IMPACT REPORT

Healthy Start Initiative-Eliminating Racial/Ethnic Disparities
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Healthy Babies, Inc.

Northeast Wichita Healthy Start Initiative (NEWHSI)

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

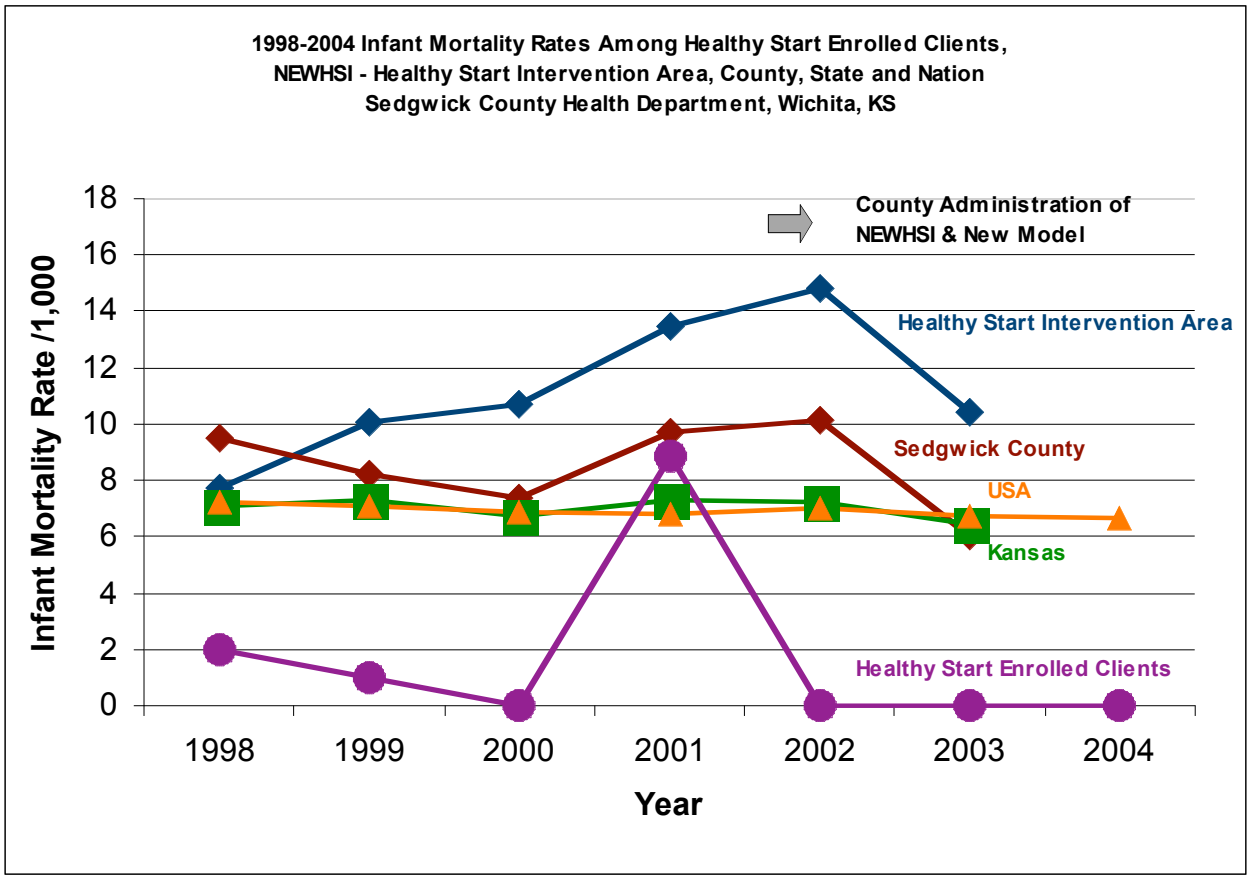
Infant mortality continues to be a problem for the Northeast Wichita Healthy Start Initiative (NEWHSI) target area and there are racial/ethnic disparities in risk factors for infant mortality. SCHD conducted a zip code and census tract code stratified analysis for disparities in morbidity, mortality, and infectious and chronic diseases in the 1990s and again during 2002-2003. Through this investigation SCHD discovered that 3 out of the 43 zip codes of the county had extremely high rates of infant mortality, especially concentrated among African-American and Hispanic infants. Based on this analysis, the Northeast Wichita Healthy Start Initiative (NEWHSI) home visitation program identified 3 zip codes in northeast Wichita (67208, 67214, and 67219), in which mothers are at high risk for low birth weight and premature deliveries, substance abuse, and sexually transmitted diseases. The infant mortality rate and risks for African Americans are especially high in this target area; between 1999 and 2003 the infant mortality rate has ranged from 17.3 to 18.3 per thousand live births. Essential stratified perinatal health indicators are displayed in the table below.

1999-2001 3-Year Cumulative Infant Morbidity/Mortality Indices for 3-Zipcode NEWHSI Area, by Race/Ethnicity [1, 2]
Sedgwick County Health Department, Wichita, Kansas

	Race/Ethnicity [2]				
	Black	Hispanic[2]	White [2]	Other	Total – All Races
# Live Births	1164	406	1038	111	2719
# Infant Deaths (Age 0-364 days, excludes fetal deaths)	21	6	3	1	31
Neonatal Infant Mortality Rate ((Neonatal deaths / births) X 1,000)	10.3	12.3	1.9	9.0	7.4
Post-Neonatal Infant Mortality Rate ((post neonatal deaths / births) X 1,000)	7.7	2.5	1.0	0	4.0
Infant Mortality Rate ((Infant deaths / births) X 1,000)	18.0	14.8	2.9	9.0	11.4
Incidence of Low Birth Weight, as percent (1500 g < BWT< 2500g)	15.4%	5.7%	6.9%	2.7%	10.2%
# Deaths Due to SIDS	0	0	0	0	0
Incidence of Births to Mothers with Age < 18, as percent	9.9%	8.1%	3.2%	4.5%	6.8%
Incidence of Births with First Trimester Prenatal Care, as percent	72.5%	63.1%	88.8%	73.9%	77.4%
Incidence of Births With Adequate Prenatal Care (APCNU Index = Adequate or Adequate Plus), as percent, 2003 (KDHE did not collect these data from 1999-2001)	73.6% (2003)	57.6% (2003)	87.1% (2003)	87.9% (2003)	77.0% (2003)

[1] Data available in NEWHSI Health Statistics and Infant Mortality Summary Data Tables by Year, in Appendix A. These data were obtained from Bureau of Vital Statistics, Kansas Department of Health and Environment, Topeka, Kansas.
[2] In these data, Bureau of Vital Statistics, Kansas Department of Health and Environment has treated Race/Ethnicity as one variable. "White" excludes Hispanic. In Kansas, Hispanics are primarily of Mexican and Central American descent.

The NEWHSI targeted zip codes have been identified as being high risk for low birth weight and premature birth. The overall infant mortality rate in the targeted area went from 14.32 in 2002 to 10.40 infant deaths per 1,000 live births in 2003. However, the infant mortality rate for African-American babies in the NEWHSI zip codes remained steady at 17.39 infant deaths per 1,000 live births. The infant mortality rate for clients enrolled in the NEWHSI program has remained at 0.00 since 2002. As the figure illustrates, NEWHSI enrolled clients have lower infant mortality than the overall infant mortality in the target area where they are served. The figure also illustrates decreases in the infant mortality rate in the Healthy Start Intervention Area after County administration began and the subsequent change in the home visiting model. No secular changes in perinatal care are known to account for these decreases in infant mortality. It is surmised that the decrease in NEWHSI IMR has contributed to the decrease in Sedgwick County's IMR.



Data received from the Kansas Department of Health and Environment (KDHE) for 2003 show that 77% of the African-American women in the NEWHSI area initiated prenatal care during their first trimester and that 74% of those women received adequate prenatal care. These figures are higher than the proportions for Hispanic women, 61% of who received prenatal care during their first trimester and only 58% of who received adequate prenatal care. It seems to be a paradox that Hispanic women have better birth outcomes than their African American counterparts who initiate prenatal care earlier in their pregnancies. However, the local data from our target area reinforce national research, which also shows that adequate prenatal care is not the only factor affecting birth outcomes.

II. Project Implementation

Core Services

Outreach and Client Recruitment

During our last grant cycle, Healthy Babies had much success in their outreach and recruitment processes within Sedgwick County as a whole. At times, we had a large waiting list for our services. With closer inspection of our stats, however, we learned that we were still facing a challenge in reaching clients living in the NEWHSI zip code area. As we evaluated our resources for referrals, it was learned that the vast majority of referrals were coming from two of our own programs [Mother and Infant Clinic (M&I) and Women, Infants and Children (WIC). Generally, all clients from these two resources were being referred to the Healthy Babies program. It was decided that we needed a more tangible system for prioritizing referrals and that referrals needed to be based on client need, not on referral source as was the practice during the early stages of the grant while the program was under different management. Prioritization of NEWHSI zip codes as well as other factors that put mothers at high-risk had to be the main focus of our referral efforts. Once we had agreed on the new protocols, we provided training to the agencies that send us the most referrals and we gave them an assessment tool that they use with all their clients to determine if they meet criteria for our program. With these guidelines in place, we still receive a number of referrals from M&I and WIC, but we find that the referrals they send to us are more likely to meet program criteria. To meet this piece of our action plan, we have revised our Referral Form and our Prenatal Risk Assessment Form. We continue to evaluate the effectiveness of these changes and have seen an increase in the at-risk referrals received. These new processes have also proven to save time for both our staff and the referring agency.

NEWHSI also began exploring methods of reaching into our target community through collaboration with community partners located in the NEWHSI area. A plan was devised to approach the media (specifically radio stations that are regularly listened to by our at-risk clients). Without funding for radio advertisement, we could not afford to pay for commercial airtime. Instead, we have solicited for public service announcements spotlighting our Healthy Babies program. We are excited that NEWHSI will be spotlighted as Charity of the Month in November 2005 on radio station Power 93.9; the number one listened to radio station by our target population in Sedgwick County. This is a big accomplishment compared to our ability to have such “advertising” four years ago.

Other methods of outreach into our NEWHSI zip codes have been explored and new ideas continue to develop. Per feedback from community members and participants, we began an outreach plan in the spring of 2005 to collaborate with community businesses to reach the hard-to-reach clients. In addition to collaborating with Laundromats and churches, we are also partnering with beauty shops and cosmetology schools who have consistent and direct contact with our target population. As one of our African-American Consortium members told us, even if an African-American woman is struggling to pay her bills, she will make sure she budgets to get her hair done.

