Westside Healthy Start (WHS) is an MCHB grantee with a seven-year history of improving perinatal outcomes for West Side communities in Chicago, Illinois. Our target population consists of high-risk African American and Latina women and their infants, who in Chicago, experience significant disparities in health outcomes, including an infant mortality rate nearly double that of the White population. Program participants are afforded a complete continuum of care by WHS, ranging from direct health care services to mental health and substance abuse treatment.

Access Community Health Network (ACCESS), the fiscal agent for WHS, is a network of 45 freestanding federally qualified health centers located throughout Chicago and its surrounding suburbs. It is our mission to provide high-quality, safe and comprehensive primary and preventive care to anyone regardless of their ability to pay. We collaborate with neighboring community-based organizations to provide a cadre of enabling and supportive services through grant-funded programs such as WHS. ACCESS has partnered with seven organizations on the West Side to implement our WHS program for several years, including:

- Four community-based health centers, including Lawndale Christian Health Center, Mile Square Health Center, PCC Wellness Center, and Circle Family Care;
- The largest substance abuse treatment center in Chicago, Haymarket Center;
- An Early Intervention program, the University of Illinois Chicago’s Early Childhood and Family Intervention Program; and
- The Mount Sinai Hospital Psychiatric Department.

The past year yielded many accomplishments that improved and strengthened our program. ACCESS has succeeded in strengthening the infrastructure of WHS and its many women’s health programs, which are a primary focus of our 2004-2006 Strategic Plan. Our additions to this infrastructure include:

- New management level administrators and staff,
- A new evaluation team to upgrade our data collection and analysis (new contract pending MCHB approval),
- Initiatives to improve the quality of maternal child health services, and
- Updated policies to standardize service provision.

While WHS has continued to make progress toward our overall goals, we have struggled with several challenges along the way. Our major challenges during Calendar Years (CY) 2003 and 2004 were:

- The resignation of our Project Manager and Evaluator,
- The subsequent transition of program leadership and evaluation, and
- Bringing consistency to data collection activities for non-case managed participants.

In addition to frequent communication with our MCHB Project Officer regarding these challenges, we have worked closely with
partner organizations, senior management personnel and frontline staff to continually adapt and improve the WHS’ effectiveness. Despite this year’s adversities, our program successfully delivered direct patient care, enabling services and population-based services to hundreds of high-risk women and infants.

I. Overview of Racial and Ethnic Disparity
Westside Healthy Start serves the communities of Austin, West Garfield Park, East Garfield Park, and North Lawndale on Chicago’s far west side. Of a population of 198,412 (2000 Census), over 90 percent were non-Hispanic Blacks. Twenty-six percent of the population are women of childbearing age. Nine percent of the population consists of children less than five years of age, and 48 percent of children under the age of 18 are living in families with incomes below the federal poverty level.

The area is plagued by many of the social ills associated with poverty; homicide, HIV/AIDS, domestic violence, drug addiction, heart disease, cancer, and elevated lead screenings are all experienced at higher rates here than in Chicago as a whole. By many measures, the communities have among the lowest quality of life in the City. In each of the communities except Austin, the poverty rate is more than twice the city average.

Westside Healthy Start (WHS) has a history of improving perinatal outcomes for high-risk women and children living in four low-income community areas. Historically a predominately African American population, this area is also home to a smaller but growing Latino population. These four community areas experience significant disparities in health outcomes, including an infant mortality rate nearly double that of the white population. Healthy Start program participants receive comprehensive assessment and a complete continuum of care, ranging from direct health care services to mental health care and substance abuse treatment.

Table 1. Demographic Characteristics of Westside Healthy Start (WHS) Communities Compared to Chicago and US, Census 2000

<table>
<thead>
<tr>
<th></th>
<th>Austin</th>
<th>West Garfield Park</th>
<th>East Garfield Park</th>
<th>North Lawndale</th>
<th>WHS Project Area</th>
<th>Chicago</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>117,527</td>
<td>23,019</td>
<td>20,881</td>
<td>41,768</td>
<td>203,195</td>
<td>2,896,016</td>
<td>281,421,906</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaskan Native</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Asian</td>
<td>Black or African American</td>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>Caucasian</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------</td>
<td>---------------------------</td>
<td>-------------------------------------------</td>
<td>-----------</td>
<td>---------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1%</td>
<td>90%</td>
<td>0%</td>
<td>6%</td>
<td>3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>98%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>98%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>94%</td>
<td>0%</td>
<td>3%</td>
<td>3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4%</td>
<td>93%</td>
<td>0%</td>
<td>4%</td>
<td>2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4%</td>
<td>37%</td>
<td>0%</td>
<td>42%</td>
<td>16%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Hispanic or Latino</th>
<th>Not Hispanic or Latino</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4%</td>
<td>96%</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>1%</td>
<td>99%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>1%</td>
<td>99%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>5%</td>
<td>95%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>4%</td>
<td>96%</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>26%</td>
<td>74%</td>
<td>26%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Median HH Income ($)</th>
<th>33,663</th>
<th>23,121</th>
<th>24,216</th>
<th>18,342</th>
<th>24,836</th>
<th>38,625</th>
<th>41,994</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Poverty Rate b</td>
<td>26%</td>
<td>40%</td>
<td>37%</td>
<td>52%</td>
<td>34%</td>
<td>20%</td>
<td>12%</td>
</tr>
<tr>
<td>High School Graduates c</td>
<td>66%</td>
<td>58%</td>
<td>61%</td>
<td>60%</td>
<td>64%</td>
<td>72%</td>
<td>80%</td>
</tr>
<tr>
<td>Unemployment Rate d</td>
<td>17%</td>
<td>22%</td>
<td>23%</td>
<td>26%</td>
<td>20%</td>
<td>10%</td>
<td>6%</td>
</tr>
</tbody>
</table>

---

*a* Women of child bearing years are women between the ages of 15 and 44.

*b* Families poverty rate is the percent of children under the age of 18 in families with annual incomes below the federally defined poverty level in 1999.

*c* High school graduates are among those 25 years and older.

*d* Unemployment Rate is the percent of resident civilians over age 16 who are without work and actively seeking work.

The ACCESS mission is to provide high-quality, comprehensive primary and preventive care to all in need, regardless of ability to pay. ACCESS collaborates with neighboring community-based organizations and churches to provide health promotion and risk reduction interventions, including HIV prevention and breast and cervical cancer early detection. To help carry out its mission, ACCESS has been awarded numerous grants from HRSA, the Centers for Disease Control, SAMHSA, the State of Illinois and local philanthropies.
II. Project Implementation

a. Core Service:

*Outreach and Client Recruitment*

Westside Healthy Start targets residents of the four target community area who are: pregnant, interconceptual, or of reproductive age; women with infants under age two; women with infants under two at risk for developmental delay or with an identified delay; and family members of these women including fathers, partners, grandparents, siblings, other close relatives, and foster parents.

The male responsibility supervisor is a seasoned outreach manager who is a Hispanic male who speaks Spanish; he has one African American male responsibility coordinator reporting to him. They conduct both outreach and education.

*Westside Healthy Start outreach staff:*

- ACCESS outreach/peer educators, 2 fte, African American females, targeting all four community areas;
- ACCESS outreach/peer educator, 1 fte, on in-kind through Closing the Gap, African American female, targeting Austin (direct contract with Illinois Department of Human Services Title V agency);
- ACCESS male responsibility team, .5 fte supervising Hispanic male and 1 fte African American male, targeting all four community areas (see also their roles within [HE1-4]);
- Circle Family Care (subcontracting agency) outreach/peer educator, 1 fte, African American female, targeting Austin;
- Lawndale Christian Health Center (subcontracting agency) 1 fte, bi-lingual outreach/peer educator, Latina, targeting Hispanic population in target area, primarily Austin and North Lawndale.

*Outreach methods:*. The specific outreach modalities used were: street and community outreach including door-to-door canvassing, as well as outreach to local community groups with special emphasis on targeting of preschools, day care centers, block clubs, churches, and early intervention programs.

Westside Healthy Start outreach/peer educators also staffed health fairs and special events in the community, and helped community groups plan events that include a health education theme, drawing in other team members such as the nurse practitioner and nurse health educators as needed. Also, Westside Healthy Start outreach/peer educators targeted small businesses in which workers and their families are uninsured. For example, we worked with human resources to provide health education and KidCare (SCHIP) enrollment for families of a group of seasonal workers in Austin who are employed by a moving company.

Westside Healthy Start maintains several key relationships for targeting some of the hardest-to-reach and most at risk populations:

- **Very high risk/hard to reach**: ACCESS supports a midlevel provider on a legal, privately operated needle exchange van which parks in North Lawndale and in Austin one consistent half day each per week. Through this van and ACCESS staff on the van (a
collaboration funded in part by the city's public health department), Westside Healthy Start peer educator/outreach staff are able to build trust to link target area women who are injection drug users and/or sex workers to Westside Healthy Start. Pregnant women with addictions can be linked directly to residential treatment at Haymarket Center and to the ACCESS health center on site at Haymarket Center.

• **Low income uninsured workers:** Westside Healthy Start has a long-standing relationship with two unions and a community organizing entity representing uninsured homecare workers, the majority of whom are middle aged women who are becoming grandparents and are seeking a healthy start for their next generation. Our outreach/peer education staff will provide educational sessions to these workers at their union meetings to build relationships and keep them informed of Healthy Start opportunities.

• **Department of Corrections:** The Westside Healthy Start team visits the women's furlough program of the Cook County Department of Corrections on a monthly basis. The outreach/peer educators work to establish relationships of trust and nurse health educators and other staff provide health education on such topics as HIV prevention and substance abuse treatment.

• **Faith-based outreach:** ACCESS is engaged in two faith-based collaborations that take place in West Side churches—a breast and cervical cancer early detection program, and a diabetes education program. Because these programs reach many West Side women, we will use contact opportunities to introduce Westside Healthy Start outreach/peer educators into these churches in which we have established relationships.

All of our community outreach strategies aim to increase residents' awareness and name recognition of our program. Our educational or promotional literature contains the consistent Westside Healthy Start logo, which we have used for seven years, as well as information about program services and access points.

**Enrollment:** To enroll program and community participants, the outreach/peer education team used an attractive, 3 inch by 6 inch 4-ply referral form—one for the patient, one for the site, one for the community relations representative, one for the program director—as its primary mechanism for initial contact documentation. This form includes the peer outreach/peer educator's name and phone number which the program and community participants can retain for their own use should they want to initiate follow up.

**[OR1]. Recruitment and retention** Potential program and community participants are identified during outreach contacts and then referred to the appropriate health center for program enrollment. Our outreach/peer educators initiate new participant relationships with in the community, and follow up as needed: they may schedule an appointment for new program participants and may even meet them at the door of their first scheduled appointment if this seems to ease the way for the program participant.

Once a client enters the health center system for care, a physician and the ancillary staff conduct the patient visit and assess women to determine their case management needs. The enrollment process for program participants is as follows:

• Initial visit, including pregnancy confirmation if appropriate, and initial screening for risk by the medical provider and/or medical assistant;
Assignment to the appropriate case manager according to the level of risk determined by this screening—either a Chicago Family Case manager for lower risk clients, or a Healthy Start or Closing the Gap case manager for higher risk clients.

Enrollment by the case manager by completing the consent forms and conducting our intake assessment.

On occasion, a Chicago Family Case Manager may discover a level of risk through the intake assessment that was not detected during initial screening. In these cases, the program participant and family are immediately referred for intensive case management by a Healthy Start or Closing the Gap case manager.

**[OR2]. Program participant capacity:** The Westside Healthy Start program is staffed to enroll and serve 1300 to 1500 pregnant, postpartum and interconceptual program participants annually. The most significant limiting factor in the number of program participants to be served is case management capacity, and this capacity is determined by program space as well as by program budget.

Our experience shows that we currently enroll 55.5% of pregnant women in their first trimester, and our goal is to move this to 70% over the five years of the program. Currently about 35% enter in their second trimester and 10% in their third trimester; in part, these rates reflect the very hard to reach women we are engaging, including women with addictions who are frequently isolated from traditional systems of care.

If faced with an influx of pregnant and interconceptual women and infants, our response would be as follows:

- we can add provider capacity at ACCESS; with 160 current medical providers at 43 sites, we can add sessions of medical care to meet demand across our system;
- similarly, we can engage additional licensed clinical social work, psychiatry and developmental pediatrics capacity as needed through the ACCESS and Mount Sinai networks;
- we can program more group visits than individual sessions to maximize health education;
- we can contract for additional nutritionist time as a reasonable cost.

We have some flexibility with case management case loads which we calculate based on a range, to accommodate month-to-month variations in program participant volume and intensity of service need.

**[OR3]. Client retention.** Our Local Health System Action Plan (LHSAP) which guides our program design is driven by the goal of meeting the needs that clients identify to keep them engaged in our program.

- Case managers collaboratively create care plans with their clients to stimulate ownership and commitment to the plan and its required actions,
- Health educators encourage clients to participate in designing the education curriculum for their group, and
- Program and community participants have regular contact with peer workers (outreach/peer educators, male responsibility staff, peer lactation counselors) who can provide peer support for maintaining a focus on a healthy birth process.
Further, retention is supported by enabling services provided by the case managers including:

- Bus tokens to return for care;
- A bonded and insured car transportation service to transport patients to the health center in high risk situations; and
- Limited funds for emergency child care.

**Incentives.** The Consortium traditionally attracts product donations (for example, Mrs. Dash seasonings and recipes, beauty products etc) that in turn serve as incentives for consortium meeting and consumer conference participation.

**Faith and community messages.** Westside Healthy Start maintains relationships in the community that also help support client retention including faith based relationships which send a powerful message of endorsement for promoting health births. The local print and radio media campaign also support client retention.

**[OR4]. Training and supervision.** Outreach/peer educators report to the Westside Healthy Start program director. The male responsibility staff reports to a supervisor who has Healthy Start experience; he, in turn, reports to the Westside Healthy Start program director.

Outreach/peer educators have a formal educational program shared with case managers and peer lactation counselors with five program elements: perinatal health, smoking cessation, substance abuse treatment linkage, SIDS and interconceptual care including depression and other mental health issues. In addition, outreach/peer educators receive education by attending Consortium meetings Town Hall meetings in the target community, and the consumer conference. As full members of the Westside Healthy Start team, they derive educational benefits from attending team meetings at the individual health center sites.

Also, the ACCESS outreach/peer educators attends regular meetings and retreats of the larger ACCESS community affairs group which offers collegial support for best practice implementation, community safety, and process improvement for a group of ten outreach workers working throughout a two-county area.

**[OR5]. Coordination and integration** Outreach is the glue that binds program and community participants with the core services of Westside Healthy Start. Their communication and coordination with case managers and health educators is essential to the success of our clients and our program.

Outreach activities, including the following, are complementary to the other core services in numerous ways:

- Conducting informal community needs assessments to catalog assets and service gaps while working in the community,
- Identifying potential program participants,
- Recruiting participants for different levels of service, such as prenatal, interconceptional, and community participants,
• Building relationships with community participants, agencies, organizations and churches that have an investment in healthy births in the community, and
• Following up with case managed clients about compliance issues, and accompanying case managers on home visits as needed.

The outreach/peer educators, as mentioned, are full members of the program team and of their local health center site teams.

Key relationships in the community include: day care centers, small businesses, churches, the park district, substance abuse treatment agencies, the needle exchange van, the correctional furlough program, and local centers of activity such as beauty parlors, currency exchanges, and laundromats. These relationships are maintained through direct face-to-face contact between our outreach/peer educators and key pastors, local owners and directors of these venues. Our outreach/peer educators leave behind flyers, brochures, and small tokens such as key chains as appropriate to reinforce the Westside Healthy Start message.

b. Case Management
Case management has continued to be a highly important core service for our participants. Case managers assess families and track their progress and outcomes throughout the length of their enrollment in Westside Healthy Start. They are the most important resource in helping program participants design and carry out their own care plan, receiving adequate prenatal and interconceptual care.

[CM1]. Services and multi-level risk management: The case managers practice the following activities in their scope of work:
• Administering the intake assessment at the initiation of enrollment,
• Creating a care plan for the mother and infant through a client-centered participatory process,
• Providing monthly assessments of physical, mental and psychosocial functioning,
• Following up with clients to ensure program compliance,
• Educating clients about perinatal health and risky behaviors, and
• Documenting and following up with referrals to various social services that will improve their clients’ lives.

Three levels of case manager care for women in the program: Chicago Family case managers who participate in-kind and follow 125 to 150 low risk clients; Healthy Start case managers with caseloads of 40 to 60 clients each; and Closing the Gap and high intensity case managers who participate in kind to follow 20 clients each.

All Healthy Start case managers are bachelors prepared. They receive a common Healthy Start educational curriculum described in a later section. Two (ACCESS/Kling and Lawndale Christian) are bicultural and bilingual. All of the case management staff have several years of experience serving clients and families in West Side communities.

[CM2]. Risk assessment and follow up schedule: Case managers initiate monthly, face-to-face contact with high-risk clients of all types. The first contact is scheduled within 72 hours of an eligible client enrolling in a Westside Healthy Start health center.
As often as possible, medical and case management appointments are coordinated so they occur at the health center on the same day for our client’s convenience. Home visits and other contacts are made more often as required by the needs of a particular client.

**Typical Pregnant High-Risk Client:** Face-to-face case management contact is monthly; medical contact is according to the medical provider’s plan. Home visits are completed quarterly or more frequently as needed. The case manager works with the program participant to schedule at least four monthly education sessions.

**Typical Postpartum/Interconceptional Client:** Face-to-face case management contact is monthly for high-risk clients and bimonthly for low-risk clients. Medical contact is according to the medical provider’s plan. Home visits are as needed. The case manager works with the program participant to schedule at least ten monthly education sessions.

**Infants and Toddlers:** Face-to-face case management contact is monthly, beginning with an infant risk screening (Ages and Stages); medical contact is according to the medical provider’s plan. Home visits are as needed.

**[CM3]. Client involvement in care plan** Developing, executing and monitoring a client’s care plan is the joint responsibility of the program participant, the case manager and other program staff included in the plan. During their initial appointments, women work to develop the plan with the case manager, frequently drawing on input from family members who are present. All clients must sign their care plan which in turn becomes part of the medical chart.

To the extent possible, Healthy Start screening and behavioral change interventions are interactive, with screening forms that cue members of the care team to work directly with their patients to determine a course of treatment. For example, interventions to promote smoking cessation follow a flexible, interactive screening protocol, allowing the client to determine how and when to initiate and maintain behavior change, whether directed by the case manager, health educator, social worker, midwife or physician.

**[CM.4]. Case conferences** Case conferences are used to facilitate the management of care among various service components for specific clients with more intense needs. They also provide a forum for focused communication about client and staff needs for providing services to those clients.

*End-of-session:* Brief case reviews are typically lead by the obstetrician/gynecologist at the end of the obstetrical session. In the sites that have training programs (ACCESS/Kling and ACCESS/Madison), these end-of-session reviews are supplemented by weekly Friday morning conferences covering selected cases from the prior week, including but not limited to Healthy Start cases.

*Monthly case conferences:* In addition, on a monthly basis, the extended Westside Healthy Start team reviews case studies with an emphasis on risk management for women with medical and psychosocial complications that require team analysis to set a direction for care management. Case managers typically refer cases for review.
The purposes of these case conferences are to: discuss programmatic issues, receive peer consultation and supervision regarding patient care, discuss follow-up activities with outreach workers, and receive education about perinatal health topics and effective practice techniques.

*Medical provider colloquia and case reviews*: For Healthy Start medical providers in the ACCESS network, our women's health medical director convenes monthly case conference meetings to discuss medical management issues.

**[CM5]. Barriers to care.** Our target population experiences cultural barriers such as stigma and distrust of the medical and public service establishment. In particular, clients with substance use disorders, or a history of incarceration, or who survive as sex workers, and/or who have had a child taken from them by the child welfare system are frequently reluctant to engage in new relationships with health care workers and medical providers. Among Hispanic clients we see a widespread reluctance to talk about their immigration status. Westside Healthy Start not only provides outreach to these hard-to-reach women and their families, but also makes every effort to provide a comprehensive continuum of perinatal care either directly or through subcontract to guarantee access to our clients and expedite their entry into services.

One of the ways we address these barriers is through the consistent presence of our outreach team in the community, serving as peer outreach/health educators. We have also engaged peer lactation counselors. The use of "peer" personnel mediates some of the boundaries between our program and the lives of our program participants in the community. A further summary of practices designed to mitigate barriers is as follows.

### Barriers to Care and Westside Healthy Start Response

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Westside Healthy Start Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>Case managers provide bus tokens; leased, bonded and insured transport is available in high risk situations at the case manager's discretion.</td>
</tr>
<tr>
<td>Shortage of social services</td>
<td>Case management and licensed clinical social work available</td>
</tr>
<tr>
<td>Substance abuse treatment slots for pregnant women is limited</td>
<td>Westside Healthy Start has priority admission to Haymarket Center and strong relationships with other treatment facilities; access to treatment is not a barrier for our clients</td>
</tr>
<tr>
<td>Stigma, mistrust</td>
<td>Westside Healthy Start recruits staff who are from or familiar with the local community who view the program as an important part of community building. Our policies and procedures, as reflected in our practices, emphasize safety and confidentiality. Our visibility locally increases trust. Our outreach/peer educators go to locales to build trust with and engage very hard to reach patients.</td>
</tr>
<tr>
<td>Language</td>
<td>Two of our sites have bi-lingual, bi-cultural staff which is critical for the small minority of Westside Healthy Start patients who are Mexican and Mexican American.</td>
</tr>
</tbody>
</table>
Citizenship

Westside Healthy Start accepts all patients regardless of nationality, citizenship, clinical presentation, public aid eligibility and ability to pay.

