

NORTHWEST INDIANA HEALTHY START

**IMPACT SUMMARY
PROJECT PERIOD
February 1, 2002—January 31, 2006**

**Submitted by
Northwest Indiana
Health Department Cooperative
June 1, 2006**

HEALTHY START IMPACT REPORT

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

The Northwest Indiana Healthy Start Project consists of the cities of East Chicago, Gary, Hammond and Lake Station in Lake County, Indiana.

The combined population of the Project Area cities during the project period was 248,673, which is over half of the total population of Lake County, according to the 1990 U.S. Census. The ethnic-racial mix of the Project Area is approximately 44.98% African American; .16% Native American; 24% Asian/Pacific Islander; 40.49% White; and 13.94% Hispanic.

Women comprise slightly more than half of the population of the Project Area (131,299) or 52.80%. Of the population of women, 52.29% (68,661) are women of reproductive age.

During the three year period 1996-1998, 759 infants were born to child-bearing females aged 18 and younger. Over half (52%) of these births, 399 were to African-American females, while 239 births were to white females. Hispanic females in this age range recorded 116 births, and 5 births were to females of other racial/ethnic origins.

The infant mortality rate for the Project Area during the project period was 13.9 deaths per 1000 births. This was a primary area of disparity between whites and blacks as evidenced by the infant mortality rate of 8.7 for whites compared to 18.4 for blacks. The Hispanic infant mortality rate for this same period was 7.6. The State Title V needs assessment identified Lake County as having the worse black infant mortality rate in the State.

The neonatal mortality rate for this time frame was 8.3 which was well above the State rate of 5.1 in 1998. The average rate for the three year period 1996-1998, by race/ethnicity was: white 5.6; black 12.3 and Hispanic 5.0.

The average rate of post neonatal deaths in the Project Area for 1996 through 1998 was 4.2 per 1000 live births. The racial/ethnic breakdown shows a white rate 3.0; 6.1 for blacks, and 2.5 for Hispanics.

Low birth weight infants account for 13.1% (536) of the total births during 1996-1998. Of these babies, 10.4% (426) were of low birth weight, while 2.7% (110) were very low weight births. Sixty-five percent of the low weight infants were born to black women.

In addition to the disparities outlined above, the needs assessment identified inadequate prenatal care, delayed entry into prenatal care, smoking, substance abuse and lack of adequate financial and health resources as contributing factors to poor birth outcomes in the Project Area. This was especially true in the African American and Hispanic communities.

II. Project Implementation

Outreach and Client Recruitment

A. Outreach/Recruitment was determined to be an integral part of the delivery of comprehensive prenatal care services. The role of the outreach worker is to promote community awareness and perform case finding techniques for the purpose of recruiting new participants. Many women who could benefit from prenatal care services may not be aware of service availability nor know how to access various community resource agencies.

B. Many methods were used to reach potential participants, including, door to door canvassing, collaborative health fairs, marketing program services to various community agencies, physicians, as well as public service announcements. Materials distributed included those written in Spanish in order to meet the needs of the Hispanic population located in the Project area. Outreach workers, products of their own communities and knowledgeable of resources, took the program to the women who were termed as being “hard to reach”. In addition, the Project promoted the hiring of bilingual Outreach Workers to facilitate delivery of services to the Spanish-speaking participants.

There was a change in the role of the Outreach Workers based upon the loss of program funding for this budget period. In prior years, Outreach Workers also served in more of an ‘advocacy’ role where they had more direct client contact. Also during this time, Outreach Workers/Health Advocates were only assigned to one city in the project area. With the cut in funding the role was changed as mentioned above and the workers were assigned to more than one city.

C. This service was successfully implemented as planned by the project.

Case Management

A. Early in program implementation it was determined that adhering to a strict medical model of delivering services would not adequately meet the needs of the population residing in the Project area. Residents were faced with financial problems resulting from lack of employment and health care benefits. In addition, social problems such as inadequate housing, lack of familial support, absence of public transportation, and limited knowledge of risk factors that impact the outcome of pregnancy were obvious issues of concern. Case Management/Care Coordination services were implemented to address the socioeconomic risk factors that impact upon the health and well being of mother and child that were not readily accessible through the medical model. Economic factors can adversely affect the outcome to pregnancy. The lack of funds translates into limited or denied medical care, inadequate nutrition and limits access to needed transportation.

B. Because of the high ratio of socioeconomic problems to strict medical concerns, social workers were used to staff the model. Social workers have the skills needed to assess medical and social problem areas. Based upon the assessment, a plan of care is developed and implemented. Given the social workers knowledge of community resources and eligibility requirements for those resources, barriers to service access are minimized.

The case manager/care coordinator is responsible for coordinating service delivery, charting the course of action, linking participants to resources, monitoring outcome and providing an ongoing assessment/ reassessment of the participant's situation to ensure adequate, timely and appropriate intervention. The provision of these functions addresses the barrier of lack of access and linkage to available community resources. The assessment explores the health, medical, social, financial, environmental, nutritional, and psychological needs of a participant in collaboration with the participant.

C. This has been an ongoing model for Northwest Indiana Healthy Start and has been fully implemented for several years.

Health Education and Training

A. Based upon the belief by the Consortium that risk taking behaviors are best addressed by education, and the fact that there was a lack of consistent, convenient, and relevant health education offerings within the Project area, Health Education was initiated. Prior to Healthy Start, area hospitals offered limited Health education classes to perinatal women. Class attendance was contingent upon the ability to pay. Class schedules were not flexible. Transportation and child care were also barriers to attendance. In addition, few, if any classes were available in Spanish.

B. The Health Education and Training model is staffed by two registered nurses, one of whom is Spanish speaking. Classes such as breast feeding, child development, infant and car seat safety, cigarette smoking, STD's, the effects of substance abuse and domestic violence provide information on which the participant may base life style changes and reduce risk taking behaviors. Budgeting, exercise, and stress reduction are offered to aid in the overall well being of participants. Classes are also available for child development and parenting. Armed with adequate knowledge and understanding the consequences of risk taking behaviors, participants are more likely to reduce some of the "risky" behaviors.

Case managers make referrals to Health Education based upon participant's needs and the Plan of Care.

With the closing of the freestanding sites as mentioned before, the locations of Health Education classes had to change. Fortunately the community partners allowed collocation and the two Health Educators travel to the different locations in the project area.

C. The intervention was successfully implemented due to the assistance of the community partners that serve the same population and allocated space to Healthy Start.

Interconceptional Care

A. To implement interconceptional care services, an emphasis was placed upon retention of women who were enrolled in the program during the prenatal period and recruitment of post partum

women. One of the reasons this approach was taken was to allow continuity for program participants since Case Managers provide these services. Recruitment of post partum women was increased in an attempt to educate them on health issues between pregnancies.

B. The core of the program is its counseling services, which centers on health issues that women face. Qualified and experienced social workers provide the counseling services and facilitate access to needed services. Health Educators are available to provide additional information. The need to allow the body to heal between pregnancies, eating nutritiously, and family planning options are addressed with each interconceptional care client. Counseling about risky behaviors is referred to external agencies as needed. Parenting issues are broached through utilization of the Beginnings Parents' Guide. The guide provides information on child care from 2 weeks until age 3 years. Information is given to the client regarding well baby check-ups, immunizations, home safety, and infant and toddler feedings. Obesity and childhood diabetes information is also distributed.

While the Case Management function has been active for quite a while, there was a program change during this period dictated by the Division. The program now extended service intervention until age two as opposed to the infant's first birthday. Because of this, Case Managers had to be trained in handling more issues pertaining to post partum women. The Beginnings Guide for postpartum was used as a tool for Case Managers to use with these women.

C. This intervention was successfully implemented.

Depression Screening and Referral

A. The approach for Depression Screening and Referral was developed in a manner that would allow existing Healthy Start staff to deliver these services since there would be no additional staff hired.

B. Prenatal clients are screened using the Postpartum Depression Risk Assessment During Pregnancy scale. Clients who are post partum are screened using the Edinburgh Postnatal Depression Scale. Case managers perform the screenings for depression; however, Health Educators may also provide screening. Clients who appear to be at risk are referred to the family doctor or to the local community mental health center. The Case Manager provides follow up contacts to ensure compliance. The screening is reviewed with the client at eight weeks, six, twelve, eighteen and 24 months.

C. The working policies of the local community mental health center have somewhat detracted from the overall success of this intervention. The mental health centers are cooperative but have not embraced the concept of establishing protocols for perinatal referrals. As a result, there are no established procedures that facilitate service access. It is impossible to get direct feedback from the centers. Better feedback would aid in the development of a more comprehensive case management aftercare plan as well as expedite exchange of information on the client's progress.

Local Health System Action Plan (LHSAP)

A. The LHSAP developed for the project period consisted of two activities. The goal of the first plan was to create an integrated referral system that would allow pregnant women linkage to appropriate prenatal care and social services from multiple points of entry. The primary focus of this plan was the formation of regularly functioning network of providers. This effort was chosen to assure local agencies had a forum for ongoing communication and education about various programs and services. This had been attempted in years past with some degree of success but had waned. Since the project area has a number of MCH programs, it was felt that the best approach would be to assure that services were coordinated and as integrated as possible. It was determined that the best way to do this was creating a MCH network.

The second plan was developed to heighten awareness about post partum depression and to increase resources for women who become depressed after pregnancy. This plan was developed to fill an unmet need in the project area. The area community mental health centers do not provide any special services to pregnant women nor was there any effort to do community education on the subject.

B. The components of the MCH Network are the local MCH providers and their participation. Meeting locations are rotated among the membership. The State Title V agency provided a small amount of funding for the network, mainly to promote MCH services. These funds are funneled through a local non-profit agency. The agency, Health Visions Midwest, also provides staffing for network meeting coordination and follow-up and clerical assistance.

