HEALTHY START IMPACT REPORT

Introduction

The purpose of the Healthy Start (HS) Impact Report is to provide a written summary, from the grantee's perspective, of the experience and impact of Healthy Start. Please use the following outline in writing your project>s Impact Summary. (Narrative must be limited to 100 pages).

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

Identify the racial, ethnic or other disparities that your project focused on. Highlight from your initial community needs assessment the data that led to your community's decision to focus on the identified disparities. The following highlights disparities that consumers experience in Doña Ana County:

- Less than 70% of women enter prenatal care during the first trimester. This percentage represents 99% White Non-Hispanic and only 61% White-Hispanic mothers.
- The percentage of births to women who had no prenatal care is greater than 2%. Of the almost 5% of births with no prenatal care, 94% involved White-Hispanic women, while 4% were to White Non-Hispanics.
  Therefore, 6% of White-Hispanic women gave birth with no prenatal care, compared to 1% White Non-Hispanic.
- Only 58.2% of children from 0 to 2 years old presented with a complete schedule of immunizations.
- Forty-four percent of children under 18 years of age live with their families at incomes below the Federal Poverty Level. This percentage clearly exceeds the 19.9% guideline for this population.

II. Project Implementation

Using as a framework the five Healthy Start Core Services (Outreach and Client Recruitment; Case Management; Health Education and Training; Interconceptional Care; and Depression Screening and Referral) and the four Core Systems-building Efforts (Local Health System Action Plan; Consortium; Collaboration and Coordination with State Title V and Other Agencies; and Sustainability) identify how your Healthy Start Project implemented each service and system intervention. For each one, answer sequentially the following: Underpinning the implementation of the five Healthy Start Core Services and Four Core Systems Efforts is the cultural and socio-political context of the project area. Doña Ana County (DAC), the project area, is located in south central New Mexico and shares a common border with Texas and Chihuahua, Mexico. The area is physically diverse and includes mountain ranges, a rich narrow agricultural valley, and desert terrain. It is ethnically, culturally, and economically diverse and covers a land area of 3,807 square miles. As an international border area Doña Ana County faces bi-national issues. The county has four incorporated municipalities: Las Cruces (the county seat), Hatch, Mesilla, and Sunland Park

and 36 unincorporated communities called colonias. These federally designated areas, within 150 miles of the U.S.-Mexico border, are hardscrabble communities that lack potable water, adequate sewage and other utility systems, and decent, safe and sanitary housing and schools.

Doña Ana County holds the second-largest population in the state at 180,464 in 2000, with 58.6% Hispanic, 38.3% White Non-Hispanic, 1.9% Black and 0.8% Native American. Currently 9.8% of the state's population resides in the county. In 1998 11% of all New Mexico's births occurred in DAC. Doña Ana County is growing faster than any Metropolitan Statistical Area (MSA) in the state and is the ninth-fasting growing in the nation (U.S. Census Bureau).

Doña Ana County grew 40.7% from 1980 to 1990. Growth is estimated to increase annually at 2.4%, reaching 227,009 by 2010.

Despite its growth, the county has experienced prolonged and persistent poverty. The county is the fifth poorest MSA in the nation. Doña Ana County has the seventh-highest adult poverty rate in the state, with almost 30% of the population living below the Federal Poverty Level (1993). Approximately 30% or 53,000 Doña Ana County residents live in impoverished colonias. Doña Ana County ranks worst in the state and nation for children under 18 living in poverty, with 43.5% below the Federal Poverty Level according to a 1995 estimate (U.S. Census Bureau).

Female head-of-household make up over 45% of DAC residents living below the poverty level: 56.1% are with related children under the age of 18, and 70.2% are with related children under 5 years of age (U.S Census, 1990).

There are approximately 3,000 births in DAC annually. Two thousand, three hundred forty-eight (2,348) or 79% of all live births annually are to White-Hispanic women.
Teen pregnancy in DAC, especially involving Hispanic teens, continues to rank among the highest in the state and nation. Vital Statistics Reports 48(6) ranked New Mexico the fifth highest in the nation in teen birth rates. The current teen pregnancy rate for Doña Ana County is 19%. The year-three average of births to teens is 13 % or 574 births annually. Eighty-five percent (85%) or 489 births are to Hispanic teens.

The three-year average infant mortality rate in the county is 6.83%. In 1997 the rate decreased 1.5 % from the previous year. However, in 1998 the mortality rate increased by 4% to a rate of 9% for the year. A similar trend is reported for neonatal deaths with a three-year average of 4.3%. A 4.0% increase was reported from 1997 to 1998. The 1998 neonatal death rate was 6.7%. Over 18% of residents' births occur in other states. Mortality rates for out-of-state births are not available.

Access to prenatal care continues to be a problem, especially for Hispanic women in the county. The three-year average of births to pregnant women who had no prenatal care in DAC is 4.9%. White-Hispanic women represent 94% of the total population who received no prenatal care compared to 4% of White Non-Hispanic women, 1% of Black women, and 1% other women. Entry into first-trimester care is more likely to occur for White Non-Hispanic women compared to Hispanic women in the county. Sixty-eight percent of pregnant women entered prenatal care

during the first trimester, according to a three-year average. Ninety-nine percent of White Non-Hispanic women enter care in the first trimester compared to 61% of White-Hispanic women.

Access to health care is limited by factors such as lack of transportation to facilities, vast distances between patient and health care providers, shortage of health care providers, limited health care coverage, and endemic poverty. Most services and many people reside predominantly in Las Cruces. Although services are expanding, surrounding rural communities still experience shortages of primary, dental, emergency, social service preventive and adolescent health care services that are adequately geared to the economic status of residents. Doña Ana County is designated a Medically Underserved Area, Exceptionally Medically Underserved, a Health Care Underserved Area and a Health Provider Shortage Area (HPSA) by the U.S. Department of Health and Human Services.

Prior to implementation of the project, DAC was experiencing an exodus of physicians over two years with at least 35 physicians leaving the project area.

Approximately 50% of DAC population lives outside the city of Las Cruces, but more than 90% of physicians practice in the city. Hatch residents must travel at least 40 miles to Las Cruces or Truth or Consequences for specialized health care services and labor and delivery. Cross-border utilization of services has been identified in Doña Ana County for twenty-five percent of patients of Mexican physicians living in the United States. Southern Doña Ana County residents often cross state lines into El Paso, Texas, or national borders south to Ciudad Juárez, Chihuahua, Mexico for health care. More than 17% of DAC resident births occur in Texas (Border Health Office).

Absence of health care coverage is another factor that limits access to care. Lack of health care coverage for all residents is 24.5%, with Hispanics having rates twice as high (34.2%) as Non-Hispanics (15%). Chart 4 below provides a view of coverage among adults by ethnicity in the county.

In 1998, Doña Ana County had the highest percentage of uninsured adults in the state at 70.8% (NM Health Policy Commission).

Another important consideration that impacted the implementation was the sale of our only public hospital to a private-for-profit national chain of Hospitals.