All NEWHSI staff members participate in the outreach and recruitment process. The RNs, Community Liaisons and Project Managers collaborate with local providers to increase the recruitment of clients into NEWHSI services. Presentations to civic groups, participation in community fairs and NEWHSI Community Forums are documented and discussed. This assists in evaluating the effectiveness of each type of outreach that we are involved in to determine what future outreach efforts will entail. Prior to the current Director coming on

board, the Community Forums had ceased. After researching what the old Forum set-up looked like and trying to understand reasons why it didn't work well, such as regularly changing Forum locations, only using word-of-mouth advertisement and little interest in topics provided, we implemented a new structure and assigned new personnel to be in charge of organizing the Community Forums late in 2004. The new structure seems to work quite well for our target population based on location, client schedules and client needs. We have seen a consistent increase in attendance at the Forums since they started again in late 2004 and by the end of 2005 we expect to average 60 clients at each Forum.

In addition to our monthly Community Forums, we continue to participate in health fairs and community events, as well as building partnerships that eventually assist with our outreach efforts. One of our greatest partnerships is with the local school district, USD 259-Wichita Public Schools, which serves nearly 50,000 elementary, middle and high school students. The NEWHSI project manager serves as our liaison with the school district and we have nurses assigned to each middle and high school. This collaboration ensures that NEWHSI receives referrals for pregnant teens and the referrals most often occur in the first or second trimester. On numerous occasions a NEWHSI Home Visitor has been called upon to be present when a teen reveals her pregnancy to her parents. The school nurses know that we can provide this kind of support and our services can then support the whole family, not just the pregnant teen.

Perhaps what speaks most highly about our Outreach process is the clients themselves, who refer their pregnant family members and friends to us. NEWHSI has maintained a client retention rate of around 96% in the last few years. Clients are primarily closed due to program completion or if they move out of the service area. Occasionally clients will choose to discontinue services rather than transferring to another provider if their provider terminates employment with our program. The excellent retention rate for NEWHSI is evidence of the quality program and quality staff that serve the client population.

Case Management

Our case management is provided by Home Visitors, including (4) Registered Nurses (RN) and (2) Community Liaisons (CL). Potential clients are screened for risk factors using our Prenatal Risk Assessment Form (PRA). Those who are found to be at high-risk for medical complications are referred to an RN for Case Management. Those at low-risk are referred to CLs for Family Support Services. Joint home visits are conducted by CLs and RNS for those high-risk clients in need of additional Family Support Services, as well as low-risk clients who develop potential medical complications. The nurses also provide a Welcome Home postpartum and infant assessment visit when the low-risk moms deliver.

It is important to note that our services are intended to enhance, not replace, regular prenatal care by a physician. Home Visitors (HV) utilize the Kessner Index to determine if clients are receiving adequate prenatal care. One of our program goals is to ensure that clients receive prenatal care within one month of program entry. In order to meet that goal, our HV provides referrals to physicians and prenatal clinics, and assists clients in making their first appointment, if necessary. HVs also follow-up with the client at each home visit to ensure that they are following through with prenatal appointments.

Over the past few years, we have revised our case management protocols to ensure that our services are available to the most high-risk clients in our targeted zip codes. All incoming referrals are checked for zip code location, age of mom, number of pregnancies and deliveries, and risk factors noted on the referral form. If adequate information is not provided

on the referral form, a Community Liaison (CL) makes a visit to the potential client to complete a Prenatal Risk Assessment (PRA) to determine risk factors. We are the only Home Visitation program in Sedgwick County to provide case management by Registered Nurses. We also provide family support services to ensure the client is taken care of mentally, socially, and physically.

In 2002, NEWHSI management realized the need to have the ability to serve a larger number of high-risk clients than we were currently serving. After much research, we determined the most feasible way to accomplish this goal was to change from using the Nurse Family Partnership (NFP) model for home visiting to the Partners for Healthy Baby Curriculum, a research-based model based out of Florida State University. We reviewed other programs and decided to create our own set of standards that were similar to the NFP model, but which lacked some of the NFP home visit restraints. NFP, while being an outstanding model for home visitation, has a set maximum number of 25 clients per home visitor and a specific number of home visits that must be done with each client per month. The Healthy Babies Management Team redesigned, from the ground up, a new program, utilizing many of the best practices of NFP and switching to the Partners for a Healthy Baby curriculum. We updated our forms, created new protocols allowing staff to carry a larger caseload, slightly decreased the required number of home visits/month required by staff and hired Community Liaisons (CLs), who had a broad range of knowledge related to family support services, to help the RNs with some of their more high-risk and time-consuming clients. These CLs are also able to carry caseloads of clients who qualify for our program, but who are considered to be at a lower-risk for premature births and medical complications. RNs are also able to transfer clients, who are doing well, to a CL, at the infant's six- month birthday until their two-year birthday. This serves to free the RNs up to provide care to our highest-risk clients. While increasing caseload requirements for staff, the Management Team implemented further changes to decrease charting time by staff so that more time could be provided in direct care service hours. The data collection tool has undergone numerous revisions and the staffs' Progress Notes have been put into an electronic format to streamline staffs' efficiency during their indirect service hours. We have seen a noted improvement in the size of caseload our program can serve with these changes.

During home visits, the RNs and CLs provide health education using the research-based Partners for a Healthy Baby curriculum, developed by Florida State University. Clients are screened for Domestic Violence (DV), Depression, and Blood Lead exposure. Infants and toddlers are screened for developmental delays, utilizing the Denver II screening tool. Client educational and career goals are assessed and an individualized plan is established to facilitate client success in attaining their objectives. RNs also provide prenatal, postpartum and infant/toddler health assessments during home visits.

NEWHSI Community Health Nurses (4) have 40-45 high-risk clients each. Most clients enter the program in their first trimester or during the early part of their second trimester and each high-risk client receive an average of 14-18 prenatal home visits and then 16-20 interconceptional visits over the course of two years. NEWHSI Community Liaisons (2) also serve 40-45 low-risk clients each, including some overlap with high-risk clients who are also served by the Community Health Nurses. Most low-risk clients receive 8-12 prenatal visits and 12-16 interconceptional visits over the next two years.

Home visits for all newly enrolled pregnant women are made at least weekly for the first four weeks, then monthly until delivery. Upon delivery each client and her infant is seen weekly for the first four weeks, then monthly until the baby's first birthday. After the twelfth month

postpartum visit, the client and toddler are to be seen every three months until the child reaches its second birthday. During the second year, phone contacts are made the months that home visits are not scheduled.

Home Visitors work with clients to develop service/treatment plans based on program protocol and individual needs. Part of that plan is built into our program goals (i.e. prevention of prematurity, low birth weight and family planning). The rest of the plan focuses on the specific needs and goals of the mom (i.e. domestic violence, depression, schooling, employment and budgeting). The Home Visitor provides the client with a Home Visitor Form at each visit that the client signs acknowledging her planned activities until the next visit. These activities are composed of smaller, attainable goals designed to facilitate the accomplishment of the long-term goal.

When screening and observations indicate that a client is at risk for domestic violence, the Home Visitor will encourage the client to remove herself from the dangerous situation. Often this takes ongoing mental and physical preparation for the client. The Home Visitor will assist the client in assessing her financial situation, make plans for emergency housing, packing a bag and having a plan of escape in place. She will work with the client to encourage her to seek professional counseling. This often occurs prior to the client's departure.

All of our clients are screened for HIV. A verbal screening is done at enrollment and at the two-month postpartum visit. If the client is positive for HIV, they are referred for counseling if they are not already receiving it. Clients also receive education regarding HIV and STIs at their home visits during both their prenatal and interconceptional period. Additionally, all clients who wish to be tested for HIV are referred to the Sedgwick County Health Department which offers testing and counseling on a sliding fee scale.

No other program in Sedgwick County offers the scope of services that NEWHSI does. We are known for providing Nurse Case Management as well as Family Support Services (FSS) to our clients, which addresses the individualized needs of each family member and each family. Registered Nurses (RNs) carry the highest risk clients in their caseload, while Community Liaisons (CLs) provide case management to lower risk clients. CLs are also utilized by the RNs, if a high-risk client is in need of additional FSS. RNs will assist the CLs with their clients if a medical concern arises. They also provide a Welcome Home postpartum and infant assessment when the low-risk moms deliver.

Participation in NEWHSI provides numerous benefits to clients and their families. Home Visitors often play the role of advocate on behalf of clients when having difficulty with health care providers, Social and Rehabilitation Services (SRS), the school system, and the court system; as well as providing emotional support and encouragement. The outcome of this support leads to clients reaching above their own expectations. During home visits, the RNs and CLs provide health education using the Partners for a Healthy Baby Curriculum, educational videos and other handouts. Our goal, if a client is not receiving prenatal care upon entering the program, is to connect her with a medical home within thirty days of enrollment. Home Visitors accomplish this by determining each client's current insurance coverage or their eligibility to receive a medical card. The RNs and CLs educate and/or assist clients in accessing proper forms and filling them out, including providing interpretation/translation for Spanish-speaking clients. If clients do not have insurance and do not qualify for a medical card, a referral to the Sedgwick County Health Department's Mother and Infant Clinic (M&I) is provided. This clinic provides prenatal care to the pregnant mom utilizing a flat, reduced fee system.

Care coordination between RNs and physicians, clinics, and other healthcare agencies often takes place when clients have more complicated problems such as diabetes, failure to thrive, hypertension, cerebral palsy, mental health problems, congenital abnormalities, and developmental delays. All Home Visitors assess and educate prenatal clients on the signs and symptoms of preterm labor at every encounter. Education and support are provided on other topics such as family planning, STIs, and breastfeeding.

Every client receives a nutritional assessment at least once during the prenatal period and is referred to Women, Infants, and Children (WIC) for nutritional counseling and food assistance. WIC is also part of the Sedgwick County Health Department, which has helped our Home Visitors obtain appointments for our clients in a timely manner. Our Home Visitors work closely with each client to set individualized short and long-term goals and assist them in accessing the tools necessary to meet their objectives.

Transportation and childcare are common problems for those we serve. Together with the client, the Home Visitor assesses how they can best utilize their network of family and friends to meet their childcare and transportation needs. Home Visitors educate and assist clients in accessing transportation paid by their medical card (a benefit which clients are often not aware of). For those clients without a medical card, transportation, paid out of HSI funds, is provided for medical/mental health appointments, WIC appointments, and to Community Forums. Social and Rehabilitation Services (SRS) and Early Head Start (EHS) offer child care assistance to families who have educational and employment goals; our staff helps clients access these services also.

NEWHSI has shown cultural competence by providing Home Visitors and staff that mirror the population we serve. All staff is trained on cultural sensitivity through the Sedgwick County new employee orientation, as well as attending other trainings cultural trainings as the opportunity presents itself. There is a total of eight bilingual staff, both in-kind and HSI funded. They are direct service providers, interpreters and office support staff. All materials provided to clients are available in Spanish, as well as all Community Forums (CF) being interpreted for the Spanish-speaking population.

Health Education and Training

As mentioned above, in 2002 the decision was made to change from the Nurse-Family Partnership (NFP) Model of home visitation. This change has allowed our program to serve a larger number of clients in different stages of their lives, thus increasing the impact we are making in our target population. The health education services provided by our program are outlined below. Those services have remained stable over the last three years, with occasional and slight changes to our protocols made as program needs arise.

