I. Overview of Racial and Ethnic Disparity Focused on by Project

During the 2001 – 2005 grant cycle, the Dallas Healthy Start (DHS) project focused on addressing the racial/ethnic disparities for six specified zip codes in Dallas County with high infant mortality rates and poor perinatal outcomes. The service area consisted of the following zip codes in the south, west and central areas of Dallas County: 75212, 75215, 75216, 75217, 75224 and 75228. Analysis of perinatal health outcomes led to the selection of this service area as these zip codes were determined to be the areas with the greatest racial disparities in infant mortality rates and adequate perinatal health care in Dallas County.

At the time of the initial community needs assessment, the target area zip codes represented a total population of 243,370 which included 62,835 women of child-bearing age. Approximately 50% of the population was African American. Infant mortality rates for the African American population in the target area averaged 13.6 infant deaths per 1,000 births. In selecting the targeted areas, DHS’ purpose was to ensure that all Healthy Start efforts were focused on those communities with elevated infant mortality.

In order to document the high infant mortality rates for the targeted areas, the rates of African Americans were abstracted to provide a clearer picture of key problem areas.

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>1996-98 Infant Mortality Rate (African Americans)</th>
<th>Average IMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>75212</td>
<td>11.7</td>
<td>11.7</td>
</tr>
<tr>
<td>75215</td>
<td>11.3</td>
<td>11.3</td>
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<tr>
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<tr>
<td>75224</td>
<td>23.3</td>
<td>23.3</td>
</tr>
<tr>
<td>75228</td>
<td>12.2</td>
<td>12.2</td>
</tr>
</tbody>
</table>

The three-year average data shows that the zip code with the highest IMR for African Americans is 75224 with 23.3 infant deaths per 1,000 births. While the data indicated that the Hispanic population had better perinatal outcomes than did African Americans, diabetes, hypertension and obesity continued to be problematic for this population. The language barrier also presents difficulty for many Hispanics in navigating the health care system. Outreach, transportation, health education and other services to the minority African American and Hispanic populations have been major components of DHS from its implementation in 1994 and continued to be a focus during the 2001-05 grant cycle. This grant cycle added the Native American population as new recipients of Healthy Start services, as Native Americans were also shown to have distressing perinatal health outcomes.

According to 1990 census data, residents in the project area achieved relatively low levels of formal education. Among the adult population, 82.5% have a high school diploma or less. Maternal education, as a measure of socioeconomic status as well as signifying the possession of knowledge of preventive health care and access to medical care, is positively related to survival...
prospects of both mothers and infants. Approximately 23% of all births in the project area were to mothers with less than a high school education.

According to data from the Texas Department of Health three-year average (1996-98) needs assessment, 6% of women in the target area received no prenatal care prior to delivering their babies. Of those who received prenatal care, approximately 71% received it in the first trimester of pregnancy. Approximately 50% of postpartum women received family planning information following delivery.

Based on the community needs assessment, the following racial disparities were found to exist in the target service:

* African American infant mortality rates were disproportionately higher than whites and Hispanics.
* A clear disparity existed among the three racial/ethnic groups for perinatal health indicators.
* In those communities with lower infant mortality rates, there was an elevated low and very low birth weight rate for babies.
* The teen pregnancy rates demonstrated disparities for African Americans compared to whites and Hispanics.

II. Project Implementation

Outreach and Client Recruitment

The outreach and client recruitment component focuses on the development of a system of care that offers services that are coordinated, comprehensive, culturally appropriate and responsive to the underserved population. This component has evolved over the years in response to the changing needs of the targeted population. The approach selected for outreach is multifaceted and represents an integration of peripatetic, detached and domiciliary methods. These approaches are used interchangeably in order to increase effectiveness and reach a larger audience. They also allow greater flexibility and create opportunities for positive outcomes. These methods were selected due to the diverse needs within the Dallas Healthy Start service area.

Dallas Healthy Start has become a co-learner in the community. This has enabled the program to learn about the nature of the community from the community, learn its values, and learn what community members think will help bring about positive change. The Dallas Healthy Start service area is plagued with many adverse social and economic conditions. In spite of these obstacles, there remains a commitment to community and family. Community members often organize themselves in order to improve their circumstances. The collaborative relationship between Dallas Healthy Start and the community has helped facilitate great success.

Dallas Healthy Start has systematically initiated outreach and client recruitment. The unification of outreach and case management redefined service delivery; however, the nucleus of outreach and recruitment was maintained. With this merge, outreach workers became case workers. Case
workers continue to be the key resource in providing this core component of outreach, however all Healthy Start staff members are involved in some form of outreach and recruitment. There are currently six case workers that provide key outreach services and actively recruit pregnant and post partum/interconceptional program participants. These case workers, indigenous to the target area we serve, assist families with accessing health and social service programs available through the grantee agency, Parkland Health & Hospital System (PHHS) and the greater Dallas community.

Case workers provide breastfeeding education & support to participants, language assistance & translation services, home-based prenatal/parenting education, and facilitate child safety events that include car seat education and distribution. Case workers seek to help eliminate barriers to service access and assist in meeting the comprehensive needs of women and children to increase self-reliance. They assist with the financial eligibility process to refer participants to appropriate eligibility programs that may include Medicaid, WIC, CHIP and other MCH programs. Pregnant women and their families may be referred into case management; however, not all pregnant women and families need case management and referrals to this next level of service varies depending on risk factors and the intensity of need for each individual/family.

Prevention and education programming have been the main strategies used in the outreach component to identify and recruit participants to utilize preventative care programs. Outreach workers have been placed in the schools, clinics, and Maternal and Child Health facilities within the target area to identify families in need of Healthy Start services. While productivity has improved, efforts will continue to be focused on locating women who are not aligned with any community organization through street outreach, word of mouth referrals, and partnerships with local businesses, agencies, and churches. The outreach component continues to receive increased requests from local agencies for participation in health fairs, children’s activities, and other presentations. As a result, the number of encounters of women who are in their first trimester of pregnancy has increased and this has led to increased retention rates amongst participants.

Throughout the grant cycle, there were administrative changes at PHHS that have directly impacted outreach & recruitment. When Dallas Healthy Start moved from the Community Oriented Primary Care (COPC) division to the Women & Infants’ Specialty Health (WISH) division, two part-time outreach worker positions were eliminated. Also, the partnership between Healthy Start and the Mom-mobile transportation model changed. Mom-mobile became a sole component of the COPC division therefore no longer operated as a coordinated service under Healthy Start. This meant that Healthy Start could only make referrals for transportation services as opposed to providing the direct service. The impact of this loss was profound particularly due to the inadequacies within the Dallas city public transportation system.

Changes in patient demographics at PHHS have caused the program to re-evaluate outreach strategies. New collaborations were established with local hospitals and outside providers in order to further identify African American women who were at higher risk for a negative pregnancy outcome. As a result of these changes, outreach and recruitment services to this population have steadily increased. There were a total of 3,491 pregnant women and 1,858 interconceptional women who received outreach services during the 2002 – 04 calendar years.
While there has been progress in many areas, efforts will continue to be focused on tracking the disposition of each participant found through outreach to ensure linkages to appropriate services. Tracking the outcome of referrals made to resources within the PHHS system and outside providers has been difficult and Healthy Start has continued to seek ways to manage this information. The overall data collection system has improved and access to Parkland’s patient record system has allowed the program to monitor participant births, appointments, and emergency admissions. This task however is difficult to monitor for the participants who are not receiving prenatal care through PHHS. Continued relationships with all providers of OB/GYN and pediatric services will help to track progress for these participants. Healthy Start remains committed to inform women and families about the importance of prenatal care, increase access to service, and reduce cultural, linguistic and financial barriers. Community outreach and recruitment are key to helping reduce infant mortality.

**Case Management**

Dallas Healthy Start case management services are provided in a culturally sensitive manner in both community and clinical settings. The case management team is multidisciplinary and has worked to establish linkages throughout the perinatal health care system. The introduction of this component caused a shift in the original responsibilities of the outreach worker. The outreach workers became responsible for providing outreach services and also intensive case management services. The original case management model consisted of 6 paraprofessional outreach/case workers, 2 Masters level licensed case managers, and 2 clerks. These staff members worked jointly to provide case management services.

Prior to the inception of this component, case management was a minor element of outreach services. Women received follow-up care to reduce barriers to service access however; care coordination was limited and unstructured. Case management involves identifying services and agencies the participant needs or already uses, and ensuring that they receive those services without gaps or duplication. Case management also involves follow-up and evaluation effectiveness. The case management model for Dallas Healthy Start became fully operational in July 2002. Since then, there have been a total of 380 pregnant women enrolled into case management services.

Case management operates from a client-centered perspective. The individual needs of each family are identified and then it is determined how best to provide assistance through a coordination of agency and community resources. Case management staff members work with the participant to meet all their needs and to help them negotiate various systems. Also, a partnership exists between the participant and Healthy Start as demonstrated through direct participant involvement in all aspects of their care planning decisions. Case management staff members advocate for their participants and network to fill gaps in service delivery. They accompany participants to appointments as needed. Case management services are not provided with the assumption that all participants need the same amount of time or the same amount of information. Case management staff members are trained to individualize their work with participants.
With the original model of case management services, outreach workers conducted all prenatal home visits. Families received Low or High Risk case management services based on significant medical and psychosocial factors. Case management services include teen pregnancy prevention activities, family planning assistance, translation services, home assessments, and post partum depression screening. Case management staff monitors participant receipt of services and works to eliminate any barriers to access including health care assistance, insurance/Medicaid assistance, and transportation assistance. Case management services are also provided to adolescents in their school environment in collaboration with the Pregnancy Education and Parenting program of the Dallas Independent School District.

The Dallas Healthy Start Case Management component has developed greater structure and increased its capacity to adequately address the changing needs of program participants. The position of Case Management Supervisor was created in 2004 to help re-design case management to increase effectiveness. New guidelines have been written for case management core services including new protocols for participant follow-up according to levels of risk. In order to further distinguish High Risk participants from Low Risk participants, the Moderate Risk level category was introduced in 2004. This level allows women who have moderate risk factors to receive care that is beyond that received by Low Risk participants, yet less intensive than those who receive High Risk case management. Service intensity is driven by a risk assessment that evaluates psychosocial and medical factors as they relate to the mother and her infant. The low and moderate participants are case managed by case workers, whereas High Risk participants are case managed by case managers.

There has also been an increase in the number of women that are presenting with High Risk issues. There are several factors that may be contributing to this phenomenon. Outreach and recruitment, which is the primary referral source into case management, has increased its efforts to locate women who are at the highest risk of poor pregnancy outcomes. Also, new collaborations with agencies and clinics that provide services to high risk populations have helped to expand services in this area. Areas that have the highest rates of infant mortality are usually areas that are plagued with significant social problems. As Dallas Healthy Start becomes more visible in these communities, the rate of women with high risk issues intensifies. Lastly, the restructuring of the risk level system has provided more consistency in areas of identification and classification. This has resulted in case management staffing changes and the addition of one case manager position. Current staffing includes 6 case workers, 3 case managers, and 1 clerk.

Services to pregnant and parenting adolescents continue to be an important aspect of case management. In order to address the needs of this population, it was vital to increase collaboration with the Dallas Independent School District, particularly those schools within our targeted zip code. Adolescent mothers are able to receive case management services at school, which allows easier access to services. It also allows Dallas Healthy Start the opportunity to closely track and monitor service provision to this special population.

