Grantee Name: City of New Orleans
Project Name: Great Expectations Foundation, Inc.
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HEALTHY START IMPACT REPORT
2001-2004

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Introduction

The following is the Final Impact Report for the Great Expectations Healthy Start Project. Great Expectations Foundation has successfully implemented the Healthy Start model in its service area and realized a great impact in the community.

The Great Expectations New Orleans Healthy Start Program operated from Community Care Centers located throughout the city. In most cases, these complexes also house other medical and social service agencies such as Well Baby Clinics, Head Start, WIC, community economic development offices and housing services. The proximity to these other community based providers have made it possible to integrate services and make "one stop shopping" convenient for Great Expectations Foundation consumers. Service provided within the same facility increased service coordination and reduced the number of places clients have to access in order to receive services, thereby increasing compliance. The Community Care Centers also raised community awareness regarding health issues and the Great Expectations program services.

This Final Impact Report allowed the Great Expectations Foundation to demonstrate the qualitative and quantitative impact it has had in its service area. This retrospective evaluation covers the reporting period from 2001 - 2005.

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

Great Expectations Healthy Start (GEHS) initiative has chosen to focus its efforts to address disparities in infant mortality and other perinatal health indicators among African-Americans and Hispanics or differences occurring by education, income, disability, or living in underserved and impoverished areas.

The GEHS service area includes approximately 59, 124 women of child bearing age (ages 10-44). Sixty-eight percent (68%) of the residents are African-American, 28% are White, 3% are Asian, and 1% Other. Thirty-two percent (32%) have incomes below the federal poverty level and the unemployment rate in the service area is 13%. In addition, 32% of persons 25 years or older have not attained a high school diploma. The initial needs assessment determined that there was a declining rate of live births per annum from 1997 through 1999 from 3924 to 3019.Also, there were high levels of low birth weight infants (<2500 grams) 15% and high post neonatal infant mortality of 7.7 per 1000 live births. Pre-term infants < 38 weeks gestation was 16% and proportion of children under two receiving age appropriate immunizations levels of 54% for African-Americans vs. 92% for Whites. An increasing incidence of HIV/AIDS was also noted.

II. Project Implementation

The Great Expectations Healthy Start Program serves its five targeted areas in the City of New Orleans by providing coordinated community based assistance at three community care centers and two satellite offices. The Healthy Start team uses an integrated team approach that consists of Case Managers, Case Specialists, Nurses and a Mental Health Coordinator. GEHS utilizes this team to implement its core services: Outreach and Client

Recruitment, Case Management, Health Education and Training, Interconceptional Care, and Depression Screening and Referral. In order to enhance service delivery to its clients GEHS has also developed Facilitating Services to assist clients with such things as transportation and translation. Great Expectations has also made strides in its Core Systems Building Efforts (Local Health System Action Plan; Consortium; Collaboration and Coordination with State Title V and Other Agencies; and Sustainability).

The method and means to the implementation of the Core Services and Core System Building Efforts are critical to the success of the program.

A. Outreach

GEHS management implemented the Outreach model during Phase II (1997-1998) of the Healthy Start initiative. Management determined the outreach model essential to the success of the program. It is imperative that potential clients know of the services and resources available through the Healthy Start program and share the information with their friends and acquaintances. The result is increase exposure for the program and puts the program in touch with those who need their services thus affecting birth outcomes.

GEHS utilizes various outreach strategies in an effort to reach the target population. Currently there are 9 Case Specialists, 3 Case Managers, and 1 Male Involvement Coordinator who provide direct client outreach and recruitment activities. In addition to program staff, Consortium members also participate in outreach and client recruitment activities.

GEHS sponsors and participates in numerous outreach efforts, including community canvassing, out-stationing at health clinics and building relationships with medical and social service providers to reach the target population. Outreach for interconceptional care consists of collaborating with the labor and delivery departments at area hospitals and infant intensive care units to refer patients who have had a poor birth outcome. Outreach for the mental health component consists of establishing referral agreements with several mental health clinics. In an effort to increase communication between GEHS and providers and educate the providers on GEHS services, the program contacts providers directly through written correspondence.

An Outreach Committee was developed during this project period with the purpose of reviewing the outreach process and developing new strategies. The Committee recommended modifying the outreach approach to concentrate on targeting medical providers who would then refer their patients for Healthy Start Services.

GEHS's outreach activities have proven to be successful during the reporting period. GEHS sponsors Healthy Baby Celebrations, National Nutrition Month Celebrations; a Father's Empowerment Conference and participates in other outreach activities. Informational brochures are distributed as an additional client recruitment tool. GEHS also provides free pregnancy tests in an effort to identify women who are in their first trimester. Great Expectations also implemented an information/referral line as another mechanism for outreach to potential clients. Callers receive information about program services during and after business hours.

B. Case Management

Case management was implemented during Phase I of the GEHS program. Management developed a multidisciplinary case management model which provides services for pregnant, postpartum, infants and children up to 24 month. GEHS uses a multi level case management system to ensure clients receive the needed services based on identified risks. A risk assessment is conducted on all clients and they are screened for postpartum depression. Based on risk, clients are assigned to Level I, II, or III. Levels I and II are deemed low to moderate risk and require less supervision. GEHS' model uses a client driven culturally sensitive approach to identify needs and establish pans of care. The Case Manager works directly with the client to develop a personalized service plan and monitors the plan to ensure clients are receiving their services.

The Case Specialist work in each of the CCCs and follow their clients to make sure their needs are met such as attending educational classes, Medicaid enrollment, and prenatal visits. The Case Specialists provide services to Level I and II clients at 100% FTE and either possess a Bachelor of Social Work or related field, or a paraprofessional who is indigenous to the communities that GEHS serves. The program currently has 9 Case Specialists on full-time staff. Level 1 and II clients are given an initial home visit in which a number of assessments are conducted.

High-risk case management services were implemented during the second year of Phase I. After further review by GEF management, a more integrated model was implemented Year 01 Phase II better utilizing the case management staff in the Community Care Centers (CCCs). High risk clients are assigned to Level III Case Management services.

Level III is granted to any client who possesses a medical risk factor. Level III clients are given case management services by a High Risk Case Manager and a Community Health Nurse. All clients participate in an intake visit in which access to medical care, insurance, transportation, previously identified risk factors will be reviewed. Clients maybe assisted with additional services based on the outcome of the intake visit including transportation, Medicaid application, WIC or other services.

C. Health Education

At the onset of this project, the GEHS Healthy Start staff recognized that clients faced many challenges that not only affected their unborn children but also had an impact on their ability to fully engage in the healthy start program. Some of the barriers included misinformation about health and social issues, lack of health care, etc.

The health education component was fully implemented during Phase II of the project to help to address more of the needs of GEHS clients. It was decided that only a multi-faceted approach to health education and training could address the needs of the clients since often times clients were facing several obstacles at once. Client's current and future birth outcomes could only be improved by educating them and helping them to cope with their situation. The approaches include prenatal parenting,

interconceptional care classes, one-on-one family planning, STD risk reduction, and emotional wellness counseling.
In addition, the program also offers smoking cessation courses and HIV/AIDs awareness. GEHS believes that interactive, hands-on learning methods are the best for its clients and makes extensive use of these in its training.

Collaborations are also very important in the education process and GEHS conducts follow-up to ensure client participation.

The GEHS Case Managers, Case Specialists, Community Health Nurse, and Mental Health Coordinator all participate in development, planning, and delivery of the classes and training under the supervision of the Site Administrators and Chief Program Officer.

The lack of transportation continues to be a barrier to women accessing the health education and training services. GEHS does provide some transportation assistance however this is still seen as a barrier for many clients.

D. Interconceptional Care

During this reporting period, GEHS conducted research on models for interconceptional care of high-risk women and infants. Although GEHS began its interconceptional care component since the inception of the program, they felt it was necessary to identify an approach that would address the unique needs of their clients. The research identified 3 models which proved promising. GEHS understood that whatever approach they pursued must have special focus on the means of handling life stressors and on encouraging positive coping behaviors and lifestyles. It should avoid attempting to change the individual, allege deficiencies inherent to her culture or beliefs, or blame her for her problems.

GEHS implemented a dynamic approach to interconceptional care utilizing an integrated multidisciplinary team, consisting of health educator, mental health coordinator, case managers, case specialists and community health nurses. The program provides a number of services consisting of risk assessment, coordination of care, case management, client support, and health and risk reduction education services that include family planning, smoking cessation and depression screening.

E. Depression Screening

A multitude of high-risk factors are evident in the program service area. As mentioned previously, the area suffers from high unemployment rates, poverty, and homelessness, increasing rates of substance abuse, high rates of sexually transmitted diseases, and a host of other life stressors. These factors all contribute to poor birth outcomes as well as

impacting psychosocial health. In light of these challenges, it is very important that the program adequately assess the mental well-being of its clients and to specifically assess depressive symptoms. Several models were reviewed during the program period including the Perceived Stress Scale (PSS), PRIME-MD, and Beck Depression Inventory (BDI). Great Expectations determined that the best approach to meet this objective would be to implement a mental health model in three phases. The phases consisted of the initial implementation of the Edinburgh Postnatal Depression Scale (EPDS). In Phase II, an easy to score screening instrument was developed to identify those at risk new clients and other screening forms and communications. Phase III was the ongoing evaluation of the depression model.

The Edinburgh model was discontinued shortly after implementation when it was determined during pre-testing with clients and staff that the questions and scoring were unclear. The PDSS proved much easier to understand by both clients and staff. During the course of the program period, it was determined that two distinct models should be utilized to assess prenatal and postpartum periods. The Prenatal Questionnaire is administered to all pregnant clients with their permission. It is a self-administered, 24-question assessment at a ninth grade reading level. This tool assesses the client's risk of perinatal depression. For postpartum clients, the Postpartum Depression Screening Scale (PDSS) created by Cheryl Beck is being utilized. The PDSS is a self administered questionnaire which identifies actual symptoms of depression.

The Centers for Epidemiological Studies – Depression Scale (CES-D) is utilized for interconceptional care clients. It is a 20-item, self-report scale.

Case Managers and Community Care Nurses are responsible for administering and scoring the depression screenings. Great Expectations Health y Start hired a full-time Mental Health Coordinator to coordinate all perinatal depression screening services and mental health interventions.

Depending on the results of the assessment the client my be referred to individual therapy sessions conducted in the GEHS offices on either a short-term or long term basis, group therapy sessions, education classes regarding depression, self care techniques, or referral to other mental health agencies and professionals offering the necessary services not available at GEHS including mental health care for medication and intensive psychotherapy and substance abuse clinics and support programs. There is also a Postpartum Depression group session.

F. Local Health System Action Plan

Initially, the Local Health System Action Plan (LHSAP) planning and development activities were conducted by the Consortium since the LHSAP committee had not been fully developed. The Consortium took the lead in identifying material and child health issues to be addressed in the target community. Since the GEHS Healthy Start program was in its early stages, the consortium recognized the need for coordinated staff education and training and data sharing and collaboration between local maternal and child health care providers. With the approaching implementation of the interconceptional care and

depression screening early in this reporting period there was a strong need for training and development of GEHS staff and the local MCH providers. Information and data sharing among local MCH providers has historically been a major challenge. The Consortium directed GEHS to ensure that dialogue, information/data sharing, and programs be initiated.

During the reporting period, the action plan was modified to address a reorganization of the initial partnership with the Office of Public Health and other MCH providers. The overall development and implementation of the LHSAP was most challenged by staffing concerns. During the initial grant years, the work was hindered by the allocation of staff to work on coordinating the external collaboration. Resources were shifted with the hiring of the Consortium Coordinator and realignment of duties. Also, the narrowing of the perinatal problems for the target area posed a challenge as well.

G. Consortium

Since the inception of Great Expectations Foundation in 1995, there has been an active and productive relationship between Board members, consortium, staff, and the community. Early on, the program did face some challenges in securing consortium members and ensuring active participation. These challenges were overcome by educating potential consortium members on the goals and objectives of GEHS Healthy Start, deeply involving the consortium members in the direction and operation of the organization, and accessing a broad profile of individuals and organizations to participate. Once the potential participants understood the goals of the organization and the part they could play in its success, recruitment and retention of consortium participants was much easier. In addition, GEHS utilized the SAAC (Service Area Advisory Council) to further develop the consortium. The SAACs are representative subsections of each of GEHS's project areas. Each SAAC is comprised of community residents, consumers, businesses, churches and community leaders. The consortium completed its planning in August 2001 and prioritized the issues to be addressed from the GEHS strategic plan in line Healthy Start goals.

The consortium consists of a network of medical, social service, faith-based, community-based, TITLE V representatives, SAAC members, consumers and other key stakeholders. Currently, the consortium has over 80 members. The consortium membership is distributed as follows:

Consumers	63%
Public agencies or organizations	11%
Community based organizations	9%
Providers contracting with the Healthy Start Program	6%
Private agencies or organizations	4%
Other – Government Agencies	4%
Other Providers	3%

The racial/ethnic makeup of the consortium is shown below:

African-American	85%
Caucasian	13%
Native American	1%
Hispanic	1%

Active status with the consortium is defined as attending at least 50% of meeting of the full consortium. Currently, 75% of Great Expectations Foundation Healthy Start consortium members are currently active.

The primary focus of the consortium is to continually and comprehensively advise and evaluate the GEHS staff and program. In order to achieve its objective, the consortium members participate on the 5 sub-committees setup by the Board of Directors of the Great Expectations Foundation. There are 3 members of the consortium on the 15 member Board of Directors. These committees were developed for the sole purpose of providing leadership and guidance in specialized areas effectively. The 5 committees are: Executive, Program Services, Fund Development, Finance, Nominations and Board Development, and Planning and Evaluation.

The consortium has been instrumental in establishing a number of partnerships and collaborations during the reporting period. The consortium has played a vital role in the development, facilitation, and/or implementation of the following partnerships or events:

- Local Court Systems
- Elected officials
- Social and Faith-based groups
- Business Owners
- Office of Public Health, Maternal Child Health
- New Orleans Police Department
- "GE Hits the Streets" – community canvassing
- KIDMED – signed an agreement with GEHS to supply health educational materials and training to GEHS staff. Relationship has led to GEHS participating in three insurance conferences.
- LaCHIP (Louisiana Children's Health Insurance Program) – assisted with several community outreach events providing information to the community on insurance policies and procedures.

One unique aspect of this community is the influence that consumers have over community members who are not actively involved in the program. Although all consumers are initially skeptical about the program, once educated on its goals, objectives, and benefits, consumers become the most influential advocates of the program. This has proved very valuable to recruitment and retention of consortium members.

As mentioned, consumers were initially very skeptical about participating in the Healthy Start program. GEHS instituted with leadership from the consortium, an education

campaign for consumers and other potential consortium members. More thorough education on the program dispelled the misconceptions many consumers had about the program and opened the door for them to become fully engaged in the process. In addition, GEHS developed incentives for consumers to participate in the consortium and consortium sponsored activities. Clients are provided transportation, receive nutritional supplements at the meetings and obtain points when they attend meetings that assist them in obtaining GE bucks. The Consortium Coordinator has conducted in service training to all GEHS staff to educate them on the seriousness of consumer participation in the Consortium. The coordinator has also attended prenatal, parenting and health education classes to directly express to clients the need for their participation in the consortium.

The consumer has always played a key role in the administration of the project through participation in the governing committees of GEHS, Inc. As mentioned these committees are: Executive, Program Services, Fund Development, Nominations and Board Development, and Planning and Evaluation. These committees provide oversight and direction of the healthy start program. Consumers are able to assist in budget planning, sustainability, programmatic issues, quality assurance, and evaluation. Each committee has at least 2 consortium members. As consumers, they are able to give feedback that cannot be attained from any other source. Consumers are the first to understand if we are targeting the right areas, if we are services are adequate at addressing the needs of clients, and if we are utilizing our resources appropriately. Their participation on the committees gives them an opportunity to utilize their unique perspective to enhance service delivery.