The second plan focusing on post partum depression has very few components. The screening tool used by Healthy Start – The Postpartum Depression Risk Assessment During Pregnancy scale and the Edinburgh Post Natal Depression scale was shared with other area providers for incorporation in their practice. These interventions and activities were handled by the project Case Managers and Outreach Workers.

C. State funding has been instrumental in the formation of the MCH Network. This has allowed for promotional activities as well as staff to assist the network.

Discussions held with the area mental health center representatives served to bring more attention to post partum depression and clarify basic referral procedures. However, the mental health providers are still resistant to creating special protocols for the perinatal population.

Collaboration and Coordination with State Title V and Other Agencies

A. Since its inception, Northwest Indiana Healthy Start has placed a high priority on collaboration. There has always been a working relationship with the State Title V MCH agency. The project's participation has been based upon strategies outlined in the Title V five year needs assessment. These strategies have been developed through continuous discussion with the Title V consultant based upon the needs of the local community. Or, the Healthy Start involvement is based on the needs of the State. For example, to assist in the development of the needs assessment, Healthy Start assisted with the development of community focus groups. Another collaborative

effort with the State agency is the “Baby First” Campaign. This is a public awareness campaign to promote healthy pregnancies throughout the state.

During this project period Healthy Start has been collocated in three WIC sites, an MCH clinic and three locations of the Lake County Division of Family and Children Services. These community locations were developed after the decrease in funding necessitated the closing of the freestanding Healthy Start sites in the project area cities. The collocation allowed the project to continue a community presence.

Healthy Start provides case management /care coordination services for the adolescent health center based in Central High School in the city of East Chicago, IN. The clinic was not funded by the State for this service and had no way to provide social services to pregnant teens.

B. Components of the collaborations outlined above include consumer and community recruitment for the focus groups and the utilization of educational materials from the “Baby First” campaign which were developed by the Indiana Perinatal Network. These items are free and are used by Case Managers and Outreach Workers.

The collocation of Healthy Start with other community agencies is at no cost. Case Management and Outreach staff is assigned to the various locations during the week. In some locations it has been necessary to provide a phone line for staff use.

Providing case management/care coordination for the high school requires a Healthy Start Case Manager on site three days a week to provide counseling and referral. The Case Manager also does home visits.

C. It was Healthy Start’s history of commitment to collaboration that paved the way for collocation when the federal funding was decreased and the new budget could not support the freestanding sites in the project area cities. There was no hesitation when the agencies were queried about space.

A lack of funding also precipitated the intervention with the high school. It seemed natural for Healthy Start to step and fill a gap.

Consortium

A. The Northwest Indiana Healthy Start consortium was initially established in 1991 in compliance to federal program requirements. Over these many project cycles the consortium has seen many people move in and out and have had to overcome weak consumer participation. A good deal of the loss in overall participation was caused by a decrease in funding. Because of this funding decrease, previous freestanding Healthy Start sites in the local communities were closed. These sites were mostly operated with contracted staff and these contracts were not renewed.

B. The components of the consortium consist of providers, consumers and staff. Resources can vary. For example, nutritional supplements are provided at each consumer meeting. To overcome

the loss of membership and rejuvenate the consortium, this project cycle saw a merger of the Healthy Start consortium with the Lake County Maternal Child Health (MCH) Network. This is significant for the local communities because it brings all of the MCH providers together in one meeting as opposed to several meetings per month. This is an improvement for Healthy Start since the consortium is no longer occupied with providers that are contracted with the program.

C. The State's funding of the Lake County MCH Network provided staffing which helped to bring the provider community together.

D. Consortium

1. The consortium was formed as a result of a decline in attendance by previous members, most of whom were providers. Coupled with this was the problem of no consumer attendance. Fortunately there were no barriers in merging with the MCH Network. Barriers in developing the consumer group were those that are often problems for this population – transportation and child care. To overcome these barriers, transportation is provided by Healthy Start and children are allowed at the meeting.

2. The consortium operates with two working groups. One group, called the Lake County MCH Network is composed of providers. The other group is composed of all consumers.

For the MCH Network, the group is all female; all are providers and also has Title V representation. The racial breakdown is 26% white, 48% black and 26% Hispanic. There are 23 members with 80% active participation.

3. The process utilized to assess ongoing needs is not formalized but done through monthly communication at the meetings. The identification of resources is done via the MCH Network. This has been experienced with a developing project to obtain safe infant cribs for families that cannot afford to purchase them. After identifying the need in the project area during a network meeting, staff from Health Visions Midwest began to work on obtaining the necessary funds. For this project the manner of implementation and monitoring was discussed at the meeting and then assigned to an adhoc committee to ferret out the details.

4. The community's major strength that enhanced consortium development is the recognition of the number of infant deaths in the community is still unacceptable. In addition, there is a commitment to working together among the MCH provider community.

5. There were no barriers to the merger of the Healthy Start consortium with the MCH Network. Barriers to the formation of the consumer group included transportation and child care.

6. The project set a goal to increase consumer participation in consortium activities. After much deliberation, it was decided to allow the consumer to have their own group. To facilitate this, promotional information about the purpose of the consortium was developed. The Case Managers and Outreach Workers made a concentrated effort to recruit program participants to the meetings. When the first meeting of this group was held they were given a historical look at the Healthy Start

project both nationally and locally. After this, discussion centered on how the project could be improved and what activities the group would like to do or what information they wanted.

7. Since the consumers have their own regularly scheduled meetings, it has been easier to obtain consumer input. Consumer input has been obtained in the direction of the overall program prior to submission of the continuation applications. Input has also been sought on informational and promotional items.

8. Program participants have been instrumental with the communications and media efforts. The project has been developing new brochures and flyers for project area distribution. Before these were published and distributed, a complete review was done by program participants. Any suggestions for changes were followed.

E. Sustainability

1. Northwest Indiana Healthy Start has contracted with the area Medicaid Managed Care Organization (MCO), Managed Health Services. The contract is reviewed annually and has case management and care coordination as its deliverables. The MCO faxes information regarding their insured and the case is assigned to the appropriate Case Manager. There are two other MCOs in the area but they employ staff to provide case management/care coordination services.

2. It has been very difficult to obtain funding that will sustain the components of the Healthy Start project. One of the primary obstacles is the tax status of the Northwest Indiana Health Department Cooperative – the grantee agency. The agency was developed as an interlocal cooperative between the four cities in the project area. However, it does not meet the criteria of the Internal Revenue code to qualify as a 501c3 organization. This is a hindrance since foundations are looking to donate to designated not-for-profit organizations.

State Title V funding has been funneled through the local health departments or the nonprofit agency Health Visions Midwest. This has been done to assure program continuity since these organizations have a diverse funding base.

3. To date this barrier has not been overcome. There will be ongoing dialogue with the Governing Board to determine the best strategy for obtaining additional resources. This may entail a total restructure. Having merged the Healthy Start consortium with Health Visions Midwest should prove to be an even better association since Healthy Start may be able to partner with them to obtain additional funding.

III. Project Management and Governance

A. Northwest Indiana Healthy Start is managed by the Project Director, Director of Case Management and Outreach, and the Director of Health Education. Everyone at the administrative level has been with the project in some capacity since 1995 and are well seasoned with both the program and the community it serves.

- B. The city of East Chicago serves as the fiscal agent for Healthy Start. This is a valuable asset since the city Controller's staff provides accounting services and handles the financial reporting.
- C. The management staff has remained stable during this period. The Governing Board is composed of the mayors and health officers of the project area cities. During this project period, two of the mayors were replaced through the election process.
- D. Early in the life of Northwest Indiana Healthy Start the Governing Board developed a resource allocation procedure that included staff development and justification, consortium review/comment and final approval by the Board. This process has remained in place but has often had to be modified. For example, if the governing board is unable to meet for the final approval, the Executive Director, who is a health officer and member of the board, is empowered to give final approval.
- E. The project did not use non-HS funds to provide quality assurance, program monitoring or service utilization. As an established program, these functions are handled internally.
- F. Cultural competency was not an issue for the project. Project staff is representative of the communities served. Contractors utilized have been engaged to provide technical expertise and have no direct client contact.

IV. Project Accomplishments

Outreach/Recruitment

Project Period Objective: By 1/31/2006, increase to at least 75%, the number of HS enrollees who entered into prenatal care during the first trimester of pregnancy.

Project Period Objective: By 1/31/2006, increase by 15%, the number of pregnant women residing in the Project area that has been recruited and receiving services.

Project Period Objective: By 1/31/2006, increase by 50%, the number of Hispanic participants who enter into prenatal care in the first trimester.

Accomplishments: During the Project Period, the primary outreach/recruitment strategy was to hire needed outreach staff; provide training and orientation to the job, the program and the participant population; establish and maintain enrollment and/or pregnancy testing sites in each community and promote overall awareness of program availability, services and benefits. Another strategy was to enhance program visibility by participating in area events such as health fairs, making rounds to day care centers, grocery stores, physician's offices, and schools as well the annual door to door canvassing event.

Cultural sensitivity is an integral part in the provision of outreach services in view of the large Hispanic population in the area. Bi-lingual outreach staff was needed to minimize the language barrier for Spanish speaking participants.

