

HEALTHY START IMPACT REPORT

Introduction

This Impact Report is for La Clinica De Familia (LCDF), Doña Ana Healthy Start Program for project period FY 2005/2009. Our program is located in Doña Ana County in South Central New Mexico.

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

Our project focused on addressing racial, ethnic and health disparities experienced primarily by our Hispanic United States and Mexico border population. To qualify for “Border Community” funding, our program met the federal, 62 miles within of the Mexican border designation. Our service area is not only within the 62-mile requirement it encompasses a portion of New Mexico’s 180 miles of common border with Mexico. Below is a brief contextual description of our service community followed by additional data from our initial community needs assessment that lead to our focus on the identified disparities.

In 2005, Doña Ana County was one of the fastest growing counties in the United States with a 1990-2000 growth rate of 22.4%. County expansion was being driven by growing employment in maquiladoras also known as maquilas, increasing demand for farm labor and by skyrocketing land prices in Mexico. The cheapest lots in Juarez, Mexico, at the time, cost between \$43,000 and \$87,000 an acre, while in Doña Ana County, New Mexico a comparably developed (or undeveloped) lot in a colonia can be bought for between \$6,000 and \$12,000 an acre, according to William Siembieda of the School of Architecture and Planning at the University of New Mexico. Despite growth, the county is one of the poorest in the country. Throughout this decade our County unemployment statistics have been the highest in the state and significantly higher than the national average. In the years of 1999 to 2001 the average unemployment rate for the United States was 4.3, for New Mexico 5.1 and for Doña Ana County 7.3.

The DAHS serves an ethnically and culturally diverse, economically challenged population in the south central portion of New Mexico. Southern Doña Ana County (DAC), the target area, covers more than 3,500 square miles and is composed of a rich narrow agricultural valley, mountains and desert terrain. The most southern border of DAC is contiguous with one of the most rural and poorest areas of Mexico, and many of the people live in underdeveloped colonias. “More than two-thirds of colonia residents were born in the U.S. (i.e., they are U.S. citizens), if you add in those who have green cards, more than 98% of colonia residents are in the U.S. legally.” (Source: Texas Department of Human Services.) Hispanics comprise an estimated 60.9% of our population, up from 56% in 1990. The effect of the 54,000 people living in the 37 colonias in DAC on our health delivery systems is inescapable: cultural traditions are reflected in sometimes reluctant attitudes toward the necessity of routine health care and, in particular, prenatal and postpartum care, family planning and inter-conceptional care. With all the burdens faced by women and their families in the colonias, prenatal care is not always perceived as a priority.

Highlight from our initial community needs assessment is data that led to your community's decision to focus on the identified disparities. First and foremost, the DAHS Program met the following three additional eligibility factors:

- The 68.2 % of Doña Ana County pregnant women entering prenatal care in the first trimester is less than 80% by verifiable three-year average data for years 1999 through 2001. (Source: New Mexico Department of Health Primary Care/Rural Health)
- The 12.5% of Doña Ana County births to women who had no prenatal care in the first trimester is greater than 2% by verifiable three-year average data from years 1999 through 2001. (Source: New Mexico Department of Health Primary Care/Rural Health)
- The 28.9 % of Doña Ana County children under-18 years of age, with family incomes below the federal poverty level exceeds 19.9% for year 2000. (Source: U.S. Census Bureau, Census 2000)

Focus groups conducted by Doña Ana County Maternal Child Health Council (MCHC) in 2001 confirmed that access to health care remained a serious issue in our County. The most commonly cited barriers are finding out about services, getting appointments, transportation and cost of services. Other barriers include vast distances between patient and the health care provider, shortages of health care providers and endemic poverty. (Source: Doña Ana County Maternal and Child Health Plan Update 2003.)

Doña Ana County Demographics¹	1999	2000	2001	County 3 Yr. Avg.	HS Doña Ana 1999-2001 Avg.
County Population	96,340	135,941	169,165	133,815	133,815
Live Births	2,917	3,025	3,005	2,982	7492
Infant Deaths	12	15	20	15.7	02
Neonatal Mortality	6	11	14	10.3	02
Post neonatal Mortality	6	4	6	5.3	02
Low Birth Weight	199	222	236	219	432
VLBW > 1500					202
Births To Teens 19 and Younger	557	575	596	576 (19%)	7012 (94%)
1st Trimester Initiation Of Prenatal Care	2094	1954	2057	2,035 (68 %)	4792 (64%)
# Live Births No Prenatal	304	433	384	374	02

Care					
Infant Mortality Rate	4.1	5.0	6.7	5.27	02
% White Non-Hispanic	17.5% ³	17.5% ³	13.5% ³	16.17%	4.40% ²
% White Hispanic	79.0% ³	78.95% ³	82.5% ³	80.15%	75.7% ²
% Black	1.78% ³	1.78% ³	1.8% ³	1.79%	0.4% ²
% Asian and Pacific Islander	0.99 ³	0.99% ³	1.2% ³	1.06%	02
% Native American	0.75% ³	0.75% ³	1.0% ³	0.83%	02
% White Other					16% ²
% Other Hispanic					2.67% ²
NM DOH Primary Care/Rural Health1 Doña Ana Healthy Start Program Data2 Natality Characteristics by County NM Resident Live Births - Doña Ana County3					

The DAHS serves all women of reproductive age and their families with a focus on underserved women and infants, up to the age of 24 months. The primary consumer subpopulation of the DAHS Program is:

- Underserved pregnant women with English as a second language (primarily Hispanic) and parenting families of babies, ages zero to two, including fathers/male partners.
- Underserved pregnant and parenting teens of babies ages zero to two, including fathers and male partners.

Doña Ana County holds the second-largest population in the state at 169,165 in 2001. Doña Ana County is growing faster than any Metropolitan Statistical Area (MSA) in the state and is the ninth fastest growing in the nation (U.S. Census Bureau).

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

Estimated Number and Percent of People in Poverty 1999		
	Doña Ana County	New Mexico
All Ages in Poverty	42,475 (24.9%)	326,223 (18.2%)
Children Age < 18 Years	17,416 (33.8%)	133,194 (26.4%)
Related Children Ages		

5-17 years	12,356 (32.9%)	92,333 (25.0%)
Source: U.S. Census “Estimates Model 1999”		

Females comprise 50% of the county’s total population. Women of reproductive age in DAC represent 46% of the total female population. A profile of women of reproductive age is provided in Chart C below. As illustrated, Hispanic females represent the highest proportion of women of reproductive age in the county.

Women of Reproductive Age in Doña Ana County						
Age Groups	White	Black	Hispanic	Asian	Indian	Total Population
15 TO 19 years	2,636	127	5,546	78	97	8,484
20 TO 24 years	3,035	207	4,757	108	111	8,218
25 TO 29 years	1,700	135	3,097	109	50	5,091
30 TO 34 years	1,666	92	3,174	123	49	5,104
35 TO 39 years	2,200	86	3,721	115	47	6,169
40 TO 44 years	2,472	107	3,322	98	36	6,035
Total of All Ages	13,709	754	23,617	631	390	39,101
Ethnic Distribution	35.06%	1.93%	60.40%	1.61%	1.00%	100.00%

* University of New Mexico Bureau of Business and Economic Research 1999

Female head-of-household make up over 45% of DAC residents living below the poverty level: 50.1% are with related children under the age of 18, and 63.4% are with related children under 5 years of age (U.S Census, 2000). The following demographic information are three-year averages (1996-1998) from data available in the 1998 New Mexico Selected Health Statistics Annual Report published October, 2000, unless otherwise indicated in the text.

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

The three-year average infant mortality rate in the county is 6.83%. In 1997 the rate decreased 1.5% from the previous year. However, in 1998 the mortality rate increased by 4% to a rate of 9% for the year. A similar trend is reported for neonatal deaths with a three-year average of 4.3%. A 4.0% increase was reported from 1997 to 1998. The 1998 neonatal death rate was 6.7%. Over

18% of residents' births occur in other states. Mortality rates for out-of-state births are not available.

II. Project Implementation

Core Services

Core Service: Outreach and Client Recruitment

- A. The DAHS Program utilizes a community based indigenous work force (Promotora) model to conduct outreach services. The Promotora Model is built on framework originating from communities in Mexico where resources are scarce and/or limited. We selected to use this model based on the population that we serve, i.e. Mexican immigrant with limited resources, fear of deportation, isolation, uninsured or under-insured, etc. Our premise is that families are more likely to access services when a trusted community leader (Promotora) is available to provide information, answer questions and provide support in navigating service systems. A challenge of this model is that a Promotora typically with a high school education are called upon (by consumers) to address issues beyond her/his expertise. For example, a Promotora may be asked by a program participant to address issues of domestic violence and substance abuse.
- B. Components for outreach: Our outreach services are defined as client recruitment and client retention. Client recruitment refers to those outreach strategies that are used to identify and get pregnant women into early prenatal care and parenting families into inter-conceptual care and infant case management services. Client retention refers to outreach strategies designed to keep women and or families in care and include client find for no show appointments and family support services. Family support and or “home visiting services are targeted interventions directed by case managers to help families practice behavioral interventions such as creating a safe and consistent environment for the baby, monitoring child safety and development, or socialization opportunity for isolated women. The program maintained 5 FTE Promotoras to provide outreach throughout the project period. To advance our outreach model, we recruit and utilize Promotoras who are working on or have completed Bachelors degrees in community health or related fields. Currently, three of our five Promotoras have a bachelor’s level education and are from the communities that they serve.
- C. Our outreach model is not a “formally” documented evidence based practice. Despite the lack of rigor typically applied to demonstrate the practice as evidence based we have continually exceeded the proposed target number of program participants identified and recruited to be served by the program, indicative that the model is an effective approach. Promotoras are continually held in high regard within the community they serve.
- D. Despite State budget shortfalls our Healthy Start Program successfully implemented and maintained outreach services in the project area. The Promotora Program, a long time collaborator with our Healthy Start Program, lost MCH funding and its ability to continue assisting with the delivery of outreach client find and retention services.

Core Service: Case Management

- A. Our decision for our case management approach is based on our desire to reduce racial and ethnic disparities experienced in our communities by creating and implementing an “equitable” service in the project area, reduce duplication and avoid unnecessary competition across case management systems. To that end, our approach builds on and enhances an existing Medicaid funded Case Management model titled Families FIRST. Components of the Families FIRST model include a bio-psychosocial strengths and risks assessment, targeted care plans, specified contacts per trimester, and concluding with a post-partum visit. Our Healthy Start Program enhanced the model by required depression and substance use screenings, interconceptional care, health education and home visiting services. All program participants regardless medical insurance/Medicaid status, receive at a minimum those services noted above. A bio-psychosocial assessment is completed in prenatal and pediatric (babies zero to three) phases of services.
- B. To provide the core service of case management the project utilizes a professional and para-professional work force model. The components to case management include a bio-psychosocial assessment, depression and substance use screenings, interconceptional care, care plans, referral and follow-up. A Social Worker typically conducts the bio-psychosocial assessment in consultation with an RN, develops the care plans and coordinates implementation with Promotoras. The program utilized 2 FTE Social Work-Professional Services Supervisors and 3 FTE Social Worker funded by Healthy Start, Families FIRST and CYFD Home Visiting Program to conduct case management. In addition to providing supervision and guidance to a team consisting Social Worker, Health Educators and Promotoras the Professional Services Supervisors each carry a case load of about 20 to 40 program participants. Professional Services Supervisors also provide some mental health services for program participants who scored positive for depression.
- C. Our case management approach has a proven record of consistently and effectively distinguishing between high risk and non-high risk program participants. The model has clear and consistent care plans that link to all high risk or problem area.
- D. Despite budget cuts in our State we successful initiated and implemented of case management services. Our State contracts with Health Maintenance Organizations (HMO) (Molina, Presbyterian, Lovelace and Blue Cross Blue Shield) to manage and provide services to Medicaid eligible consumers. Two of the HMO (Molina and Lovelace) sub-contracted to the State Department of Health, Families First Program to provide case management services to pregnant women and parenting families with babies ages zero through three. The State Families First Program in-turn sub-contracted with providers in communities to provide the services. Our Healthy Start Program is one of the sub-contracted providers. There were many challenges and barriers encountered to actualize Families FIRST as viable funding option to sustain case management for our program participants. The first challenge was that not all HMO (Presbyterian and Blue Cross/Blue Shield) funded Families FIRST for case management. Those program participants who did not select Lovelace or Molina as their HMO could not receive community based case management services paid by Medicaid. Therefore, our Healthy Start Program served

those program participants. A second significant problem was that the reimbursement was inadequate. For example a case load of between 150 and 160 was needed to maintain 1 FTE Social Worker.