H. Collaboration and Coordination with State Title V and Other Agencies

During this reporting period, GEHS has continued to maintain its collaborative and coordinating activities with the State Title V. There have been a number of collaborative efforts with many of the MCH providers including task forces, committees, planning councils, etc. Title V and GEHS have collaborated on the following projects:

- Improving Maternal and Child Health in Louisiana – two day workshop on Fetal and Infant Mortality focusing on reviewing the Maternal Child Data Book that was completed by MCH, Epidemiology Assessment and Evaluation Department of Louisiana Office of Public Health. The book was a report on the status of Maternal Child Health in Louisiana. The majority of the data was collected by the descriptive analysis of vital records data, including birth, fetal death and linked birth death files. There were representatives from each region of the state and those regions broke into smaller groups to more closely analyze the data and determine what resources presently existed for women and children. Service gaps were also identified as well as strategies to close those gaps.
- Office of Public Health SIDS Program – GEHS served on this committee which developed a SIDS multimedia campaign and the statewide social marketing summit for SIDS. During the summit, the team evaluated OPH's "SIDS/Safe Sleep Environment Media Campaign". The program was designed to educate consumers on the proper sleep position for infants. GEHS helped to develop television commercials, informational cards, Onesies, and posters. The "onesies" displayed the words, "This Side Up" on front of the Onesies. OPH provided these onesies to GEHS for distribution to all mothers in the program with newborn children.

- Region VI Conference, Title V and Healthy Start Partnerships: Interventions to Eliminate Health Disparities – GEHS assisted with securing the necessary resources to allow Title V staff to attend the Region VI conference. GEHS staff and the Title V representative were able to interact with other participants from across the state, exchange ideas, and gain insight into the programs and initiatives which are available in the state that affect the health of women, infants and children.
- Louisiana Statewide Healthy Start Initiative – during this reporting period, the Healthy Start Programs across the state of Louisiana convened a number of conference calls to work on developing a statewide initiative. A meeting was held in December 2002 with all the programs statewide and the Office of Public Health to develop a list of activities the programs could collaborate on. The Monroe project was not able to attend the meeting.
- Louisiana Pregnancy Risk Assessment Monitoring System (LAPRAMS) – LAPRAMS is an ongoing population based risk factor surveillance system of selected maternal behaviors in Louisiana. Great Expectations staff served on the LAPRAMS committee for the Office of Public Health.
- Great Expectations staff and Title V staff served on the planning committee for the 2002 Region VI conference held in Oklahoma and 2004 Region VI held in San Antonio, Texas.

I. Sustainability

Sustainability continues to be a major focus for Great Expectations Foundation Healthy Start. The continued success of the program relies heavily on its ability to identify resources beyond those available via the Healthy Start funds. The consortium identified this need early in the life of this program and has taken steps to identify resources. In addition, the management of the Healthy Start program is now a major resource for sustainability. Currently, the City of New Orleans contracts with Great Expectations Foundation to manage the Healthy Start Project. The City of New Orleans is committed to assisting Great Expectations in locating additional resources and assist GEHS in becoming a sustainable agency.

During this reporting period, the Fund Development Committee of the Great Expectations Foundation Board of Directors developed a 5 year Capital Fund Campaign program to raise $150,000 for investment capital for administration and operation sustainability.

Another key to increased sustainability is improving and developing relationships with new and existing partners. Please see the section regarding collaborations for more details. In order to maximize resources and enhance service integration, GEHS has been coordinating with a number of other organizations and agencies. During this reporting period GEHS has worked with others on grant projects. As a result of the Maternal Child Health Collaborative, GEHS, New Orleans Health Department, Louisiana Stat University Health Science Center and the Louisiana Office of Public Health Maternal Child Health Program developed a coordinated set of service strategies to address gaps in the current Maternal and Child Health Care Delivery System. GEHS and LSU were awarded

$206,000 by the Office of Public Health Maternal Child Health Program, to hire six social workers, provide supervision of their activities, and operational support to this project.

In its capacity as a non-profit organization, GEHS has many opportunities for resource development. Identifying alternative funding sources that support programs matching the needs of the community and the mission of the organization are significant steps to sustainability. During the reporting period, GEHS has identified the following funding sources:

- Great Expectations received an award of $1500.00 from the CJ Foundation for SIDS to assist with the implementation of the Grandma's Hands Program.
- Great Expectations Foundation was awarded a grant in the amount of $122,516 from the United Way of Greater New Orleans to implement the Healthy Choices program to address the issue of teen pregnancy and the targeted population consists of youth between the ages of 11-19. The overall goal of the Healthy Choices program is to promote healthier lifestyle choices.
- The Louisiana Office of Public Health HIV/AIDS Program awarded Great Expectations in the amount of $50,000 to implement the Women to Women Program, a replication of the SISTA Project.
- GEHS received an $119,000 unrestricted grant from Glaxo/SmithKline to provide asthma awareness.
- CDC, SISTA grant for $250,000.00 annually for the past 3 years.

As a source of revenue, GEHS receives reimbursement for processing Medicaid and LaCHIP applications. All of Great Expectations Healthy Start sites are Medicaid enrollment centers. Given the great number of eligible women in the communities GE serves, the reimbursement could become a significant source of funds for the program. For each approved application, GEHS receives $14 reimbursement. Also, during the reporting period, the Chief Financial Officer, Director of Quality Assurance and Director of HIV Services attended a Third Party Reimbursement Training sponsored by the Health Resources and Services Administration of the US Department of Health and Human Services. The training focused on identifying methods of improving existing business processes and exploring billing arrangements that would allow HRSA grantees to claim allowable reimbursements under state's Medicaid programs.

III. Project Governance

In 1991, the City of New Orleans Health Department created the Great Expectations program to address the problem of infant mortality. In 1995, the leaders of the Great Expectations community based consortium established the Great Expectations Foundation, Inc. (GEF) to ensure continuation of the program. The City of New Orleans entered into a partnership agreement with GEF to administer the Healthy Start project in 1997.

The Great Expectations Foundation, Inc. is a non-profit 501(c) 3 organization that is governed by a 15 member Board of Directors consisting of eight appointments by the Mayor of New Orleans, three by the Medical Center of Louisiana in New Orleans (MCLNO) and four by the Healthy Start Consortium.

During the reporting period there were a number of personnel changes. The most notable was the resignation of the Executive Director, Ms. Angela Shiloh Cryer. Mr. Robert Sevalia was named Executive Director after her resignation. Also, during this period the Hispanic Case Specialist position was eliminated after an assessment was completed that determined there was a very low level of utilization for this resource.

During this reporting period, GEHS implemented a comprehensive Quality Assurance Program to assist in the identification of programmatic and process issues and resource allocation. The QA program is one that is directly linked to the local evaluation. These two components work hand-in-hand to ensure the program remains on track. The Director of Quality Assurance conducts regular audits of client files and databases and along with local evaluation activities, the two identify the areas where the program needs more focus. Initially the QA program was loosely structured around service delivery. However, it was determined by GEHS management that QA should take a more comprehensive and strategic role in the organization. The QA Plan was developed covering service delivery, people issues, data integrity, and local evaluation. The entire GEHS staff was trained on the new QA policy and procedures during a one day workshop.

IV. Project Accomplishments

Great Expectations has successfully implemented each of the Core Services and Core System-building efforts. Over the course of the reporting period, the program has work diligently on continuous improvement of the project services. The Case Management service has proven to be most effective in achieving the desired impact to birth outcomes. In addition, GEHS has a very strong Outreach and Client Recruitment initiative that involves the entire program staff. This has led to increasing levels of new clients. Overall, the program has made significant accomplishments over the program period. Please refer to Appendix A for details regarding accomplishments.

V. Project Impact

A. System of Care

Since its inception, Great Expectations has been deeply committed to supporting the development of collaborative efforts among local community organizations and agencies to enhance the services provided to women, infants and children.

GEHS has been at the forefront in establishing collaborative opportunities. In order to foster collaborative efforts, GEHS creates opportunities through sponsoring health

fairs, participating in conferences and panels that address maternal child health issues, and partnerships with local agencies.

GEHS has enhanced its case management services in order to better facilitate the referral process and the actual needs assessment. By conducting more complete assessments during intake, the case specialist can identify the overall needs of the client and work on an individualized plan to address those needs that often times means referral to other agencies or groups to receive services. GEHS staff has been trained in the intake process and in understanding the eligibility requirements for Medicaid and LaCHIP. This allows for greater rates of approved Medicaid applications resulting in higher reimbursements for GEHS. Clients are also assessed for mental health during the case management process and may be referred to an outside provider for care. GEHS has developed its case management process such that case managers provide follow-up with the clients and arrange transportation where necessary to ensure that these referrals are completed.

Through the work of GEHS to enhance the level of care for women, infant and children they have created a number of key relationships that have proven to been invaluable to the program. Some of the most notable relationships are with the Office of Public Health which provides a myriad of services in collaboration with the program. Also, GEHS has broadened its relationship with the LaCHIP program and Medicaid. In addition, GEHS has developed collaborative agreements with the following community based agencies:

Tulane University /School of Social Work	Planned Parenthood
Housing Authority of New Orleans	Goodwill Industries, Inc.
American Red Cross	Children's Bureau of New Orleans
Brotherhood, Inc.	Adolescent Mothers Initiative Program
Heritage Funeral Home	Job Corps, Inc.
Contemporary Eye Care	CNO Lead Poisoning Prevention Dept.
March of Dimes	New Orleans Public Schools
Medical Center of Louisiana	Project New Hope
HIV Outpatient Program	Project Lazarus
Shelter Resources, Inc.	Second harvester Food Bank
SUNO School of Social Work	Total Community Action, Inc.
Women In Community Service	New Orleans District Attorney
Dress For Success, Inc.	Jefferson Parish Human Services
Central City EOC/Head Start	N'R Peace

The major vehicle for consumer involvement with the GEHS Healthy Start Project is through the SAAC (Service Area Advisory Council). These groups are comprised of residents, consumers, educators, clergy, service providers, and other community leaders from each target area. As mentioned previously, the SAACs work closely with the consortium to provide insight into the needs of the community and the most effective and efficient means for addressing those needs.

B. Impact to the Community

The project has had a profound impact on the community it serves. Primarily via the SAACs consumer and residents have a direct link to the program and can make a positive impact on the services that are rendered. The SAACs are a key component of the Consortium. This gives consumers are real opportunity to affect the maternal child health care system in the community.

GEHS has continued to conduct health fairs, community canvassing and a multitude of other outreach activities to inform clients of the services and opportunities available through the project. 44% of clients based on the latest data from this reporting period heard about the program from a friend. This tells us that a very significant portion of the community is aware of the services we provide.

In order to provide culturally sensitive services, GEHS has continued to hire staff directly from the community in which they serve. This has helped in client recruitment and to bring a sense of legitimacy to the project for area residents. GEHS provides numerous opportunities through health fairs, outreach events, collaborations with outside agencies and such for consumers to network and team build. These same efforts also provide a chance for consumers to get involved with some decision making. In addition, GEHS has worked with other Community-based Organizations and Faith-based Organizations on collaborative initiatives to empower community residents and their consumers. These initiatives have included joint health fairs and symposia including social services and MCH providers.

C. Impact on the State

Great Expectations and the State Title V MCH continue to maintain a mutually beneficial relationship. During the reporting period, the two organizations have collaborated on several projects including the Maternal Child Health Task Force. This joint effort between several agencies developed strategies to help improve the maternal child health care system in Louisiana. In addition, GEHS has worked on state MCH issues and presenting its program findings at these initiatives.

The State of Louisiana is fortunate enough to have three fully operational Healthy Start Projects. These projects are located in Baton Rouge, New Orleans and Monroe. Great Expectations has taken a leadership role in fostering collaboration among the projects to impact the system of care state wide. The projects have conducted several conference calls to exchange ideas, share information, and discuss best practices. In addition, these sites have been to GEHS for mentoring visits.

D. Local Government Role

The City of New Orleans (CNO) plays a vital role in the success of the Healthy Start program. As the grantee, the City has ultimate fiscal and administrative liability. CNO is also active in working to ensure the sustainability of the project. The local partnership with CNO has expanded the capabilities and resources for GEHS. For

example, there is more data sharing which will be used in the Geographic Information System (GIS) project which will benefit both GEHS and CNO in its planning and resource distribution. In addition, the role of working in collaboration with CNO clinics have increased the overall outreach and client recruitment activities. Lastly, the role of sustainability for GEHS was enhanced in working with CNO on a collaborative basis for future grants and opportunities.

VI. Local Evaluation

HEALTHY START LOCAL EVALUATION REPORT

PROJECT NAME: Great Expectations –New Orleans Healthy Start

TITLE OF REPORT: Local Evaluation Report

Authors: Jeffrey Guidry, Ph.D

Section I: Introduction

Local Evaluation Component
Key Questions/Hypotheses

Section II: Methodology

Describe Methodology, data sources, and instruments used

Section III: Findings/Discussion

Results
Discussion
Limitations of findings

Section IV: Recommendations

Policy, program, practice and other recommendations

Section V: Impact

Changes in perinatal system, community, etc.

I . INTRODUCTION

A. Local Evaluation Component

The Healthy Start initiative was developed to address significantly elevated infant mortality rates and the associated risk factors. Some of these risk factors include teen pregnancy, lack of prenatal care, substance abuse and poverty. The challenges for reducing infant mortality were addressed through coordinated efforts that include case management, outreach, education, and public health collaboration. Healthy Start believes that communities themselves can best formulate effective strategies and approaches to reduce infant mortality in their communities. The New Orleans Healthy Start Program is Great Expectations, Inc. that is operated by Great Expectations Foundation, Inc. (GEHS). Collaboration is a major portion of Healthy Start's model of care. They have worked closely with community-based organizations to bring greater accessibility to needed services for women, infants, and children.

Great Expectations Healthy Start project area consisted of 59 census tracts in Greater New Orleans, LA. The tracts were prioritized by their infant mortality rates. There were 5 target areas that were carved from the census tracts and grouped according to geographic location and similar characteristics. The GE service area is comprised of the (1) New Orleans East District, (2) the Lower Ninth Ward (3) the Central City District (4) St. Bernard/Gentily and (5) Algiers. In addition, there were 3 Community Care Centers and 2 Satellite Offices. The project area is significantly African-American, approximately 70% percent, and suffers from a very high unemployment rate, low education attainment, and a high rate of poverty, all major risk factors for high infant mortality.

The following is the Final Impact Report for the Great Expectations Healthy Start Program. GE has successfully implemented the Healthy Start model in its service area and realized a great impact in the community. This Final Impact Report allows Great Expectations Healthy Start Program to demonstrate the qualitative and quantitative impact it has had in its service area. This retrospective evaluation covers the period from 2001 through 2004.

In an effort to provide the most effective and objective report possible, Great Expectations Foundation, Inc. elected to seek an external consultant to conduct the analyses for the Final Impact Evaluation report. Dr. Jeffrey Guidry of Guidry & Associates in Humble, TX was awarded the contract to perform the evaluation. Dr. Guidry is an Associate Professor at Texas A&M University and has over 10 years of experience in program evaluation and public health initiatives.

II. METHODOLOGY

The evaluation was conducted to assess the effectiveness of project activities. The evaluator utilized a hybrid methodology that combines elements of the formative, process, and outcome study types to effectively assess the Great Expectations program. The report was prepared with the assistance of project staff for documentation and data collection. In addition, interviews were conducted with Consortium members. Information for the four years of the reporting period was collected and an in-depth analysis was conducted to determine the impact of the GE's Healthy Start program on its target area. Past local Evaluations, Year End Reports, Continuation Applications, Budget Period Objectives, and Participant Data and Major Service Tables were analyzed to assess the program impact over during the grant period.

III. FINDINGS

Great Expectations has realized significant impact on the community it serves. In spite of the challenges the organization has faced with funding, staff changes, and population shifts, it is still evident that GE has impacted its clients and community and is moving forward to a future of further success. The accomplishments of the program span the service models from outreach, facilitating services, case management, and education. This section illustrates those achievements in qualitative and quantitative terms.

A. Outreach and Client Recruitment

1. Discussion

Management determined the outreach model essential to the success of the program. It is imperative that potential clients know of the services and resources available through the Healthy Start program and share the information with their friends and acquaintances. The result is increase exposure for the program and puts the program in touch with those who need their services thus affecting birth outcomes.

2. Model

Great Expectations outreach model is very unique in its approach to relationship building between clients and outreach providers. The model consisted of a Nanan (Case Specialist) who is a resident in the community where the clients reside. These were older persons (usually women) who can be someone the clients can feel comfortable. Nanan is a local word for "Aunt" or "Godmother". Currently there were 9 Case Specialists formerly called Nanans. An Outreach Coordinator supervises the outreach team. GE sponsors and participates in numerous outreach efforts, including community canvassing and community outreach to the target population. In an effort to increase communication between Great Expectations and providers and educate the providers on GE's services, the program contacts providers directly through written correspondence.