Identify how your LCDF Healthy Start Project implemented the core service **Outreach and Client Recruitment.**

A. Describe how you decided on your approach to Outreach and Client Recruitment and the rationale for your particular approach based upon your particular community's needs, service system and its challenges and assets. Our approach to Outreach and Client Retention services was built on an existing community-based model. The model emphasizes the use of Promotoras (Community Health Workers) indigenous to the communities being served. The Promotoras' history of involvement and leadership within their local communities places them in the position to act as cultural guides for

the target population. Another important attribute of the Promotora is the ability to communicate with the target population. Promotoras are bilingual (Spanish/English) and able to understand the colloquialisms of the border Spanish dialect. They also have a good working knowledge of the community's dynamics, culture and needs**.**

B. Identify the components of your Outreach and Client Recruitment intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes. Our Outreach Model has two components, ***client identification/ recruitment and client retention/family support*****.**

Client identification/recruitment refers to a variety of client find strategies designed to: 1) identify and help pregnant women access prenatal health care and care coordination services (preferably in the first trimester of pregnancy); and 2) identify and help parenting families of children ages zero to two access care coordination services. Client find strategies include, but are not limited to, health fairs, presentations at WIC and other public health agencies and organizations or locations where consumers go to receive services, door-to-door, word-of-mouth, distribution of written materials, etc.

Client retention refers to activities designed to keep pregnant women and parenting families connected to on-going health care and social services. There are two types of Outreach Client Retention Activities, 1. Follow-up for no show appointments and 2. Family Support. Follow-up to now show appoints is initiated with a referral from a medical provider, care coordinator, or health educator, to the Promotora to find and get the client back into services. *Family Support services are provided in the families home are designed to support continued involvement in care. Family support includes but is not limited to infant care and safety, parent role modeling/education, social/emotional support (Platicas), home safety, respite, health information, etc.)* Outreach services were provided by 2.88 FTE Promotora under contract with the Promotora Program and .50 FTE Promotora in the Healthy Start Program. Promotoras funded through our State Title V Program and out State Border Health Office also provided Outreach/Client Identification/Recruitment services. A deviation in our outreach model occurred in year two of the program to help us improve our data collection. Initially, promotoras provide case management for a small caseload of low-risk consumers. The Promotora approach to case management did not lend itself to effective data collection. We therefore changed outreach services and created "family support" services as a component. Family support outreach services are driven by a case management needs assessment that establishes intervention, level and duration of care.

C. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of your Outreach and Client Recruitment intervention. The Healthy Start did not receive State Title V MCH Program funding. However, the Promotora Program, our contract provider for outreach services, receives funding from our State Title V MCH Program for outreach services that are used to enhance outreach to pregnant and parenting families. Unfortunately, due to State budget shortfalls, the Promotora Program has experienced a

reduction in this funding over that last three years.

Identify how your LCDF Healthy Start Project implemented the core service **Case Management.**

D. Describe how you decided on your approach to Case Management and the rationale for your particular approach based upon your particular community's needs, service system and its challenges and assets. To implement Case Management, the DAHS built upon case-finding activities in collaboration with Families FIRST and Title V MCH Contractors to increase case management services to pregnant women and parenting families with infants ages 0-2. Our Healthy Start case management builds upon "Families FIRST" model. Families FIRST, is a State Medicaid funded care coordination service. Agreements between the HS and Families FIRST (FF) program to blend models to enhance services and build capacity represented the first phase of systems integration.

There were several reasons why this model was selected. First, Families FIRST was being underutilized in our community. We felt that it was important to maximize State Medicaid funding to demonstrate need and plan for sustainability. Second, we felt that we would have greater success if we built upon an existing approach and expanded it to address gaps in the model. Third we wanted to avoid duplication and unnecessary competition. Finally we wanted to create an equitable model of case management services in the project area.

E. Identify the components of your Case Management intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes. Our Healthy Start Case Management approach was designed to empower women to select and design a course of prenatal and postpartum care that best fits their needs and allowed them to care for and sustain their families over time. The purpose is to assure the coordination of multiple services required to effect positive lifestyle changes and outcomes for pregnant women, babies, and families. The development of the Healthy Start case management services were driven by three common challenges:
   - The need to integrate services to overcome fragmentation and to ensure care for the whole person;
   - The need for continuity of care as challenges change and;
   - The need for individualized treatment to meet the individual's unique constellation of challenges.

Case management services were provided by 4 FTE Social Work, and 1 FTE RN, Case Managers, funded by Healthy Start, 1 FTE funded by Children Youth and Families Department and 1FTE funded by Families FIRST. The RN primarily provided case consultation to Social Work Case Managers.

The components of our case management included: Enrollment, Assessment, Referral & Follow-up and Case Closure. All participants receiving case management through the perinatal system of care received an enrollment number issued by the Healthy Start

Data Manager. This step helped to prevent duplication, track mix of service and levels of care, and gathers evaluation data.

During the prenatal period, participants received, at a minimum, the level of case management identified below:

- Three face-to-face contacts and one telephone contact during the prenatal period and a home visit two weeks postpartum
- A complete and comprehensive psychosocial assessment (see attached Perinatal and Prenatal Assessment), typically in the first trimester, that identifies strengths, needs, and risks along life domains that will include physical and mental health, family support, domestic violence, substance and alcohol use patterns, housing, income, education, employment, and relevant cultural information.
- Depression screening
- Individualized service plan
- Family and interconceptional planning
- Prenatal and postpartum health education

Case managers provide a home visit to a newly delivered mother within two weeks. This visit ensures that the mother has arranged for her postpartum clinic appointment and has initiated care for her infant. A forty-eight hour post hospital contact procedure has increased participation rates of postpartum follow-up contacts and completion rates of the two-week newborn check up. Case managers also recruit into the Healthy Start system mothers who presented into labor at the hospital without any prenatal care.

Case management continued for the family through the first postpartum year up to 24 months. Visits are made, and the newborn education pathway is followed to ensure basic parent education on safety and infant growth and development.

Families with infants enrolled into the system can expect, at a minimum, the following level of care:

- Face-to-face contacts at 2 months, 4 months, 6 months, 8 months, 12 months, 15 months, 18 months, and 25 months
- Case managers who track maternal postpartum, family and interconceptional planning services, infant well-child visits and immunizations, and continue assessment and referral according to the psychosocial assessment and case plans
- Use of the Infant Ages and Stages Questionnaire (ASQ). The ASQ is designed to help parents understand and monitor child development (additional details on the ASQ are included in the Health Education section of this application).
- Breastfeeding support and education
- Health education.

To facilitate the coordination of medical and social services 5 TRIAD Teams composed of RN, Social Worker and Promotora have been established. TRIAD is a misnomer in that the team has grown to include a Health Educator and in some clinics the physician.

Prenatal days have been established in medical facilities that provide prenatal care. The Triads meet to complete assessment and plan a course of care. All Triad teams meet quarterly to discuss success, challenges and review program data.

F. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of your Case Management intervention. Our Families FIRST Medicaid funded Program is managed by three different HMOs, Presbyterian, Lovelace and Molina. Each HMO has its own set of operating procedures and reimbursement rates. One HMO changed procedures regarding prior approval and ultimately prevented reimbursement for case management. Another did not reimburse for case management beyond the post-partum period. This two events lead to loss in funding and an increase in clients served with Healthy Start funding only. Families FIRST case management is reimbursed at an inadequate flat rate per client. The model does not reimburse or pay for depression screening, substance abuse screen, client retention, or other support services. Healthy Start enhances the model of case management by providing for these screenings. We have found maximizing Medicaid funding is an ongoing challenge. Low reimbursement rates equal high caseloads (approximately 150 clients) to maintain one FTE Social Worker position.
Describe how you decided on your approach to Health Education and the rationale for your particular approach based upon your particular community's needs, service system and its challenges and assets. The Healthy Start utilized a community-and clinic-based model for the provision of health education core service. The model was designed to engage and encourage early and on-going prenatal care. .

G. Identify the components of your **Health Education** core system-building effort and the resources (including personnel) needed to implement the core system-building effort. Note any changes over the project period and the rationale for the changes.
The Health Education components included community outreach and education for recruitment, and one on one and group didactic eight-topic curriculum for perinatal health.
Promotoras used a curriculum titled Comenzando Bien as an outreach tool to enable communities to help identify women who are planning a pregnancy or are already pregnant but not accessing prenatal care The Comenzando Bien Curriculum is a March of Dimes set course designed specifically for childbearing women. The Comenzando Bien program provides training on how to bring the information to consumers about prenatal health.

The perinatal health educator provides health education to women enrolled in the program that included but is not limited to: preconception; comprehensive prepared childbirth classes; breastfeeding; baby basics; interconceptional education; child development; family planning including basal body temperature, bilateral tubal-ligation and vasectomy; breast and cervical cancer; and hormone replacement therapy. Participants were also able to access education on gestational diabetes, healthy nutrition, parenting, smoking cessation and life style change. Bilingual literature and videos enhanced our health education services.

The Healthy Start Program utilized 2 FTE Health Educators to improve access to health education services for women of childbearing age in the project area.

H. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of your Health Education core system-building effort. Integration of Program Bien Estar with the Healthy Start Program and cross training of all health education advanced core system building and increased the number of Health Educators available to provide Health Education on a broad range of topics. Currently the system has 5 FTE Health Educators that provide all health education.

Identify how your LCDF Healthy Start Project implemented the core service **Interconceptional Care**.

Describe how you decided on your approach to Interconceptional Care and the rationale for your particular approach based upon your particular community's needs, service system and its challenges and assets. We utilize an education and case management approach to Interconceptional Care in the project area. The approach was selected to encourage early access to services and selection of family planning methods. Our goal is for women to select a family planning by the third trimester.

I. Identify the components of your Interconceptional Care intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes. Interconceptional care typically begins during the first trimester of a woman's pregnancy and continues until case closure (ideally two years post-partum). The components of our interconceptional program are education and case management.

Education is designed to address health risks of a second pregnancy, myths regarding breastfeeding and pregnancy, and contraceptive methods. Case Management is designed to help women access (referral) and receive on-going (through tracking) Family Planning Services. We utilize an interconceptional tracking form to continually address care throughout the client's participation in the program.

J. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of your Interconceptional Care. Our project area experienced the loss of Planned Parenthood as a result of budget shortfalls. This loss was particularly detrimental to teens that relied on Planned Parenthood for free and confidential birth control.

Identify how your LCDF Healthy Start Project implemented the core service **Depression Screening and Referral.**

K. Describe how you decided on your approach to Depression Screening and Referral and the rationale for your particular approach based upon your particular community's

needs, service system and its challenges and assets. We utilize an education and case management approach for Depression Screening and Referral. Analysis of our depression data revealed that a large number of women in the project area experience feelings of social isolation. To address this issue Community Involvement Teams (CIT) were established in 5 communities in the project area. The CIT provide an opportunity for women to socialize with other people in the community, provide input on services and gaps, and acquire information on a variety of Health Education topics.

L. Identify the components of your Depression Screening and Referral intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes. The Program uses the Center for Epidemiological Study Depression Screening Tool to assess for risk of depression. The instrument was selected based on the rate of reliability and validity established with Mexican American population. Participants are typically screened at intake and post-partum. Participants scoring at-risk for depression are referred for mental health services and to their primary physician.

M. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of your Depression Screening and Referral intervention. Our State has historically not provided for a depression screening such as the one that we use.

Identify how your LCDF Healthy Start Project implemented the core system-building effort **Local Health System Action Plan.**

N. Describe how you decided on your approach to Local Health System Action Plan and the rationale for your particular approach based upon your particular community's needs, service system and its challenges and assets. The Local Health System Action Plan for this project involved a multi-pronged approach targeted to both link existing community services with the target population and to create new linkages between existing entities and the target population, under the auspices of the Consortium. Doña Ana County is currently served by a number of social service agencies. The Local Health System Action Plan focused on creating stronger partnerships with public and private services within in the community.

O. Identify the components of your Local Health System Action Plan core system-building effort and the resources (including personnel) needed to implement the core system-building effort. Note any changes over the project period and the rationale for the changes. The components of our Local Health Systems Action Plan include, ongoing needs assessment and strategic planning, training and implementation and coordination. The resources needed included Management Team made up of I FTE Program Director, 1 FTE Health Education Services Coordinator, 1 FTE Case Management Services Coordinator and 1 FTE Consumer Involvement Coordinator and time and efforts of the Leadership Team and Consortium Members. Our efforts yielded the following results:

- Integration of the Case Management System. We successfully integrated Families FIRST, Adolescent Family Life Program and Healthy Start Case Management under one umbrella. The integration resulted in the creation of a uniform data collection system, comprehensive model of case management and implementation of 4 P Plus Screening for Substance Use/Abuse, Depression Screening and Interconceptional care.

- Integration of Health Education Services: We successfully integrated Healthy Start with Programa Bienestar to enhance Health Education Services to the target Population.

- Established cross systems coordination with Women, Infants, and Children (WIC) to assure resources and services to consumers. Healthy Start and WIC collaborated to provide easier initial access to services and maintenance thereof. Established a Lactina Loan Program to promote breastfeeding. Collaborate with local Breastfeeding Task Force to promote breastfeeding in the project area.

- Established Leadership Team to coordinate services with Mental Health and Substance Abuse Programs, Early Head Start and Head Start Programs and to promote and advocate for perinatal best practices.

- Customer Satisfaction – Continued monthly Consortium meetings with consumers enrolled in the program. Established Community Involvement Teams is several communities to develop better means of receiving feedback from consumers, whose general lack of transportation makes attending consumer satisfaction meetings difficult. The Consortium developed incentives as a means to support meaningful consumers participation in the consortium.

- Public Relations – Implemented a grass-roots public relations campaign designed to generate recognition of Healthy Start in the community. Bilingual radio and print campaigns, as well as brochures were distributed by hand in areas with little media access. All material were published bilingual English/Spanish.