Core Service: Health Education and Training

- A. Our Healthy Start Program utilized individual and group, office/clinic, home and community based approaches to deliver a broad range Health Education topics. For pregnant women, we utilized Comenzando Bien Curriculum designed by March of Dimes for the provision of prenatal health education specifically for Hispanic populations. The curriculum is continually up-graded and modified to assure that accurate and up-to-date information is being provided to participants. Pregnant women primarily receive an individual didactic approach office/clinic based prenatal health education. (A pregnant participant must complete 8 health education sessions to be counted as completed health education). Our rationale for this approach was driven by the need to establish health education as a valuable component of overall prenatal care. Linking our health education to prenatal care visits assisted us in establishing credibility and completion rates. For parenting families, services were typically provided in the home. We used Beautiful Beginnings Curriculum designed to help families support infant/child development, bonding and parent/child relationships for our families. Community based education is provided via Community Involvement Teams and is driven by the needs identified by the community. Community education is provided by program staff and/or by other community partners. All program participants received health education materials that complemented the broad range of topics covered. Materials were bilingual (English/Spanish) and written at a level that is simple, clear, and easy to understand. In addition, audio-visual materials such as, videos were used to conduct program participant health education. These videos are bilingual and have been carefully previewed toward appropriateness of language, cultural/religious sensitivities, and of any potentially offensive images.
- B. Health education components include prenatal (including fetal development, breastfeeding, etc.) inter-conception, smoking cessation, life style change, diabetes, home safety, car seat safety, oral health, parenting and other health related topics. Two FTE health educators funded by Healthy Start provide all the office/clinic based prenatal health education. One FTE, State funded, health educator provides smoking cessation, second hand smoke and prevention education and counseling. Care coordinators and Promotoras employed by the program provide and/or coordinate the provision of home and community based health education services. No changes were made to our health education/training core services.
- C. The Comenzando Bien continues to be an effective curriculum for the delivery of health education to our target populations.
- D. There were no events that detracted from our successful initiation and implementation of perinatal health education.

Core Service: Interconceptional Care

- A. Our Healthy Start Program utilizes a case management model to link, track and monitor the provision of inter-conceptional care (ICC) services provided to program participants. As defined in the grant application “interconceptional care” refers to services provided in the interval between birth and up to two years, or until a subsequent pregnancy occurs. Underpinning, the case management model for ICC is the strong emphasis on culturally sensitive education, counseling and family support services including fatherhood/male involvement. Our Healthy Start Program conducts inter-conceptional care as follows:
1. Case managers employed by the Healthy Start Program provide the ICC services for program participants.
 2. Service begins in the third trimester of prenatal care and includes:
 - a. Review of health/risk information regarding pregnancies during the inter-conceptional phase.
 - b. Review of birth control methods/options. Counseling to assist client in selection of a birth control option (BCO)
 - c. Explore access to selected BCO; assess issues including ability to pay, and barriers including cultural beliefs. Provide referrals as needed.
 - e. Use an ICC Tracking Form to document all contacts.
 3. A postpartum follow-up visit is completed to reinforce and/or determine the status of BCO and assist client to identify and establish a medical home if one has not already been established.
 4. Refer client to needed family planning services as needed and follow-up on referral within two weeks.
 5. Conduct subsequent ICC follow-up visits at 2 months, 4 months, 6 months, 8 months, 12 months, 16 months, 18 months and 24 months to coincide with pediatric case management visits
- B. Interconceptional care is provided by program case management and/or health education staff. Following are the components for inter-conceptional care:
1. Service begins in the third trimester of prenatal care and includes:
 - a. Review of health/risk information regarding pregnancies during the inter-conceptional phase.
 - b. Review of birth control methods/options. Counseling to assist client in selection of a birth control option (BCO)
 - c. Explore access to selected BCO; assess issues including ability to pay, and barriers including cultural beliefs. Provide referrals as needed.
 - e. Use an ICC Tracking Form to document all contacts.
 2. A postpartum follow-up visit is completed to reinforce and/or determine the status of BCO and assist client to identify and establish a medical home if one has not already been established.
 3. Refer client to needed family planning services as needed and follow-up on referral within two weeks.
 4. Conduct subsequent ICC follow-up visits at 2 months, 4 months, 6 months, 8 months, 12 months, 16 months, 18 months and 24 months to coincide with pediatric case management visits

- C. The program utilizes on-going record audits to facilitate improvement in interconceptional care.
- D. There were no events that detracted from our successful initiation and implementation of Interconceptional Care Services.

Core Service: Depression Screening and Referral

- A. Our program selected the Center for Epidemiological Study Depression Scale to screen for depression based on its reliability and validity to our target population. To further account for the cultural diversity among our clients the program translated the instrument into Spanish. Our workforce is primarily indigenous to the project area and is bilingual English/Spanish
- B. The 2 FTE PSS and 3 FTE case managers employed by the Healthy Start Program conduct all facets of our perinatal depression screening services. Services include a Center for Epidemiological Study Depression Scale screen, education on the signs and symptoms of depression, referral for needed services, and follow up. Clients who score at-risk for depression are referred to internal or external mental health professionals for further assessment, diagnosis and treatment. A referral is also made to the clients OBGYN or primary care provider. Our Healthy Start Program with one-time funding from HRSA provided some on-site mental health interventions that had favorable results. We developed and implemented a six week intervention that we called *Circuitos de Seguridad*. Women who scored positive for depression and agreed to participate for the duration of the intervention were recruited to participate. The model consisted of one weekly two-hour experiential hands-on session. The model included scrape booking, story booking, dialoguing, and body movement/image. Post-depression screening revealed a significant reduction in depression symptoms and consumer satisfaction surveys were consistently positive.
- C. The Center for Epidemiological Study Depression Scale screen is a validated and reliable instrument for identification and diagnosis of clinical depression.
- D. While the need for universal screening for depression in pregnant women is gaining acceptance throughout our state wide system of care the lack of resource to provide mental health services continues to be a deterrent. A State driven work group, of which our Healthy Start Program is a member, has been established to promote universal screening, identify best practices and advocate for appropriate services.

Core Systems

Local Health System Action Plan

- A. How were the priorities for the plan identified?

Priorities for our Local Health Systems Action Plan (LHSAP) were identified through formal and informal needs assessments that included review of the State MCH Plan, Community and program staff focus groups and review of healthy start data.

B. What was the overall goal of the plan?

The LHSAP for this project involved a multi-pronged approach emphasizing meaningful family and community leadership and participation. The overarching goal of our LHSAP was to develop an integrated service delivery system with access to a broad array of services to serve women of childbearing age and families of children ages zero to two more efficiently and effectively. The aim of our LHSAC is build on the strengths of the existing health and social services infrastructure, identify gaps, forge partnerships and reallocate resources to address unmet perinatal health care needs.

To accomplish this, we worked on strengthening the role and capacity of the Healthy Start Consortium to spearhead LHSAP efforts, fortify existing partnerships and create new partnerships between Healthy Start and public, as well as private service providers within the community by focusing on the goals below:

- 1) Community Involvement: Public Education, Relations and Visibility - To create community investment and buy-in to the perinatal system of care.
- 2) Establish an effective collaboration between State Title V Maternal Child Health and other child serving agencies and organizations.
- 3) Integrate Behavioral Health and Substance Abuse Services into the Healthy Start Program - To address the gap/lack and or access to mental health and substance abuse treatment.
- 4) Integrate Family Support Services - To help families' access early ongoing family support services.

C. How was the plan linked with the State Title V action plan?

As indicated above we utilized our State Title V plan to establish our priorities.

D. What systems building activity did the plan address?

Bulleted below are the Systems building activity that the plan addressed and were achieved:

- Integration with Early Head Start Program and
- Linkages to other child development services
- Linkages to mental health services
- Linkages to Oral Health Providers
- Linkages to State MCH Program
- Linkages with State PRAMS Steering Committee

- Leveraged funding and implemented Infant Mental Health/Home Visiting Service

E. How has the plan improved overall perinatal service delivery in the target area?

Our plan assisted us to improve overall perinatal service delivery in the target area as follows:

- Universal substance use screens are now conducted within LCDF perinatal service delivery system
- Healthy Start participants who complete oral health education receive a voucher for free oral health screening and exam and are prioritized to receive services
- Healthy Start Program participants have been established as a priority population to be served by the Early Head Start Program
- Prenatal care days have been established in five health clinics to improve access to early prenatal care
- Mental health services have been integrated within health clinics and

Consortium

- A. Highlight how the Consortium was established and identify any barriers that emerged in its establishment and how they were addressed.

Our consortium, initially established in 1999, under the auspices of the Doña Ana County Maternal Child Health Council, despite hiccups, bumps and changes along the way was maintained throughout the project period. The consortium, titled Healthy Advisory Council (HAC), evolved from the commitments of our local Healthy Start Program, Early Head Start Program, and two Head Start Programs to integrate like program requirements to reduce duplication, make better use of our limited resources and serve families in our communities. Thus, we merged our Healthy Start Consortium with Early Head Start and Head Start Programs with Health Advisory Council requirement to carry out our consortium core service mandate. These four programs represent the core agencies that is further described below.

- B. Briefly describe the working structure of the Consortium which was in place for the majority of the implementation, its composition by race, gender and types of representation (consumer, provider, government, or other). Also, please describe the size of the consortium, listing the percent of active participants.

By-laws organize the working structure of our HAC. The HAC has an open general membership consisting of representatives from agencies, organizations, and community (including Community Involvement Team and Policy Council representatives), a voting membership of 16 including a chair and co-chair, voted on by the general membership and an organizing committee for the four core agencies.

A Chair and Co-Chair are elected by the general membership at an annual meeting. The Chair presides over all meetings. The Co-Chair presides over meetings when the Chair is absent.

The Organizing Committee comprised of the core service programs noted above and the consortium chair, develop meeting agendas, notifying members of meetings, take and distribute minutes of previous meetings, and coordinate logistics for all meeting.

The HAC establishes Ad Hoc committees to carry out the priorities of the HAC. Currently HAC has five working committees; Mental Health Committee that focuses on acquiring services for children ages zero through eight and their families, Parent Involvement Commitment, Coordination of Early Childhood Services Committee, and Nutrition Committee.

Consortium membership composition by type is as follows:

- State or local government 6%
- Program participants 49%
- Community participants 19%
- Community-based organizations 12%
- Private agencies or organizations (not community-based) 11%
- Providers contracting with the Healthy Start Program 1%
- Other providers 1%
- Faith based 1%

Demographic composition of the consortium:

- 91% White-Hispanic/Latino
- 7% White-Non Hispanic
- 1% American Indian
- 1% Black

Gender:

- 95% Women
- 5% Men

Due to the open nature of the consortium membership size and composition fluctuates. On average we have a total of 149 members with 92 being program participants and community representative and 57 being agency representatives participating in the consortium.

- C. Describe the activities this collaborative has utilized to assess ongoing needs; identify resources; establish priorities for allocation of resources; and monitor implementation. Describe your relationship with other consortia/collaborative serving the same population.

As indicated above the consortium actively works to address priorities via ad-hoc committee. The consortium reviews Healthy Start Performance Measures and outcome data on a quarterly basis, develops and implements strategies for improvement as needed. Core agencies conduct on annual needs assessment and report findings to the consortium to establish priorities and recommendations. Our Healthy Start Program has been a catalyst for development of comprehensive system of care for early childhood. We work closely

relationships with organizations that provide services to the same populations. We are currently completing a PDSA Cycle with one of our Part C providers with the aim of assuring that services are not duplicated. We work closely with our Department of Healthy Families FIRST Program to Examples include Part-C providers, oral health providers, WIC, TANF and other key service providers.