3. *Implementation, Barriers, and Advances*

Anticipated barriers and challenges to enrolling clients in the Healthy Start Program are, lack of education, mental health issues, substance abuse, domestic violence and personal priorities.

Great Expectations Healthy Start Program outreach activities have proven to be successful during the reporting period. The findings in relation to outreach are outlined in the following section.

Great Expectations has performed well in its outreach activities. Through the 2001-2003 Reporting Period, the program reached 4526 families. This equates to approximately 125 families per month. The number of families reached has increased each year during the reporting period resulting in an increase of 76%. The graph below illustrates the findings for families assisted by outreach.

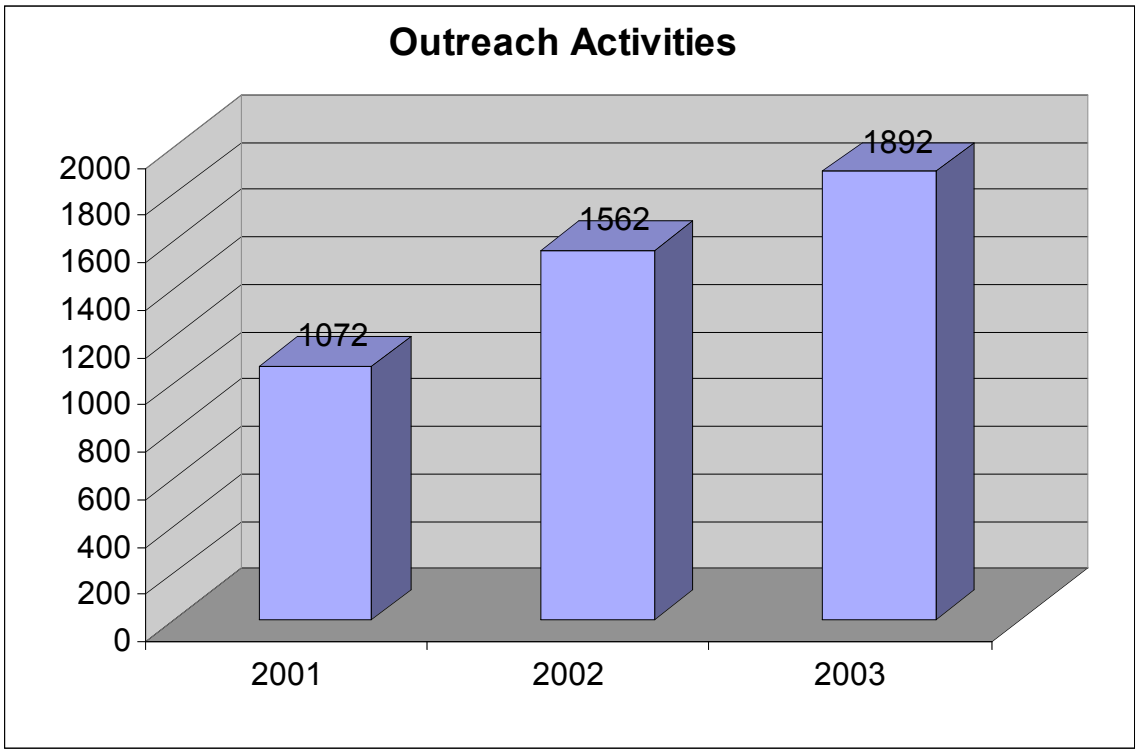

Figure 1

* 2004 data not available

In addition, Great Expectations outreach staff have contacted 150,000 individuals through outreach activities, community canvassing, and participating in public events. Please note that this is a total overall encounter. This number of encounters suggests a very large section of the community is being introduced to GE's program activities.

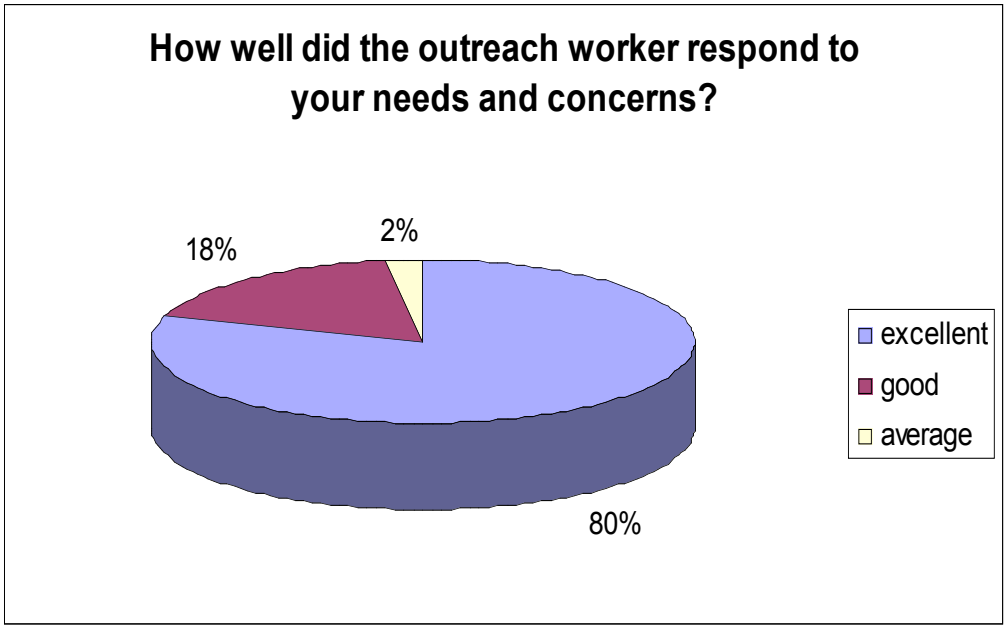

Figure 1

The data reports that 80% of the clients felt that the outreach workers response to their needs and concerns were excellent. 18% felt that the response to needs and concerns were good. There were only 2% responses to this question that were answered as average by any of the clients.

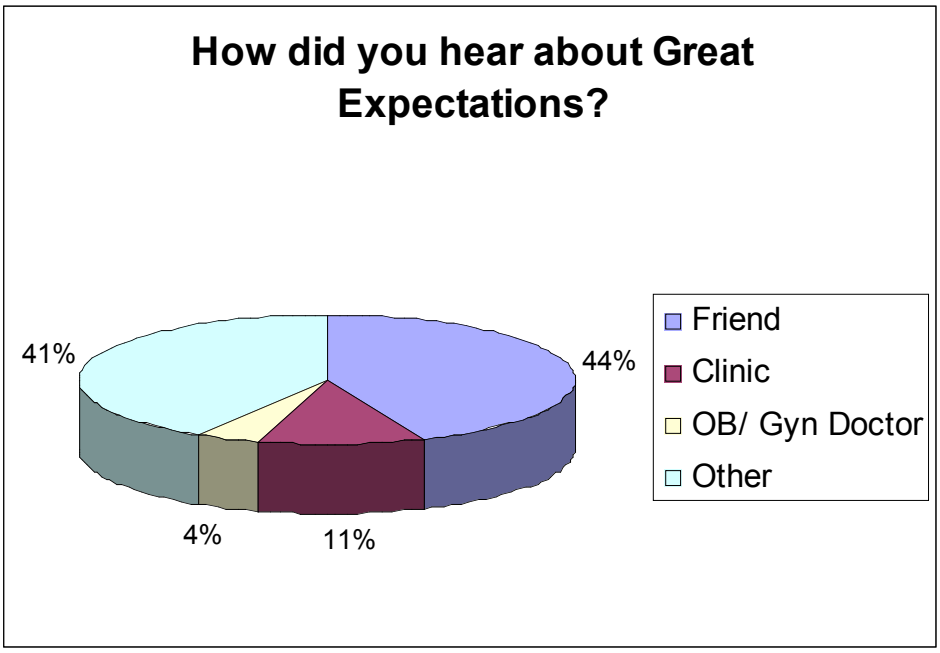

Figure 3

Data was averaged for CY01-04, program data reports that 44% of the clients heard about Great Expectations through a friend. That shows that GEHS services are producing and good basis of positive word of mouth correspondence throughout the GEHS target areas. Nearly, 11% of the clients reported hearing about GEHS from their respective clinics. 41% reported other means of hearing about GEHS services and this needs to be investigated further by the GEHS staff in the future to fully account for all the various means and avenues of recruiting clients into the GEHS service. Only 4% of the clients reported having heard about GEHS services from their doctor.

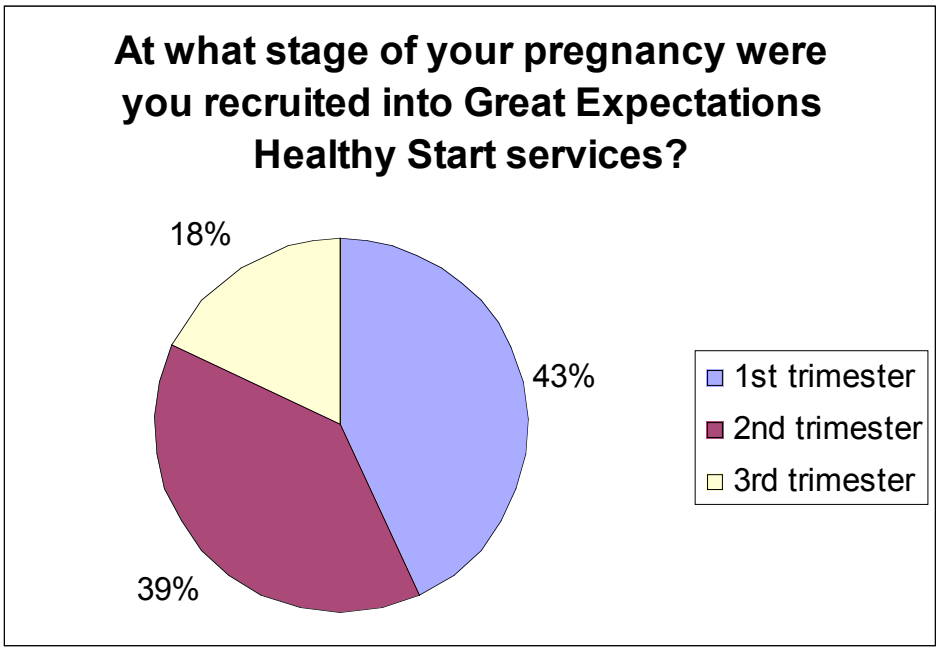

Figure 4

It is very important to the success and implementation of the GEHS program that clients enter into the services as early into the pregnancy as possible. Program data shown above indicates that the majority of the clients are in fact entering into the program earlier more so than later into the stages of their pregnancies. On an average for data reporting period, 43% clients were recruited into GEHS services in their first trimester. Another 39% were recruited into the program in their second trimester. Only a very small portion of clients, roughly 18%, were recruited into the program in their third trimester of pregnancy.

B. Case Management

1. Discussion

Management developed the model for low risk case management to address needs of pregnant clients and mothers with newborns. High-risk case management services is implemented into the program. This a integrated model utilizing the case management staff in the Community Care Centers (CCCs).

2. Model

Enrollment Specialist enrolls clients in the case management program and assigns them either a high or low risk case specialist they were assessed for risk. If they were deemed high risk after the assessment they may be assigned to another case specialist. The Case Specialist work in each of the CCCs and follow their clients to make sure their needs were met such as attending educational classes, Medicaid enrollment, and prenatal visits.

The model includes the nurse, health educator and CCC administrators. A risk assessment process was implemented as well. The CCC administrators assess each case for any social or clinical risk factor targeting pregnant women most at risk. Clients were assigned to a level depending on the results of their assessment either Level I, II, or III with Level III being the highest risk level. Clients deemed to be at low risk receive Level I and will be tracked and monitored by the Case Specialist. Clients exhibiting environmental or psychosocial risk factors were assigned to Level II. Level III is granted to any client who possesses a medical risk factor. A High Risk Case Manager and a Community Health Nurse gave level III clients' case management services. All clients participate in an intake visit in which access to medical care, insurance, transportation, previously identified risk factors will be reviewed. Clients maybe assisted with additional services based on the outcome of the intake visit including transportation, Medicaid application, WIC or other services.

3. Implementation, Barriers, and Advances

As a result of budget constraints, the number of case specialists has been reduced which directly affects the number of clients that can be monitored. There has been significant staff turnover and positions go unfilled for long periods of time. The relocation of many housing development residents severely hindered GE's ability to recruit and retain clients. Due to the population shifts as a result of the demolition of the housing developments, Great Expectations has had to restructure the geographic area served by the program.

GEHS has identified access to prenatal care as a significant barrier to the clients. A lack of knowledge regarding the importance of prenatal care is prevalent in the communities that GE services.

The chart shows the success in case management participation Great Expectations has had over the reporting period. The consistent ability of reporting over 800 families assisted by case management is a testament to the Great Expectations staff. During the reporting period, the number of families assisted by case management services has decreased from year 2001 to 2004, however this primarily due to the restructuring of the service areas. There was a following increase from 839 in 2002 to 882 in 2003.

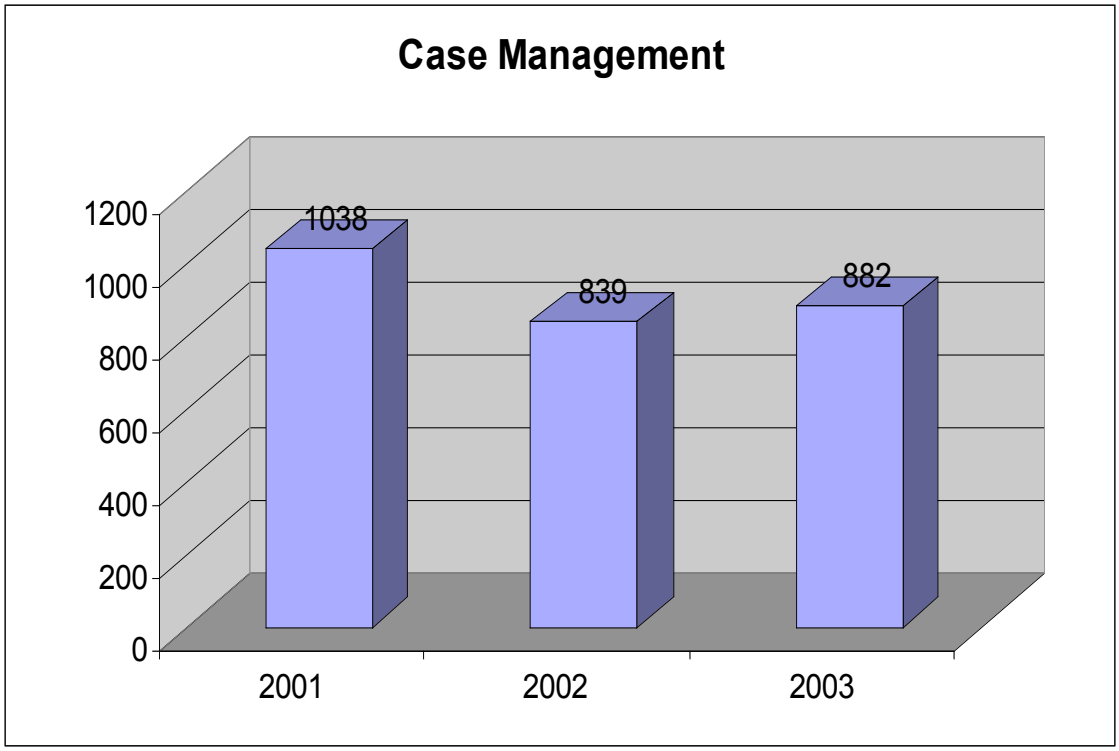

Figure 5

*2004 data not available

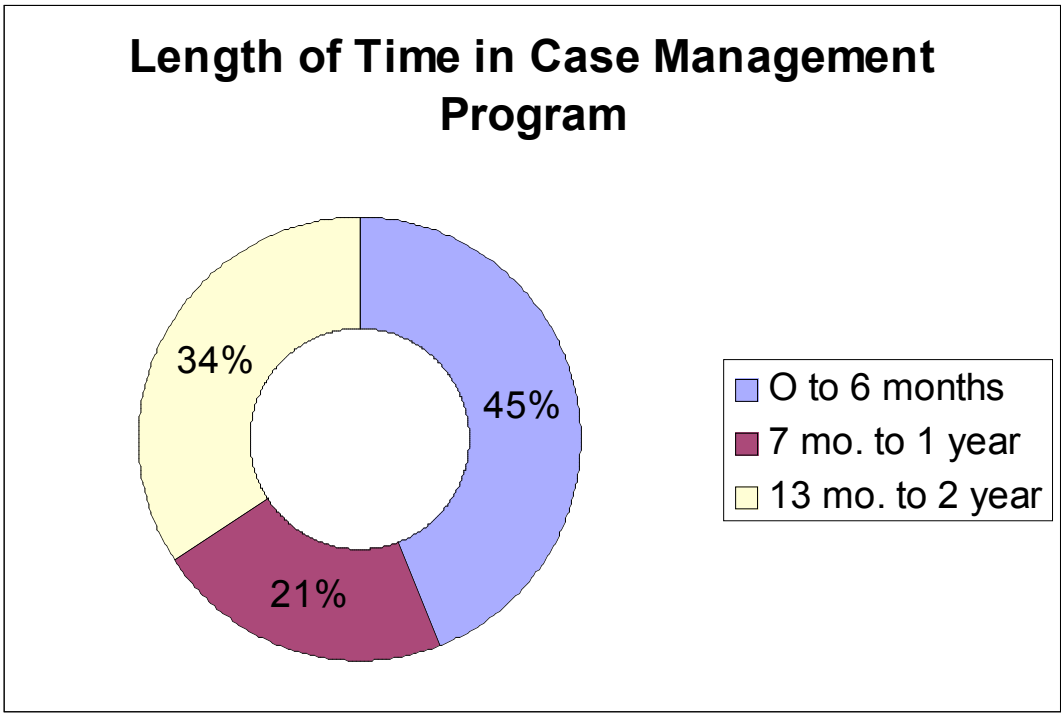

Figure 6

The majority of clients in the case management component are involved with the program for under a year. Of our overall client base, according to figure above, 45% of these clients were in case management for a period of 0-6 months. Nearly 21% of the clients were involved with case management for a period of 7 months to a year. Combining these thus yields that 55%, approximately two-thirds of the client base is in case management for a period of 7 months to 2 years. Another 34% of the remaining clients were in case management for a period of 13months to 2 years from the data reported.