Gender relations

Men frequently lack peer support and role models for supporting their pregnant partners and newborns; the male responsibility and health education programs are designed to reach out to men and help them connect to our systems of care.

[CM6]. **Completion of referrals**: Case managers follow-up with clients and the referral agency to ensure that appointments are kept, and that care is provided and services are coordinated. This information is documented in case notes, copied to the medical chart and tracked in the Westside Healthy Start database.

One of the advantages of including Haymarket Center as one of the Westside Healthy Start subcontractors is that their two case managers track and report back compliance with the follow up care of Healthy Start patients referred to them.

The Chicago Family Case Management system requires all case management data to be entered into Cornerstone, which is the state's case management database for this program. Westside Healthy Start sites are in full compliance with data entry requirements for Chicago Family Case Management.

A summary of case management tracking forms and systems is as follows:

<table>
<thead>
<tr>
<th>Form</th>
<th>When to complete</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal information form</td>
<td>At intake and after every contact</td>
<td>For efficient tracking of follow up activities, to indicate when follow up is needed</td>
</tr>
<tr>
<td>Medical record, case management section</td>
<td>At intake and after every contact</td>
<td>For communication with the rest of the team regarding case management milestones</td>
</tr>
<tr>
<td>Monthly statistical report</td>
<td>Due 7th working day of the month</td>
<td>To track program outcomes</td>
</tr>
<tr>
<td>Prenatal and interconceptual class attendance logs</td>
<td>Collected at health education classes and due monthly</td>
<td>To document receipt of services</td>
</tr>
<tr>
<td>Transportation log</td>
<td>Updated as clients receive services</td>
<td>To document use of transportation services and to assure fiscal management of transportation budget</td>
</tr>
<tr>
<td>Case managers schedule</td>
<td>Weekly</td>
<td>Tracking and accountability for staff serving multiple sites</td>
</tr>
</tbody>
</table>
Case management activities are audited by the program director with assistance from the local health center site manager through chart review and observation. Chart audits for case management include assurance that all contacts are documented as required and are appropriate for the stage and risk status of the client; and that referrals are documented and tracked; and that appropriate screenings are conducted.

[CM7]. Established guidelines Adequacy of prenatal care is measured using the Kotelchuck guideline, which measures gestational age against the ratio of actual prenatal visits and expected prenatal visits.

HIV counseling is within the scope of service for our case managers. If high intensity counseling is required to help the client, a referral will be made to one of our on-staff mental health providers. Medical providers at the Westside Healthy Start sites will administer an HIV test when requested by a case manager or the client.

Westside Healthy Start providers have extensive experience with HIV and with prevention. ACCESS receives Title I, II (through the AIDS Foundation of Chicago), III and IV funds to care for patients with HIV; ACCESS also recently initiated rapid testing at two sites in direct collaboration with the Centers for Disease Control. ACCESS currently administers the Sista Program through a cooperative agreement with the Centers for Disease Control; this program will begin to serve the Department of Corrections Women's Furlough Program bringing an HIV prevention and risk reduction strategy to this high risk group which will also be served as needed by Westside Healthy Start.

[CM8] Medical home. Ten of the eleven Westside Healthy Start sites serve as a medical home for their patients of all ages and their families. The eleventh, the James West Health Center at Haymarket Center, serves as a medical home while patients are in treatment which can be of nearly two years in duration if needed. However, when patients leave Haymarket Center, the Healthy Start case managers link them to a community health center in their home neighborhoods. More of their residential clients are from the West Side than any other area.

Community health centers. The community health centers that anchor Westside Healthy Start are all fully equipped to provide a medical home to patients, with linkage to a consistent medical provider. Patients who can schedule and keep appointments have all the advantages of office-based care with a consistent provider. While the health centers also accept walk-in patients to accommodate as diverse a population as possible and to address the greatest amount of need. However, all patients are encouraged to maintain a consistent relationship with their medical provider by scheduling and keeping their appointments.

Coordination with hospitals. To the extent possible, our obstetrician/gynecologists manage their own deliveries, primarily at Mount Sinai Hospital and also at West Suburban Hospital. While Westside Healthy Start has made strides in forwarding perinatal information for delivery, and in turn, forwarding the birth record to become part of the infant's medical record, strengthening these systems will take further work by the program director. We have succeeded, however, at Mount Sinai Hospital, in scheduling prior to discharge both pediatric and postnatal maternity follow up appointments at the referring community health center.
Aggregated community-based services. When possible, we provide as many services at one location as can be arranged. Case management, health education, nutrition, lactation counseling, social work and psychiatrist are all schedule to coincide with obstetrics sessions. Typically, for interconceptual and pediatric care, both the mother and infant can be seen in the same clinic, in some cases by the same family practitioner and on the same day.

Enabling services that facilitate attachment to a medical home include:

- Outreach,
- Case management,
- Home visiting,
- Prenatal and parenting education,
- Male responsibility program,
- Breastfeeding and childbirth education,
- Nutrition counseling,
- Tour of the hospital prior to delivery,
- Benefits counseling and enrollment,
- Public transportation fare cards and transportation service when needed,
- Mental health services including psychiatry,
- Care for the whole family on site,
- Culturally and linguistically competent providers and services.

Care Coordination for Substance Abusing Women- Case Managers play an integral role in closing the gaps in care, for they act as social service brokers, liaisons between organizations and coordinators of various types of care provided to an individual client.

Over several years, we have maintained our efforts to coordinate care for substance abusing women. One full time case manager at ACCESS’ Madison Family Health Center is acting as the care coordinator between prenatal care providers and Family Guidance Center, a co-located methadone maintenance facility. This case manager functions as the primary liaison regarding all care issues for clients receiving perinatal services and drug treatment through Westside Healthy Start.

Haymarket Center also has two full-time case managers to perform similar duties at their treatment facility, one of whom is specifically assigned to the Maternal Addiction Center (MAC). The MAC is comprised of two units with 16 beds each. The program also accommodates up to two children between birth and four years of age. Parenting women with newborns and/or children up to age four are eligible for a 60-90 day treatment program and necessary supportive services at the Haymarket Maryville facility.
**Barriers.** Barriers to linkage to a medical home include the very high mobility rate of our urban population, poverty and unemployment, and community safety concerns. The communities in our service area are federally designated Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPs) and Health Professional Shortage Areas (HPSAs). Welfare reform has caused many recipients to lose or have reduced Medicaid benefits.

Barriers such as substance use and stigma are described in the section above. The span and location of our service network is designed to help make Westside Healthy Start as accessible to West Side residents as possible.

**[CM10] Supervision and training for case managers:** Case managers receive ongoing supervision from the Program Director and the local site managers to assure that they are following protocols for client retention, education, referral and risk reduction. Westside Healthy Start provides ongoing training for case managers to supplement the supervision they receive relative to program expectations. These trainings are scheduled to accommodate all of the Healthy Start case managers as well as the in-kind case managers integrated into the program.

Trainings for case managers at minimum covers the identification and management of clients focusing on the following risk factors:

- Depression
- Substance abuse
- HIV, STDs, other infections
- Smoking
- Multiple diagnoses.

In addition, trainings for the entire team including outreach/peer educators, male responsibility team, and peer lactation counselors will be scheduled on an ongoing basis taking advantage of opportunities and availability of guest speakers within Chicago as well as using our own curricula. During the past two years, for example, the following topics were covered during training sessions:

- Breastfeeding,
- KidCare (Title XXI) and Medicaid Presumptive Eligibility (MPE) enrollment,
- Rape Counseling,
- Domestic Violence,
- Perinatal Depression,
- Homelessness and its effects,
- Sexually Transmitted Infections,
- SIDS prevention, and
- Using data collection to make case management services more responsive to clients’ issues.
[CM11] Other case management programs. The integration of the two Closing the Gap case managers at ACCESS in Austin and the high intensity case manager at Lawndale Christian in North Lawndale have been described above. These three case managers follow 20 clients each.

Further, this narrative has already summarized the integration of the five Chicago Family Case Managers into Westside Healthy Start (3 at ACCESS, 1 at Circle Family Care, 1 at Lawndale Christian). These five case managers follow 125 to 150 low risk clients each.

Both of these programs are funded through contracts with the Illinois Department of Human Services Title V agency; this agency collects contact and client data using the Cornerstone system, an electronic database installed at all participating sites.

The Office of Adolescent Pregnancy Programs supports a demonstration at several ACCESS south side health centers, providing case management to 160 pregnant youth. We have applied to the Centers for Disease Control for research funds to study a similar model at ACCESS/Kling in North Lawndale.

The purpose of these case management programs are similar to those of Healthy Start:
- The reduction of infant mortality for program participants,
- Early entry into prenatal care,
- Assuring client compliance with prenatal care visits, well child visits and infant immunizations, and
- Assistance with issues such as transportation and childcare, and
- Establishing support systems.

In addition to these maternal and child health case managers, ACCESS and Lawndale Christian each employ HIV case managers on the West Side through direct and subcontractual Ryan White funds. ACCESS provides primary health care for over 300 clients with HIV, each of whom receive case management and psychosocial services. Over one third live on the West Side.

[Registry: The ACCESS 2004 to 2006 strategic plan adopted by our board of directors calls for continuing improvement of perinatal care management supported by information technology. In Calendar Year 1, Westside Healthy Start will complete the planning and begin the implementation of an electronic patient care registry. The use of patient care registries is a central component of future direction for care management across the ACCESS network.

When Westside Healthy Start first sought to use electronic systems for data collection seven years ago, we chose to collect data on Microsoft Access and Excel programs on laptops used by case managers. Although this was the affordable state-of-the-art seven years ago, this remains a clumsy way to collect data because it required a second analyst to integrate the data which is more labor intensive than need be, given advances in network based systems. Further, the tables that Westside Healthy Start uses for data collection have been revised from year to year, making multi-year analysis particularly cumbersome.
In the project year ahead, we plan to engage Amethyst, a consulting group that has designed the ACCESS internet and intranet programs, to create a web-enabled, network-based patient care and case-management registry that all sites and subcontractors can use to build and analyze a common body of information.

c. Health education

Westside Healthy Start offers a comprehensive array of education topics that are individually tailored to fulfill the education needs of each program participant. Health education is provided individually and in groups to 1) pregnant and postpartum program participants, 2) Consortium members and community participants, and 3) staff and providers.

Health education takes many forms in the Westside Healthy Start program. Clients learn about perinatal health, the birthing process, parenting, taking care of their families and planning for the future. Education occurs on individual and group levels with outreach/peer educators, case managers, clinical educators, nutritionists, nurse practitioners and peer lactation counselors. In the community, the male responsibility program addresses the education needs of male partners and spouses, and the town hall meetings, Consortium activities and regional consumer conferences provide additional forums for community education.

An important part of the education process is an understanding of where the audience needs to begin and what they want to learn about. Westside Healthy Start engages clients in planning their educational experience by conducting a brief assessment of clients’ learning needs and desired outcomes at the beginning of each encounter.

Westside Healthy Start education services are conducted in a linguistically and culturally appropriate manner. Clients are also provided with extensive education materials geared to a grade school literacy level in either English or Spanish.

ACCESS is a learning organization that has invested considerable resources in physician and staff education. Two of the Westside Healthy Start sites train residents (Madison is the family practice residency site, and Kling is the teaching site for the pediatrics and the obstetrics and gynecology residencies of Mount Sinai Hospital). Staff receive education on numerous topics every year; informed staff who are knowledgeable about current health trends and research are critical to the program.

Known as an organization that invests in on-site professional development to enhance staff practice skills, ACCESS was recently chosen by JCAHO as a demonstration site to create a training film on the use of their new tracer methodology for their ambulatory care surveys. Recently, the American Medical Association returned to ACCESS to make a second round of training films in which our medical providers demonstrate competence in racially and ethnically sensitive communications with patients.
**Methods for program participant education.** All Westside Healthy Start health education activities for program participants are facilitated by program staff. At ACCESS, clinical nurse educators provide individual and prenatal and parenting education. Peer lactation counselors provide individual and group childbirth and breastfeeding education. Nutritionists supplement this education with information on healthy diets in the context of food readily available in the neighborhood. Case managers provide education and support to clients on an individual basis to reduce risk behaviors.

Each of the subcontracting community health center partners provides education services for their clients through nurse educators, case managers and outreach/peer educators. The partners do not currently employ to provide those services.

Our education curriculum is translated and offered in Spanish at sites where some patients may be monolingual Spanish speakers. Packets of education materials are distributed to all clients in either English or Spanish, depending on their preferred language. All education activities are documented in the patient’s medical record.

**Health education team and program participants.** The medical providers are drivers of the individual health education provided to all 1300 to 1500 program participants. Other members of the education team will focus on those high risk patients followed by the Healthy Start case managers and the high intensity in-kind case managers.

The educator team consists of: Outreach/peer educators, Case managers, Nurse educators, Nurse practitioner, Nutritionist, Peer lactation counselors, and Male responsibility team.

All of the high risk women will receive group education, along with family members as appropriate. Individual education can be offered as directed by the medical provider; this can include home visiting by the appropriate team members as needed. We anticipate reaching 500 to 600 high risk women through this effort. The education groups will welcome low risk pregnant women and their interested family members as space allows.

**Education for pregnant program participants and supportive family members.** Nurse educators provide prenatal and parenting education to pregnant clients using our MCHB-approved curriculum. In response to patient feedback, we have recently reformatted our education classes to incorporate multiple modules into one session, therefore reducing the number of total classes from ten to four. Many patients were unable to attend ten sessions and expressed a preference for fewer but longer classes.

The table that follows provides a general overview of the content of our prenatal education modules. The classes are sequenced as follows:

- Class one and two are recommended for the first and second trimesters, and
- Class three and four are recommended in the third trimester.
## Prenatal/Parenting Class Modules

<table>
<thead>
<tr>
<th>Class/Module</th>
<th>Time</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1: Pregnancy Changes and Preventing Complications</td>
<td>2 hours</td>
<td>Process of conception and prenatal visits</td>
</tr>
<tr>
<td>Module 1:</td>
<td>30 minutes</td>
<td>Body changes and common discomforts</td>
</tr>
<tr>
<td>Module 2:</td>
<td>30 minutes</td>
<td>Health and safety (risk reduction)</td>
</tr>
<tr>
<td>Module 3:</td>
<td>30 minutes</td>
<td>Danger signs of pregnancy/preterm labor</td>
</tr>
<tr>
<td>Class 2: Relaxation/Breathing and Nutrition</td>
<td>2 hours</td>
<td></td>
</tr>
<tr>
<td>Module 5:</td>
<td>60 minutes</td>
<td>Breathing and relaxation</td>
</tr>
<tr>
<td>Module 6:</td>
<td>30 minutes</td>
<td>Nutrition during pregnancy</td>
</tr>
<tr>
<td>Module 7:</td>
<td>30 minutes</td>
<td>Health and safety (exercise, sleep and hygiene)</td>
</tr>
<tr>
<td>Class 3: Labor and Delivery</td>
<td>2 hours</td>
<td></td>
</tr>
<tr>
<td>Module 8:</td>
<td>90 minutes</td>
<td>Labor and delivery</td>
</tr>
<tr>
<td>Module 9:</td>
<td>30 minutes</td>
<td>Family planning and birth control</td>
</tr>
<tr>
<td>Class 4: Newborn Care and Postpartum Care</td>
<td>2 hours</td>
<td></td>
</tr>
<tr>
<td>Module 10:</td>
<td>30 minutes</td>
<td>Maternal needs postpartum</td>
</tr>
<tr>
<td>Module 11:</td>
<td>30 minutes</td>
<td>Newborn care &amp; &quot;back to sleep&quot;</td>
</tr>
<tr>
<td>Module 12:</td>
<td>60 minutes</td>
<td>Parenting</td>
</tr>
</tbody>
</table>

**Peer education by outreach staff.** Outreach/peer educators begin the client education process in course of the first contact in the community. They listen to concerns about health, barriers, fears and hopes, and respond as needed with educated messages that help attach potential program participants to a medical home within Westside Healthy Start.

**Peer education by lactation counselors:** The peer lactation counselors provide education in the prenatal period about the multiple benefits that breastfeeding provides to both the infant and mother and they answer any questions that a mother has about pregnancy and childbirth. The childbirth education classes that they offer are very popular and well attended. These peer counselors also follow their clients to Mount Sinai Hospital to support women and their newborns with breastfeeding, and can make post partum home visits as needed.

Our peer lactation counselors have been cross-trained as doulas. For high risk patients who need extra support during the birth process, such as young mothers who lack family support or for those with multiple medical problems, the peer lactation counselor may make home visits prior to the birth, and may attend the birth if the desired and needed by the patient.
Male responsibility: Next project year, we will be adopting a male responsibility program developed, refined and implemented by another of the Illinois grantees, the South Side Health Consortium. We will contract with them to train our male responsibility supervisor and staff member to use this curriculum with which they have had so much success with males on the South Side. Based on this train-the-trainer transfer of knowledge, we will implement their curriculum for male partners and spouses in our program.

The male responsibility program spans the prenatal and interconceptual periods. Group and individual educational contacts will be offered to program participants on site at the health centers as well as in the community at health fairs, town hall meetings, the Consumer conference, and in the course of street and community outreach.

Postpartum/Interconceptional program participant education. Education on postpartum care is provided by nurse educators through our Prenatal/Parenting Education Modules in Class 4, which participants attend prior to delivery. After the delivery of the baby, the case manager, accompanied by other team members as needed, completes a home visit to determine a mother’s needs, answer questions about the feeding process, and ensure that mothers experience as few problems as possible that might deter a healthy start. Case managers monitor the comfort of the patient with feeding and the bonding of the mother and child through home visits, face-to-face health center encounters and regular phone calls.

The interconceptual care education curriculum consists of ten classes intended to support program participants as young parents. The classes also support women and their spouses or partners to make informed family planning choices and to maintain their own health.

Case managers and nurse health educators will facilitate a monthly support and education session (repeated at an alternative time for participants’ convenience), including the following sessions:

- Stress Management/Relaxation/Nutrition
- Career Planning
- Financial Planning/Budget
- Working and Taking Care of the Home
- Male and Female Relationships (2 sessions)
- Family Planning
- Mom/Dad/Family: Future Directions (2 sessions)
- Male Responsibility/Nutrition for Moms
- Graduation

Many of these topics were selected by the Consortium and by former program participants; the topics may be further modified, or even expanded, based on program participant input.
Sista. Selected high risk interconceptual African American women can receive interconceptual group support from our Sista project, a Centers for Disease Control cooperative agreement that provides guided peer opportunities for women in recovery, who have a history of incarceration, and other behavioral risks. The program emphasizes HIV prevention and risk reduction. Program participants meet at the ACCESS/Madison Family Health Center.

Risk behaviors: The medical providers and the case managers provides individual screening, testing and individual risk reduction education for program participants in areas of HIV and STD counseling and testing, substance abuse, and domestic violence.

[HE2] Subcontracting educators. Program and community participants received some education from subcontracted speakers at Consortium meetings, at our town hall meetings, and at our regional consumer conference. Clients were asked to sign in and/or register; at large meetings, product donation incentives are dispensed when the client registers or signs in. Sign up logs are maintained by the program director and the local evaluator.

[HE3] Community participant health education. Community health education is delivered through outreach/peer educator and male responsibility team contacts with individuals and groups, Consortium meetings, town hall meetings, and the consumer conference.

Health fairs and other community events: The outreach/peer educators team arranges for other team members to accompany them to health fairs, small business events, day care centers and other locations where small presentations to groups and screenings for individuals are welcomed. Arrangements for these contacts are driven by the outreach/peer educators team in response to local interest and need.

Consortium: Every Consortium meeting includes time to discuss health concerns raised by community participants, so many topics are covered on an as-needed basis. In the past, the Westside Healthy Start Consortium has identified the following topics for study: Child Safety, Health, Housing, Education and Welfare Reform on the West Side, Parent and Child Bonding, Healthy Interpersonal Relationships, Parent Rights, and Toy Safety. These topics will be interspersed with community-oriented topics that relate to the overall Healthy Start educational plan: smoking cessation; HIV and STD prevention and early identification; substance abuse prevention, treatment and recovery; and "back to sleep." Educational content will be provided by staff as well as outside guest speakers identified and engaged by the Consortium coordinator.

d. Interconceptual care

[IC1] Services and staffing model. The Westside Healthy Start interconceptual care model consists of ongoing care by our medical and mental health providers for women and their infants, case management by the Healthy Start case managers and the in-kind high intensity case managers, developmental screening and follow up for infants, and health education including an ongoing male responsibility component. We provide this array of services to both lengthen the interconceptional interval and to address the families’ health care needs, reduce risk and mitigate barriers.
Contact for interconceptual care is driven by the medical care plan for each mother and child, and will include at minimum:

- All of the medical and mental health care needed by each post partum woman;
- All of the well-child visits, including immunizations, according to the schedule recommended by the American Academy of Pediatrics;
- A developmental screening for the infant and follow up by a consulting developmental pediatrician if needed;
- Monthly face-to-face contacts with the case manager for higher risk program participants, and alternate month face-to-face contacts with the case manager for lower risk program participants;
- Ten educational sessions and peer lactation counseling support as needed; and
- Home safety assessment and additional home visits as needed in risk situations.

