HEALTHY START IMPACT REPORT

Introduction

The purpose of this report is to provide a written summary of the experience and impact of the San Antonio Healthy Start program.

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

The communities targeted by San Antonio Healthy Start represent areas of perinatal health disparities related to teen pregnancy, low educational levels, newly immigrated women (usually from Mexico and Latin America), residents of public housing (both single family homes and multi-family structures), and families who have recently moved from the inner-city to less dense areas of the City of San Antonio. In addition to these socio-economic risk factors, the data presented in this section will show that Hispanic women and African American women are disproportionately affected by these risk factors and subsequent poor birth outcomes.

The initial community assessment (upon which the first Healthy Start grant was based) revealed a population of 1.35 million people in San Antonio, Bexar County, Texas. Fifty eight percent (58%) of the population is of Hispanic origin. The overall infant mortality rate for Bexar County at the time of the initial Healthy Start needs assessment was 6.3. The number of teen births within the county was more than 2 times the national average. Table I-1 (page 3) shows the three-year (1996-1998) average birth data for the target population. Table I-2 (page 4) shows a detailed breakdown of the 36 census tracts targeted for San Antonio Healthy Start, the average number of births in each census tract, the average number of births to women under the age of 19, the percent and average number of women receiving prenatal care in the first trimester of their pregnancy, the percent and average number of infants weighing less than 2500 grams, and the average number of infant deaths in each census tract. The data in Table I-2 show an infant mortality rate of 14 per 1000 live births for the 36 census tracts originally targeted by this grant. This infant mortality rate (for these 36 census tracts) was more than twice the San Antonio overall infant mortality rate and 3 times the Healthy People 2010 objective of no more than 4.5 per 1,000 live births.

The 1996-1998 average infant mortality rate for the 36 census tracts originally targeted for this project indicated an average infant mortality rate for the African American population of 40.8, compared to the Caucasian and Hispanic rates of 14.4 and 12.2 respectively. All of the 1996-1998 rates exceeded the Healthy Start threshold of 10.8 per 1000. In addition, the incidence of low birth weight infants differed among the ethnic groups, being 6 % for White, 12% for Black, 8% for Hispanic and 7% for other races and ethnic groups. Compared to the national average of 7.2% or the Healthy People 2010 goal of 5.0 per 1000, the African American incidence of low birth weight is twice that of Caucasian low birth weight infants, highlighting an obvious disparity within the targeted community. The neonatal mortality rate for the same period of time was 9.7 per 1,000 (White 11.5, Black 34, and Hispanic 8) with a post neonatal mortality rate of 4.5 per 1,000 (White 5.7, Black 6.8, and Hispanic 4.2). This post neonatal death rate of 4.5 is twice the Healthy People 2010 goal of 1.2 and higher than the national average of 2.4 per 1000. The number of women under
22 years of age having three or more children comprised 125 of the 2880 births (4.3%).

The percentage of women entering prenatal care in the first trimester for this population was relatively high (81%); however, data was not available about missed appointments or lifestyle for the initial assessment. For the period 1996-1998, 89% of Whites, 80% of Blacks, 80% of Hispanics and 86% of other races and/or ethnic groups received prenatal care in the first trimester for an overall percentage of 81%. The overall rate for no prenatal care was 2.5% (Whites, 1.4%, Blacks, 3.5%, Hispanics, 2.5%).

Within the 36 census tracts the total population was made up of 159,289 individuals, of which 23% were White, 14% were Black, 62% were Hispanic and 1% were defined as Other. Almost half, 45.3% (72,121) of the total population was women of childbearing age.