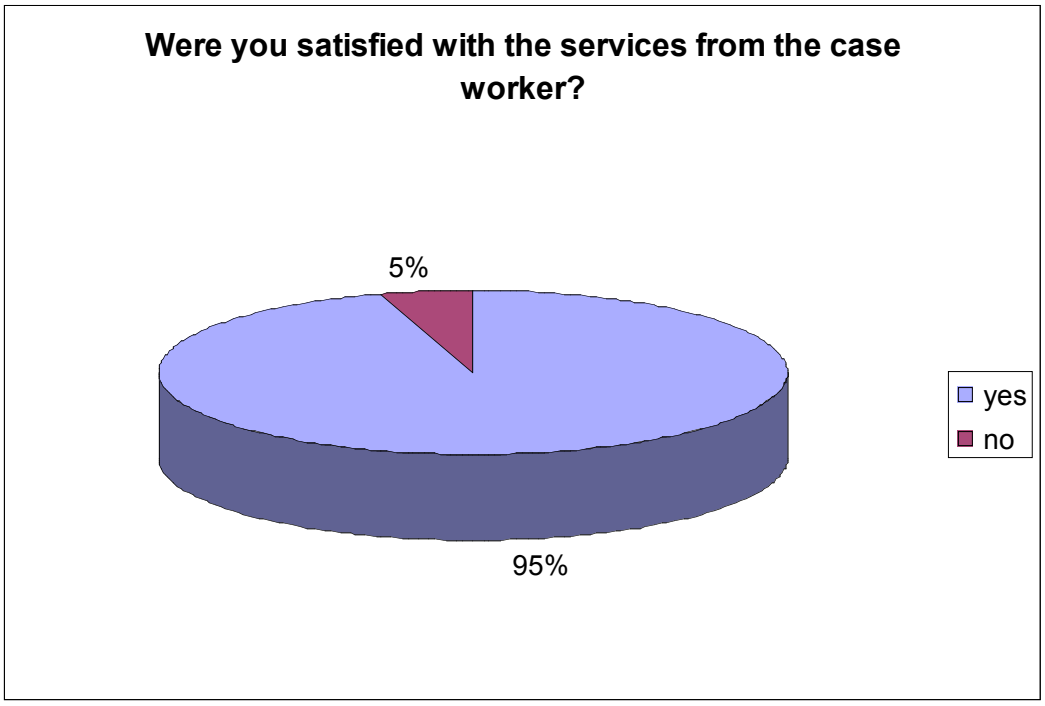

Figure 7

Approximately 95% on average during the reporting period, of the clients in the GEHS program reported being satisfied with the services from the case workers and their interaction with the clients. This is a positive indicator that the case managers are being effective in their methods of service to the clients participating in the program.

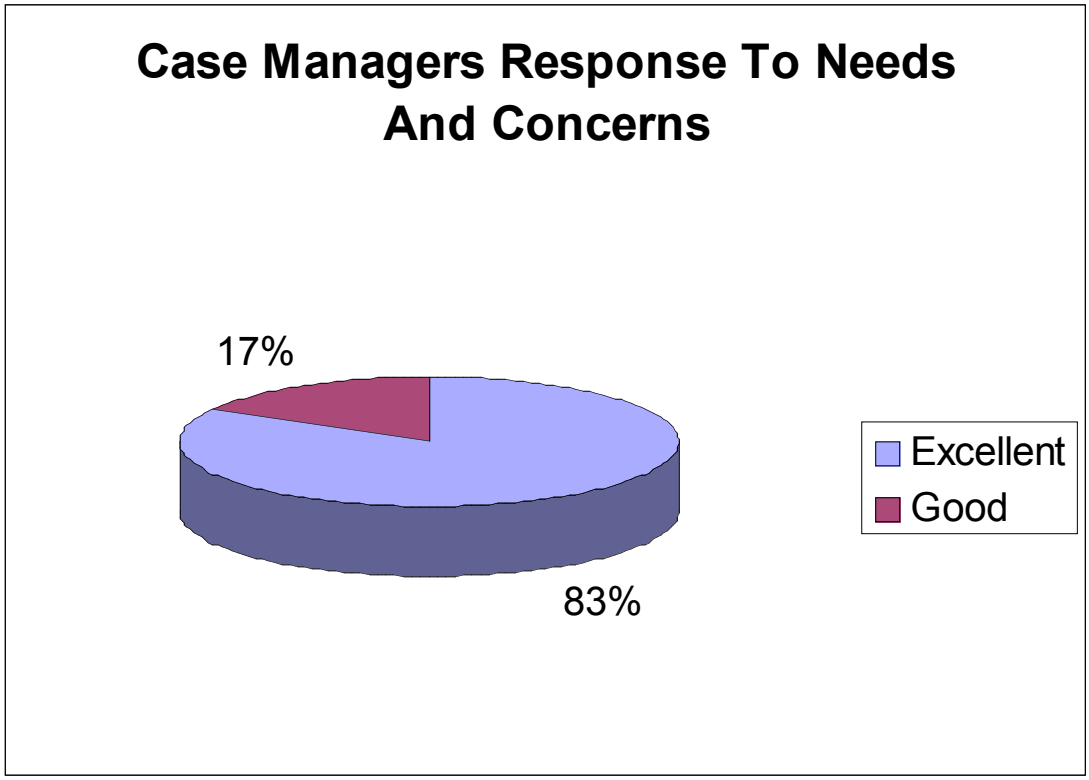

Figure 8

The CY02-04 averages show that 83% of the clients felt that the case managers response to their needs and concerns were excellent. 17% felt that the response to needs and concerns were good. There were no negative responses to this question by any of the clients. In relating to the response of the GEHS staff, the information that was distributed to the clients was done in a very positive manner in that 97% of the clients reported the information received from the case manager was extremely helpful. This also shows that the there was a very positive sense of support and efficiency by the GEHS service staff to the clients in the services.

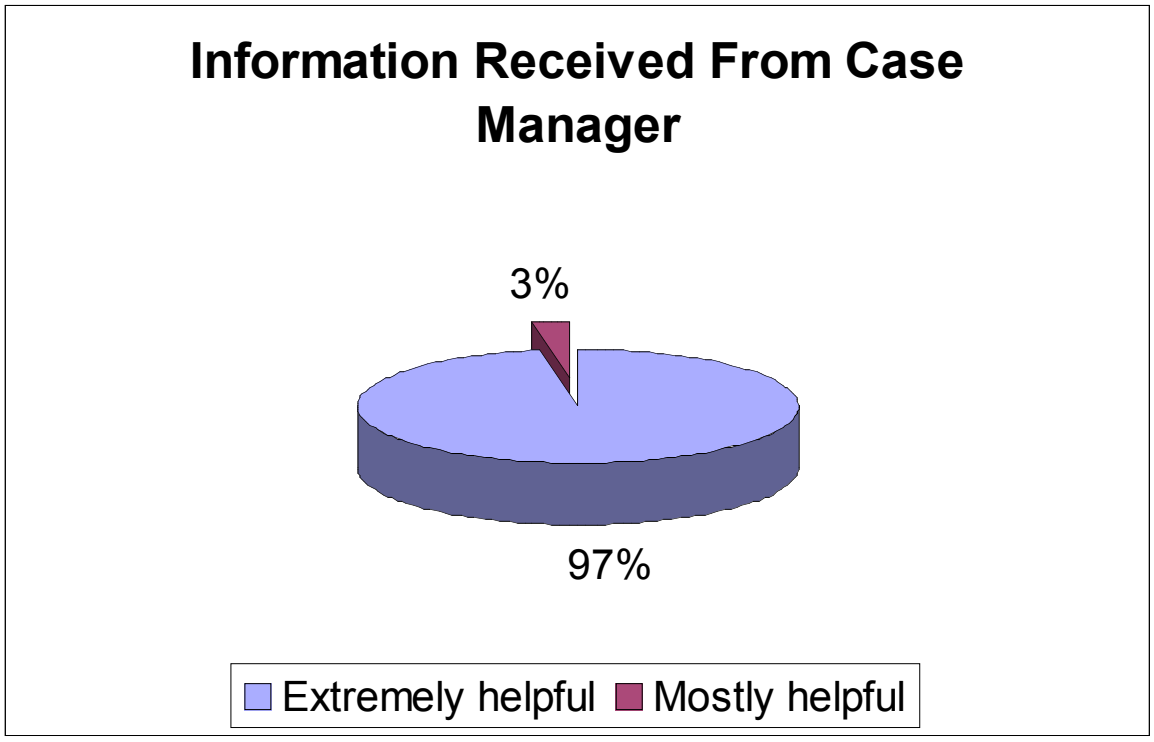

Figure 9

According to the data illustrated above, 100% of all the clients reported that they felt better prepared to plan for their child's and their own health from participating within the GEHS program and its services. That is an excellent indicator that the purpose and mission of GEHS is being properly maintained and passed along to the clients of the program and the GEHS services are having the proper and appropriate effectiveness that was wanted.

C. Health Education and Training

1. Discussion

The Great Expectations management team developed the education and training models in which several strategies were utilized to assist clients in working through some of the issues that put them at risk for poor birth outcomes. Teen pregnancy, lack of resources, poor parenting skills were all contributing factors to a high-risk pregnancy. GE seeks to mitigate these factors through education.

2. Model

GE provided Family Planning Counseling, Prenatal Education, Parenting Education, and individualized nutrition education when needed. The educational programs were conducted by an array of GE staff members.

The Case Specialist and High Risk Case Manager prior to the third trimester conduct Family Planning Counseling. The timing is important to stress the significance of spacing between births and considering the use of contraceptive methods.

The Community Health Nurse conducts Parenting and Prenatal classes. These classes were conducted in a group session that is culturally appropriate and directly relate to the needs of the group. Issues such as family planning, pregnancy and birth, smoking and substance abuse, and parenting skills were addressed during the Prenatal and parenting classes. The classes focused on modifying behavior and provide an opportunity for bonding and support among the women who participate. GE has recognized an addressed a need for reaching teens in schools. Classes were now being offered in several area high schools to reach this critical population. The prenatal education consisted of a series of 4 classes and parenting series has 6 classes.

3. Implementation, Barriers, and Advances

The lack of transportation continues to be a barrier to women accessing prenatal and parenting educational services. Although GE provided transportation services many clients were still hindered by mobility issues. Education and training has allowed GE to reach many people in the community. This is important to continued recruitment and making changes in the overall health of the community. The following charts show the level of penetration GE has achieved in its education and training programs.

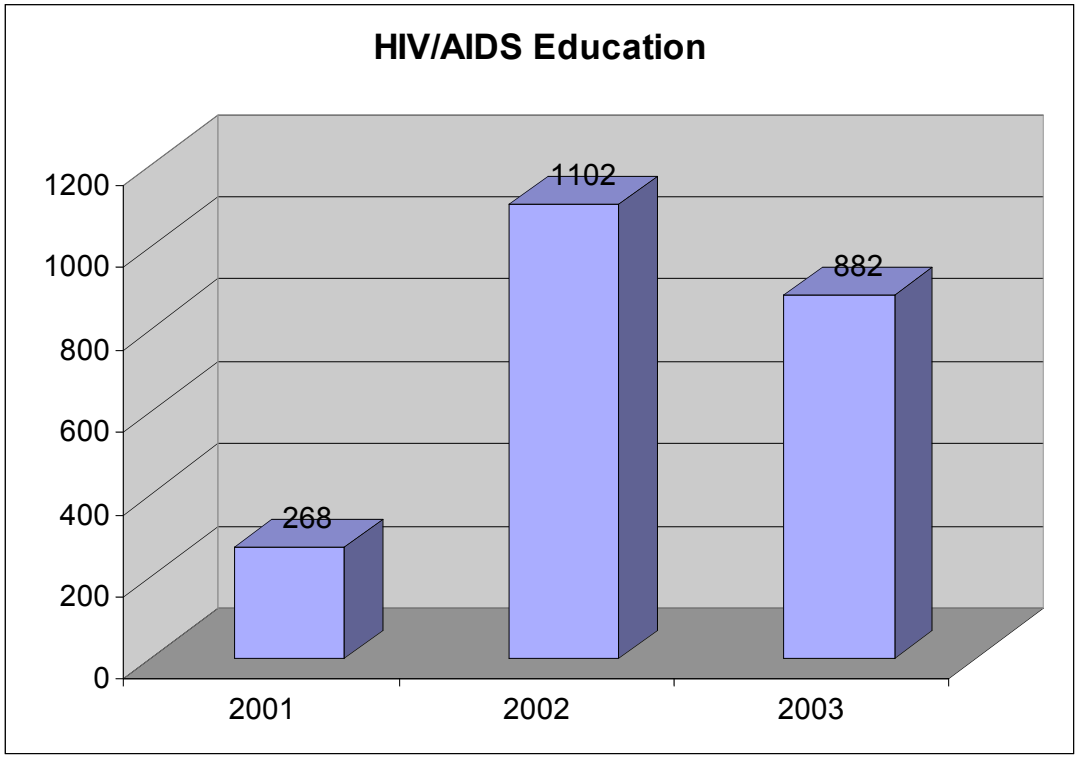

Figure 10

*2004 data not available

During the evaluation period the number of clients receiving HIV/AIDS education has changed significantly. The numbers show that a large percentage of all GE clients during the period received HIV/AIDS education. The level of accomplishment here was significant since AIDS is a major concern in the African-American community. This segment of our population has the highest rates of infection. GE has an opportunity in this area to make a significant impact. Many of their trainings related to HIV/AIDS were provided by other GE HIV/AIDS projects that exemplify agency program coordination.