The case management plan for high risk post partum women is as follows:

<table>
<thead>
<tr>
<th>Contact</th>
<th>Where/Type Contact should occur?</th>
<th>Activity</th>
<th>Forms to complete**</th>
<th>Materials to distribute</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 wks PP</td>
<td>Clinic or clients home</td>
<td>1. Discuss Child Care, Family                                    1. New Care Plan</td>
<td>1. Infant Guide</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Planning, Breastfeeding (if applicable)                        2. Service Referral as needed                                                       2. Referrals as needed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Discuss interconceptual care program &amp; Workshops               3. Interconceptional Care log                                                      3. Congratulations letter &amp; gift</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Follow-up on Birth information &amp; Immunization Information      4. Complete birth information &amp; Post partum Info in Perinatal log &amp; Medical Record</td>
<td>5. Edinburgh Screen</td>
<td></td>
</tr>
<tr>
<td>Contact</td>
<td>Where/Type Contact should occur?</td>
<td>Activity</td>
<td>Forms to complete**</td>
<td>Materials to distribute</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------------</td>
<td>----------</td>
<td>---------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>4 month</td>
<td>Clients home</td>
<td>mother</td>
<td>abstraction</td>
<td></td>
</tr>
</tbody>
</table>
|         |                                 | 1. Enroll mom in Interconceptional care workshops  
|         |                                 | 2. Follow-up on Birth information & Immunization Information  
|         |                                 | 3. Discuss career goal and future planning  
|         |                                 | 4. Perform developmental assessment  | 1. Developmental Screening  
|         |                                 | 2. Home safety Checklist  
|         |                                 | 3. Tickler  
|         |                                 | 4. Anticipatory Guidance 4mos  
|         |                                 | 5. Edinburgh Screen  | 1. Infant Guide for 4 month  
|         |                                 | 2. Home safety checklist  |
| 6 month | Clinic or home                  | 1. Follow-up on immunization information.  
|         |                                 | 2. Follow-up, educate on risk behaviors  
|         |                                 | 3. Discuss nutrition & budgeting  
|         |                                 | 4. Discuss Career planning & goals  
|         |                                 | 5. Home Infant safety Review  
|         |                                 | 6. Re-assess  | 1. Developmental Screening  
|         |                                 | 2. Tickler  
|         |                                 | 3. Anticipatory Guidance 6mos  
|         |                                 | 1. Revise care plan if indicated  
<p>|         |                                 | 2. 6 month Abstraction  | 1. Infant Guide for 6 month  |</p>
<table>
<thead>
<tr>
<th>Contact</th>
<th>Where/Type Contact should occur?</th>
<th>Activity</th>
<th>Forms to complete**</th>
<th>Materials to distribute</th>
</tr>
</thead>
</table>
| Family Planning method and participants use | 9th month Clinic or Home | 1. Address Client issues & concern.  
2. Conduct Developmental Screening on infant  
3. Follow-up on Immunization Information | 1. Developmental Screening  
2. Tickler  
3. Revise care plan if indicated  
4. Behavioral Change Form  
5. Anticipatory Guidance-9 mos. | 1. Infant Guide |
| Home or office | 12th month Home or office | 1. Address Client issues & concern.  
2. Conduct Developmental Screening on infant  
3. Follow-up on Immunization Information | 1. Developmental Screening  
2. Tickler  
3. Revise care plan if indicated  
4. Risk Assessment  
5. Anticipatory Guidance-12mos  
6. 12 month abstraction | 1. Happy Birthday Card  
2. Infant Guide |
| Clinic or Home | 15th month Clinic or Home | 1. Address Client issues & concern.  
2. Conduct Development | 1. Developmental screen  
2. Tickler | 1. Happy Birthday Letter  
2. Copy of Case Closure forms.  
3. Referral forms as |
<table>
<thead>
<tr>
<th>Contact</th>
<th>Where/Type Contact should occur?</th>
<th>Activity</th>
<th>Forms to complete**</th>
<th>Materials to distribute</th>
</tr>
</thead>
</table>

*Italicics* indicate forms for evaluator

**IC.2** Tracking and assurance of a medical home. Interconceptual care for both women and infants ideally occurs at the same medical home established for them during prenatal visits. Every effort was made to ensure that the health center is the client’s ongoing medical home in the interconceptional period and beyond. Services that mitigate financial barriers, such as on-site benefits counseling and enrollment in Medicaid, ease the process of securing a medical home for our clients.

A new Illinois regulation allows the community health centers to be reimbursed for pregnant women to make an anticipatory guidance visit to their future pediatrician which in turn helps facilitate linkage back to this pediatrician at the community health center "medical home" post delivery.
As indicated earlier, the first appointments for interconceptual care for the women and infant are typically scheduled by the hospital after delivery, prior to discharge from the hospital. Because most mothers choose their community health center as their medical home, infants also have a medical home there. Our on-site benefits counseling program also facilitates enrollment in aid programs that service infants, such as WIC and KidCare (Illinois SCHIP program). Helping families obtain resources to access medical care helps them use the care available to them at their health center. The same enabling services already described for pregnant women (transportation services and tokens, emergency child care) are available for interconceptual care program participants.

Case managers are responsible for:

- Pursuing monthly contact with their clients to ensure well-being and compliance with all scheduled prenatal and postpartum visits
- Monitoring their clients’ medical charts and adherence to medical recommendations,
- Assuring that clients get all Healthy Start resources as needed including lactation counseling, nutrition counseling, education, mental health and psychiatry services, developmental pediatric care,
- Linking clients with community resources and facilitating referrals,
- Providing individual risk reduction and risk counseling, and
- Communicating with providers and other team members to coordinate needed care.

For the patient who misses a postpartum or infant care visit, their case manager contacted them by phone or made a home visit, both of which are tracked in case notes and in the Westside Healthy Start database.

Westside Healthy Start case managers use a tracking log for interconceptional clients based on the interconceptional care model, “My Future, Your Future, Our Future”. Case managers update the interconceptional log in this database on a monthly basis and update the case management section of the medical chart after every contact.

[IC3] **Family planning.**  The medical provider establishes a family planning method with each client during the initial post partum visit. For some women, a further discussion of options and barriers to these options may be useful, either with the nurse educator or social worker. Case managers follow up with high-risk clients monthly and low-risk clients bimonthly about continued use of their selected family planning method and if other methods need to be considered. The medical providers also follow up with each post partum patient on their family planning choice at every visit.

[IC4] **New enrollment.**  Women and infants in the target area are be welcomed into the Westside Healthy Start interconceptual care management program at any time during their infant's first year of life, even if the mother did not receive prenatal care with the program. Each new patient will receive risk screening upon enrollment and assignment to a case manager. An orientation to the program will be part of the first case management contact.
An infant is only enrolled as a program participant if the mother is enrolled as an interconceptional client. This population includes all women who were enrolled prenatally; cases continue until the infant/toddler reaches two years of age. Infants of high-risk women who enter the program during the interconceptional period are also enrolled and assigned the same case manager as the mother.

**[IC5] Infant and toddler care management.** The care management plan for infants and toddlers is presented above [IC1], integrated with the interconceptional care plan; we view the entire family as the client. Case management services are provided to both the mother and the infant until program eligibility expires. As described, case management is provided with greater intensity based on risk status. All case managers monitor compliance with the well-baby visit schedule and follow-up with the parent(s) to address any existing barriers to care. In addition, they coordinate with the developmental pediatric specialty provider as needed.

Similar to the tracking process that monitors the mother’s compliance with her postpartum visits, newborn visit information is tracked by case managers in the infant’s medical chart. Follow-up is conducted as needed by case managers as well. All information is documented in the case management file as well as the Westside Healthy Start database, which is designed to track each client’s visit history.

**[IC6] Newborn and infant care tracking. a) and b) Medical home and first visit.** As described, an anticipatory guidance visit to the pediatrician or family practitioner may be scheduled prior to the birth, and a first infant care visit is typically scheduled by the hospital prior to discharge. Since the same Westside Healthy Start case manager stays with the mother for interconceptional care, this case manager verifies that the visit is scheduled and obtained within 4 weeks.

The case manager may facilitate referral to another provider if the client chooses. Case managers verbally inquire with participants if the infant has a medical home and verify that the birth record information is in the medical chart. Information regarding a medical home is tracked in the client’s case files and in the database.

**c) Immunization.** Case managers access immunization data in the infants’ medical chart and help our medical providers manage immunization compliance using the TOTS database, a state-wide system that tracks immunizations received regardless of where they are administered in Illinois. TOTS is an asset to our program for clients who relocate or who use different medical providers sporadically.

**Follow up.** Follow-up procedures for infants who miss appointments and/or are not fully immunized include:
- Contact with the parent by telephone,
- Home visits for those that are inaccessible by phone, and
- Parent education to increase understanding of the importance of well child care and immunizing infants.

**[IC7] Additional information: Screening conducted by medical providers and responsive interventions.** As already described, the compensation for ACCESS medical providers rewards the use of interactive preventive screening for risk and interventions to address problems identified through screening. All post partum women, for example, are screened by their medical provider for depression using the Edinburgh tool, for domestic violence and for substance use. We have increase the amount of psychiatry sessions available to Westside
Healthy Start post partum women because of our finding that 11 percent screen positive for depression. As needed, our licensed clinical social workers provide counseling and supplement the problem solving around risk and psychosocial concerns offered by our case managers. In order to increase the number of providers who deliver family planning counseling and contraceptive education to our patients, we have included these as components of our provider compensation program.

*Reach Out and Read.* Our ACCESS/Westside Family Health Center offers a privately funded Read Out and Read program, which is part of a national program to help build reading readiness in young children, and to help build a personal library for children in the program. Volunteers read to patients in the waiting room, and the child's physician provides a book (English and Spanish are available) for the child to take home. This is a very popular program with patients, staff, and community leaders including our elected officials.

*Developmental pediatrics program.* During the year ahead, through a subcontract with the Mount Sinai Department of Pediatrics, we will expand our focus on promoting infant development as a systematic component of Westside Healthy Start. Our approach will be based on the Healthy Steps model. The Healthy Steps program addresses “the importance of a child’s development and of behavioral issues – two essential components of health care for young children.” Many assessment tools are available; to begin, we will use the Ages and Stages tool with which many of our staff are familiar.

Our consultant developmental pediatric specialist will provide education for all Westside Healthy Start medical providers to offer a standardized approach for assessing and providing interventions for less complicated patients. Healthy Steps has developed a training program for pediatricians which will be used it on an at least a monthly basis to train peer level developmental screeners as well as medical providers.

Our overall developmental pediatric project will be designed to build capacity within each health center. The Ages and Stages tool will help our teams sort out by stages what issues will be the province of the primary caregiver and what would be referred to him for specialty care follow up. The vision is that stage 1 issues will be managed at health center; stage 2 issues will be referred for consultation and but followed at the health center, and stage 3 issues will be referred for longitudinal follow up by the developmental pediatric specialist. For those infants assessed to have more complicated problems (2nd or 3rd stage cases), our consultant will be able to offer direct care, either at the ACCESS/Kling site or at other sites if there is sufficient need.

This effort drawing on the strengths of Westside Healthy Start supplemented by developmental pediatrics expertise. The effort will feature:

- A continuum of two years of seamless care for the infant
- Medical home at one site
- Standardized anticipatory guidance reflecting developmental pediatrics input
- Surveillance of normal development

---

• Management of patients with developmental problems
• Parent education on developmental expectations
• Transition into Head Start or other educational or early intervention program
• Expansion of Reach Out and Read as possible.

As we continue to collect data on patient outcomes, we expect to show that this effort will improve long-term outcomes for high risk infants.

Advocacy for personal and family advancement. Westside Healthy Start case managers will address personal and community issues with each of their clients, including community safety and housing. In particular, we will implement a new focus on helping interested program participants obtain access to education, training and employment. This is a direct response to community need, and to issues raised by program and community participants in the Consortium. By establishing relationships with a few key resources such as the Mayor's Office of Employment and Training and STRIVE (a full service workforce development agency), the case managers will be able to leverage these relationships to provide good information and access to programs that may build opportunity for families with infants.

e. Depression screening

Westside Healthy Start has built depression screening into its prenatal and interconceptual care practices, as well as screening for substance use, domestic violence and risk behaviors. As a result of high rates of positive screening results, we have increased the psychiatry and high risk case management time devoted to the program. Our program consists of a few core elements:

- Active screening of clients for perinatal depression,
- Building data tracking systems for outcomes,
- Linking patients to mental health services,
- Providing mental health services on site, and
- Monitoring patient compliance with treatment through case management.

[PD1] Perinatal depression screening services. Within Westside Healthy Start, both medical providers and case managers may provide depression screening depending on the staffing and protocol followed at each site. At ACCESS sites, the medical provider implements the post partum screening and the case managers complete the other screenings; at subcontractor sites, the case managers provide the screening.

The Edinburgh tool is used at all sites for this screening at three different times during the perinatal period: the initial risk assessment at intake, a three month follow-up after the initial screen, and again within six weeks after delivery.

Our vision is that every prenatal patient (about 1300 women) will be screened for depression. Our performance objective is to screen 100 percent of our clients. We have done very well in providing screening to our patients to date.
**[PD2] Cultural relevance:** Westside Healthy Start makes available both English and Spanish versions of the Edinburgh screening tool for our program staff to use. Perinatal depression screening is conducted by providers and case managers who are of the same cultural background and able to speak the same language as the client. Providers and case managers working with the Spanish speaking population conduct the screening and provide relevant education in Spanish. The tool has not been adapted in any other way because it is an externally validated instrument.

Because the Edinburgh screening does not account for different cultural practices or culturally nuanced clinical presentations, we rely on the provider and case manager to identify different manifestations of perinatal depression that might not be apparent based on the screening process. For instance, a client may deny any inclination to harm herself because of the stigma in her culture, but the provider is able to recognize a pattern of self-destructive behavior that is dangerous to her health. While this behavior may not indicate perinatal depression specifically, a further assessment by our on-staff licensed clinical social workers is arranged for these clients.

**[PD3] Program and community participant education.** Westside Healthy Start program participants are educated about the signs and symptoms of perinatal depression throughout their period of eligibility for the program. Providers and case managers use the screening process as an opportunity to explain basic information about perinatal depression, including the signs and symptoms to be aware of and what to do if they are detected. More in-depth education occurs in prenatal and parenting education classes and at Consortium meetings. Our peer lactation counselors are frequently sensitive to maternal reactions, and can offer education and referrals to their clients as needed.

Our outreach/peer educators and male responsibility staff can also alert community participants to the signs and symptoms of depression as they reach out to community groups. The issue of perinatal depression is also one of four key issues identified in our Local Health System Action Plan as described below, a plan that receives visibility far beyond our own program staff.

**[PD4] Clinical assessment and treatment.** Women who screen positive for depression are referred to our on-staff licensed clinical social workers for further assessment and diagnosis. Given the number of women in need of intervention, we have increased our sessions of contracted psychiatry from Mount Sinai Medical Group to provide further assessment and diagnosis on site at the health centers as needed.

When a client’s diagnosis is of mild to moderate severity, our on-staff social workers develop and implement an appropriate treatment plan with the client. When our social workers diagnose a client as having severe depression or other severe problems, the client is referred to the psychiatrist on site. While access to psychiatry in the community is limited, Healthy Start patients have direct access, often on site, through our contract with Mount Sinai Medical Group.

We have found that patient compliance with mental health services is greatly improved by have the services located on site. Inpatient and emergency psychiatric services are available through Mount Sinai Hospital and Cook County Hospital, both of which are located on the West Side.
[PD5] **Tracking and follow up.** Case managers monitor the completion of their clients’ referrals, including those for mental health. They track and monitor all aspects of care, including the status and outcomes of prescribed therapy and self-care. Social workers and psychiatrists can call upon the case managers for assistance with follow up for patients who miss appointments. If the client is not accessible by phone or appointment, the case manager will make a home visit to follow up. Follow up information is recorded in case management notes and tracked in the Westside Healthy Start database.

[PD6] **Additional information.** *Program capacity.* To date, the Westside Healthy Start program emphasis on screening for depression using the Edinburgh tool has increased the capacity of our primary care providers to recognize depression and intervene effectively. Since our primary care providers have a range of comfort in managing mental illness, we have increased the mental health capacity of our program, both in social work and psychiatry. Overall we believe our data on identification and management of depression will show a salient effect on birth outcomes and infant development.

*Depression Collaborative.* As a PHS 330 grantee, ACCESS has enrolled in the HRSA Depression Collaborative organized by the Bureau of Primary Health Care. Given a choice of issues on which to focus, ACCESS elected to participate in the Depression Collaborative in order to apply to the Healthy Start program the practice improvement knowledge gained from this Collaborative.

f. **Evaluative Measures**

*Project's Local Evaluation* The project’s local evaluation is a combined outcome and process evaluation intended to assess the impact of Westside Health Start (WHS) on reducing infant mortality, decreasing incidence of low-birthweight, and eliminating disparities on the Westside of Chicago. The evaluation will be lead by a team of epidemiologists at the Sinai Urban Health Institute (SUHI), affiliated with ACCESS through Sinai Health System.

SUHI joined the WHS team last February replacing the program’s previous evaluators. Founded in 2000, the Institute’s mission is to provide evidence-based examination of community health status, the effectiveness of interventions and clinical care, and health-care delivery methodologies for the Sinai Health System. They have conducted numerous program evaluations, including the evaluation of several maternal and child health interventions. A major component of the Institute’s work involves social issues such as poverty and how they impact on health.

In addition, evaluation team will include an Evaluation Advisory Committee with representatives from SUHI, the WHS Program Director and other program staff, as well as, consumers. The Evaluation Advisory Committee will monitor ongoing evaluation activities, propose new directions in evaluation for the project, and help to translate research findings into practice at the WHS sites.
The evaluation plan has a three-part focus: a process evaluation of the project implementation, an outcomes evaluation of the project’s effectiveness in improving outcomes for project participants, an impact evaluation of the impact of the project on reducing perinatal disparities in the project area.

**Process evaluation.** The process evaluation of Westside Healthy Start program is aimed at enhancing the program by understanding it more fully. The process evaluation will look at what is done by the program and for whom the services are provided. Specifically, the process evaluation will focus on how participants enter the program, the depth of the services provided to them, and the organizational/structural context of the service delivery. Information gathered in the process evaluation will be presented quarterly to the Evaluation Advisory Committee in order to pinpoint where improvements can be made or where the program can be expanded.

**Outcomes evaluation:** The outcome evaluation is designed to assess the program’s effectiveness in improving outcomes for the project participants. In general, it will rely on analyses of time trends, comparing measures over the four years of the project, in order to appraise the project’s successes.

WSH participants will be the unit of analysis for this study. To be included, the participant must meet the following WHS enrollment criteria:

- Be a pregnant or a parenting woman with an infant less than 2 years old
- Be resident of the WHS program area
- Be assessed as medically or socially high risk according to defined criteria
- Receive care at a WSH site
- Agree to participate in WHS case management activities

Westside Healthy Start evaluation team has identified several indicators specific to the program’s core services for the time trend analysis. A few examples of these indicators are listed below; however, a complete list can be found in the appendix. These indicators will be used in addition to the Performance Measures required by MCHB.

**Partial List of Indicators for the WHS Outcomes Evaluation**

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td>• The proportion of WHS prenatal participants who enter prenatal care in the first trimester</td>
</tr>
<tr>
<td>Case Management</td>
<td>• The proportion of WHS prenatal participants who adequately use prenatal care (as measured by the Kotelchuck)</td>
</tr>
<tr>
<td></td>
<td>• The proportion of WHS prenatal participants who report any smoking, drinking, or substance use in their 3rd trimester</td>
</tr>
<tr>
<td>Interconceptional Care</td>
<td>• The proportion of WHS prenatal participants who visit 6 weeks postpartum</td>
</tr>
<tr>
<td></td>
<td>• The proportion of WHS postpartum participants who report using a method of family</td>
</tr>
<tr>
<td>Planning at 1 year postpartum</td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td></td>
</tr>
<tr>
<td>• The proportion of WHS prenatal participants who report that they place their infants on their back to sleep at 6 weeks postpartum</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Depression Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The proportion of WHS prenatal participants who complete a referral for treatment after screening positive for depression, domestic violence, and/or substance abuse</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The proportion of WHS prenatal participants who attend at least one prenatal class during their pregnancy</td>
</tr>
</tbody>
</table>

In general, the outcomes evaluation will be of a pre-post test design where changes in indicators over time are measured as indicative of the effect of WHS. Selected indicators will also be compared to those of the ACCESS Community Health Network as a whole, to community level data, and ultimately to non-Hispanic White women in Chicago (those with the best perinatal outcomes in Chicago). The goal of the analysis is to see disparities for selected indicators narrow between WHS participants and those in our comparison groups.

A variety of data sources will be used to evaluate the WHS project in order to assure the breadth and depth of the information available. These sources include: participant interviews, case management records, medical records, observational data, key informant interviews, pre-post tests, and hospital billing/appointment data.

However, the vast majority of the information for the outcomes evaluation will come from data abstracted from a battery of forms completed by WHS case managers. These forms collect data on basic demographics, risk assessment, screening for depression, drug-use/domestic violence, clients’ needs/referral, and utilization of WHS services such as prenatal education, smoking cessation counseling, etc. The forms, as well as, their schedule of administration, are included on the WHS Activity Plan included in the appendix. The case managers will complete these forms based on client interview, medical record review, and professional assessment. These forms serve a dual use: 1) for WHS case managers to assess the situation their client, and 2) to describe the participants, activities, and outcomes of the WHS program.

Key information from these forms will be abstracted for analysis at several points in time by the WHS case managers and/or evaluation research assistant:
• Intake into WHS
• Initial postpartum visit
• 6 month postpartum visit
• 12 month postpartum visit
• 24 month postpartum visit
The case manager/research assistant will enter in all data to the WHS database. Analysis of the selected indicators will be conducted at least quarterly for review by the Evaluation Advisory Committee. The results of the outcome evaluation will be compiled into a final report at the close of the program.