D. Describe the community's major strengths which have enhanced consortium development. The major strengths of our community which have enhanced consortium development include:

- Commitment to work together to improve the health status of our families by creating a system of care that makes sense and utilizes our combined resources effectively. Partners are very aware and understand the need to work together to survive during our current National economic crises
- Bright, innovative, and enterprising professionals and workforce
- Recognition and knowledge of existing services and gaps
- Willingness to share idea's and resources

E. Describe any weaknesses and/or barriers which had to be addressed in order for the consortium to be moved forward.

The most significant challenge for our consortium is the lack of resources to carryout its activities. We also struggle to maintain adequate consumer representation. Reasons for this include lack of resources, lack of public transportation, complex and high risk and need population. Currently, a shared cross systems strategy is being used to coordinate meetings, including meeting announcements, minutes, and other meeting logistics.

F. Discuss what activities/strategies were employed to increase resident and consumer participation. How did these change over time?

Our Healthy Start Program utilizes a Policy Council and Community Involvement Team structure to increase consumer participant in the consortium. A hundred percent of our Policy Council membership is program participants and/or community members. Policy Council members receive a gas card each time they attend a meeting. Program participants who are voting members of the HAC also receive gas cards. Child care and English/Spanish translation services are available for all meetings. Nutritional snacks are provided at all CIT, Policy Council and HAC meetings. Partner agencies take turns providing nutritional snacks for the meetings. Sometimes program participants will have pot-luck meals for the meetings.

G. How did you obtain consumer input in the decision-making process?

Our primary strategy to obtain consumer voice is through Community Involvement Teams strategically developed throughout the project services area. Each of our 5 CIT selects a representative to represent them on the Policy Council and HAC. Consumer input is also obtained through annual focus groups and consumer surveys.

H. How did you utilize the suggestions made by the consumers?

Consumer input was used to approve policy, improve service delivery, identify priorities and provide training and education opportunities that best meet their needs.

Collaboration and Coordination with State Title V

A. What type of linkages occurred with the State and Local Title V agencies?

Linkages to State and local Title V agencies include the following:

- a. Children's Medical Services
- b. WIC
- c. PRAMS Steering Committee

B. Describe how this linkage promoted cooperation, integration, and dissemination of information with other community services funded under the Maternal and Child Health Block Grant.

Linkages with MCH Block Grant funded programs helped us to get program participants get needed services, e.g. WIC, Children's Medical Services, and referrals into our program.

Sustainability

A. Describe your efforts with managed care organizations and third party billing.

Much effort was made to leverage funding from managed care organizations for care coordination services and behavioral health services. Annually we leveraged on average \$60,000.00 annually for care coordination services. We received a contract from Value Options to provide mental health services but for two years consecutively payment was not forthcoming. Non-payment from Value Options was not isolated to our program. Mental Health providers across the State of New Mexico have not received reimbursement for services that were delivered.

B. Describe major factors associated with the identification and development of resources to continue key components of your interventions without HS funding.

Major factors associated with the identification and development of resources to continue key components of our program include current economic condition that include budget cuts, the uncertainties associated to health care reform, and shifting priorities.

C. Describe whether or not you were able to overcome any barriers or to decrease their negative impact.

Healthy Start Program Leadership maintained active participation in State level initiative with the aim of securing funding to support, enhance or sustain core services. Efforts

yielded home visiting funding for first time pregnant and parenting teens. Our program influenced funding formula that benefited all Home Visiting Providers in our State.

III. Project Management and Governance

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

The grantee agency for our Healthy Start Initiative is La Clinica de Familia, Inc., an established 501 C3 Community Health Care Center System with over thirty years experience servicing the uninsured and under-insured population in rural south central New Mexico. La Clinica de Familia Community and Migrant Health Center (CHC 330 e, g and 501C3) is JCAHO Accredited agency with a multi-site medical and dental program that includes a federal Healthy Schools, Healthy Communities school-based clinic. The Chief Executive Officer (CEO), under a community Board of Directors (BOD), is responsible for the administration and fiscal management of all LCDF, Inc medical, dental and social service programs. A Chief Financial Officer, under the direction of the CEO and BOD maintains fiscal management for the proposed Healthy Start program. The DAHS Program management is provided by 1 FTE Program Director who reports to the CEO of the LCDF, Inc. The grantee organization is responsible for hiring key personnel with recommendations from the Healthy Start Consortium and is responsible through the Program Director for communication with the Healthy Start Consortium and Community Involvement Teams. The Program Director coordinates the preparation and submission of required reports, monitoring the progress of the project toward its objectives, monitoring contract deliverables and the writing of continuation grant applications for future years. The applicant agency has assumed the final responsibility of monitoring and assuring the performance of the Healthy Start contract deliverables. The Program Director works with a Management and Cross Systems Management Teams to carryout the mandates of the program. The management team consisting of Program Director, Data Manager, Administrative Assistant and 2 FTE Professional Services Supervisors coordinate core service activities, including program/staff development, service delivery, file management, and data collection/management and reporting. The cross systems management team, consisting of the Healthy Start's and Early Head Start's Program Directors, key program personnel coordinate services across systems, consortium meetings/events, and training.

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

La Clinica de Familia, Inc. has an administrative structure, policies and procedures in place and capacity to manage all essential aspects of program operations: human resources, accounting, Information Technology support, reporting and purchasing resources.

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

No changes in management or governance occurred over the project period.

- D. Describe what process had to be developed to assure the appropriate distribution of funds and what happened with the process over time.

The process for assuring appropriate distribution of funds is accomplished through joint meetings with key program personnel and LCDF fiscal staff who develop and make budget recommendations. Budget recommendations are submitted to the Policy Council for review and final recommendation to the LCDF Board of Directors. The LCDF Board of Directors is responsible for approving the final budget and monitoring expenditure throughout the year. The Healthy Start Program Director meets with a Senior Accountant, assigned by LCDF to oversee all financial aspects of the HSI contract including maintaining records and reports and perform contract draw-downs, on a monthly basis.

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

As our project moved forward with implantation over this project period we obtained the following resources that became important.

Quality Assurance, Program Monitoring & Service Utilization:

- Office of Performance Review provided planning and technical assistance to develop strategies to reduce teen pregnancy rates, including second pregnancies and improve rates for completed 6-week post-partum follow-up visits.
- State PRAMS provide county level data for competitive and continuation application. Program Director is a member of the State PRAMS steering committee
- LCDF provided technical assistance and support on data collection and management.

Training and Technical Assistance

- River, Sierra, & Company provide training and technical assistance on improving accessing to domestic violence for program participants
- State of NM Families FIRST provided training for prenatal and pediatric case management staff
- Safer New Mexico provide Car Seat Safety training and certification to program staff and car seats at a reduce cost for program participants
- New Mexico Department of Health provided funding and training for

- smoking cessation/initiation counseling and second hand smoke education
- Southern Area Health Education Center provide training for program staff on home safety and home safety products such as, fire extinguishers, monoxide detectors, etc for program participants
- Early Head Start coordinated early child development training opportunities for staff
- New Mexico Children, Youth and Families, Home Visiting Program provided training, educational materials, and support towards the development of home visiting service
- Southwest Region Healthy Start Coalition provided

F. To what extent was cultural competency of contractors and of project staff an issue? If cultural competency was an issue, how was it addressed, and were any noticeable benefits realized?

Cultural competency was not an issue for project staff as over 95% of the staff are indigenous to the project area and are familiar of the norms, customs, beliefs and challenges of our target population

IV. Project Accomplishments

A. Please detail your calendar year (CY) objectives and overall project period (PP) objectives for your program, and for all 15 National Performance Measures. Within the narrative (or using the suggested format in Attachment A) describe in quantitative and qualitative terms the degree of success in achieving the goals and objectives for each CY objective, as well as your PP objective. Describe any barriers and challenges encountered during implementation and how they were addressed for objectives that were achieved, as well as those that were not achieved. Summarize all lessons learned.

07: The degree to which MCHB supported programs ensures family participation in program and policy activities.				
By 6/30/13, increase to maximum score of 18 resulting in increment of family participation in program and policy activities.				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	15	16	17	18
Score	15	14	14	14
Accomplishments:				
<ul style="list-style-type: none"> • The Healthy Start Program established community involvement teams to foster family participation in program and policy activities. • The Healthy Start Program utilizes an indigenous workforce to provide services; some of our workforce members were former participants. • Program participants make up membership to the policy council 				
Barriers:				
<ul style="list-style-type: none"> • Continued flat funding has made it difficult to maintain consistent family participation 				

10: The degree to which MCHB supported programs have incorporated cultural competence elements into their policies, guidelines, contracts and training				
By 6/30/13, increase to maximum score of 69 resulting in increment of integration of cultural competence into our policies, guidelines, contracts and training				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	61	62	64	67
Score	68	68	68	68
Accomplishments:				
<ul style="list-style-type: none"> All our written products are in both English and Spanish All staff are bilingual English/Spanish Community Involvement Team trainings are conducted in the program participants' primary language, typically Spanish in our community 				
Barriers:				
<ul style="list-style-type: none"> None at this time 				
14: The degree to which States and communities use "morbidity/mortality" review processes in MCH needs assessment, quality improvement, and/or data capacity building				
LCDF Healthy Start Program currently doesn't have a Mortality/Morbidity Review process in place.				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	0	0	0	0
Score	3	0	0	0
<ul style="list-style-type: none"> Not applicable 				
17: The percent of all children from birth to age 18 participating in MCHB supported programs that have a medical home				
By 06/30/13, increase/maintain to at least 94% the number of program participants from birth to age 18 that have a medical home				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	88.8%	88.8%	88.8	89.9%
Annual Indicator	99.6%	100%	100%	100%
Numerator	241	217	126	151
Denominator	242	217	126	151
Accomplishments:				
<ul style="list-style-type: none"> Our Healthy Start Program is embedded within a Health Care Center System that has made significant strides to implement comprehensive health services Our program is constantly assuring quality of care and promoting health services Referrals are available if needed 				
Barriers:				
<ul style="list-style-type: none"> None 				
20: The percent of women participating in MCHB supported programs who have an ongoing source of primary and preventive care services for women.				

By 06/30/13 increase/maintain to at least 89% the number of program participants that have ongoing source of primary and preventive care services for women				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	75%	78%	81%	84%
Annual Indicator	100%	100%	100%	100%
Numerator	543	543	332	351
Denominator	543	543	332	351
Accomplishments:				
<ul style="list-style-type: none"> • Our Healthy Start Program is embedded within a Health Care Center System that has made significant strides to implement comprehensive health services • Our program is constantly assuring quality of care and promoting health services • Referrals are available if needed 				
Barriers:				
<ul style="list-style-type: none"> • None 				
21: The percentage of women participating in MCHB supported programs requiring a referral, who receive a completed referral.				
By 06/30/13 increase to at least 80% the number of women requiring a referral, who receive a completed referral.				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	69%	71%	73%	75%
Annual Indicator	77.9%	75.2%	76.4%	77.7%
Numerator	355	194	110	181
Denominator	456	258	144	233
Accomplishments:				
<ul style="list-style-type: none"> • Our Case Managers make referrals for all prenatal women who have been identified as needing a referral • We follow-up on all referrals to verify that they were completed within 30 days of referral • We utilize Promotoras to assist on follow-up client's who no-show for appointments 				
Barriers:				
<ul style="list-style-type: none"> • None 				
22: The degree to which MCHB supported programs facilitate health providers' screening of women participants for risk factors				
By 6/30/13, maintain maximum score of 64 and continue to facilitate screening of women participants for risk factors				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	60	61	62	63
Score	61	64	64	64