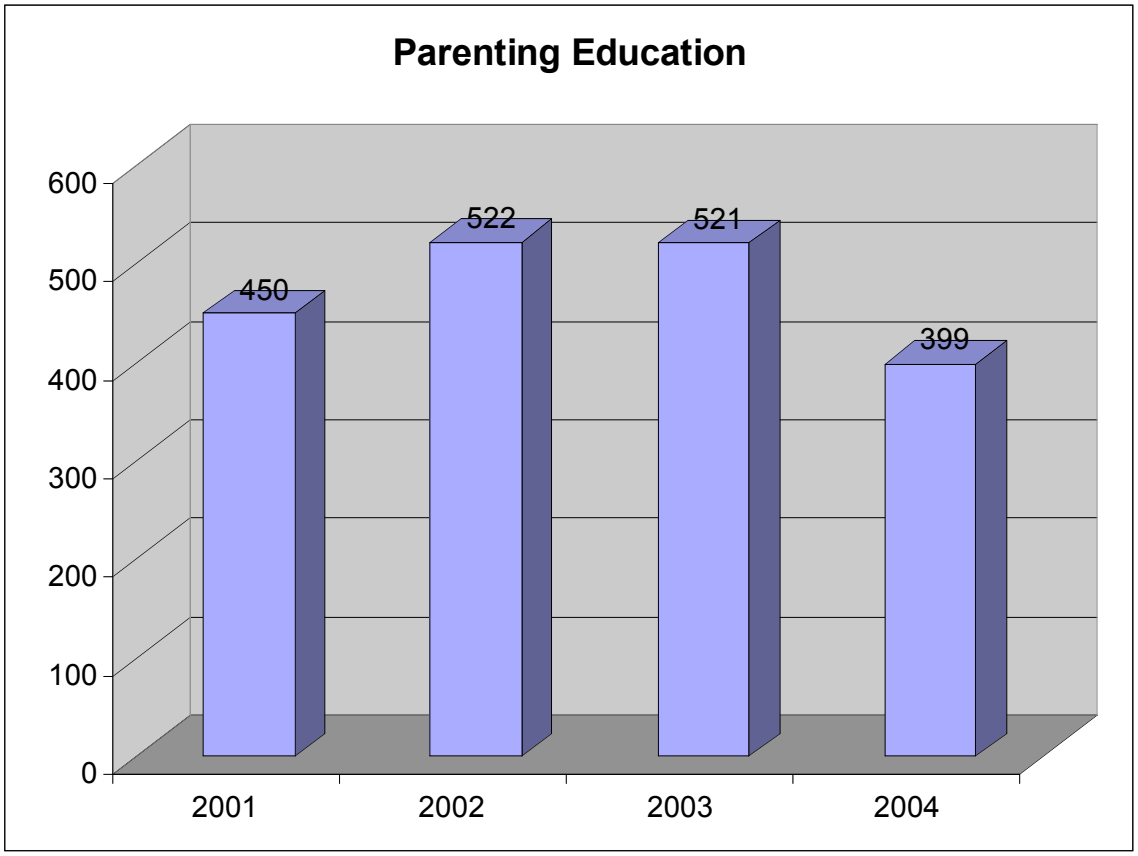

Figure 11

Parenting education is an important part of the services Great Expectations provides. The chart above shows the level of penetration Great Expectations has had with its clients in providing parenting classes. The data shows an increase in the number of participants who received parenting education during the project period. The numbers rose from 2001 to 2002 from 450 participants receiving education to 522. However, there was a slight decline in the number of clients from 2003 to 2004 from 521 to 399. There have been staffing changes that have affected the program's ability to maintain its level of service in these years, which is the primary factor in the decreasing numbers for 2004.

When viewed collectively for the reporting period, the program was able to reach the majority of the total enrollment of pregnant clients, which is a major accomplishment. This is an area for further analyses for their overall Health Education and training. Great Expectations has already taken steps to build upon this foundation by securing alternative funding and collaboration with other educational initiatives. These changes will be instrumental in the further success of the parenting education initiative.

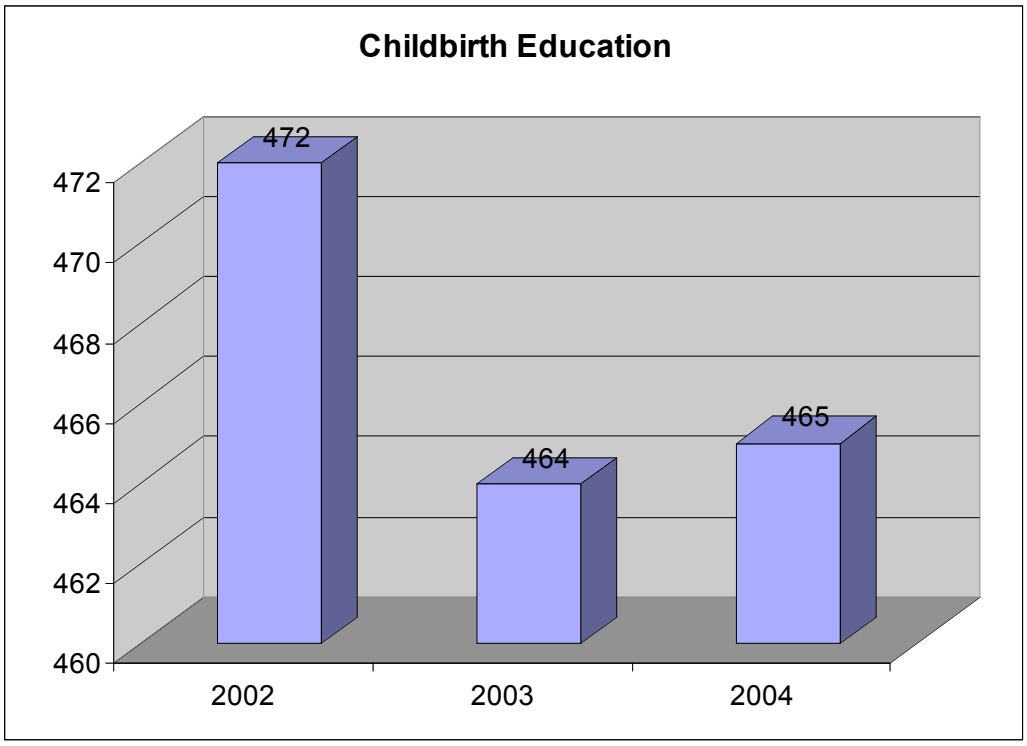

Figure 12

*2001 data was not available

Childbirth education is an important part of the services Great Expectations provides. The chart above shows the level Great Expectations has had with its clients in providing childbirth classes. The data shows very slight increase in the number of participants who received parenting education during the project period from 2003 to 2004. The numbers rose from 2003 to 2004, however, there was a slight decline in the number of clients from 2002 to 2003 from 472 to 464. This minor decline has not negatively affected the program's ability to maintain its quality level of service in these years.

When viewed collectively for the reporting period, the program was able to reach the majority of the total enrollment of pregnant clients, which is a major accomplishment. This is an area for further analyses for their overall Health Education and training. These changes will be instrumental in the further success of the childbirth education initiative.

D. Interconceptional Care

1. Discussion

Great Expectations utilizes an integrated and a multidisciplinary team, consisting of a health educator, mental health professional, case managers, case specialists, and community health nurses to provide interconceptional care services.

2. Model

GE provides an array of services consisting of risk assessment, coordination of care, case management, client support, and health and risk reduction education services that include family planning, parenting, smoking cessation, depression screening and emotional support services. Other facilitative services provided by GE are Medical/LACHIP enrollment, transportation, and referrals to health and social services.

3. Implementation, Barriers, and Advances

GE has implemented various strategies to identify and recruit high-risk women that are in the interconceptional care period. Collaborations were formed and/or enhanced with medical providers, well baby clinics, programs that target women who delivered without prenatal care, substance abuse centers and other programs in an effort to identify and enroll high risk women. Free pregnancy tests were conducted at each community care center as a strategy to engage women who are at risk for an adverse pregnancy outcome or who have had one in the past.

GE influence plays a role in the overall health of the community as evident in the outreach numbers and the numbers of live births shown below. From 2001 through 2004 the total number of live births in the census tracts served by GE has steadily increased. The program is focused on reducing the number of infant deaths through increasing their participants.

Overall, the number of new infant participants was on the decline. There was an increase in infant participants between 2002 to 2003. This increases coincided with staffing, funding and services challenges for the organization. Once these challenges were addressed by identifying alternative funding sources, replacing staff, and redefining roles then numbers began to decline. For the reporting period, the numbers have fallen from a high of 449 to a low of 246 in 2004. See the graph below for specific results.

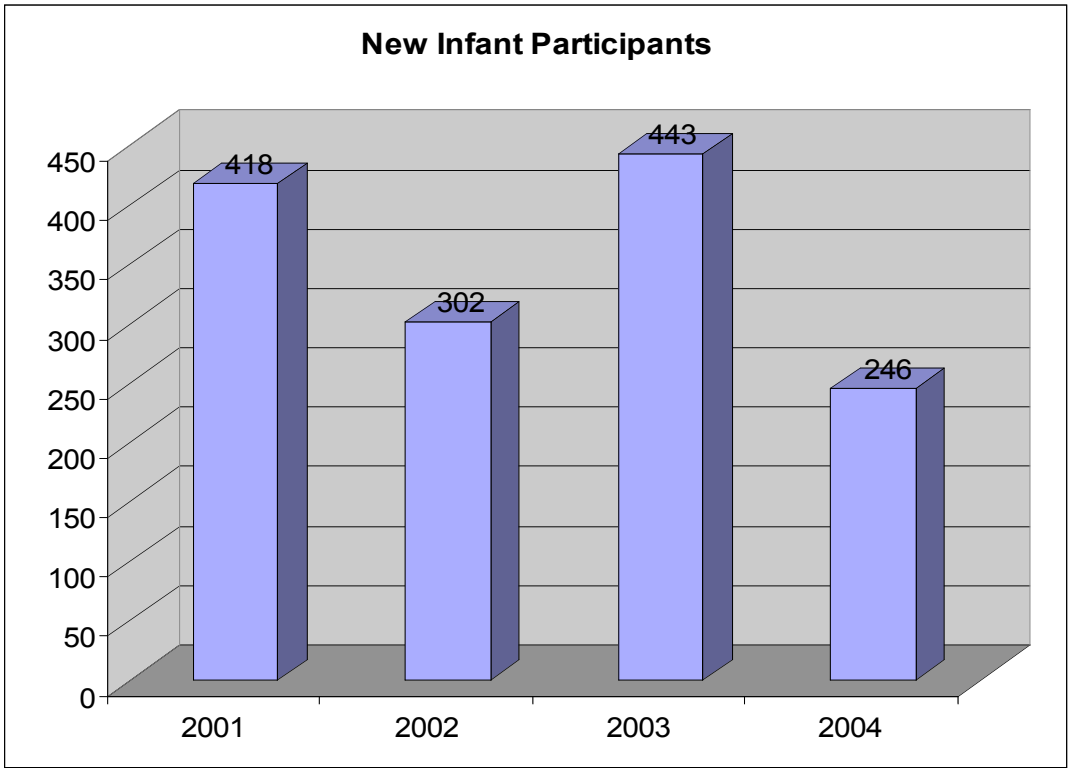

Figure 13

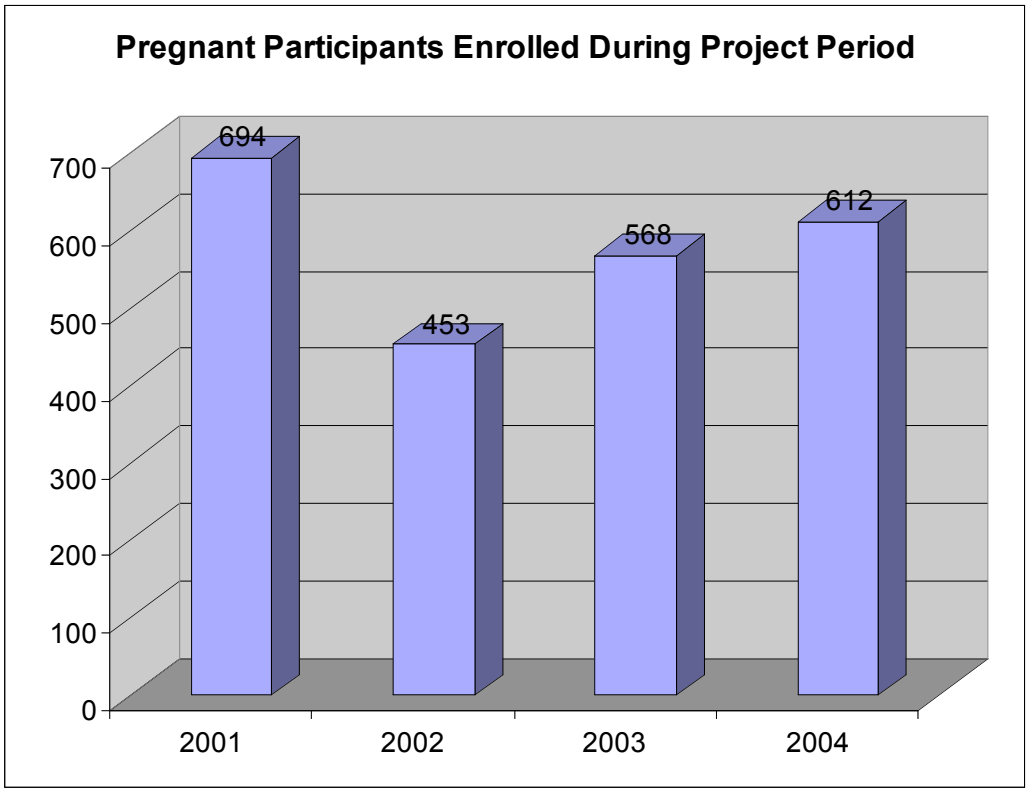

Figure 14

According to the data reported, after addressing program changes earlier in the project period, CY2004 saw the highest rise in the number of pregnant participants during this reporting period. CY2004 reported 612 participants which had risen from CY2003 which reported 568. This follows an additional increase in participants from 2002 to 2002 of 453 to 568. This data reflects the positive changes in the level of recruitment and outreach within the GEHS program. The GEHS staff should continue to implement more ways and strategies to continue this positive increase in the level of participants being reached during the project periods of the GEHS program.

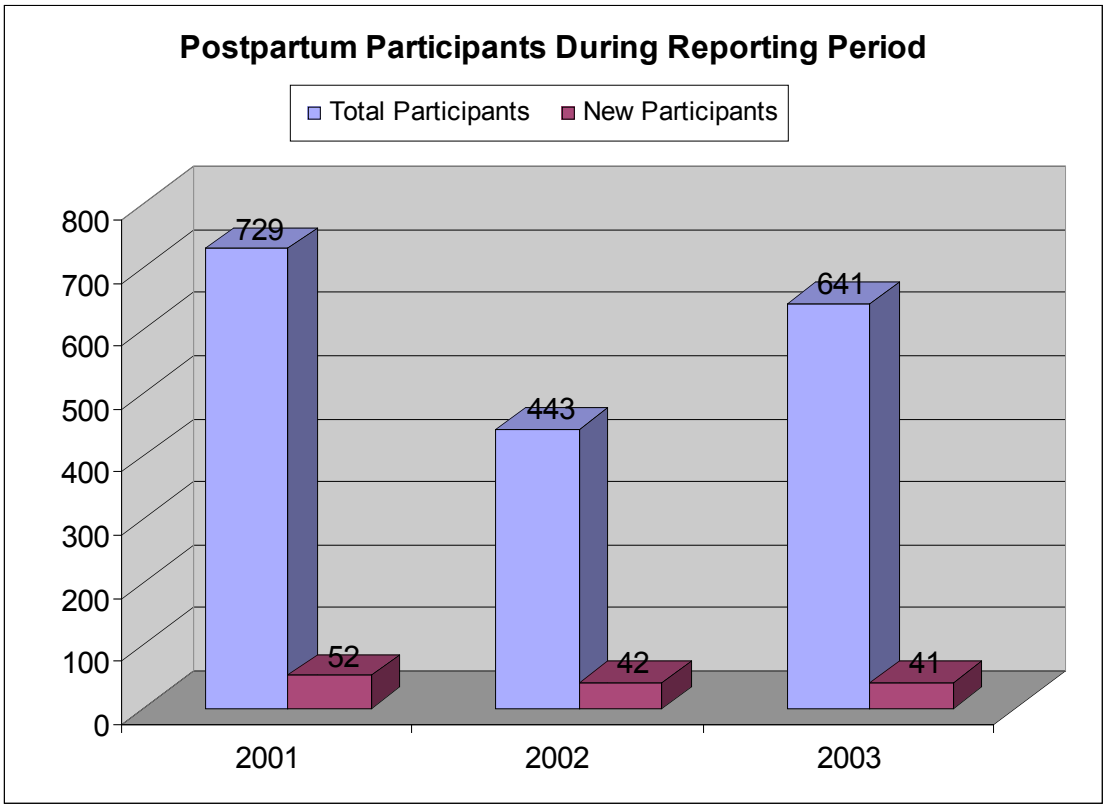

Figure 15

*2004 data not available

According to the data reported, after addressing program changes earlier in the project period, CY2001 saw the highest number of postpartum participants during this reporting period. CY2003 reported 641 participants which had risen from CY2002 which reported 443. This follows a decrease in participants from 2001 to 2002 of 729 to 443. This data reflects the positive changes in the level of recruitment and outreach within the GEHS program. The GEHS staff should continue to implement more ways and strategies to continue this positive increase in the level of participants being reached during the project periods of the GEHS program.