With the addition of case management services, came a need for more staff support and training. Case conferences are used to discuss participant progress. They are held bi-monthly in group format to help ensure that all participants are receiving the proper level of care and to facilitate
teamwork amongst case management staff members. Case conferences allow case management staff a forum of which to share successes, failures and utilize the expertise of their colleagues. Continuing education for case management staff occurs monthly and as needed. Training and workshops are held on-site. On-going training occurs on various aspects of case management including protocol and procedures. Case management staff also participate in PHHS and community workshops & trainings that are relevant to maternal and child health. Any new needs identified by the case management staff become topics for future trainings.

Dallas Healthy Start has responded to the needs of a system that is constantly evolving. The Case Management team remains committed to providing a high level of care and establishing relationships with women and families so that infants are healthy, newborns will thrive, and families will continue to make progress.

**Health Education and Training**

Formalized Health Education was a new component of the Dallas Healthy Start project; therefore a needs assessment was conducted early in 2002 to determine what education services were being provided both by Parkland and the community clinics and to identify the gaps in those services. In addition to interviewing the director of perinatal education within the WISH Division, Parkland COPC clinics and Women's Health Centers were visited and staff were interviewed. As a result of the assessment, it was determined that patients were accessing the childbirth preparation classes offered at the hospital; however, there was not much health education available in the community. Within DHS, one on one education, mostly on an in home basis, was being conducted by outreach workers with their participants and was coordinated through the Outreach Coordinator. Staff training and education was also coordinated by the Outreach Coordinator.

Upon completion of the needs assessment, a concerted effort was begun to provide coordinated health education services to staff, Healthy Start participants and the community. Educational classes were scheduled at Parkland COPC clinics, community clinics such as Los Barrios Unidos Community Clinic and to community residents through apartment complexes such as the Parks at Wynnewood. Presentations were provided by members of the Healthy Start Consortium on topics such as nutrition, smoking cessation, substance abuse, domestic violence and parenting. One on one education continued to be provided by case management and outreach staff through Florida State University’s “Partners for a Healthy Baby” curriculum. Monthly staff training was offered on maternal and child health issues and other relevant topics. Provider training was provided through quarterly Consortium meetings.

Due to the resignation of the Health Education coordinator early in 2003 and the position being open until early 2004, full implementation of the Health Education component began in 2004. Early in 2003, the Health Education Coordinator resigned and that position was vacant until spring 2004. In February of 2004, a bilingual public health educator was transferred from Parkland and assigned to DHS. Based on the original needs assessment and provider and consumer input, the decision was made to offer a comprehensive multilevel approach to the Health Education component. Education would be offered to program and community
participants, both in the community and at the Healthy Start office. Staff training would be coordinated through case management and provider training coordinated through Consortium.

Since that time, the Health Education component of Healthy Start has expanded to include presentations at five of Parkland's COPC clinics, Women's Health Centers such as Lake June and Lake West and community clinics such as Martin Luther King Jr. Center and Los Barrios Unidos. Health Education has also been expanded to students at nine DISD high schools and one middle school. Additionally, through collaboration with the Consortium component, various apartment complexes located in the service area have been identified for health education.

Pre-natal education is offered weekly at the Healthy Start office for program and community participants. Two classes are held, one in Spanish and one in English. From February 2004 - December 2004, a total of 121 presentations were held reaching 1,594 program and community participants. Educational topics offered through Healthy Start include: nutrition, fetal development, substance abuse and smoking cessation, labor and delivery, family planning, breastfeeding, immunizations, parenting, women's health, HIV/STD's and domestic violence.

Staff training is now coordinated with case management and monthly staff inservice trainings are provided. Staff have also participated in workshops and seminars offered through community service providers in addition to presentations offered by the Texas Healthy Start Alliance. Topics have included resource information on housing, substance abuse and smoking cessation, child abuse and neglect, brain development, developmental delays and training in the “Partners for a Healthy Baby” curriculum. Technical assistance workshops offered by HRSA were offered to staff, community and the Consortium on domestic violence, maternal depression and substance abuse during pregnancy.

**Interconceptional Care**

Interconceptional care services began in July 2002 and are provided by the Dallas Healthy Start case management team. Women and infants/toddlers that are enrolled into case management during the interconceptional period receive similar services to those who enroll during pregnancy. The length of program participation for interconceptional services is determined by the age of the infant/toddler at entry. As occurs with prenatal participants, program intensity is driven by a risk assessment that evaluates psychosocial and medical factors as they relate to the mother and her infant. Risk levels are Low, Moderate, and High. The low and moderate participants are case managed by case workers, whereas high risk participants are case managed by case managers.

Interconceptional program participants are provided with information and referrals for all social, medical, or emotional needs; tracking and monitoring of scheduled appointments; home assessment and evaluations; post partum and parenting education; family planning assistance; and depression screening. Dallas Healthy Start also provides case management services to coordinate care for infants/toddlers. Services to infants/toddlers include arranging a medical home; monitoring accomplishment of developmental tasks; ensuring proper nutrition and adequate resources; immunization tracking; and helping families secure needed baby items.
The enrollment, recruitment, and retention of women during the interconceptional period have been an important component of Dallas Healthy Start case management. There has been an increase in women enrolled during the interconceptional period as the project has established new community partnerships. However, it appears that women who are enrolled into Dallas Healthy Start case management during the interconceptional period have a much lower retention rate than those enrolled during pregnancy. Since July 2002, there have been a total of 70 women enrolled into case management services during the interconceptional period.

Well woman care is particularly important to women enrolled during the interconceptional period. Collaborations with key community women’s organizations have helped identify women for recruitment and have been valuable resources for referrals into case management. Interconceptional care case management continues to help women and infants become healthier individuals and aids in the prevention of unplanned pregnancies.

**Depression Screening and Referral**

Dallas Healthy Start began the screening and referral process for Post Partum Depression in 2003. The tool that was decided upon for utilization was the Post Partum Depression Screening Scale (PDSS) created by Cheryl T. Beck. The rationale for using the PDSS was that one of the former major collaborators, Children’s Medical Center’s Low Birthweight Development Center, had used the PDSS for over 5 years and they were able to provide comparative data for evaluation purposes. Also, the PDSS can be completed within a 5 to 10 minute time frame and is written on an 8th grade reading level. Once this tool was selected for use, it was presented to the Interconceptional Care Committee of the Consortium and an ad-hoc committee was appointed to work on Perinatal Depression issues.

Dallas Healthy Start case management staff has been trained to administer depression screening services. They have also participated in several workshops and seminars about the diagnosis and treatment of post partum depression. Case workers and case managers complete the PDSS in the home of each participant at 6 – 8 weeks post partum. In the event of a positive screening for depression, the participant is referred to a mental health provider for further clinical assessment and diagnosis. If the participant appears to be in imminent danger to herself, her child or others, she is referred for immediate crisis intervention. Dallas Healthy Start has established collaborations with several mental health clinics that provide individual and group treatment for various types of depression.

Dallas Healthy Start has recognized that although a woman may receive a positive screening for depression, she may be reluctant to access services particularly because of the stigma attached to mental health. To address this barrier, case management staff help to arrange an appointment with a local mental health provider and when necessary, accompany the participant to her initial counseling appointment. The goal is to provide support to the participant through the entire therapeutic process.

There have been 157 women screened for post partum depression. Of that number, 39 had elevated scores and 21 referrals were made for more intensive screening and treatment.
Depression screening continues to be an effective tool in identifying women who are experiencing symptoms related to post partum depression.

**Local Health System Action Plan**

Dallas County has a complex and diversified perinatal health care system, which includes many separate public health entities, health systems and hospitals, medical/service providers, medical training institutions and a public hospital district (the grantee organization). Due to the multifaceted nature of the local perinatal health system, DHS’ initial approach with regards to the Local Health System Action Plan (LHSAP) focused on identifying community resources, developing collaborative relationships and mobilizing community partnerships. This approach to the LHSAP aligned with the goals of the DHS Consortium, specifically the goal of collaboration and coordination of resources within the health system to allow for optimal service provision of maternal and child health.

A key consideration in the development of the LHSAP was to ensure that it was in congruence with the Texas Department of Health MCH Title V Needs Assessment. It was determined that this document and its recommendations would serve as the template for local perinatal health programs and planning activities.

The DHS Consortium originally conceived the idea of developing a local health system action plan centered on women and children's services during the strategic planning project conducted in May 1999. One of the major barriers to eliminating health disparities was the uncoordinated maternal and child health services for the targeted community. In spring 2001, DHS initiated the process to develop a strategic plan to address barriers to providing services to the target community. A strategic planning workgroup was established consisting of DHS staff and Consortium/Executive Committee members. An external facilitator coordinated the strategic planning process and provided technical assistance in the development of the plan.

The strategic plan that was developed included a comprehensive environmental assessment of the service area and an assessment of the local perinatal health care system. It also included objectives and strategies for each core component. Upon completion of this strategic plan in 2002, the workgroup’s next plan of action was to conduct gap analysis of the maternal and child health system for the targeted area. This process would be the basis for the development of the Local Health System Action Plan.

The workgroup initially convened in 2001 did produce a comprehensive strategic plan; however, the group fell short of its goal to complete the process of developing a LHSAP at that time. In the fall of 2004, DHS management revisited the LHSAP development progress and developed a new timeline for completion. A LHSAP Task Force was convened and charged with building on the 2002 strategic plan and environmental assessment to draft a LHSAP for the 2005-09 grant cycle. This workgroup, consisting of representatives from key MCH agencies, met on several occasions to identify issues of concern in the local maternal and child health system. A survey of Consortium members was also conducted to obtain feedback on issues. In addition, the external facilitator that drafted the 2002 strategic plan participated in the process and conducted an updated environmental assessment of DHS’ service area. Members of the DHS management
team and the Executive Committee reviewed the issues that were identified and established Local Health System Action Plan priority areas. The priority areas were assigned to the Consortium subcommittees for further development and implementation of activities to address the issues. The final LHSAP document was produced in May 2005.

**Consortium**

The Dallas Healthy Start Consortium was established in 1994 and continues to focus on building grassroots capacity of residents to improve the quality of life. The consortium of individuals, neighborhood residents, participants, medical providers, social service agencies and faith representatives join together to focus on building collaborative partnerships and for capacity building. Efforts have increasingly focused on examining the greater social, economic and environmental context of infant mortality and on engaging communities in public health solving because infant mortality is a community problem. Building community capacity and collaboration has been effective as evidenced in Dallas County by decreasing infant mortality rates in some of DHS targeted zip code areas.

The Consortium has been rebuilding throughout the 2001-05 project period. Prior to the 2001-05 grant cycle, the consortium was structured and operated in a manner aligned with DHS’ focus on contracting with subcontractors to provide services to participants in the service area. However, as DHS changed its operations to be a provider of services through its core components rather than to subcontract, the Consortium purpose and structure has likewise been modified.

By-laws for the Consortium were amended to reflect current programmatic operation. The consortium Executive Committee consists of at least 15 elected and appointed members. The Executive Committee carries out the mandate of the Consortium and acts on its behalf in recommending programs that meet community needs. Members of the Executive Committee consist of community and program participants, representatives from maternal and child care agencies, service providers and an appointed staff member of the grantee agency, Parkland Health & Hospital System. The standing committees of the DHS Consortium are Membership, Public Information/Education, Sustainability, Interconceptional Care/Women’s Health and Community Involvement Teams (CIT).

Consortium goals have focused on the development of true partnerships and strengthening and sustaining a system in which existing agencies closely coordinate their activities at sites which are most accessible to participants. DHS collaborates with at least 50 organizations and service providers. Referral systems have been established with member healthcare/social service providers to generate participant referrals into case management and prenatal/parenting education.