<p>Accomplishments:</p> <ul style="list-style-type: none"> All program participants are screened for risk factors at intake time Assessments are conducted by the case manager on all referrals received to determine risk and need for case management <p>Barriers:</p> <ul style="list-style-type: none"> None 				
<p>35: The degree to which States and Communities have implemented comprehensive systems for women’s health services</p>				
<p>By 6/30/13, increase to maximum score of 28 to improve our health infrastructure and systems of care for women</p>				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	28	28	28	28
Score	26	26	26	26
<p>Accomplishments:</p> <ul style="list-style-type: none"> Our Healthy Start Program is embedded within a Health Care Center System that has made significant strides to implement comprehensive women’s health services Our State is working on development of a women’s health initiative <p>Barriers:</p> <ul style="list-style-type: none"> Political climate and economic conditions 				
<p>36: The percent of pregnant participants of MCHB supported programs who have a prenatal care visit in the first trimester of pregnancy</p>				
<p>By 6/30/13, increase to at least 57% the number of pregnant participants who have a prenatal care visit in the first trimester of pregnancy</p>				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	50.5%	51%	51.5%	52%
Annual Indicator	55.8%	54.3%	56.1%	58.6%
Numerator	254	253	160	184
Denominator	455	466	285	314
<p>Accomplishments:</p> <ul style="list-style-type: none"> Partnered with DOH to identify pregnant women at the time of pregnancy testing Set informational tables at health fairs and public events to aide women to set identify onset and early stages of their pregnancy <p>Barriers:</p> <ul style="list-style-type: none"> To meet the Federal Objective of 75% of women entering care in the first trimester the program will continue to utilize a variety of outreach strategies including media, bill boards, hand bills, door to door contacts, etc. We will also work with program participants to find out if that have initiated early prenatal care in another geographic are such as Mexico. 				
<p>50: Percent of very low birth weight live births</p>				
<p>By 6/30/13, maintain/reduce annual performance indicator of 1% of very low birth weights live births</p>				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008

Annual Performance Objective	1.1%	1.0%	1.0%	1.0%
Annual Indicator	0%	.7%	0%	0%
Numerator	0	2	0	0
Denominator	167	272	183	193
Accomplishments:				
<ul style="list-style-type: none"> The Healthy Start Program has maintained 0% of very low birth weight live births 				
Barriers:				
<ul style="list-style-type: none"> None 				
51: Percent of live singleton births weighing less than 2,500 grams				
By 06/30/13, maintain/reduce annual performance indicator of 10% of live singleton births weighing less than 2,500 grams				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	13%	12%	11%	10%
Annual Indicator	6.6%	7.7%	3.8%	3.6%
Numerator	11	21	7	7
Denominator	167	272	183	193
Accomplishments:				
<ul style="list-style-type: none"> The Healthy Start Program has maintained a percentage below annual performance objective of 10% for live singleton births weighing less than 2,500 grams 				
Barriers:				
<ul style="list-style-type: none"> None 				
52: The infant mortality rate per 1,000 live births				
By 06/30/13, maintain/reduce annual performance indicator to 1.0% of infant mortality per 1,000 live births				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	1.0%	1.0%	1.0%	1.0%
Annual Indicator	0%	3.7%	0%	0%
Numerator	0	1	0	0
Denominator	167	272	183	193
Accomplishments:				
<ul style="list-style-type: none"> The Healthy Start Program has maintained 0% of infant mortality per 1,000 live births 				
Barriers:				
<ul style="list-style-type: none"> None 				
53: The neonatal mortality rate per 1,000 live births				
By 06/30/13, maintain/reduce annual performance indicator to 1.0% the neonatal mortality rate per 1,000 live births				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	1.0%	1.0%	1.0%	1.0%
Annual Indicator	0%	0%	0%	0%
Numerator	0	0	0	0
Denominator	167	272	183	193

Accomplishments:				
<ul style="list-style-type: none"> The Healthy Start Program has maintained 0% of neonatal mortality per 1,000 live births 				
Barriers:				
<ul style="list-style-type: none"> None 				
54: The post-neonatal mortality rate per 1,000 live births				
By 06/30/13, maintain/reduce annual performance indicator to 1.0% the post-neonatal mortality rate per 1,000 live births				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	1.0%	1.0%	1.0%	1.0%
Annual Indicator	0%	0%	0%	0%
Numerator	0	0	0	0
Denominator	167	272	183	193
Accomplishments:				
<ul style="list-style-type: none"> The Healthy Start Program has maintained 0% of post-neonatal mortality rate per 1,000 live births 				
Barriers:				
<ul style="list-style-type: none"> None 				
55: The perinatal mortality rate per 1,000 live births				
By 06/30/13, maintain/reduce annual performance indicator to 1.0% the perinatal mortality rate per 1,000 live births				
	By 12/31 of Calendar Year			
	1: 2005	2: 2006	3: 2007	4: 2008
Annual Performance Objective	1.0%	1.0%	1.0%	1.0%
Annual Indicator	4.02%	3.7%	0%	0%
Numerator	7	1	0	0
Denominator	174	272	183	193
Accomplishments:				
<ul style="list-style-type: none"> The Healthy Start Program has maintained 0% of the perinatal mortality rate per 1,000 live births 				
Barriers:				
<ul style="list-style-type: none"> None 				

- B. For those projects that received mentoring or technical assistance from another site, please discuss any activities/lessons learned from those projects that you utilized in your project. If you provided technical assistance, describe your activities, feedback received on them, and any other lessons learned.

Our project provided training and technical assistance to the newly hired Program Coordinators of the Luna County Healthy Start in New Mexico as the project experienced leadership turnover. We provided the site with training on infant mental health, reflective supervision, data management and collection. We shared samples of our assessments and standard operating procedures. We also provided training and technical assistance to Program Director and staff of the Healthy Start Program in Nogales on all aspects of Healthy Start core services, data collection strategies, reporting etc. The Healthy Start sites within the Region VI

have a long history of working together as the first Regional Conference was a joint venture between the Healthy Start sites and the Title V offices from all five states in 2001. The initial meeting served as the catalyst for a five state collaborative. Shortly thereafter, the Southwest Region Healthy Start Coalition (SWRHSC) was established by Healthy Start Program Directors to support the advancement of Healthy Start Programs and to be a voice for infants and families in the Southwest Region (Federal Region VI). The mission is to sustain existing programs and promote service delivery to un-served and/or under-served communities in the region. Member states (sites) within the Region are – Arkansas (1), Louisiana (4), Oklahoma (2), New Mexico (2), and Texas (6).

The goals for the Coalition are defined as follows:

1. To organize an annual conference
2. To develop and distribute a quarterly newsletter
3. To identify and implement a joint evaluation agenda

The coalition established working committees to carry out its efforts as follows:

- Steering Committee – facilitates the progress of the SWRHSC.
- Conference Planning Committee – organizes an annual Regional Conference.
- Communication Committee – develop and operate a Regional web-site and develop and distribute an electronic quarterly newsletter.
- Evaluation Committee – select a joint evaluation agenda for study within the region.
- Development/Sustainability – to continuously secure funds/resources to support the activities of the SWRHSC.

As mentioned, this group has a sound history of working together to providing formal and informal training and technical assistance and support. Peer level communication has been established at various levels around the Region. Formal projects include the planning and facilitation of an annual conference, the development of a Regional web-site, and the production and dissemination of an electronic newsletter.

The annual conference has been hosted by all participating states/sites. Diligent effort has been put into the establishment of a working conference each year that focuses on capacity building for Healthy Start projects and Title V personnel. Industry experts have been secured as presenters for each year's conference. The theme has varied over the years, but the quality of content presented each year has improved. The launching of the SWRHSC website and the production of the electronic quarterly newsletter is set for Fall 2009.

V. Project Impact

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

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

infant health and social support services.

1. Describe the approaches utilized to enhance collaboration.

Approaches utilized to enhance collaboration. The program utilized a leadership model to promote and enhance collaboration.

- We spearheaded and supported cross systems training and education to key leaders on “systems of care”
 - Increased membership in the consortium
 - Established cross systems teams to coordinate service delivery and referrals. Teams also work to identify and resolve barriers/challenges
 - Established or joined work groups to develop strategies around pressing community concerns such as Teen Pregnancy, Breastfeeding, car seat safety, immunizations, environmental health, depression, etc.
 - We provided capacity building through training and education to consumers/communities throughout the project area.
 - Established Community Involvement Teams to facilitate program participant voice and ownership.
 - Established cross systems committee to coordinate consortium activities
 - Established Memorandum of Agreement to supporting agencies/organizations
2. Identify the extent to which structured changes, such as procedures or policies, have been established for the purpose of system integration.
 - Policies and procedures were established and facilitated full integration of Healthy Start with an Early Head Start Programs
 - Coordination of medical, dental and social services is occurring as a result of interdisciplinary team structure
 - Established a Cross Systems Management Team to manage the operations across systems and coordinate the activities of the consortium.
 - Brought forth policy change within La Clinica de Familia Clinics prioritize and help pregnant women access early and ongoing prenatal care. Established prenatal care days within five medical clinics to facilitate early entry into care
 - Established collaborative partnership to improve oral health care for pregnant women. Healthy Start and Dental Providers established free early oral health screenings events at community locations and provided voucher for free dental cleanings for Healthy Start participating pregnant women.
 - Standard Operating Procedures (SOP) referral and timely follow-up to mental health and substance abuse services
 - Established SOP to bring uniformity to Case Management Services

3. Describe key relationships that have developed as a result of Healthy Start efforts covering the following areas:
 - a. Relationships among health service agencies; between health and social service agencies; and with community-based organizations;
 - Our Healthy Start Program has a strong working relationship with medical and dental health providers. Communication and coordination of services occurs between LCDF medical, dental and Healthy Start case management and Health Education providers
 - Created working partnership with Early Head Start and Head start Programs
 - Established MOA with Domestic Violence Providers
 - Established partnership with Breastfeeding Task Force to promote breastfeeding
 - Maintained relationship with WIC to identify and recruit pregnant women into early prenatal care
 - Maintained cross systems referrals between Part C Providers and Healthy Start
 - Established cross systems referral and follow-up process
 - Integrated case management services with Early Head Start Program resulting in cross sharing of staff.
 - Implemented 4 Ps Plus Substance Abuse Screening for all Pregnant women receiving services with in LCDF Health Care Center System
 - Implemented depression screening and referrals to medical providers
 - Integrated case management Services
 - Integrated Health Education Services
 - b. Relationships that focus on involvement of consumers and/or community leaders (who are not employed by a health or social service agency) with any of the agencies/organizations listed above or any additional agencies.
 - Our Healthy Start Program established and utilizes Community Involvement Teams (CIT) and a 100% consumer/community representative Policy Council to assure consumer and community voice/participation in the program planning, evaluation and other consortium activity. Each of the five CIT represents a different community within geographic service area. The Policy Council has representation from each CIT. Members from the CIT and Policy Council participate in Health Advisory Council. See Consortium above for more specific details on role and responsibility of the Health Advisory Council.
4. Impact that our HS project has had on the comprehensiveness of services

particularly in the following areas:

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

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

- b. Barriers to access and service utilization and community awareness of services;

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

- c. Care coordination including descriptions of mechanisms implemented to assure continuity of care, quality improvement and follow up system(s) for client referrals;

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

- d. Efficiency of agency records systems and sharing of data across providers (within the confines of confidentiality rules) to reduce the need for repetition.

La Clinica de Familia has SOP regarding confidentially and release of information that guide the Healthy Start Program and

the sharing data across providers within the System. For those consumers who do not receive their medical services within the LCDF system consumers sign a Release of Information indicating the type of information that we are permitted to release. Referrals to needed services are given to the consumer to initiate contact.

5. Describe the impact on enhancing client participation in evaluation of service provision in the following areas:
 - a. Provider responsibility in maintaining client participation in the system and provider sensitivity to cultural, linguistic and gender (especially male) needs of the community;
 - b. Consumer participation in developing assessment and intervention mechanisms and tools to serve perinatal women and/or infants, and the extent of implementation and utilization of these tools or mechanisms.

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

1. Residents knowledge of resource/service availability, location and how to access these resources;

Our Healthy Start Program enrolls over 1000 participants into the program annually. We reach approximately one third of the county's 3000 annual births. This fact is indicative of name recognition and knowledge of our resources. Further, program staff has been strategically housed within LCDF medical clinics that are scattered throughout the service area, to enable them to assist program participants to access to medical, dental and Healthy Start services. Promotoras conduct outreach at community centers and WIC Offices that continually inform residents about our services. Knowledge and ability for participants to access health care independently and proactively when needed has also been expanded through Community Involvement Teams capacity building education and training opportunities.