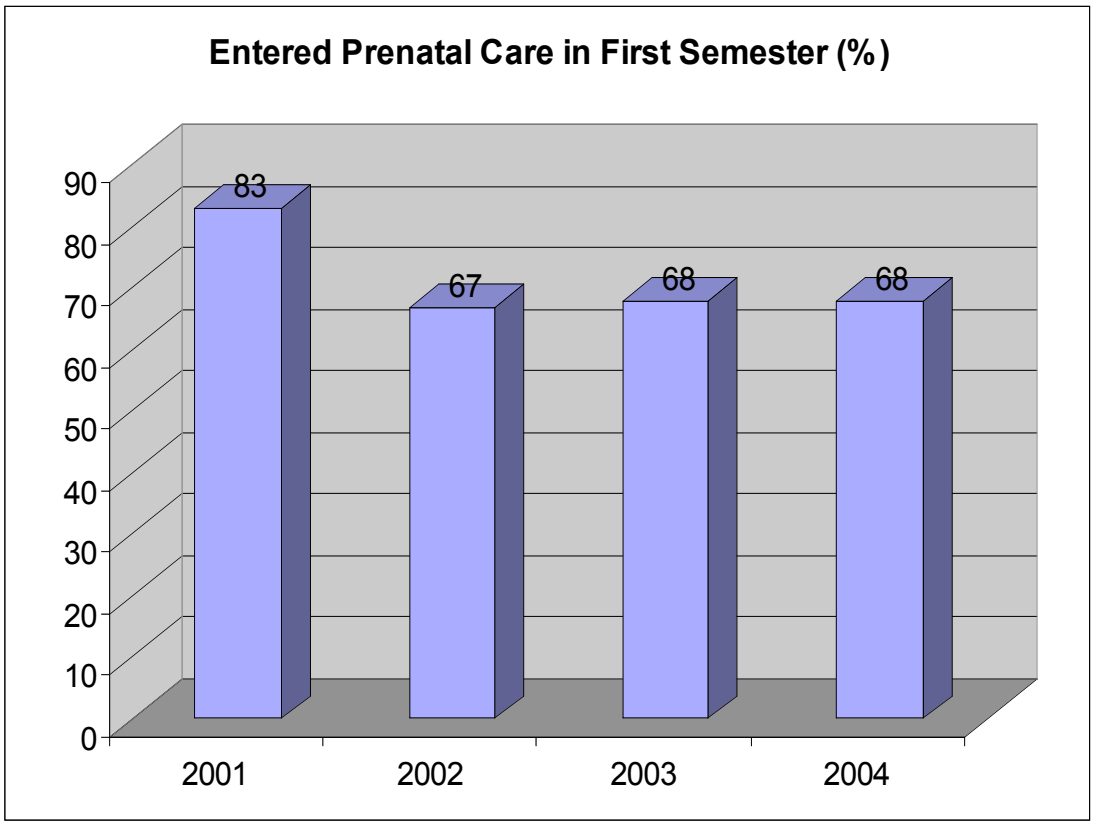

Figure 16

Prenatal care is essential to successful birth outcomes. The chart above demonstrates Great Expectations success with clients entering care in the first trimester. The rates show a slight decline in the rate from 2001 to 2004, decreasing by 16% from 83% to 67%. It should be noted that this was a period of during which GE underwent staffing changes and program issues. A decline of only 16% under such circumstances should not be noted as weakness of the program. The increase in care from 2002 of 1% shows the programs ability to quickly rebound from its challenges. Remarkably, results show an steady 68% rate of clients entering program care in their first trimester. This success can be attributed to GE's level of outreach activities and community education efforts.

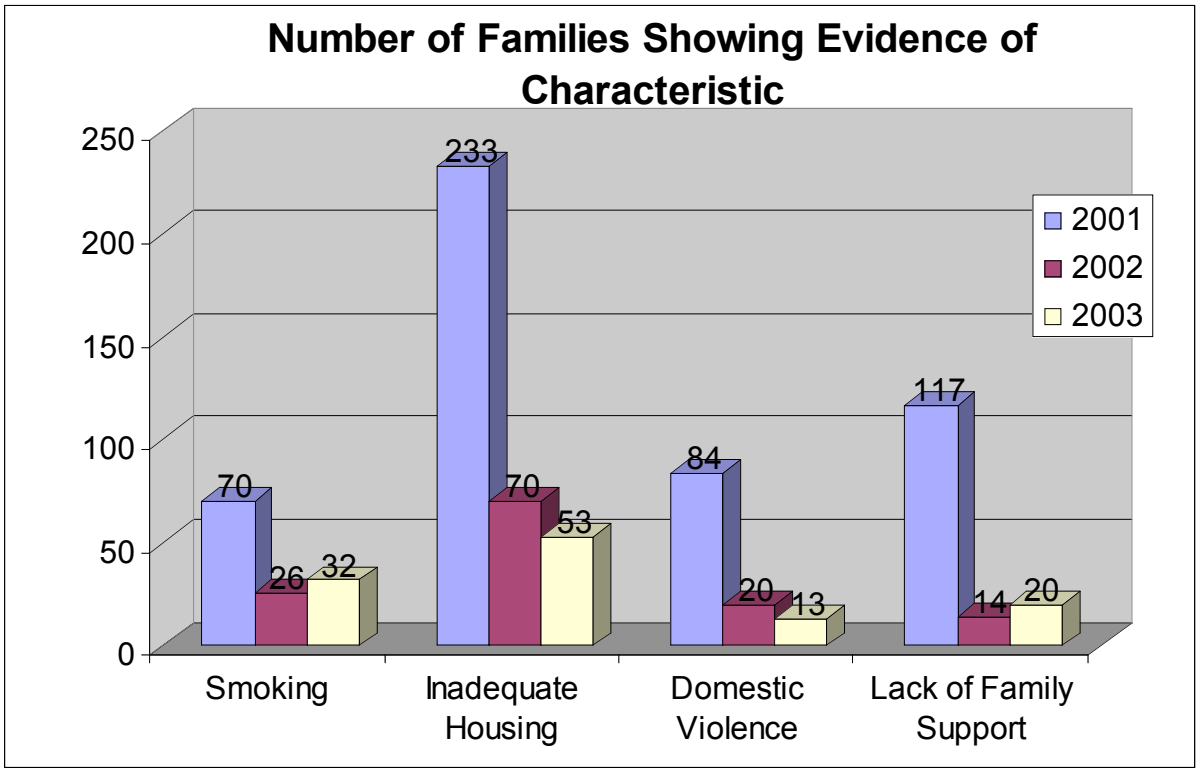

Figure 17

The data of the risk factors over the this three year period reflect that there has been a substantial overall decrease in the level of participants reporting these risk factors over the course of this program. Inadequate housing has produced the greatest positive impact reported in the GEHS program. The amount of domestic violence and lack of family support has also decreased significantly. The reporting of smoking as a risk factor has shown the lowest level of change although that factor has lowered from the 2001 year.

The Consortium is an important factor in the delivery and management of services to GEHS consumers. Consortium members are recruited from various segments of the larger community and comprise of consumers, providers, and agencies. Members assist GEHS staff with health fairs, outreach efforts in the community and also participate in additional activities such as Healthy Baby Week, Father's Day Conference, Mother's Day events, etc.

The Consortium consisted of several agencies which provided linkages to the local Maternal and Child Health (MCH) system and served as a referral network for GEHS. They include agencies such as substance abuse agencies, welfare to work, local pubic health units, state public health agencies that provide primary care for pregnant mothers and their families. A strength of the Consortium lies in the diversity within its racial and ethnic composition that closely resembles the makeup of the GEHS service area. The design of the consortium has been modified in an effort to make the program friendlier and resourceful.

Great Expectations has been able to develop an excellent support system in terms of its Consortium. The Consortium works tirelessly to assist GE in all areas of support including program development, funding, and outreach. The graph reflects an increase in the number of members of the consortia that were part of GEHS training. This is a vital aspect of the consortium that needs to continue to see an increase to maximize the level of involvement within the consortium as well as the level of training to best equip the consortium members with the GEHS program and its services.

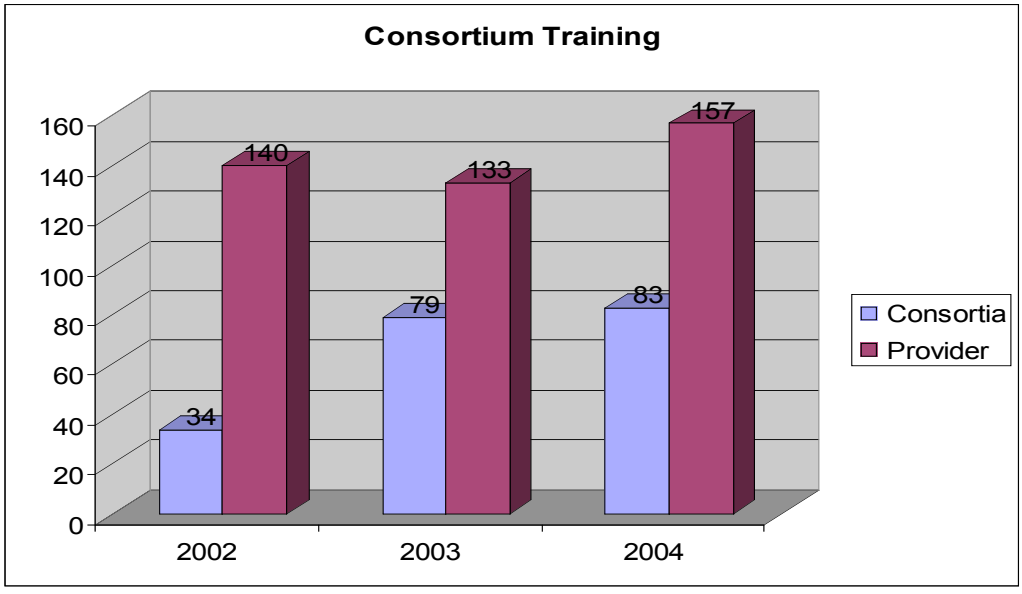

Figure 18

E. Depression Screening and Referral

1. Discussion

GE has hired a full time Mental Health Coordinator to conduct and coordinate all the perinatal depression screening services and provide mental health interventions.

2. Model

GE depression screening guidelines dictate that all clients receive a depression screening during the prenatal and postpartum periods. All clients are to receive a depression screening upon the first visit immediately following intake.

3. Implementation, Barriers, and Advances

GE has identified ways to fill gaps in screening and assessment services for depression during and around the times of pregnancy through an integration of perinatal and mental health services. GE has developed and increased community capacity and infrastructure that integrates depression screening into local health care through the Maternal Mental Health Forum and presentations conducted at Central City Mental Health Center and substance abuse residential facilities serving mothers and their children. GE has also created formal linkages with area perinatal and community mental health providers through existing relationships with medical providers and community presentations.

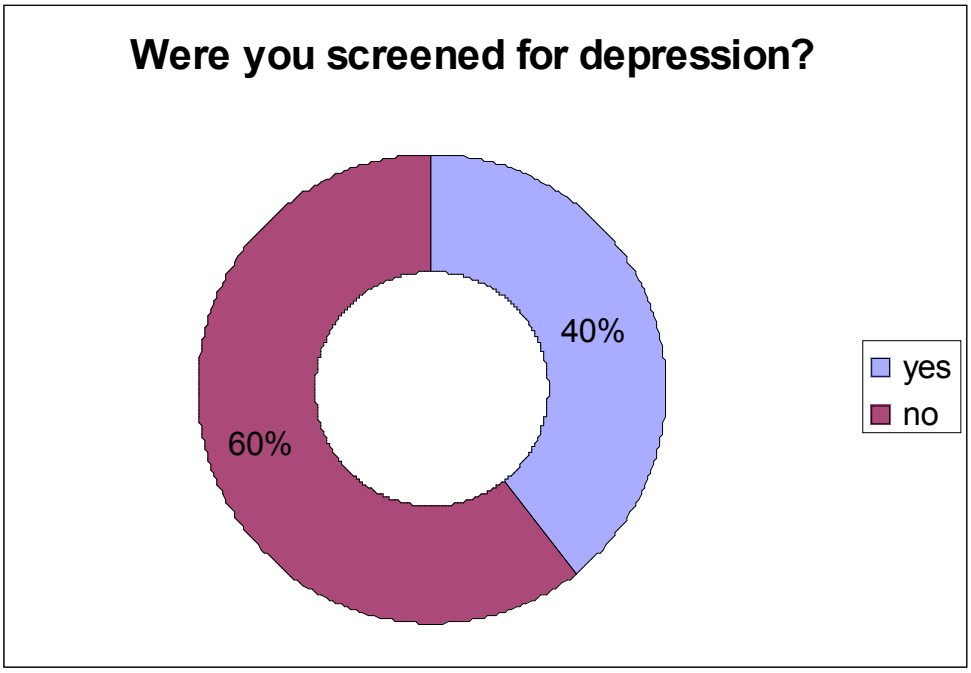

Figure 19

Average data from client surveys reflects that in regards to the Depression Screening, 40% of the clients reported being screened. On the otherhand, 60% reported not being involved in this component of the GEHS program.

GEHS has made significant effort to create synergies that allow clients to do "one-stop shopping" by making numerous services available in their centers. The primary means to creating the synergy is through receiving and completing referrals. The analysis included looking at the total number of referrals and the results are as follows:

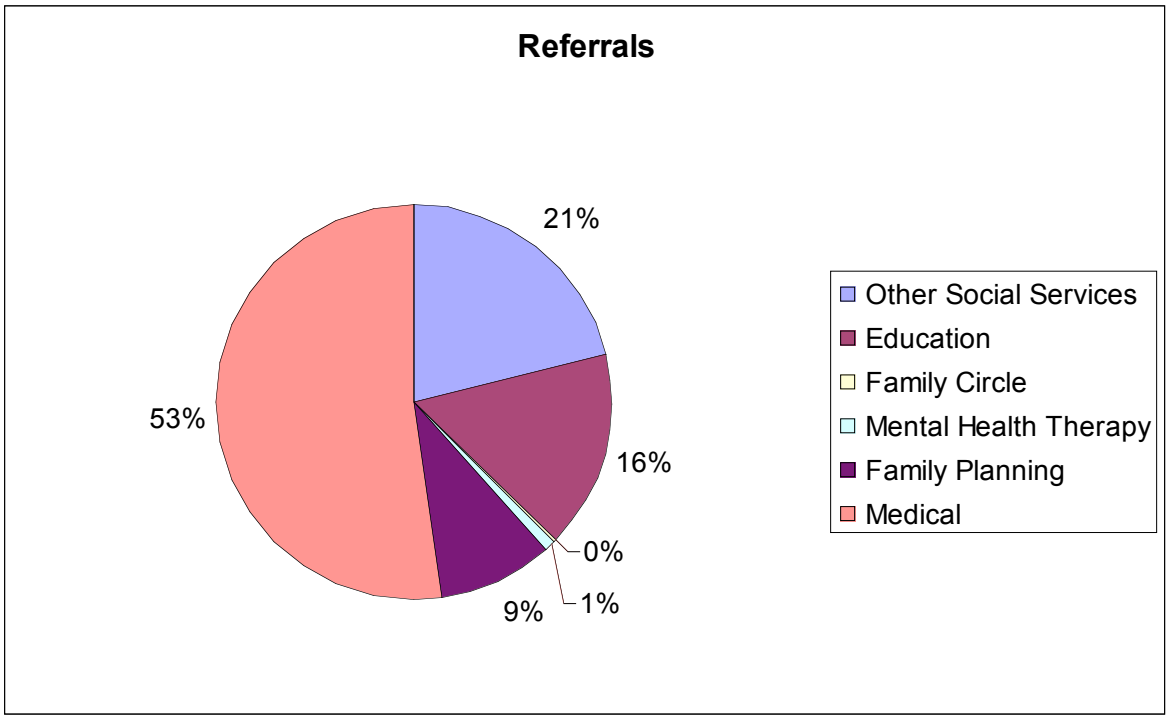

Figure 20

The referrals were made to a number of different services and agencies such as for Medical Services, Family Planning, and Educational Services. Over the project period approximately 53% of the referrals were made for Medical Services. 16% of the referrals were made for Educational Services and 9% were made for Family Planning Services. Smaller percentages were observed for other referrals such as to Family Circle, for Mental Health Therapy and another 21% for other Social Services.