**Impact evaluation.** At the community level, a longitudinal comparison is used to measure and observe changes in selected perinatal indicators with the program area over time. As state vital records data become available (these data are delayed by two years in Illinois), the changes in the Westside Healthy Start program area will be compared to changes in two reference areas, the City of Chicago and State of Illinois, during the same time period. If possible, the evaluation team will try to establish an agreement with the Illinois Department of Public Health to use birth/death data that can be linked to Westside Healthy Start Program Participants. The evaluation team will also try to identify additional community area(s) for comparison that have similar demographics/perinatal outcomes to the WHS program area, but without a Healthy Start Program.

Lastly, the Westside Healthy Start evaluation team will provide epidemiological assistance to the program as needed. Specific responsibilities may include: developing/finalizing the evaluation design and data collection tools; designing the databases in which the data will be stored; training program staff (including partners) on recruitment, data collection and data entry; supervising the data collection and data entry process; periodic monitoring of the data to ensure its quality and integrity; analyzing the data using the appropriate statistical methods; preparing the data for presentation (both written and oral); assisting in the preparation of reports; and reviewing the literature.

g. **Impact (Core Systems and Efforts)**

Westside Healthy Start actively participates in State and local efforts to collectively build infrastructure, deliver comprehensive maternal child health services to the target population, educate the community, and maintain a responsive system of care. Over seven years, we have created infrastructure to sustain our program and measure outcomes that guide our program and business planning. Specific activities are reported in the following sections below:

- **Local Health System Action Plan,**
- **Consortium,**
- **Collaboration with State Title V Program and Other Agencies,**
- **Sustainability,** and
- **Administration and Management.**

**a. Local Health System Action Plan (LHSAP)** Westside Healthy Start is a key driver in the formation of a comprehensive perinatal care system in West Side communities. Our program is a coordinated effort among the West Side’s chief health care, substance abuse and mental health providers to increase the provision of and access to quality services in an area of concentrated need. Our vision is that comprehensive services addressing the complex needs of our target population will ultimately improve health and birth outcomes.
[LHSAP1] Community plan. The LHSAP for the West Side of Chicago was developed over a year ago and continues to be the guiding format for planning for the future of our Healthy Start program. It is currently being implemented and is always under review.

[LHSAP2] Challenges to developing the LHSAP. Initially the major challenges to developing our LHSAP were:
- Lack of adequate staffing levels to perform formal needs assessments,
- Turnover of staff leadership and minimal transition of information, and
- Balancing competing interests and priorities in a community with multiple needs.

During the past year we have had the staff resources to convene regular partner meetings, to review priorities, to establish the plan for this application, and to maintain and revitalize community relations beyond the community health center partners. Our very robust Consortium is also an asset in developing and maintaining a realistic, community responsive LHSAP.

[LHSAP3] LHSAP stakeholders. A variety of stakeholders are included in the local planning process, including Westside Healthy Start staff across all the contracting partners, Consortium members including both program and community participants, representatives from our Title V program and other grantees in the region who have shared their best practices with our program.

The program director and the Consortium coordinator will continue to bear lead responsibility for revisiting and revitalizing the LHSAP as needed.

[LHSAP4] Describe how priorities in the LHSAP were identified. Priorities were identified primarily through discussion with the stakeholders, who drew on their own experiences, their knowledge of the Consortium, and their analysis of community and program data which was circulated to support decision making and prioritization.

[LHSAP5] Use of the plan. The LHSAP is reviewed annually by our project partners and other local grantees to guide program planning and implementation, including Consortium and consumer education activities.

[LHSAP6] Responsibility for implementation. Lead staff responsibility for implementation of the LHSAP is shared by the program director and Consortium coordinator. Responsible parties include the grantee and partner staffs, as well as the Planning Committee for the Consortium. The Planning Committee is described in a later section.

[LHSAP7] Implementation challenges. Our service area is one that faces many intertwining needs, many arising from long standing poverty and unemployment. The challenge has been to balance widespread community interest in taking on large community-building issues on one hand, with, on the other hand, the considerable but more narrowly focused challenges of reducing infant mortality and low birth weight. The resolution of this challenge has been for the LHSAP to focus on community health issues, while our Consortium takes on additional priority issues, such as housing, that are pertinent to the lives of the program and community participants, but are not traditional public health or health care delivery issues.
[LHSAP 8] Additional information Our LHSAP calls for Westside Healthy Start to focus on four issues of particular importance in our service area.

**Lack of Insurance** - Due to high rates of poverty and unemployment within our target population, lack of insurance remains a community issue. According to the American College of Physicians, as compared to insured individuals, the uninsured are: 1) four times less likely to have a medical home, and 2) up to four times more likely to delay seeking needed care, including prenatal care.1 A primary objective of the Westside Healthy Start program is to secure a medical home for families during and after their participation in our program to prevent future pregnancy complications and other health conditions.

Case managers as well as on-site benefits counselors at the health centers can assess clients and their families for program eligibility and enroll them in appropriate programs. Clients are enrolled in programs such as: 1) the Medicaid Presumptive Eligibility (MPE) program for coverage during their pregnancy, 2) Medicaid, 3) KidCare, the Illinois SCHIP program, 4) FamilyCare, a similar program for parents, and 5) WIC. They can also help family members with these programs and access to pharmaceuticals, as well as circuit breaker and utility services.

In the year ahead, we will work with Community Catalyst, a national advocacy group, to implement their Real Benefits electronic application system at one Westside Healthy Start site (ACCESS/Warren) to test the value of an electronic application system with regard to LHSAP goals.

**Substance Abuse** - The abuse of alcohol and other substances is directly related to low birth weight and pre-term birth, as well as infant mortality. All Westside Healthy Start participants are counseled on the dangers of substance abuse while pregnant and assessed for at-risk behaviors. Our partnership with Haymarket Center and the co-location of Family Guidance Centers services at the ACCESS/Madison site ensure that Healthy Start participants receive expedient admissions into inpatient and outpatient treatment programs for pregnant and parenting women. Case Managers work with medical staff to provide prenatal care that is coordinated with their treatment needs.

We have also created several culturally appropriate brochures that discuss the implications of substance abuse on fetal development and advice for how to parent a drug exposed baby.

**Postpartum Depression** - Mental health issues are prevalent during the perinatal period because of rapid biological changes and other social stressors. Our goal is to screen all program participants for postpartum depression and link those needing care to mental health providers.

We are currently succeeding in having all of sites screen clients for postpartum depression using the Edinburgh screening tool. ACCESS has also implemented a provider compensation program to encourage medical providers to perform depression to identify women in need of mental health services.

---

HIV/AIDS- ACCESS works with several health and social service agencies on the West Side to coordinate HIV services and prenatal care for pregnant women. We work in coalition with eight human services agencies includes several Westside Healthy Start partners (in italics) – Access Community Health Network, Family Guidance Center, Genesis House, Haymarket Center, Lawndale Christian Health Center, PCC Community Wellness, Test Positive Aware Network, and Vital Bridges – to share HIPAA compliant key patient information to facilitate case coordination, patient access to services and continuity of care. These advances are particularly useful for coordinating the complex needs of pregnant women with HIV/AIDS.

Community Empowerment Education- To sustain an active and invested Consortium and engaged community, Westside Healthy Start has worked to catalyze community empowerment education in West Side communities through the following:

- A one-day regional Leadership Conference for consumers of several Healthy Start grantees,
- A Consortium meeting about parents’ rights, presented by the Department of Child and Family Services (DCFS), that included information about welfare reform, DCFS, and the family court system in Illinois, and
- The publication of four brochures that address (1) drug use during pregnancy, (2) practical, nonjudgmental advice for parenting a drug-exposed baby, (3) child custody and drug use and (4) SIDS prevention.

h. Consortium
The Westside Healthy Start Consortium is well-established and successful—it draws membership, has consistent leadership, operates by rules of order, sets priorities, and has produced important results for program and community participants. The Consortium is a source of pride for staff as well as for patients and the community, and is an important part of the Westside Healthy Start identity in the target area.

[CO1] Current status. The Westside Healthy Start community-based Consortium has been in existence since 1997. Our Consortium meets bimonthly and provides participants with a hot breakfast; education on health, parenting and community topics; networking and social opportunity; training on community empowerment; and opportunities to be further involved in the program and the community.

All participants have experience, skills or resources to contribute to a maternal child health program in an advisory capacity. We have representation from the following sectors:

- Health care providers,
- Current and former program participants,
- Core service providers,
- Illinois Department of Human Services, our state Title V agency,
- Developmental pediatrics and early intervention staff,
- Substance abuse treatment providers,
- Community participants who are in recovery and are clients of Westside Healthy Start, and
- Staff of other Healthy Start grantee programs in Chicago.
[CO2]. History. Our community-based Consortium was established seven years ago. This Consortium was built by community resident members of the boards of the participating PHS 330 community health centers and key staff leaders, working together to design joint programming for the West Side. The collaboration among the health center staff, board members, and Haymarket Center predated the Healthy Start grant program.

[CO3]. Consortium’s roster. Our current Consortium Roster appended lists 68 individuals who are active members. A breakdown of their representation in the community is as follows (note: many of members represent more than one category; thus the total presented here is greater than 100 percent.)

Table 8: Consortium Representation

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public agencies or organizations</td>
<td>6 %</td>
</tr>
<tr>
<td>Community-based organizations</td>
<td>51 %</td>
</tr>
<tr>
<td>Private agencies or organizations</td>
<td>0 %</td>
</tr>
<tr>
<td>Subcontracting providers</td>
<td>33 %</td>
</tr>
<tr>
<td>Other providers</td>
<td>26 %</td>
</tr>
<tr>
<td>Program participants and community participants</td>
<td>40 %</td>
</tr>
<tr>
<td>Other- university</td>
<td>1 %</td>
</tr>
</tbody>
</table>

[CO4]. Race and ethnicity. The current membership is 85 percent African American with Hispanic and white members comprising the rest of the group. The Consortium is committed to assuring that the race and ethnicity of all program participants is represented. Further, the Consortium strives to reach out to program and community participants with risk histories representative of those in the community, including residents in recovery and those living with HIV/AIDS.

The proportion of African American members may continue to grow with the current project emphasis on the four community areas that are predominately African American. For the past few years, Westside Healthy Start included South Lawndale, a predominately Hispanic community. With shifts in infant mortality and demography, the current project focuses on the four community areas (North Lawndale, East and West Garfield, Austin) that were the original focus of the Consortium and the program when it was established seven years ago.


Regular education meetings: The Consortium is currently planning their agenda related to future project objectives. This will include an educational plan keyed to the educational objectives for Westside Healthy Start program participants: prenatal health, parenting,
interconceptual health, risk factors and how to address risk. Further, the Consortium will address community-building and personal advancement issues such as education and employment.

In recent meetings, the Consortium has chosen to focus on the following topics:

- **Child Safety:** Tips for childproofing your home, protecting your child from harm and preventing the ingestion of poison were presented.
- **Health, Housing, Education and Welfare Reform:** This event highlighted important community issues in an interactive discussion with our local Congressman Danny K. Davis. It resulted in a commitment from Congressman Davis to advocate for community residents to have priority access to new public housing units under construction at that time, and subsequently resulted in some very visible successes to date.
- **Parent Bonding:** The importance of holding, playing, talking and singing to your child at an early age was discussed.
- **Interpersonal Relationships:** Participants explored communication styles and relational styles of men and women. Consumers identified strengths and challenges in their own relationships and solutions to common issues within the context of parenting.
- **Parents Rights:** Presented by the Department of Child and Family Services (DCFS), consumers learned about DCFS, the court system and eligibility for TANF benefits.
- **Toy Safety:** During last year's holiday season, consumers were informed about toy recalls, differentiating safe and unsafe characteristics of toys for various age groups, and tips for storing and altering toys to be more child-safe.

**Town hall meetings.** As described in the education section, these meetings will be co-sponsored by our Congressman and the Illinois Maternal and Child Health Coalition, and will be oriented toward community change that affects the future of the generation born within the Healthy Start program. Again, as mentioned, the first town hall meeting will focus on housing; the second meeting will also reflect a community empowerment theme to be determined based on experience in the first meeting.

**Consumer conference.** In the past, Westside Healthy Start has collaborated with other Illinois grantees to mobilize a very large and well attended conference that serves to provide education, resources, and revitalized energy among program and community participants in our Healthy Start programs. Although this was suspended when "partnership funds" were eliminated, all of the grantees are committed to leveraging their resources to bring back this very successful venue for empowering consumers and generating visibility for Healthy Start goals and services. Plans for this conference are described in the Collaboration section below.

[CO6] **Active participation.** At least half to three quarters of members attend each of the meetings. A meeting this year with the city's Deputy Housing Commissioner drew more than 100 percent attendance; last year's meeting with the Congressman was equally popular.

[CO7] **Consumer roles in the Consortium** Our Consortium maintains a solid proportion of consumer membership and leadership.

**Consumer mobilization:** Some of the ways the Consortium has succeeded in maintaining its consumer focus has included:

- Maintaining a committee of consumers to lead annual planning,
- Offering practical education that addresses the interests of consumers in a fun and participatory fashion,
Working with vendors to provide product donations which serve as tangible "take-home" incentives for participation,
Drawing experts and leaders to meet with the community, and
Awarding consumers a certificate of completion to acknowledge their efforts to become informed parents and community members.

Each Westside Healthy Start site recruits Consortium participants and provides enabling services as needed to facilitate attendance including emergency child care and transportation.

Certificate of attendance: The certificate is provided to every community resident who attends a full Consortium education session. This is a very important and publicly acknowledged verification of community residents' interest in their own futures and the futures of their children. For residents who have had a history of risk behaviors, this certificate is acknowledged by our family courts and our child welfare agencies as legitimate evidence of personal investment in managing their futures. This has been a highly rewarding accomplishment for consumers in the Consortium.

Orientations to the Consortium. Consortium meetings open with a brief orientation to the purpose and vision of the Consortium and of Healthy Start to assure that meetings are welcoming to new participants.

Consumer leadership. Our Consortium chair is a consumer who was hired by ACCESS last year to provide peer lactation counseling and developmental screenings. The transition from a consumer role to a full time job with benefits provides an important role model within the organization. This chair has also been elected to the board of the National Healthy Start Association, and as such, represents consumer leadership at many levels.

The role of consumers is critical to the in the planning and evaluation of our program. Most of our partner agencies are federally funded community health centers with user-majority Boards of Directors; several consumer board members maintain an active interest in the Consortium and more than one have attend meetings since the beginning of the program.

A committee of active consumers comprises the Planning Committee of the Consortium. These women not only plan and organize the six annual Consortium meetings, but they also work with the Project manager to create a strategic plan, expand the scope of services that Westside Healthy Start offers, and enhance our recruitment efforts through communication and media.

[CO8] Challenges. Our major challenges are in the planning and evaluation of our Consortium. Despite, the Consortium's history of collaboration, cooperation and positive impact, we continue to face three barriers: 1) insufficient staff time to assist the Consortium in its efforts, 2) irregular attendance by members due to high community mobility, and 3) building male attendance and participation.
Staffing. The addition of a skilled (contractual) consistent Consortium coordinator addresses the issue of staff time devoted to the Consortium. This coordinator is our former infant development specialist, now retired and very personally invested in Healthy Start. She has relationships with Consortium members and the community, and is a highly skilled role model for use of rules of order, and planning well-organized meetings. Her quiet, highly effective style of advocacy is impressive and inspirational.

Community mobility. To mitigate the attendance issue, the Consortium planning committee consists of the most consistent members, so that the long-range vision is sustained by the permanent members. Not all Consortium activities require long-term commitment: the town hall meetings are likely to reach deep into the community and do not require attendance at more than one forum.

Outreach to men. Both the town hall meetings and the consumer conference are likely to draw men in the community based on past experience with the consumer conference. Both the male responsibility staff and the Consortium planning committee have tasked themselves to reach out to male program and community participants to build the representation of men within the Consortium in the year ahead.

Evaluation. Our local evaluator will survey Consortium members this year to measure effectiveness relative to Healthy Start goals as well as goals that the Consortium has set for itself in the following areas:
1. Consumer education and empowerment,
2. Strengthened integration of medical services,
3. Improved identification of perinatal depression, substance abuse and domestic violence, and
4. Response health disparities by increasing access to services.
The outcomes of the survey will be used to further strengthen our overall program planning and will contribute to sustainability.

[CO9] Additional information. The long history of these working relationships and of the Consortium itself are important attributes of the current success of the Consortium. Many small community based projects, including local faith institutions, have come and gone during this period—they fact that the Consortium continues on in the community with some highly visible achievements over these years gives it stature.

i. Collaboration and coordination with Title V MCH and other community stakeholders

[COLLAB] Key linkages. Illinois is home to six federally funded Healthy Start projects which collaborate as the "Illinois Healthy Start Partnership" to share resources, exchange best practices, and join efforts on sustainability strategies. These six projects, all of which are applicants in the current cycle, are lead by the following organizations: ACCESS Community Health Network (Westside Healthy Start); Aunt Martha's Youth Services Center (Aunt Martha's Healthy Start); Chicago Department of Public Health (Greater Englewood Healthy

---

3 The six Illinois grantees shared in the development of this narrative section and have submitted similar responses in their applications for this section.
Start); Health Consortium of Illinois (Southeast Chicago Healthy Start); Illinois Department of Human Services (Chicago Healthy Start); and Southern Illinois Healthcare Foundation (East St. Louis Healthy Start).

The Illinois Healthy Start Partnership is strengthened by having the Illinois Department of Human Services at the table at every meeting in an organizing role; not only is this agency the state's original Healthy Start grantee, but also, it develops and administers the state's Title V Maternal and Child Health State Plan. As a result, all of Illinois Healthy Start grantees enjoy a high degree of integration of their infant mortality and low birth weight initiatives with the Maternal and Child Health State Plan and have access to related state services that support women, infants and families.

In turn, the six Illinois Healthy Start projects contribute to the effectiveness of the State Plan which is built around both national and also statewide performance measures, several of which match closely with Healthy Start objectives.

Integration of Healthy Start grantee programs with the Title V agency plan
The Illinois Healthy Start Partnership administers several programs jointly with the state's Title V Maternal and Child Health Program:

- **Family Case Management.** All six Healthy Start grantees in Illinois participate in the state's Family Case Management Program which provides low income pregnant women with linkage to public benefits and basic human services with the goal of promoting a stable beginning for each newborn.

- **High Risk Care Management.** All high risk infants born in Illinois, including those with low birthweight, and those who are substance exposed, receive public health nursing followup care through this state program.

- **Information Systems.** The Illinois Department of Public Health administers several tracking and registry programs that are critical resources for Healthy Start grantees. The Adverse Pregnancy Outcomes Reporting System (APORS) data base helps track neonatal risk, and represents a critical resource for assuring service linkages for infants at risk. The state's "Cornerstone" database system generates an annual statewide portrait of psychosocial issues affecting pregnant women and services levels afforded through case management. Finally, the state's Healthy Start grantees also use the Tracking Our Toddlers' Shots (TOTS) system which provides an immunization registry to facilitate timely childhood immunization.

[COLLAB2] Linkages. Our working relationships go far beyond those who are subcontractors and the key community stakeholders who have provided appended letters of support. With our richly experienced outreach/peer educator teams and our new male responsibility program, Westside Healthy Start will continue its presence in churches, schools, day care centers, small businesses, laundromats, beauty parlors, parks, health fairs, and where ever the community comes together.

---


5 National Performance Measures include: #7 fully immunized two-year-olds, #11 breastfeeding at hospital discharge, #15 very low birthweight, #18 first trimester prenatal care. State Performance Measures include: #1 adequate prenatal care, and #2 interpartum interval.
Our ties to churches are deep. Lawndale Christian and Circle Family Care are both faith based programs; ACCESS operates three faith based programs that cut across the West Side. Our program has maintained consistent relationships with elected and appointed officials on the West Side since our inception.

[COLLAB3] Other joint Healthy Start grantee programs/dissemination of best practices
Since 2001 when the Illinois Healthy Start Partnership grew to six projects, the Partnership has shared resources focused on training providers, staff, patients, and other consumers. Early examples of collaboration include grantee conferences to share best practices (for example, consortium development strategies) as well as to share training resources (for example, education by national experts on screening for substance use). Three grantees participate in a research project funded by the Maternal and Child Health Bureau to the Illinois Department of Human Services conducted by Children's Health Triangle to demonstrate the effectiveness of substance abuse screening tools with pregnant women. This research project is referenced in the state plan.

The collaboration with perhaps the most dramatic impact on the visibility of the Illinois Healthy Start grantees and their effectiveness within their respective communities has been the sponsorship of three consumer conferences. These conferences, planned and organized by consortium members from across the state, brought together hundreds of Healthy Start patients and family members to focus their attention on resources valued by patients (for example, stress management techniques), their families (for example, male involvement practices), and their communities (for example, keynote by Congressman Jesse Jackson, Jr). A widely distributed summary of the second conference offers a replicable model of the structure of the conference, discussing the impact of the conference on future community level activity.

[COLLAB4] Additional information: Future partnership agenda
The Illinois Healthy Start Partnership continues to meet every six to eight weeks to pursue an agenda in line with the Title V State Plan. During the project period ahead, the Partnership effort will include the following joint activities:

- **IDH collaboration.** The grantees will continue to implement the state's Family Case Management program, link appropriate families to High Risk Management, and participate in the APORS, TOTS and Cornerstone statewide data collection programs and registries.

- **Depression screening.** In response to the work of the six grantees, the state has convened an Illinois Perinatal Depression Task Force and has initiated an effort to promote provider education on anticipated morbidity rates, screening tools and intervention mechanisms. Drawing on our expertise in depression screening and on the data that we have compiled on maternal depression, the Illinois Healthy Start Partnership will continue to be an advocate for mental health resources for pregnant women and for parents of infants.