- Needs assessment update – Supported our local MCH Council to complete a community needs assessment

P. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of your Local Health System Action Plan core system-building effort. Reduction in funding due to State budget shortfalls and the subsequent decision by Board of County Commissioners to dissolve the MCH Council resulted in funding losses, service reductions, and hindered meaningful coordination across programs in the project area. Another event

that adversely impacted advances to our LHSAP was the restructuring of Programs at the State level that resulted in significant personnel changes.

Identify how your LCDF Healthy Start Project implemented the core system-building effort **Consortium.**

Q. Describe how you decided on your approach to Consortium and the rationale for your particular approach based upon your particular community's needs, service system and its challenges and assets. The Healthy Start Program utilized a multi-level Consortium model that successfully builds on existing community resources and develops new infrastructure for greater consumer participation. The Doña Ana County Maternal Child Health Council acted as the project area consortium for the HS Program. The Council was a county-appointed advisory group actively involved in assessment, planning, advocacy and coordination of maternal and child health services since 1992. From the inception of the Healthy Start Program in 1999 until approximately 2003 the Council expanded its role to include advising the Healthy Start Program in its effort to eliminate disparities in perinatal health and increase consumer participation. Council members were instrumental in writing the Healthy Start grant application in 1999 and along with consumers, were also involved in developing all applications for the grant period of the impact report. To assure program compliance the Council created the Healthy Start Advisory committee to work with the program.

In FY 02/03 the Healthy Start Advisory Committee spun off from the MCH Council and created the Healthy Start Consortium. The Healthy Start Program continued to be a part of the MCH Council and acquired voting privileges. The Healthy Start Advisory Committee (HSAC) assumed consortium responsibilities for the Program. The HSAC eventually developed new bylaws and adopted the title; Healthy Start Consortium. The Healthy Start Consortium continues to utilize a multi-level consortium model. The model emphasizes active participation in, rather than competition and duplication, and leads community initiatives towards positive policy changes and best practices.

R. Identify the components of your Consortium core system-building effort and the resources (including personnel) needed to implement the core system-building effort. Note any changes over the project period and the rationale for the changes. As described in the previous section the Consortium for our Healthy Start Program experienced numerous changes for its original status within the Maternal Child Health Council to the eventual structure. Inherent in the initial relationship was the mutual responsibility over fiscal management/distribution of resources, and contract deliverables. The unforeseen consequential tension tested the core of the relationship and lead to the current structure for our consortium. We began our consortium experience within a Council with 10 years experience advocating for and coordinating maternal and child health services in the project area. The Council conducted business within a committee structure established through by by-laws. The council maintained 1 FTE Coordinator to coordinate the business of the Council. The position was partially funded (.50 FTE) by the State Title V MCH Block Grant and .50 FTE through Healthy Start Program. The Coordinator was responsible for coordinating meetings and training events, including General Council Meetings, Executive Committee Meetings and Contractor Meetings. The Healthy Start Program also provided funds for childcare, translation services, educational materials and

supplies and training events. In fiscal year 2002/03 the consortium established the Healthy Start Advisory Committee to carryout the oversight responsibilities of the program. By the end of 2003 the Healthy Start Advisory Committee became the Consortium for the Healthy Start Program.

The components of the current Consortium include a committee structure as follows:

- Policy Council consisting of Healthy Start and Early Head Start Program participants and CIT representation primarily provide advise and advocacy around program policy and access
- Leadership Team consisting of medical/dental/mental health providers, Early Head Start and Head Start representatives, Promotora Director, Health Education Coordinator, Case Management Coordinator and the Data Manager primarily provides "leadership" in practice and systems change. Members of the Leadership team are involved in community initiatives such as the Health Allliance, Tobacco Free Coalition, Breastfeeding Task Forces, Border Health Council and to coordinate and supports efforts.
- 5 Community Involvement Teams consisting of Healthy Start participants, community members, promotoras, and other community leaders primarily provide information on community needs and mobilizing members for policy action.

TheHealthy Start Program staff coordinates all the meetings of the Consortium, in collaboration with the Consortium and committee chairs. The administrative assistant completes minutes of all meetings, sends out agendas and meeting notices. The Policy Council meets bi-monthly. The Leadership Team also meets bi-monthly. Each CI T has at a minimum one monthly event. The Consortium as a whole meets twice annually.

S. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of your Consortium core system-building effort. The loss of our local Maternal and Child Health Council was an unfortunate event that presented significant challenges. Despite this event the Healthy Start Advisory Committee emerged as new leader and visionary for the new era in maternal and child health in the project area. The decision by the Doña Ana County Maternal and Child Health Council to fiscally and physically relocate under Doña Ana County government detracted from implementation of some of planned activities to our Local Health Systems Action Plan (LHSAP).

T. For consortium, please address the following additional elements:

   a. Highlight how the Consortium was established and identify any barriers that emerged in its establishment and how they were addressed. The current Healthy Start Consortium was a spin off from a local Maternal and Child Health Council with 10 years experience in addressing maternal child health issues in the county. Since the Council initially acted as the Consortium for Healthy Start we did not experience some of the 'growing pains' that typically come with starting a new program. However, as the Council evolved and it's priorities

shifted, their role in the Healthy Start Program changed. The eventual spin-off, although not without some challenge, helped to bring focus and re-direct resources to consumer services.

b. Briefly describe the working structure of the Consortium which was in place for the majority of the implementation, its composition by race, gender and types of representation (consumer, provider, government, or other). Also, please describe the size of the consortium, listing the percent of active participants. Committees, established through by-laws are the working structure by which the Healthy Start Consortium was implemented. One (1) FTE Coordinator facilitated the work of the committees. The by-laws delineate committee structures and responsibility. The Executive Committee held the primary responsibility for carryout the mandates and directives of Consortium and to:

   i. Ensure that the Council operates within the framework of the CMCH Plan Act;
   ii. Establish and oversee functional standing/ad hoc committees and charge them to perform specific tasks;
   iii. Oversee long range planning to carry out Council activities;
   iv. Support the coordinator in all decisions and actions consistent with policies of the MCH Plan Act, the county comprehensive plan and the current scope of work and contract;
   v. Working with MCH Contractors, Healthy Start and La Clinica de Familia, Inc. Administration and other entities to develop a process to review for support in distribution of funds and project plans;
   vi. Ensuring consumer representation and input at all General Council meetings.

   The Healthy Start Advisory Committee was the formal structure by which consumers and community representatives can participate in the program policy making of the Healthy Start project. The advisory committee ensures that a community collaborative effort is involved within the project. Further, the advisory committee has the responsibility to advocate for the concerns of Healthy Start consumers.

   This Advisory Committee was a sub-committee of the Maternal Child Health Council and evolved to become the Healthy Start Consortium to:.