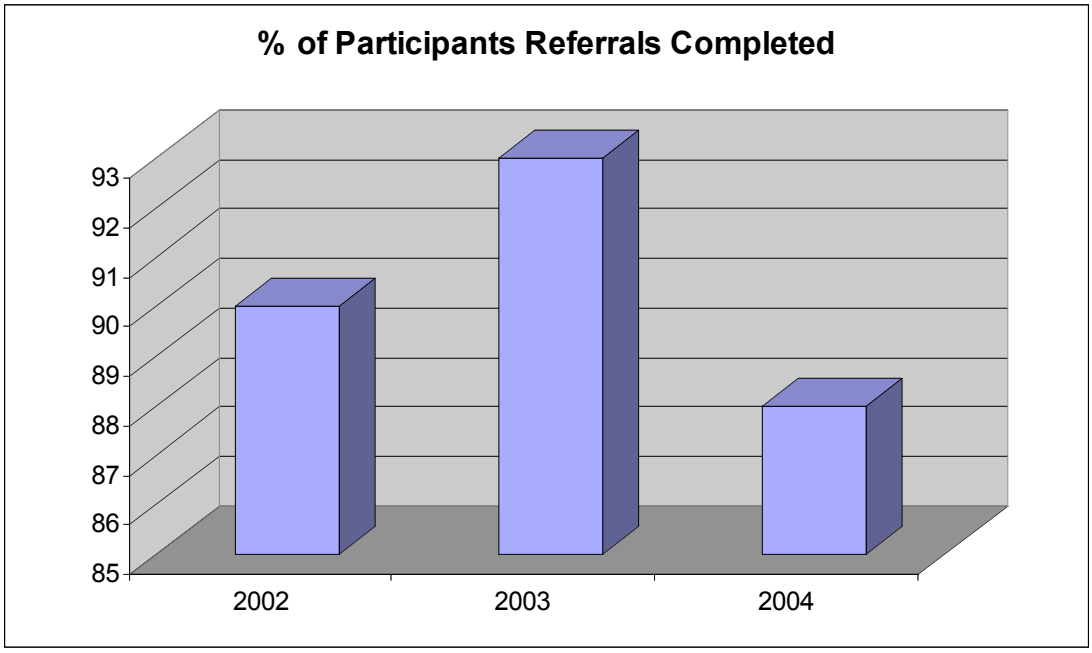

Figure 21

*2001 data not available

GEHS referrals were completed across the program. This is a definite strength of the program. Of the thousands of referrals received, the vast majority were completed resulting in a satisfactory completion rate averaging approximately 90% each year. However, there was a slight decrease from the 2003 reporting period of 93% completion to 88%.

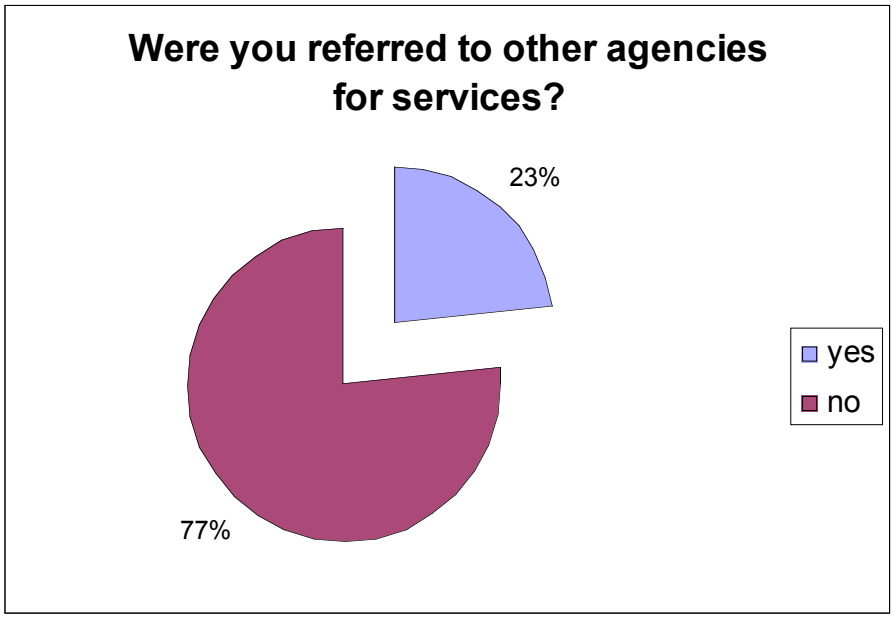

Figure 22

Clients participating in the program are presented with referrals to other agencies for various services to assist them as part of the GEHS program. On average over the project, 77% of the clients were able to utilize these additional services through referrals by the case managers they were in contact with. This data shows a positive component of the program in its enabling to satisfy the needs of its clients.

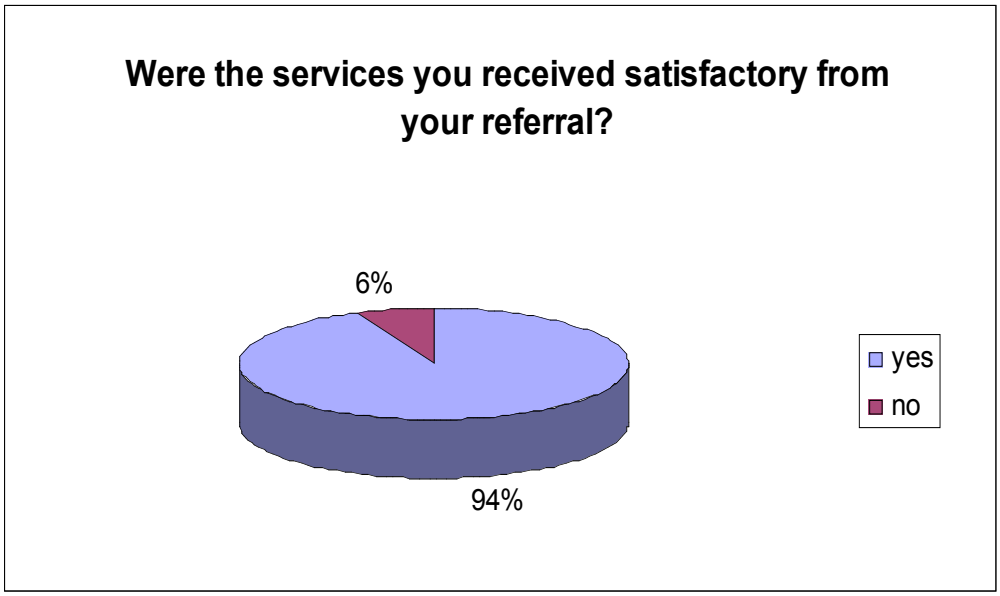

Figure 23

Data reflects that 94% of the clients that were referred felt that the services referred to were satisfactory in their providing of the service. This data shows a positive component of the program in its enabling to satisfy the needs of its clients through the use of interacting with other programs to best suit the needs of the clients.

IV. RECOMMENDATIONS

Recommendation 1

Central City should be used as a model for outreach and case management services for clients to develop similar results in other areas.

Recommendation 2

Hispanics can greatly benefit from GEHS services. More work needs to be done to recruit from this population over the next project period.

Recommendation 3

Continue to review and further develop more specific and easily measurable survey questions to get feedback on each session. Make sure that there is a continual incorporation of the completion of surveys into the actual session to help boost the number of surveys returned. A pre and post conference survey will help to gauge the level of education received.

Recommendation 4

There is room for improvement in the rates for all areas however Central City should be the focus. Staff should seek increase outreach and recruitment efforts in the new location to better results.

Recommendation 5

Continued success will depend upon the staff to continue this level of service in the new project areas. In order to recruit and retain clients in the service locations, there must be a significant number of outreach events and a number of those geared to special populations.

Recommendation 6

Continue to increase outreach efforts to target more high-risk individuals. In addition, push for greater data collection on new clients and more efficient reporting to better facilitate the tracking of clients through the data.

Recommendation 7

Data continues to show a very low Hispanic presence in the GEHS target areas. This may be true; however it should be verified by reviewing census data for those areas. More work needs to be done to recruit from this population

V. IMPACT

GEHS Program concentrates heavily on risk reduction and health promotion education. GEHS Program offers several types of education and health promotion services. The parenting & prenatal curriculum includes educational surrounding harmful effects during and around pregnancy, such as smoking, substance abuse, and domestic violence. The local evaluations have been an useful tool in analyzing the strategies and effectiveness of various means of providing these services and goals.

GE has been working in a collaborative venue to ensure that services are provided with the goal of full integration of our services. In addition, the local health system action plan has been evaluated to be used as a tool for directing program services and a tool for increasing collaboration among GEHS and local MCH providers.

The GEHS program has also made tremendous progress in implementing its goals from the information received from the local evaluations of GEHS. These evaluation have had positive impact on the successful manner in which the GEHS operates.

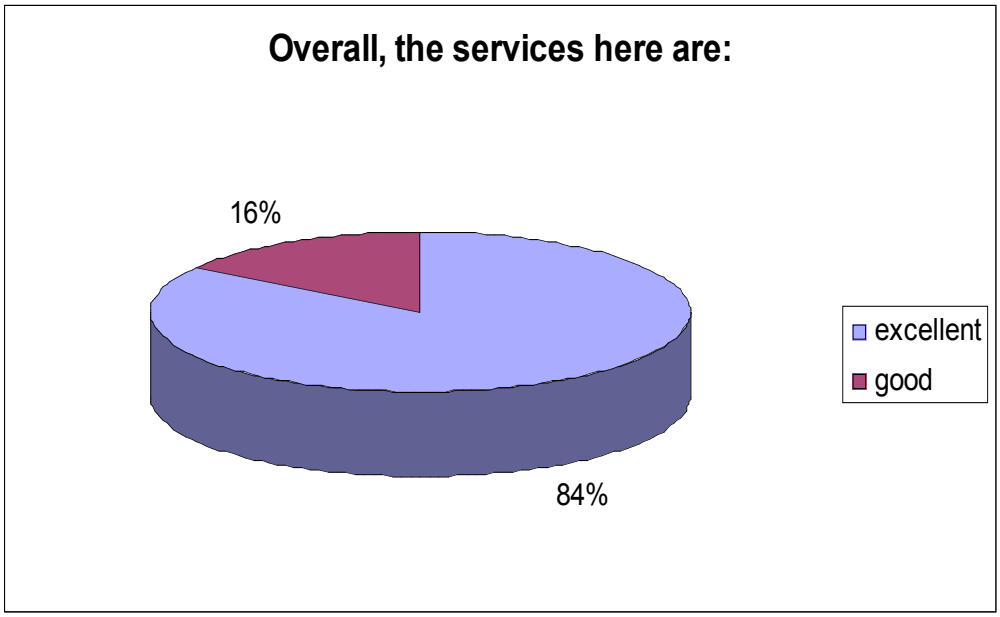

Figure 24

Survey participants were asked to rate the overall services they received through the GEHS Program. Respondents could rate the services as excellent, good, fair, or poor. 84% of all respondents rated the overall healthy start services as "Excellent". 16% rated the overall services as "Good" and their were no fair or poor ratings reported. The averaged data suggests a high level of overall client satisfaction. GEHS should continue with these types of efforts and

methods of service as it relates to maintaining this excellent level of service reported by the GEHS clients.

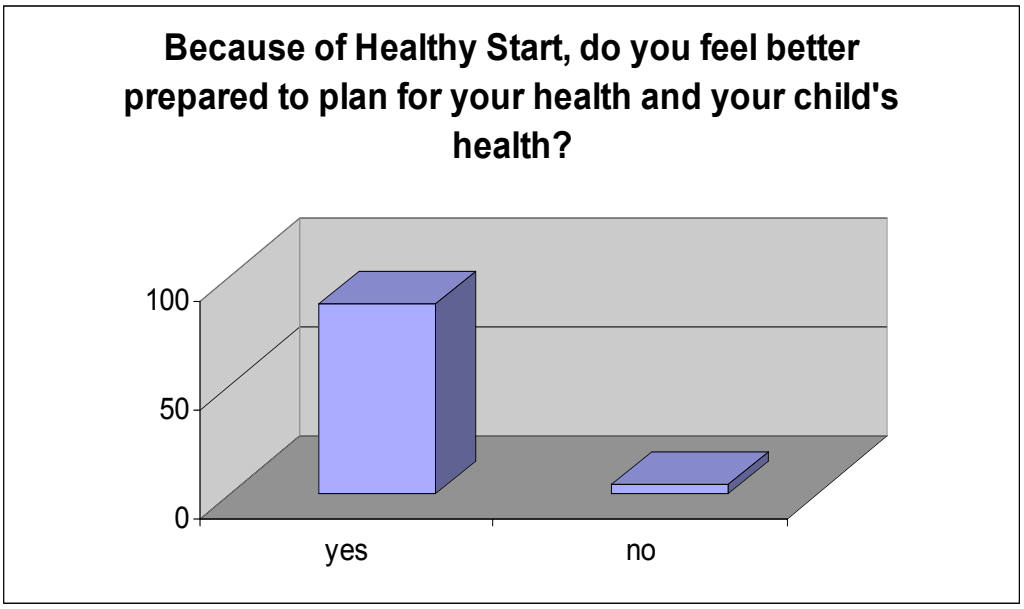

Figure 25

According to the data illustrated above for a 3-year average, 87% of all the clients reported that they felt better prepared to plan for their child's and their own health from participating within the GEHS program and its services. Only 4% of the responses were negative, while 9% reported no response to the question. That is an excellent indicator that the purpose and mission of GEHS is being properly maintained and passed along to the clients of the program and the GEHS services are having the proper and appropriate effectiveness that was wanted. This also reflects that the program itself actually accomplishing the goals that are set out for GEHS services.

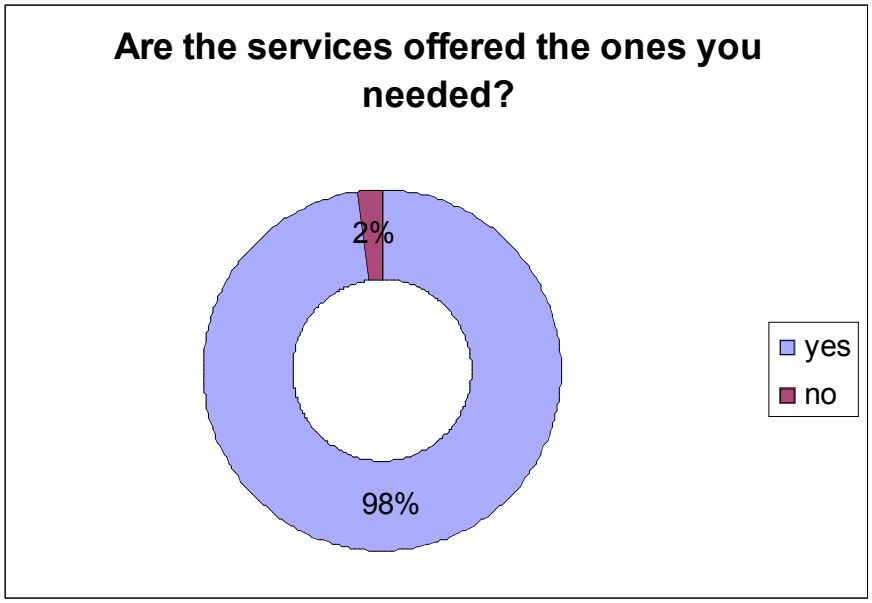

Figure 26

Overall, the data averaged over the years demonstrate an overwhelming 98% of the clients felt that the services offered were the ones that they needed. This data shows that case managers were very attentive to the specific needs of each individual case. This indicates that GEHS methods are appropriate.