Meetings of the entire consortium are held at least biannually. The purpose of the Dallas Healthy Start Consortium meetings has been to share the programmatic progress of Healthy Start, provide attendees with information on infant mortality and guidance on DHS programming. The consortium is a major intervention and a critical source of community input. Topics for the Consortium have included the importance of prenatal care, breastfeeding, findings of a study conducted on the status of Fetal Infant Mortality Review teams, and March of Dimes
Prematurity Campaign, etc. Meetings also include networking opportunities and educational forums, which often offer continuing education credits for health care professionals. The Executive Committee meets bimonthly to review program operations and recommend programmatic enhancements.

At the end of the grant cycle, there were more than 253 Consortium members consisting of community residents and service providers charged with the responsibility of providing guidance on DHS programming. Of the 253 members on the Consortium, approximately 30-40% are active participants in DHS activities at a given time. The racial make-up of the consortium roster is 49% African American, 27% Caucasian, 19% Hispanic and 5% other. The members are 84% female and 16% male. The membership falls into the following representation categories: consumer (community and program participants)—33%; provider—38%; government—12%; community-based agency—11%; and other—6%.

The DHS Consortium has allowed collaboration with other agencies that share the same interest and a venue for exchange of information between providers and program participants. The most active participants in prior years have been providers. Through annual consortium surveys, providers have indicated that coordination of services is the most difficult issue to address and that education was the most important role of the DHS consortium followed by networking and planning.

Program and community participation has increased; however consistent and active community participation continues to be a challenge. Gaining participant and community involvement has been slow, difficult and challenging requiring a great deal of energy and time to convene and sustain. Cultures across the service area, changing demographics, difficulty completing enrollment forms, trust of the organization, lack of understanding, a community disconnect, lack of childcare and transportation are all barriers to consumer involvement and attendance at consortium meetings. DHS staff has intervened to facilitate access to transportation and childcare to enable participant participation. For example, the mom-mobile transportation has provided rides to consumers and childcare have been coordinated among the residents within a particular complex. These types of interventions have resulted in increased participant involvement.

Increased DHS visibility and the establishment of small consortia in target zip code areas were also employed to increase resident and consumer participation. Consortium development, revitalization and training are ongoing. Training and education is provided to consumers to become active Consortium members, to elevate to executive positions and to participate in all subcommittees. Training outcomes include increased knowledge of health issues facing the community; cultural competency including knowledge of racial and ethnic disparities; awareness of DHS and related community development initiatives; knowledge about the concept and its importance to the mission of building community capacity while reducing infant mortality; and knowledge of their role in sustaining participation in project activities.

A staffing change in the program Consortium Coordinator position was made in April 2004 to build consumer participation in underserved areas and identify service providers to serve on the Consortium. Thus far the efforts of the Consortium Coordinator have been recruitment,
strengthening consumer participation and rebuilding subcommittees. Collaborative relationships remain with the regional Title V, TDH office and local community service providers.

In addition to implementing strategies to increase consumer participation, DHS expanded its focus and working relationship to include other hospitals in the Healthy Start service area. Although the grantee, Parkland Health & Hospital System, is the major provider of prenatal care to uninsured women, DHS has been establishing partnerships with health care systems that have a significant admission of minority women and children.

Additionally, the Consortium Coordinator has been very visible and actively involved in the high-risk communities where health disparities need to be addressed. Consortium activities have centered on community development, community building and mobilizing community partnerships with apartment complexes, families/pregnant women and healthcare providers. DHS has provided support services to many other small community based programs who are addressing the health of women, children, youth and families as well as linking them to other community services to ensure access to comprehensive and quality systems of care. Identifying key grassroots persons, continually assessing community need through subcommittees and increasing consumer participation were key contributing factors to sustaining viable DHS services in the 2001-2005 grant years.

DHS has initiated many evaluation tools and worked with other providers in the consortia serving the same population to assess the effectiveness, accessibility and quality of maternal and child health care services within the community and project area. Surveys, focus groups and door-to-door canvassing have all been methods utilized to assess community needs, levels of awareness and program effectiveness. Participant satisfaction surveys and Consortium surveys are completed annually to ensure the standards of performance are met as well as to identify areas in which improvement is needed.

Consumer input into the decision-making process has occurred on the project and community levels. Consumer and residents’ attendance at consortium meetings and activities facilitates input and feedback for DHS planning. Participants are provided ongoing opportunities during encounters with DHS staff to give feedback on clinic and program service. Consumer input into the decision-making process has occurred on a community level such as helping to identify and recruit other potential participants within their apartment building and neighborhoods. Additionally, consumers have provided input on planning of community events to target other residents within their community and communicating what environmental and health issues are important and need to be addressed in DHS strategic planning.

**Collaboration and Coordination with State Title V and Other Agencies**

Dallas Healthy Start has worked in partnership and cooperation with the State Title V program and many other federal programs, state and local governments, and public/private agencies to positively impact the MCH infrastructure and service delivery. During this grant cycle, DHS established a strong linkage with the state Title V program through its participation in the Texas Healthy Start Alliance (TXHSA). The partnership with TXHSA, which is an incorporated non-
profit organization made up of the six Healthy Start projects in the state of Texas, is described in more detail in the Impact on the State section.

The state Title V program collaborated with all the Healthy Start projects through the coordinated efforts of TXHSA. TXHSA conducted quarterly meetings with the Texas Department of State Health Services Title V program staff including the Title V Director and the Perinatal Health Program Coordinator. These quarterly meetings provided opportunities to discuss Title V program updates and current issues including Healthy Start, Title V, MCH Legislation, and the Pregnancy Risk Assessment Monitoring System (PRAMS).

The Title V program solicits the input of perinatal health programs and service providers including Dallas Healthy Start for their 5-year needs assessment. DHS’ grantee agency, Parkland Health & Hospital System, submits a health system-wide response for the needs assessment which incorporates the perspective of DHS.

In addition to collaborating with the state Title V program, DHS has played a key role in community education and advocacy for maternal and child health issues as evidenced by collaborating with agencies such as the March of Dimes, Dallas Area TexCare Coalition, the Dallas County Health Department, the Dallas Independent School District and other key community agencies, coalitions and service providers. DHS involvement has included promoting efforts that supports women and children such as FIMR legislation, CHIP funding restoration, newborn screening and childcare issues and concerns.

As stated, a significant portion of DHS work has been accomplished through collaborative partnerships. The summary below provides an overview of many of the collaborative efforts with community stakeholders.

**March of Dimes**
The DHS and March of Dimes community partnership continued to expand. DHS collaborated with the March of Dimes to raise public awareness of the problem of prematurity and to find ways to reduce the occurrence of premature births in the target area. The March of Dimes Dallas chapter’s Director of Program Services became a member the DHS consortium Executive Committee and participated in the Local Health System Action Plan development process. In addition, the DHS program manager joined the March of Dimes Regional Program Services Committee. The partnership is particularly essential as the March of Dimes developed ideas and action plans for its African American Outreach Initiative. DHS was an active participant in planning sessions and stakeholder meetings/interviews.

**State Children’s Health Insurance Program (CHIP)/Dallas Area TexCare Coalition**
DHS partnered with the CHIP Coalition for North Texas to implement outreach activities for the State CHIP. The TexCare Outreach Coalition mobilizes community support to help families apply for CHIP and Medicaid through work with Dallas service providers. DHS was an active participant on this coalition. Dallas Healthy Start staff continue to distribute CHIP applications and are committed to assisting program and community participants with completing applications and obtaining insurance coverage for their children.
Dallas County Health Department
DHS developed a strong partnership with the health department. A representative from the health department serves on the consortium Executive Committee sharing input and feedback on maternal and child health issues on the county level. There was also county health department representation in the Local Health System Action Plan development process.

City of Dallas Environmental and Health Services Division
DHS collaborated with the City of Dallas Child Health Services clinics, which provide pediatric services. The clinics served as referral source for pediatric care for DHS participants. Representatives from the City of Dallas were also participants in the Local Health System Action Plan development process.

Dallas Independent School District
A key partnership for DHS has been the relationship with the Dallas Independent School District’s (DISD) Pregnancy, Education and Parenting (PEP) program. PEP is a DISD program aimed on enhancing the life skills of students who are pregnant or parenting and need help to remain in school. DHS staff worked closely with PEP facilitators who are involved in system referrals to all the DHS components. Outreach/case management and Health Education activities were conducted on site at the DISD high schools located in the Dallas Healthy Start service area. In addition, the PEP facilitators regularly attended consortium activities and worked in many cases as part of the DHS team to address the needs of pregnant or parenting students.

Dallas Children’s Advocacy Center (DCAC)
DCAC facilitates the Child Death and Infant Mortality Review Team (CDRT), which is a multidisciplinary team that reviews infant and child deaths to identify gaps in community services. A DHS representative participates on the review team and the team is partially supported with funding provided by DHS. In addition, the CDRT director was a member of the consortium Executive Committee.

Health Systems
DHS has built relationships with other hospitals systems serving residents of the target area. This became necessary as more and more participants in the target community began accessing private physicians and private hospitals for prenatal and postpartum care. Referral systems have been established with health systems such as Methodist Dallas Medical Center, Methodist Charlton Medical Center and Baylor University Medical Center.

Community Health Clinics
DHS has established strong collaborations with the two federally qualified health centers in Dallas, the Martin Luther King Jr. Family Clinic and Los Barrios Unidos Community Clinic. DHS Case Workers are placed at these locations providing a direct referral source into case management services.

Urban Inter-Tribal Center of Texas
Urban Inter-Tribal Center of Texas is a non-profit American Indian corporation dedicated to improving the health and socioeconomic status of American Indians living in the Dallas/Fort Worth area. Perinatal health care needs identified for the American Indian population include
access to early and adequate pre- and postnatal care. Through the efforts of DHS, Parkland Hospital offers a special prenatal clinic for American Indian women at one of its Women’s Health Centers. In addition, DHS employs an American Indian caseworker who recruited women and provided services directly on-site at the Urban Inter-tribal Center.

**WIC Program (Supplemental Nutrition Program for Women, Infants, and Children)**

Collaboration between DHS and WIC allowed for the placement of DHS Case Workers at WIC clinics serving the target area population. This provided a direct referral source for clients to be enrolled in DHS case management services. In addition, the director of the WIC clinic for the City of Dallas was a member of the consortium Executive Committee.

**Community Coalitions**

Participation in community coalitions has provided a venue for DHS to network with community agencies to inform, educate and identify social services needed to enhance service delivery in the DHS target zip codes and Dallas county overall. Coalitions that DHS collaborated with include Weed & Seed community programs; the Ferguson Road Initiative; South East Dallas Coalition; Oak Cliff Coalition; West Dallas Community Coalition; South Dallas Youth Services Providers; Child Abuse Prevention Coalition; and Immunization Coalition.

**Sustainability**

Dallas Healthy Start places high importance on seeking ways to sustain the project into the future. Although Dallas Healthy Start has been the recipient of HRSA funding for many years, the program has been successful in raising additional private funds to supplement the federal grant. Still, there is a critical need to establish a mechanism that will provide ongoing sustainability of this program to compensate for the eventual loss of federal support. Under the current structure, two factors have contributed to the appeal of DHS to funders; (1) the association with Parkland Health & Hospital System and its positive reputation; and (2) the involvement of the community in all aspects of Healthy Start programming.

DHS seeks funding from private and public funding sources such as private foundations, corporations, and charities, and grant opportunities. In addition to seeking funding from external sources, DHS also seeks donations of goods and supplies. Most recently, DHS was awarded a grant for car seats and has been able to provide a total of nearly 200 car seats to families. DHS has also received monetary grant awards from private and community agencies which supplement federal Healthy Start funding. The program has been the recipient of numerous donations of infant clothing, shoes, books, toys, feeding supplies and personal/baby care items. These types of donations have been received from corporations, local businesses and individuals. DHS has also partnered with community agencies in efforts to secure funding. DHS has joined efforts with community agencies to apply for funding to support the activities of programs providing services to the same target population (e.g. neighborhood Weed & Seed initiatives).