Health education is a key component in our NEWHSI program. We realize that our responsibility goes beyond the individual education we provide our clients; it must reach the community as a whole to affect positive change. The health of any population affects every person that lives within it. This necessitates health education that will impact the individual lives of those who make up the community-at-large. Community Forums is one way that we provide health education to our community. The number of participants continues to grow with each forum. Additionally, NEWHSI staff members provide health education messages to students at public schools and through health fairs and community events. Our access to the

health educators who serve the Sedgwick County Health Department also give us the opportunity to leverage additional health education in our target area.

Registered Nurses (RNs) and Community Liaisons (CLs) provide individual education in the home setting. Because the education is one-on-one with the client, it can be customized to the specific questions/needs of each client. Regularly scheduled screenings and ongoing assessments of the client's health and environmental status are completed on each client. If additional education is necessary, the Home Visitor can increase the number of home visits with the client, or refer to other community agencies depending on that individual's specific need. Education is disseminated primarily through the curriculum we utilize, Partners for a Healthy Baby. Videos and other written materials are also available for home visitors to use with their clients in order to enhance health education. Educational topics include, but are not limited to: methods of birth control, sexually transmitted infections, immunizations, signs and symptoms of preterm labor, breastfeeding, child growth and development, and parenting. After delivery, the home visitor will assess the client's use of a family planning method at every visit. If the client isn't utilizing birth control, they will be referred to their medical provider or the local Health Department's Family Planning Clinic.

With NEWHSI's strong focus of increasing breastfeeding initiation rates among our target population as well as all of Sedgwick County, all program staff, including support staff and the management team, successfully completed the Certified Breastfeeding Educator (CBE) training in May 2005. This will enable any staff person to be able to answer breastfeeding questions over the phone or be able to go into the community to help with breastfeeding issues and education.

Monthly Community Forums (CF) provides free educational opportunities open to our clients and the community-at-large. On the days that CFs are held, the church opens its food pantry and clothes closet, which they operate as community outreach, and make it available to those in attendance. Childcare, refreshments donated by local restaurants, door prizes and interpretation for the Spanish-speaking population is also provided as an incentive. For NEWHSI clients, transportation, which is funded by the HSI grant, is provided to the CFs. Educational topics have included Domestic Violence, STIs, Car Seat Safety Checks, Voter Registration, Age Appropriate Toys and Toy Safety, Budgeting, Blood Lead Screenings, Flu-Shots for Pregnant Women, Identi-Kid by the Wichita Police Department, Managing Holiday Stress, Salvation Army Holiday Assistance, Nutrition, Substance Abuse, Infant Massage, Child/Infant CPR and Relationship and Sex Issues. These events provide clients with the opportunity to have social interaction with other families as well as helping them access other agencies and services within the community. Information on these educational events is disseminated to the community through flyers that are both in English and Spanish. The flyers are posted in area businesses such as laundry mats, grocery stores, beauty shops, and churches. Flyers are provided to the parent involvement workers at all of the public schools in the target area for distribution. Flyers and information are emailed to the Consortium members to be passed on to the clients they serve through their agencies. The projected number of persons, which attend CFs, is 50-100 per month, or a total of 600-1000 persons per year. NEWHSI has a Community Forum Committee, which spearheads the activities. This committee is comprised of the following: two consumers, three NEWHSI funded staff and two Healthy Babies staff funded via other grants. All Healthy Babies staff members are expected to participate in the implementation of this monthly event. The Community Forum events went through a transition period between 2003 and 2004 in order to assess how to better reach our target population and increase participation in these events. As of September 2004, forums

have been held on a monthly basis, as outlined above, and have shown great success by the ever-increasing number of consumers and community members that participate.

NEWHSI staff persons provide regular training and education sessions to health providers, consortium members, clients and the general population. Each event is staffed according to size and design of the event. NEWHSI also sets up displays at Health Fairs, block parties and annual community-wide events, such as River Festival held each May. The expected reach for these events is well into the thousands.

We also coordinate our health education activities with the Sedgwick County Health Department's three Health Educators, who provide community education to a variety of audiences, specifically targeting HIV/STIs, tobacco cessation and oral health.

Smoking cessation programs: All Healthy Babies staff will be trained in the 5A's method of smoking cessation at the end of 2005. This will help staff to improve their current processes of screening and assessing client's readiness to quit smoking. Currently, NEWHSI verbally screens all clients at enrollment and at the first, two-month and six-month postpartum visits for smoking. An ongoing assessment of the home is made to check for anyone smoking inside the home. Partners for a Healthy Baby, the curriculum we utilize, covers the topic of smoking and its effects during the prenatal and interconceptional periods. We also have written materials and videos from different agencies, such as the American Lung Association, which we provide to clients that need further education and information on the topic. The Smoke-Free Homes Program, through the Environmental Protection Agency, provides our program with free educational packets that are available in both English and Spanish. They are distributed to all clients and are also made available to community members at the monthly Community Forums. The Kansas Quit-line, which is a free hotline for anyone wishing to quit smoking, is a resource that we refer clients and their family members to for smoking cessation. Staff from the Kansas Department of Health and Environment will provide speakers on the topic of smoking and its related effects, and we plan on having them speak at one of our Community Forums next year.

Prevention, early identification, testing and treatment for HIV and STIs, especially syphilis: All NEWHSI clients are verbally screened at enrollment and at the two-month postpartum visit for HIV and STIs. We provide clients with information on this topic during the prenatal and interconceptional periods utilizing our curriculum, educational videos, pamphlets and speakers at Community Forums. High-risk clients, who are seen by RNs, receive a nursing assessment at each visit, which includes discussion and evaluation of signs and symptoms of STIs to determine risk. If it is determined that there is potential risk of an STI, the client is immediately referred to their medical provider or the local Health Department. Home visitors assess and encourage clients to keep their annual Well-Woman Check as well as following any medical treatment prescribed by their medical home. If a woman doesn't have a medical home or health insurance coverage, she is referred to the Health Department for services on a sliding fee scale.

Preterm labor: All pregnant clients are screened at each visit during the prenatal period for signs and symptoms of preterm labor. Clients, who are initially enrolled as low-risk and later present any symptoms of preterm labor, are automatically transferred to an RN so that they may benefit from a thorough nursing assessment on a more frequent basis. Much emphasis is placed on educating our clients about the lifestyle choices they can make to reduce their chance of going into preterm labor. Signs and symptoms of preterm labor and when to call their medical provider or go to the hospital are also discussed on an ongoing

basis. Our curriculum, Partners for a Healthy Baby, provides many handouts on preterm labor, but staff also utilizes videos and other written materials from the March of Dimes, which cover this critical topic.

Information on back to sleep/safe sleep: Information on back to sleep and SIDS prevention is provided and discussed during the prenatal period through the use of our curriculum, videos and other pamphlets and written material on the topic. The local SIDS Foundation provides our program with English and Spanish packets for each client, which includes written information on SIDS and a Sleep Sack for their baby. Sleep safety is also assessed and discussed at every postpartum visit.

Substance abuse prevention: NEWHSI verbally screens all clients at the enrollment and the two and six-month postpartum visits to assess for substance abuse. The home visitor performs visual assessments of the home environment at every home visit to evaluate potential substance abuse issues. Education on substance abuse and its effects is covered prenatally and during the interconceptional period. Handouts from the Partners for a Healthy Baby curriculum and March of Dimes, as well as videos on this topic are utilized to provide client education. One of the Community Forums planned for 2006 will also cover the topic of substance abuse and prevention. If substance abuse issues are determined with a client or a family member, a Community Liaison will be brought in to the case, if one is not already involved with the family. Referrals are also made to local drug and alcohol treatment programs and/or agencies that provide counseling, including the Sedgwick County Health Department's Behavioral Health Center.

NEWHSI Registered Nurses and Community Liaisons attend continuing education classes provided through the Sedgwick County Health Department and through other various approved providers of health education such as area hospitals and Social and Rehabilitation Services. Some of the education topics have included training on Methamphetamines, Mental Health issues, a Maternal Child symposium, Infant Massage, Bonding & Attachment, and Nursing Law. Staff members are kept current on topics that apply to the direct services they provide to clients.

Interconceptional Care

Over the course of this grant cycle, we have improved the service delivery of our interconceptional care services by implementing a new home visitation model in 2002 and by adding Community Liaisons in 2003. This has allowed our program to serve a greater number of clients during the interconceptional period, as well as increasing our ability to provide more in-depth family support services.

NEWHSI provides case management services to coordinate care for infants and toddlers up to two years of age, whose mothers enrolled in the program during the prenatal period. Registered Nurses (RN) and Community Liaisons (CL) provide interconceptional services for NEWHSI clients. Interconceptional clients receive health education through utilization of videos and handouts from the Partners for a Healthy Baby curriculum, as well as pamphlets and other written material from programs such as the March of Dimes, SIDS Foundation and local community agencies. Ongoing assessments and screenings are completed at specific intervals during the client's participation in our program, including Domestic Violence, Depression, Blood Lead Exposure and Denver II Developmental Screenings. Referrals to community agencies are made on an as-needed basis. Interpreters are available for visits with Spanish-speaking clients as well as providing all written materials and videos in their

language. Clients who need transportation to medical and mental health appointments, etc. and who do not have a medical card have taxi service scheduled and paid for them through NEWHSI funds.

NEWHSI home visitors visit postpartum clients a minimum of twice the first month after delivery. Home visits then are scheduled once a month through the child's first birthday. After the 12-month visit, the client is seen quarterly. Phone calls are made to assess client need each month between the quarterly visits. This visitation schedule can be adjusted for more frequent visits per client need.

An RN completes a Welcome Home visit with every postpartum client. Part of their assessment includes checking with the client to find out if they have a six-week postpartum visit already scheduled with their medical provider. The RN or CL will follow up with the client at the two-month postpartum home visit to verify that the six-week postpartum check has been completed. If the client received prenatal care at the Mother & Infant (M&I) Clinic through the Health Department, all of this information can be verified; otherwise, it is obtained through client self-report. Completion of the six-week postpartum medical visit is recorded on our Participant Data Tool.

At the first and second month postpartum visits, the Home Visitor will assess if the client and infant have a medical home. If the client has a medical card, we access her medical home information via the Internet, on the Kansas Medicaid Assistance Program (KMAP) website. Otherwise, the information is obtained through client self-report. Medical home information is tracked on our Participant Data Tool.

The importance of completing the postpartum check-up will begin prior to birth and will be reviewed at each postpartum home visit until the client has complied. If a client does not follow up with her six-week postpartum visit, the Home Visitor will strongly encourage her to make an appointment and will assist with scheduling or accompanying her to the appointment, if necessary. If a client does not have a medical home, she will be referred to the Sedgwick County Health Department's Family Planning Clinic for an exam. M&I clients that are more than ten weeks postpartum and have not completed their six-week medical appointment, will also be referred to the Family Planning Clinic.