VII. Fetal and Infant Mortality Review

VIII. Attachment I - Products

IX. Attachment II -Project Data

Attachment II -A -MCH Budget Details (Form 1)

Project Name:	Great Expectations	City:	New Orleans
Project Grant #:	H-49 MC 00099-02-01	State:	Louisiana

FORM 1

MCHB PROJECT BUDGET DETAILS FOR FY _____ 2004

1. MCHB GRANT AWARD AMOUNT			$2,125,000.00
2. UNOBLIGATED BALANCE			$0.00
3. MATCHING FUNDS (Required: Yes [ ] No [ ] If yes, amount)			$0.00
A.	Local funds	$0.00	
B.	State funds	$0.00	
C.	Program Income	$0.00	
D.	Applicant/Grantee Funds	$0.00	
E.	Other funds	$0.00	
4. OTHER PROJECT FUNDS (Not included in 3 above)			$0.00
A.	Local funds		
B.	State funds		
C.	Program Income(Clinical or Other)		
D.	Applicant/Grantee Funds(includes in-kind)		
E.	Other funds (including private sector, e.g. Foundations)		
5. TOTAL PROJECT FUNDS (Total lines 1 through 4)			$2,125,000.00
6. FEDERAL COLLABORATIVE FUNDS			
(Source(s) of additional Federal funds contributing to the project)			
A.	Other MCHB Funds (Do not repeat grant funds from Line 1)		
	1) SPRANS	$0.00	
	2) CISS	$0.00	
	3) SSDI	$0.00	
	4) Abstinence Education	$0.00	
	5) Healthy Start	$0.00	
	6) EMSC	$0.00	
	7) Traumatic Brain Injury	$0.00	
	8) State Title V Block Grant	$0.00	
	9) Other	$0.00	

B.	Other HRSA Funds		$0.00
	1) HIV/AIDS		
	2) Primary Care	$0.00	
	3) Health Professions	$0.00	
	4) Other	$0.00	
C.	Other Federal Funds		$0.00
	1) CMS	$0.00	
	2) SSI	$0.00	
	3) Agriculture (WIC/other)	$0.00	
	4) ACF	$0.00	
	5) CDC		
	6) SAMHSA	$0.00	
	7) NIH	$0.00	
	8) Education	$0.00	
	9) Other:	$0.00	

7. TOTAL COLLABORATIVE FEDERAL FUNDS $2,125,000.00

OMB 0915-0272 Expiration: January 31, 2006

Attachment II –B Healthy Start Participants (Form 5)

Project Name:	Great Expectations Foundation, Inc. HS	City:	New Orlear
Project Grant #:	6H49MC0099	State:	Louisiana

FORM 5

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED)

By Type of Individual and Source of Primary Insurance Coverage

For Projects Providing Direct Health Care, Enabling or Population-based Services

Reporting Year:
2003 2004

Table 1	(a)	(b)	(c)	(d)	(e)	(f)
Pregnant Women Served	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/Other %**	**None %**
Pregnant Women (All Ages)		**612**	**0%**	**93.0%**	**1%**	**6.0%**
10-14	**13**					
15-19	**172**					
20-24	**276**					
25-34	**126**					
35-44	**25**					
45 +	**0**					

Table 2	(a)	(b)	(c)	(d)	(e)	(f)
Children Served	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/Other %**	**None %**
Infants <1		**488**	**86.0%**	**0.0%**	**2.0%**	**12.0%**
Children 1 to 22			**81.0%**	**0.0%**	**1.0%**	**18.2%**
1-4	36					
5-9	0					
10-14	21					
15-19	182					
20-24	285					

Project Name:	Great Expectations Foundation, Inc. HS	City:	New Orlear
Project Grant #:	6H49MC0099	State:	Louisiana

FORM 5
(continued)

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED)
By Type of Individual and Source of Primary Insurance Coverage
For Projects Providing Direct Health Care, Enabling or Population-based Services

Table 3

	(a)	(b)	(c)	(d)	(e)	(f)
CSHCN Served	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/Other %**	**None %**
Infants <1		**12**	**100.0%**	**0.0%**	**0.0%**	**0.0%**
Children 1 to 22		**14**	**100.0%**	**0.0%**	**0.0%**	**0.0%**
1-4	26					
5-9						
10-14						
15-21						

Table 4

	(a)	(b)	(c)	(d)	(e)	(f)
Women Served	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/Other %**	**None %**
Women 22+		**502**	**0.0%**	**81.2%**	**2.0%**	**16.8%**
22-24	230					
25-29	134					
30-34	84					
35-44	54					
45-54	0					
55-64	0					
65 +	0					

Table 5

	(a)	(b)	(c)	(d)	(e)	(f)
Other	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/Other %**	**None %**
N/A						

Table 6	(a)	(b)	(c)	(d)	(e)	(f)
TOTALS	**Number Served**	**Total Served**	**Title XIX %**	**Title XXI %**	**Private/Other %**	**None %**
		1628	**53.0%**	**44.0%**	**1.0%**	**8.7%**

OMB #0915-0272 Expiration: January 31, 2006

Attachment II- C
Common Performance Measures (Form 9)

Grantee Name: City of New Orleans
Project Name: Great Expectations Foundation, Inc.
Project Grant No.:H-49 MC 00099

FORM 9
TRACKING PERFORMANCE MEASURES
Annual Objective and Performance Data

	Baseline	CY 2001	CY 2002	CY 2003	CY 2004
Performance Measure #07 Degree to which programs ensure family participation.					
Annual Performance Objective				**18**	**18**
Annual Performance Indicator				**14**	**15**
Numerator		-	-	-	-
Denominator		-	-	-	-
Performance Measure #10 Degree to which programs ensure Cultural Competency.					
Annual Performance Objective		-	-	**69**	**69**
Annual Performance Indicator		-	-	**59**	**61**
Numerator		-	-	-	-
Denominator		-	-	-	-
Performance Measure #14 Degree to which morbidity/mortality review processes are used.					
Annual Performance Objective		-	-	**7**	**8**
Annual Performance Indicator		-	-	**9**	**9**
Numerator		-	-	-	-
Denominator		-	-	-	-
Performance Measure #17 Percent of children 0-2 years of age with a medical home.					
Annual Performance Objective		-	-	-	-
Annual Performance Indicator		-	-	**77%**	**78.5**
Numerator		-	-	**341**	**380**
Denominator		-	-	**443**	**484**

FORM 9
TRACKING PERFORMANCE MEASURES
Annual Objective and Performance Data

	Baseline	CY2001	CY2002	CY 2003	CY2004/ 05
Performance Measure #20 Percent of women participants who have an ongoing source of primary care.					
Annual Performance Objective		--	--	**75**	**80**
Annual Performance Indicator		--	--	**84.3**	**77.5**
Numerator		--	--	**749**	**668**
Denominator		--	--	**888**	**862**
Performance Measure #22 Degree to which programs facilitate screening for risk factors.					
Annual Performance Objective		--	--	**72**	**64**
Annual Performance Indicator		--	--	**47**	**56**
Numerator		--	--	--	--
Denominator		--	--	--	--
Performance Measure #35 Percent of communities having comprehensive systems for women's health services.					
Annual Performance Objective		--	--	**42**	**28**
Annual Performance Indicator		--	--	**33**	**24**
Numerator		--	--	--	--
Denominator		--	--	--	--
Performance Measure #36 Percent of pregnant participants who have a prenatal visit in the first trimester of pregnancy.					
Annual Performance Objective		--	--	**85**	**85**
Annual Performance Indicator		--	--	**67.8**	**67.6**
Numerator		--	--	**385**	**414**
Denominator		--	--	**568**	**612**

FORM 9
TRACKING PERFORMANCE MEASURES
Annual Objective and Performance Data

Performance Measure #50 Percent of very low birthweight (<1500 grams) infants among all live births	**Baseline**	**CY2001**	**CY2002**	**CY 2003**	**CY2004**
Annual Performance Objective		-	-	4	3
Annual Performance Indicator		1.3%	2.8%	0.9	2.8
Numerator		5	7	2	7
Denominator		366	250	222	245
Performance Measure #51 Percent of live singleton births weighing < 2,500 grams among all live births					
Annual Performance Objective		-	-	2	6
Annual Performance Indicator		5%	3.6%	5	11.8
Numerator		18	9	11	29
Denominator		366	250	222	245
Performance Measure #52 The infant mortality rate per 1,000 live births					
Annual Performance Objective		-	-	18	12.2
Annual Performance Indicator		-	-	-	-
Numerator		4	2	4	3
Denominator		418	302	222	245
Performance Measure #53 The neonatal mortality rate per 1,000 live births					
Annual Performance Objective		-	-	-	-
Annual Performance Indicator		2	-	9	8.2
Numerator		2	2	2	2
Denominator		418	302	222	245
Performance Measure #54 The post-neo-natal mortality rate per 1,000 live births					
Annual Performance Objective		-	-	-	10
Annual Performance Indicator		-	-	9	12.2
Numerator		2	0	2	3
Denominator		418	302	222	245

Performance Measure #55 The perinatal mortality rate per 1,000 live births				**2003**	**2004**
Annual Performance Objective		**-**	**-**	**9**	**23.9**
Annual Performance Indicator		**-**	**-**	**-**	**-**
Numerator		**-**	**-**	**9**	**6**
Denominator		**-**	**-**	**231**	**251**

Attachment II -D
Characteristic of Program Participant Table

Project Name:	Great Expectations	City:	New Orleans
Project Grant #:	H-49 MC 00099	State:	Louisiana

DIVISION OF PERINATAL SYSTEMS AND WOMEN'S HEALTH D

Section A. Characteristics of Program Participants

Characteristics of Program Participants Page 1 of 3	Race (Indicate all that apply)								
	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	Caucasian	Unknown	Total	Hispanic or Latino	N
a. Number of Pregnant Women									
Under age 15			13				13		
Aged 15-17			104				104		
Aged 18-19			68				68		
Aged 20-23			276				276		
Aged 24-34			120		6		126	4	
Aged 35-44			25				25		
45+							0		
Total # of Pregnant Women			606		6		612	4	
b. Number of Pregnant Women with Incomes:									
Below 100 Percent of the FPL			568		5		573	3	
Between 100-185 Percent of the FPL			38		1		39	1	
c. Number of Pregnant Participants who Enter Prenatal Care:									
During First Trimester			412		2		414	2	
During Second Trimester			176		4		180	2	
During Third Trimester			18				18		
Receiving No Prenatal Care			0				0		
Unknown			0				0		
Total			606		6		612	4	

DIVISION OF PERINATAL SYSTEMS AND WOMEN'S HEALTH DATA SHEE

Section A. Characteristics of Program Participants Page 2

Characteristics of Program Participants Page 2 of 3	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	Caucasian	Unknown	Total	Hispanic or Latino	N
d. Adequate Prenatal Care									
Number Pregnant Participants Receiving Adequate Prenatal Care (Kotelchuck[1],or similar index)			480		3		483	2	
Level of Adequate Prenatal Care Unknown									
e. Live Singleton Births to Participants									
Number of live births to participants			246		1		246	0	
Number of live singleton births between 2499grams and 1500 grams to program participants			29				29		
Number of live singleton births less than 1499 grams to program participants			7				7		

Project Name:	Great Expectations Foundation	**City:**	New Orelans
Project Grant #:	H-49 MC 00099	**State:**	Louisiana

DIVISION OF PERINATAL SYSTEMS AND WOMEN'S HEALTH DATA SHEE

Section A. Characteristics of Program Participants Page 3

Characteristics of Program Participants Page 3 of 3	Race (Indicate all that apply)								
	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	Caucasian	Unknown	Total	Hispanic or Latino	N
f. Number of Program Participats in Interconceptional Care/Women's Health Activities									

Under age 15	9		9	
Aged 15-17	103		103	2
Aged 18-19	48		48	1
Aged 20-23	267	1	268	2
Aged 24-34	126	2	128	4
Aged 35-44	30	1	31	1
Aged 45 +			0	
Total	583	4	587	10
g. Infant/Child Health Participants				
Number of Infant Participants Aged 0 to 11 months	312	3	315	4
Number of Child Participants aged 12 to 23 months	161	1	162	3
Total	473	4	477	7
h. Male Support Services Participants				
Number of Male Participants 17 years and under	32	1	33	1
Number of Male Participants 18 years and older	112	1	113	4
Total	144	2	146	5

Attachment II -E
Risk Reduction/Prevention Services Table

Project Name:	Great Expectations Foundation
Project Grant #:	H-49 MC 00099
City:	New Orleans
State:	Louisiana

	B. RISK REDUCTION/PREVENTION SERVICES Page 1 (For Program Participants)			
RISK FACTORS Page 1 of 3	**Number Screened**	**Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling**	**Number whose Treatment is Supported by Grant**	**Number Referred for Further Assessment and/or Treatment**
a. PRENATAL PROGRAM PARTICIPANTS				
Group B Strep or Bacterial Vaginosis	612	0	0	0
HIV/AIDS	612	445	0	2
Other STDs	612	482	0	44
Smoking	612	402	0	37
Alcohol	612		0	15
Illicit Drugs	612	612	0	22
Depression	612	44	25	25
Other Mental Health Problem	612	2	2	2
Domestic Violence	612	74	0	19
Homelessness	612	142	0	33
Overweight & Obesity	612	112	0	11
Underweight	612	5	0	1
Hypertension	612	24	0	4
Gestational Diabetes	612	7	0	7
Peridontal Infection	612	0	0	0

Asthma	612	3	0	3

Attachment II -F
Major Service Table

C. HEALTHY START MAJOR SERVICE TABLE*

*** When data is collected on both program participant and community participants, please report data separately for each category of participant.**

PP=Program Participant	
CP= Community Participant	
a. DIRECT HEALTH CARE SERVICES	
Prenatal Clinic Visits:	
Number of Medical Visits by All Prenatal Participants	3684
Postpartum Clinic Visits	
Number of Medical Visits by All Postpartum Participants	1178
Well Baby/ Pediatric Clinic Visits	
Number of Any Provider Visits by All Infant/Child Participants	2615
Adolescent Health Services	
Number of any Provider Visits by Participants age 17 and under	412
Family Planning	
Number of Participants Receiving Family Planning Services	862
Women's Health	
Number of Participants Receiving Women's Health Services	862
b. ENABLING SERVICES	
Total Number of Families Served	862
Number of Families in the Prenatal Period Assisted by **Case Management**	612

Number of Families in the Interconceptional Period Assisted by **Case Management**	597
Number of Families in the Prenatal Period Assisted by **Outreach**	404
Number of Families in the Interconceptional Period Assisted by **Outreach**	468
Number of Families in the Prenatal Period Receiving **Home Visiting**	452
Number of Families in the Interconceptional Period Receiving **Home Visiting**	512
Number of Participants Age 17 and Under who participated in **Adolescent Pregnancy Prevention Activities**	103
Number of Families who participated in **Pregnancy/Childbirth Education Activities**	465
Number of Families who participated in **Parenting Skill Building/Education**	399
Number of Participants in **Youth Empowerment/Peer Education/ Self-Esteem/Mentor Programs**	452
Number of Families Who Received **Transportation Services** Includes Tokens, Taxis and Vans	661
Number of Families Who Receive **Translation Services**	0
Number of Families Receiving **Child Care Services**	22
Number of Participants Who Received	653

Breastfeeding Education , Counseling and Support

Number of Participants Who Received **Nutrition Education and Counseling Services** including WIC Services	220
Number of Participants in **Male Support Services:**	151 males attend classes with prenatal and postpartum clients
Number of Participants Referred for **Housing Assistance**	87
Total Participants assisted with **Jobs/Jobs Training**	11
Total Participants served in **Prison/Jail Initiatives**	0

c. POPULATION

Number Of **Immunizations** Provided	0
Public Information/Education: Number of Individuals Reached	45,000

d. INFRASTRUCTURE BUILDING

Consortia Training Number of Individual Members Trained	83
Provider Training Number of Individual Providers Trained	157