- **Sustainability.** All of the delivery sites within the Partnership are either Federally Qualified Health Centers (FQHCs) or public health department clinics. This grantee structure in turn provides a set of agency and voluntary advocacy association contacts for

---

the Partnership which are critical for program sustainability. For example, the original Healthy Start "clinical model" which allowed grantees to build high risk obstetrics and gynecology resources for high risk women in underserved areas has resulted in sustainable provider practices, which are now enhanced by Healthy Start enabling services. In turn, the funders that support these health centers and clinics view the collaboration with Healthy Start as a key model for building programs for the underserved given limited funds for primary health care and enabling services.

- **National association.** The Illinois Healthy Start Partnership is a founding member of the National Healthy Start Association. Currently, Illinois has sent a consumer/lay advocate representative to their governing board and two senior staff participate on their sustainability committee. This Association provides a robust network for education regarding best practices and a forum for promoting Healthy Start program sustainability.

- **Local association.** Several Illinois Healthy Start Partnership members are active in the Illinois Maternal and Child Health Coalition, a decades-old voluntary association with a strong history of advocacy and education, promoting opportunities for women and infants.

**Specific joint activities for the program cycle ahead**

The Partnership has identified three areas for joint programming during the project period ahead.

- **Consumer conference.** Although the six grantees are no longer supported by Healthy Start "partnership funds" to conduct consumer conferences, the Partnership has committed to convening a fourth consumer conference, building on the successes of past conferences. As in past years, the consumer conference will generate visibility for program goals through the broad patient and family participation these conferences attract. Again, the conference will draw together patients and family members involved in our programs from across the state for a set of Healthy Start-related events planned and executed by consortium members.

- **Male involvement.** The Partnership will build on best practices in promoting male involvement learned through experience to date. The grantees will develop a replicable model for creating a service network for men and for developing programs to connect men to the Healthy Start experience.

- **Advertisement and promotion.** By pooling resources, the grantees will implement a strategy to create visibility for the Healthy Start programs in Illinois. This strategy will include media relations and advertising. The grantees will seek opportunities for joint presentations of replicable program elements in local meetings (such as the Illinois Primary Health Care Association) and national conferences (such as the American Public Health Association).

In addition to these three programmatic efforts, the Partnership will continue to provide joint training and exchange of best practices within our regular meetings. We will continue to implement the state Title V plan and expand the reach of our programs by using IDHS case management and data resources.

---

7 Membership dues paid to associations are NOT derived from federal Healthy Start funds by any of the Illinois grantees.
Shared investment in Closing the Gap
As a successful grantee of "Closing the Gap" funds to address infant mortality in the highest risk areas of Chicago, the Illinois Department of Human Services will continue during the project period to work in partnership with two other grantees, the Chicago Department of Public Health in Englewood and the Access Community Health Network in Austin. The working relationships established through the Illinois Healthy Start Partnership have allowed for rapid mobilization of local resources to focus on these very high risk areas of our state, building on the Healthy Start infrastructure, and leveraging the Healthy Start to achieve an impact in these neighborhoods. By focusing on these areas and leveraging Healthy Start capacity, the Closing the Gap program will deploy additional outreach, access points, provider capacity and case management, using proven strategies and shared expertise gained through years of Healthy Start collaborative relationships.

Summary of leveraged resources through the grantee Partnership
Our six funded programs provide our state with the opportunity to benefit in ways that outstrip the capacity of any one grantee acting alone. No single grantee alone could have the impact on the state of the state Title V Maternal and Child Health Plan as compared with the effect of the six programs together. Further, no grantee alone will be able to mobilize the types of education, consumer involvement through conferences, expertise, and advertising capacity that the grantees can launch together. Each grantee has an important role at our table, each contributing complementary strengths, and sustaining working relationships built through years of Healthy Start experience. The promise of six collaborative grantees in Illinois, all focused on the infant mortality and low birthweight components of the state's Maternal and Child Health Plan, remains highly important for the state as a whole as well as for each grantee community.

j. Sustainability

The services provided by WHS are sustained through coordinated services and shared resources, fundraising efforts, third party reimbursement, and enhanced infrastructure.

[SA1] Local funding agencies. Westside Healthy Start draws on public funding as follows:
- Title V (for the Chicago Family Case Management, Closing the Gap and high intensity case management programs) relationships have been described in the case management section and are further detailed in the collaboration section below.
- All community health centers are able to provide onsite enrollment of program participants into Medicaid and SCHIP.
- Every health center has a direct relationship with a local community WIC program.
- Westside Healthy Start is located in an Empowerment Zone, and funding from this program was used for planning Healthy Start over seven years ago.
- The developmental pediatrics program described above includes a component for linkage and referral relationships with Headstart and the local Early Intervention programs.
Public and private funding. Westside Healthy Start is comprised, as mentioned, of all the private community health center sites in the target area. Both the state and local health departments are Healthy Start grantees; our deep level of collaboration is described in the next section.

Among key successes in securing external funds to date include:

- ACCESS has received a grant from the Office of Adolescent Pregnancy Prevention for an Adolescent Family Life Demonstration project. Like Healthy Start, the goal of this program is to reduce infant mortality and poor birth outcomes for adolescent mothers. Our Chicago Adolescent Pregnancy Project replicates the Healthy Start model and includes peer-led support groups and health education for pregnant teens. While focusing on the South Side, this program bring best practices and an active peer culture among program staff that fosters investment in process improvements that benefit program participants.
- As a PHS Section 330 grantee, ACCESS applied for and received funding to expand the provision of mental health services, including the treatment of perinatal depression, through additional psychosocial staff. Again, while not supporting the West Side directly, this grant strengthens our mental health systems and infrastructure.
- As a PHS 330 grantee, ACCESS participates in the HRSA Depression Collaborative of the Bureau of Primary Health Care which offers resources and effective practice models for our Healthy Start perinatal depression screening and mental health program.

Currently, ACCESS awaits response from several applications pending to help expand and sustain Healthy Start:

- A request to expand of our Office of Adolescent Pregnancy Programs grant to develop a male responsibility component;
- An application to the Bureau of Primary Health Care for increased mental health capacity and case management for patients at our Austin Family Health Center; and
- An application to the Centers for Disease Control to replicate our adolescent pregnancy demonstration at our Kling Health Center.

Third party reimbursement. Maximizing third party reimbursement is critical to the success of WHS’ business plan. Collection rates for these payor sources are much higher than for self-pay patients, creating a stable stream of program revenue. The following efforts in place help to maximize third party reimbursement pertinent to our participants:

- Benefits counseling to enroll participants in Medicaid and Medicaid Presumptive Eligibility, Medicare, KidCare, and Family Care to maximize reimbursement from state and federal insurance programs.
- Active negotiation with managed care organizations to secure higher reimbursement rates for our services. ACCESS has relationships with all Medicaid managed care organizations in Illinois.
- Strong relationship with the state Medicaid program which provides priority payment to community health centers which is critical in Illinois which experiences occasional cash problems.
Responsibility. Sustainability is the responsibility of all of the partners and the Consortium. Roles and division of labor includes the following.

- The ACCESS external affairs area led at the vice president/senior management level takes lead responsibility for sustainability from outside sources and from Healthy Start.
- Each community health center and agency chief financial officer or finance director at the senior management takes lead responsibility for maximizing third party reimbursement.
- Our Consortium chair is on the board of the National Healthy Start Association. The ACCESS CEO and the Westside Healthy Start perinatal director are on the Sustainability Committee of this Association. Westside Healthy Start is a dues-paying Association member and co-founder.
- Our Consortium leads the effort to involve our Congressman and state and local elected officials in our activities, and to foster collaboration with our Congressman to address resident issues relevant to maternal and child health.
- The ACCESS CEO and CEOs of each of our partners maintain positive relationships with our Congressman and local elected officials on behalf of Westside Healthy Start.
- The six Illinois grantees collaborate on sustainability as described in the next section.

Additional information. We believe that the size, scope, collaborations, and experience of our project are assets in sustainability; this depth allows us to deploy multiple simultaneous sustainability strategies as described above.

III. Project Management and Governance

Administration and Management

The Westside Healthy Start applicant entity is Access Community Health Network. ACCESS subcontracts with other community health centers, Haymarket Center, a local evaluator and other resources to provide the full array of services and accessible options for perinatal care on the West Side. Two hospitals, Mount Sinai Hospital and West Suburban Hospital serve as partners for labor and delivery; all of our medical providers have privileges at one or both of these hospitals.

Because perinatal care management to address racial and ethnic disparities is the lead quality goal in the ACCESS strategic plan, ACCESS employs a full time perinatal services director who oversees the organization's entire perinatal program including Westside Healthy Start. Reporting to her is a full time Westside Healthy Start director who has responsibility for all aspects of the LHSAP and Westside Healthy Start program described in this report. In the past four years, we have undergone significant turnover in this position, however, we were able to continue with the program plan through the leadership of our Senior Management team. Currently, the position is vacant and we are in the process of hiring someone for this position.

Lead agency. Access Community Health Network (ACCESS), the lead agency for Westside Healthy Start, is a network of 43
freestanding federally qualified health centers located throughout Chicago and its surrounding suburbs; seven of these health centers located on the West Side form the grantee hub of Westside Healthy Start.

ACCESS has a 12 year history of managing large programs that reach deep into the community to address the needs of hard to reach patients and which draw on the strengths of multiple community based partner agencies and public programs. Our largest current collaborative program is our multi-million dollar REACH 2010/Stand Against Cancer funded by the Centers for Disease Control, the state health department and private agencies to reach women of color throughout the state through their church affiliations to encourage early breast and cervical cancer detection.

**Organizational structure.**

<table>
<thead>
<tr>
<th>Role</th>
<th>WHS Project Manager</th>
<th>Women’s Health Program Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Coordinate all aspects of the Westside Health Start Project to be implemented at eleven sites with additional participation by community and public health agencies;</td>
<td>• Assist in monitoring and assuring that all facets of program models replication are carried out;</td>
<td>• Serve as the central point of contact for information about the project; assist the Project Manager as a liaison to the Maternal and Child Health Bureau;</td>
</tr>
<tr>
<td>• Monitor and assure that all facets of program model replication are carried out;</td>
<td>• Provide lead staff support to the Consortium;</td>
<td>• Monitor the contracts with community partners;</td>
</tr>
<tr>
<td>• Identify issues to be addressed by the Consortium structure;</td>
<td>• Serve as the liaison among participants and other interested parties, affirming project goals and strategies, and</td>
<td>• Supervise the data liaison.</td>
</tr>
<tr>
<td>• Assure integration of the Westside Healthy Start implementation with existing women’s health programs;</td>
<td>• Identifying problems and potential solutions;</td>
<td></td>
</tr>
<tr>
<td>• Communicate the vision for the Westside Healthy Start collaboration to our partners and the community.</td>
<td>• Maintain communication among all project partners;</td>
<td></td>
</tr>
</tbody>
</table>

Key administrative roles are as follows:

**Roles and Responsibilities of Key Program Administrators**

The ACCESS vice president for strategy, planning and external affairs is the senior management "champion"; she is one of the initial architects of the project along with several ACCESS consumer board members and our late CEO Mike Savage. Within this external affairs area report the cluster of staff leaders who implement the program: the director of grant program management, the perinatal director, the Westside Healthy Start director and the women's health grants manager are the lead project management staff.

The ACCESS CEO is a maternal and child health nurse by training, and has been an active supporter of Westside Healthy Start since its first days. The presence of senior leadership that have stewarded the project since the beginning lends strength to program management. As we continue to mourn the tragic, unexpected loss of our late CEO last summer, many of the board and staff are moved by memories of his deep investment in this project and leadership to establish the National Healthy Start Association. Our staff remain honored to carry out his vision for healthy births on the West Side.
[AM3] Organization capacity. As an agency that manages $12 to $15 million annually in external grant and philanthropic funds, ACCESS has strong administrative capacities that can be replicated and expanded as needed.

All of the agencies in the program have been in the community for decades. We have high quality medical providers who are subject to review by their peers, HMOs, and the state public health agencies. ACCESS has well-developed quality assurance policies and mechanisms, and an ongoing mock-survey process replicating the JCAHO survey. ACCESS is accredited by JCAHO.

Our strong linkage with Illinois Department of Human Services which includes our Title V agency includes several case management and outreach pieces of our program which they fund directly and which they would continue to fund even in the absence of Healthy Start, to the extent their funding is renewed.

[AM4] Administrative coordination. The Healthy Start director coordinates all elements of the service delivery, Consortium and evaluation components of the project across the contracting partners. The women's health grants manager coordinates all fiscal management. Upon award, the grants manager works with the Program Director to make any budget adjustments recommended by the program officer, and then proceeds to issue subcontractual agreements for CEO signature. She then develops a payment and monitoring schedule for management of project funds and oversees fund distribution. The ACCESS finance area arranges for agency audit, completion of tax forms and FSR reports.

[AM5] Subcontracts. ACCESS issues 75 or more subcontracts every year, to carry out its collaborative grant program responsibilities. Our grants management staff is experienced, and has modeled its policies and procedures on those of federal agencies.

ACCESS secures an annual audit. The audit for the fiscal year ending June 30, 2004 is currently nearing completion and will be available for submission if a Healthy Start grant is awarded. All past audits have received clean management reports.

[AM6] Staff organization. ACCESS has invested in a full time perinatal director in line with our strategic plan to address racial and ethnic disparities in perinatal care. This is envisioned as a permanent position, funded in part by Healthy Start, and also by other grants. When Healthy Start funds come to an end, we will seek other external funds to support this all other direct service positions. The only position that we would not sustain would be that of the Healthy Start director; as has been the case with other grant programs that have come to an end, we seek career opportunities within ACCESS and partner agencies for positions such as this which are no longer supported.

ACCESS and its partners will make every effort to sustain all direct service positions, which are being used by so many low income families at present. By mission and design, all partners are committed to service to these families and will attempt to sustain direct services as is feasible beyond the grant period. The program and Consortium will both require outside funds to carry on after the grant ends.

ACCESS faces demands on our resources due to the high poverty and unemployment, not only on the West Side, but also in other areas we
serve. One in every four ACCESS patient is uninsured and pays about $15 on a sliding scale for each comprehensive medical visit. However, our PHS 330 grant funds represent less than ten percent of our budget. While our size helps achieve economies of scale, and while our infrastructure and scope of service help us attract outside funds, ACCESS is at times forced to make difficult decisions to assure that the organization survives in the face of economic pressure. Our strategic plan is an asset in protecting our future, both in terms of quality, securing our financial future, and maintaining partnerships that help us leverage local resources.

**[AM7] Quality assurance.** Quality is monitored by each partner agency using its own systems for chart audit, peer review and patient satisfaction. In addition, Westside Healthy Start has its own monitoring systems, implemented by the project manager, the women's health grant manager, and the local evaluator.

The project manager convenes key staff members from partner organizations to meet on a monthly basis to resolve issues around data collection, program planning and consumer activities. Partners rotate the host site for each meeting so that all of our partners are informed about and familiar with the activities of each organization. These meetings have been particularly useful in sorting out logistical issues that arose around the implementation of our data collection tool and its interface with our partner’s existing data systems.

An ongoing goal of our program to improve communication and cooperation between our partner organizations. ACCESS staff works directly with its partners to communicate about program activities by phone, email as well as in one-on-one meetings. ACCESS will continue to provide on-site training and technical assistance to partners throughout the year.

The perinatal director, project manager and women's health grants manager will make site visits to each partner site at the onset of the project to observe activities and appraise their data systems. They will review the partner subcontract agreements, the goals and objectives of the current year, as well as those of the upcoming fiscal period, the roles and responsibilities of all grant-funded staff members, and the data collection required by MCHB. These visits will both provide monitoring and technical assistance on establishing corrective actions as needed.

The information generated by the local evaluator is also important to quality assurance. The evaluator is a partner in the Consortium and also attends monthly partner meetings to provide feedback and insights from local evaluation.

*Perinatal health within the strategic plan:* ACCESS programming is driven by a current 2004 to 2006 strategic plan adopted by our community based, patient-majority board of directors early in 2004. The plan calls for ACCESS to address racial and ethnic health disparities in three areas, including perinatal care management. Healthy Start is our anchor program for carrying out this plan.
In addition to these eleven sites within the target area, ACCESS operates another 36 sites in the greater Chicago area, and PCC Community Wellness operates another site in neighboring Oak Park. A small minority of West Side residents, including pregnant and postpartum women and infants, choose to use services in other centers operated by partners, based on their own personal preferences.

IV. Project Accomplishments
Implementation Plan

**Core Service: Outreach**

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Calendar Year 2005 Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>O1. By 12/31/05 the proportion of pregnant participants receiving prenatal care in the first trimester will be increased to at least 76%. Baseline: 2894 of 4231, or 68.4%, of women in the service area received prenatal care during the first trimester in 2000. Source: Chicago Department of Public Health (CDPH) data</td>
<td>O1. Increase the proportion of pregnant participants who receive prenatal care in the first trimester to 76% by 12/31/05. * Please note that the Project Period and Calendar Year objectives have been corrected to reflect participant data rather than service area data.</td>
<td><strong>Strategy:</strong> Aggressive case finding to reach women in the first trimester. <strong>Activities:</strong> O1a. Continue canvassing of targeted venues (homes, storefront churches, laundromats, beauty salons, etc.) to identify pregnant women that are not in care. O1b. Include Outreach Workers in monthly team meetings to increase their role in retention of patients according to protocol. O1c. Continue to provide training for Outreach Workers on important aspects of prenatal care so that they can serve as community health workers. O1d. Develop and implement a comprehensive outreach tracking tool to collect the following information about contacts: 1. Demographics 2. Appointments made 3. Referrals given 4. Follow-up efforts 5. Completed referrals. O1e. Develop and implement an incentive program to retain clients in the program.</td>
<td>O1a. Ongoing. O1b. Begun in February 2004 Ongoing. O1c. Ongoing. O1d. Begun April 2004- Ongoing. O1e. Ongoing.</td>
</tr>
<tr>
<td>Project Period Objective</td>
<td>Calendar Year 2005 Objectives</td>
<td>Strategy and Activities</td>
<td>Progress</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------</td>
<td>-------------------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| **O2.** By 12/31/05, increase the percentage of program participants who receive adequate prenatal care as measured by the Kotelchuck to 70%. | O2. Increase the percentage of program participants who receive adequate prenatal care as measured by the Kotelchuck to 70% by 12/31/05. | **Strategy:** Same strategy as ACCESS Performance Measure O1.  
**Activities:**  
O2a. – O2e. Same activities as ACCESS Performance Measure O1.  
O2f. Case Managers will assess patient compliance with prenatal care schedule at each visit.  
O2g. Case Managers will document patient compliance in the Healthy Start database.  
O2h. Overall patient compliance will be measured through our local evaluation. | O2f. Documentation is noted in patient’s medical records. Ongoing.  
O2g. Database has not been created but subcontract negotiation with a Database company has begun. O2h. Ongoing. |
## Core Service: Case Management

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Budget Year Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
</table>
| CM1. By 12/31/05, decrease the proportion of low birth weight infants born to Healthy Start participants to 5.4% and very low birth weight infants to 0.9%. | CM1. Decrease the proportion of low and very low birth weight infants born to Healthy Start mothers to 5.4% (LBW) and 0.9% (VLBW) by 12/31/05. | **Strategy:** Assess all pregnant women entering the system for risk of poor outcomes and provide more intensive case management services to the highest risk women.  
**Activities:**  
CM1a. Screen all pregnant women entering health care through outreach or other means using the risk assessment tool to differentiate high and low risk women.  
CM1b. Maintain enrollment of at least 480 high-risk women (40 per Case Manager) in intensive case management services, including partner sites and proposed personnel.  
CM1c. Maintain and strengthen our coordination with the Title V funded Chicago Family Case Management program to address the needs of low-risk women.  
CM1d. Require Case Managers to attend at least two workshops on related health topics each year.  
CM1e. Provide health education and risk reduction information and support groups to case managed participants.  
CM1f. Link case managed participants to health education classes provided through our program.  
CM1g. Provide support groups for at-risk women to reduce risk behavior.  
CM1h. Refer high-risk participants as needed to specialized services, including smoking cessation programs, substance abuse treatment and mental health services. | CM1a. Ongoing.  
CM1b. Each Case Manager has at least 40 high-risk cases.  
CM1c. Ongoing.  
CM1d. Case Managers attended workshops on Child Abuse & Neglect and STD/HIV prevention.  
CM1e. Ongoing.  
CM1f. Ongoing.  
CM1g. Ongoing.  
CM1h. Ongoing. |
<p>| CM1i. Continue to provide mental health services through our on-staff Licensed Clinical Social Workers (LCSWs). | Ongoing. CM1i. Ongoing and we continue to improve communication between Case Managers and Social Workers. |
| CM1j. Maintain our contracts with Haymarket Center, a substance abuse treatment facility, and Mount Sinai Hospital Psychiatric Department. | CM1j. Ongoing. |
| CM1k. Enroll parents upon delivery into interconceptional care. | CM1k. This started out slowly but we are improving in this area. |</p>
<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Budget Year Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM2. By 12/31/05, reduce the percentage of pre-term infants born to Healthy Start mothers to 6.0%.</td>
<td>CM2. Reduce the percentage of pre-term infants born to Healthy Start mothers to 6.0% by 12/31/05.</td>
<td>Same strategy and activities as Case Management Objective CM1.</td>
<td>Ongoing.</td>
</tr>
</tbody>
</table>

**Baseline:** In 2000, 88 of 1,140 (7.7%) Healthy Start babies were pre-term. **Source:** WHS program data
### Project Period Objective

**CM3.** By 12/31/05 reduce the percentage of small for gestational age infants born to Healthy Start mothers who receive prenatal care to 2.6%.