The Project accomplished the hiring of the needed staff. Two outreach workers were hired and successfully completed the orientation and training program in all of the necessary program and service performance areas. One worker is bi-lingual. In addition, enrollment and pregnancy sites have been established and continue to be maintained in various communities in each of the four Project area cities. The outreach staff, with the assistance of case management, administered 350 pregnancy tests at the various outreach sites in the four Project cities. Printed literature such as brochures, pamphlets, information sheets and the quarterly newsletter are available in Spanish. Outreach distributed 35,000 pieces of written information to 5,000 homes during the last door to door canvassing event. During the Project Period, 20,000 homes were canvassed and 115,000 pieces of literature in English and Spanish were distributed. Staff participated in a total of 47 health fairs (including church sponsored health fairs), visited 102 physician's offices, made 24 middle school presentations and completed frequent rounds to seven day care centers. Outreach referral cards were submitted for 1,260 duplicated prospective program participants during the Project Period. Outreach provided services to 1,363 prenatal families and 184 interconceptional care families.

There are 1,236 active prenatal, post partum and infant cases in the data management system to date. The recruitment strategies are working as far as engaging participants. Although the outreach staff was aggressive in the case finding process, the timeliness of recruitment was a major factor in not obtaining the goal of early entry into care. Many factors impact the entry into care. . State sponsored focus groups, involving Project area women of child bearing age, revealed that some of the reasons for delay are: not being sure of the pregnancy, not knowing the signs of pregnancy, financial concerns, previous uneventful pregnancies and unsatisfactory previous health care experiences.

The basic lesson learned is that in spite of the availability of services and the awareness of the services, some women still delay seeking care. Efforts to recruit in first trimester will be intensified. Information regarding the signs and symptoms of pregnancy will be distributed door to door and made available at all pregnancy testing centers.

The decrease in staffing may have had a negative effect on the outcome of this indicator. The staffing pattern utilized when the baseline was established was larger, by 62%, than the current pattern. Even then, 53% of enrollees were enrolled in the first trimester. In spite of the staffing pattern, outreach was able to recruit 47% of the participants in the first trimester. The first objective to recruit 75% of enrollees in the first trimester was not achieved. Forty seven percent of enrollees, enrolled in the first trimester of pregnancy. Approximately, forty six percent enrolled in the second trimester.

The second objective was to increase penetration in the Project area to recruit more women into the program. Outreach staff was able to recruit 23% of the number of pregnant women residing in the Project area based upon baseline data. This Objective was met. The lesson learned is that the strategies and techniques used were effective for recruitment purposes.

The third objective was designed to reduce racial disparities in accessing health care among Hispanic women. The goal was to increase the number of women entering into care in the first trimester. In the first year of the Project Period, 15 Hispanic women accessed care in the first trimester. Over the next three years, the number of Hispanic women who entered into care in the first trimester was 36, 10 and 18. The percentage of increase averages out to 30.1%. The increase in number is 2.4%, 66% and 1.2%. The increase in number is 1.2 which exceeds the 50% goal.

Case Management

Project Period Objective: By 1/31/2006, 80% of referrals made for prenatal and post partum participants receiving case management services will be completed.

Project Period Objective: By 1/31/2006, increase to at least 70% the proportion of 2-year old enrollees with self reported age appropriate immunizations.

Project Period Objective: By 1/31/2006, reduce to at least 5% the number of Low Birth Weight infants born to participants who prenatally received Case Management services.

Project Period Objective: By 1/31/2006, reduce to at least 1% the percentage of Very Low Birth Weight infants born to women who received prenatal Case Management services.

Project Period Objective: By, 1/31/2006, reduce to at least 10% the number of preterm infants born to women who received prenatal Case Management services.

Project Period Objective: By, 1/31/2006, Increase the number of Black and Hispanic women, enrolled in the Healthy Start Program who receive adequate prenatal in accordance with the Kotel (Kotelchuck) Index.

Accomplishments: The four objectives for case management were designed to enhance and facilitate participant access to services. Some of the obstacles to care are of a social, psychosocial, nutritional and developmental nature. Others may involve the reduction of risk taking behaviors such as smoking, drinking and substance abuse. These concerns pose problems that have a definite effect upon the outcome of pregnancies. Physical obstacles such as the lack of adequate transportation to needed services delays participant access to care. The strategy for case management is to reduce and/or remove these barriers. The tools used by case management are assessment of the needs of the participant and the development of a plan of action that addresses each individual participant's unique needs. The plan implemented most frequently involves providing in home education on risk taking behaviors and providing information and referral to available community resources to address other issues. Transportation, in the Project area, is a major obstacle for residents in all four cities. Healthy Start provides transportation to participants to medical and social appointments.

Case management staff, consisting of eight social workers, renders ongoing services to 1,236 prenatal, post partum and infant program participants. The number of families receiving duplicated services is 1, 348. Home visits were completed for each family. Visiting frequency is adjusted to meet the needs of at risk participants and those not at risk. Needs are reassessed at predetermined intervals to ensure the adequacy of services. The receipt of referral services is the foremost indicator of service provision.

Family planning services were provided to 759 participants and 356 families used the transportation services. The above objectives were realized in addition to the Project Period Objectives listed below.

The objective of validating receipt of services is foremost in the case management process. This objective was met. At least 80.1% of referrals resulted in participants getting what was needed. Referrals are classified as internal or external. The completion rate is higher for internal referrals made to program services such as Health Education. Transportation, a program service, is contracted to a provider. Missed appointments by participants and the service provider contribute to the number of incomplete referrals. Completion of external referrals is negatively impacted by failure of the participant to follow through, unknown changes in agency guidelines and ineligibility for services based upon additional data.

One of the lessons learned by case management is that follow up must be timely. Also, the eligibility requirements for resource agencies should and will be reaffirmed annually.

Age appropriate immunization of infants ensures better health outcomes. Case management staff seeks to make certain that infants are immunized. The objective for this indicator was exceeded. More than 75% of the infants in the program are age appropriately immunized.

The objectives to reduce the incidence of very low birth weight, low birth weight and preterm infants were not successfully completed. In order to better analyze the variables such as substance abuse, adequate weight gain, nutrition and adequate care, the Project is working on a tool that matches risk taking behaviors to birth weight. Based upon the outcome of the study, case management services can be better tailored to meet participant's needs.

The final case management objective concerning adequate medical care for African American and Hispanic participants has not been completed due to data management issues. Those issues continue to be addressed for institution of the monitor.

Interconceptional Care

Project Period Objective: By 1/31/2006, increase the percentage of enrolled post partum women with infants under the age of two.

Project Period Objective: By 1/31/2006, increase to at least 85% the proportion of participating post partum women who receive at least one interconceptional counseling session within eight weeks of delivery.

Project Period Objective: By 1/31/2006, at least 90% of the infants deemed to be At risk will receive risk appropriate services.

Project Period Objective: By 1/31/2006, reduce the number of HS mothers with pregnancies that occur within 24 months of a previous birth.

Accomplishments: Several strategies are used in this phase. In order to improve the physical health outcomes of interconceptional care women, the Project promotes longer intervals between births. Longer intervals between births, allow the mother's body to heal adequately, provide needed infant care and time to address other life style issues such as job training, career development and educational interests. It is of the utmost importance that women are made aware of available contraceptives in order to make an informed decision regarding usage.

In order to render viable services for women in the interconceptional phase, staff required additional training regarding women's post partum health issues. The services of a local gynecologist were used to enhance the staff's knowledge of post partum physical risk factors. Information on contraceptives, their use, effectiveness and family planning counseling were revisited. Additional in-services were conducted on breastfeeding, nutrition and stress management. Job training programs were researched and added to the list of available community resources. Case management has also added several new educational topics for this group of women on job finding, how to complete a job application, the use of credit and budgeting.

It was necessary to develop policies and procedures for this new category of care. Guidelines were established and staff received the necessary training. The visiting frequency and in home teaching criteria was developed and implemented. Beginnings, (Parent's Guide) was introduced and is utilized as an in home training tool. A review of the material in the Guide was completed prior to implementation of the guide. Upon completion of training regarding the needs of interconceptional care women, the objectives were addressed.

The first objective was met. Due to the efforts of outreach, and retention of participants by case management, 25.9% of the participant population is post partum women.

The second objective of providing interconceptional care counseling (family planning services) was not achieved at the 85% targeted. However, 80.1% compliance was achieved.

The third objective was achieved and exceeded. Infants deemed to be at risk, were referred to and received services to meet their needs. The majority of these infants, 27 or 87.1% had their needs met.

The final objective in this category, to reduce the number of women with subsequent pregnancies was achieved. When the monitor was established 13.3% of the participants had subsequent pregnancies. Currently, 11% of the participants had subsequent pregnancies.

Depression Screening and Referral

Project Period Objective: By 1/31/06, increase the number of participants with completed depression risk screening assessments.

Project Period Objective: Increase the number of participants with identified mental health needs who receive the needed mental health services.

Accomplishment: One of the strategies implemented during the interconceptional phase is to pursue a course that assists women and their infants to have better health outcomes through the promotion of comprehensive mental health care follow ups

To promote better mental health outcomes for new mothers, Healthy Start utilizes a screening process to determine if a mother is at risk for post partum depression. Based upon recent developments, there is an increased awareness of depression that may occur following child birth. If left untreated, post partum depression can progress to a psychotic stage and be detrimental to the women and her family. In order to address these objectives, staff needed additional training in mental health issues and women's health issues.

Mental health training was provided by the Tri City Comprehensive Mental Health Center. The training included signs and symptoms of depression, psychotropic medications frequently used to treat depression, and the guidelines for admission to the mental health unit. The difference in Baby Blues and post partum depression was explored. Staff also received training on utilization of the depression guide developed by the Indiana Perinatal Network. The Guide provides definitive information in four areas. The areas are: signs and symptoms, treatment, screening tools and resources. The signs and symptoms of baby blues, post partum depression, post partum obsessive/compulsive disorder, postpartum onset panic disorder, and postpartum psychosis are identified. Treatment and pharmacologic

interventions are listed for each disorder with the exception of baby blues. Baby blues does not usually require treatment. Effective screening tools are identified and explained in the guide.