The Home Visitor assesses at the first postpartum visit whether the client has chosen a family planning method. Client self-report is the method utilized to obtain this information. The home visitor follows up with the client to assess her compliance with the method at each home visit, which is at a minimum on a monthly basis. If the chosen method is determined by the client as not being one that is working or is too difficult to maintain, the home visitor will provide information on alternate forms of birth control to encourage compliance.

Prenatal clients at low-risk for medical complications are seen by a Community Liaison (CL) and they will continue receiving family support services from the CL through the child's second birthday. An RN will complete a Welcome Home visit with all low-risk clients to assess medical need after delivery. High-risk clients who are seen by an RN prenatally will continue to receive home visits from the RN until the infant has reached six months of age. At that point, if the mother/baby dyad is stable and there are no medical concerns, case management will be transferred from an RN to a CL for the duration of the program. If medical concerns develop with the infant/toddler, the RN will resume involvement with the client on an individual, as-needed basis. If the infant is considered to be at high risk at six months of age, then the RN

will continue to follow, in conjunction with the CL, the infant until the baby is at low medical risk or to program completion.

All HB clients receive a copy of the current immunization schedule. NEWHSI Home Visitors assess the immunization status of infants/toddlers in their caseload during home visits. The information is obtained by viewing the child's immunization card. If the parent does not have the immunization card available or it has not been updated, the Home Visitor will contact the child's medical provider or the Sedgwick County Health Department to obtain this information. Immunization information is tracked on the Healthy Babies Immunization Form, which is kept on the client chart. If an infant is not up-to-date on immunizations, NEWHSI Home Visitors strongly urge clients to immunize their infants/toddlers and the HV review with the client the importance of completing the recommended immunization schedule. The Home Visitor continues to assess the infant's immunization status throughout participation in the program.

NEWHSI recognizes the importance of providing health services to women and their children during the interconceptional period. We enroll clients prenatally in order to have the greatest impact on their families and future birth outcomes. Community Forums, described in the Outreach and Recruitment and Health Education sections, also support our efforts to provide interconceptional care through education efforts.

Depression Screening and Referral

Registered Nurse (RN) and Community Liaison (CL) Home Visitors (HV) conduct perinatal depression screenings with all NEWHSI clients. These HV are also responsible for referring clients who screen positive for depression to area mental health centers and following up on client compliance.

In the past, the Edinburgh Postpartum Depression Scale was utilized to screen postpartum clients for depression. It was decided in 2004 to start utilizing the Center for Epidemiologic Studies Depression Scale (CES-D) because it is designed for use at any stage of life, not just during the postpartum period, and it is a more sensitive tool than the Edinburgh. The CES-D is used to screen all pregnant and interconceptional clients for depression. Pregnant clients are screened at the time of enrollment, again during their third trimester, and at two and four months postpartum. The CES-D may also be administered at other times as needed.

Education on the signs and symptoms of perinatal depression is disseminated at home visits via handouts from our curriculum, Partners for a Healthy Baby. We also provide other written materials on depression from various resources. All materials are provided in English and Spanish. Depression is one of the topics covered at our Community Forums, which are open to NEWHSI clients and the community-at-large.

If a client screens positive for depression, the HV will provide the client with a printed handout that includes information on local mental health agencies. All of these providers accept insurance, Medicaid and Medicare and they also offer a sliding fee scale for self-pay clients.

The HV completes the three-part Community Referral form when they refer a client to a community mental health provider for services. The top two copies are dated and kept in the client's chart. The third copy is tracked in a database by support staff. At the next point of contact, the Home Visitor will assess if the client complied with the referral. The HV will follow up on all referrals within 60 days. After 60 days, support staff will notify the HV's supervisor of any incomplete referrals and the supervisor will get a status update from the HV.

If a client does not follow through with the recommended mental health treatment, the HV will continue to assess her status with additional CES-D screenings and through client self-report. The client will be provided with encouragement and support on an on-going basis to seek mental health services.

Within the Healthy Babies program, NEWHSI and in-kind Registered Nurses (RNs) and Community Liaisons (CLs) have attended two workshops on mental health/depression in the last year. They have received training on various communication techniques to better interact with clients who are depressed. All of our RNs also have a background in mental health topics, and four of our five CLs have a degree in social work or a related field.

RNs are able to work with the client, or in tandem with a CL. This joint home visit approach (with the RN and CL both present at the visit) is particularly beneficial when there are multiple, complex issues going on with a depressed client. In some cases, there have been clients who have presented with depression as well as other mental illnesses, or who are mentally challenged. These clients can require more than the average amount of time for home visits. The CL is able to follow-up to determine if the client has obtained counseling, and the RN follows-up with the prenatal care provider regarding the medical/medication component.

The rapport NEWHSI staff have with their clients is a critical element to supporting and impacting a depressed client's follow-through with seeking help. Clients are often more likely to share feelings of depression during a home visit than they would in a clinical setting. When a client shares these feelings with a HV or has a positive score on the CES-D, the prenatal care provider is contacted to assure coordination of care and follow-through. HV work to assist clients to seek appropriate care for depression including referral for counseling.

Depression screening makes a difference in the lives of clients and contributes to positive health outcomes for children, families and the community. In early 2004, one Spanish-speaking client in the NEWHSI program screened negative for depression eight-weeks post partum. Then at six months, the client disclosed to the HV that she was having trouble waking up in the morning and would hide in the bathroom from her husband. This report in addition to her anxious behavior prompted the HV to administer the CES-D, which resulted in a high positive score. Initially, the client's spouse objected to her seeking mental health services. However, after consultation with her bilingual HV, she was connected to a bilingual therapist. The therapy sessions are provided on a sliding fee and NEWHSI has supported her transportation to therapy. Recently, she has become a mentor to other Hispanic mothers through the Parents as Teachers program. She will graduate from the program in February 2005. Both mother and toddler are doing well.

Core Systems-building Efforts

Local Health System Action Plan

The Local Health System Action Plan for NEWHSI utilizes existing coalitions and existing systems while also seeking to create new targeted systems to focus on our specific maternal health issues. One strength of this program is the strong partnerships that have been developed in a variety of settings that impact the health systems utilized by our target population.

For years our community has talked about the importance and need for public health and how best to come together to meet those needs. Since December 2003, three comprehensive strategic planning community initiatives have begun which directly relate to the Local Health System Action Plan (LHSAP).

In March 2004, Sedgwick County Government hosted a Health Assembly to solicit advice about the direction and goals for public health in our community from community health and business leaders, who directed the County to focus efforts on:

1) Coordination of care
2) Increased prevention efforts to address oral health disparities (our community water is not fluoridated) and efforts to prevent obesity
3) Increased access to primary care services.

In June 2004, the community began a "visioneering" process with the goal of creating a Visioneering Wichita Strategic Plan. Through a "Strategic Thinking" process, opportunity has been given to efficiently develop a Vision, with Strategies and Action Steps in six foundation areas that will eventually result in a Wichita Area 20 year Strategic Plan (Quality of Life, Education, Infrastructure, Government, Economic Development, and Private Sector Leadership). Key emphasis in this process will be placed on the implementation of our ideas. Accountability will be assured through the annual measurement of benchmarks.

This process is important because among the strategies identified in the final plan for what the community hopes to become, NEWHSI and its Consortium play an important role. The strategies identified include:

- Increase the accessibility and quality of healthcare while lowering the cost by:
    - Encouraging healthy lifestyles, wellness, fitness and education programs that focus on tobacco, obesity, drug, alcohol, and violence issues.
    - Improving dental health for all ages.
    - Promoting and strengthening free and/or reduced cost clinics as a substitute for emergency room use for indigent health care and promote awareness of these resources.
    - Encouraging physicians and nurses to provide services to the Wichita Metropolitan Statistical Area indigent patients.
    - Dramatically increasing the use of technology in administrative functions.
    - Having comprehensive coordinated medical care (including mental, dental, and health) for all people regardless of ability to pay and provide easy access to services. Establish a community-wide expert committee that advises us on health care costs and quality.
    - Promoting disease prevention.
    - Ensuring the availability of qualified nurses.

The Quality of Life foundation (one of six focus areas for Visioneering) has identified areas of expertise that a wide-range of local agencies can begin to address the strategies listed above. This group is moving forward, facilitated well, and the Health Department is well represented in a leadership role in this piece of our LHSAP.

Another piece of the LHSAP is the involvement of United Way of the Plains and their development of Community Impact Councils. These Councils have written vision statements and logic models that determine how the United Way will make funding decisions in the future,

based in large part on the direction being given by the LHSAP. Members of the NEWHSI Consortium Steering Committee serve on various United Way Impact Councils. The United Way Of The Plains Children And Families Community Impact Council vision statement is: Our community will be safe and nurturing for every child and family.

It is our hope that we can utilize information learned by United Way and the Visioneering process, in the creation of a Maternal and Child Health Coalition in Sedgwick County to address the needs specific to preconception, prenatal, and postpartum care. This coalition would serve as a think-tank to help guide the priorities of the Local Health Systems Action Plan in the area of Maternal-Child Health. The priorities to be addressed will include, but are not limited to, prevention of prematurity and low birth weight, increasing breastfeeding initiation rates, access to adequate prenatal care, and healthcare for children. Wesley Medical Center has already expressed a sincere interest in working with NEWHSI in the creation of a Maternal and Child Health Coalition in Sedgwick County. Members of the NEWHSI Consortium Steering Committee will be part of the proposed Coalition, attending all scheduled meetings, as well as providing feedback and ideas for future plans.

The Local Health System Action Plan is currently being drafted as was described above. A number of activities are underway within the coordinated Sedgwick County Health Department programs and within the community to develop a strong LHSAP for the community and NEWHSI. In addition to the core services described in this narrative, there are three local health systematic efforts to highlight here as part of our continuing strategies for the next four years. These are the Breastfeeding Initiative, Prenatal Periods of Risk (PPOR), and a community Fatherhood Initiative.

For the Breastfeeding Initiative, funding for training and materials is a barrier as it is not in our budget from Healthy Start. To overcome this challenge we partnered with WIC to seek grant funding to cover training and materials purchases. All NEWHSI staff and all WIC dieticians are now Certified Breastfeeding Educators. With this training complete, all NEWHSI staff persons are better equipped to help and are stronger advocates for breastfeeding.

NEWHSI has been working with the Kansas Department of Health and Environment (KDHE) since 2004 to create a Prenatal Periods of Risk process in Sedgwick County. Per CityMatch, Phase 1 of PPOR protocol requires a minimum of 60 infant deaths over a period of not more than five years in order to provide statistically accurate data. However, in our three NEWHSI targeted zip codes, we are 7 infant deaths short of that requirement for the period 1999 thru 2003. We are awaiting vital statistic data for 2004 to determine if we can do the Phase 1 PPOR process for the five-year period, 2000 thru 2004, for just our NEWHSI zip codes.