   - Carry out the mandate of the Consortium and act on its behalf in helping to develop programs that meet community needs;
   - To establish ad-hoc committees and charge them to perform specific tasks and set timelines for them;
   - To help develop the Healthy Start grant applications and the project budget with the Program Director and recommend its approval to the Consortium Executive Committee;
   - Have the responsibility to plan, review, advise, and participate in

program contract monitoring in cooperation with La Clinica De Familia;

- Review progress reports and financial status of compliance with grant application from the Program Director on a quarterly basis;.
- Designate one of the Advisory Committee Co-Chairs to be a member of the Consortium Executive Committee and report regularly at Consortium meetings;
- Provide input to the general direction of DAHS in accordance with the Memorandum of Agreement between the MCHC and LCDF.
- Provide written input for the annual performance review of the Program Director to the appropriate staff of LCDF and, if the need arises, provide input into the selection process of a new director; and
- Attend Advisory Committee meetings and appropriate activities of the Consortium.

1. ***Consumer Involvement*** – The advisory committee consisted of 51% consumers and was evaluated annually to ensure that percentage was met. Consumers are identified as individuals not employed by a service provider in a professional or an administrative capacity. Consumers were persons who are likely to receive Healthy Start services. This would include pregnant women, women of child-bearing age, fathers of young children, families of the above, caregivers/guardians or other persons who are likely to benefit from Healthy Start services.
2. ***Number*** - The Advisory committee consisted of a minimum of seven and a maximum of fifteen members, four of which were the chairpersons of the Community Involvement Team's. Two members were elected by and from the Consortium, one of whom served as co-chair of the Advisory Committee. The other co-chair was a consumer elected by the Advisory Committee from its ranks. One community member from the business, volunteer or faith-based community shall be elected to the Advisory Committee through the nominating process (Article 3, Section D). The remaining members of the Advisory Committee were selected as follows: For every two consumers elected through the nomination process, the consortia elects one member and the Advisory Committee elected another community member through the nomination process. Every effort was made to represent the business, faith and volunteer community. The total membership of the Advisory Committee did not, at any time, exceed a total of fifteen.
3. ***Diversity*** - The diversity of the Advisory Committee strived to reflect that of the population it served, i.e., age, ethnicity, gender and language. The Council also established a consumer-driven, countywide Healthy Start Consumer Advisory Group composed of four Community Involvement Teams, (CIT). The Community Involvement Team(s) (CIT) represent different geographic areas of Doña Ana County (DAC). The CITs are a mechanism to ensure consumer participation in the Healthy Start Advisory Committee (HSAC) and the Council. They are the Las Cruces, Sunland Park, Del Cerro and Chaparral CIT,s. With support and

technical assistance from HS staff, Community Involvement Teams meet on a monthly or bi-monthly basis to plan and host meetings, events or community trainings based on needs and issues that they have identified.

Community Involvement Teams are responsible for providing feedback on Healthy Start and related services in the community, barriers to accessing care and identifying needs. In order to ensure consumer voice in the DAHS, each CIT selects a consumer representative from their membership to participate as a voting member of the HSAC. Consumer representatives advocated for Healthy Start program participants to help evaluate services provided by Healthy Start (and related services) and identify gaps and needs for new program services. Each CIT has a designated part-time HS staff member (promotora) responsible for recruiting consumers and community members to their local CIT. Promotoras assist in the coordination of CIT activities, make referrals to Healthy Start or related services, and serve as consumer advocates..

Membership in the CIT is open to consumers and residents of the project area, with a focus on Hispanic pregnant women and Hispanic women of childbearing age and their families. The profile of a CIT member is any resident of DAC not being compensated by the Healthy Start grant. The CITs strived to include a diverse membership (ex: age, ethnicity, gender, language).

The average annual composition of the full consortium was:

- Race, 80.9% Hispanic, 18.2 % White, .09% Native American
- Gender, 86.4 Female, 13.6 % Male
- Consumers, 46.6 %, Providers 53.4 %

c. Describe the activities this collaborative has utilized to assess ongoing needs; identify resources; establish priorities for allocation of resources; and monitor implementation. Describe your relationship with other consortia/collaborative serving the same population. To assess ongoing needs, identify resources; establish priorities for allocation of resources, the Consortium conducted a community needs assessment spearheaded by the Maternal and Child Health Council. The needs assessment included findings from review of State vital statistics data, community /consumer focus groups, State Title V MCH Block Grant Plan and provider surveys. The consortium for the healthy start program was actively involved with several collaborative efforts servicing the same population. The following are examples of some of those relationships:

- We collaborated with the local chapter of the State Tobacco Free Coalition. Our role in this effort was to coordinate consumer involvement in a public education and awareness campaign and promote smoke free environments for families. Our efforts resulted in a City and County no smoking ordinances.

- We are members of the Child Abuse Awareness Team that was created to develop and implement child abuse awareness and prevention strategies. Healthy Start through our CIT cosponsored several countywide Child Abuse Awareness and Prevention education and training events.
- Collaborated with Advocates for Children and Families on grant proposal to fund information and referral system and grand parents raising grandchildren services.
- Collaborated with Southern Area Health Education Center and March of Dimes to cosponsor the Regional Title V MCH and Healthy Start Partnership Conferences in Las Cruces, NM.
- Collaborated with Luna County Healthy Start to secure training from Dr. Ira Chasnoff, on Fetal Alcohol Syndrome.

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

The community's major strengths that have enhanced the consortium include the following:

- Commitment and dedication to services and that meet the needs of underserved populations
- The infrastructure of La Clinica de Familia's system of care provided guidance and support for programming and services otherwise not available to new initiatives. They also facilitated the recruitment of consortium members via their vast network of clinics.
- Untapped resources such as faith groups who previously did not participate for lack of never being asked.

e. Describe the activities this collaborative has utilized to assess ongoing needs; identify resources; establish priorities for allocation of resources; and monitor implementation. Describe your relationship with other consortia/collaborative serving the same population. To assess ongoing needs, identify resources; establish priorities for allocation of resources, the Consortium conducted a community needs assessments spearheaded by the Maternal and Child Health Council. The needs assessments included findings from review of State vital statistics data, community /consumer focus groups, State Title V MCH Block Grant Plan and provider surveys. The consortium for the healthy start program was actively involved with several collaborative efforts servicing the same population. Following are examples of some of those relationships:

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- Collaborated with Luna County Healthy Start to secure training from Dr. Ira Chasnoff, on Fetal Alcohol Syndrome.

f. Discuss what activities/strategies were employed to increase resident and consumer participation. How did these change over time?
The Consortium provide stipends to six part-time Community Involvement Team Organizers through a combination of funds leveraged from the Doña Ana County Turning Point Partnership and the Department of Health's Improving Health Initiative to advance the work of the Consumer Advisory Groups/Community Involvement Teams. By creating a linkage with the Doña Ana County Health Council (county-wide health advisory council), the Consortium was able to leverage funds to enhance the work of the Consumer Advisory Group, provide stipends for Community Involvement Team organizers and offer additional leadership development training. This partnership also helped create greater community voice at the Health Council level as well as support issues related to the perinatal system of care within the broader context of community health systems of care. The Healty Start Program provided child care, language translation services and incentives to promote and support resident and consumer participation.

g. How did you obtain consumer input in the decision-making process?
To obtain consumer input in the decision making process the program:
   i. Drafted Consortium by-laws that call for 51 % consumer participation in the policy council.
   ii. Established Community Involvement Teams primarily composed of consumer to identify needs and training topics
   iii. Conducted focused groups,
   iv. Hosted community meetings/Events

h. How did you utilize the suggestions made by the consumers?
Suggestions made by consumers were used to:
   i. Develop community training
   ii. Schedule meetings times and locations
   iii. Establish priorities as they pertained to communities
   iv. Influence best practices

Identify how your LCDF Healthy Start Project implemented the core system-building effort **Collaboration and Coordination with State Title V and Other Agencies.**

U. Describe how you decided on your approach to Collaboration and Coordination with

State Title V and Other Agencies and the rationale for your particular approach based upon your particular community's needs, service system and its challenges and assets.