The Project area chose to use the Edinburgh Postnatal Depression Scale for screening purposes. The Post Partum Depression Assessment During Pregnancy screening tool is used during the prenatal period to determine if factors are present that may indicate a possible risk for post partum depression. Extensive in-services were provided by internal staff on the use and scoring of the scales. A time framed protocol was developed for administration of the screenings. To enhance mental health outcomes, each interconceptional phase women is administered a screening for symptoms at six to eight weeks postpartum and every six months thereafter.

The Project Period objective was to increase the number of women for whom screenings had been completed by 85%. The number of women screened was: 52 the second year; 49 the third year and 84 the fourth year. In the third year there was a .5 decrease in the number screened. In year four there was an increase by 1.6% in the number screened as opposed to an 85% increase. The objective for the number was exceeded; however, the three year percentage average was not.

The focus of the second objective was to ensure that women with mental needs received the needed services. Several obstacles impeded progress in this area. Four participants with diagnosed mental health issues refused the services. In each situation, the participant was not deemed to be at risk by mental health technicians. Two participants moved from the area before follow up could be completed. Two additional patients were to see private psychiatrist. Based upon confidentiality, psychiatrist do not validate participants receiving care. These eight women were excluded from the total count. Of the remaining twenty four referrals, 70.8% were completed. Although, the Project is making progress in this area, the goal was not achieved.

Overall, the Project was able to achieve a degree of success in spite of a number of obstacles. The introduction of providing services to a large number of post partum women, posed concerns for the Project. Training issues were predominant and time consuming. Cost for training had to be kept to a minimum. Additionally, new budget constraints resulted in drastic staff reductions while the requirements resulted in an increase in the participant population to be served. Case load size was a concern. Providing transportation services was a challenge due to the loss of agency vans. Care Coordination reimbursement shifted for direct Medicaid payment to managed health care organizations. New prenatal care agencies were established. The data management system needed to be redesigned in order to capture needed data. These are a few of the obstacles faced.

All staff received the training to implement the interconceptional care and depression screening parts of the program. Policies and procedures were established and reviewed as indicated. In-services are held monthly to enhance staff knowledge on medical and social issues. General staff meetings and supervisory meetings supplement the in-services. Costs for training are kept at a minimum by utilizing free speakers.

To address caseload size, consideration is being given to the uses of volunteers to provide certain services.

Transportation arrangements were made with a local conveyor to ensure the availability of transportation in the Project area. Transportation is one of the largest obstacles in the four cities.

To minimize turf issues, Healthy Start, works with other prenatal care agencies in the area. HS provides education and transportation for other prenatal agencies. Those agencies are to reciprocate by referring their post partum clients to Healthy Start.

Healthy Start is working with managed health care organizations by providing care coordination.

The managed information system continues to be addressed.

These obstacles were successfully reduced.

Health Education

Project Period Objective: By 01/31/2006, increase to 100% the number of professional and paraprofessional staff whose pre- and post-test scores reflect at least a 20% enhancement in knowledge as a result of education and/or training.

Project Period Objective: By 01/31/2006, increase to at least 80% the number of participants who self-report a reduction in risk-taking behavior due to enhanced knowledge of the risks of substance abuse including alcohol and cigarette smoking.

Project Period Objective: By 01/31/2006, increase to at least 62% the number of active participants who attend one or more Health Education classes.

Project Period Objective: Increase the number of enrollees completing the Essential Life Skills, Family Planning and Sexually Transmitted Diseases curriculum.

Project Period Objective: By 01/31/2006, increase to at least 50% the number of enrollees attending Stress Reduction class.

Accomplishments: The strategy involved with the first objective was that by increasing the knowledge and skills of professionals and paraprofessionals serving the NWIHS community, the quality of services would be enhanced and the overall impact of the project would be improved. The education needs of the staff were assessed and periodically re-assessed and input was solicited from the professionals and paraprofessionals to ascertain what perinatal health topics they felt they needed more education about. In-services were offered to NWIHS professionals and paraprofessionals (as well as staff members from other agencies and NWIHS Consortium members) numerous times every year. For example, in CY2005 alone, there were 11 in-service training sessions held on topics such as pediatric care, tobacco cessation, large for gestational age babies, gestational diabetes, and infant nutrition. Presenters included Lake County Tobacco Prevention and Cessation, Women's Wellness Center, Prevent Child Abuse Indiana, and the two NWIHS Health Educators. Professionals and paraprofessionals from other agencies were invited to attend in-service education offerings. In CY2004, the Health Education Department began composing and distributing a

publication entitled “All About Health.” This quarterly informational newsletter provides synopses of recent perinatal health news as well as feature articles about various women’s health issues. Recent relevant findings in the numerous professional journals are also summarized. Also, a list of reputable internet sites was created in CY2003. This list was updated and distributed to NWIHS staff annually. The internet sites provided more information about all health education topics.

IV. Project Accomplishments

A.

Health Education

Project Period Objective: By 01/31/2006, increase to 100% the number of professional and paraprofessional staff whose pre- and post-test scores reflect at least a 20% enhancement in knowledge as a result of education and/or training.

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For the project period of 02/01/02 through 01/1/06, 90.1 % (10) of the 11 professional and paraprofessional staff maintained pre and post-test scores that reflected a 20% enhancement in knowledge as a result of education and training (Source: NWIHS Health Education data). There were not any major barriers to implementation of this strategy. One lesson learned had to do with the fact that the staff has not experienced a lot of turnover. When professional and paraprofessional staff members scored 100% on the pre-test for a given topic, adjustments needed to be made. Topics such as nutrition and substance abuse could not be eliminated from the training topics. This was remedied by having the same information presented in a different format, sometimes by a different agency.

The strategy involved with the second objective was to decrease risky behavior by increasing the participant's knowledge of healthy lifestyles through education and training. The effect of said education was to have a positive impact upon maternal and infant mortality and morbidity. Smoking Cessation and Substance Abuse classes were offered on a regular basis throughout the project period. Information about second-hand smoke was distributed. Participants were provided with information and education regarding the use of illegal/illicit drugs and the effects these drugs, to include alcohol, have on the fetus. Handouts were provided in English and Spanish. PowerPoint presentations were created for both of these classes. Every year, the NWIHS Health Educators held community presentations about the harmful effects of smoking and second-hand smoke. In CY2005, 559 community participants received education about the dangers of smoking (Source: NWIHS Health Education data, Indiana State Department of Health Free Pregnancy Test Log). A referral system was established to allow Case Managers to refer those who smoked cigarettes and/or were substance users to receive the appropriate health education services. In-service training was provided annually on the effects of substances upon the fetus. During the project period of 02/01/02 through 01/31/06, of the 153 participants enrolled in Health Education substance abuse classes, 71 (43.2%) self-reported a reduction in risk-taking behavior due to enhanced knowledge of the risks of substance abuse including alcohol and cigarette smoking (Source: NWIHS Health Education data). The largest barrier to implementation of this strategy was the fact that the participants who needed this particular education the most were often the most reluctant when it came to attending the classes. To overcome this barrier, the Health Educators discussed the benefits of avoiding tobacco, drugs and alcohol participants in person as well as via phone contact. Informational fact sheets were created and distributed to participants. One lesson learned was that while it was good to have Smoking Cessation and Substance Abuse classes offered on a regular basis, participants may be more responsive to a one-on-one approach.

The strategy involved with the third objective was that knowledge of the medical needs and the changes in the body during pregnancy would enhance the participants' understanding and would be likely to produce lifestyle changes that would have a positive effect on pregnancy outcomes. The health education curriculums were updated as needed. PowerPoint presentations were created for each of the classes. Each of the PowerPoint presentations followed the curriculum so to ensure continuity and consistency in information disseminated. Health Education calendars were distributed to participants. A monthly health education brochure was sent to approximately 40 social service agencies, physician offices and prenatal clinics since CY2003. Health education materials that were distributed were culturally appropriate for all populations. Handouts for the classes were generated in English and Spanish. Case Managers and Health Educators work together on a regular basis to meet

the needs of the program participants. In CY2002, a Health Educator who is bilingual in Spanish was hired so that classes could be offered in both English and Spanish. Pre- and post-tests were administered to those in attendance. For the project period of 02/01/02 through 01/31/06, 367 of 1,671 (22%) active participants attended one or more Health Education classes (Source: NWIHS Health Education data). Health Education was provided to 660 community participants from 01/01/2003 through 01/31/2006 (Source: NWIHS Health Education data). Health information was provided for 2,127 women who received a free pregnancy test from CY2003 through CY2005 (Source: Indiana State Department of Health Free Pregnancy Test logs). A significant barrier to the implementation of this strategy was the loss of the sites in each city. The loss of the sites in each city, combined with the fact that the community had been told that the NWIHS project was closing, were huge obstacles. However, once agencies in each community provided space for NWIHS Health Educators to conduct classes, and the community members realized that the NWIHS project indeed was still open, the barrier became less formidable. Another barrier was the lack of child care. Without NWIHS-provided child care services, many of the participants were forced to also tend to their children during class. Because of this, the Health Educators became proactive and brought age-appropriate toys for the children to play with while the parent(s) participated in the class. Still another barrier was getting the participant to attend a Health Education class. In CY2005, the Health Educators began attempting contact with every program participant. After three attempts for a phone contact (if the number was not disconnected or out of service), the Health Educators would send a letter (encouraging the participant to contact her), a class calendar and a handout on a topic such as Stress Relief. One lesson learned was that individual contact may have helped get more of the program participants to participate in health education classes.