These 36 census tracts were located in two geographic areas of Bexar County – the San Antonio inner city area encompassing the near west side and the east side, and sections of what is known as “rural South Bexar County.” This area had a large proportion of individuals living in poverty. With the average median annual income at $18,146.00, it was not surprising that 32% of the target population lived below the Federal Poverty Level. Of those living in poverty, an even higher percent were children under the age of 18 (40% for White, 42% for Black, 48% for Hispanic and 42% for Other). In addition, almost half of the population over the age of 18 (46%) had not graduated from high school. Furthermore, a striking number of residents, more than a 1/4th of the population, (27%) had less than a 9th grade education. Consistent with these levels of poor educational attainment and low median income, the primary sources of employment opportunities for the population included low-paying service occupations, administrative support, and laborers. With a total of 49,045 households in the area, almost 1/4th, (22.3%) were headed by females. Most of the businesses located within the targeted area were local, small operations. The rural section of the target area consisted of small farming and ranching operations.

San Antonio Healthy Start considered many risk factors in selecting the target population. It was determined that Infant mortality is related to a variety of complex often linked factors, such as preterm birth, low birth weight, and congenital anomalies. For more than 20 years, the national research data have indicated that there are significant disparities in infant mortality rates. Among the most important clues to the underlying causes of racial disparities in infant mortality is the prevalence of different, pre-existing conditions such as vaginal infection, hypertension, lack of social support systems, or more general underlying physical conditions such as obesity and poor nutrition.

Many of the known risk factors associated with low birth weight and infant mortality may be beyond the woman’s immediate control, such as socioeconomic status, ethnicity, and obstetric history. On the other hand, lifestyle behaviors, cigarette smoking, weight gain during pregnancy, drug and alcohol use, are within the woman’s control and may influence the birth outcome.

Culture, especially relating to Hispanic women, is another factor that may affect birth outcomes. The status of the Hispanic woman within the family may lead to powerlessness and decreased self-esteem. This environment can often lead to domestic violence and/or a decrease in self-worth, which can lead to clinical depression. The lack of adequate prenatal care may lead to undiscovered
gestational diabetes, pregnancy induced hypertension, and untreated urinary infections, all contributing to either a difficult delivery situation or birth defects in the child.

While San Antonio Healthy Start initially focused on 36 census tracts, the 1999-2003 City of San Antonio Vital Health Statistics Report has indicated that most of the areas of concern lie within 15 zip codes. Within these 15 zip codes, the infant mortality rate for Hispanics is 10.80 deaths per 1000 live births, and for African Americans it is 14.46 per 1000 live births. This makes for a combined Hispanic-African American infant mortality rate of 12.11 per 1000 live births.

In addition to the high rates of infant mortality, the proportion of infants born weighing less than 2500 grams is 9.7% in comparison to the 2002 CDC National Average of 7.8%. The number of children who receive their 4.3.1.3 series of immunizations is 52.47% in comparison to 75% reported by the CDC National Immunization Survey for Bexar County. Only 82% of pregnant women enter prenatal care in the first trimester compared to the Healthy People 2010 Objective of 90%.

The total population for the 15 zip code target area includes 322,685 Hispanics and 41,185 African Americans, with 63,000 (17.3%) of the total population living below the national poverty level. San Antonio perinatal health data is summarized in Table I-3 (page 6).