Our State Title V MCH Program functioned in an advisory and technical assistance capacity to the Healthy Start Program by mutual decision. The Healthy Start Program engaged the State Title V MCH Bureau in discussion to develop a meaningful working partnership. Marilyn Sakara, State Title V Director at that time, visited the program and assigned a staff member to work with the Healthy Start Program. The results of the meetings have been positive. The applicant is linked and receives support from several components of the State and local perinatal systems of care.

Identify the components of your Collaboration and Coordination with State Title V and Other Agencies core system-building effort and the resources (including personnel) needed to implement the core system-building effort. Note any changes over the project period and the rationale for the changes.

Components of collaboration and coordination with our State Title V MCH Program included:

- Quarterly site visits to facilitate meetings with Consortium and MCH funded programs
- Training and technical assistance around program development, PRAMS, best practices
- Coordination of services with local State funded MCH Providers.
- Participation in reviewing the State MCH Plan
- Participation in Regional Title V MCH and Healthy Start Partnership meetings and Federal grantee meetings.

V. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of your Collaboration and Coordination with State Title V and Other Agencies core system-building effort.
As indicated previously in this document, State budget shortfalls, programmatic restructuring, and consequent personnel changes detracted from ongoing collaboration and coordination with our State Title MCH on core systems building efforts. Losses in funding to our project area strengthened our County Commissioner resolve to merge their Council efforts with a broader County Health Alliance vision on the County residence health. The impact of the County Health Alliance on Maternal and Child Health core systems issues is not yet known. As indicated in the consortium section of this document the Healthy Start Consortium has representation on the Health Alliance and will act on behalf of the Consortium on core systems issues. Despite changes and budget State budget shortfalls Healthy Start and State Title V MCH continue to work on improving the Health Status of pregnant women and parenting families in the project area.

Identify how your LCDF Healthy Start Project implemented the core system-building effort **Sustainability.**

W. Describe how you decided on your approach to Sustainability and the rationale for your particular approach based upon your particular community's needs, service system and its challenges and assets. We selected a practical approach to sustainability that incorporates traditional grant writing strategies, establishing contractual relationship with State programs (including HMO/Medicaid) and/or foundations. The approach includes public relations and marketing strategies building on our successes, high-lighting gaps and need for funding.

Identify the components of your Sustainability core system-building effort and the resources (including personnel) needed to implement the core system-building effort. Note any changes over the project period and the rationale for the changes. The components for sustainability include; resource development, integration of services and resources, and institutionalizing best practices when possible. La Clinica de Familia has a resource development office that continually researches, evaluates and compares fiscal resource opportunities for sustainability of core systems.

X. Identify any resources or events (your State experienced a budget shortfall) that either facilitated or detracted from successful initiation and implementation of your Sustainability core system-building effort. Budget shortfalls across the country and State create an element of uncertainty towards sustainability of core systems building. Our experience and effectiveness at leveraging funding facilitated advancement in sustainability. Contractual relationship with 3 HMO for case management has set a foundation on which advocate for adequate funding and sustainability of case management. Promoting a career ladder and professional track for promotora lead to our State adopting the program as a model. It is now being purported by National Legislatior as a preferred outreach model for hard to reach populations.

Y. For sustainability, please address the following <u>additional</u> elements:

a. Describe your efforts with managed care organizations and third party billing. The program established a contractual relationship, through Families FIRST Program, with three HMO Medicaid contractors. Through contract we are able to provide limited care coordination to pregnant women and depending on the HMO to some parenting families.

b. Describe major factors associated with the identification and development of resources to continue key components of your interventions without HS funding. A major factor associated with the identification and development of resources to continue key components of our interventions without Healthy Start funding lies within our successfully integrating into the comprehensive system of care with La Clinica de Familia, Inc.

c. Describe whether or not you were able to overcome any barriers or to decrease their negative impact. Thus far we have been able to deflect any negative impact by working to infuse best practices into the perinatal system, promoting

cross training of program staff and redirecting resources.

III. Project Management and Governance

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

The grantee agency for the Healthy Start project was La Clinica de Familia, Inc., an established 501 C3 Community Health Care Center System with over twenty eight years experience servicing the uninsured and under-insured population in rural south central New Mexico. La Clinica de Familia Community and Migrant Health Center (CHC 330 *e, g* and 501C3) is JCAHO Accredited agency with a multi-site medical and dental program that includes a federal Healthy Schools, Healthy Communities school-based clinic. La Clinica de Familia also has established community-based education/social services programs that all address maternal/child issues. La Clinica de Familia, Inc. has an administrative structure, policies and procedures in place and capacity to manage all aspects of program operations: human resources, accounting and reporting, and purchasing for managing the proposed Healthy Start Initiative.

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

The LCDF organization integrated entirely the Healthy Start Program. The Chief Executive Officer (CEO), under a community Board of Directors (BOD), is responsible for the administration and fiscal management of all LCDF, Inc medical, dental and social service programs. A Chief Financial Officer, under the direction of the CEO and BOD will maintain fiscal management for the proposed Healthy Start program. The DAHS Program management is provided by 1 FTE Program Director who reports to the CEO of the LCDF, Inc The Program Director coordinated the preparation and submission of required reports, monitoring the progress of the project toward its objectives, monitoring contract deliverables and the writing of continuation grant applications for future years. The applicant agency has assumed the final responsibility of monitoring and assuring the performance of the Healthy Start contract deliverables.

The CEO maintains an open door policy to promote communication, and works with the Healthy Start Director to monitor project objectives and deliverables, including preparation and submission of required reports and future continuation grants. The CEO attends regional and national meetings to ensure compliance with national objectives. The Healthy Start Director participates in the LCDF monthly Directors' Meetings and Board Meetings to promote program understanding and integration. The HS Program Director also provides a written report that outlines Core Service accomplishments/challenges, productivity, participant enrollment and HS Consortium/community participate activities. Other Healthy Start personnel with management responsibility include: 1FTE Data Manager responsible for the collection and management of all program data and supervision of 1 FTE Data Entry Clerk; 1 FTE Administrative Assistant who supports the activities of Program Director; 1 FTE Case Management Services Coordinator responsible for the management and supervision of case management services; and 1 FTE Health Education Services Coordinator, responsible for the coordination and supervision of health

education services and 1 FTE Consumer Involvement Coordinator. The program evaluator is contracted.