**Baseline:** In 2000, 31 of 938 infants (3.3%) born to mothers who received prenatal services had short gestational age.

**Source:** WHS program data

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Budget Year Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM3. Reduce the number of infants who are small for gestational age born to Healthy Start mothers to 2.6% by 12/31/05.</td>
<td>Same strategy and activities as Case Management Objective CM1.</td>
<td>Ongoing.</td>
<td></td>
</tr>
<tr>
<td><strong>Project Period Objective</strong></td>
<td><strong>Budget Year Objectives</strong></td>
<td><strong>Strategy and Activities</strong></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>---</td>
</tr>
</tbody>
</table>
| **CM4.** By 12/31/05 increase the percentage of completed referrals among case managed Healthy Start participants to 90.0%.  
**Baseline:** In 1998, 365 of 1609 (22.7%) of referrals were completed among case managed Healthy Start participants.  
**Source:** WHS program data | **CM4.** Increase the percentage of completed referrals among case-managed Healthy Start participants to 90.0% by 12/31/05. | **Strategy:** Improve data collection through use of our enhanced data system and increase case manager supervision.  
**Activities:**  
CM4a. Continue to track the completion rate of all case management referrals using our data collection tool.  
CM5b. Continue to engage Case Managers in multidisciplinary case conferencing and monthly supervision where completed referrals are discussed. | **CM4a.** Database has not been created but subcontract negotiation with a Database company has begun. This is being done manually.  
**CM5b.** Ongoing. |
<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Budget Year Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CM5.</strong> By 12/31/05 increase the percentage of Healthy Start participants receiving health education and smoking cessation services who self-report lowered frequency or elimination of this behavior to 80.0%. Baseline: In 2000, 42 of 206 women, (20.4%), who received smoking cessation education self-reported a lowered frequency or elimination of this behavior. Source: WHS program data.</td>
<td><strong>CM5.</strong> Increase the percentage of Healthy Start participants receiving health education and smoking cessation services who self-report lowered frequency or elimination of this behavior to 80% by 12/31/05.</td>
<td><strong>Strategy:</strong> Provide assessment of risk behavior and linkage to smoking cessation services. <strong>Activities:</strong> CM5a. Continue to assess risk behavior monthly throughout the participant’s enrollment in the program using our screening tool. CM5b. Train Case Managers in smoking cessation education. CM5c. Develop a resource manual for program staff listing all referral agencies in the service area, including those with smoking cessation programs. CM5d. Continue to prevent and reduce smoking incidence by providing smoking cessation education materials and referrals to cessation programs through case management services.</td>
<td>CM5a. Ongoing. CM5b. Completed in September 2004. CM5c. Begun in October 2004. Ongoing. CM5d. Ongoing.</td>
</tr>
<tr>
<td>Project Period Objective</td>
<td>Budget Year Objectives</td>
<td>Strategy and Activities</td>
<td>Progress</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| CM6. By 12/31/05 increase the percentage of Healthy Start participants receiving health education or treatment in substance abuse who self-report lowered frequency or elimination of this behavior to 80.0%. | CM6. Increase the percentage of Healthy Start participants receiving health education or treatment in substance abuse who self-report lowered frequency or elimination of this behavior to 80.0% by 12/31/05. | **Strategy:** Same strategy as ACCESS Performance Measure CM5.  
**Activities:**  
CM6a. Continue to assess risk behavior monthly throughout the participant’s enrollment in the program using our screening tool.  
CM6b. Continue to prevent and reduce substance abuse incidence by providing education materials and referrals to treatment programs through case management services.  
CM6c. Maintain our contract with Haymarket Center, where Healthy Start participants receive expedited admission into their inpatient substance abuse treatment programs for both pregnant and postpartum women.  
CM6d. Collaborate with Haymarket Center staff to strengthen our referral and tracking processes. | CM6a. Ongoing.  
CM6b. Ongoing.  
CM6c. Ongoing.  
CM6d. Ongoing. |

**Baseline:** In 2000, 206 of 206 women, (100.0 %), who received treatment for substance abuse self-reported a lowered frequency of or elimination of this behavior.  
**Source:** WHS program data from Haymarket Center, an inpatient substance abuse treatment facility.
Westside Healthy Start  
Access Community Health Network  
August 30, 2005  
Grant Number: 2 H49MC00098-05

### Core Intervention: Health Education

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Budget Year Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
</table>
| HE1. By 12/31/05 increase the number of Healthy Start women participating in prenatal and parenting classes to at least 70%. | HE1: Increase percentage of women who have prenatal education documented in their charts to 70% by 12/31/05. | **Strategy:** Aggressive marketing of prenatal and parenting classes.  
**Activities:**  
HE1a. Provide ongoing group and individual education to pregnant women at each participating health center during OB clinics.  
HE1b. Train Case Managers to co-facilitate prenatal education classes.  
HE1c. Train Case Managers to facilitate parenting education classes.  
HE1d. Continue to document attendance of women at all education sessions (both individual and group) through sign-in sheets, with attendance records noted in medical charts and in Healthy Start database.  
HE1e. Develop a pre/post test to measure knowledge gain.  
HE1f. Develop linkage with the Department of Child and Family Services (DCFS).  
HE1g. Pilot the usage of a certified parenting program for two 30-week sessions, one teaching effective African American parenting skills and the other effective Latino parenting skills (conducted in Spanish).  
HE1h. Case Managers will conduct six-month follow-up with participants of parenting classes to assess DCFS involvement with the family following their parenting instruction. | HE1a. Has not begun, but Case Managers refer clients to Doulas for prenatal education classes.  
HE1c. Has not begun, but Case Managers refer clients to Doulas for prenatal education classes.  
HE1d. Ongoing.  
HE1e. Being done by Doulas.  
HE1f. Ongoing.  
HE1g. Has not begun this program but Doulas work with each client to assure knowledge of effective parenting skills. |

**Baseline:**  
916 of 2,196 (41.7%) women participated in classes in 2000.  
**Source:** ACCESS health center records
<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Budget Year Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
</table>
| **HE2.** By 6/30/02 all Medical Assistants, Case Managers and Outreach Workers will have documented participating in Healthy Start competency training program. | **HE2:** Provide and document competency training to all Medical Assistants, Case Managers, and Outreach Workers. | **Strategy:** Implementation of policies and procedures of annual competency training and testing activities.  
**Activities:**  
HE2a. Provide prenatal and parenting education sessions for all Medical Assistants, Case Managers and Outreach Workers.  
HE2c. Expand competency training and testing to partner sites. | HE2a. Completed and Ongoing.  
HE2b. Begun in early 2004 and is Ongoing.  
HE2c. Will begin later in the year. |

**Baseline:** 8 of 8 Medical Assistants (100.0%) and zero (0.0%) of Case Managers or Outreach Workers participated in 2000.  
**Source:** ACCESS Human Resources records
## Core Intervention: Interconceptional Care

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Budget Year Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IC1.</strong> Train 80% of well-baby providers at partner sites on their role in interconceptional care.</td>
<td>IC1. Increase percentage of physicians trained to 80% by 12/31/05. Provide follow-up consultations with physicians on interconceptional care.</td>
<td><strong>Strategy:</strong> Provider training including seminars and individual consultation. &lt;br&gt; <strong>Activities:</strong> IC1a. Project Director and Medical Department staff will provide training and periodic consultation to physicians regarding their role in our Interconceptional Care Model, “My Future, Your Future, Our Future”, described in section IC6 below.</td>
<td>IC1a. Ongoing.</td>
</tr>
<tr>
<td>Project Period Objective</td>
<td>Budget Year Objectives</td>
<td>Strategy and Activities</td>
<td>Progress</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| IC2. By 12/31/05, provide at least 2,000 screenings for developmental delay to infant program participants. | IC2. Screen at least 500 infant participants during each project year. | **Strategy:** Provide screenings to infants at all partner sites.  
**Activities:**  
IC2a. Hire two Child Development Specialists to provide screening and linkage services to replace our prior contract with ECFIP.  
IC2b. Contract with Dr. Wynetta Frazier (retired Director of ECFIP), a certified Child Development Specialist in four areas, to provide necessary training to the hired Child Development Specialists and Case Managers.  
IC2c. Provide screenings in the field at specified times and venues. Enroll identified infants in case management services and link to care through city Early Intervention programs.  
IC2d. Track referrals made and completed for infant participants. | IC2a. In November 2004, one of the two Child Development Specialist was hired. We hope to hire the second soon.  
IC2b. Completed and subcontract is on file.  
IC2c. Ongoing.  
IC2d. Ongoing. |
<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Budget Year Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>IC3. By 12/31/05 increase the percentage of completed referrals among case managed Healthy Start infants with Special Health Care Needs to 80.0%. Baseline: In 1998, 66 out of 649 (10.2 %) infants with special health care needs had completed referrals. Source: WHS program data</td>
<td>IC3. Increase the percentage of completed referrals among case managed Healthy Start infants with Special Health Care Needs to 80.0% by 12/31/05.</td>
<td><strong>Strategy:</strong> Improve communication between Case Managers, Child Development Specialists and Early Intervention programs. <strong>Activities:</strong> IC3a. Include Child Development Specialists in all staff meetings and case conferencing activities. IC3b. Child Development Specialists will track all referrals and maintain relationships with Early Intervention programs.</td>
<td>Continuous process. IC3a. Ongoing. IC3b. Ongoing.</td>
</tr>
<tr>
<td>Project Period Objective</td>
<td>Budget Year Objectives</td>
<td>Strategy and Activities</td>
<td>Progress</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>IC4. By 12/31/05 increase the percentage of two-year-olds who have received the full schedule of age-appropriate immunizations to 80.0%.</td>
<td>IC4. Increase the percentage of two-year-olds who have received the full schedule of age-appropriate immunizations to 80.0% by 12/31/05.</td>
<td><strong>Strategy:</strong> Educate providers and Case Managers on their roles in raising participant awareness about the importance of childhood immunizations. <strong>Activities:</strong> IC4a. Include immunization information in the provider training described in IC1. IC4b. Provide training to Case Managers about the importance of immunizations on an as needed basis. IC4c. Access TOTS, the state database for tracking immunizations, to monitor the immunization needs of program infants and track compliance.</td>
<td>IC4a. Completed and Ongoing. IC4b. Ongoing. IC4c. Ongoing. We are trying to implement this database program into all Healthy Start sites.</td>
</tr>
<tr>
<td>Project Period Objective</td>
<td>Budget Year Objectives</td>
<td>Strategy and Activities</td>
<td>Progress</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>IC5. Establish baseline on interpregnancy intervals for program participants and set goals for lengthening these intervals. <strong>Baseline:</strong> To be established by the program Evaluator. <strong>Source:</strong> WHS program data</td>
<td>IC5. Baseline and goals to be established in Year 4.</td>
<td><strong>Strategy:</strong> Establish baseline data and increase participants’ access to family planning services and education on the benefits of longer interpregnancy intervals. <strong>Activities:</strong> IC5a. Include the development of baseline data in the Evaluator’s scope of work. IC5a. Establish baseline on interpregnancy intervals among participants by adding appropriate data fields to Healthy Start database. IC5b. Provide family planning counseling to all participants through well-woman and well-baby health care providers and Case Managers. IC5c. Utilize Case Managers to help participants communicate about and have access to effective contraception.</td>
<td>Completed. IC5a. <strong>Baseline:</strong> In 2004, 7.4% of WHS participants have a short interpregnancy interval (IPI): i.e., less than 12 months to next pregnancy. This can be compared to Chicago with a short IPI rate of 3.4% and to the target area (Austin, E. and W. Garfield Pk, and N. Lawndale) with a short IPI rate of 4.3%. (Source: IDPH data, 1999-2001. IC5b. Ongoing. IC5c. Ongoing.</td>
</tr>
<tr>
<td>Project Period Objective</td>
<td>Budget Year Objectives</td>
<td>Strategy and Activities</td>
<td>Progress</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| IC6. By 12/31/05 increase the percentage of postpartum Healthy Start women who receive interconceptional care to 85.0% | IC6. Increase the percentage of postpartum Healthy Start women who receive interconceptional care to 85.0% by 12/31/05. | **Strategy:** Offer a comprehensive array of interconceptional care services based on the “My Future, Your Future, Our Future Model”.  
**Activities:**  
IC6a. Case Managers will reassess participants for psychosocial issues following the delivery of the baby—monthly for high-risk clients and bimonthly for low-risk clients.  
IC6b. Case Managers and participants (including families) will revise the care plan as needed.  
IC6c. Family planning education and selection of a method will occur and be documented.  
IC6d. Risk assessment tool for families will be developed and implemented.  
IC6e. The mother will be assessed for postpartum depression using the Edinburgh screening tool.  
IC6f. The mother will be entered into the | IC6a. Ongoing.  
IC6b. Ongoing.  
IC6c. Ongoing.  
IC6d. Ongoing.  
IC6e. We had a rocky start but this is Ongoing and we hope to improve in this area.  
IC6f. Ongoing.  
IC6g. The educational sessions are taking place but we have yet to start the support groups. We hope to begin these in the future.  
IC6h. We continue to provide leadership and support to the Case Managers and hope to see improvement in this area.  
IC6j. We continue to provide leadership and support to the Case Managers and hope to see improvement in this area. |
interconceptional care tracking log.

IC6g. Case Managers will facilitate a monthly support and education session (repeated at an alternate time for participants’ convenience), including the following sessions:

1. Stress Management/Relaxation
2. Career Planning
3. Financial Planning/Budget
4. Working and Taking Care of the Home
5. Male and Female Relationships (2 sessions)
6. Family Planning
7. Mom/Dad/Family: Future Directions (2 sessions)
8. Male Responsibility/Nutrition for Moms
9. Graduation

IC6h. Case Managers will contact low-risk families bi-monthly to reassess care plans and address outstanding issues.

IC6i. Case Managers will continue to contact high-risk families monthly.
### Core Service: Depression Screening

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Budget Year Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
</table>
| **D1.** By 12/31/05, increase the percentage of program participants who are screened for depression to 80.0% | **D1.** Increase total number of women screened system-wide to 80.0% by 12/31/05. | **Strategy:** Implementation of Edinburgh screening tool for depression at all sites, including partners.  
**Activities:**  
D1a. Continue screening throughout system.  
D1b. Improve screening rate at ACCESS sites through provider compensation program, which provides a monetary incentive for performing the screening. | D1a. Ongoing.  
D1b. Ongoing. |
<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Budget Year Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
</table>
| D2. By 12/31/05, link 100.0% of women identified as depressed to mental health services. | D2. Assure appropriate referrals and care for 100.0% of women screened as in-need each year. | **Strategy:** Provision of mental health services at health center sites and at Mount Sinai Hospital.  
**Activities:**  
D2a. Continue to utilize on-staff Licensed Clinical Social Workers (LCSWs) to provide complete assessments of depression after referral by physicians or Case Managers.  
D2b. Update protocols for treatment of patients, either through referral or on-site, specific to Healthy Start.  
D2c. Maintain contract with Mount Sinai for psychiatrist to work two sessions/week at Healthy Start sites.  
D2d. Develop and implement a tracking system for referrals to LCSWs and psychiatrist.  
D2e. Document completed referrals. | D2a. We have had difficulty in this area with lack of communication between the Case Managers and LCSW’s. We have invited the LCSW’s to monthly case conferencing meetings and things are beginning to improve.  
D2b. Ongoing.  
D2c. This is a slow process but we have selected a lead LCSW to work with the psychiatrist in getting the referrals processed. Ongoing.  
D2d. We continue to find ways to make this happen and we are hoping that with the new database system, we will be able to improve.  
D2e. We continue to find ways to make this happen and we are hoping that with the new database system, we will be able to improve. |
### Core Service: Consortium

<table>
<thead>
<tr>
<th>Objective</th>
<th>Budget Year Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1. By 12/31/05 provide education on perinatal health and community issues to 5.0% of Healthy Start women through Consortium activities. <strong>Baseline:</strong> In 1998, 12 of 2260 program participants (0.5%) received education through Consortium activities. <strong>Source:</strong> WHS program data</td>
<td><strong>C1.</strong> Provide education on perinatal health and community issues to 5.0% of Healthy Start women through Consortium activities by 12/31/05. <strong>Strategy:</strong> Recruit Consortium participants by providing education that is responsive to their needs. <strong>Activities:</strong> C1a. Hold partners accountable for their responsibility to recruit Consortium participants. C1b. Continue to ensure that Consortium meetings are held at the most convenient time and location for participants. C1c. Continue to provide transportation tokens to women who would like to attend the Consortium meetings and need transportation. C1d. Continue to design activities and education around needs identified by Consortium participants. C1e. Continue to provide hot food and small incentives to Consortium members.</td>
<td>C1a. Ongoing. C1b. Ongoing. C1c. Ongoing. C1d. Ongoing. C1e. Ongoing.</td>
<td></td>
</tr>
<tr>
<td>Project Period Objective</td>
<td>Budget Year Objectives</td>
<td>Strategy and Activities</td>
<td>Progress</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| **E1. Increase all partners’ ability to collect timely, accurate data for measuring effects of program by creating baseline data by 12/31/05.** | **E1.** Establish baseline data for each partner by 12/31/05. | **Strategy:** Establish baselines and improve data collection methods for daily project activities. **Activities:**  
E1a. Create an Evaluation Advisory Board including evaluation staff, program staff, partners, and consumers.  
E1b. Implement the evaluation plan developed by the Evaluator, an Epidemiologist from the Sinai Urban Health Institute.  
E1c. Refine data collection tools to capture more needed data points directly from project personnel (i.e. by recording immunizations, etc. at the time of service instead of abstracting these data from medical records later).  
E1d. Expand and update the current Access database to include new data points, queries for reporting and MCHB Performance Measures.  
E1e. ACCESS Case Managers will use paper versions of the assessment tool and submit copies monthly to the Evaluator for data |  
E1a. We have not begun this process but hope to do so when the Director’s position is filled.  
E1b. Ongoing.  
E1c. Ongoing but with some difficulty. We have to constantly remind the Case Managers, LCSW and providers on completing this.  
E1d. We begun doing this but with the departure of the Director of Maternal and Child Health, we have had a set back and we hope to hire for this position soon.  
E1e. We provide continuous reminders to Case Managers and have seen an improvement.  
E1f. Completed.  
E1g. Ongoing. |
### Project Period Objective

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Budget Year Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
</table>
| E2. Analyze quarterly outcome data from Westside Healthy Start program to guide service delivery in achieving stated outcomes through 12/31/05. | **E2. Analyze program data quarterly and review at Advisory Board meetings through 12/31/05.** | **Strategy:** Use Evaluator to produce quarterly data reports and the Advisory Board to review the data set.  
**Activities:**  
E2a. Evaluator will run data reports for ACCESS and aggregate it with partner data.  
E2b. Advisory Board will review reports at quarterly meetings, identify trends and gaps, and utilize information in planning for the following quarter.  
E2c. The Advisory Board will compare vital records data for the service area (the most recent year available) to program data to measure the program impact. | E2a. Ongoing.  
E2b. Since the departure of the Director of Maternal & Child Health, we have lacked in this area and we hope to hire for the position and improve in this area.  
E2c. Since the departure of the Director of Maternal & Child Health, we have lacked in this area and we hope to hire for the position and improve in this area. |
<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Budget Year Objectives</th>
<th>Strategy and Activities</th>
<th>Progress</th>
</tr>
</thead>
</table>
| E3. Use Westside Healthy Start data set to leverage external funding for further research on and additional services for maternal and child health in the service area. | E3. Identify one potential funder at each of four Advisory Board meetings. Discuss at Partner Meetings as time permits. | **Strategy:** Identify potential funders and develop proposals for maternal and child health research and programs.  
**Activities:**  
E3a. The Advisory Board will consult with senior management, partners, development staff and other maternal child projects in the service area to develop funding proposals. | E3a. Ongoing. |
V. Project Impact

a. Systems of Care

*Outreach*

Westside Healthy Start has had a consistent core of outreach workers since our first project period. The majority of these individuals are residents of the communities they serve and therefore are familiar with where and how to reach people to let them know about our services. Each of the outreach workers has undergone extensive training provided on-site and by our state Title V agency. They work in the community providing information about our services at health fairs, to local businesses, social service agencies, and through canvassing neighborhoods.

We fell somewhat short of our goal of serving 8,400 individuals through outreach, having reached just over 6,600. Despite this, we easily attained our goals in terms of prenatal and case management services. In addition to marketing our program in the community and reaching women early in their pregnancies, our outreach workers assist case managers in maintaining contact with participants during the course of their pregnancy and help to retain them in care.

*Case Management*

One of the major accomplishments of case management over the past year has been the full implementation of our intake and data collection tool at each of the Access sites. This tool was developed to incorporate various screening tools, such as the Edinburgh tool for depression, the 4 Ps for substance abuse, and a brief screening for domestic violence into one easy to use instrument. The case managers have all received training on how to use the tool with their patients, correctly collecting data and acting on that data to provide appropriate services. All three of the screenings noted above, for instance, are used to identify women with problems in particular areas and then to refer them in-house to more in-depth services. Westside Healthy Start currently has specific services for smoking cessation, substance abuse treatment, perinatal depression, and domestic violence.

Westside Healthy Start offered training sessions for all case managers on a variety of topics during the year. These included perinatal depression, adoption, Title X family planning, HIV/AIDS, adolescent case management, substance abuse, early childhood development and screening, case management 101, domestic violence, services for deaf clients. Ongoing training is a critical part of assuring that all our case managers are capable of providing the highest level of service to their clients. We believe that we have created an ongoing curriculum that meets most of the important needs identified in our population.
In November we started regular multidisciplinary case conferences at one of the Healthy Start sites and will be moving to others sites in the coming year. At these staff meetings the case managers, medical personnel social workers, clinical directors, and outreach workers discuss specific cases and how the team can work together to better serve their clients.