**Table I-1: 1996-1998 Demographic and Statistical Data**

<table>
<thead>
<tr>
<th>Variable</th>
<th>White</th>
<th>Black</th>
<th>Hispanic Origin</th>
<th>Other</th>
<th>(N) Total</th>
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</thead>
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<tr>
<td>1990 Census Data for each of the following:</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Population by Racial Distribution (number)</td>
<td>36,730</td>
<td>22,171</td>
<td>99,227</td>
<td>1,161</td>
<td>159,289</td>
</tr>
<tr>
<td># Women of Reproductive Age (WRA)</td>
<td>7529</td>
<td>9090</td>
<td>20513</td>
<td>238</td>
<td>37,370</td>
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<tr>
<td>% Children under 18 in families with incomes below Federal Poverty Level (FPL)</td>
<td>40%</td>
<td>42%</td>
<td>48%</td>
<td>42%</td>
<td></td>
</tr>
<tr>
<td>1996 – 1998 (Three Year Average) for each of the following:</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td># Live Births</td>
<td>348</td>
<td>147</td>
<td>2,371</td>
<td>14</td>
<td>2880</td>
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<tr>
<td># Births to Teens 18 and younger</td>
<td>22</td>
<td>19</td>
<td>422</td>
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<td>464</td>
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<tr>
<td># Live Births to women entering the care in the first trimester</td>
<td>310</td>
<td>118</td>
<td>1886</td>
<td>12</td>
<td>2327</td>
</tr>
<tr>
<td># Live Births with No Prenatal Care</td>
<td>5</td>
<td>5</td>
<td>60</td>
<td>1</td>
<td>71</td>
</tr>
<tr>
<td># Infant deaths under one year of age</td>
<td>5</td>
<td>6</td>
<td>29</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td># Neonatal Deaths (28 days or less)</td>
<td>4</td>
<td>5</td>
<td>19</td>
<td>0</td>
<td>28</td>
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<tr>
<td># Post Neonatal Deaths (29 to 364 days)</td>
<td>2</td>
<td>1</td>
<td>10</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td># Infants born weighing 2500 grams or less</td>
<td>21</td>
<td>18</td>
<td>193</td>
<td>1</td>
<td>232</td>
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### Table I-2: 1996-1998 Demographic and Statistical Data of 36 Census Tracts

<table>
<thead>
<tr>
<th>Census TRACTS Avg 1996-98</th>
<th>Births</th>
<th>Births &lt;19</th>
<th>%</th>
<th>Prenatal care &lt;4m</th>
<th>%</th>
<th>Weeks of Preg &lt;38</th>
<th>%</th>
<th>LBWB &lt;2500 Grams</th>
<th>%</th>
<th>Births to Single Mom</th>
<th>%</th>
<th>Infant Deaths</th>
<th>Rate per 1000 Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>1620</td>
<td>126</td>
<td>20 16%</td>
<td></td>
<td>110 87%</td>
<td></td>
<td>23 18%</td>
<td></td>
<td>8 7%</td>
<td></td>
<td>35 28%</td>
<td></td>
<td>1</td>
<td>5</td>
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<tr>
<td>1521</td>
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<td>8 11%</td>
<td></td>
<td>62 85%</td>
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<td>10 13%</td>
<td></td>
<td>3 4%</td>
<td></td>
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<td>9 10%</td>
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<td>1709</td>
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<td>18 17%</td>
<td></td>
<td>80 78%</td>
<td></td>
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<td></td>
<td>10 9%</td>
<td></td>
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<td>2 7%</td>
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<td></td>
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<tr>
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<td></td>
<td>6 10%</td>
<td></td>
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Project Name: Eliminating Disparities in Perinatal Health  
Project Grant # H49MC00101  
City & State: San Antonio, Texas