The strategy involved with the fourth objective was to increase the period between pregnancies and provide participants with options. The criteria for monitoring the Interconceptional Care model were reviewed. The Essential Life Skills curriculum was selected and reviewed and the Health Educators were trained. During the project period, with regard to the Sexually Transmitted Diseases (STD's) class, a special emphasis was put on educating participants about Syphilis. A special handout was created and distributed about Syphilis and pregnancy. In addition to the STD's class, a separate class about HIV/AIDS was created and offered. This class had three separate handouts that were distributed to participants. The handouts provided information about the early signs of HIV, the risk factors for HIV, and the treatment options for those who are HIV+. Also, for each of the years in the project period, in accordance with National HIV testing day, a list of sites that provided free HIV testing was made available. During the project period, 89 community participants attended a health education class about HIV and/or STD's (Source: NWIHS Health Education data). Another opportunity to provide information to community participants was during the administration of a free pregnancy test. In CY2005 alone, 156 women received information about STD's and HIV risk and 174 women received information about Family Planning after a free pregnancy test was done (Source: Indiana State Department of Health Free Pregnancy Test Log). A class that was created to accomplish the goals listed in this objective was a specific class entitled Subsequent Pregnancies. This class encouraged women to allow sufficient time between pregnancies. The NWIHS Health Educators conducted community presentations on the topics of Family Planning and Subsequent Pregnancies. The Health Educators promoted the benefits of this curriculum package to eligible program participants and received feedback on how to make

the Essential Life Skills class attractive to other participants. For the project period of 02/01/02 through 01/31/06, 171 of 1,671 (10.2%) program participants completed the Essential Life Skills, Family Planning and Sexually Transmitted Diseases curriculum (Source: NWIHS Health Education data). The fact that the Essential Life Skills class was a series of classes may have been a barrier for attendance purposes. Also, because NWIHS had to rely on other agencies for space to allow for health education was initially a barrier but once the space was allocated it was just a matter of letting women know where to go for health education services.

The strategy involved with the fifth objective was that skills in reducing stress would enhance better pregnancy outcomes and improve overall mental health. The curriculum for the Stress Reduction class was reviewed. Updated materials were secured and the staff was trained regarding stress. During this project period, a handout was created that advocated ways to reduce stress. Information was provided to the participants in English and Spanish. Stress management/relief classes were offered. Different relaxation techniques have been researched. What seemed to work the best when it came to stress management was the use of activity-based classes. The most popular stress management class involved scrapbooking. The participants enjoyed creating a memories page and the various ways that they could use their creativity. One participant even commented that the class caused her to forget about the worries in her life for an hour. In addition to the Stress Reduction class, the NWIHS Health Education Department offered specific classes on Prenatal/Perinatal Depression as well as Postpartum Depression. Community participants were offered this same education when community presentations on perinatal depression were done for the general public. During the project period, 167 community participants attended education classes about Perinatal/Postpartum Depression and/or Stress Relief (Source: NWIHS Health Education data). By opening up the topic of depression in public, knowledge was disseminated in hopes of encouraging women to know the signs of depression and know where to get help. While attending a class about depression was not directly in this objective, treating depression had the potential to be a way of reducing stress in and of itself. Classes and information were made available in English and Spanish. For the project period of 02/01/02 through 01/31/06, 189 of 898 (21%) of enrollees attended Stress Reduction Class (Source: NWIHS Health Education data). One of the most significant barriers with this objective was getting program participants to attend the class. In response to this, and the lesson learned, was that the NWIHS Health Educators then worked toward making the class more interactive as well as increased the frequency of activity-based classes.

Project Impact

A. Systems of Care

1. Collaboration has been a priority since the inception of Healthy Start in 1991. This project period showed that the efforts have not been in vain. To clarify, when the freestanding service sites Healthy Start established in the project area had to close due to funding cuts, the MCH provider community responded without hesitation to the need for office space. Because of this, Healthy Start is now collocated in the offices of various WIC sites in the project area. Although not a MCH program, the Division of Family and Children Services has allowed space in three of its offices within the project area. This is the state Medicaid office so it is a very essential partnership. With Healthy Start staff onsite, Case Workers are able to make instant referrals of pregnant women seeking benefits.

2. System integration occurred in the area of enrollment for the Medicaid program 'Hoosier Healthwise'. This is Indiana's health insurance program. Enrollment forms have been stream lined and Healthy Start Case Managers have been trained to complete the application. This collaboration helps in removing the barrier of clients having to go to multiple locations for services. At one time a client had no choice but to travel all over for health and social services.

The city of East Chicago is fortunate to have an adolescent clinic in Central High School. Central's Life Awareness Support Services (CLASS) is designed to meet the health, nutritional and psychosocial needs of the students. Among these needs are services to pregnant teens. The CLASS clinic receives it's funding the state Title V office. In 2003 when the clinic was not funded to include a Care Coordinator, Healthy Start stepped in to provide these services. In providing this service o the clinic, several policies and procedures were redrafted to fit the collaboration. These changes included how teens are recruited into services, the frequency of visits and the inclusion of home visiting.

Another collaboration that was started by Healthy Start was 'Moms, Kids & Co.' Briefly, this is a unit in the Columbia Housing Development in Hammond that is used to house the offices of Healthy Start, WIC and This effort was started several years ago but was closed due to the funding loss. After some discussions with WIC and the Hammond Housing Authority the site was reopened. Today in addition to Healthy Start and WIC, a county wide nutrition program and pediatric dentist are in the facility.

3a. Longtime proponents of Healthy Start like to believe that the current trend of collocation in the project area is a direct result of the foundation laid by the project. Three of the project are cities (East Chicago, Gary and Hammond) have developed facilities to house health and social service agencies. It is in these facilities that the relationship between health and social services is best seen. Clearly, the Healthy Start program did not contribute financially to these facilities but the Project Director was a part of the planning and development of each. Therefore, the establishment of collaboration and the sharing of as much information as possible is strongly encouraged.

3b. Healthy Start was instrumental in assuring that consumer input was sought in the development of services for the reopening of 'Moms, Kids &Company". Quarterly consumers attend a discussion group to determine how the site is operating and asked about

new suggestions for offerings. As a result several community education activities were planned.

4a. As stated earlier, Healthy Start Case Managers are certified to enroll women into the Hoosier Healthwise insurance plan. This allows the Case Mangers to better assist clients obtain medical care because this application has been completed.

b. Healthy Start has helped reduce barriers to access and services by providing the facilitating services of transportation. The case management/care coordination system has also helped reduce barriers by providing an advocate to help navigate through resources when necessary.

Community awareness of services was done through ongoing outreach efforts. Door to door canvassing is a Healthy Start 'trademark' activity that has received a lot of positive feedback. Articles in the local newspaper have also helped to spread the word about services in the community.

c. During this project period Healthy Start was able to provide care coordination services until the infant was age two. Other area programs are only able to provide one or two visits after birth. Because of this extended coverage, a mechanism of referral was developed with the providers in the MCH network for ongoing case management and interconceptional care.

d. Data is shared within legal limits between Healthy Start and WIC on a regular basis because of the collocation. The enrollment efforts for the Hoosier Healthwise Program also allow for sharing of data to expedite services for women and children.

5a. The Healthy Start case managers work at encouraging ongoing participation in services. Topics of cultural sensitivity, linguistic and gender needs are discussed frequently at MCH network meetings. However, there were no efforts to extend this discussion beyond this group.

b. Healthy Start consumers have been organized to meet on a monthly basis. During these meetings their input has been sought about materials used for health education and service promotion. Their evaluation of assessment and screening tools has been minimum.

B. Impact to the Community

1. Outreach activities have been ongoing and have successfully informed residents in the communities about service availability and resources. The annual door-to-door canvassing delivers community resource material to hundreds of households in the project area. Not only is Healthy Start information distributed but also information on several other community resources. Recognizing that this activity is limited to targeted neighborhoods in the communities, information is always distributed in areas that the service population frequents. This includes grocery stores, currency exchange locations, food pantries and beauty supply stores.

2. Little was done in the area of consumer/community organizing to create change. This is due in part on the time it took to revitalize the consortium and maintain consumer participation. Consumer input has been sought regarding position papers submitted Indiana Perinatal Network. This has some impact on service delivery standards across the state.

3. Team building and conflict resolution was the main focus of creating change for the Gary Community Health Center. The Healthy Start Project Director began a term as board president during a time when staff moral and board and staff relations were poor. Drawing upon experience used for the development of Healthy Start and other health initiatives, relationships have greatly improved. Recently, the health center was awarded federal funding to enhance services.

4. Staffing has remained stable during this project period as it has for several years. No new jobs were created. Unfortunately, one of the long time Outreach Workers died during this funding cycle.

C. Impact on the State

The project's relationship with State Title V has been consistent since the beginning. During the project period Healthy Start has participated in the planning for the statewide Disparities Conference held in Indianapolis. Participants learned about causes of racial disparities in birth outcomes from various speakers. The group was also given findings from the 'Friendly Access Program'.

For the development of the MCH five year needs assessment, Healthy Start assisted in conducting a series of focus groups in Lake County. The involvement included recruitment of participants, locating meeting space and providing refreshments.

As previously stated, Healthy Start serves as an enrollment site for the state SCHIP program. Case Managers refer to state sponsored programs as needed for special health care needs and prenatal smoking cessation and drug use counseling.

Healthy Start also served as a member of the State team formed to participate in the AMCHP Disparities Action Learning Lab. The Director of Case Management and Outreach was a part of the Indiana's home team that developed the presentation for the meeting held in Atlanta, GA.

The benefits of having a good working relationship with State Title V are numerous. Data on birth outcomes and their analysis is one of the many services provided. This is invaluable and helps the project develop intervention strategies. Ongoing staff education is another benefit. There are many offerings sponsored by the agency or in collaboration with them. Finally the availability of an experienced MCH consultant is priceless. She has had valuable input for program planning and implementation.