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

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

- Consumer participation to establish, change and/or impact policy primarily occurs through participation the Policy Council. Consisting 100 % program participants and community

representatives the policy council is responsible for approving and making policy change recommendations.

- Consumer participation also occurs through five Community Involvement Teams
3. Community experience in working with divergent opinions, resolving conflicts, and team building activities:
 - a. The Program had significant experience in working with divergent opinions and resolving conflicts. The premise that we work from is that change of the magnitude that we are striving for will bring with it conflicts and tensions from internal and external sources. In anticipation we establish ground rules for meetings that honor and give every individual a voice. We use Roberts Rules of Order to conduct meetings with majority rule decision making. Other strategies included translation services to address language barriers and team building events, such as the annual Healthy Start Retreat. The retreats are specifically designed to work through differences/tension areas and create opportunities for the participants to experience success.

4 Creation of jobs within the community:

Healthy Start provides jobs to 17 employees that are fully or partially funded by the program.

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

Our State Title V MCH Block Grant facilitated project development by:

- Including us in State wide training such as Families FIRST case management
- Providing technical assistance and including us as members of the Statewide PRAMS Steering Committee, Depression Work Group and Home Visiting Work Group
- Providing empathy bellies to use for training of young fathers.
- Sharing county and state level PRAMS data
- Inviting us to participate in the MCH plan up-date
- Inviting us to present and share Healthy Start data at State-wide forums.

The benefits and lesson learned from the relationship include:

- Mutual accountability and responsibility.
- Mutual sharing of information for the benefit of all
- The State can learn from the experience of local projects
- Local projects can influence large systemic change. For example our Healthy Start Program influenced our State Families FIRST Program to develop a web-based data collection and reporting system that was implemented state-wide. Our program influenced funding strategy for Statewide Home Visiting program.

D. Impact on Eliminating Disparities in Perinatal Health: Describe how the project has reduced the racial and ethnic disparities in perinatal health in our community. Racial and ethnic disparities have been reduced by:

- Increasing the number of Spanish speaking only Hispanic women entering first trimester care
- Influencing educational systems to provide contraceptive care in the schools with aim of reducing Hispanic Teen Pregnancy and school drop out rates
- Provision of Spanish language educational materials
- Opportunities for Spanish speaking only consumers to participate in community events by providing translation services

E. Local Government Role: Highlight activities/relationships at the state and local level that facilitate project development. Briefly describe barriers at the state and local level, and the lessons learned in dealing with these barriers.

Our program has relationships with various State government entity that facilitate project development. Our State Department of Health Tobacco Use Prevention and Control Program (TUPAC) provide funding for tobacco use prevention and cessation services. TUPAC provides training to help us serve disparity populations. The Office of Border Health in collaboration with Southern Area Health Education trained Healthy Start to conduct home safety assessment, training and infant/child sun safety education to program participants. Home safety equipment such as fire extinguishers, lead screens, first aid kits, outlet plugs, smoke and carbon monoxide detectors, etc., and funding for sun safety products were provided by the Office of Border Health. Further, program staff inform local, staff and national official on program status. Program participants provide education to elected officials on the impact that our program has on there well being.

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

Other lessons learned include the following:

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

VI. Local Evaluation

A. Describe the activities undertaken by your local evaluator over the past four years.

Activities of the Program Evaluator included attendance in quarterly consortium meetings, at least one visit at each of 5 program sites annually, monthly review of program data, and ongoing meetings with Program Director and Data Manager. Program Evaluator developed and provided an annual evaluation report consisting of:

1. A pre-experimental, one group, post-test only evaluation design, the performance indicators listed above will be used to monitor and assess the program’s outcomes.
2. A process evaluation will measure implementation of program design and target population service ability.
3. A Cost/Benefit analysis to assess if program achieves its success at a reasonable cost. The 1st step of the analysis will divide program costs into categories.

B. Healthy Start Local Evaluation Reports for years 2005-2008

TITLE OF REPORT: Program Evaluation for Calendar Year 2005

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Background

With roots imbedded in the federal agency Health Resources and Services Administration (HRSA), the primary mission of the LCDF Healthy Start Program is that of improving the health and general well-being of women of child-bearing age, infants, children, and families residing in predominantly Hispanic communities in southern Dona Ana County, New Mexico. The LCDF Healthy Start Program is headquartered in Las Cruces with satellite offices in the municipalities of Anthony, Chaparral, Sunland Park, and San Miguel, New Mexico.

Need for Local Evaluation

The call for this evaluation arises from a need to provide Healthy Start's administration an independent assessment of the program's effectiveness as called forth by the terms of proposal. As an aid to Healthy Start's program director, it presents a set of recommendations for consideration as the program continues to move forward to address prominent community health - enhancing issues.

Purpose of Evaluation

This evaluation gauges the effectiveness of Healthy Start personnel in its attempt to satisfy the intent of their proposal in terms of prescribed goals and objectives. This assessment covers activities during the period commencing January 01, 2005 and ending December 31, 2005. In conjunction with this effort, the evaluation further examines various elements of the Healthy Start project, including administrative and field activities and the manner in which they are able to function in a holistically – based fashion to ensure the success of the total project.

Limitation(s) of Evaluation Process

As with a great number of program evaluations, the methodology utilized to achieve aforementioned purpose is not scientific in nature. It is rather based on direct and indirect observation, on extensive interviews with administration and staff members, data gathered from Healthy Start program participants via culturally- based questionnaire instrument; examination of record – keeping practices, and on longstanding experiences of the evaluator in the areas of multi-disciplinary program development and administration. Data utilized by evaluator to measure the extent of effectiveness in reaching the objectives of the program were collected and provided by Healthy Start's data collection and reporting system.

Healthy Start Goals

The following goals are contained in Healthy Start's Proposal.

Goal 1: Organize existing health care agencies into an integrated and seamless system through which broad perinatal health and related social services can be provided.

Goal 2: Utilize Healthy Start to expand capacity and sustain existing case management service.

Goal 3: Enhance consumer participation in a consumer/professional partnership

Goal 4: Cultivate respect, enhance knowledge and increase the involvement of culturally diverse populations that reside in the project area by including families, community leaders, and practitioners in identifying culturally appropriate services

Healthy Start Objectives: The following objectives are contained in Healthy Start's Proposal

Objective 1.

Core Service: Outreach and Client Recruitment

1. Core Services Outcome Measures 01: By 6/1/09, increase to at least 52.5% of pregnant program participants of MCHB supported programs that have a prenatal care visit in the first trimester of pregnancy.

Objective 2.

Core Service: Outreach and Client Recruitment

Core Services Outcome Measures 02: By 6/1/09, increase to at least 51.0% where the number of outreach face-to-face infant contacts that are linked to a completed referral.

Objective 3.

Core Service: Outreach and Client Recruitment

Core Services Outcome Measures 03: By 6/1/09, increase to at least 51.0% where the number of outreach face-to-face women contacts that are linked to a completed referral

Objective 4.

Core Service: Health Education

Core Services Outcome Measures 04: By 6/1/09, increase to at least 83.0% percent the number of program participants who receive Health Education.

Objective 5.

Core Service: Health Education

Core Services Outcome Measures 05: By 6/1/09, increase to 60% percent the number of program participants receiving health education/treatment in smoking cessation who self report lowered frequency or elimination of this risky behavior.

Objective 6.

Core Service: Health Education

Core Services Outcome Measures 06: By 6/1/09, increase to 25% percent the number of program participants who breast feed until their babies are six months old.

Objective 7.

Core Service: Case Management

Core Services Outcome Measures 07: By 6/1/09, increase to 77% percent the number of completed referrals among prenatal program participants.

Objective 8.

Core Service: Case Management

Core Services Outcome Measures 08: By 6/1/09, increase to 77% percent the number of completed referrals among infant program participants.

Objective 9.

Core Service: Case Management

Core Services Outcome Measures 09: By 6/1/09, increase to 93% percent the number of program participants who received Mid/High levels of prenatal care.

Objective 10.

Core Service: Interconceptional Care

Core Services Outcome Measures 10: By 6/1/09, increase to 51% percent the number of program participants who receive at least three interconceptional/family planning visit.

Objective 11.

Core Service: Depression Screening and Referral

Core Services Outcome Measures 11: By 6/1/09, increase to 51% percent the number of program participants who are screened for depression.

Target Audience (Source: Healthy Start proposal)

(1) Underserved pregnant women with English as a second language (primary Hispanic and parenting families of babies, ages zero to two, including fathers/male partners.)

(2.) Underserved pregnant and parenting teens of babies ages zero to two, including fathers and male partners.

Evaluation/Introduction

Equally yoked with dedication, how successfully Healthy Start continues to accomplish its mission of serving expectant mothers and families is a function of its staff's ability to fully understand and execute the terms of the proposal; to synergistically work in harmony with colleagues to accomplish this important endeavor. This important feat requires a holistic understanding of how one's assigned area, whether it be health education or case management or any other function, interacts with the various other elements to make Healthy Start work effectively. For example, reporting or collecting data are not functions on their own, but ones that are intrinsically linked

with one's own activities in serving a greater need - that of our clients. These activities are also connected to administration because in theory, they serve to meet the latter's expectations. Like the parts to an automobile engine or the organs in one's own body, there is an interrelational function that is essential to the successful operation of that organism. Such a distinction is essential in making the system operate not only efficiently, but with added coherency. Specifically, this challenge requires that each staff member be required to read the proposal until there is an understanding of how its components interact internally within Healthy Start and externally with the functions of supporting agencies to bring about the best that we are able to offer to our target audience.

Assurance that the aforementioned plan is in essence producing the desired results can best be achieved not by a system of random supervision, but with a plan that places supervision closer to field activities, at the direct disposal of field personnel such as members of the TRIAD. While maintaining open lines of communication with upper administration, such a plan would entail on a rotating basis, consistent visits to all five sites within the target area. The essence of such a plan is that it provides a consistent flow of training and supervision to field staff, that all activities are tied to a common plan, and the assurance that the conditions of the proposal met in its fullness.

Additionally it provides the vehicle for needed ongoing and harmonious interaction between administrative, supervisory, and field staff.

The dividends of pushing this staff development agenda as a priority and within a well executed plan is certain to be realized in numerous ways. The most notable to be manifested in both the qualitative and quantitative levels of services provided to the project's target audience. Others are also deduced from observation during the interview process. They are enumerated as follows.

(1) Because the objective is to increase programmatic understanding and to place people on the

same page, one can expect improved communications among field staff and between management and staff (2) It allows less room for confusion and misunderstandings (3) Improves both the qualitative and quantitative aspects of the service delivery system (4) An improved understanding of proposal is likely to motivate staff to share their perspectives, and the opportunity to innovatively expand their methodology in providing services to participants as the need arises. (5) Enhances morale by instilling a sense of ownership in Healthy Start. People that are content produce more, achieve more. (6) Because of an increased understanding of program's direction at all levels, it increases the facility in managing the program (7) It provides the basis for much needed consistency and accuracy in data collection and reporting (8) Improves readiness in responding to internal and external requests for information (9) Enhances unity among staff and management thus improving teamwork efficiency. (10) Allows Healthy Start to establish meaningful and effective relationships with collaborating agencies (11) allows an administrative and programmatic decision making process that is less arbitrary and one that is based on traceable facts (12.) Allows program participants to better understand program and to share with friends and relatives programmatic opportunities. (13) Instills in staff a need for greater professionalism. (14) A common, official plan allows less time for individualized agendas.

Recommendations: The following recommendations are based on programmatic reviews during a period of five months.

Recommendation 1: Orienting and unifying staff to a common mission, goals, and objectives

Knowledge is the essence for success. It is suggested that each professional member of the staff be requested to read and thoroughly understand the contents of proposal and the interrelational aspects that of each major component has with on another other. Such an effort should extend to any other proposal, grant, or cooperative agreement that may specifically cover their respective

responsibilities. Group opportunities to discuss subject matter content should be allowed when ever permissible. Pre-testing and post testing as is commonly done in the business- retail industry would not only be enjoyable but beneficial.