KDHE has completed Phase 1 PPOR for the entire county. However, due to state legislation, KDHE is not able to release linked birth and death identifying information in order for Phase 2 PPOR (chart reviews) to be completed. While Wesley Medical Center and FirstGuard Health Plan (HealthWave) have both expressed a willingness to share chart contents with us in the event of an infant death, we have a number of legislative hurdles to get passed before we can work out an agreement with KDHE that will allow us to have access to actual linked birth-death identifying information in order to know which patient charts to review.

The NEWHSI Program Director will continue to work with the Health Department Director and the Health Department Medical Director to facilitate an agreement with KDHE to allow access to all personal information tied to each infant death. As we continue to implement new interventions in our targeted areas, we anticipated the gradual decrease of the IMR, especially

in our African-American families. So, if we find ourselves in a situation where we don't have the numbers to accurately complete the PPOR process, we will consider FIMR or other research-based initiatives to assist us with determining the specifics surrounding each infant death.

Integrating the Fatherhood Initiative into our LHSAP will not be a problem as there is widespread support for such a program and we have existing partnerships to create these events. Healthy Babies works closely with the Male Focus Coalition of Sedgwick County to involve males in the lives of their children. The Coalition hosts Downtown Dads' Lunch-and-Learns for men, sporting events, father's rights forums, and speakers on topics of interest. Attendance has been phenomenal. Our Downtown Dads' lunches have become so popular a waiting list is necessary. Several members of the Healthy Babies consortium are also members of the Male Focus Coalition of Sedgwick County. Healthy Babies will continue to collaborate with this group to bring fatherhood issues to the forefront of the LHSAP.

Consortium

The Sedgwick County Early Childhood Coordinating Council (SCECCC) used to function as the full Consortium for NEWHSI. The SCECCC is mandated to exist by law, through Part C of the Individuals with Disabilities Act, to coordinate services for children ages 0-5 that have, or are at-risk for, disabilities. Its members include 40 community agencies, of which the Sedgwick County Health Department (represented by the Healthy Babies program director) is a mandated participant. The council is also required to have parent/client participation and in Sedgwick County we have expanded our scope to include pre-birth through age eight. In addition, the SCECCC places it's focus on prevention and is the largest group of its kind in the state of Kansas.

The idea of using the SCECCC as the NEWHSI full Consortium was a good concept; however, it did not work as anticipated when implemented. While the SCECCC has a membership of over 40 community agencies, only a few of them focus directly on preconception, prenatal, maternal, and newborn issues. Also, the member agencies do not always have representation at each meeting and if they do it is often a different person. Meeting for three hours on a quarterly basis does not allow adequate time to get an update from each member program and discuss issues directly related to NEWHSI.

So, after much contemplation we formed our Consortium Steering Committee (CSC) in 2004. The CSC provides guidance to NEWHSI by reviewing program policies and procedures and also provides new ideas to enhance our service delivery. The chairperson of the CSC is the Director of Early Childhood Services for our school district so she brings a tremendous amount of knowledge and creative drive to the table as do the other 15 community members, program participants and Healthy Babies employees who complete the membership of the CSC. The CSC meets for lunch on a bi-monthly basis. All discussions of the CSC include information sharing and updates from Committee member agencies as well as updates by clients; as we realize that community collaboration is the key to ensuring that the high-risk families in Sedgwick County receive the assistance they need and are entitled to.

Often during our CSC meetings, we hear of new programs that have been or will be implemented by member agencies or by other community agencies and we share information about perspective grant opportunities. In our first few meetings, we realized that just within our small group, we had duplication of service that none of us were aware of. That realization has enabled us to make better use of the unique services each of the agencies provides and it has

also enabled the member agencies to become very familiar with one another, resulting in an increase in the number of referrals processed between the agencies.

As discussed above, Sedgwick County has a Local Health System Action Plan (LHSAP). As that plan is the blueprint for our county for the near future, we must consider components of the plan along with our grant requirements before we jump into new endeavors. While the plan does not hinder our ability to create new opportunities, it does require that we follow specific processes to reach our intended goals. When working to implement new processes and incentives to reach the high-risk population in our targeted zip codes, we first consider our grant objectives, most of which are based on MCH 2010 and Healthy People 2010 objectives. As a second step, we look to see how our plans fit into the LHSAP. Third, we take our ideas to our Consortium Steering Team for discussion and brainstorming. It is during that time that we not only get approval or rejection from our Steering Team, but we also get the very valuable information about how our plans fit into other initiatives being implemented in other community agencies. It is during this discussion that we sometimes find that we are planning something that another community agency already does or is planning to do. In most cases, this allows us the opportunity to contact the other agency to discuss how we can partner for the initiative to ensure that all clients are being served. All new initiatives are presented to the full SCECCC Council during their quarterly meetings, in order to keep the community informed, to get additional feedback and to avoid duplication of services.

Our program ensures that our CSC is culturally diverse and that it represents the cultural/racial mix of the population we serve. We strive to recruit a diverse group of members within the agencies who are members of the SCECCC, as well as on our steering committee. Cultural diversity allows for the members of the CSC to have a stake in our program and the services we provide. We have just added two more members to our CSC and by the end of 2006; we hope to add another five people to the CSC membership.

The CSC holds at least one training/conference for the entire community per year and is also active in outreach and recruitment for the NEWHSI. The CSC also provides opportunities for partnerships with NEWHSI to provide educational opportunities for program participants and community members. One such collaborative event was “Parents University” which has held October 2004. It was an event that provided speakers, in English and Spanish, on parenting and child-related issues and allowed for local community agencies to set up informational booths. Childcare was provided free-of-charge by staff members of several agencies, including NEWHSI. NEWHSI provided scholarships for 15 program participants as well as transportation for those in need.

NEWHSI will maintain an 80% active rate for the CSC. Our meetings are held bi-monthly during the lunch hour at one of the member’s agency locations. This enables our members to become familiar with one another’s programs, and thus increases opportunity for collaboration between agencies. Lunch is provided to make the meetings convenient for members to attend.

The anticipated role of consumers in the NEWHSI CSC is ever expanding. We currently have two very active program participants on our CSC and one of these consumers was elected in 2004 to serve on the National Healthy Start Board. Consumers help plan Community Forums and other educational opportunities for program participants and the community-at-large. They are also active in promoting NEWHSI in the community by telling of their positive experiences while in the program and also share their wonderful ideas on how to most-efficiently utilize our NEWHSI dollars for providing direct services. We will continue to recruit consumers for the NEWHSI CSC and provide trainings for them to maximize the benefit of

serving on our group. Their ideas and suggestions will be sought from direct participation within the CSC as well as through surveys and questionnaires and will be carefully evaluated and implemented for positive program changes.

The NEWHSI CSC provides a much needed service within Sedgwick County. It has brought local organizations and community members together to work towards a common goal of healthier families. The CSC has also helped to bring the services offered by Healthy Babies (which includes NEWHSI) to the spotlight in the community, which is evidenced by agencies and community members referring potential clients to our program on a regular basis. NEWHSI has earned a reputation, through the CSC, for providing the highest quality home visitation and case management services in the County. Community members know they can look to our program for monthly educational opportunities (Community Forums), and this is due in part to the outreach efforts of our CSC. The CSC has helped NEWHSI by providing our program with direction on what the community's greatest needs are and how our Healthy Babies program can best serve them.

The successful management of NEWHSI CSC efforts is best demonstrated by a client success story. In May 2001, a pregnant 17 year-old high school junior enrolled in the NEWHSI. She was pregnant with her first baby and was very engaged in the program and in the visits with the RN assigned to her case. She delivered a healthy baby boy in January 2002. In addition to achieving above average grades, she participated in Parents As Teachers and devoured any and all information on parenting, infant development, and attended any event that would help enhance her relationship with her child and her boyfriend. Even as an active teen, she made a conscious effort to successfully breastfeed her son until one year of age.

She graduated from high school in May 2002, and started taking college classes that summer, as well as working a part-time job. She moved into her own apartment with her son and boyfriend in January 2003. As a couple they chose "abstinence", though they were living together, to strengthen their relationship as well as their faith.

She graduated from the NEWHSI/Healthy Babies program in January 2004, upon her son's second birthday. Since that time, the client has maintained contact with her Home Visitor, updating her on her endeavors. In July 2004, the client and her boyfriend were married. She is currently attending Wichita State University and she began the nursing program in January 2005. Upon completion of her Nurse Aide Certification (CNA), and with the help of her former Home Visitor, she recently gained employment as a Patient Care Tech in the Cardiac Intensive Care Unit of a local hospital.

She remains involved in the Healthy Babies Program by serving as a member of our CSC and our Community Forum planning committee. She represented NEWHSI by traveling to Chicago for a Healthy Start Conference in May 2004 and in October 2004 she was elected to serve on the National Healthy Start Board. Her enthusiasm is contagious and despite her busy schedule, she has offered herself and her husband to be mentors for teen parents.

Collaboration and Coordination with State Title V and Other Agencies

During 2004, a 55 member interdisciplinary panel, including the Sedgwick County Health Officer, Doren Fredrickson, MD, PhD, convened to create the State Title V MCH Block Grant 5-year Needs Assessment. Referred to as MCH 2010 because it covers the period of federal

fiscal years 2005-2010, the three priority needs identified for the population group Pregnant Women and Infants are:

1. Increase early and comprehensive health care before, during and after pregnancy
2. Reduce premature low birth weight births
3. Increase incidence and duration of breastfeeding (6 months exclusively)

The next step was an assessment of the current organizational capacity of MCH to meet the identified needs. Based on the Capacity Assessment for State Title V (CAST-5) process, an outline was created highlighting the strengths, weaknesses, opportunities and threats (SWOT) related to carrying out the strategies proposed to address the identified priorities. While it was determined that MCH had strength in such items as their partnerships and interagency collaborations and that they had support from the governor for their public health efforts, their weaknesses were evident in their lack of such items as: public awareness, data/technological limitations, communication and collegiality and training.

While workgroups continues to address these and other identified needs, it was also recommended that the panel of experts meet again in the fall of 2005 to discuss progress made.

One of the initiatives tied to the MCH2010 goal above (2) – Reduce premature and low birth weight birth – is the collaboration between FirstGuard Health Plan (HealthWave – SCHIP) and KDHE for FirstGuard's Performance Improvement Project (PIP) to reduce the incidence of Low Birth Weight Births. This initiative has encouraged partnerships between local health departments and FirstGuard in an effort to identify and serve those clients at high-risk for delivering a low birth weight infant. Our collaborative effort with State Title V, Healthy Babies and FirstGuard has resulted in increased referrals to NEWHSI and enhanced communication between partners for the PIP initiative as well as other local and state endeavors.