D. Local Government Role

An Interlocal Cooperative Agreement on July 17, 1992 formed the Northwest Indiana Health Department Cooperative, as authorized by Indiana Code 36-1-7. The parties to the Interlocal

Cooperative are the City of Gary, City of East Chicago, City of Hammond, City of Lake Station, and Lake County. The purpose of the Northwest Indiana Health Department Cooperative is to provide Public Health Services to the governmental units that are party to the agreement. The Cooperative services shall include Primary Medical Care or other health services through clinics or other delivery systems and to seek funds, grants, and other sources or revenues to improve health services to the public.

This effort is unique and innovative in that it is an attempt to consolidate resources and efforts between and among cities that have been competitive in search of funds to assist citizens in each city. The agreement and programs are administered by the Joint Governing Board that is composed of the Mayors of each participating city and a county Commissioner. The Joint Governing Board is authorized and empowered to adopt rules and bylaws and shall have the same powers to supervise its internal affairs as other municipal administrative bodies.

The Health Officer of each participating governmental unit is a member of the Management Committee of the Board. The Management Committee is responsible for the implementation of policies of the Joint Governing Board and for the formulation of an organizational structure to accomplish the policies, goals and objectives of the Cooperative.

The Cooperative is required to use the services of a member city as a Fiscal Agent. The disbursement and fiscal management procedures used in these finance departments are set forth in state statutes and approved by the Indiana State Board of Accounts. This relationship allows for efficient project governance and management as well as maintains good financial controls.

E. Lessons Learned

Most of the lessons learned have been outlined in other parts of this report. In addition to those are a few thoughts about the project's experience with consortia. There have been some difficult times over the lifecycle of the project, all surrounding power and control. It is best to be clear to all potential members of the consortium about their roles, responsibilities and span of control. The notion of consortia development was new to the project area and somewhat confusing, particularly since the group was asked to be more than advisory but less than governing. It was difficult for some professional to grasp this concept and caused some power struggles between staff, consortium and board.

Over time this has been overcome. Having identified a process for mediation and conflict resolution from the onset would have been helpful.

VI. Local Evaluation

Local evaluation has somewhat improved but is still a project weakness. The outcome of a project satisfaction study has been attached but does not conform to the prescribed format. This area will be worked on for improvement.

VII. Fetal and Infant Mortality Review (FIMR)

The area did not have a FIMR project in operation during the project period. Planning began in the fall of 2005 for implementation in 2006.

VIII. Products

As suggested, pictures of items purchased during this period have been included. Print materials developed are included as an attachment.

IX. Project Data

The data has been submitted electronically as requested.

Final Report/Implementation Plan

Attachment A

**Grantee: Northwest Indiana Health Department Cooperative Healthy Start Project
Intervention: Outreach/Recruitment**

Project Period Objective	Strategy and Activities	Accomplishments
<p>By 1/31/2006, increase to at least 75%, the number of HS enrollees who entered into prenatal care during the first trimester of pregnancy.</p> <p>Baseline: 436 (numerator) of 999 (denominator) enrollees, or 43.5% were enrolled into prenatal care during the first trimester. (Data Source: NWI HS Data system and Case Management logs January 1 - December 31, 1999)</p>	<p>Strategy: Perform aggressive case finding activities designed to find women in the first trimester of pregnancy</p> <p>Activities:(With Implementation Time Frames) 1a. Hire two Outreach Workers (March 2002) 1b. Expand free pregnancy testing area in all four cities. (January, 2005) 1c. Develop and distribute new informational flyers concerning early entry into prenatal care. (February, 2005) 1d. Plan and initiate one city wide community recruiting event in each of the four cities (June, July, August, September, 2002) 1e. Re-institute monthly news article for area monthly Black newspapers regarding early prenatal care (March, 2005) 1f. Conduct one massive door to door outreach campaign in each city. (April, May, June and September 2004) 2a. Develop and implement prenatal care pregnancy ads for local cable television channel. (March 2005) 2b. Evaluate effectiveness of current off site outreach centers. Relocate as indicated. (March, 2005)</p> <p>Revised</p>	<p>As of 1/31/06, of the 546 women enrolled since 2/1/02, 254, (47%) entered into care in the first trimester.</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

Project Period Objective	Strategy and Activities	Accomplishments
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Project Period Objective	Strategy and Activities	Accomplishments
<p>By 1/31/06, increase by 15%, the number of pregnant women residing in the Project area who have been recruited and receiving services.</p> <p>Baseline: Of 4,095 (denominator) women residing in the Project area with live births, 2005 (numerator), 48.9 % were recruited and receiving case management services. (Data Source: Indiana State Department Bureau of Vital Statistics (1996-1999) and HS case management data) Note: Return to 1999 baseline in keeping with Guidance. Baseline established in 2002 and changed in 2003 has been voided.</p>	<p>Strategy: Perform aggressive case finding activities designed to find women in the first trimester of pregnancy</p> <p>Activities:(With Implementation Time Frames) 1a. Pursue monthly announcement of free pregnancy testing sites and dates in newspapers and local cable channels.(2003-2005) 1b. Maintain outreach pregnancy sites in each city. (2002-2005) 1c. Partner with other perinatal care agencies at Health Fairs (2002-2005) 1d. Continue to maintain working relationships with key churches in each community. (2003-2005) 1e. Continue to refine relationships with local women=s groups. (2003) 2a. Identify areas with higher risk behaviors by zip codes and tailor outreach activities accordingly. (2002-2005) 2b. Conduct door to door canvassing in each community. (2002-2005) 3a. Conduct flyer campaigns in each city on a quarterly basis. (2004-2005) 3b. Conduct monthly outreach team strategy meetings. (2002-2005) Revised</p>	<p>As of 1/31/06, Of 4,095 women residing in the Project area in 2/1/02, 935, (23%) of the women were recruited and received services.</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

Project Period Objective	Strategy and Activities	Accomplishments
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Project Period Objective	Strategy and Activities	Accomplishments
<p>By 1/31/2006, increase by 50%, the number of Hispanic participants who enter prenatal care in the first trimester.</p> <p>Baseline: During the period 1/1/01 - 6/30/01, 419 (numerator) of 791(denominator, or (46.3%) Hispanics were enrolled into prenatal care in the first trimester. (Data Source: Local Evaluation Data)</p>	<p>Strategy: Perform aggressive case finding activities designed to find women in the first trimester of pregnancy</p> <p>Activities:(With Implementation Time Frames) 1a. Continue to update (as needed) the Hispanic Women=s Club Directory, list of Hispanic churches, agencies and organizations. (2003-2004) 1b. Continue outreach activities at both Hispanic community centers in East Chicago. (2002-2005) 1c. Continue to provide perinatal care information in Spanish (2002-2005) 2a. Conduct Hispanic focus groups in East Chicago, Lake Station and Hammond. (January, March and June 2005) 2b. Develop working relationship with Hispanic community groups, ie. LaCasa. (March 2005) 3a. Initiate new outreach activities based on Focus Group information. (February, April, and July 2005)</p> <p>Revised</p>	<p>As of 1/31/06, of the 256 Hispanic women enrolled since 2/1/02, 79, (30.1%) entered into care in the first trimester.</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

Final Report/Implementation Plan

**Grantee: Northwest Indiana Health Department Cooperative Healthy Start Project
Intervention: Case Management**

Project Period Objective	Strategy and Activities	Accomplishments
<p>By 1/31/06, 80% of referrals made for prenatal and post partum participants receiving case management will be completed.</p> <p>Baseline: Between 4/1/99 and 3/31/2000, of the 4,437 referrals made by case management 2,512 (56.7%) referrals were completed.</p>	<p>Strategy: In order to have a positive impact upon pregnancy outcomes, needed medical, social, psychosocial, nutritional, developmental and financial referrals must be realized.</p> <p>Activities:(With Implementation Time Frames) 1a. Continue to work with MCH, mental health, DCFS, WIC and other perinatal care agencies to develop a universal referral system and tool (2002-2005) 1b. Continue to work with case management staff to identify services gaps in each of the four cities (2002-2005) 1c. Implement CQI tool to track referral completion (January, 2005) 2a. Trouble shoot, analyze and revise the managed information system. (January 2005 and Ongoing)</p>	<p>As of 1/31/06, of the 2241 referrals made since 2/1/02, 1795, 80.1% of the referrals were completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

Project Period Objective	Strategy and Activities	Accomplishments
<p>By 1/31/2006, increase to at least 70%, the</p>	<p>Strategy: Appropriate immunization is essential to better health outcomes</p>	<p>As of 1/31/06, of 551 infants enrolled since 2/1/02, 418, (75.7%) have</p>

Project Period Objective	Strategy and Activities	Accomplishments
<p>proportion of 2-year old enrollees with self reported age appropriate immunizations.</p> <p>Baseline: Of 91 (denominator) enrolled infants, 44 numerator (48.4%) had self reported age appropriate immunizations. (Data Source: Healthy Start case management data, 2/02 - 11/03)</p>	<p>Activities:(With Implementation Time Frames)</p> <p>1a. Continue making rounds to day care centers to promote immunizations (Bi-monthly, 2005)</p> <p>1b. Update informational immunization flyers and distribute at outreach sites and day care centers.(Quarterly, starting March 2005)</p> <p>1c. Conduct door to door canvassing in each community. (2002-2005)</p> <p>1d. Conduct flyer campaigns highlighting immunization information in each city on a quarterly basis. (March, 2005)</p> <p>1e. Provide in home teaching re: immunization. (2002- 2005)</p> <p>Revised</p>	<p>self reported age appropriate immunizations.</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