Recommendation 2: Staff Development

The development of a staff development system that moves from “behind –the-desk” , random supervision to informed, consistent, and continuous, on-sight supervision aimed at assuring that the following needs are fully met..

(1) An assurance that the programmatic and administrative requirements of the Healthy Start proposal and/or any existing cooperative agreement(s) that may bind the responsibilities of staff or administration are fully satisfied (2) that the instructional and related resource needs of Healthy Start field professionals and paraprofessionals such as TRIAD members and promotoras are fully met. (3) That ample opportunity for community and client participation is in fact in place (4) Assurance that the lines of communication between higher administration and field staff are open and effectively utilized (5) Assurance that case loads are consistent, accurate and realistic (6) Assurance that staff fully understands the system of reporting data; that reporting is accurate, reliable, and on a timely manner (7) Assurance that the executive director is, on a daily basis, apprised of issues that are eminent to the ongoing success of the program. (8) Assurance that with very few approved exceptions, the majority of field activities are an integral part of a greater Healthy Start official plan as opposed to one that is haphazardly disconnected from a greater planned activity (9) That instruction be made available in helping staff make the connection between their assigned responsibilities and other functions of the program (10) That staff are empowered and encouraged to make meaningful contributions during times of grant submission or special on-the –spot requests (11) That staff are encouraged to expand the scope of their

current activates to fulfill expanded needs of participants. (12) That a supervisory- monitored system of evaluating individual and/or group weekly progress is established. These results should at least be verbally reported on a weekly basis to executive director of Healthy Start. [13] The assurance that recruitment of program participant is neither arbitrary nor selective in nature but one that is inclusive of all qualified membership. [14] An assurance that the recruitment process is not static, but one that actively and continuously seeks new and eligible participants thus maintaining Healthy Start files invigorated with activity.

Recommendation 3: Data Collection and Reporting

The data information system utilized during this reporting period has been replaced with a new system. Abstracting data at least under the old system did not leave the individual using the data with the comfort that the information is accurate; that it has research validity nor reliability. There is still an uncertainty even at the managerial level for example, as to the actual number of active participant cases at any given time. This information is essential as it safeguards one's credibility and allows upper management to make sound decisions.

Irregardless of their value, even state-of-the-art technology depends on reliable input from individuals that take data collection and reporting seriously. During the interview process, there were expressions of adamant in having to report. Unfortunately, reporting is not a choice nor is it an independent process; it is a requirement by entities that provide funds that support programs such as these. Training on the importance of reporting, its flow through the system, and its inter-connection to the total Healthy Start system is highly recommended.

Recommendation 4: Need for independent Caseload Audit

Records that accurately reflect caseloads are important for more than one reason. The fact that they provide the framework for sound decisions and the effective and progressive management of

programs is one to note. Additionally, data that is reliable allows management to allocate and re-allocate resources efficiently, as the need arises. Importantly, it allows management to certify to funding entities and taxpaying public how their money is spent.

Coming up with figures from different sources or at various times from same source within the system that were consistent presented an uneasy task and one that was less than reassuring. In line with the thought of promoting an on-site review system of checks and balances as suggested by Recommendation 2, it is recommended that an independent, unbiased effort to audit all caseload records be exerted. A simple system whereby case managers periodically certify caseload numbers would also be in order.

Recommendation 5: Teamwork and TRIAD

At the community level, there are signs that point to a disenfranchised effort among TRIAD team members. In that economic poverty, the lack of travel accommodations, and familial obligations resurface as major obstacles in caring for clients, it behooves us to ensure that services are provided with the least inconvenience to our clientele. Instances where participants are inconvenienced by uncoordinated team effort appear common in the minds of participants and team members that are mindful of providing quality services to their clients. Reportedly, there are instances where health educators, nurses, and/or case managers share an individual as a common participant, yet that fact remains unknown among them.

While the objective of this particular recommendation is not to single-handedly bring to light incidences such as these, they do point to an issue - the need for more conscientious and coordinated effort among members of the TRIAD. It needs to be recognized that the purpose of a triad is to promote communication and team effort and most importantly, to better serve our clients.

Recommendation 6: Improved Communications in administration

The number of employees that make up the Healthy Start staff is relatively small. Depending on definition, at most two or three individuals occupy the top positions. Administrative discord whether personal, official, or in combination is more often than not, damaging. It disallows the program from being executed in the manner that it was meant to be. It is costly in terms of displacing taxpayer dollars and deprives program participants from benefiting. In small systems discord may quickly breeds vicious thoughts, deceitfulness, and weathers away unity. The sooner we rectify situations such as these, the sooner we will be able to get back to productivity.

Recommendation 7: Collaborative efforts

An empowered staff as described by introductory section above is more likely and able to communicate to collaborating agencies what Healthy Start is all about and what the needs of its clients are. Hence, they will be in better positions to draw resources (including expert advice) to the program. From experience, many professionals such as university professors include in their agendas, a community service item either as a choice or as a requirement to the university's public service mission. The nature and interest in topics such as addressed by Healthy Start provide an excellent opportunity for the establishment of such partnerships.

In the health care arena, Dona Ana county commission agendas now call for the establishment of partnerships and improved coordination among those that provide health care services. By some accounts and because of a number of variables such as time constrains, conflicting schedules, and coordination, it appears that the Healthy Start's consortium may be falling short in fully functioning as an advisory board. Taking a special look at how the may cooperating entities may best function in their and in the best interest of Healthy Start is timely.

Recommendation 8: A need for group gatherings.

The fact that participants suffer spells of isolation from the mainstream of society was shared during the group interview process. Communicating personal issues with relatives residing in distant lands or with the few friends they may locally have, is not always possible nor conducive to their well beings. A number of participants expressed the need to be contacted by Healthy Start professionals with more frequency (even if by telephone) to ensure their wellbeing during times with greater risk.

Many in the groups expressed an appreciation for group gatherings, the opportunity to speak out, with strong interests in continuing these gatherings. They also have a desire to meet other participants with similar needs and the opportunity to share ideas that may be beneficial to all group members. A number of participants suggested gatherings during the evening, when spouses and other members of the family could attend.

Faculty and staff at the NMSU Cooperative Extension Service are noted for devoting vast amounts of evening time to their clientele. Group gatherings, where participants feel more empowered to express their true feelings are strongly encouraged. Information gathered in such environments will prove invaluable to the planning and recruitment processes.

Recommendation 9: Services to Teenage Pregnancies (see cost analysis)

An NMSU news release and a Sun News report outline with ample concern an alarming rate of births to teenage mothers in Dona County. Ranked 50th, New Mexico is cited for a lack of timely prenatal care by the Annie E. Casey Foundation, a Maryland non-profit organization that looks after the interests of children. The impacts that this concern has on society are briefly discussed. In light of such dilemma, it might be wise to consider the thought of redirecting more of Healthy Start's energy to this segment of its target population. Collaborating with entities such as NMSU department of health and others may draw needed resources to Healthy Start.

Recommendation 10: A Model for the diffusion and adoption of ideas

In efforts to facilitate and enhance the communication and adoption of health-related ideas among its target audience, Healthy Start might consider implementing a model known as “diffusion and adoption of innovations”. This particular model is based on a belief that within a society, certain individuals adopt ideas or concepts at faster rates than others. On a scale of five variables, individuals who adopt ideas at more rapid rates are known as innovators. They are likely to be leaders within their communities. Those at the opposite side of the scale are known as laggards or individuals that are less likely to adopt. They are not risk takers. In between are early adopters, the early majority, and the late majority. The key to communicating ideas and getting people to adapt to ideas is that of identifying community leaders who are able to model their successes to others. Other than successfully communicating specific lessons to target audiences, this model is capable of enhancing unity among members of the community.

Recommendation 11: End of Year Progress Report

A self explained progress report as provided by Healthy Start’s data collection manager is attached. There are a total of eleven major objectives addressed by proposal. With limited exceptions such as health education objectives 04 and 05, and interconceptional care objective 10, all other areas appear to be within range of being satisfied. In some instances (six objectives) the objectives were exceeded.

Concerns over Healthy Start’s accuracy in collecting and reporting data have been expressed during evaluation interviews. As recommended earlier, a system that allows closer on-site-supervision and scrutiny is highly desirable. Such would greatly enhance the probability that the data is reliable, accurate, and verifiable.

Cost/Benefit Analysis

End of the year statistics provided by Healthy Start’s data reporting office indicate that a total of 2,729 original and recurring contacts were made by Healthy Start professionals and paraprofessionals during the evaluation period beginning on January 01, 2005 and ending December 31, 2005. Definitions and composition of this statistic can be easily derived by “Exhibit A” is attached. During that same period, a total of 616 active cases were reportedly maintained. By location they are as follows:

Location	Number of Active Cases Jan 31, 2005 To Dec 31, 2005	Total Number of contacts as per performance measure report	Total Reported Expenses
Anthony	156		
Sunland Park	99		
Chaparral	125		
Las Cruces	132		
San Miguel	104		
Totals	616	2,729	\$815,950

While literature released by the Health Resources and Services Administration points to the importance of providing prenatal and interconceptional care services to participants, making cost effective inferences from data shown above or from data shown on exhibit can perhaps be best delegated to health professionals with specialties in the area of comparative health cost effectiveness. Although there is perhaps no scientific way of scientifically proving or disproving the impact that Healthy Start did have on any given birth, there are statistics that point to the value of prenatal and interconceptional care services as provided by this program.

For instance, according to HRSA, mortality rates and low birth rates for infants of Hispanic origin

are twice as high as those for the white population. Social and medical care costs for infants born with low birth weight and very low birth weights are astronomical. On an annual basis, medical costs to care for low birth babies that survive the first year average are \$93,800. The cost per year for the caring of very low birth weight babies is estimated at \$273,900. Using hypothetical data and statistics as reported by HRSA, preventing low birth weights in 15% of a population of 400 expectant mothers translates to an estimated cost savings to society of \$5,628,000. The cost savings in the prevention of very low birth weights utilizing these assumptions is estimated at \$16,434,000 per year. Of interest is that normal weight births (over 2500 grams or 5.5pounds) end up saving \$59,700 in medical expenses during the infant's first year. Increasing the infant's weight by ½ pound during its development saves an estimated \$12,000 to \$16,000 in medical expenses during the first year. Although the importance of statistics such as these cannot be overly emphasized, the real impact belies in a belief healthy babies are likely to grow into more responsible and productive adults and ones that are more able to contribute positively to society. The value of services provided by the Dona Ana Healthy Start program increases as local concerns deepen over the alarming rate of teenage pregnancies and ensuing birthrates. According to a recent news release by NMSU health faculty, one in every birth in Dona Ana County is attributed to an expectant mother less than twenty years of age. In New Mexico alone, yearly costs for adolescent pregnancies and parenting reach as far as 88 million dollars. The significance of these findings is that that pregnancies and births among this population result in a number of undesirable social ills. Listed are medical and economic burdens to already stress society; unachievable educational goals, and alarming rates of poverty.

TITLE OF REPORT: Program Evaluation for Calendar Year 2006
AUTHORS: Willie L. Lujan, Ph.D., Lujan and Associates, LCC

February 28, 2007

Ms. Jonah Garcia
Executive Director
Dona Ana Healthy Start Program
Las Cruces, New Mexico 88001

Dear Jonah:

Thank you again for allowing me to review Healthy Start's programmatic and administrative progress as it accomplishes objectives established for calendar year 2006. I sincerely enjoyed working with you and your staff in a most professional manner and particularly appreciate your assistance in facilitating evaluation activities during the formative and summative aspects of these processes.