Another collaborative effort with State Title V is the State Fatherhood Initiative. Agencies from around the state work together under the umbrella of the State of Kansas Social and Rehabilitative Services (SRS) to form the Kansas Fatherhood Coalition. At the county level, the Male Focus Coalition consists of Sedgwick County agencies that have a unified goal of promoting male involvement in a child's life. As a member of the Male Focus Coalition, the NEWHSI Community Events and Grant Coordinator is the liaison between the local and state coalitions. The statewide Kansas Fatherhood Summit is held each spring and NEWHSI staff attended the conference. This three-day conference brings parents, grandparents, and providers together to gain knowledge on a variety of fatherhood and male involvement topics.

Also, we were pleased to have Chris Tuck, our Title V KDHE Representative, attend our Healthy Start Regional conference in 2004. Chris has been helpful in our partnership with USD 259 nurses by promoting the NEWHSI program and encouraging the nurses to refer pregnant teens to the Healthy Babies program. Chris also helped facilitate our partnership with FirstGuard for the PIP discussed above. Chris continues to promote our program activities throughout the state and she has been instrumental in finding trainings and conferences that will benefit our staff.

NEWHSI has established positive working relationships with many community agencies, such as the Center for Health and Wellness, Connecting Point, Sedgwick County Early Childhood Coordinating Council, Parents as Teachers, New Beginnings Seventh Day Adventist Church, St. Anthony's Baby Warehouse (provides free gently used baby clothes and furniture), SAFEKIDS Coalition, SIDS Network of Kansas and the United Way. Additionally, over the last

year an RN and a CL from our program have been designated as the contact persons between Healthy Babies and all of the USD 259 Secondary School Nurses. This collaboration has allowed the school nurses to familiarize themselves with our services and has helped increase the number of pregnant teen referrals coming in to our program from the school system. In 2004, 32 pregnant teens were referred to the Healthy Babies Program. This familiarity has also resulted in requests for presentations, provided by our program staff, on a variety of health topics for student groups within the secondary schools.

NEWHSI recognizes the importance of collaboration between agencies in Sedgwick County, thus it is expected that all staff, including management, participate in activities that foster those relationships. Recent collaborative efforts have included a meeting with Catholic Charities, a program that offers a variety of services such as counseling, emergency assistance, adoption services and a Domestic Violence Shelter, Harbor House. Such meetings allow for sharing of program information and discussion on how to best work together to meet the needs of the community, without duplicating services.

In early 2005, NEWHSI and Wesley Medical Center began to discuss collaborative ways to decrease premature birth and low birth weight births in our targeted population. The NEWHSI Director and other members of the NEWHSI management team meet with the Wesley team on a monthly basis to discuss partner needs. In addition, NEWHSI has made presentations to NICU staff, social workers, labor and delivery nursing staff and supervisors at Wesley Medical Center. Through this partnership, we have been able to provide more intensive wraparound services to our shared clients as we have a system in place that ensures communication between hospital and NEWHSI staff whenever the client presents at the hospital for services or whenever the HV determines that the client has medical concerns that need addressed. In addition, Wesley has the same objective for ensuring that their patients are initiate breastfeeding and that they continue to breastfeed for the first 6 months. In addition to Wesley increasing the number of Lactation Specialists on staff, NEWHSI HV also visit their clients in the hospital to ensure the success of the breastfeeding mom. Another aspect of our partnership is the opportunity for NEWHSI clients to attend all Wesley classes, including car seat safety, infant and toddler CPR, infant safety, infant massage and childbirth education, at very discounted rates. Wesley tracks attendance of NEWHSI clients at their classes and they provide that information to us on a monthly basis.

Per continuing discussion with the other large hospital in Wichita, Via Christi Regional Medical Center, we hope to develop a similar partnership to the one with have with Wesley.

NEWHSI partners with the Center for Health & Wellness (CHW), a community health center located in the NEWHSI targeted area, that serves clients of all ages. Their focus is wellness education and prevention efforts and they also provide primary care for children and adults. The Director at CHW is also a member of the NEWHSI Consortium Steering Committee. CHW is also a NEWHSI partner via another grant collaboration, the Knight Foundation Wichita CARES (Children Able to Read Excel in School) Initiative. In addition to accepting referrals from CHW and referring clients to them for immunizations and well-child checks, we refer clients to CHW for education and wellness classes. Clients earn points via the Stork's Nest Incentive Program for all classes that they attend and once they accumulate enough points, they can trade in their Stork's Nest points to purchase new items, such as baby care products, baby clothes, and diaper bags. As a partner with Center for Health & Wellness, NEWHSI purchases items to help stock the Stork's Nest.

Another member of our NEWHSI Consortium Steering Committee is the Executive Director of the Pregnancy Crisis Center (PCC). In addition to our partnership to share client referrals, in Spring 2005 PCC received notification that they would receive $500,000 in federal funds to develop abstinence education through the Wichita Initiative for Sexual Health (WISH Program). As this program develops, NEWHSI will support and coordinate outreach and education efforts with PCC to support their abstinence education efforts.

NEWHSI also collaborates with March of Dimes to support Prematurity Awareness Day and Walk America. On Prematurity Awareness Day in November 2004, NEWHSI staff wore March of Dimes provided T-shirts and delivered information to doctor's offices and clients. March of Dimes provides materials for our Home Visitors to take to our clients with information about prematurity and birth defects. NEWHSI returns our support by recruiting fundraising teams for Walk America and through event sponsorship.

NEWHSI has a good working relationship with local businesses. When we find clients in need of extermination services, our Home Visitors call the pest control company we partner with, who then provides services to our clients at a discounted rate. Additionally, NEWHSI has a good working relationship with a car repair shop. When we learn that clients have critical car repair needs and no financial means to make those repairs, we are able to refer to this service provider who will assess the car, help clients choose the minimum repairs needed and can also assist them with financing options.

NEWHSI partners with the University of Kansas School of Medicine-Wichita (KUSM-W) in two ways. First, we are currently going thru the RFP process with hopes of entering into a contract with KUSM-W to provide the local evaluation for NEWHSI. Second, many of our NEWHSI clients receive their pregnancy care through our Health Department who has an agreement with Wesley Medical Center for delivery. KUSM-W residents deliver many NEWHSI babies. Additionally, recognizing that oral health has an impact on pregnancy outcomes, NEWHSI clients are referred to Wichita State University's dental hygiene clinic for reduced-cost teeth cleanings.

Monthly Community Forums are held in a local church, New Beginnings Seventh Day Adventist Church. The church provides use of the facility for free, clients have access to the church's clothes closet and the church provides food baskets for all clients who sign up to receive them. In the spring of 2004 we began working on a plan to provide intensive outreach via partnerships with churches, hair salons and laundromats located in our NEWHSI zip codes.

Community-based and Minority Organizations:

- NEWHSI collaborates with the Center for Health & Wellness (an African American Community Based Health Center - CBHO) for NEWHSI and for the Wichita CARES initiative. NEWHSI has made numerous attempts to collaborate with Family Services Institute, another CBHO located in the middle of the NEWHSI area, but their director has declined invitations to partner with NEWHSI.
- The director of the Urban League has agreed to serve on the Male Focus Coalition, a group we also participate in.
- Sunflower Community Action is a Hispanic CBO who has worked with NEWHSI in the recent past to support Community Forums by promoting the forum and assisting with voter registration.
- El Pueblo, a Hispanic Neighborhood Association has recently formed in the target area and plans are in place to begin promoting NEWHSI programs and community forums

within that group. Our partnership with Parent's University includes partnerships with La Familia, a group that supports and advocates foster grandparenting.

Sustainability

Over the course of the last grant cycle, in addition to our Healthy Start funding, we maintained our funding from MCH, SRS and local county monies. We also received a five-year grant award from the James L. and John S. Knight Foundation in 2003 to be a partner in the Wichita CARES project and we began billing our home visitation services to Medicaid (Title XIX), HealthWave (Title XXI) and private insurance in 2004.

The Title V MCH funding recipient in our community is the Sedgwick County Health Department. The Healthy Babies program, of which NEWHSI is a part of, receives a portion of this annual grant amount. The staff, outreach, and education efforts of the recipient programs in the health department are highly integrated. These programs work together to develop education materials that will support consistent messages about healthy pregnancies and healthy baby care.

While the Healthy Babies program does not directly receive any Title X Family Planning funds, they do collaborate closely with the Family Planning Clinic at the Health Department to ensure that clients in need of that service have access to it.

In September 2004, after a year of making a number of changes to our Quality Assurance processes, we were able to start billing our home visitation services to Medicaid (Title XIX), HealthWave (Title XXI) and private insurance companies. While all of the services we provide are nationally recognized billable services, less than 60% of the services we provide are recognized as reimbursable by Medicaid and HealthWave for a Local Health Department provider type, which is what we are. We have discussed this issue with the state on a number of occasions but while they acknowledge that the services we provide do meet national Current Procedural Terminology (CPT) criteria, Medicaid and HealthWave cannot afford to reimburse us for the services. In addition to not being able to bill for all the services we provide, we also must consider that fact that Medicaid reimbursements cover less than half the actual costs of providing the billable services. The fee-for-service revenue that we are able to bring in goes back into the program to help sustain services and make the money we receive from grantors go a little farther. The Healthy Babies program also receives annual grant money from SRS to support program objectives similar to NEWHSI objectives in other areas of the county.

The Wichita CARES (Children Able to Read Excel in School) grant was awarded to Healthy Babies in 2003 as a collaborative effort with Centers for Health and Wellness (a medical facility in the NEWHSI targeted area) and Wichita Public Schools. The intent of the grant is to show that early prenatal intervention, home visitation, appropriate medical care and playgroup therapy all work together to enhance a child's ability to learn once they enter kindergarten. The target population for the CARES grant overlaps the target population for NEWHSI so we are able to provide our NEWHSI clients we an even higher level of interventions than we were able to do in the first year of our grant cycle in 2001-2002.

Sustainability planning is primarily the responsibility of the NEWHSI program director, with active assistance from the Healthy Babies Community Events and Grant Coordinator. We utilize the community connections of the Consortium members and other partner agencies to cooperatively seek additional private and public funding. The program director also utilizes the

Health Department's Grant Writing Coordinator to seek additional funds. At this writing, we are waiting to see if we will receive the March of Dimes grant award that we applied for.

Healthy Babies draws nearly 40% of its program funding from Healthy Start. The other sources are flat funding while our community continues to have increasing needs. Additionally, employee and benefit costs increase annually and those increases have to come out of our grant funding. While much has been done to develop other funding sources to shore up sustainability, Healthy Start funding is the largest single contributor to the program. The loss of those funds would have a dramatic impact on the families served, the community and the NEWHSI Healthy Babies program.

III. Project Management and Governance

Healthy Babies is a Maternal and Child Health (MCH) home visitation program that has been active in some form in Sedgwick County for over 20 years. The Healthy Start portion of Healthy Babies was established in 1997. In January 2002, the oversight of the Healthy Babies program was transferred from a Wichita-Sedgwick County partnership to direct oversight by the Sedgwick County Health Department. This new partnership has facilitated many positive changes in the program. In August 2003, a new Program Director was hired to lead the Healthy Babies team.