In addition to the private and public funds DHS seeks to supplement federal Healthy Start funding, the program receives a significant amount of in-kind resources from the grantee organization, Parkland Health & Hospital System. Parkland has continued to be committed to the ongoing success of the Dallas Healthy Start program and has made resources available in
support of this commitment. The program is under the auspices of Parkland’s Division of Women and Infants’ Specialty Health (WISH). Key staff in the WISH division including the senior vice president, director of professional practice support, division finance operations manager and a perinatal health educator support the operations of DHS. There are other staff members from the departments of Finance, Information Systems and Strategic Planning & Population Medicine that provide their expertise to DHS. The total annual dollar amount for the in-kind staffing is approximately $70,000. Additional information about the in-kind contribution follows:

- Parkland’s Director of Professional Practice Support provides overall project oversight as Project Director.
- A bilingual health educator was re-assigned full-time to DHS to provide community health education services in the target zip codes. This includes education activities in schools, churches and other community sites. Half of this educator’s salary is provided in-kind to DHS. In addition, DHS participants that deliver at PHHS are the beneficiaries of preparation for childbirth classes and postpartum discharge classes taught by perinatal educators.
- Financial and accounting support to the DHS project has been ongoing by the PHHS WISH Financial Operations Officer.
- The Mom-Mobile, a transportation program of Parkland’s Community Oriented Primary Care (COPC), makes available transportation services to DHS participants in need of them. This includes transport to and from prenatal, postpartum, dental, well child and WIC appointments.
- DHS is supported by many other departments within Parkland for which it is not possible to enumerate a specific in-kind dollar amount. These departments include Human Resources, Purchasing, Engineering, Environmental Services, and Telecommunications to name a few.

Parkland also provides in-kind resources in the form of building space and maintenance. During this grant cycle, the Dallas Healthy Start headquarters were moved from a leased space to a building on the Parkland campus. The current office headquarters are located in a building owned by Parkland; therefore, federal Healthy Start funds are no longer used for office rental. The amount of this in-kind contribution totals approximately $60,000 on an annual basis.

Medicaid and CHIP are the largest insurers of the participants served by Dallas Healthy Start. DHS has an opportunity therefore, to become eligible to bill for services. In addition to Medicaid and CHIP, another opportunity for third party reimbursements is from private insurance providers. DHS recognizes that research shows that African American women, regardless of socioeconomic status, still have higher rates of pre-term birth than White women of similar status. Therefore, the opportunity exists for DHS to target women living in the target area who have private health insurance. These women could be enrolled in case management services for which their insurers would be billed. It is envisioned that these are possibilities for ways to support project sustainability.

Sustainability is a key responsibility for the program’s management team, particularly the program manager. The program manager has the responsibility to continually seek private and
public funding opportunities. This is accomplished by researching funding opportunities; networking with donor agencies; working closely with the Parkland Foundation to solicit funds; and applying for funding from sources that support the DHS mission.

The Texas Healthy Start Alliance (TXHSA), of which DHS is an active member organization, is committed to continue seeking grant opportunities for its members to continue the established core services beyond the project period through other funding streams. TXHSA demonstrated this commitment to its members by creating the position of TXHSA Program Advisor who is spearheading research of additional funding opportunities. The TXHSA Program Advisor provides guidance for the organization and direction for the purpose of sustainability for both TXHSA and individual Healthy Start sites.

The DHS consortium also plays a key role in sustainability for the program. The consortium has a Sustainability committee which has the charge of assisting in the identification of funding sources. The committee provides a valuable resource to the program through the input of and knowledge of resources of others in the community. The program manager will work closely with the Sustainability Committee to develop a plan to ensure long-term sustainability for the program. Sustainability for DHS is also supported by the assistance of an external consultant whose sole responsibility has been to identify and pursue external funding opportunities. Through the methods outlines above, DHS is preparing for the ability to sustain the Healthy Start initiative without federal grant support.

III. Project Management and Governance

A. Dallas Healthy Start is a program of the grantee agency, the Dallas County Hospital District/Parkland Health & Hospital System. DHS is administratively located in Parkland’s Women and Infants’ Specialty Health (WISH) division, formerly the division of Women and Children’s Services (WCS). The management structure for Dallas Healthy Start includes a Project Director and a Program Manager in order to adequately manage a multitude of administrative responsibilities and program issues. The Project Director is responsible for project oversight, communication with HRSA, accountable to and responsible for integration with services of the grantee agency, and generally accountable for all administrative functions of the project, including financial soundness. The Program Manager has direct responsibility for all day-to-day programming and staffing, monitoring responsibility for program subcontracts and serving as liaison with community collaborative agencies. The Project Director and/or Program Manager meets regularly with WISH management and attends other grantee agency meetings as designated.

B. Dallas Healthy Start has benefited greatly through the resources available from the grantee organization, particularly those resources provided by the Parkland Foundation. The Parkland Foundation performs grants and contracts fiscal management for Parkland Health & Hospital System. The Parkland Foundation’s Grants Management Department shares responsibility with the financial management area of WISH and DHS leadership for fiscal management. The Parkland Foundation is responsible for required financial reporting to HRSA and for the annual audit.
DHS’ fiscal and program management have also benefited greatly by the availability and accessibility of resources from Parkland departments such as the Purchasing Department, Accounting/Finance Department, Legal Affairs, and Human Resources Department. The expertise available from these departments aids DHS staff in managing operations and fiscal issues.

C. A change that took place in year one of the grant cycle was the movement of DHS from one division within Parkland, the Community Oriented Primary Care (COPC) division, to another, the Women & Infants’ Specialty Health (WISH) division. At the time, it was anticipated that the transition from one major division to another within an enormous hospital district would be extremely challenging. However, the transition went well and it has been an administrative success having DHS under the umbrella of the division responsible for the delivery of maternal and child health care. In addition to this change, DHS experienced the following management staffing changes during this grant cycle:

- In May 2002, Jerry Roberson, program manager, resigned from the agency and was replaced by Antonio Chavez.
- In 2002, Kathleen Hanold became the Sr. Vice President for Division of Women and Infants’ Specialty Health, which oversees the DHS project.
- In 2003, Dr. Grace Burke, Director of Professional Practice Support in the Division of Women and Infants’ Specialty Health, was named Project Director of the Dallas Healthy Start project.
- Gerilyn Laurence was recruited in March 2004 as Program Manager, replacing Antonio Chavez.
- In March 2004, the Consortium Coordinator, Kathy Chapman, was re-assigned to become Health Education Coordinator.
- In March 2004, the Outreach Coordinator, Deborah Lane, was re-assigned to become Consortium Coordinator.
- The project’s case management component was completely redesigned with recruitment of a new position of Case Management Supervisor. Carla Lester was hired into this position in July 2004.

D. As described above, the Parkland Foundation provided fiscal oversight and monitoring of the Healthy Start grant and has done so since the inception of the program in 1994. In order to monitor distribution of grant funds, the Parkland Foundation Grants Specialist met monthly with program management to review and reconcile program expenditures. In addition, the Parkland Foundation periodically conducted site reviews of those agencies that DHS contracted with for services. The Foundation’s oversight of the federal grant was also subject to review by external auditors on an annual basis.

E. The majority of the quality assurance and monitoring and technical assistance has been either funded through the Healthy Start grant or provided as in-kind resource by the grantee agency. As a program of Parkland, DHS must conform to and maintain operations which meet the rules, regulations, policies and procedures by which the hospital district is governed. From time to time throughout the grant cycle, DHS has
contracted with external consultants to provide assistance in projects such as resource development/sustainability, strategic planning and database development.