Although it is impossible to implement in the short term most of the significant changes that you and I discussed relative to last year's evaluation results, I am increasingly optimistic in that these issues remain at the front burner and by a belief that important decisions on your behalf are apt to allow Healthy Start to move forward in a more efficient, unified, and organized manner. You will recall that major issues that surfaced as a result of last year's evaluation included the following general areas: (1) a need to significantly improve the reliability and validity of data collected and reported; (2) a need to solidify the knowledge base of staff as it relates to improved understandings of Healthy Start's proposal. Such a challenge includes an ability by staff to effectively recognize the need for added synergy between their respective efforts and the many administrative and programmatic functions of Healthy Start so that its goals and objectives are met in unity and not as independent entities; (3) To ensure that such a plan is accomplished by redirecting much of the higher-end supervision, training, and monitoring of field staff activities away from Healthy Start's central office to a continuous on-site basis. Such a plan allows both field staff and members of

administration to strengthen its communication base and thus to most effectively achieve the mission of Healthy Start. Combined, the summative affect of aforementioned items transcends into a program that is increasingly communicative, unified, and effective in pulling resources, in responding to the needs of consumers and individuals with vested interests in the success of Healthy Start.

As an accepted principal, accuracy in data collection, processing, and reporting activities is important in that it enables both management and staff not only to monitor a program's direction as needed but to justify the utilization of public funds for specified and official purposes. Your important decision to employ the Challenger processing system I believe is sound in that it enhances both of these challenges. Although the process of obtaining needed information from your data –processing unit during the formative stages of the evaluation process was rather trying, I have been able to devote considerable last- minute time to evaluating data that you and I were able to pull from the Challenger system last February. Its potential I believe looks promising. Aside from being colorful to look at, its value perhaps best belies in that its on-line capabilities allow management to make on-the –spot administrative decisions not as handedly possible under the old system. As a precaution however, I would like to emphasize again that even state-of-the-art systems depend on reliable data and on staffs that are well trained and able to appreciate how the data entered into the system is used in the overall mission of any given program.

LCDF's expediency with the recent appointment of a data processing manager and your forthcoming addition of an 'administrative assistant' are destined to help you strengthen the aforementioned programmatic areas and provide a renewed opportunity to bridge the gap between administrative expectations and field activities. I would like to suggest that both of these individuals be encouraged to grasp a thorough understanding of the proposal's content so that they

are able to conceptualize their responsibilities most effectively and simultaneously, to help you synergize and unify all of your staff's activities. This need is particularly important for the individual taking on the position of administrative assistant or its equivalent. These achievements, combined with careful reviews of last's year's evaluative findings and recommendations should position you to manage the program with much added success. Because productivity has its roots where the action is, I would again emphasize the physical presence of both positions at the community level on a routine basis or at minimum, until it is evident that activities are functioning according to expectations. In my experience, programs that are frequently monitored and not left to chance have the greatest probability of succeeding. Certain aspects of data exposed by the data processing system attest

I am attaching for your review two important pieces of information as follows: (1) a computerized progress report used in gauging the extent that you and your staff were able to fulfill Healthy Start's objectives as called for by its proposal (see Attachment "A") and (2) a survey instrument summarizing responses on behalf of Healthy Start's consumers at the following Healthy Start locations: Anthony, San Miguel, Sunland Park, Chaparral, Anthony and, Las Cruces (see Attachment "B"). Data used for the objective progress report as you know was generated by Healthy Start's data collection and reporting unit. I believe that the contents of this report are self explanatory. As inferences are drawn from these data, it might be helpful to point out that a number of key staff positions remained open during that reporting period. The fact that a new data reporting system was being implemented might also be important to note.

A total of fifty one consumers responded to the survey instrument administered at each of the above mentioned locations. Accordingly, I am attaching a copy of an English – translated instrument, including the number and nature of responses provided for each given situation.

Responses to open-ended questions are also enumerated below the survey instrument. The results of these studies are impressive and indicative that on Likert scales, approximately 95% of consumers are significantly satisfied with the services provided by Healthy Start. Because comments from consumers represent grass root opinions that are important to the planning processes, I suggest that respective responses be incorporated into Healthy Start's overall planning process and that they be shared with appropriate staff members and members of Healthy start's consortium.

In drawing a cost analysis, developing a system that is scientific and capable of capturing all that a given program in reality accomplishes can become a taunting if not a formidable task. Thus, it is important that such a notion be thoughtfully considered as inferences are drawn from any cost estimate. In the development of the Healthy Start estimate, considerable time was spent analyzing and formulating relationships between classes of data provided by the Challenger system.

Utilizing documented data that provided consistency, measurability, and comprehensibility in terms of best representing the efforts of staff remained the goal of this task. Categorically by major curricular tasks and respective descriptors, attached Table I depicts such an arrangement. These tasks are as follows: (1) outreach, (2) Case management, (3) Health education, (4) Depression screening, and (5) Smoking cessation.

Data provided by La Clinica de Familia accounting department indicates that a total of \$826,053 was expended by Healthy Start in providing aforementioned levels of services during calendar year 2006 (see Table I). Utilizing these two figures and Table I as a reference, estimated cost per unit amounts to \$ 272 per unit output as depicted by Table I. Although a differing approach was utilized, you will note that this figure is comparable to last year's.

Again, thank you for the opportunity to work with you and the rest of the Healthy Start staff. I will

be happy to entertain any questions you may have.

Table I.

Data for Cost Estimate		
Slide Ref No.	Description of Services by Task	No. of Occurrences
	Outreach	
30	Outreach Case Loads, January to November 2007	398
	Case Management	
12	Case Loads by Case status, January to November 2007	576
	Health education	
48,52,57	Health Education Prenatal Clients that Received Services January 2006 – December 2006	1353
	Depression Screening	
64	Depression High Risk Clients	182
	Smoking Cessation	
43	Smoking Cessation Encounters, July 2006-December 2006	32
45	Second Hand Smoke Encounters, July 2006 – December 2006	501
	Total reported occurrences	3,042
	Total funds expended	\$826,053
	Estimated cost per unit	\$272.

TITLE OF REPORT: Program Evaluation for Calendar Year 2007

AUTHORS: Willie L. Lujan, Ph.D., Lujan and Associates, LCC

April 18, 2008

Ms. Jonah Garcia
Executive Director
Dona Ana Healthy Start Program
Las Cruces, New Mexico 88001

Dear Jonah:

Thank you once again for the opportunity to review Healthy Start's programmatic and administrative activities as they join to accomplish a number of prominent HRSA objectives during calendar year 2007. I have enjoyed working with you and your staff in a most professional manner and particularly appreciate your assistance throughout the year as we periodically

examined programmatic activities at each of your Healthy Start Locations. Thank you also for inviting me to various Healthy Start functions as they all provide invaluable insights that lead to a better understanding of Healthy Start and how it best serves its target audiences. These are all invaluable to the evaluation process.

Overall, it is my professional opinion that the management of all Healthy Start activities at all locations has been conducted in a most professional, proficient, and progressive manner. As indicated by the attached Challenger annual data report (see Attachment A), you and your staff were able to meet with notable effectiveness the great majority of HRSA performance measures for 2007. As you and I know first hand, the significance of these accomplishments transcend beyond the simple task of computing percentages as in the real world they may in essence determine the fate, the lives of new born babies, through their adolescent stages and beyond. As HRSA research readily points out, Healthy Start system contributions of this nature are most appreciated under the realization that they help reduce undesirable medical abnormalities such as weights below average during birth, dreaded mortality rates, and long-term sufferings for Healthy Start consumer families. Additionally, because of high costs associated with the health and medical industries, it is possible that savings to the tax-paying public may run in the millions of dollars.

In addition to meeting the challenge of fulfilling your main objectives for 2007 with relative success, additional quantitative and supporting data provided by Challenger indicates that workloads and efficiency rates remain at all time highs. Attachment B for example, depicts that the lives of Healthy Start consumers were touched in one way or another total of 4,673 times during the 2007 reporting period. By variable, the following work loads are reported: (1) Outreach Case Loads, 894; (2) Case Management, 894; (3) Prenatal Clients that received educational

services, 1,477; (4) Depression screening, 770 including 181 high risk clients; (5) Smoking Cessation encounters, 183; (6) Second - Hand smoking encounters, 455.

The nature of these variables and correlated data are important factors to the evaluation process in that they provide high correlations between Healthy Start's curricular offerings and the grass root needs of consumers as ascertained by my own research. My own findings in the words of consumers further indicate a need for Healthy Start services in the following and more specific areas: (1) continued education on nutritional practices for infants and older members of families; (2) requests (particularly by younger and less experienced consumers) for additional education in caring for their babies; (3) assistance with issues related to depression, seemingly culminating from economic conditions, familial stress and a sense of isolation from society; (4) a related and notable need to more frequently meet in group settings for the purpose of updating their maternal skills, networking, and learning from fellow consumers. Although there appears to be an on-going issue with a lack of transportation within Healthy Start's consumer group, every effort needs to be exerted to meet item number three as it greatly benefits both your consumer base and Healthy Start professionals as a means of accurately planning curricular activities. Educational activities work best when they are based on the needs of target audiences; group settings provide the dialogue to accomplish such a goal. Attachments C, D, E, and F provide additional detailed responses to the survey instrument administered last December at each of the Healthy Start localities. You will note that this year I am providing you as the project administrator summaries of consumer responses by individual sites as a means of helping you throughout the management process.

Consumer levels of satisfaction with services provided by Healthy Start continue to excel. During the last four years, I have had the privilege of interviewing approximately 130 program

participants. Less than four percent of these individuals are repeat respondents, thus providing us with a broader number of randomized consumers who are able to submit their respective opinions. Such is also important as it helps to establish the research validity and reliability of these ratings. Finally, as I mentally ponder on the contents of the 2005-2006 evaluation report as a baseline, I see positive changes in the Dona Ana Healthy Start program due to your leadership and that of your staff. I note a program that appears to be administratively and programmatically more cohesive, whose programmatic functions are more readily defined and better understood by members of your staff. This allows you to achieve the goals and objectives of the program in synergistic fashion, with relative ease and increased efficiency. I note in particular increased proficiency and accuracy in reporting data. Through leadership provided by Challenger staff and your data processing manager, I also note that field staff is gaining deeper understandings of how their daily activities tie in to Healthy Start's reporting system, to its mission, goals, and objectives.

As I visit Healthy Start sites, I pleasingly note opportunities given consumers in voicing their needs and opinions- often via the adeptness and enthusiastic leadership of consumer advocates - presidents. Consumer participation as any educator can attest certainly provides the impetus needed for effective planning and programming. Used in conjunction with educational models designed to convince the less likely to adopt desirable health behaviors, active consumer participation under the leadership of consumer advocacy presents a powerful means of developing curricular agendas that meet the grass root needs of your communities. I would be glad to re-visit with you the use of particular diffusion models widely used in education to accomplish such a desirable goal.

In terms of recommendations, I believe that many of those provided to you during previous

evaluations are seemingly still in your mind. I would encourage you to continue using as a reference, the first report submitted to you during the 2005-2006 evaluation.

In passing, I note that during the proposal writing process and under the evaluation section, HRSA emphasizes (on a yearly basis) the need to effectively market recipient projects to community groups as well as agencies that may be in positions to assist us with additional funding. Although I know that you have done a good job in contracting Healthy Start services with outside agencies such as Families First, we might want to discuss other possibilities if you also feel that it is appropriate.

Data reported by La Clinica is indicative that expenditures for reporting year 2007 total \$844,865 were necessary to sustain the level of activities shown by exhibit B. Given that each and every contact with consumers requires the defrayment of financial resources, the cost per unit during this same reporting period is \$181.00 per unit. Utilizing similar methodologies, this figure compares to \$272 per unit incurred during reporting period 2006. A number of variables may be attributed to this success; some are discussed during the opening paragraphs of this report. Restructuring activities, increased stability in staffing patterns, redirecting staff, training, re-setting priorities, and redefining activities are likely to be contributors in terms of program efficiency.

I would like to congratulate you on a job well done and thank you for the opportunity to visit Healthy Start throughout 2007. Should you or anyone have questions regarding the contents of this report, please feel free to contact me.

TITLE OF REPORT: Program Evaluation for Calendar Year 2008

AUTHORS: Willie L. Lujan, Ph.D., Lujan and Associates, LCC

April 21, 2009

Ms. Jonah Garcia
Executive Director
Dona Ana Healthy Start Program
Las Cruces, New Mexico 88001

Dear Jonah:

Thank you and La Clinica de Familia for the opportunity to examine the various facets of the Dona Ana Healthy Start Program during programmatic calendar year 2008. Professional – level visitations with you and members of your staff remain informative and pleasurable as they were in 2006, when we first conducted Healthy Start’s formative and year-end summative evaluations.