The Healthy Babies field staff consists of Registered Nurses (RN), Community Liaisons (CL), and Spanish Interpreters. Home visitation services are offered throughout the entire county. The RNs provide service to clients at high risk for medical complications. The CLs were added in 2003 as a result of our new partnership with Sedgwick County. The CLs are social workers and outreach workers who provide family support services to clients at low risk for medical complications but who demonstrate need. Often, the RNs and CLs provide joint visits to ensure that all client needs are being addressed.

Healthy Babies service protocols, revised in 2003, are designed to improve birth outcomes and to decrease premature and low birth weight birth, infant mortality and child abuse in high-risk families. Outcomes are achieved via a combination of early prenatal care, intensive case management, domestic violence and depression screens, health education, family support services and referrals to other community agencies.

Capacity and Cost Estimation for Home Visitation Services: In 2003, we also began using our new home visitation curriculum, Partners for a Healthy Baby, which allowed our staff to increase their caseloads to 40-45 each. The previous David Olds Model for Nurse Family Partnerships capped individual caseloads at 25. In 2004 the Healthy Babies Program served 535 families, 215 of which were NEWHSI clients. In the future we expect to be able to serve 240 pre and post partum maternal clients per year at a cost of $2,292 per maternal client year. For all clients (240 mothers + 120 babies = 360) cost will be $1,528 per client year.

NEWHSI management are directly involved with all aspects of project implementation including all Community Forum and Consortium activities, as well as networking within Sedgwick County to increase awareness of NEWHSI. The Administrative Management Team (AMT) consists of the Program Director, the NEWHSI Project Manager, the MCH Project Manager and the Program Director of the Behavioral Health Center (who also supervises the Healthy Babies Community Liaisons). The Community Events/Grant Coordinator and the Office Manager both provide support to AMT on a daily basis. The Program Director oversees the day-to-day functions of the program and she works with AMT to evaluate

program data on an on-going basis to ensure that the quality and quantity of services meets our set objectives. In addition to meeting weekly as a group, AMT members also meet bi-weekly with their individual staff for Reflective Supervision. Project Managers provide supervision in the field twice per year for each Home Visitor to assure quality of direct services in the home. Monthly Team Meetings/Case Conferences give all Healthy Babies staff the opportunity to discuss program issues and client concerns.

NEWHSI is a program within the Healthy Babies Program, which is part of the Health Department. Sedgwick County Government provides administrative and fiscal oversight and management support for the Sedgwick County Health Department. The Financial Services division has 34 employees under the direction of the Chief Financial Officer (CFO) with many years of experience to guide grant and contract financial management.

The Healthy Babies program manages funding from five other sources in addition to Healthy Start Program funds. The NEWHSI Program Director has experience managing contracts, grants, Medicaid, HealthWave and private insurance revenue, and she works closely with the Finance Manager at the Health Department and the Revenue Manager in the Sedgwick County Financial Services Division.

Sedgwick County's Financial Statements are audited annually by Allen, Gibbs and Houlik, LC. Additionally, the auditors perform an OMB A-133, Single Audit Report which includes the Independent Auditor's Report On Compliance and on Internal Control Over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance With Government Auditing Standards and the Independent Auditors' Report On Compliance With Requirements Applicable to Each Major Program and Internal Control Over Compliance In Accordance With OMB Circular A-133 And Report On Supplementary Information- Schedule of Expenditures Of Federal Awards. During the last grant cycle, there were no Financial Statement Findings and no Federal Award Findings and Questioned Costs. Furthermore there were no material weaknesses identified or reportable conditions identified that are not considered to be material weaknesses in the internal controls over major programs. Therefore no corrective action plans have been developed or implemented within the last several years in response to A-133 findings.

Monitoring of all grant expenditures is completed using SAP business software. The Finance Manager creates reports quarterly for the NEWHSI Program Director. Grant expenditure information is available to Sedgwick County Government finance department staff, the Sedgwick County Health Department Finance Manager and the NEWHSI Program Director daily through SAP. The Finance Manager of the Health Department creates FSR Financial Status Report annually. Form 272 is completed quarterly and submitted to the Payment Management System for HRSA.

Since 2002, when the Healthy Babies Program came under Sedgwick County for fiscal and administrative oversight, significant efforts have been made to increase and sustain the program through additional funding sources. First, the Healthy Babies Program (of which NEWHSI is a part) has grant funding from other sources--both private and public grant money and local tax dollars. Second, the program began billing fee-for-service in the fall of 2004. Third, continuous efforts are being made to increase collaboration with other agencies to assure that clients receive the kind of case management and support they need to ensure successful pregnancies and healthy infants. Fourth, the Program Director works closely with the Community Events/Grant Coordinator for Healthy Babies, as well as the Grants

Coordinator for the Health Department, to seek out additional grant funding opportunities. We currently have a pending grant application with March of Dimes.

The ability to implement and monitor the NEWHSI project is already in place and has been proven to be a fully functional system. The Healthy Babies Program has a total budget of $1,503,174. Healthy Start funding is one of six funding streams for Healthy Babies. Because of the foundation provided by Healthy Start and the successful administration of these funds, we are able to leverage these additional funds. The combination of our competent NEWHSI staff and the access to Sedgwick County Health Department and Sedgwick County Government resources results in exceptional capacity to manage staff and funding.

IV. Project Accomplishments

We are pleased that NEWHSI is on track in meeting our grant-required goals and objectives, as shown in the Project Implementation Work Plan tables in Attachment 1.

In addition to meeting accomplishing these goals and objectives, we are pleased with the vast number of other accomplishments that NEWHSI has realized the past four years.

- There have been no infant deaths experienced by NEWHSI participants in the past three years.
- Per feedback from community members and participants, we began an outreach plan in the spring of 2005 to collaborate with community businesses to reach the hard-to-reach clients. In addition to collaborating with Laundromats and churches, we are also partnering with beauty shops and cosmetology schools who have consistent and direct contact with our target population. As one of our African-American Consortium members told us, even if an African-American woman is struggling to pay her bills, she will make sure she budgets to get her hair done.
- Based on our new outreach plan, increased collaboration with new community partners and the fine-tuning of program protocols, we provided 620 home visits in April 2005, up from 554 visits in April 2004.
- In September 2004, after a year of making a number of changes to our Quality Assurance processes, we were able to start billing our home visitation services to Medicaid (Title XIX), HealthWave (Title XXI) and private insurance companies. The Medicaid reimbursement rate remains well below our cost to provide services but we are still quite pleased with our ability to bring in this additional program revenue.
- With NEWHSI's strong focus of increasing breastfeeding initiation rates among our target population as well as all of Sedgwick County, all program staff, including support staff and the management team, successfully completed the Certified Breastfeeding Educator (CBE) training in May 2005. This will enable any staff person to be able to answer breastfeeding questions over the phone or be able to go into the community to help with breastfeeding issues and education.
- NEWHSI has maintained a client retention rate of around 96% in the last few years. Clients are primarily closed due to program completion or if they move out of the service area. The excellent retention rate for NEWHSI is evidence of the quality program and quality staff that serve the client population.
- Monthly Community Forums (CF) provides free educational opportunities open to our clients and the community-at-large. On the days that CFs are held, the church opens its food pantry and clothes closet, which they operate as community outreach, and make it available to those in attendance. Childcare, refreshments donated by local restaurants, door prizes and interpretation for the Spanish-speaking population is also provided as an incentive. For NEWHSI clients, transportation, which is funded by the

HSI grant, is provided to the CFs. Educational topics have included Domestic Violence, STIs, Car Seat Safety Checks, Voter Registration, Age Appropriate Toys and Toy Safety, Budgeting, Blood Lead Screenings, Flu-Shots for Pregnant Women, Identi-Kid by the Wichita Police Department, Managing Holiday Stress, Salvation Army Holiday Assistance, Nutrition, Substance Abuse, Infant Massage, Child/Infant CPR and Relationship and Sex Issues. These events provide clients with the opportunity to have social interaction with other families as well as helping them access other agencies and services within the community. Information on these educational events is disseminated to the community through flyers that are both in English and Spanish. The flyers are posted in area businesses such as laundry mats, grocery stores, beauty shops, and churches. Flyers are provided to the parent involvement workers at all of the public schools in the target area for distribution. Flyers and information are emailed to the Consortium members to be passed on to the clients they serve through their agencies. The projected number of persons, which attend CFs, is 50-100 per month, or a total of 600-1000 persons per year. NEWHSI has a Community Forum Committee, which spearheads the activities. This committee is comprised of the following: two consumers, three NEWHSI funded staff and two Healthy Babies staff funded via other grants. All Healthy Babies staff members are expected to participate in the implementation of this monthly event. The Community Forum events went through a transition period between 2003 and 2004 in order to assess how to better reach our target population and increase participation in these events. As of September 2004, forums have been held on a monthly basis, as outlined above, and have shown great success by the ever-increasing number of consumers and community members that participate.

- 100% of all NEWHSI-enrolled clients are screened for Depression, Domestic Violence, Substance Abuse, Smoking, Lead Poisoning and HIV/AIDS. Clients who screen positive are referred for appropriate services and NEWHSI home visitors follow-up on all referrals to ensure compliance.
- Formation of our Consortium Steering Committee (CSC) in 2004. The CSC provides guidance to NEWHSI by reviewing program policies and procedures and also provides new ideas to enhance our service delivery. The chairperson of the CSC is the Director of Early Childhood Services for our school district so she brings a tremendous amount of knowledge and creative drive to the table; as do the other 15 community members, program participants and Healthy Babies employees who complete the membership of the CSC. The CSC meets for lunch on a bi-monthly basis. All discussions of the CSC include information sharing and updates from Committee member agencies; as we realize that community collaboration is the key to ensuring that the high-risk families in Sedgwick County receive the assistance they need and are entitled to. In our first few meetings, we realized that just within our small group, we had duplication of service that none of us were aware of. That realization has enabled us to make better use of the unique services each of the agencies provides and it has also enabled the member agencies to become very familiar with one another, resulting in an increase in the number of referrals processed between the agencies.

V. Project Impact – Please refer to other narrative in this report

A. Systems of Care
B. Impact to the Community
C. Impact on the State
D. Local Government Role

VI. Local Evaluation

The motivation for the local evaluation involved the need to monitor our productivity and, to some degree, assess our impact on the community. An outcome evaluation model was adopted using SPSS software. The local evaluation was contracted out in 2001 because the program staff did not have the time or expertise to adequately construct the software program or generate reports. The program contracted with Sigma at Wichita State University for data processing and analysis.

Program performance data was communicated to Sigma on a regular basis and necessary reports were then generated. Periodic meetings occurred to determine if our data gathering techniques were effective and to examine whether the conclusions that we were forming from this data were valid. Additionally, Sigma conducted focus groups in the community with current and past clients and with other community service providers. Consortia members were included in these focus group sessions.