Project Period Objective	Strategy and Activities	Accomplishments
<p>By 1/31/2006, reduce to at least 5%, the number of</p>	<p>Strategy: Reduction of risk taking behaviors , smoking, alcohol and substance abuse enhances pregnancy outcomes</p>	<p>As of 1/31/06, of 321 infants born since 2/1/02, 45, (14%) were of LBW;</p>

Project Period Objective	Strategy and Activities	Accomplishments
<p>Low Birth Weight infants born to participants who received prenatal Case Management services. By 1/31/2006, reduce to at least 1%, the percentage of Very Low Birth Weight infants born to women who received prenatal Case Management services. Baseline: Of 1,339 (denominator) infants born to women who received prenatal Case Management services, 91(numerator) 6.8% were of LBW: 24 (numerator), 1.79% were VLBW: 174 (numerator) between 1/1/98 - 12/31/98. Source: (Case Management Logs, Local Evaluation data and program records)</p>	<p>Activities:(With Implementation Time Frames) 1a. Review and revise, as needed, guidelines for referral to perinatologist, nutritionist and dietician for at risk participants. (2005) 1b. Provide staff in-service on revisions. (2005) 1c. Provide in home education on smoking, bacterial vaginosis, peridontal disease, substance and alcohol abuse. (2005) 2a. Develop tool to monitor in home teaching. (2004) 2b. Continue to monitor case management compliance with Screening Frequency Guidelines (2005) 3a. Provide staff with in-services with area gynecologist. (2005) 3b. Review screening criteria for Domestic violence, nutrition, substance abuse bacterial vaginosis and periodontal disease. (2005) 3c. Provide staff with education cultural differences that impact health care, nutrition and service access. (January, 2005)</p> <p>Revised</p>	<p>35, (10.9%) were of VLBW</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

Project Period Objective	Strategy and Activities	Accomplishments
<p>By 1/31/2006, reduce to at least 10% the number of preterm infants born to</p>	<p>Strategy: Reduction of risk taking behaviors , smoking, alcohol and substance abuse enhances pregnancy outcomes</p> <p>Activities:(With Implementation Time Frames)</p>	<p>As of 1/31/06, of 321 infants born since 2/1/02, 49, (15.1%) were preterm births</p>

Project Period Objective	Strategy and Activities	Accomplishments
<p>women who received prenatal Case Management services.</p> <p>Baseline: Of 1,339 (denominator) infants born to women who received prenatal Case management services, 13% were preterm births between 1/1/98 - 12/31/98.</p> <p>Source: (Case Management Logs, Local Evaluation data and program records)</p>	<p>1a. Review and revise, as needed, guidelines for referral to perinatologist, nutritionist and dietician for at risk participants. (February, 2005)</p> <p>1b. Provide staff in-service on revisions. (March, 2005)</p> <p>1c. Provide in home education on smoking, bacterial vaginosis, peridontal disease, substance and alcohol abuse. (2004-2005,)</p> <p>2a. Develop tool to monitor in home teaching. (2005)</p> <p>2b. Continue to monitor case management compliance with Screening Frequency Guidelines (2003-2005,)</p> <p>3a. Provide in home teaching on kick counts and the signs of preterm labor. Review information with case management staff. (May, 2005)</p> <p>Revised</p>	<p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

Project Period Objective	Strategy and Activities	Accomplishments
<p>By 1/31/2006, increase the number of Black and Hispanic women enrolled in the HS Program who receive adequate prenatal</p>	<p>Strategy: Receipt of adequate prenatal care helps ensure better pregnancy outcomes.</p> <p>Activities:(With Implementation Time Frames)</p>	<p>This monitor is under development.</p>

Project Period Objective	Strategy and Activities	Accomplishments
care in accordance with the Kotel (Kotelchuck) Index. Baseline: To be determined	1a. Develop mechanism to adequately track client compliance. February, 2004) 2a. Continue to work on a viable collection tool for data system (2003-2005) 3a. Continue to consult with MIS regarding collection tool and input methods. (2002-2005) 4a Implement system (2005) 5a. Monitor progress (2005) Revised	Incomplete Incomplete Incomplete Incomplete Incomplete

Final Report/Implementation Plan

Grantee: Northwest Indiana Health Department Cooperative Healthy Start Project

Intervention: Interconceptional Care

Project Period Objective	Strategy and Activities	Accomplishments
By 1/31/2006, increase	Strategy:	As of 1/31/2006, of 766

Project Period Objective	Strategy and Activities	Accomplishments
<p>by least 20%, the number of post partum women with infants under the age of two who are enrolled in HS.</p> <p>Baseline: In 2001, Of 1,939 (denominator) enrollees, 32 (numerator) 1.7% were newly enrolled post partum women. (Data Source: HS Participant Data and Local Evaluation Data.)</p>	<p>Promote better health outcomes for post partum women and infants.</p> <p>Activities:(With Implementation Time Frames)</p> <p>1a. Implement recruitment campaign in housing projects in Gary, Hammond and East Chicago and trailer parks in Lake Station. (January - December 2005)</p> <p>1b. Continue making rounds to area day care centers (2005)</p> <p>2a. Revise and update all recruitment posters, flyers and leaflets. (April, 2005)</p> <p>2b. Continue to develop flyers for interconceptional population in English and Spanish. Have consortium review for appropriateness. (2004-2005)</p> <p>3a. Continue to work with hospitals and the perinatal Network on referral guidelines. (2003-2005)</p> <p>revised</p>	<p>women enrolled since 2/1/02, 199, (25.9%)are post partum women with infants under age two</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

Project Period Objective	Strategy and Activities	Accomplishments
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Project Period Objective	Strategy and Activities	Accomplishments
<p>By 1/31/2006 increase to at least 85%, the proportion of participating post partum women who receive at least one interconceptional counseling session within eight weeks of delivery.</p> <p>Baseline: During the periods, 9/1/.99 - 8/31/2000, of 122 (denominator) participating post partum women, 81 (numerator), 66.1% received at least one interconceptional counseling session within eight weeks of delivery. (Source: Case Management log and program records.)</p>	<p>Strategy: Longer intervals between pregnancies help to ensure better pregnancy and health outcomes.</p> <p>Activities:(With Implementation Time Frames) 1a. Continue to review (with staff) information on various contraceptive methods and devices (2002-2005) 1b. Enhance relationship with Planned Parenthood (2002-2005) 2a. Reaffirm relationship with community health centers (2004) 3a. Implement the referral and tracking tool developed jointly with Health Education to track interconceptional counseling provided by Health Education. (January, 2005) 4a. Consult with Health Education for development of health educational track for women during this phase (March, 2005) Revised</p>	<p>As of 1/31/06, of 498 post partum women since 2/1/2002, 403, (80.1%) received interconceptional care counseling within eight weeks of delivery.</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed`</p>

Project Period Objective	Strategy and Activities	Accomplishments
By 1/31/2006, at least	Strategy:	As of 1/31/06, 31 infants

Project Period Objective	Strategy and Activities	Accomplishments
<p>90% of the infants deemed to be Aat risk will receive risk appropriate services.</p> <p>Baseline: Between 9/1/99 - 3/31/200, 44 (denominator) were deemed to be at risk, 33 (75%) received the needed services. 13 (denominator) of the 44 were identified between 9/1/99 - 12/31/99, 10 (numerator) 70% received needed services. (Source: Case Management System)</p>	<p>Early identification and timely receipt of appropriate medical and social services reduce the severity of risk factor</p> <p>Activities:(With Implementation Time Frames)</p> <p>1a.Continue in service on developmental delays (February, 2005)</p> <p>1b.Develop MOA with First Steps, local agency for children with special needs. (2003-2005)</p> <p>1c. Continue to review criteria and eligibility guidelines for Children with special needs programs. (April, 2005)</p> <p>2a. Develop referral procedure with agencies addressing special care needs of children (March, 2005) Revised</p>	<p>were deemed to be at risk since 2/1/2002, 27, (87.1%) received risk appropriate services.</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

Project Period Objective	Strategy and Activities	Accomplishments
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Project Period Objective	Strategy and Activities	Accomplishments
<p>By 12/31/2006, reduce the number of HS mothers with pregnancies that occur within 24 months of a previous birth.</p> <p>Baseline: Of 383 enrollees (denominator), 51 (numerator), 13.3% had subsequent pregnancies. This is the baseline established 12/31/03. (Data source: Case Management Logs and NWI HS data system)</p>	<p>Strategy: Periods of two years or more between pregnancies contribute to the overall health and well being of mothers and their infants</p> <p>Activities:(With Implementation Time Frames) 1a. Continue to work with MIS for development of an effective tracking system. (January, 2005) 2a. Review medical risk factors with staff (August, 2004) 3a. Develop in conjunction with Health Education , health education curriculum for this group (March, 2005) 4a. Develop and distribute written information leaflets on risk factors. (2004-2005)</p>	<p>As of 1/31/06, of 948 mothers since 2/1/2002, 52, (11%) have had pregnancies that occurred within 24 months of a previous birth.</p> <p>Completed</p> <p>Completed</p> <p>Completed Completed</p>

Final Report/Implementation Plan

Grantee: Northwest Indiana Health Department Cooperative Healthy Start Project

Intervention: Depression Screening and Referral

Project Period Objective	Strategy and Activities	Accomplishments
<p>By 1/1/2006, increase the number of post partum participants with completed depression risk screens to 95%.</p> <p>Baseline: During the period, 1/1/03 - 12/31/03, of 54 (denominator) post partum clients, 48 (numerator), 88% had completed depression risk screening assessments. (NWI HS data system)</p>	<p>Strategy: Timely assessment and intervention of medical and/or social health needs aid in achieving better health outcomes for families</p> <p>Activities:(With Implementation Time Frames) 1a Evaluate current data collection tools (February, 2005)</p> <p>2a. Review Frequency of Screening Guidelines and tools with staff (May, 2004)</p> <p>3a. Provide in service on Post partum Depression and Symptoms (September, 2004)</p> <p>4a. Review State Perinatal Depression Screening Guidelines (February, 2004)</p>	<p>As of 1/31/06, of 244 post partum participants since 2/1/2002, 185, (75.8%) had completed depression risk screens.</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