F. Cultural competency of contractors and project staff has not been an issue for DHS.
### IV. Project Accomplishments

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<thead>
<tr>
<th>Project Period Objective:</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
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</table>
| Project Period Objective: By 6/1/05, increase by 25% (342) DHS clients who are 2 year olds and who have received the full schedule of age-appropriate immunizations. Baseline: DHS reached 274 clients with 2-year-old who have received the full schedule of age-appropriate immunizations for CY2000. (DHS database) | Strategy: To pursue clients with 2-year-olds to ensure full schedule of age-appropriate immunizations. Activities:  
  - Case workers to teach clients responsibility of scheduling appointments on Mom-Mobile and will follow-up to ensure appointments are made.  
  - Case workers to teach clients responsibility of scheduling immunizations and well-child appointments and follow-up to ensure appointments are made. | As of December 2003, there was an increase of 63% (522) in clients who were 2 year olds and received full age-appropriate immunizations. (Data unavailable for 2004)  
  - Completed  
  - Completed |
| Project Period Objective: By 6/1/05, increase by 25% (211) DHS clients who initiate prenatal care in the first trimester. Baseline: DHS reached 169 clients who initiated prenatal care in the first trimester. (DHS database, CY 2000) | Strategy: Utilize all available resources to provide prenatal education to target population. Activities:  
  - Ongoing training for case finders and family advocates.  
  - Work with TDH on Medicaid outreach to pregnant women.  
  - Door to door canvassing, referral and follow-up regarding prenatal care in 75217.  
  - Case workers to teach clients responsibility of scheduling appointments on Mom-Mobile and will follow-up to ensure appointments are made.  
  - Coordinate with PHHS Perinatal Education program.  
  - DHS Health Education Coordinator will focus on community sites not serviced by PHHS perinatal educators.  
  - Assign DHS outreach worker to community sites not serviced by PHHS perinatal educators.  
  - Coordinate Family Planning and parenting classes with available resources.  
  - Folic Acid awareness campaign to target mom in child-bearing years. | From July 2002 – May 2005, 42.9% (192 of 448) of DHS program participants initiated prenatal care in the first trimester. (Note that baseline included community participants)  
  - Completed  
  - Completed  
  - Completed  
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<tr>
<th>Project Period Objective: By 6/1/05, decrease by 6% Low Birth Weight (singleton) infants born to Dallas Healthy Start clients who prenatally received Healthy Start services.</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project Period Objective:</strong> By 6/1/05, decrease by 6% Low Birth Weight (singleton) infants born to Dallas Healthy Start clients who prenatally received Healthy Start services.</td>
<td>Strategy: To bring HS target area women who are pregnant into the DHS program.</td>
<td>From July 2002 - May 2005, 11.7% (35 of 300 births) of infants born to program participants were low birthweight.</td>
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<tr>
<td>Baseline: DHS reached 169 Dallas Healthy Start clients who initiate prenatal care in the first trimester, of which 12% (20) was low birth weight babies. (DHS database, CY99)</td>
<td>Activities:</td>
<td>- Completed</td>
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<td>• Coordinate with PHHS Perinatal Education program.</td>
<td>- Completed</td>
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<td>• DHS Health Education Coordinator will focus on community sites not serviced by PHHS perinatal educators.</td>
<td>- Completed</td>
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<td>• Assign DHS outreach worker to community sites not serviced by PHHS perinatal educators.</td>
<td>- In progress</td>
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<td>• Recruit peer mentors to assist in persuading pregnant teens to attend prenatal classes throughout pregnancy.</td>
<td>- Completed</td>
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<td>• Folic Acid awareness campaign to target moms (in child-bearing years).</td>
<td>- Completed</td>
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<td>• Door to door canvassing, referral and follow-up regarding prenatal care in 75217.</td>
<td>- Completed</td>
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<td>• Case workers to teach clients responsibility of scheduling appointments on Mom-Mobile and will follow-up to ensure appointments are made.</td>
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<td>From July 2002 - May 2005, 11.7% (35 of 300 births) of infants born to program participants were low birthweight.</td>
<td>- Completed</td>
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<td>Project Period Objective: By 6/1/05, decrease by 1.5% Very Low Birth Weight (singleton) infants born to women who prenatally received Healthy Start services.</td>
<td>Strategy: To capture HS target area women at-risk to deliver Low Birthweight infants.</td>
<td>From July 2002 - May 2005, 4% (12 of 300 births) of infants born to program participants were very low birthweight.</td>
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<tr>
<td>Baseline: DHS reached 169 Dallas Healthy Start clients who initiate prenatal care in the first trimester, of which 4% were very low birth weight babies. (DHS database, CY99)</td>
<td>Activities:</td>
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<td>• Folic Acid awareness campaign to target moms in child-bearing years</td>
<td>- Completed</td>
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<td>• Door to door canvassing, referral and follow-up regarding prenatal care in 75217.</td>
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<td>• Case workers to teach clients responsibility of scheduling appointments on Mom-Mobile and will follow-up to ensure appointments are made.</td>
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<td>• Coordinate with PHHS Perinatal Education program.</td>
<td>- Completed</td>
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<td>• DHS Health Education Coordinator will focus on community sites not serviced by PHHS perinatal educators.</td>
<td>- Completed</td>
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<td>• Assign DHS outreach worker to community sites not serviced by PHHS perinatal educators.</td>
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<td>• Recruit peer mentors to assist in persuading pregnant teens to attend prenatal classes throughout pregnancy.</td>
<td>- In progress</td>
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<tr>
<td>Project Period Objective: By 6/1/05, decrease by 8% of preterm (singleton) infants born to women who prenatally received Healthy Start services.</td>
<td>Strategy and Activities: Strategy: To capture HS target area women at-risk to deliver Very Low Birthweight infants. Activities:  • Folic Acid awareness campaign to target moms in childbearing years.  • Door-to-door canvassing, referral and follow-up regarding prenatal care in 75217.  • Case workers to teach clients responsibility of scheduling appointments on Mom-Mobile and will follow-up to ensure appointments are made.  • Coordinate with LifeSpan and PHHS Perinatal Education.  • DHS Health Education Coordinator will focus on community sites not serviced by PHHS perinatal educators.  • Assign DHS outreach worker to community sites not serviced by PHHS perinatal educators.  • Recruit peer mentors to assist in persuading pregnant teens to attend prenatal classes throughout pregnancy.</td>
<td>Accomplishments: From July 2002 - December 2004, 18% (47 of 259 births) of infants born to program participants were preterm.  • Completed  • Completed  • Completed  • Completed  • Completed  • Completed  • In progress</td>
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<td>Project Period Objective: By 6/1/05, increase by 25% (596), clients accessing early prenatal care, who speak English as a second language (ESL).</td>
<td>Strategy: To capture HS target area women who speak English as a second language, to receive prenatal care. Activities:  • Coordinate with PHHS Perinatal Education program to utilize bilingual (Spanish/English) assistants.  • Assign bilingual DHS outreach workers to assist Health Education Coordinator at community sites not serviced by PHHS perinatal educators.  • Recruit bilingual peer mentors to assist in persuading pregnant teens to attend prenatal classes throughout pregnancy.  • Utilize bilingual outreach workers to train Consortium, TAC &amp; CIT Members on infant mortality issues.  • Coordinate with Mom-Mobile coordinator to give presentations on Mom-Mobile policies in Spanish.  • Coordinate Family Planning and parenting classes with available resources with bilingual capabilities.  • Train bilingual outreach workers to facilitate Family Forward parenting groups.  • Folic Acid awareness campaign to target Spanish moms in childbearing years.  • Provide bilingual information and access to preventative care, nutrition and exercise.</td>
<td>From July 2002 – May 2005, 67.1% (57 of 85) of Spanish-speaking program participants accessed prenatal care in the first trimester. (Note that baseline included community participants)</td>
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<td>Project Period Objective:</td>
<td>Strategy and Activities</td>
<td>Accomplishments</td>
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<td><strong>Project Period Objective:</strong> By 6/1/05, increase by 25% consumer participation in the work/activities of the Consortium.</td>
<td>Strategy: To include Consumer in all aspects of DHS activities to increase awareness of Infant Mortality and Low Birthweight Babies. Activities: • Ask Consortium to assist in conducting surveys for: a) client satisfaction and b) client needs. • Utilize DHS Health Education Coordinator to train Consortium, TAC &amp; CIT members on infant mortality issues</td>
<td>As of May 2005, community and program participants were 33% (84 of 253) of the Consortium membership. • Completed • Completed</td>
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<td>Baseline: DHS experienced 101/134 (75%) consumers participating in the work/activities of the Consortium. (DHS database, CY2000)</td>
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<td><strong>Project Period Objective:</strong> By 06/01/2005, increase by 25%, (2,250) completed referrals among case-managed HIS participants.</td>
<td>Strategy: To educate Family Advocates/Case Finders to appropriately refer to appropriate sources, HS target area women in their child-bearing years. Activities: • Recruit teen mentors to refer pregnant teens to attend prenatal classes throughout pregnancy. • Ongoing training for Case workers. • Establish service plan developed by case management team. • Hold monthly case conference for client service plan. • Door to door canvassing, referral and follow-up regarding prenatal care in 75217. • Include Mom-Mobile literature in all prenatal education classes.</td>
<td>For calendar year 2003, 82% (629 of 757) of referrals were completed among program participants. For calendar year 2004, 82% (157 of 291) of program participants completed referrals. • In progress • Completed • Completed • Completed • Completed</td>
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<tr>
<td>Baseline: DHS reached 1,800 completed referrals among case-managed HIS participants (DHS database, CY2000).</td>
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<td><strong>Project Period Objective:</strong> By 06/01/2005, increase by 25% (706) completed referrals among case-managed HIS infants with Special Health Care needs.</td>
<td>Strategy: To educate Family Advocates/Case Finders to appropriately refer to appropriate sources, HS target area women in their childbearing years. Activities: • Recruit teen mentors to refer pregnant teens to attend prenatal classes throughout pregnancy. • Ongoing training for Case workers. • Establish service plan developed by case management team. • Hold monthly case conference for client service plan. • Door to door canvassing, referral and follow-up regarding Special Needs care to infants in 75217. • Include Mom-Mobile literature during all prenatal and postnatal contacts.</td>
<td>Data is not available as DHS does not subcategorize Children with Special Health Care Needs (CSHCN).</td>
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<td>Baseline: DHS reached 565 completed referrals among case-managed HIS infants with Special Health Care needs (Parkland Neonatal Care Unit, CY1999).</td>
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<td>Project Period Objective:</td>
<td>Strategy and Activities</td>
<td>Accomplishments</td>
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<td><strong>Project Period Objective:</strong> by 06/01/2005 increase by 25% (128) HSI participants who receive interconceptional services.</td>
<td>Strategy: To educate Family Advocates/Case Finders to seek out DHS target area women in their childbearing years.</td>
<td>As of December 2004, there was a 288% (396) increase in the number of program participants receiving interconceptional services.</td>
</tr>
</tbody>
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| Baseline: DHS reached 102 HSI participants who receive interconceptional services (Parkland High-Risk Clinic Records, CY99). | Activities:  
- Conduct/Solicit surveys for: a) client satisfaction and b) client needs.  
- Coordinate Family Planning and parenting classes with available resources.  
- Folic Acid awareness campaign to target mom in childbearing years.  
- Partner with Bureau of Women’s Health to sponsor a women’s health fair in target communities.  
- Determine adequate and safe housing for mother and child.  
- Determine basic necessities, e.g., formula, car seat, bassinet/crib, diapers.  
- Determine adequate childcare, early childhood intervention, preschool needs.  
- Coordinate training for screening of post-partum depression.  
- The Case Management team will conduct screening for post-partum depression. |  
| | | • Completed  
| | | • Completed  
| | | • Completed  
| | | • Completed (partnered with different agencies)  
| | | • Completed  
| | | • Completed  
| | | • Completed  
| | | • Completed  
| Project Period Objective: By 06/01/2005 increase by 25% (195) clients receiving HIS funded health education in smoking cessation that self-report lowered frequency or elimination of HIS risk behavior. | Strategy: To educate women in their interconceptional years on the effects of smoking via wellness, nutrition and preventative healthcare. | As of December 2004, there was a 328% (667) increase in the number of program and community participants that received Health Education classes related to smoking cessation. |
| Baseline: DHS reached 156 clients receiving HIS funded health education in smoking cessation that self-report lowered frequency or elimination of risk behavior (DHS database, CY2000). | Activities:  
- Coordinate Family Planning and parenting classes with available resources.  
- Partner with Bureau of Women’s Health to sponsor a women’s health fair in target communities to include the effects of smoking during pregnancy.  
- Refer clients into accessible smoking cessation programs.  
- Coordinate health education classes on the effects of smoking while pregnant. |  
| | | • Completed  
| | | • Completed (partnered with different agencies)  
| | | • Completed  
| | | • Completed  
| | | • Completed  
| | | • Completed |
| Project Period Objective: By 06/01/2005, increase by 25% (445) clients receiving HIS funded health education in substance abuse who self report lowered frequency or elimination of HIS risk behavior. | Strategy: To educate/treat pregnant women and women in their interconceptional years on the effects of substance abuse via wellness, nutrition and preventative healthcare. | Accomplishments: As of December 2004, there was a 101% (732) increase in the number of program and community participants that received substance abuse related Health Education classes.  
  • Completed  
  • Completed (partnered with different agencies)  
  • Completed  
  • Completed  
  
Baseline: DHS reached 365 clients receiving HIS funded health education/treatment in substance abuse who self report lowered frequency or elimination of HIS risk behavior. (DHS database, CY2000).  
Activities:  
  • Coordinate Family Planning and parenting classes with available resources.  
  • Partner with Bureau of Women’s Health to sponsor a women’s health fair in target communities to include the effects of smoking during pregnancy.  
  • Coordinate training for screening of post-partum depression.  
  • Coordinate with available resources regarding nutrition, prevention, and wellness during interconceptional years.  

| Project Period Objective: By 6/01/2005 increase by at least 85% screening of all postpartum case managed clients.  
There is no baseline for this objective since depression screening has not been used in the past. | Strategy: To ensure that every postpartum client is screened for depression and referred for mental health services if needed. | Accomplishments: For April 2003 – May 2005, 59% (157 of 265) of program participants that delivered received postpartum depression screening.  
  • Completed  

Activity: DHS Case Managers will screen every postpartum case managed client for depression using the Beck Postpartum Screening Tool.
B. During this grant cycle, DHS received technical assistance from three Healthy Start sites—Fort Worth (Texas) Healthy Start, Great Expectations Healthy Start (New Orleans, LA), and Valley Primary Care Network (Brownsville, Texas Healthy Start).

As part of DHS’ efforts to obtain technical assistance to aid in a case management component overhaul, DHS staff visited two Healthy Start sites. In February 2004, Dallas Healthy Start program staff—including management, case managers and case workers—visited the Fort Worth Healthy Start program. In June 2004, the project director and program manager visited the Great Expectations Healthy Start in New Orleans. During both of these site visits, DHS benefited from the programs’ willingness to share information about their outreach and case management operations. DHS staff found the assistance provided by other Healthy Start programs to be invaluable in identifying strategies for program development and enhancement.

In November 2004, Brownsville Healthy Start/Valley Primary Care Network staff members provided training on Florida State University’s “Partners for a Healthy Baby” curriculum. This training was provided for Dallas Healthy Start case managers and case workers who administer the curriculum in the home setting. The purpose of the training was to serve as a refresher for previously trained staff and initial training for new staff.