Two things were determined from these focus groups. The first was that we were not reaching the most dysfunctional mothers**,** those experiencing the broadest range of detrimental behavior. Secondly, we were realizing the limitations of the Nurse Family Partnership (NFP) model that we were following at that time. This model limited us relative to the mothers that could be enrolled in the program, because of strict prenatal and postpartum enrollment guidelines. These narrow NFP parameters meant that we had to utilize a separate nursing model (Omaha) to serve a wider range of mothers. These two nursing models did not blend well for program staff or clients. The difficulties connected with both of these nursing models that arose over time led us to discontinue the Nurse Family Partnership model as well as the Omaha model. We began using the Partners for a Healthy Baby model in 2002.

Ultimately, we became convinced that we needed to take a more detailed look at performance indicators and performance auditing and that we needed a more sophisticated local evaluator to assist us. This was one of the reasons that led to the termination of the Sigma contract in 2004.

In October 2005, NEWHSI will be completing an RFP for a Local Evaluator. Lessons learned point to the need for a local evaluation that includes development of specific evaluation protocols for each of the three indicator areas: performance, systems, and health. The protocols will detail the purpose of the evaluation, including short-term objectives and long-term objectives; they will also detail the plans for monitoring, including performance indicators, performance audits, self-study, and any special approaches such as PPOR mapping. The protocols will identify variables and data sources; they will detail the plans for sampling, measurement, data collection, data management, biostatistical analysis, local reporting, and scholarly communication. A local evaluator will be identified who has a Ph.D. in biostatistics, expertise in demography, considerable research consulting experience, and experience working with electronic vital statistics records from more than one state, and experience developing original statistical methods for vital statistics data. The local evaluator will provide leadership to, and collaborate with, NEWHSI project staff toward construction of the evaluation protocols.

VII. Fetal and Infant Mortality Review (FIMR)

Sedgwick County does not have a FIMR process in place, but there has been discussion regarding implementation of one.

NEWHSI has been working with the Kansas Department of Health and Environment (KDHE) since 2004 to create a Perinatal Periods of Risk (PPOR) process in Sedgwick County. Per CityMatch, Phase 1 of PPOR protocol requires a minimum of 60 infant deaths over a period of not more than five years in order to provide statistically accurate data. However, in our three NEWHSI targeted zip codes, we are 7 infant deaths short of that requirement for the 5-year period 1999 thru 2003. We are waiting for KDHE to release 2004 birth and death data to determine if the five-year period 2000-2004 data will allow completion of Phase 1 PPOR for our NEWHSI zip codes.

KDHE has completed Phase 1 PPOR for the county. However state law forbids release of personal identifiers. Hence, KDHE is not able to release linked birth and death data to complete Phase 2 PPOR (chart reviews). Wesley Medical Center, one of the two delivery sites, and FirstGuard Health Plan (Medicaid and SCHIP in Kansas) have both expressed willingness to share chart contents with us in the event of an infant death. However we must work out an agreement with KDHE that will allow us to have access to actual identifying information in order to know which patient charts to review. We hope to achieve this during 2006.

The NEWHSI Program Director will continue to work with the Health Department Director and the Health Department Medical Director to facilitate an agreement with KDHE to allow access to all personal information tied to each infant death. As we continue to implement new interventions in our targeted areas we anticipate a gradual decrease in IMR, especially among African-American families. If we find a situation in which adequate numbers do not exist to permit Phase 1 PPOR, we will discuss with CityMatch the appropriateness of relaxing the usual minimum infant death limits, or we will conduct some other research-based initiative such as FIMR to assist us with determining the specifics surrounding each infant death.

VIII. Products

The current Healthy Babies program brochure was created in 2004. Brochure images are of Healthy Babies clients and children of Healthy Babies staff. **See Attachment 1**

IX. Project Data

Per instruction, all Project Data has been sent electronically.

X. Attachments

Attachment 1 – Project Implementation Work Plan tables
Attachment 2 – Program Brochure

Attachment 1

Project Implementation Work Plan by Core Service Area (CM)		
Project Period Objective by 06/01/09	**Intervention Strategies and Activities for the Project Period**	**Accomplishments**
The percent of live births to NEWHSI program participants that are Preterm will be at most **(10%)**. Baseline: 16 of 97 (17%) live births to program participants in the NEWHSI project area were Preterm. **HP 2010: 16-11: Reduce preterm births.**	Strategy: Identify risk factors associated with Preterm Birth. Activities: 1. Screen and perform NEWHSI client assessments and interventions per case management protocols, (Including nutritional screening, 24 hour diet recall and weight gain grid analysis). 2. Refer all NEWHSI clients prenatally to WIC and/or Food Banks. 3. Have RN Home Visitors monitor for and instruct NEWHSI clients on signs and symptoms of premature labor during home visits (e.g.: bleeding, leaking of fluid, more than 5 contractions per hour, lower back pain, pressure and diarrhea). 4. Screen for tobacco, alcohol and illicit drug use. Refer to necessary treatment program and/or counseling. 5. Discuss STI's with NEWHSI clients and refer to appropriate agencies for testing and/or treatment. 6. Assess dental decay, distribute toothbrushes and tooth paste, and refer to appropriate services for caries treatment during pregnancy.	As of 5-31-05, all clients enrolled in NEWHSI were being screened for risk factors associated with preterm birth Current protocol Current protocol Current protocol Current protocol Current protocol Current protocol
Project Performance Indicator: The percent of live births to NEWHSI program participants that are Preterm.		
Data Source: CY 2003 local project evaluation report		
Person Responsible: Home Visitor		

Project Implementation Work Plan by Core Service Area (CM)		
Project Period Objective by 06/01/09	**Intervention Strategies and Activities for the Project Period**	**Accomplishments**
The percent of Very Low Birth Weight (VLBW) infants among all live births to NEWHSI program participants will be equal to or less than **(1%)**. Baseline: 2 of 97 (2%) live births to program participants in the NEWHSI project area were VLBW (< 1499 grams). **HP 2010: 16-10: Reduce Low Birth Weight (LBW) and Very Low Birth Weight (VLBW).**	Strategy: Identify risk factors associated with Very Low Birth Weight (VLBW) among consumers. Activities: 1. Screen and perform NEWHSI client assessments and interventions per case management protocols, (Including nutritional screening, 24 hour diet recall and weight gain grid analysis). 2. Refer all NEWHSI clients prenatally to WIC and/or Food Banks. 3. Have RN Home Visitors monitor for signs and symptoms of Pregnancy Induced Hypertension (PIH) (e.g.: check weight gain, blood pressure and swelling/edema). 4. Screen for tobacco, alcohol and illicit drug use. Refer to necessary treatment program and/or counseling. 5. Discuss STI's with NEWHSI clients and refer to appropriate agencies for testing and/or treatment.	As of 5-31-05, all clients enrolled in NEWHSI were being screened for risk factors associated with VLBW. Current protocol Current protocol Current protocol Current protocol Current protocol
Project Performance Indicator: Percentage of Very Low Birth Weight (VLBW) infants among all live births to NEWHSI program participants.		
Data Source: CY 2003 local project evaluation report.		
Person Responsible: Home Visitor		

Project Implementation Work Plan by Core Service Area (CM and PD)		
Project Period Objective by 06/01/09	**Intervention Strategies and Activities for the Project Period**	**Accomplishments**
The degree to which MCHB supported programs facilitate health providers' screening of women participants for risk factors will be **(100%)**. Baseline: 230 of 230 (100%) of NEWHSI prenatal and interconceptional maternal program participants in the project area were screened at least once for Family Violence and Depression.	Strategy: Identify and refer program participants experiencing Family Violence. Activities: 1. Assess, screen, document, refer and follow-up with NEWHSI clients experiencing Family Violence. 2. If necessary, ensure NEWHSI client finds a "Safe House". 3. Assist NEWHSI clients with transportation and/or childcare to receive necessary treatment and/or counseling from community agencies. 4. Assess, screen, document, refer and follow-up with NEWHSI program participants experiencing depression. 5. Conduct Depression Screening using the CES-D Screening Tool. 6. Refer NEWHSI women to community agencies for treatment and/or counseling. 7. Assist NEWHSI clients with transportation and/or child care to ensure referred appointments are kept. 8. Home Visitors will follow-up at each visit to ensure counseling and/or treatment services are received. * Family Violence and Depression screening is done twice during the prenatal period and twice during the interconceptional period.	As of 5-31-05, all clients enrolled in NEWHSI were being screened for risk factors associated with Family Violence. Current protocol Current protocol Current protocol Current protocol Current protocol Current protocol Current protocol
Project Performance Indicator: Percentage of NEWSHI maternal program participants receiving screening for the risk factor of Family Violence and Depression at least once.		
Data Source: CY 2003 local project evaluation report		
Person Responsible: Home Visitor		

Project Implementation Work Plan by Core Service Area (CM)		
Project Period Objective by 06/01/09	**Intervention Strategies and Activities for the Project Period**	**Accomplishments**
The percent of women participating in MCHB supported programs requiring a referral, who receive a completed referral, will be no less than **(100%)**. Baseline: 230 of 230 (100%) of NEWHSI program participants in the project area required a referral and received a completed referral.	Strategy: Identify Healthy Start participants who are in need of a referral to another community agency. Activities: 1. Home Visitors will follow-up with NEWHSI client at each visit to ensure completion of community referral. 2. Provide transportation and assistance with childcare to allow NEWHSI clients to attend appointments made by community referrals.	As of 5-31-05, all clients enrolled in NEWHSI were being assessed to identify if a referral to a community agency was necessary. Current protocol Current protocol
Project Performance Indicator: Percentage of NEWHSI program participants requiring a referral, who receive a completed referral.		
Data Source: CY 2003 local project evaluation report		
Person Responsible: Home Visitor		

Project Implementation Work Plan by Core Service Area (HE)		
Project Period Objective by 06/01/09	**Intervention Strategies and Activities for the Project Period**	**Accomplishments**
The percent of NEWHSI program participants that use cigarettes and/or illicit drugs and decrease their use of cigarettes and/or illicit drugs will be at least (**95%)**. Baseline: 62 of 75 (83%) of NEWHSI program participants in the project area who used cigarettes and/or illicit drugs decreased their use of cigarettes and/or illicit drugs. **HP 2010: 16-17: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.**	Strategy: Educate program participants on the harmful effects of cigarettes and/or illicit drugs on themselves and their children. Activities: 1. Actively educate NEWHSI program participants on effects of cigarette and illicit drug use. 2. Refer NEWHSI program participants for counseling and/or treatment. 3. Assist NEWHSI program participants with transportation and/or child for counseling and/or treatment appointments.	As of 5-31-05, all clients enrolled in NEWHSI were being screened for risk factors associated with smoking, second hand smoke, and/or illicit drugs. Current protocol. Current protocol. Current protocol
Project Performance Indicator: Percentage of NEWHSI program participants who used cigarettes and/or illicit drugs decreased their use of cigarettes and/or illicit drugs.		
Data Source: CY 2003 local project evaluation report		
Person Responsible: Home Visitor		