We have had one important staffing change in the case management area in the past year. Our coordinator, Emily Carter, left us at mid-year for a new opportunity. When she left, we decided to eliminate her position and replace it with a case manager who would spend all her time in client services.

**Health Education** – Health education continues to be one of the strongest features of Westside Healthy Start. We have implemented our comprehensive eight-session prenatal and parenting education curriculum at each of our sites and continue to provide this service to many women each week. At most sites the classes are provided during obstetric clinic hours so that women can attend both services in only one visit to the health center. This gives the added advantage of allowing clinic staff to remind mothers about the importance of prenatal education and to actively steer them into the classes as they wait.

Classes are taught by different staff at each of the sites using the curriculum developed by Access. This curriculum has been translated into Spanish and we are offering the classes in Spanish at one site.

**Depression Screening and Referral** – During the past year, we continued to screen women for perinatal depression, though we have not yet screened as large a percentage as we would like to. We held a full-day training on the use of the Edinburgh tool with all of the partners early in the year and have since been working on implementing screening at all of the sites. Not all of the partners have begun screening, and this will be a major goal for the coming year.

Westside Healthy Start screened 501 women using the Edinburgh tool during the year, or about 13.2 percent of participants. Of these, 45, or 8.9 percent, required further assessment and/or treatment. Women who were identified as depressed during the period were referred to a staff licensed clinical social worker (LCSW) for a complete assessment and treatment plan. For those with serious problems, referrals were made to Mount Sinai Hospital for the care of a psychiatrist, Dr. Viktoria Ehrhardt.

In addition to identification during formal screenings conducted by case managers, we identified two women as needing depression services during the course of our interconceptional screening for developmental delay. Our developmental screeners from ECFIP spend a good deal of time with mothers and babies while they are assessing physical and intellectual development on the part of Healthy Start children. Part of the screening involves extensive play with mother and child in the clinic. During these sessions the screeners have a good opportunity to interact with mothers, and see them in an everyday situation. The women who were identified during this time were referred to the LCSWs for additional care.
One pregnant participant during the period was diagnosed as psychotic and was hospitalized through Mount Sinai. Our case manager and LCSW are following up with this woman during the course of pregnancy and during aftercare. Healthy Start services helped to assure a seamless continuum of care for this woman between the outpatient and inpatient setting.

**Interconceptional Care** – The key facets of Westside Healthy Start’s interconceptional care program have been ongoing case management for mother and baby through the second year of the child’s life and screening and treatment for developmental problems through a contract with the Early Childhood and Family Intervention Program (ECFIP) at the University of Illinois at Chicago.

ECFIP has now been working with Westside Healthy Start for almost two years, since the renewal of our program for a second project period. During 2002, ECFIP’s developmental specialists screened 1,404 infants and toddlers across eight Healthy Start Sites, the four Access sites, Mile Square, Circle Family Care, Haymarket Center and Westside Future, all partners in WHS program.

Approximately 20 percent of the children screened in 2002 were found to require further screening or additional assessment. Thirty percent of the total received secondary screenings because they had reached the age requiring the second screen. Of the 20 percent requiring additional assessment, 15 babies were enrolled in the Early Intervention Program at UIC. An additional 15 babies are in their second year of intervention services, having been identified in our 2001 program year. Some of these babies in the second year program are being served at the center and the rest receive services in the home.

Approximately 10 percent of the babies screened last year were diagnosed with Failure to Thrive (FTT). These babies are found to be FTT not for medical reasons, but due to lack of maternal bonding. ECFIP offers these parents one-to-one services, either in the center or in their home, where the childhood specialist or therapist explains the benefits of mother-infant bonding to the overall development of the baby and demonstrates ways the mother can improve in this area.

The overall follow-up rate for babies who screen positive for additional development help has been good, although Hispanic mothers has been somewhat more reluctant to access services than their African American counterparts. The screeners have told us that Hispanic mothers often feel that developmental problems are an indication of her failure and that accessing services would demonstrate her failure to her family. Our program is working to reduce this stigma through the creation of personal relationships with clients and careful education.
Early intervention services, whether they are administered at the childhood center or in the parent’s home, are accompanied by incentives specific to the needs and age of the child. These incentives include developmental toys or simple household items. Some examples include:

- Fine and gross motor skills: child is given a small wagon or truck or some item or toy that requires the child to use and develop these skills.
- Communication problem: Parent will be given a variety of books and teaching tools to stimulate the child’s speech.
- Cognitive problems: The parent would be encouraged to use safe household items (Plastic bowls, spoons) involving the child in day to day activities like washing dishes, preparing meals, also helping to strengthen the child’s attention span.
- ADHD or behavioral problems: The parent would be guided in ways to avoid spanking and hitting the child, instead using time out and other less punitive forms of behavioral modification.

All of the developmental screeners work under the supervision of Dr. Wynetta Frazier, who is credentialed in all four areas of early childhood development, developmental psychology and parent advocacy. A variety of early intervention specialists make up the team of providers, including occupational and physical therapy, speech and language specialist, and a developmental therapist. The parent liaisons, who also work with the parents, must complete two years of college, 30 hours of Starnet training, 12 hours of systems overview and be a parent, in order to begin working in the clinic with the parents and children. Tamela Wolf, also the Healthy Start Consortium Chairperson, is one of two fulltime parent liaisons. The parent liaisons communicate with the parents, explain the value of early childhood screening, and answers questions about the role of the family. Most importantly, the liaison closes the gap between the parent and the doctor or other service provider.

In Illinois, as in most states, 50 percent of the education budget is spent on special education or on children with special needs. More often than not these needs are not noticed until children reach school age and are enrolled, and previous issues such a low birth weight or prenatal drug exposure are identified as having led to negative outcomes. Earlier identification can increase the chances of success in school by allowing children early access to physical, occupational and speech therapy, and social services geared towards the specific needs of these children. These services are available to all program participants through our partnership with ECRIP at the University of Illinois.

Early intervention services are billable to the State and thus services are rendered at no expense to the family. If a child is borderline high-risk, we will collect contact data for the mother and work with the Healthy Start case managers to perform a rescreening every four months, allowing us to monitor these children’s development. If the mother of an infant is a teenager, we automatically do rescreenings every six months.
b. Impact to the Community

Each of the participating agencies in Westside Healthy Start have worked diligently to improve the perinatal services system and to educate our community about the problem of infant mortality that results from poverty and lack of services. During its existence, Westside Healthy Start has:

- Created ongoing, functional linkages between the primary providers of prenatal and postpartum care to women and children in our service area,
- Created a system to screen hundreds of children each year for developmental delay and link them to services,
- Nurtured community participation in decision making and service delivery through the work of the consortium and each of our participating agencies consumer-majority boards,
- Linked substance abusing women to high-quality treatment program through co-location of outpatient treatment in community health center sites and health services at inpatient sites, and,
- Improving coordination of care between Title V funded case management and more intensive service programs.

c. Impact on State & Local Government

Local and state program integration. Since its inception, Westside Healthy Start has worked with local, state and national networks. In these circles, Westside Healthy Start is locally prominent as a resource and advocate for promoting healthy birth outcomes:

- The Westside Healthy Start Consortium has attracted 60 to 75 regular program participant and community participant members who have established and implemented a highly visible advocacy agenda. Among best practices are the consortium's very popular "consumer conferences" serving as a resource fair to address perinatal health, and more recently, the consortium's success in helping members apply for and succeed in moving into new housing.
- Westside Healthy Start operates from a local health systems action plan developed by the Consortium in collaboration with key staff and leadership from all of the partnering organizations.
- As one of six Healthy Start grantees in Illinois, Westside Healthy Start participates in regular meetings of all the grantees, organized five years ago to exchange best practices, promote sustainability, and take advantage of economies of scale through shared agendas including press conferences and consumer conferences. These meetings continue on a regular quarterly basis and more often as needed; the current agenda is described further in the narrative.
- Westside Healthy Start is a member of the Illinois Maternal and Child Health Association, an established, visible advocacy group which convenes interested experts in the Chicago area to promote expert practice, and which maintains a Springfield presence to advocate for prudent state expenditure on programs that promote maternal and child health. Westside Healthy Start perinatal services director, Angela Ellison, has long been a board member and executive committee member of this organization.
- Westside Healthy Start is key to implementation of the Illinois Maternal and Child Health Title V State Plan. Itself a continuing Healthy Start grantee (one of the original from the first phase of funding), the Illinois Department of Human Services also
administers a state plan that explicitly references Healthy Start as central to its infant mortality and low birth weight reduction efforts.

**Funded state programs collaborating directly with Westside Healthy Start.** The Illinois Department of Human Services works directly with Westside Healthy Start to extend its programmatic reach by providing resources that build and sustain the program:

- **Chicago Family Case Management** provides on-site case management services that allow all of the Westside Healthy Start sites to offer a basic level of case management for the approximately 1200 pregnant women and infants served within the target area. The Illinois Department of Human Services collects and aggregates data for all case management program participants in its Cornerstone information system. These Chicago Family case managers, who maintain caseloads of approximately 125 families at a time, serve Westside Healthy Start by conducting an initial risk screening of program participants; no Healthy Start funds are sought to support this level of case management which is already covered through a contract with the Illinois Department of Human Services at several participating sites (ACCESS Madison, Westside, and Warren sites; Circle Family Care, and both Lawndale Christian sites). Project participants who are found to have an elevated level of risk receive follow-up by case managers engaged through Healthy Start funds to provide a more intense service level aimed at reducing infant mortality and low birth weight.

- **Closing the Gap/Intensive Case Management.** The Illinois Department of Human Services piloted a perinatal intensive case management program at Lawndale Christian during the past Healthy Start program period, allocating one case manager to focus on 20 high risk cases. Replicating this experience, the Illinois Department of Human Services has established "Closing the Gap," a new cooperative agreement between HRSA and the Department to focus additional resources on perinatal care delivery in very high risk Chicago areas. One of these areas, Austin, lies within the Westside Healthy Start target area. The Austin Closing the Gap program, led in Austin by ACCESS through a subcontract from the Illinois Department of Human Services, adds outreach and intensive case management services in this area, building on and supplementing the care offered by Healthy Start. Again, no Healthy Start funds are sought to provide services provided by Closing the Gap, and no duplicative services are provided.

**PHS 330 and Medicaid resources.** To operate their community health centers, each PHS 330 community health center organization receives direct grant support for partial support of uninsured patients as well as the opportunity to bill for Medicaid fee-for-service visits at an enhanced encounter rate. In the target community, the majority of pregnant women and infants seeking care at Westside Healthy Start sites are eligible for Medicaid or the state's SCHIP program for children ("KidCare"). Because of these PHS 330 and Medicaid program resources, Healthy Start grant funds are not requested for most of the obstetrical, pediatric and other direct medical care services provided to program participants. The PHS 330 and Medicaid programs are both key to the long term sustainability of Westside Healthy Start.
Section I. INTRODUCTION

Local Evaluation Component

A. **Discuss the impetus for the local evaluation. How was the local evaluation designed? Were project staff involved in conducting the local evaluation or was the evaluation contracted out? If contracted out, identify the name of the contractor.**

A number of national programs have been developed to address the public health problem of infant morbidity and mortality and the racial and ethnic disparities in perinatal outcomes. One such program is the Healthy Start Initiative. As one of the initial sites, Westside Healthy Start (WHS) has been committed to increasing access to prenatal care and ancillary resources for women at high risk for adverse birth outcomes. The program serves four communities on Chicago’s Westside: Austin, East and West Garfield Park and North Lawndale.

The Sinai Urban Health Institute (SUHI), affiliated to ACCESS through Sinai Health System, is conducting the local evaluation of WHS. SUHI contracted with ACCESS in February 2004 to replace the Center for Health Administration Studies in providing evaluation services to WHS. The evaluation team is lead by Jocelyn Hirschman, MPH, the local evaluator for the project. The director of SUHI, Steven Whitman, PhD, and Abigail Silva, MPH, a senior epidemiologist at SUHI, act as advisors to the evaluation. Sheena Freeman, a research assistant at SUHI, replaced the previous Data Liaison.

The local evaluation team has many years experience in the area of community health program evaluation and maternal and child health. Founded in 2000, SUHI is the main source for evaluations and community health research within the Sinai Health System. Under their direction, evaluations have been conducted related to pediatric asthma, newborn infants discharged from the neonatal intensive care unit, the ability of an intervention to facilitate the reintegration to their communities of injured children, smoking cessation and HIV counseling and testing. Findings from these evaluations have been widely disseminated and have impacted program and policy decisions both within the Sinai Health System and on a wider scale.

The evaluation team also includes an Evaluation Advisory Committee with representatives from SUHI, the WHS Program Director and other program staff, and the Consortium Chair.
Present a brief history of the local evaluation and describe all components. Was each of these components the subject of an evaluation study? Were some components of the evaluation added, dropped or modified? Please explain.

For the first three years of current project period (2001-2003), researchers at the Center Health Administration Studies (CHAS) at the University of Chicago led the local evaluation for WHS. They worked closely with the Data Liaison, a member of the WHS administration team, to facilitate the data collection at the health center sites. However, in late 2003 the decision was made to discontinue the relationship between WHS and CHAS and the Data Liaison position was eliminated. By February 2004, a new contract with SUHI for the local evaluation was implemented.

Changing evaluators midstream posed significant challenges to the evaluation of WHS. There was difficulty obtaining project data from the original evaluation team. Most of this data was finally made available in the form of summary tables and graphs. In addition, much of the knowledge about how data was collected and reported to MCHB during the project period was lost in several administrative transitions further complicating the handover of program knowledge. Thus, much of the work of the current evaluation team has been focused on piecing together the work of the previous evaluators, as well as reviewing the systems in place for data collection and the relationships between ACCESS and its WHS partner agencies. The evaluation team also developed a new evaluation plan for the upcoming four-year cycle.

Due to the late transitioning of the current evaluation team and the poor continuity of documentation from the previous evaluators’ work, the evaluation described herein is limited in scope. Specifically, the evaluation sought to assess the implementation of three components of the project: the Consortium, program administration, and the case management of WHS participants. Other important component of the program (i.e., outreach, health education, depression screening) were examined, but not with the same level of detail. Throughout the evaluation specific attention was paid to the data systems in place for capturing the necessary program data. The methods used to evaluate each component are detailed in Table I-1.

<table>
<thead>
<tr>
<th>DATA SOURCES</th>
<th>Consortium</th>
<th>Program Administration</th>
<th>Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Interviews with key informants</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Program records</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospital delivery records</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Other secondary data sources</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
C. Discuss the type of study (e.g., formative, process, outcome, SEE DEFINITIONS), and the involvement of the community and the consortia in conducting the evaluation.

Much of the local evaluations’ work has focused on a process evaluation of the program, especially since the program underwent major administrative restructuring during the project period. The process evaluation examined what was done by the program and for whom the services were provided. Specifically, the process evaluation focused on how participants entered the program, the depth of the services provided to them, and the organizational/structural context of the service delivery.

The evaluation also included an analysis of outcome measures using a secondary data source. This is described in more detail in the following section.

Information gathered in the evaluation was presented quarterly to the Evaluation Advisory Committee, which includes members of the Consortium. The evaluation team also attended all Consortium meetings and evaluation plans, procedures, and findings were regularly reported to the Consortium. The Consortium also provided feedback and helped orient the evaluation team to the culture and expectation of the consumers and health providers in the community.

Key Questions and Hypotheses

Discuss key questions and hypotheses the local evaluation used.

The evaluation team sought to determine whether specific performance measures changed in desired ways during the program period. The evaluation was based on the assumption that the measures would have been unchanged, or possibly improved, if there had been no intervention. Under this assumption, improvements must be significant before the program will be considered successful. Even in this case, however, it is not possible to conclude unambiguously that the program was successful, since the change may have been due to other exogenous factors. Likewise, lack of significant positive improvements does not mean that the program failed.

Section II. PROCESS

A. Discuss the procedures for conducting the local evaluation. Describe the role of the community or consortium in conducting the evaluation. Discuss the methodology (ies) in the local evaluation (e.g., case study of five agencies, secondary analysis of vital records data, pre and post interviews with women participating in health education, etc.). Describe the sampling design, if any and any comparison or control groups used.
Because of the challenges described above in using WHS program data for the local evaluation, the evaluation team relied largely on observation data, interviews with program staff in the fourth-year of the project, and the review of program data to assess the program’s process success. To analyze the program’s effect on outcomes, secondary data sources were largely used.

Specifically, delivery records for Mount Sinai Hospital, one of the major hospitals of delivery in the WHS target area, were the primary source of data for the outcomes evaluation. Data were examined for all eight years of program operation: 1997 to 2004. Subjects were stratified into two groups: 1) women who received the majority of their primary care at a WHS site and 2) women who received the majority of their primary care at another non-WHS ACCESS health clinic. The second group acts as a quasi-comparison group used to somewhat control for non-WHS related changes in perinatal services during the project period. However, the second group is not a true control group – it is not known the extent to which the second group differs from the WHS group in important factors known to influence maternal and child health.

Changes over time were measured as indicative of the effects of WHS; however, it is impossible to conclude definitively whether the change was directly due to the program or if no change would have occurred in the absence of the program. Similarly, the lack of desirable change in a specific outcome does not necessarily mean that the program failed.

As mentioned previously, the evaluation team shared findings with the Evaluation Advisory Committee and the Consortium regularly. Both offered feedback and helped to guide all aspects of the evaluation.

C. Identify and describe the data sources.

A variety of primary and secondary data sources were used to evaluate the following components of the WHS project: Consortium, program administration, and case management of WHS participants. Data sources for each category are listed below.

**Consortium**

Data for the evaluation of the WHS Consortium were gathered through a variety of means and sources. These include:

- Meeting documents
- Observational data
- Key informant interviews
- Annual surveys of Consortium participants

In the fourth-year of the project, the evaluation team conducted semi-structured interviews with the Consortium leadership. Open-ended questions were asked about the role and function of the Consortium, the degree of consumer participation in the planning and
implementation of its activities, and their satisfaction with the support (i.e., financial, logistical, mentoring) provided by the WHS administrative staff. The evaluation team also attended the majority of Consortium meetings and gathered additional observational data on Consortium’s meeting structure and function.

Program Administration
In depth interviews were conducted with administrative and clinic leaders at each of the partner organizations during the fourth-year. Again, open-ended questions were asked about the program structure and implementation at each site and their satisfaction with support from the WHS administrative staff. In addition, several meetings were scheduled with the partners to specifically discuss data collection and evaluation. Each partner was asked to produce an activity plan detailing the structure of their program and to present their data collection system to the evaluation team and WHS Program Director.

Case Management
Sources for the evaluation of the case management of WHS participants include:
- Personal interviews with the case managers
- Patient interviews
- Abstraction of case management records
- WHS program data
- Secondary data sources: hospital delivery records and medical charts

Open-ended interviews were also conducted with the case managers. Questions focused on case management workload (number of clients, how long open, hours/week on case management activities), description of typical case management activities, and work environment (supervision, communication, support). The evaluation team also attended case management team meetings.

Community Data
In addition, any evaluation of WHS would have been incomplete without some review of the project’s milieu – both as it affects project effectiveness, but also as it reveals the appropriateness of project design and goals. To develop a profile of these communities, secondary data sources (e.g., US Census, Chicago Department of Public Health) were used to provide a description of each community in terms of relevant SES, quality of life, and health indicators.

C. What measures were used? Describe any instruments used.

Consortium
Measures of consortium performance include:
• Frequency of meetings
• Meeting attendance
• Diversity of consortium attendees
• Consortium satisfaction with meetings/organization
• Established structure and leadership within meetings
• Member participation during meetings
• Meeting activities
• Decision making

Program Administration
Measures of program administration performance include:
• Frequency of meetings
• Meeting attendance
• Partner satisfaction with meeting/organization
• Program structure
• Monitoring and evaluation
• Timely/accurate data reporting
• Decision making

Case Management
Measures of case management performance include:
• Education and training
• Caseload size
• Retention of participants
• Participant activities
• Timely/accurate data reporting
• Participant satisfaction
• Performance measures

Section III. FINDINGS/DISCUSSION
Present the findings of your local evaluation including a discussion of any methodological limitations of the evaluation (e.g., completeness and quality of data, and response rates to survey instruments).

Description of the Community

A profile of the communities serviced by WHS was produced using secondary data sources (e.g., US Census, Vital Records, and Chicago Department of Public Health from 2000). They were used to provide a description of each community in terms of relevant SES, quality of life, and health indicators, as well as to demonstrate the need for perinatal services in these communities.

The WHS project area consists of four communities on Chicago’s Westside: Austin, East and West Garfield Park and North Lawndale. Together they have area a population of 203,195 (Table III.1). 93% of the total project area is African-American as compared to Chicago and the US with 37% and 12% respectively. The mean household income for the project area ranges from $18,342 (North Lawndale) to $33,663 (Austin), which collectively is 36% lower than the mean household income for the entire city Chicago and 41% lower than the US. The percentage of families below the federally defined poverty limit and the unemployment rate for the WHS communities are considerably higher than the respective rates in Chicago and the US, while the percentage of high school graduates is 14 to 22% lower than the US rate.