In the fall of 2003, a technical assistance review was conducted by an external consultant, Deborah Frazier. The purpose of this TA was to review Dallas Healthy Start operations for adherence to grant guidelines. Ms. Frazier’s review was very comprehensive and covered all core components and core systems as well as program management and administration. The final report was very enlightening and beneficial for DHS management. It was used to develop an action plan primarily focused on revamping the DHS case management model. As a result, the program staff made significant changes to outreach and case management incorporating new protocols and case management service guidelines.

The opportunity for Dallas Healthy Start to be the recipient of HRSA sponsored technical assistance (TA) programs was made available at the 2003 grantee meeting. At that time Dallas Healthy Start requested and ultimately was granted three TA programs. The topics of the TAs were domestic violence during pregnancy; perinatal depression; and substance use during pregnancy. The TA programs were conducted in Dallas and brought national experts in the topics to our program site. A similar format was planned and implemented for each of the three TA programs. The format consisted of a two-day program. One day of the program offered a seminar open to the DHS Consortium and the local perinatal health community including service providers, individuals from community agencies, and community residents. The second day of the program offered a seminar to clinical providers and provided continuing education credits. In addition to the seminar sessions, each TA program also included a half-day session exclusively for Dallas Healthy Start staff.

The first TA on domestic violence during pregnancy was held in May 2004 and featured Rebecca Whiteman of the San Francisco-based Family Violence Prevention Fund. The
perinatal depression TA was held in November 2004 and featured Dr. Michael O’Hara of the University of Iowa’s Depression and Clinical Research Center. The third TA, held in February 2005, featured Dr. Ira J. Chasnoff of the Chicago-based Children’s Research Triangle and focused on substance use during pregnancy. According to program evaluations, each of the programs was found to be extremely informative and very well received by staff and external attendees. The HRSA sponsored TAs were very beneficial as a tool for educating staff and the community on key perinatal issues. The opportunity to interact and gain information and feedback on DHS program components from national experts was invaluable. The information garnered from each of the TA programs has been incorporated into DHS programming.

V. Project Impact

A. Systems of Care

1. Approaches to Enhance Collaboration:

Over the last four years, Dallas Healthy Start has been actively involved in facilitating and improving collaboration among community organizations and service providers involved in providing and/or promoting maternal and child health and social support services. The approaches that DHS has used to enhance collaboration among organizations and providers includes: inter-agency collaborative activities; intra-agency collaborative activities; internal grantee resources; consortium involvement; community-based activities; agency-to-agency activities; the strategic plan task force; and the Local Health System Action Plan task force.

2. System Integration:

The extents to which structured changes have been established by DHS for the purposes of system integration are very significant. The enormous extent to which this has occurred is evident by the articulation of policies and procedures and updated protocols; the redeployment and maximization of personnel resources; the revision of the Consortium bylaws; the adoption and utilization of national performance measures; increased community collaboration; and through regular and ongoing planning meetings.

3. Key Relationships Developed as a Result of Healthy Start:

a. As previously stated Dallas Healthy Start has played an integral role in facilitating the development or enhancement of relationships among MCH organizations and providers. Examples of relationships that have been developed among health service agencies includes those between Parkland Health & Hospital System, the grantee agency, and agencies such as Baylor Health System; Methodist Health Care System; Presbyterian Health System; Children’s Medical Center of Dallas/Low Birthweight Development Center; Planned Parenthood; the two federally qualified health centers—Los Barrios Unidos Community Clinic and Martin Luther King, Jr. Family
Clinic; Dallas County Health Department; the City of Dallas Child Health Services Clinics; private physicians/providers and community clinics.

Examples of relationships developed between health and social service agencies includes those between Parkland Health & Hospital System and agencies such as the March of Dimes; Dallas Children’s Advocacy Center; Dallas County Department of Health and Human Services; City of Dallas Department of Environmental and Health Services; the WIC program; Texas Health & Human Services Commission; Medicaid Managed Care health plans (Parkland Community Health Plan and Amerigroup); State Children’s Health Insurance Program (CHIP); and YMCA.

Examples of relationships developed with community-based organizations include those with agencies such as the Urban Inter-tribal Center of Texas; Urban League Community Service Centers; faith-based organizations; Council of Churches; Dallas Concilio; daycare centers; behavioral health care organizations; and the Injury Prevention Center of Greater Dallas.

There is a great deal of value gained through the relationships for both Dallas Healthy Start and the aforementioned agencies. The nature of these relationships that DHS has fostered includes the sharing of information for the purposes of educating providers, community members and participants. In this manner, DHS has become a resource for many maternal and child health agencies and providers. In addition to information sharing, these agencies have become a resource for DHS participants. Last, the agencies are a referral source making it possible for DHS to refer participants to their services and likewise, for the agencies to refer participants for Healthy Start services.

b. Examples of relationships developed that focus on the involvement of consumers and community leaders includes: DHS program participants’ involvement with the Consortium and Executive Committee; community residents’ involvement with the Consortium and Executive Committee; apartment complex residents’ councils involvement with the Consortium; and relationships developed with civic/elected officials representing the target area such as U.S. Congresswoman Eddie Berneice Johnson, Texas Senator Royce West and Councilwoman Maxine Reese-Thornton.

4. **Impact on Comprehensiveness of Services:**

a. **Eligibility and/or intake requirements for health or social services**

Dallas Healthy Start has positively impacted service delivery and has helped to facilitate changes in intake and eligibility requirements specifically for Healthy Start participants. Within several community clinics, Healthy Start has been able to work with clinic management to establish systems that simplify intake and eligibility requirements allowing Healthy Start participants to secure prenatal care appointments in an expeditious manner. The relationships that have been established with providers, social service agencies, and other organizations have helped to expand service options for participants and have given them more freedom of choice.
b. **Barriers to access and services utilization and community awareness of services**

Dallas Healthy Start has worked towards eliminating barriers to service access and utilization in many areas. In addition to the advocacy and accompaniment that has occurred at the micro level with participants, Healthy Start has experienced success in this area at the macro level. Within the Parkland system and other health agencies, Healthy Start participants receive priority in scheduling and service fees are often waived. Dallas Healthy Start, in collaboration with the Urban Inter-tribal Center, established a weekly prenatal clinic at the Lakewest Women’s Health Center of Parkland Hospital. This clinic was established to increase the utilization of prenatal care amongst American Indian women. Healthy Start facilitated all referrals to this clinic through the outreach efforts of an American Indian case management staff member.

Ongoing programs and activities have been implemented to increase community awareness of services. The four components of Healthy Start have worked independently and collaboratively to increase inter-agency dialogue, and to ensure that community residents and program participants receive current and timely information about available resources. The Dallas Healthy Start newsletter, which is generated quarterly, has been an important mechanism from which information is distributed and shared. The community-based approach of Healthy Start services has been helpful towards unifying groups that may have experienced difficulties finding a common cause.

c. **Care coordination including descriptions of mechanisms implemented to ensure continuity of care, quality improvement and follow-up for referrals**

Collaboration with agencies that directly provide services to Dallas Healthy Start participants has helped to decrease duplication of services and has assisted with the continuity of care. The implementation of this process has enabled Healthy Start participants to maximize their receipt of services from multiple agencies. It also helps staff members to create comprehensive service plans that accurately reflect the true needs of the participant.

Healthy Start services have received ongoing evaluation to improve effectiveness. The participant-centered nature of the services provided has helped facilitate an environment in which individual and programmatic needs are constantly being evaluated for improvement opportunities. The program respects the diversity of its participants and therefore has made an extra effort to individualize services. The participant rights and responsibilities form, which is signed by each program participant at entry, makes participants aware of their rights and empowers them to solicit feedback about service delivery.

Referral follow-up remains a challenge; however, participant referrals that are made within the Parkland Health and Hospital System are tracked via access to the hospital computer system. This system gives Healthy Start the opportunity to monitor
medical appointments, financial status, emergency room admissions, and changes in
demographic information.

d. Efficiency of agency records systems and sharing of data across providers to reduce
repetition

Dallas Healthy Start referrals are received from many local community groups, health
systems, and social service agencies. This has resulted in the development of a
systematic process of information sharing and exchange which functions to provide
follow-up information and when possible, to limit duplication of data collection. Any
data sharing that occurs in done in a manner to protect the confidentiality of each
participant. Coordination of information pertaining to the status of each referral is
maintained within the confines of HIPAA regulations. Record releases are required
to distribute any personal information regarding participant involvement with Healthy
Start. Collaboration with care providers about enrollment status, as well as general
information about the overall intensity of Healthy Start services, has helped to
identify and fill gaps in service delivery. Healthy Start continues its commitment
towards working with various systems in order to be able to provide the highest level
of service to each family.

5. Impact on Enhancing Client Participation in Evaluation

a. Participation on the DHS Consortium, Executive Committee or its subcommittees
provides participants with the opportunity to impact service provision. Through the
activities of Dallas Healthy Start, there has been participant representation in
activities that are aimed at ensuring provider sensitivity to cultural, linguistic and
gender needs. For example, DHS participant input from surveys and focus groups
has been shared with providers in order to identify areas of need.

b. As stated above, participant participation in DHS activities allowed for consumers to
be involved in the process of evaluating and impacting service provision. This was
primarily accomplished through consumer surveys, focus groups and interviews
conducted by DHS with recommendations and feedback shared with providers. DHS
was unable to document the extent to which providers utilized and implemented
consumer recommendations.

B. Impact to the Community

1. Residents’ Resource Knowledge and Accessibility: DHS has had a positive impact in
this area. Case management staff members and Consortium members have worked
diligently to educate and empower community residents so that they can be informed
about available services and resources. Residents are informed about service access and
encouraged to utilize all resources available. In addition, a resource directory has been
developed by DHS and has proven to be a very useful tool for all DHS staff members.
2. **Consumer Participation Impacting Service Providers/Local Governments:** DHS consumers have attended activities sponsored by the Texas Healthy Start Alliance and the National Healthy Start Association. They have not been actively involved with establishing or changing standards with service providers and local government.

3. **Community Experience in Conflict Resolution/Teambuilding:** Participation in the DHS Consortium and Executive Committee is the best example of how Healthy Start has provided experience in working with divergent opinions, resolving conflicts, and team building activities. This multicultural group of consumers, service providers and community leaders has an array of divergent thinkers who work together to reach common ground a multitude of issues. In order to facilitate conflict resolution and team building, a consortium involvement training/orientation program was developed for new members, especially program and community participants.

4. **Job Creation:** The DHS outreach model created jobs within the project community. All of the case workers reside in the service area and many began on a part time basis as they were involved with attending school or held another part time position. One of the case workers was also a consumer. Currently, all DHS case workers are employed full time.

**C. Impact on the State**

Dallas Healthy Start has continued to strengthen its relationship with Texas MCH programs, most notably with the State Title V program. DHS’ state-level relationships are enhanced through membership in the Texas Healthy Start Alliance. The Texas Healthy Start Alliance has been an extremely beneficial tool in promoting collaboration and coordination with Title V MCH and other agencies. On July 25, 2003, the six federally funded Healthy Start projects in the state of Texas - Brownsville, Dallas, Fort Worth, Houston, Laredo, and San Antonio - became known and incorporated as the Texas Healthy Start Alliance (TXHSA), a non-profit corporation serving the Healthy Start projects and their communities throughout the State of Texas. TXHSA implemented standard operating procedures including adopting by-laws, electing officers, developing an action plan, and defining a work plan for the Alliance Coordinator. The Texas Healthy Start Alliance was organized exclusively for the purpose of addressing community-based maternal and child health issues focusing on promoting healthy lifestyles for women of child bearing age, maximizing participation in prenatal care, reduction of infant mortality, low birth-weight, racial, ethnic, and border area specific disparities in perinatal outcomes.

