it emerges.

## The Well-Woman Project



- Women**

At the center of this toolkit are resources that directly support women by addressing barriers they face seeking preventive care as well as the realities of their lives that prevent them from being Well-Women.

Access Resources
- Providers**

Providers interact directly with women for preventive care and in addressing issues when they arise. These resources support providers during the Well-Woman Visit and beyond.

Access Resources
- Health Departments & Communities**

An overarching infrastructure is necessary to support both women themselves and the providers who serve them. These resources support a systems approach to Well-Woman Care.

Access Resources

of the barriers women face seeking preventive care as well as the realities of their lives that prevent them from being Well-Women. Most importantly, the Well Woman Project includes an essential and innovative component to this attempt at understanding: women's voices. Access the Well-Woman Project tool kit and resources for women, providers, and health departments & communities in the learning portal.

# Action Learning Collaborative Approach to Coordinated Intake & Referral

## Hillsborough County

(Continued on page 11)

Using this app, referrals can be conveniently made by referral staff, health care providers, or community members. Parent Connection features a parent toolbox containing useful information and interactive activities for children, a health care provider platform, and a listing of community resources such as breastfeeding support, fatherhood programs, and food pantry information.

"[The app] increases the opportunity for touch points with the family as their needs change over time," said Barbara Macelli, Program Manager, Healthy Start Coalition of Hillsborough County. The Hillsborough team collaborated with the app developer, Centric, to set up a user-friendly back end allowing them to make changes as needed. The state partners hope to extend the opportunity to create a mobile app to other coalitions in the future. Breslow acknowledged the FL MIECHV partners stating, "Without funding, it would have been impossible to create this. We are thankful for grant funding."

# It's not just postpartum It's not just depression

*Triesta Fowler, M.D., Medical Officer,  
Eunice Kennedy Shriver National Institute of Child Health and Human Development*



**Triesta Fowler, M.D.**

Pregnancy and a new baby can bring a range of emotions. Many women feel overwhelmed, sad, or anxious at different times during their pregnancy and after the baby is born. Often, these feelings go away on their own. But for some women, these emotions are more serious and may stay for some time. To date, much of the research on maternal mental health has been on postpartum depression, which occurs after the birth of a baby. In that context, as many as 13% of women in the United States report frequent symptoms of depression after childbirth. However, current research indicates that women can experience depression and anxiety disorders during pregnancy and after childbirth, meaning the

actual number of women affected is much higher. These conditions can have profound effects on the health of the mother and her child.

The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) created the Moms' Mental Health Matters initiative to raise awareness about depression and anxiety around pregnancy, the signs of these conditions, and the importance of getting help. The initiative was shaped by the latest research on perinatal depression and anxiety and by candid discussions with moms who have experienced these conditions. A literature review also revealed the need for messaging that dispels stigma and encourages women to seek care from a professional. NICHD created educational materials—including posters, an action plan, and conversation starters—to address gaps in knowledge and promote action. The action plan categorizes symptoms by severity and provides next steps for getting help. To ensure that the materials resonate with moms, NICHD held several discussion groups during the Postpartum Progress Warrior Mom™ conference, where a diverse group of women spoke

about the challenges of recovery, provided feedback on the materials, and outlined strategies for disseminating materials in places where women seek support.

Since the initiative was launched in 2016, more than 15,000 copies of initiative materials have been distributed at sites across the country, including Women, Infants, and Children (WIC) clinics in Connecticut, Texas, and California. Health centers—such as Broward Health in Florida—are also using the materials during consultations with patients. NICHD developed an online continuing education activity, entitled *It's Not Just Postpartum; It's Not Just Depression*, to reach health care providers with the latest research and best practices for screening women during and after pregnancy.

Join NICHD in raising awareness about maternal mental health and promoting resources in the community. All materials are free and available to order on our website. Help spread the word! <https://www.nichd.nih.gov/MaternalMentalHealth>. Depression and Anxiety Happen. Getting Help Matters.



*Eunice Kennedy Shriver National Institute  
of Child Health and Human Development*

# Improving the Health of People and Places through Policy

*Brian C. Castrucci, Chief Program and Strategy Officer  
de Beaumont Foundation*

As a former CityMatch member, I know changing the odds for families' well-being is all in a day's work for urban maternal and child health (MCH) leaders. Your efforts mean more women with quality prenatal care, and more children thriving through the help of home visiting. Thanks to you, more families are staying active, quitting smoking, and eating right.

The results are measured in families' healthier lives. Urban MCH leaders have contributed to lower rates of infant mortality, better control of infectious disease, reductions in adolescent pregnancy and the advent of newborn screening. Yet these hard-won improvements for people are threatened when the places we live make them hard to maintain.

The fact is, without sidewalks, it's harder to walk and stay active. Smoking in bars and restaurants puts us all at risk from second-hand smoke. As urban MCH leaders confront challenges like obesity and type II diabetes, we know community-level change is key to families' success. Cities themselves can do more to give all residents a better shot at health. But to do so, they must look to policy change.

Understanding the power of policy in improving health, the de Beaumont Foundation created CityHealth, an assessment of nine policies tied to health in each of the nation's 40 largest cities. We looked at issues like high quality pre-kindergarten, access to safe streets, and smoke-free air. Each recommendation is backed by evidence, supported by experts, and has a record of bipartisan support.

Our analysis used expert input to assign medal standards for each policy—gold, silver, bronze, and no medal—based on the quality of cities' laws. Cities won overall medals for the total number and strength of policies on the books. Less than half received overall awards, although each city received at least one individual policy medal. Clearly, cities have a lot of opportunities for growth.



**Brian C. Castrucci**

Over the next year, CityHealth will release new, in-depth policy analyses. We'll support cities making positive policy change. We ask you to visit our website and start a conversation with health and other city leadership about using these policies to improve residents' health. Think about how maternal and child health funding can support policy efforts, and how community-based partners can play a strong role.

Ultimately, MCH leaders' efforts are amplified or undermined by the quality of life cities offer their residents—especially those who face the steepest odds. The fact is, decision-makers need to hear your trusted voices on behalf of policies that make real, lasting improvements to people's lives. That's how, as champions for community well-being, you make sure health isn't just something individuals strive for—it's something your cities put first.





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# SAVE THE DATE

The 2018 CityMatCH Leadership and MCH Epidemiology Conference



DATA, PROGRAMS, AND POLICIES FOR HEALTHY MOTHERS, CHILDREN, AND FAMILIES

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Learn more at [www.citymatch.org](http://www.citymatch.org)

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