Studies have associated families with low SES and lower education levels with also experiencing a lower quality of life. Research has demonstrated women with similar demographics are also at greater risk for adverse birth outcomes. Additional risk factors contributing to poor outcomes for infants include maternal age and smoking/substance use during pregnancy, as well as trimester at which prenatal care is initiated.
Table 1. Demographic characteristics of Westside Healthy Start (WHS) communities
compared to Chicago and US, Census 2000

<table>
<thead>
<tr>
<th></th>
<th>Austin</th>
<th>West Garfield Park</th>
<th>East Garfield Park</th>
<th>North Lawndale</th>
<th>WHS Project Area</th>
<th>Chicago</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>117,527</td>
<td>23,019</td>
<td>20,881</td>
<td>41,768</td>
<td>203,195</td>
<td>2,896,016</td>
<td>281,421,906</td>
</tr>
<tr>
<td>Women of Child Bearing Age (a)</td>
<td>28,117</td>
<td>5,340</td>
<td>4,847</td>
<td>10,183</td>
<td>48,487</td>
<td>701,509</td>
<td>61,576,997</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Am. Indian or AK Native</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Asian</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Black or African-American</td>
<td>90%</td>
<td>98%</td>
<td>98%</td>
<td>94%</td>
<td>93%</td>
<td>37%</td>
<td>12%</td>
</tr>
<tr>
<td>Native HI or Other PI</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>6%</td>
<td>1%</td>
<td>1%</td>
<td>3%</td>
<td>4%</td>
<td>42%</td>
<td>75%</td>
</tr>
<tr>
<td>Unknown</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>3%</td>
<td>2%</td>
<td>16%</td>
<td>8%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>4%</td>
<td>1%</td>
<td>1%</td>
<td>5%</td>
<td>4%</td>
<td>26%</td>
<td>13%</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>96%</td>
<td>99%</td>
<td>99%</td>
<td>95%</td>
<td>96%</td>
<td>74%</td>
<td>87%</td>
</tr>
<tr>
<td>Median HH Income ($)</td>
<td>33,663</td>
<td>23,121</td>
<td>24,216</td>
<td>18,342</td>
<td>24,836</td>
<td>38,625</td>
<td>41,994</td>
</tr>
<tr>
<td>Family Poverty Rate (b)</td>
<td>26%</td>
<td>40%</td>
<td>37%</td>
<td>52%</td>
<td>34%</td>
<td>20%</td>
<td>12%</td>
</tr>
<tr>
<td>High School Graduates (c)</td>
<td>66%</td>
<td>58%</td>
<td>61%</td>
<td>60%</td>
<td>64%</td>
<td>72%</td>
<td>80%</td>
</tr>
<tr>
<td>Unemployment Rate (d)</td>
<td>17%</td>
<td>22%</td>
<td>23%</td>
<td>26%</td>
<td>20%</td>
<td>10%</td>
<td>6%</td>
</tr>
</tbody>
</table>

\(a\) Women of child bearing years are women between the ages of 15 and 44.

\(b\) Families poverty rate is the percent of children under the age of 18 in families with annual incomes below the federally defined poverty level in 1999.

\(c\) High school graduates are among those 25 years and older.

\(d\) Unemployment Rate is the percent of resident civilians over age 16 who are without work and actively seeking work.
In 2000 approximately, 48,000 of the WHS area residents were women of childbearing age between the ages of 15-44 years old (Table III.1). Pooled statistics between 1999 and 2001 revealed that were 12,178 live births in the project area (Table III.2). 26.5% of the births were to mothers younger than 20 years of age. This was 10 to 15% higher than the Chicago and US percentages. Subsequently, the infant mortality rate for this area was 15.6 deaths per 1000 live births as compared to IMR of 10.3 and 6.9 for Chicago and the US. The percentages of low birthweight births were also significantly higher than city and national averages.

Table III.2. Birth outcomes of Westside Healthy Start (WHS) communities compared to Chicago and US, Vital Records, 1999-2001

<table>
<thead>
<tr>
<th></th>
<th>Austin</th>
<th>West Garfield Park</th>
<th>East Garfield Park</th>
<th>North Lawndale</th>
<th>WHS Project Area</th>
<th>Chicago</th>
<th>US 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Live Births</td>
<td>6,485</td>
<td>1,460</td>
<td>1,297</td>
<td>2,936</td>
<td>12,178</td>
<td>151,023</td>
<td>4,058,814</td>
</tr>
<tr>
<td>Births to Mothers Younger than Twenty</td>
<td>25.4%</td>
<td>27.8%</td>
<td>27.6%</td>
<td>27.7%</td>
<td>26.5%</td>
<td>16.2%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Births to Mothers Who Smoked During Pregnancy</td>
<td>8.6%</td>
<td>17.1%</td>
<td>19.5%</td>
<td>17.4%</td>
<td>12.9%</td>
<td>8.0%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Births with Mothers with No Prenatal Care</td>
<td>4.2%</td>
<td>8.2%</td>
<td>7.9%</td>
<td>5.5%</td>
<td>5.4%</td>
<td>2.8%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Births to Mothers Receiving 1st Trimester Prenatal Care</td>
<td>73.8%</td>
<td>61.6%</td>
<td>61.8%</td>
<td>67.0%</td>
<td>69.4%</td>
<td>76.7%</td>
<td>83.2%</td>
</tr>
<tr>
<td>Low Birthweight Births (1501-2500 grams)</td>
<td>11.3%</td>
<td>12.7%</td>
<td>13.3%</td>
<td>13.1%</td>
<td>12.1%</td>
<td>7.9%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Very Low Birthweight Births (1500 grams or less)</td>
<td>3.3%</td>
<td>2.8%</td>
<td>3.9%</td>
<td>3.3%</td>
<td>3.3%</td>
<td>2.1%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td>16.5</td>
<td>17.8</td>
<td>15.4</td>
<td>12.6</td>
<td>15.6</td>
<td>10.3</td>
<td>6.9</td>
</tr>
<tr>
<td>Sudden Infant Death Syndrome (SIDS) Mortality Rate</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.9</td>
<td>0.8</td>
<td>0.6</td>
</tr>
</tbody>
</table>
To understand the severity of the problem in these communities, data revealed a considerably higher percentage of mothers who smoked during their pregnancy (12.9%) as compared to 8.0% of mothers in Chicago who smoked during pregnancy. In East Garfield Park, the percentage of smoking mothers was as high as 19.5%. 4.2% (Austin) - 8.2% (West Garfield Park) of mothers did not receive any prenatal care during their pregnancy.

Overall, these statistics document the disproportionate rates of adverse perinatal outcomes for the WHS communities as compared to the city and national rates, while demonstrating the need for programs like WHS to concentrate resources that target specific risk factors to improve the birth outcomes for women and children in these communities.

**Process Evaluation**

Much of the evaluation team’s work has focused on assessing how the program was implemented at ACCESS and the five WHS partner sites – a so-called process evaluation. Specifically, the evaluation focused on how participants entered the program, the depth of the services provided to them, and the organizational/structural context of the service delivery. The team largely relied on monthly data reports from the partners and interviews with program staff for information on program activity. An inherent limitation to this analysis is that it relies mainly on self-report by the sites on their activities. Data was examined both on a site-by-site level, as well as aggregated as WHS. Much of this data is presented in Tables A, B, and C and are included with this report.

The two main findings resulted from the process evaluation:

(1) The WHS program is successfully targeting high-risk pregnant women. In 2004, approximately, 98% of the new pregnant participants were considered “high-risk” using established criteria. 17% had two or more criteria that defined them as medically high-risk (e.g., previous history of 3 or more STD’s, previous history of low birth weight or pre-term labor, current or previous history of depression, diabetes, etc.), 34% had 2 or more criteria that defined them as socially high-risk (e.g., teen with little or no support system, homeless or unstable housing, current or previous history of substance abuse, etc.), and 47% had multiple criteria in across both the medically and socially high-risk categories. Demographically, pregnant participants in WHS reflected the target area: 74% of the women in WHS were African-American and 13% were less than 18 years old. Most (80%) were living below 100% of the federal poverty level.
Caseloads averaged about 60 clients per case manager and 85% of those enrolled as pregnant participants were case managed throughout their pregnancies. The main reasons a pregnant participant may have left case management early included: changing healthcare providers (36%), family moving outside of target area (24%), and being lost-to-follow-up (26%). Very few (5%) refused case management services once enrolled.

The other main finding from the process evaluation is that (2) services were not being delivered consistently across program sites. Overall, the WHS partners were comprehensively screening all pregnant participants for medical risk factors (such as STD/HIV, obesity gestational diabetes, etc.), as well as risk-behaviors (smoking and drug/alcohol use) and social risk factors (homelessness and domestic violence); but the prenatal and interconceptional care models were being implemented differently across partner sites. For example, one site was not following up with their participants for two years postpartum, but instead referring them to another program within their organization. Also, the sites varied in the curriculum offered through prenatal and parenting classes and in the frequency of services offered like home visits and doula assistance. Based on these findings the WHS Program Director made considerable efforts in 2004 to bring each of the program’s partner sites in to alignment with WHS objectives.

Also worth noting is that WHS lacks of an overarching data system across sites. Instead each partner site has its own clinic specific database to capture relevant information on participant demographics, case management activities, participant outcomes, and medical care received. The data is then analyzed and compiled on a monthly basis and submitted as a “WHS Monthly Partners Report” to the WHS Project Director. The quality of these reports varied based on the data available at each site and the skill level and knowledge of the staff responsible for compiling the report.

This lack of a central data system has been an ongoing challenge in monitoring and evaluating the program. In interviews with program administrators at the partnering sites, they unanimously expressed frustration with the MCHB reporting requirements (lack of consistency, confusion with definitions, difficulty obtaining particular information), in addition to their limited budgets for administrative and technical assistance. As a result, much effort has been made to offer the evaluation team’s expertise in data collection systems to the partner agencies. Numerous meetings, including site visits to each partner, have been made and data collection tools have been streamlined and updated to address particular concerns.

**Estimating the Effect of WHS on Outcomes**

To explore the WHS program’s effect on improving perinatal outcomes for its participants, the local evaluation relied largely on secondary data sources for the analysis. As mentioned previously, changes in both the evaluation team and administrative staff during the program period made the reliance on the program data for this analysis unadvisable. Instead, the delivery records for Mount Sinai Hospital (MSH) were selected to be the main source of data for the estimating the effect of WHS services.
MSH is one of the major hospitals of delivery for the WHS project area. For example, in 1998 15% of births to women in the WHS project area occurred at MSH. It is also the main hospital of delivery for the ACCESS health system, the largest provider of perinatal services in the WHS project area. In fact, 92% of WHS participants at ACCESS delivered at MSH in 2004. Information on each birth at MSH is entered into a computerized medical record system, Meditech. The records are then uploaded regularly into an analysis program called Decision Support System (DSS). The evaluation team was then able to export the delivery data from DSS to a statistical analysis software program for further analysis. Data were examined for all eight years of program operation: 1999 to 2004.

Women who delivered at MSH who sought the majority of their primary care at either a WHS site (intervention group) or at another non-WHS ACCESS site (comparison group) were the study population of interest. However, the unit of analysis was the delivery itself; thus, a woman may be included more than once if she delivers at MSH more than once over the course of the evaluation period. Due to the limited data available through DSS, this analysis was not able to compensate for risk factors including maternal education, marital status, inter-birth interval, or family SES. Where possible, data were stratified by race/ethnicity, maternal age, and singleton births in order to examine the effects of confounding by such variables on the observed results.

Most of the analyses were based on simple trend models that aimed to identify trends over time and determine whether the trends are significant at the traditional p-value of less than or equal to 0.05. Year-by-year comparisons between the intervention group and comparison group were also tested for significance.

It is also important to be aware of a few limitations of this analysis. First, there is no true control group; thus, it is not possible to say whether the observed outcomes are likely due to the WHS intervention or some other factor. The comparison group used here is, at best, an imperfect proxy for a true control group for the reasons discussed previously. A second limitation is that the analysis only includes WHS births that occurred at MSH. It is not known to what extent outcomes of births at other hospitals would have differed from the outcomes seen at MSH; thus, it may be difficult to generalize the results at MSH for the results of WHS. Lastly, within the WHS group, there are women included that did not participate in WHS prenatal activities (e.g., low risk, refused services, sought prenatal care elsewhere); thus, any changes in outcomes that we do see are likely to underestimate the true effect of WHS services.

Four important outcomes were examined: entry into prenatal care in first trimester, adequacy of prenatal care utilizations (as measured by the Kotelchuck), low birthweight births, and pre-term births. Results for each outcome of interest are presented below.

**Prenatal care initiation and adequacy.** The percent of women who entered prenatal care in the first trimester increased from 30.4% in 1997, the first year of the project, to 48% in 2004, the last year of the project period, a statistically significant change (Figure III.1).
Women who received care at a WHS were also more likely to initiate prenatal care in the first trimester than women receiving care at a non-WHS ACCESS site in 7 of 8 years of the project.

*Figure III.1. Percent of deliveries that entered prenatal care in the 1st trimester, Mount Sinai Hospital, 1997-2004*

The trend is similar when WHS data is stratified by maternal age or by race/ethnicity (Table III.3). Interesting to note is that teen mothers (age at delivery less than 18 years) have the lowest rate of initiation of prenatal care in the first trimester. In 2004, they achieved at rate of 39.7% while adult mothers achieved a rate of 48.2% (data not shown). Hispanic mothers made the most dramatic improvement in entering prenatal care in the first trimester. Their rate went from the lowest rate 29.5% in 1997 to 50.8% in 2004 – a 20% improvement.
Table III.3. Among women who received care at a WHS site, percent of deliveries that entered prenatal care in the 1st trimester stratified by maternal age and race/ethnicity, Mount Sinai Hospital, 1997-2004

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MATERNAL AGE</th>
<th>Less than 18</th>
<th>18-34</th>
<th>35+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997-1998</td>
<td></td>
<td>27.5%</td>
<td>32.2%</td>
<td>29.8%</td>
<td>31.5%</td>
</tr>
<tr>
<td>1999-2000</td>
<td></td>
<td>26.3%</td>
<td>44.0%</td>
<td>42.2%</td>
<td>42.2%</td>
</tr>
<tr>
<td>2001-2002</td>
<td></td>
<td>32.9%</td>
<td>47.0%</td>
<td>40.2%</td>
<td>45.1%</td>
</tr>
<tr>
<td>2003-2004</td>
<td></td>
<td>35.1%</td>
<td>43.3%</td>
<td>42.7%</td>
<td>42.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MATERNAL RACE/ETHNICITY</th>
<th>NH Black</th>
<th>Hispanic</th>
<th>Other*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997-1998</td>
<td></td>
<td>31.4%</td>
<td>31.7%</td>
<td>-</td>
<td>31.5%</td>
</tr>
<tr>
<td>1999-2000</td>
<td></td>
<td>39.2%</td>
<td>46.3%</td>
<td>-</td>
<td>42.2%</td>
</tr>
<tr>
<td>2001-2002</td>
<td></td>
<td>38.6%</td>
<td>51.5%</td>
<td>-</td>
<td>45.1%</td>
</tr>
<tr>
<td>2003-2004</td>
<td></td>
<td>38.2%</td>
<td>45.4%</td>
<td>25.0%</td>
<td>42.5%</td>
</tr>
</tbody>
</table>

* Rates were not calculated when the number of women in a group was less than 25.

Similarly, the percent of women who received adequate or adequate plus prenatal care (as measured by the Kotelchuck) increased from 28.6% in 1999 to 59.9% in 2004 (Figure III.2). Women at WHS sites were also more likely to receive adequate prenatal care than women at non-WHS sites in 5 of the 8 years of the project. When stratified by race/ethnicity and maternal age the trend persists (data not shown).
Low birthweight and pre-term births. The percent of low weight births did not change significantly during over the 8 years of program operation. It ranged from a high of 10.3% in 2002 to a low of 8.1% in 2001 (Figure III.3). The rate of low birthweight births was markedly lower for women at WHS sites compared to non-WHS sites in the first two years of the project, but the rates quickly equalized after that.
Figure III.3. Percent of singleton, live births that were low birthweight (less than 2500 grams), Mount Sinai Hospital, 1997-2004

Similarly, pre-term births (i.e., less 37 weeks gestation) changed little between 1999 and 2004 (Figure III.4). This remained true when low-birthweight and pre-term were examined by race/ethnicity and maternal age. 9.2% of the births to women at WHS sites were low birthweight and 10.6% were pre-term. African-American women had higher rates of low birthweight and pre-term births than Hispanic women (13.3% and 13.8% vs. 5.8% and 8.1% respectively).
Figure III.4. Percent of singleton, live births that were pre-term (less than 37 weeks), Mount Sinai Hospital, 1997-2004

Other Outcomes

Lastly, a few other outcomes are worth mentioning. In 2004, the evaluation team and the WHS Program Director decided to expand the outcomes to be examined from those related to solely to prenatal care utilization (e.g., trimester of entry into prenatal care, adequacy of prenatal care utilization), birth outcomes (e.g., low birthweight births, pre-term births), and infant survival (e.g., infant mortality), to include outcomes that may better capture the work of the WHS program. New performance indicators were added to the program plan that measured such things as: the participation in prenatal/childbirth education, breastfeeding initiation, utilization of family planning, completed referrals for mental health care and/or substance abuse treatment, among others.

Although, baseline data do not exist to which these measures can be compared, 2004 data reveal that that WHS has been successful in several areas, specifically: 55% of pregnant participants have attended at least one prenatal/childbirth education class, 92% of those referred to drug/alcohol treatment program and 75% of those referred for mental health services complete that referral, and 77% of postpartum participants are using a method of family planning at 12 months postpartum (note: family planning data is for WHS ACCESS only). The evaluation also reveals that much more needs to be done to encourage breastfeeding initiation among WHS participants: only 27% of pregnant participants initiate breastfeeding are delivery (WHS ACCESS data only) this can be compared to 49% of African-American mothers in Illinois according to PRAMS data, 2000-2001.
The new indicators and objectives for the upcoming four-year project period have been included with this report.

Section IV.  RECOMMENDATION

A. Present all recommendations that stemmed from the local evaluation. Please be sure to include policy, program, practice as well as other recommendations.

Several recommended have resulted from the local evaluation. These include:

- Program Director needs to clarify protocol and expectations for program implementation and communicate them to program administrators at partner agencies. In addition, there needs to be more monitoring of program activity and sites must be held accountable. To facilitate this effort, it may be helpful to formalize these expectations into partner contracts as deliverables.
- WHS may benefit from a unified data system. The lack of such a system has been an ongoing challenge to monitoring and evaluating the program.
- It was also suggested that the program objectives be redesigned to include outcomes that may better capture the work of the WHS program. Thus, new performance indicators were added to program plan.

B. Discuss directions for further evaluation studied that emerged from the local evaluation.

P.R.Event Study

The local evaluation of the WHS program revealed that more research is needed to understand the complexity of and the relationship between factors contributing to adverse pregnancy outcomes, in addition to, determining the existence of additional factors impacting the ultimate health and well-being of infants and mothers.

Through the Pregnancy Risk Event Study (P.R.Event), the evaluation team hopes to shed light on the experiences contributing to adverse outcomes for high-risk women. The study aims to: 1) determine the rates of specific adverse birth outcomes including: infant mortality, low birth weight and pre-term birth for at risk women enrolled in WHS as compared to non-Healthy Start women; 2) assess the occurrence of multiple risk events (i.e. substance use and domestic violence) just prior to, during and after pregnancy; 3) verify participant satisfaction with prenatal care, hospital care and case management and 4) lastly, validate data collected by case managers for the WHS program evaluation.
Beginning in October 2005 through September 2007, the evaluation team will conduct face-to-face interviews with approximately 200 mothers 2-4 months postpartum regarding their pregnancy experiences. The women will be asked to discuss occurrences of smoking, alcohol intake, drug use and depression. Nutrition habits, presence of social support, pregnancy intendedness, and prenatal care are additional topics covered in the interview.

Data from this study will be compared to state and national statistics for low birth weight and pre-term births, as well as to other behavioral, demographic and environmental risk factors. Birth outcomes and risk exposure for WHS mothers and non-Health Start mothers will also be compared.

Findings from the P.R.Event Study will be used to improve the quality and quantity of services provided for women and children in Chicago communities. In addition, the hope is that the data will point to additional risk factors in need of concentrated research and subsequent intervention development.

**Outreach**

The local evaluation also revealed that little is known on the effectiveness of other important components of WHS; particularly outreach efforts. To address this lack of information, new tools have already been designed and implemented to facilitate the evaluation of these components.

**Section V. IMPACT BASED UPON THE RECOMMENDATIONS /RESULTS OF THE LOCAL EVALUATION**

**A. Describe changes in the perinatal system or any impact on the community in general that resulted from the local evaluation recommendations.**

Data from the local evaluation was presented to representatives from two local prenatal initiatives, Closing the Gap and Steans Family Foundation. Both organizations are working to eliminate racial disparities in the area of perinatal health in two WHS community areas: North Lawndale and Austin. These projects intend build upon the existing infrastructure of Healthy Start and other state-funded maternal and child health services to improve the outreach, case management and health education provided to high-risk women in the project area. Data from the WHS evaluation is helping them propose new directions for their programs, as well as develop a more targeted approach in to improving maternal and child health in partnership with other perinatal programs on the Westside of Chicago.
B. Describe changes in project implementation, management or administration that resulted from the local evaluation results.

As described above, the evaluation data has prompted WHS to look at how the program model has been implemented across the partnering sites and improve on service delivery to high-risk women. It has also driven the program to refine its data collection tools and expand the number of data points collected. In addition, the local evaluation results have revealed the need for more information on the experiences of high-risk women just before, during, and after their pregnancy. To that end, the local evaluation will implement the P.R.Event study to gather such information in an upcoming four-year project period.

Section VI. PUBLICATIONS

Identify all publications resulting from the local evaluation(s) conducted. Give source, title and author(s). Place copy (ies) of any publication(s) in the appendices.

None.