Project Period Objective	Strategy and Activities	Accomplishments
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Project Period Objective	Strategy and Activities	Accomplishments
<p>By 1/31/2006, increase to 95%, the number of participants with identified mental health needs who receive the needed mental health services.</p> <p>Baseline: During calendar year 2 (1/1/03 - 12/31/03), 11 (denominator) women where referred for mental health services. Of that number, 8 (numerator) or 72% received the needed mental health services. (Data source: HS Case Management data 2003)</p>	<p>Strategy: Timely assessment and intervention of medical and/or mental health needs aid in achieving better health outcomes for families</p> <p>Activities:(With Implementation Time Frames)</p> <p>1a. Continue to develop working relationship with mental health community centers (2003-05) 1b. Provide in services on symptoms, medications and interventions (2003 -2004)</p>	<p>As of 1/31/06, of 32 participants with identified mental health needs since 2/1/2002. 17, (70.8%) received the need mental health services. (8 participants were excluded from the count. see narrative)</p> <p>Completed Completed</p>

Project Period Objective	Strategy and Activities	Accomplishments
<p>By 01/31/2006, increase to 100% the number of professional and paraprofessional staff whose pre- and post-test scores reflect at least a 20% enhancement in knowledge as a result of education and/or training.</p> <p>Baseline: During CY1999, 47 (90.38%) of 52 professionals and paraprofessionals attending education and/or training sessions had test scores that</p>	<p>Strategy: Increasing the knowledge and skills of professionals and paraprofessionals serving the NWI HS community enhances the quality of services and improves the overall impact of the project.</p> <p>Activities (with Implementation Timeframes):</p> <p>1a. Determine and periodically re-asses education needs of staff. (Began February 2002) 1b. Research areas of perinatal health that are prevalent in NWIHS participants. (Began February 2002)</p> <p>2a. Offer in-service education opportunities on relevant perinatal issues. (Began February 2002)</p> <p>3a. Create staff information sheet, distributed periodically, with synopses of recent perinatal health news. (Began July 2004)</p>	<p>From 02/01/02 through 01/31/2006, an average of 10 (90.1%) of 11 professional and paraprofessional staff maintained pre and post-test scores that reflected a 20% enhancement in knowledge as a result of education and training (Source: NWIHS Health Education data).</p> <p>Completed Completed Completed Completed</p>

<p>reflected at least a 20% enhancement in knowledge (Source: NWI HS Local Evaluation Data).</p>	<p>3b. Create and update list of reputable internet sites for perinatal information. (Began October 2003)</p>	<p>Completed</p>
<p>Project Period Objective</p>	<p>Strategy and Activities</p>	<p>Accomplishments</p>
<p>By 01/31/2006, increase to at least 80% the number of participants who self-report a reduction in risk-taking behavior due to enhanced knowledge of the risks of substance abuse including alcohol and cigarette smoking.</p> <p>Baseline: In CY1998, of the 45 participants enrolled in NWI HS Health Education substance abuse classes, 25 (55%) reported a reduction in risk-taking behaviors (Source: NWI HS Local Evaluation and program</p>	<p><u>Strategy:</u> To decrease risky behavior by increasing participant’s knowledge of healthy lifestyles through education and training has a positive impact upon maternal and infant mortality and morbidity.</p> <p><u>Activities (with Implementation Timeframes):</u> 1a. Generate all handouts in English and Spanish. (Began February 2002) 1b. Review/revise smoking cessation and substance use curriculum. (February 2002-February 2005) 1c. Obtain locations to present health education classes at. (February-October 2002) 1d. Create PowerPoint presentations for smoking cessation and substance abuse curriculums. (January-March 2003) 2a. Establish protocol for referral of those who smoke cigarettes and/or are substance users, for health</p>	<p>From 02/01/02 through 01/31/2006, of the 153 participants enrolled in Health Education substance abuse classes, 71 (43.2%) self-reported a reduction in risk-taking behavior due to enhanced knowledge of the risks of substance abuse including alcohol and cigarette smoking (Source: NWIHS Health Education data).</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

data).	education services. (March 2002)	Completed
	2b. Provide in-service training annually on effects of substances upon the fetus. (Began April 2002)	Completed
	2c. Collaborate with other area agencies to teach / reach out to more people about the dangers of smoking and substance abuse, particularly during pregnancy. (Began April 2004)	Completed
	3a. Solicit participant involvement to create new smoking cessation handout. (Began June 2004)	Completed
	3b. Provide community presentation on the harmful effects of smoking and second-hand smoke. (November 2002– November 2005)	Completed

Project Period Objective	Strategy and Activities	Accomplishments
<p>By 01/31/2006, increase to at least 62% the number of active participants who attend one or more Health Education classes.</p> <p>Baseline: During CY2000, 42% (1,071) of 2,545 active participants attended one or more Health Education classes (Source: NWI HS data and case management log)</p>	<p><u>Strategy:</u> Knowledge of the medical needs and the changes in the body during pregnancy enhance the participants' understanding and is likely to produce lifestyle changes that will have a positive effect on pregnancy outcomes.</p> <p><u>Activities (with Implementation Timeframes):</u> 1a. Review/revise health education curriculums. (February 2002-March 2002) 1b. Generate all handouts in English and Spanish. (February 2002-January 2005) 1c. Acquire current health education teaching materials. (May-October 2002) 1d. Create PowerPoint presentation for each health education class. (January 2003–February 2005) 2a. Cross train case management staff on education curriculum. (February 2002-December 2002) 2b. Conduct regular meetings between Case Managers and Health Educators (Began January 2003) 3a. Distribute monthly health education brochure to social service agencies, physician offices and prenatal clinics. (January 2003–December 2005) 3b. Distribute monthly health education calendar to participants. (Began January 2004) 3c. Attempt contact with every active prenatal /</p>	<p>From 02/01/02 through 01/31/2006, 367 of 1,671 (22%) active participants attended one or more Health Education classes (Source: NWIHS Health Education data).</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

	postpartum participant to promote benefits of health education class attendance. (Began February 2005)	Completed
Project Period Objective	Strategy and Activities	Accomplishments
Increase the number of enrollees completing the Essential Life Skills, Family Planning and Sexually Transmitted Diseases curriculum. Baseline: To be established.	<p><u>Strategy:</u> Increase the period between pregnancies and provide participants with options.</p> <p><u>Activities (with Implementation Timeframe):</u></p> <p>1a. Establish/implement/review/revise criteria for monitoring Interconceptional Care model. (October 2002, January 2003)</p> <p>1b. Train staff on criteria for monitoring Interconceptional Care model. (October 2002)</p> <p>2a. Select and review Essential Life Skills curriculum. (October 2002)</p> <p>2b. Train Health Educators on Essential Life Skills program. (January 2003)</p> <p>2c. Review/revise Essential Life Skills curriculum. (March 2004)</p> <p>2d. Health Educators to provide training for Essential Life Skills, Family Planning and Sexually Transmitted Diseases curriculum package to Case Managers (February 2005)</p> <p>3a. Offer participation opportunity and promote benefits of curriculum package to eligible program participants (November 2003; May 2004; January–August 2005)</p> <p>3b. Solicit feedback from class attendees on ways to make Essential Life Skills class attractive to other participants (June 2004; January 2005)</p>	<p>From 02/01/02 through 01/31/2006, 171 of 1,671 (10.2%) program participants completed the Essential Life Skills, Family Planning and Sexually Transmitted Diseases curriculum (Source: NWIHS Health Education data).</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

	3c. Provide community presentation on family planning and subsequent pregnancies. (Began November 2002)	Completed
Project Period Objective	Strategy and Activities	Accomplishments
By 01/31/2006, increase to at least 50% the number of enrollees attending Stress Reduction class. Baseline: In CY1998, 12.7% (30) of the 236 enrollees attended the Stress Reduction class (Source: NWI HS program data).	<p><u>Strategy:</u> Skills in reducing stress enhance better pregnancy outcomes and improve overall mental health.</p> <p><u>Activities (with Implementation Timeframes):</u></p> <p>1a. Review current health education curriculum, institute necessary revisions. (February-March 2002)</p> <p>1b. Generate all handouts in English and Spanish (February 2002-January 2005)</p> <p>2a. Investigate feasibility of adding exercise class to curriculum. (June 2002)</p> <p>2b. Research different relaxation techniques available. (June 2002)</p> <p>2c. Research new and innovative methods of stress reduction (January-July 2003; May-September 2004; January-September 2005)</p> <p>2d. Create handouts that illustrate stress reduction methods (March-August 2003; June 2004; January 2005)</p> <p>2e. Add specific activity-based stress reduction classes (March-August 2003; March 2004; March 2005)</p> <p>3a. Secure updated materials and video tapes regarding stress reduction (March 2002)</p> <p>3b. Promote value of attending Stress Reduction class to NWIHS program participants (May 2004; January 2005)</p> <p>4a. Provide training for staff. (October 2002; September 2003)</p> <p>4b. Provide community presentation on perinatal depression. (Began December 2002)</p>	<p>From 02/01/02 through 01/31/2006, 189 of 898 (21%) of enrollees attended Stress Reduction class (Source: NWIHS Health Education data).</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p> <p>Completed</p>

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