The evaluation process this year continues to embody depth in examining the differing working components of Healthy Start and as a result, I applaud you and your staff in carrying forward the great majority of Healthy Start’s tasks systematically, with increasing structure, synergy, and thoroughness. Such efforts enhance the evaluation process and one’s ability to place thoughts in their most appropriate perspective.

Periodic and year-end reviews of data provided by your office, surveys derived from interviewing program participants and local committee officials as well as visitations with personnel stationed in outlying locations point to meaningful work loads and accomplishments during 2008.

I am attaching evaluative summaries and related recommendations on programmatic elements deemed essential the continuation of an already successful project. You will note that in passing or in casual conversation, a number of these have been discussed with you.

In its first review, we opted to provide you with separate summaries teen levels of satisfaction with Healthy Start. This will give you a feel for progress with this important endeavor.

Please review its contents and feel free to contact me in the event that you may have questions.

Again, thank you for the opportunity to work with the Healthy Start program.

General

Data collected and generated by the ChallengerSoft data system with input by members of your staff are indicative that with the exception of one recently elevated federal initiative as specified by performance measure number 36 - "Percent of pregnant women who have prenatal care visit in first trimester", the remaining ten major objectives were commendably achieved. With thirty percent of participants reportedly suffering from depression (Health Advisory Council, Dona Ana County, NM; April 15, 2009), levels of screening for this disease remains at an all-time high with more than 100% of objective met; mortality rates remain non-existent during the twelve month; the number of infants with low -weight issues dips below Healthy Start's projection by seven percentage points; and the percent of very-low weight infants lies within .1 percent above objective. The latter two accomplishments merit thought as one cites HRSA's research reflecting astronomical cost with socially and medically tending to the possible negative consequences of low and particularly very-low weight baby births (re: local evaluation, 2006).

A great number of participants report visitations by Healthy Start staff members in excess of five times over a year's time. The fact that Healthy Start staff did manage to surpass its own projection as far as performance measure 36 is concerned by twelve percentage points allows one to infer the probability that further programmatic concentration, prioritization, refinement and tracking of events may lead to its achievement at the 75% level and as the federal arm of Healthy Start suggests. Tracking and accounting of data has thus far proven helpful. Conservatively however, there may be impediments as dismal economic statistics along the U.S. – Mexican border point to a continuation or worsening of already escalated unemployment rates. Economic indicators as such lead to the possible disenfranchisement of participant families who may return to their homelands

or who relocate regionally elsewhere in search of economic opportunity. As is more commonly the case, apprehension over immigration reform may also act as a catalyst for relocation. Healthy Start staff frequently cites difficulties in tracking expectant mothers as a data concern.

Rural programs of this nature rely on outreach that is appropriately funded and consequently one that is able to bring staff in direct contact with participants. The proper strategic allocation of travel funds to ensure that outreach services reach potential at service points is critical, especially in geographic areas stricken by poverty. The rationale behind this correlation is that poverty is in essence a health issue as much as it is an issue of economics and social justice.

Data Collection; Processing; Reporting

As reported during last year's evaluation, the current system utilized to collect, process, and report data provides a comprehensive review of activities not only in summary format, but individually by principal investigator and geographic location. Such detail allows management to detect areas in need of further review and the need to reallocate resources as called by this need.

In that MCHB and HRSA systems require responses on a given set of established objectives some of which are outlined above, these public entities additionally suggest the collection of data that brings significance to the local area (MCHB/HRSA 2010 Grant Block Proposal; p26; sec. b. - Project Local Evaluation). For instance, that of tabulating subsets of miscarriages throughout the county. The Challenger system employed by Healthy Start accepts this type of adaptability well, as exemplified by the current integration of a recently acquired NM Children, Youth, and Family grant.

Marketing; Partnerships

Central office collaborative efforts with county and state – level agencies appear to be well established and consist primarily of health organizations with parallel interests in the health care of

families and family members, including pregnant mothers and teens, and infants. A Health Advisory Council consisting of county-wide representatives serves as the primary consortium for planning and execution of established health-related issues throughout the target area.

Symbiotically, it serves as one of several mediums utilized to publically promote and further the objectives of respective participating agencies. The following agencies are noted members or collaborative partners with Dona Ana County the Healthy Start project: HELP NM Head Start, Las Cruces Public School System Head Start, La Clinica de Familia's Primero Los Ninos project (babies come first), Las Cruces Dioceses faith based coalition, NMSU, WIC, Lions Club, Public Health of NM, and Dona Ana County Head Start. Agenda items are varied and include the following samples: nutrition, oral health for the expectant mother, vision and lead screening for the young, infant mental health, speech and hearing screening, child obesity prevention, depression screening, domestic violence awareness, teen pregnancy intervention, and educational programs for smoking cessation education.

Program Participant Responses

There is insignificant departure in 2008's level of satisfaction with Healthy Start services among participants from data collected since 2005 and in-between years. Based on a five-point Likert scale and averaged-in data, approximately 97% of participants appear to be "Significantly Satisfied" with Healthy Start services. In Healthy Start's favor is a belief that the survey instrument utilized has provided research reliability and validity over a four year period, two important accuracy research elements essential to the decision-making process.

Consumer participation during the evaluation process at Chaparral, Sunland Park, and Gadsden High School were impressive, and provided an adequate sample base to establish reliable and important inferences about participant satisfaction. In contrast and similar to prior years, turnout

at the Anthony location was less promising with two or three participants straggling late, beyond the scheduled time. (See recommendation number 2.)

The teenage pregnancy group meeting held at Gadsden Independent School District went well organized and attended. It provided an ambience conducive to interaction between interviewer and students and among students. Perceptions of Healthy Start among this group are also in the 95 percentile. Separate surveys responses both for the typically older group and teens are attached.

Cost Analysis

Data reported by La Clinica de Familia, Healthy Start's local sponsoring organization, indicates that expenditures for reporting year 2008 reached \$848,138. Because activities and expenditures on an additional \$120,000 received in late November 2008 from the NM Children, Youth and Family Department for Home Visiting Services for first - time parents are negligible and reportedly non-existent, neither is included in this year's estimate. Representative levels of activities against these expenditures are depicted on Exhibit B. Given the fact that each and every contact on behalf of consumers requires the defrayment of financial resources, the cost per unit during this same reporting period is \$151 per unit of effort. Utilizing similar methodologies previously utilized, this figure respectively compares to \$272 and \$181 per unit incurred during reporting period 2006 and 2007. As mentioned during last year's report, a number of variables may be attributed to this success; some are briefly mentioned in the opening paragraphs of this report. Improved data processing, redirection of managerial activities, improved stability in staffing patterns, staff development, increased involvement of supervision with field tasks, and prioritization are likely contributors to program efficiency.

Inflationary cost adjustments from federal sources appear to remain rather stagnant at least during

the past five years, thus complicating Healthy Start's continued ability to qualitatively and quantitatively serve the needs of borderland clientele who more than ever, struggle to maintain the bare essential in medical care for their families. Although the aforementioned managerial strategies have proven effective in maintaining the essence of national initiatives within a balanced budget, Dona Ana county Healthy Start is essentially forced to subsidize annual federal shortfalls from auxiliary localized or state funding sources. Holistically, such strains the local Healthy Start system and undesirably promotes the need to reduce much needed health services to target audiences across the U.S. – Mexico border.

Professional Recruitment

Difficulties in the recruitment and retention of certified social workers and related health professionals continue to prove bothersome as agencies at the local and state levels attempt to effectively execute their missions. Although acknowledging shortages in these fields, legislators who take interests in alleviating the problem confront similar economic obstacles currently facing the rest of the nation.

Recommendations:

Recommendation 1

At least one agenda item as offered by Healthy Start calls for the establishment of a joint consortium - community alliance for the betterment of early childhood care and education. Such a plan is apt to engender and strengthen symbiotic relationships between consortium and community, assist in the elimination of duplicated services, and importantly increase consortium's chances of acquiring county funds through joint proposals. Note: As funds become increasingly scarce, the Dona Ana County commission seems to be moving in such direction.

Recommendation 2

Over the past three years, attendance at the Anthony site has noticeably diminished at least during annual summative evaluation sessions, despite lengthy lead times allocated to local staff in preparation for these important sessions and increasingly emphasized federal mandates for the conduct of local evaluations. In contrast to behaviors at other Healthy Start sites, loss of interest in those that do attend is seemingly low. Low attendance has been reciprocal between evaluator and Healthy Start administration in the past. Although not an overarching conclusion, there is need to examine possible sources. Possible solutions may involve more aggressive outreach, increased staff empathy for the needs of an audience that commonly reports bouts of isolation and depression etc. As is common in the administration of research surveys that generate an insufficient number of responses, every effort should be exerted to contact individuals who are not responding to this and other types of program activities.

Recommendation 3

A recent request to review Health Advisory's consortium's policy abstract reveals a document that may be distant from its reader, perhaps unnecessarily cumbersome, and baffling to the scientific mind. Whether it warms up to the earthiness of group members and proceedings is questionable. As is typical, proceedings that lack readable maps give rise to disunity of thought and consequently lead to inconsistent attendance records. They are difficult to execute. Without the significant defrayment of funds, it is suggested that this document be rewritten in such a manner that provides simplicity and heightened levels of understandings, at least among the majority of those involved. Minutes written on behalf of previous gatherings provide a good foundational for a beginning.

Healthy Start Program

Performance Measures
YTD January to December 2008

Performance Measure	Numerator	Denominator	Percentage	2008 % Objective
# 17 - Percent of children with Medical Home	162	162	100%	89.9%
# 20 - Percent of women with Medical Home	345	345	100%	84%
# 21 - Percent of women with closed referrals ¹	204	232	88%	75%
# 36 - Percent of pregnant women, who have Prenatal care visit in first Trimester	198	309	64%	52%
# 50 - Percent of very low birth weight infants among all live births	2	180	1.11%	1%
# 51 - Per 1,000, low birth weight infants among all live births	7	180	3.89%	11%
# 52 - The infant mortality rate per 1,000 live births	0.0	180	0.0	1%
# 53 - The neonatal mortality rate per 1,000 live births	0.0	180	0.0	1%
# 54 - The post-neonatal mortality rate per 1,000 live births	0.0	180	0.0	1%
# 55 - The perinatal mortality rate per 1,000 live births plus fetal death	0.00	180	0.0	1%
# 1004 - Percent of Depression screening done	336	345	97.39%	91%

¹Completed referrals to external agencies as needed.

Healthy Start
Activities

Program
from

January 1, 2008-December 31, 2008

Slide Ref No.	Description of Services by Task	No. of Occurrences
	Outreach	
44	Outreach Case Loads	1,173
	Case Management	
42	Case Load by Case Type	1,173
	Health Education	
51	Health Education Prenatal Clients that Received Services	1,354
	Depression Screening	
62	Depression Screening and High Risk Clients	866 Screened 212 High Risk/Positive
	Smoking Cessation	
55	Smoking Cessation Encounters	617
59	Second Hand Smoke Encounters	416
	Total reported occurrences	5,599

VII. Fetal and Infant Mortality Review (FIMR)

We do not have FIMR in our project area.

VIII. Products

A copy of any materials that were produced under the Healthy Start grant funding include accompany this report. Examples of products include but are not limited to the following: brochures, booklets, posters, videotapes, audiotapes, diskettes, and CDs. These items will go to the Maternal and Child Health Library, Resource and Reference Collection that is housed at Georgetown University.

Hard copies of materials produced by the program have been sent our Project Officer.

The materials produced include:

- Annual education calendars 2005-2008
- Healthy Start Brochure (English and Spanish)
- Sun Safety Brochure and Poster (English and Spanish)
- Early Prenatal Care Brochure and Flyer (English and Spanish)
- Las Estrellas Flyer
- Infant Mortality Flyers (English and Spanish)
- Smoking Cessation Flyers
- Home Visiting Services Handbill (English and Spanish)

IX. Project Data

Completed and submitted in HRSA's Electronic Hand Book (EHB)