Dallas Healthy Start began its relationship with the Texas Title V agency primarily through its affiliation with TXHSA. TXHSA coordinated a working relationship with the Texas Department of State Health Services (DSHS) Title V, specifically working with Fouad Berrahou, Title V Director and Chan McDermott, TDH Perinatal Health Initiative Coordinator. Early collaborative efforts centered on organizing quarterly meetings with Title V staff to discuss a variety of maternal and child health issues affecting the citizens throughout the State of Texas.

Topics discussed during these meetings included Title V and Healthy Start Program updates, current issues including Healthy Start, Title V, MCH legislation, and the Pregnancy Risk Assessment Monitoring System (PRAMS). After a year of preliminary meetings, which served
the purpose of getting to know each other and identifying opportunities for collaboration, it was agreed upon that TXHSA and Title V would collaborate on an annual education conference. This annual conference would serve as a means to provide in-state continuing education opportunities for all TXHSA staff members as well as for other maternal and child health care/social service agencies throughout the State of Texas. This conference was also promoted on a regional and national level through the National Healthy Start Association. This conference also helped maximize travel dollars available to sites for staff training.

In response to the mandate to provide depression screening on all Healthy Start participants, the first TXHSA / Texas Title V Educational Conference held in January 2003, focused on maternal depression. This was the first real success of the TXHSA / DSHS Title V collaboration. Approximately 80 participants attended this much-needed conference. Topics included understanding post partum depression, risk factors, incidence, treatment options, and a comparison of screening tools. This relationship proved positive and successful and led to collaboration on the second TXHSA / Texas Title V education conference, “Working Together to Prevent Preterm Births,” which was held in January 2004. This conference provided participants with an overview of prematurity and specific training on related topics. Presentations, which were extremely well received, included “Coping with the Loss of a Pregnancy and Bringing the Message Home, First-hand Experience with Prematurity”. A total of 105 participants attended the conference. This conference also marked the beginning of a positive relationship on the state level with the March of Dimes State Director of Program Services, Janet Shepard. The third TXHSA / Texas Title V education conference “Bridges Out of Poverty: Strategies for Professional and Communities” presented by author Phil De Vol, was held in January 2005. Approximately 95 participants attended this conference. A pre-conference workshop, “Perinatal Periods of Risk (PPOR)” was held and included topics were: PPOR and FIMR; Lessons from the field; and Best Practices for combining PPOR & FIMR.

In addition to collaborating on the annual education conference, another result of the close relationship with our Title V representatives was the request for TXHSA representation on two Title V committees. Healthy Start representatives were enlisted to participate on the American College of Obstetricians and Gynecologists (ACOG) Providers Partnership on Perinatal Depression and the Perinatal Systems Workgroup Committees. In addition, TXHSA has been identified as a key MCH stakeholder and was asked to provide input regarding the organizational changes at the state level during 2003 and again in the 2004 State Title V Needs Assessment.

Another major result of the joint Healthy Start/DSHS Title V meetings was the interest in working together with Title V towards passing legislation to develop a statewide Fetal Infant Mortality Review (FIMR) program in Texas. TXHSA did move quickly during the 2005 legislative session and made strong efforts; however, unfortunately due to time restraints, the FIMR legislation was left pending. Efforts will continue to move FIMR legislation forward during the next legislative session.

Another hallmark accomplishment for TXHSA was the recruitment in the fall of 2004 of Dr. Tom Wells to serve as TXHSA’s Program Advisor. Dr. Wells is the former Associate Field Director for MCHPB, HRSA – Dallas Regional Office. This provides TXHSA, and its members, with access/linkages to Dr. Wells’ network of health professionals. Dr. Wells has provided his
knowledge and expertise to the Texas Healthy Start programs and has been very instrumental in the development of the Alliance.

Dallas Healthy Start has valued its membership in the TXHSA and will continue to be an active participant in its activities. During 2004, the DHS program manager became a TXHSA officer serving as the organization’s treasurer. DHS supports TXHSA and will continue membership as a means to continue and expand its role in promoting collaboration with Title V and other MCH state and community services.

**D. Local Government Role**

Through the Dallas Healthy Start Consortium, a concerted effort has been undertaken to increase the participation of local government officials. Attendance at an African American Legislative Summit afforded staff the opportunity to meet with state and local legislators for the purpose of educating them about infant mortality and MCH issues. Additionally, contact with local school board members and local religious leaders was established at the same meeting. Follow up on those contacts has continued with the goal of having active participation and program support on the Consortium.

At the County level, education on infant mortality and Dallas Healthy Start has been provided to Dallas County Commissioners representing areas with high infant mortality rates. Staff also regularly attend meetings and events hosted by Dallas County Commissioner Ken Mayfield who sponsors the Zero to Three Initiative. In addition, representatives from the Dallas County Health Department have served on the Consortium and Executive Committee. Most recently, a Health Department representative served on the Executive Committee and the Local Health System Action Plan workgroup. As a result of the Health Department participation, plans are underway to begin services to pregnant women released from the County jail who are not receiving prenatal care.

Information packets were provided to Dallas City Council members, again, for the purpose of education on MCH issues as well as for recruitment for representation on the Consortium. Response from individual council members was less than expected; however, efforts to educate and recruit continue. The City of Dallas Health Department provided representation on the Executive Committee and the Local Health System Action Plan workgroup. As services at the City level have been drastically downsized, Healthy Start services have been critical for those families who have been impacted by the reduction.

Involvement of local and state leadership continues to be a challenge for Dallas Healthy Start and the Consortium. However, education on infant mortality and the importance it has on the general health of the community in addition to the ongoing participation of local and state officials remains a primary goal.

**E. Lessons Learned**

*Note: Lessons learned have been included in previous sections.*
VI. Local Evaluation

See Local Evaluation attachment.

VII. Fetal and Infant Mortality Review (FIMR)

Dallas Healthy Start currently supports the Dallas County Child Death Review Team (CDRT). DHS provided initial start up funds to the Dallas Children’s Advocacy Center to establish the CDRT and has continued to provide financial support. In addition, DHS is one of several agencies represented on the Child Death Review team. DHS’ close involvement with the CDRT continues to enhance its image as a leader in the effort to reduce infant mortality. Although the CDRT reviews the deaths of children from 0-18 years of age, the CDRT does not function as a true Fetal and Infant Mortality Review (FIMR). Most notably, the CDRT does not investigate fetal deaths, nor does it conduct interviews with the parents experiencing the fetal/infant death. During this grant cycle, DHS made progress towards the development of a local FIMR. This was found to be important because FIMR assesses how infant morbidity and mortality occurs in specific local communities and creates an action-oriented process for change. The FIMR process offers communities a way to discover unmet needs to improve the health of mothers and infants.

Dallas Healthy Start along with the Fort Worth Healthy Start and Sunny Futures (Houston, TX) Healthy Start collaborated on a report to provide information on the feasibility of establishing a Texas Fetal Infant Mortality Review (FIMR). HRSA provided funding for the initiative. The Texas Fetal Infant Mortality Review (FIMR) Needs Assessment was conducted in 2002 to ascertain the key factors related to the development and implementation of a local, state or regional FIMR.

In March 2005, the Texas Healthy Start Alliance (composed of the six Texas Healthy Start sites—Brownsville, Dallas, Fort Worth, Houston, Laredo and San Antonio) along with the Houston Department of Health & Human Services and the Alliance for Infant Survival joined together in an effort to seek legislation concerning the development of FIMRs. The effort was focused on gaining support and passage of fiscally neutral state legislation to facilitate the creation, authority and protection of FIMR teams in Texas. The DHS Consortium Coordinator was appointed as the DHS representative on the Texas Healthy Start Alliance FIMR Subcommittee. The Parkland Hospital Director of Legislative Affairs was supportive in this legislative effort and provided consultative assistance.

The FIMR subcommittee was able to obtain sponsorship of a FIMR bill (filed as SB1183), submitted in the Texas Senate by Senator Royce West (D) and sponsored in the House of Representatives by Representative Vickie Truitt (R). Senator Royce West is a senior senator with a strong track record of bill passage and represents a district with high infant mortality rates. Testimony for the hearing before the Health and Human Services Committee included a physician, a hospital representative, a public health official, families impacted by infant and/or fetal death and a FIMR expert. Senate Bill 1183 passed in the senate but did not succeed in passing in the House of Representative due to time constraints. The Texas Healthy Start Alliance plans to continue the process of obtaining FIMR legislation in the next legislative session in 2007. The lesson learned during this process was to file legislation in the Senate and
House at the same time during the legislative process and the importance of advocacy as well as support among the Texas delegation.

VIII. Products

No products included

IX. Project Data

See Forms 1, 5, 9, Tables A, B, C (attached)
HEALTHY START LOCAL EVALUATION REPORT

PROJECT NAME: Dallas 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. This program is Dallas Healthy Start (DHS). 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.

The Dallas Healthy Start project area consisted of zip codes in the Dallas, TX area. The zip codes were prioritized by their infant mortality rates. The project area is significantly minority, particularly African-American and Hispanic, 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 Dallas Healthy Start Program. DHS has successfully implemented the Healthy Start model in its service area and realized a great impact in the community. This Final Impact Report allows the Dallas 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, Dallas Healthy Start 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. In any assessment, it is important to utilize the most effective means for analysis possible and to base findings on the most accurate and current data available. In order to assess the multiple components of the program, many different evaluation methodologies were used for the overall evaluation. These components include structural, process, and outcome methods of evaluation. Primary and secondary data analyses were conducted to assess the effectiveness of program components. The primary data collection included survey analyses; site visits/key informant interviews, and focus groups. The Consortium Partnership Assessment Tool and Client Satisfaction Survey were disseminated to Consortium members and participants. The secondary data analyses including the analysis of program data from the management information system (MIS). In addition, secondary data analyses included trend analysis for key program components, such as service delivery and modalities, for calendar year comparisons. Information for the four years of the reporting period was collected and an in-depth analysis was conducted to determine the impact of the Dallas 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 the grant period.

III. FINDINGS
Dallas Healthy Start has realized significant impact on the community it serves. In spite of any challenges the organization has faced with funding, staff changes, and population shifts, it is still evident that DHS has impacted its participants and community and is moving forward to a future of further success. The accomplishments of the program span the service models from outreach and client recruitment, case management, and education. This section illustrates those achievements in qualitative and quantitative terms. The data that is reported in this report is based on 2001-4 averages as it relates to quantitative data for Client Satisfaction Assessments and Outreach Encounters.
A. Outreach and Client Recruitment

1. Discussion

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

2. Model

   Attracting and maintaining a strong participant base is essential to the success of the Healthy Start program. In many cases, project staff must reach out to potential participants in order to gain new participants and build relationships. The DHS relationship with Parkland Health & Hospital System (grantee agency) has been a great asset to client outreach and recruitment efforts. Parkland provides services to a very large number of participants in the DHS target population, making it an ideal feeder to the program. More importantly, DHS is on target with providing services to eliminate health disparities with the enrollment of African Americans and Hispanics into their program services. The analysis of the outreach and recruitment component reviews all of the activities associated with encounters and participant statistics.

3. Implementation, Barriers, and Advances

   Anticipated barriers and challenges to enrolling participants in the Healthy Start program are lack of education, mental health issues, substance abuse, domestic violence and personal priorities. Dallas 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.
DHS has performed well in its outreach encounters. Through the 2001-2004 reporting period, the program reached 9560 adults. This equates to approximately 265 adults per month. The number of adults reached has decreased slightly each year during the reporting period, however, overall the level of encounters is still respectively substantial and demonstrates the Success DHS has had in this area. The graph below illustrates the findings for adults assisted by outreach.