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

The grantee organization was made responsible for hiring key personnel with recommendations from the Healthy Start Consortium. The grantee organization was also responsible via the Program Director for communication with the Healthy Start Consortium and Community Involvement Teams. Both changes enabled the grantee organization to facilitate full integration of communication and all personnel management operating procedures.

D. Describe what process had to be developed to assure the appropriate distribution of funds and what happened with the process over time. Ilene is getting me a short paragraph for this question

The Healthy Start program has its own unique general ledger account coding string in the General Ledger of La Clinica de Familia, delineating it from the other operations and programs of LCDF. All transactions of the Healthy Start Initiative program are coded to its own GL account for easy monitoring and financial reporting. Monthly reports are prepared based on the data gathered from the General Ledger and actual expenses are allocated to each initiative model and posted into its respective line items. A summary report is prepared. At the end of each month, the Healthy Start Program models summary report is compared to the Income Statement that shows monthly transactions, year to date transactions and the year to date budget. Budget balances are monitored by the finance department and presented to the Healthy Start Director on a monthly basis or more frequently if requested.

The program has always had an accounting system that enabled tracking of the Healthy Start Initiative funds from other programs. The process that has developed over time is the internal reporting aspect that allows for the information to be broken out by model and data presented to the Healthy Start Director. It has also honed the monitoring process of tracking the actual expenditures to the budget in a timely manner.

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

La Clinica de Familia also established community-based education/social services programs that all address maternal/child issues. Adolescent Family Life Program for pregnant and parenting teens; the Promotora Program for lay-health-worker New Mexico MCH outreach and education; an Early Head Start Program; Program Bienestar for comprehensive Health Education and life style change; and the Doña Ana Healthy Start Program. These programs represent diverse funding sources – local, state, federal, and private.

F. To what extent was cultural competency of contractors and of project staff an

issue? If cultural competency was an issue, how was it addressed, and were any noticeable benefits realized?

We (DAHS Program) recognize the importance and diligence required to advance equitable access to services to underserved populations and pride ourselves on our culturally competence efforts to achieve that. Our outreach efforts, for example, are labor intensive and personal (culturally sensitive) and focus on specific individuals in specific communities. This service is provided by "Promotoras" (Community Health Workers) who are adult Latinas trained to share information about reproductive perinatal health, interconceptional health and other DAHS services with consumers. Promotoras are Spanish-speaking women recruited from within our service area and/or program. The primary language of the population we serve is Spanish, which represents 93.4%, while English that represents 4.74% of our consumers. Our most effective promotoras relate to those who face the same challenges they faced. The heart of our Promotora Program outreach consists of interactive, peer-to-peer outreach sessions called platicas ("small talks"). Promotoras with community involvement team members coordinate and conduct platicas with neighbors, friends and family in the participants home or in another familiar setting. This successful grass-roots community based communication and recruitment strategy has resulted in dramatic changes in the lives of those in our program.

Further, the program maintains a strict adherence to employing only licensed Social Workers, who must pass a cultural competency examine as part of licensure requirement, to provide case management services.

Another tactic we use to assure access and cultural sensitivity is with the oral interpretation of written information in the program participants' first language. The DAHS staff is attentive to the individual's functional health literacy -- the ability to read and comprehend prescription bottles, appointment slips, and the other essential health-related materials required to successfully function as a patient.

Still another example of our adherence to cultural competency is use of translation services for oral and written information (English/Spanish) for all HS sponsored training events and consortium meetings.

Finally, the DAHS attention to the racial mix of staff and providers to mirror the population served has proven to be a successful strategy in helping to overcome the under representation of Hispanic physicians in our service area

Because cultural competency was addressed in a comprehensive manner by the aforementioned activities, we became aware of literacy level in any language as a barrier to communication rather than cultural norms.

IV. Project Accomplishments

A. Describe each major strategy implemented, with its goals and objectives and

accomplishments for this project period. Within the narrative describe in quantitative and qualitative terms the degree of success in achieving the goals and objectives. Describe any barriers that had to be dealt with during implementation and how they were addressed. Summarize all lessons learned. Strategies and goals and objectives that were commonly used across services can be cross-referenced. You may wish to use the Suggested Format, in Attachment A for this part of your report. The tables attached describe the strategies implemented to obtain the goals and objectives for the program over the contract period.

B. For those projects that received mentoring or technical assistance from another site, please discuss any activities/lessons learned from those projects that you utilized in your project. If you provided technical assistance, describe your activities, feedback received on them, and any other lessons learned. This does not apply.

V. Project Impact

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

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

1. Describe the approaches utilized to enhance collaboration. The program utilized a leadership model to promote and enhance collaboration.
    - We supported the training for a core and key groups of individuals to receive leadership training on "systems of care" development. This group is now recognized as the Leadership Team and continues to work on advancing system of care efforts.
    - We provided capacity building through training and education to consumers/communities throughout the project area.
    - Established Community Involvement Teams to identify and address community needs.

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

    - Established TRIAD Teams to coordinate consumer medical, dental and social services.
    - Established a Cross Systems Management Team to manage the operations across systems.
    - Brought forth policy change within La Clinica de Familia Clinics prioritize and help pregnant women access early and ongoing prenatal care.

- Established collaborative partnership to improve oral health care for pregnant women. Healthy Start and Dental Providers established free early oral health screenings events at community locations and provided voucher for free dental cleanings for Healthy Start Participating pregnant women.
- Standard Operating Procedures (SOP) referral and timely follow-up to mental health and substance abuse services
- Established SOP to bring uniformity to Case Management Services

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

   a. Relationships among health service agencies; between health and social service agencies; and with community-based organizations;
      - Established coordination of services between LCDF medical, dental and Healthy Start case management and Health Education Services
      - Created linkage with Early Head Start and Head start Programs
      - Established partnership with Breastfeeding Task Force to promote breastfeeding
      - Collaborated with Doña Ana County Advocates for children and families to enhance awareness and advance services for Grandparents raising grandchildren.
      - Integrated young father hood services
      - Established cross systems referral and follow-up process
      - Created cross systems data collection and quality improvement
      - Integrated case management services with Early Head Start Program resulting in cross sharing of staff.
      - Implemented 4 Ps Plus Substance Abuse Screening for all Pregnant women receiving services with in LCDF Health Care Center System
      - Implemented depression screening and referrals to medical providers
      - Integrated case management Services
      - Integrated Health Education Services

   b. Relationships that focus on involvement of consumers and/or community leaders (who are not employed by a health or social service agency) with any of the agencies/organizations listed above or any additional agencies.
      The Healthy Start Program recruited leaders from hard to reach Colonias specifically because of the role that they held within their communities. Many of "leaders" are active participants of the aforementioned groups.

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

a. Eligibility and/or intake requirements for health or social services;
Healthy Start efforts provided eligibility and intake by establishing point of contact intake and eligibility screening. At the point of identification consumer intake is conducted along with screening for Medicaid eligibility or other funding. The client is also referred to essential services such as a Medical Provider, WIC and Case Management Services.

b. Barriers to access and service utilization and community awareness of services;
Healthy Start infused education to support consumers in overcoming barriers to access and service utilization. We provided list of basic resources to all Healthy Start Participants receiving care coordination services. Service Plans for those participants lacking the skills necessary to access services were developed, implemented and monitored. Care coordinators advocated for those consumers who experienced ongoing difficulty in accessing services. Healthy Start distributed brochures, incentives, such as zippy cups, canvas bags, infant tee shirts, etc, to promote awareness of our services.

c. Care coordination including descriptions of mechanisms implemented to assure continuity of care, quality improvement and follow up system(s) for client referrals;
Healthy Start developed SOP that established minimum levels of care including type, frequency and duration of contacts. We created referral and follow-up standards that were monitored and reported on monthly. Social Worker who did not report a completed follow-up within 30 days of referral received notification to take immediate action. The program also developed continuous quality improvement that included record audits and review of consumer satisfaction survey responses and standards for records.

d. Efficiency of agency records systems and sharing of data across providers (within the confines of confidentiality rules) to reduce the need for repetition.
La Clinica de Familia has SOP regarding confidentially and release of information that guide the Healthy Start Program and the sharing data across providers within the System. For those consumers who do not receive their medical services within the LCDF system consumers sign a Release of Information indicating the type of information that we are permitted to release. Referrals to needed services are given to the consumer to initiate contact.

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

a. Provider responsibility in maintaining client participation in the system and provider sensitivity to cultural, linguistic and gender (especially male) needs of the community; as an international border community our program participants are constantly exposed to and sensitized to cultural differences. Our evaluation, of program participation and satisfaction clearly helped define areas needing modification to make the HS program compatible to everyone.

b. Consumer participation in developing assessment and intervention mechanisms and tools to serve perinatal women and/or infants, and the extent of implementation and utilization of these tools or mechanisms. This work was completed in the consortium goals and projects section of our committee meetings. Because we used the Promotora outreach model we always had immediate and direct communication with all our target population.

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

1. Residents knowledge of resource/service availability, location and how to access these resources. The HS program having fully integrated with the LCDF eight medical clinics and one school based health clinic plus the three dental clinics allowed meeting places strategically placed around the community. The full implementation of the HS program facilitated by case management assuring completion of referrals and amelioration of difficulties to a successful completion of services. The outreach workers (Promotoras) assure program contact in their home communities. Our Community Involvement Teams capacity building education and training, has lead to enhanced knowledge of community participants and their ability to access health care independently and proactively.

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

. Following are examples to illustrate the impact that Healthy Start had on developing and empowering communities:

i. Community Involvement Team in the Community of Chaparral successfully advocated policy change within the Gadsden Independent School District to allow School Based Health Clinics to address contraception in schools to help reduce growing teen pregnancy rates.

ii. Doña Ana County residence mobilized, through Community Involvement Teams throughout the project area, and successfully influenced County Commissioners and Las Cruces City Counselors to pass county and city wide smoking ordinances to prohibit smoking in restaurants and other public places despite opposition from affluent proprietors with wealthy tobacco backing.

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

The Program had significant experience in working with divergent opinions and resolving conflicts partially due to living in an international border area. To begin with, experience has taught that change efforts of the magnitude that we are striving for will bring with it conflicts and tensions from internal and external sources. In anticipation we establish ground rules for meetings that honored and gave every individual a voice. For example, differences in opinion resulted as the Promotora Model of care was inappropriately designated as case management. Resolution resulted in a Promotora Model of Family Support Services (not a designated as case management). Another strategy to resolve expected conflict or tensions was to use Roberts Rules of Order to conduct meetings. Other strategies included translation services to address language barriers and team building events, such as the annual Healthy Start Retreat. The retreats are specifically designed to work through differences/tension areas and create opportunities for the participants to experience shared successes and comradeship.

4. Creation of jobs within the community.

Healthy Start provides jobs to approximately 25 employees that are fully or partially funded by the program.

C. Impact on the State: Over the past four years Healthy Start has supported activities to strengthen and develop relationships with the State Title V program. In some states where there was more than one HS project, the Division of Healthy Start and Perinatal Services (DHSPS) encouraged coordinated activities across these sites. Describe the activities and impact that this approach has had on your relationship to the State Title V Agency, State Children with Special Health Care Needs Program(s), your state Medicaid and SCHIP programs, your State Early Intervention Program and other state programs. Highlight any benefits and lessons learned from these relationships.

Our State Title V MCH Block Grant facilitated project development by including us in training and technical assistance provide to other MCH providers, sharing county and state level PRAMS data and participating in the regional partnership with Healthy Start Program. They were most useful by including us and recognizing our contribution towards the improving the health status of women and addressing the disparities that experienced by underserved populations. The State Title V used data that we were collecting for our project to emphasize gaps in the system State wide. They used our data on depression to illustrate the need to incorporate the need for depression screenings of all pregnant women. Our State Title V MCH Program provide us mentoring and conflict resolution to help us resolve challenges that arose in the first two years of implementation. Our State accompanied us to regional and federal partnership and grantee meetings to learn more about Healthy Start and ways of supporting our advancement. The difficulty experienced in our relationship with our State Title V MCH Partner is that they were 300 miles away from the project area and sometimes forgot about us. An important lesson learned is that we need to establish a method for ongoing communication.

D. Local Government Role: Highlight activities/relationships at the state and local level that facilitate project development. Briefly describe barriers at the state and local level, and the lessons learned in dealing with these barriers.
Our State Title V MCH Agency participated in partnership events with the Healthy Start program at a regional, state, and at the local level. Because we serve the second largest metropolitan area in the state we have effective representation with state legislators concerning health policy legislation. We participate in a local Roundtable Event to share our needs with our Representatives prior to the legislative session. A second Roundtable is held to avail feedback from our Representatives on the accomplishments during the session. A significant barrier experienced during the report period was the dissolution of our Maternal Child Health Council previously mentioned in this report. The decision was made by our County Commissioners to resolve internal conflicts by forming a broader Health Alliance and empowering them with the MCH legislative mandates.

E. Lessons Learned: If not discussed in any sections above, please describe other lessons learned that you feel would be helpful to others. Other lessons learned include the following:

- Systems change is a complex and timely process
- Sabotage to maintain the comfortable "status-quo" can be expected
- Power struggles will surely arise and planning for them is a must
- National, State and Local priorities change
- Catastrophic and other unforeseen events impede advancements

VI. Local Evaluation

Using the suggested format in Attachment C, submit a copy of the Healthy Start Local Evaluation Report for each local evaluation conducted. Instructions pertaining to this report are provided in Attachment B.

VII. Fetal and Infant Mortality Review (FIMR) Not applicable to our program.

VIII. Products

A copy of any materials that were produced under the Healthy Start grant funding must accompany this report. Items we included in this report are calendar, baby bib, brochure, posters, badge and baby cap.

IX. Project Data