Figure 1

* 2001 data not available
DHS has also performed well in its infant outreach encounters. Through the 2001-2004 reporting period, the program reached 2470 infants. This equates to approximately 65 infants per month. The number of infants reached has increased from the 2003 to 2004 years of the reporting period. The graph above illustrates the findings for infants assisted by outreach.

* 2001 data not available
An average for 2001-04 shows that African Americans represented the major group of outreach participants during the reporting period, consisting of 52% of the outreach participants. Hispanics represented the next largest group with 40%. All other groups represented less than 5% individually and less than 10% combined. The majority of the outreach participants were in the age range of 18-24. Another group well represented was those ages 30-55. Of the remaining groups, they were not significantly varied in the number of participants, according to the data reported.
DHS has shown constant improvement in the area of participant satisfaction. The satisfaction level increased over the years, representing an overall increase from 91% to 98%. This overall average of 94% is an excellent participant satisfaction rate for DHS. There is a high level of participant satisfaction, which illustrates that DHS has been effective in its methods of program delivery during the reporting period.
Data averaged for 2001-04 show that 39% of the participants heard about Dallas Healthy Start through a hospital. 21% of the participants reported hearing about DHS from their respective clinics. 20% reported other means of hearing about DHS services. Only 6% of the participants reported having heard about DHS services from their doctor. This shows that DHS services are producing a good base of positive correspondence throughout the DHS target areas.
At what stage of your pregnancy were you recruited into Healthy Start services?

- 53% in the 1st trimester
- 31% in the 2nd trimester
- 16% in the 3rd trimester

Figure 6

It is very important to the success and implementation of the DHS program that participants enter into the services as early in the pregnancy as possible. Program data shown above indicates that the majority of the participants are in fact entering into the program earlier more so than in later stages of their pregnancies. Over 53% of participants were recruited into DHS services in their first trimester. Another 31% were recruited into the program in their second trimester. Only a very small portion of participants, roughly 16%, were recruited into the program in their third trimester of pregnancy.
The data suggested that the DHS staff provided satisfactory informational materials to its participants averaging the data for 2002-04 reporting period. The majority of the participants reported that the information that they received was extremely helpful to them. There has been a 76% reporting of participants receiving extremely helpful information over the reporting periods.
B. Case Management

1. Discussion
The case management component is implemented to assist participants with all aspects of pregnancy, to coordinate services, and to provide infants with care and support to reduce the affects of risk factors on their lives.

2. Model
The case management supervisor enrolls participants in the case management program and assigns them a case manager or case worker. The case managers and case workers work with and follow their participants to make sure their needs were met such as attending educational classes, Medicaid enrollment, and prenatal visits. Participants take part in an initial assessment visit in which access to medical care, insurance, transportation, and risk factors will be reviewed. Participants may be assisted with additional services based on the outcome of the initial visit including transportation, Medicaid application, WIC or other services.

3. Implementation, Barriers, and Advances
Staffing issues directly affect the number of participants that can be enrolled and monitored. There has not been significant staff turnover; however, when there are vacancies, positions can go unfilled for long periods of time. The relocation of different residents due to housing issues can also severely hinder DHS’ ability to recruit and retain participants.

DHS has identified access to prenatal care as a significant barrier to the participants. A lack of knowledge regarding the importance of prenatal care is prevalent in the communities that DHS services.
The majority of participants in the case management component are involved with the program for under a year. The data was pooled for 2002-04 to provide overall averages. Of our overall participant base, according to figure above, 56% of these participants were in case management for a period of 0 - 6 months. 13% of the participants were involved with case management for a period of 7 months to one year. Combining these thus yields that 69%, approximately two-thirds of the participant base, is in case management for a period of 1 month to a full year. Another 31% of the remaining participants were in case management for a period of 13 months to 2 years, from the data reported.
Data shows that although 33% of the participants in case management are in their first pregnancy, approximately 66% are not. The majority of those participants that are not in their first pregnancy are in their second (19%) or third (14%). Only 2% of the participants in the case management program were in their sixth pregnancy.
Data for 2003 and 2004 demonstrate that case management services are offered at various sites through the program to best maximize the service to the participants. Over 45% of the case management services were offered in the clinical setting. Another 36% of case management services were offered at the participant’s home. Finally, an additional 19% of the services were offered at various schools throughout the target areas of DHS.
Data shows that the case managers were effective in making themselves accessible to the participants they served. Based upon this data, the participants in the case management service were pleased with case managers being available when they needed them. Data for 2002-04, demonstrated an average of 93% of the participants in case management responded positively to the availability of case managers, while only 7% were not as positive. This data shows that case managers were very attentive to the specifics of each individual case. This indicates that DHS’ methods are appropriate.
For example, data from 2004 shows that 86% felt that case managers’ responses to their needs and concerns was excellent, while only 14% of the respondents reported that case managers were good. Participants are generally satisfied with the case managers’ responses to their needs. It is imperative that DHS continue to provide this level of service.
C. Health Education and Training

1. Discussion
The Dallas Healthy Start management team developed an education and training model in which several strategies were utilized to assist participants in working through 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. DHS seeks to mitigate these factors through individual and group education.

2. Model
DHS provided Family Planning Counseling, Prenatal Education, Parenting Education, and individualized nutrition education when needed. The educational programs were conducted by an array of DHS staff members. 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. DHS has recognized and addressed a need for reaching teens in schools to further reach DHS goals.

3. Implementation, Barriers, and Advances
The lack of transportation continues to be a barrier to women accessing prenatal and parenting educational services. Although DHS provided transportation services, many participants were still hindered by mobility issues. Education and training has allowed DHS to reach many people in the community. This is important to continued recruitment and making changes in the overall health of the community.
D. Interconceptional Care

1. Discussion
Dallas Healthy Start utilizes an integrated and a multidisciplinary team, consisting of a health educator, case managers including licensed social workers and registered nurses, and case workers to provide interconceptional care services.

2. Model
DHS 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 DHS are Medicaid/CHIP enrollment and transportation.

3. Implementation, Barriers, and Advances
DHS has implemented various strategies to identify and recruit high-risk women that are in the interconceptional 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.
Figure 13

There was a significant reporting of inadequate housing as a major risk to the adult participants in DHS for data from 2003-04. Lack of family support followed as the next largest issue of risk amongst participants. Smoking, STDs and HIV/AIDS were not reported with as much frequency according to the data for the period.
Data shows the number of participants who report a payer for health care services. The results show that 1,188 responded with Medicaid as their payer in CY2004, which is still the majority; data reported a significant increase from the 730 reported in CY2002. DHS staff should continue to work to ensure that participants provide this information during enrollment. It may be possible to increase referrals to Medicaid and CHIP if more data is collected. The large number of unspecified might include Parkland’s independent plan and those who are uninsured. This represents an avenue for DHS to increase enrollment of participants in payer systems.

*2001 data not available
E. Depression Screening and Referral

1. Discussion
DHS conducts and coordinates perinatal depression screening services and makes referrals for mental health interventions as well as referrals to other health care and social agencies and providers.

2. Model
DHS depression screening guidelines dictate that all participants receive a depression screening during the post partum period. All participants are to receive a depression screening using the Postpartum Depressing Screening Scale (PDSS) tool following delivery.

3. Implementation, Barriers, and Advances
DHS 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. DHS has increased community awareness and has promoted increased capacity and infrastructure that integrates depression screening into the local health care system. DHS has also created formal linkages with area perinatal and community mental health providers through existing relationships with medical providers and community presentations.
DHS also works with other agencies to provide services to Healthy Start participants through the referral process. Data illustrates significant increases from 2003 to 2004 in total number of referrals initiated by DHS. There were both increases in the total number of adult referrals from 2,434 to 4,878, as well as an increase in infant referrals from 903 to 1,064.

*2001 data not available*
Furthermore, African American participants made up the majority of the participants referred. Hispanics were the second largest group of participants that were referred. This trend is consistent with the overall make-up of the DHS participants as a whole. The report showed a significant number of referrals for case management. Housing, immigration and job assistance showed significant number of referrals being made also. Depression screening and GED referrals showed the lowest amount of referrals according to the data recorded. DHS staff worked to ensure that follow-ups with these referrals were completed. In addition, changes in the MIS database will increase documentation within and outside of the Parkland system.

Figure 16
DHS has made significant efforts to create synergies that allow participants to do “one-stop shopping” by making numerous services available to participants. The primary means to creating the synergy is through receiving and completing referrals. The analysis included looking at the total number of referrals. Throughout the reporting period, DHS was responsible for various program services. Data averaged for 2002-04 shows that over 52% of the participants received service in relation to the clinic, and 19% received childcare in association with employment services. Transportation and legal services received the least with each reporting that only 2% of the participants were serviced.
IV. RECOMMENDATIONS

Recommendation 1
Continue to develop additional relationships with key MCH community agencies and organizations.

Recommendation 2
Increase the level of focus on outreach encounters within the various target areas of DHS.

Recommendation 3
Increase the level and process of responsiveness to participants within the DHS program.

Recommendation 4
Further assess client recruitment by zip code to ensure that the target population is being recruited into the DHS program during the project period.

Recommendation 5
Investigate and further develop the method of recording and evaluating the insurance status of the participants in the DHS program.

Recommendation 6
Improve the linkages between the outreach and case management components to facilitate a full continuum of care.

Recommendation 7
Assess the process of recruiting participants into the program at the earliest point of their pregnancy in order to maintain the efficiency and effectiveness of DHS.

Recommendation 8
Investigate the referral process to ensure that participants receive referral follow-up services in the various DHS program components.

Recommendation 9
Continue with the process of increasing Consortium members’ knowledge of program components and processes through efficient dissemination of key information and activities.

Recommendation 10
Review the participant intake process to verify that all pertinent information is being documented within the MIS database. Structure the assessment of the MIS database to improve the analytical data being reported so that all core service components are being documented and to ensure that DHS will get the best evaluation of all areas of the program.
IMPACT

The local evaluations have been a useful tool in analyzing the strategies and effectiveness of various means of providing these services and goals. DHS has been working in a collaborative manner to ensure that services are provided with the goal of full integration of services. In addition, the local evaluation plans have been used as a tool for directing program services and a tool for increasing collaboration among DHS and local health providers.

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

![Figure 18](image.png)

DHS data shows that its participants overwhelmingly felt that the services offered by DHS were the ones that they needed. The reporting periods have yielded above a 95% rate of the participants reporting that they felt the services offered were the ones needed.
Overall participant satisfaction is important to the sustainability of the program and is instrumental in client recruitment and retention. Therefore, it is important to assess overall participant satisfaction, as well as the level of satisfaction in the program component areas. This figure details the results of the overall participant satisfaction with the level of service.

![Overall, the services here are:](image)

When asked to rate the overall level of service received from Dallas Healthy Start, respondents responded very favorably on an annual basis during the reporting period. There were no negative responses reported. Data shows that 86% of the DHS outreach participants felt that the overall level of service with DHS was excellent. This is an additional 17% increase from the previous reporting period. It is extremely important for DHS to maintain such a high level of satisfaction amongst DHS participants for the continued success of the program. Such a high level of excellence in satisfaction is a very positive indicator for the DHS program and methods. This is an excellent level of participant satisfaction and is a direct result of DHS’ hard work. This data also illustrates the general level of satisfaction and identifies opportunities that may exist to improve service levels.
Data shows that the setting at DHS was supportive and appropriate. Based upon this data, the participants in the case management service were pleased with the DHS program and services. 100% of the participants responded positively to this question regarding DHS, no responses were negative. This indicates that DHS methods are appropriate and effective and having an impact on the participants and service areas as evident by this Impact Evaluation.