Table I-3: San Antonio Perinatal Health Data

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>WHITE</th>
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<th>OTHER</th>
<th>(N) TOTAL</th>
<th>HISPANIC ORIGIN</th>
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<tr>
<td><strong>2000 Census Data:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Population by Racial Distribution (number)</td>
<td>26544</td>
<td>12438</td>
<td>3269</td>
<td>113252</td>
<td>71001</td>
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<tr>
<td># Women of Child-bearing Age (WCBA)</td>
<td>6306</td>
<td>2938</td>
<td>808</td>
<td>26950</td>
<td>16898</td>
</tr>
<tr>
<td>% Children under 18 in families with incomes below Federal Poverty Level (FPL) *</td>
<td>83%</td>
<td>78%</td>
<td>91%</td>
<td>-</td>
<td>88%</td>
</tr>
<tr>
<td><strong>1996:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Live Births</td>
<td>323</td>
<td>208</td>
<td>19</td>
<td>2085</td>
<td>1535</td>
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<tr>
<td># Births to Teens 17 years and younger</td>
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<td>23</td>
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<td>158</td>
</tr>
<tr>
<td># Births to Teens 18 and 19</td>
<td>19</td>
<td>23</td>
<td>2</td>
<td>218</td>
<td>174</td>
</tr>
<tr>
<td># Live Births with 1st Trimester entry</td>
<td>284</td>
<td>156</td>
<td>18</td>
<td>1690</td>
<td>1232</td>
</tr>
<tr>
<td># Live Births with No Prenatal Care1st</td>
<td>39</td>
<td>52</td>
<td>1</td>
<td>395</td>
<td>303</td>
</tr>
<tr>
<td># Infant Deaths</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1,000 live births)</td>
<td>3.09</td>
<td>14.42</td>
<td>0</td>
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<td>7.17</td>
</tr>
<tr>
<td># Infant deaths (birth to 28 days)</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Neonatal Mortality Rate (per 1,000 live births)</td>
<td>3.09</td>
<td>14.42</td>
<td>0</td>
<td>6.71</td>
<td>6.51</td>
</tr>
<tr>
<td># Infant Deaths (29 days to 365 days)</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Post-Neonatal Mortality Rate (per 1,000 live births)</td>
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<td>0</td>
<td>0</td>
<td>47</td>
<td>.65</td>
</tr>
<tr>
<td># Moderate Low Birth Weight (LBW) infants born with birth weight of 1501 to 2500 grams</td>
<td>16</td>
<td>19</td>
<td>2</td>
<td>114</td>
<td>77</td>
</tr>
<tr>
<td>Moderate Low Birth Weight Rates, % (birth weight 1501 to 2500 grams)</td>
<td>4.95%</td>
<td>9.13%</td>
<td>10.53 %</td>
<td>5.47%</td>
<td>5.02%</td>
</tr>
<tr>
<td># Very Low Birth Weight (VLBW) Infants born with birth weight of 1500 grams or less</td>
<td>3</td>
<td>7</td>
<td>0</td>
<td>36</td>
<td>26</td>
</tr>
<tr>
<td>Very Low Birth Weight Rates, % (birth weight of 1500 grams or less)</td>
<td>.93%</td>
<td>3.37%</td>
<td>0</td>
<td>1.73%</td>
<td>1.69%</td>
</tr>
<tr>
<td>Age Appropriate Immunization Rates of Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>79%</td>
</tr>
</tbody>
</table>
### 1997

<table>
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San Antonio Healthy Start Impact Report

II. Project Implementation

San Antonio Healthy Start was implemented using the five Healthy Start Core Services, Outreach and Client Recruitment, Case Management, Health Education and Training, Interconceptional Care, and Depression Screening. In addition, the project implemented core systems-building efforts, which consisted of a Local Health System Action Plan, a Consortium, Collaboration and Coordination with State Title V and other Agencies, and Sustainability. The following sections will discuss how San Antonio Healthy Start implemented each service and system intervention.
Outreach & Client Recruitment

A. Procedure and Rationale for Use:

Outreach and recruitment is implemented in a variety of ways. One of the primary methods is through the use of Community Outreach Advocates (COAs). In February of 2002, at the inception of the Healthy Start project, the Community Outreach Advocates were transferred into San Antonio Healthy Start from the nursing division of the San Antonio Metropolitan Health District (SAMHD). That first month was dedicated to staff training and assessment of the target areas. Staff training included orientation to program policies and procedures, training on the Florida State University "Partners for a Healthy Baby" curriculum and accurate documentation. Assessments of the target areas included the COA's going into the 36 targeted census tracts and assessing the neighborhoods. They made note of existing healthcare providers, stores, churches, schools and community gathering places. The assessments also included exploring the surrounding communities to determine where the residents of the target areas accessed needed services. The month of March, 2002 was regarded as on the job training, a time to hone interviewing skills, pilot the Initial Encounter Form and make changes as needed. The first door-to-door recruitment sweep occurred in April 2002.

The initial Healthy Start Assessment indicated that 36 census tracts should be targeted for outreach and client recruitment. To meet Texas Department of Health (TDH)/San Antonio Metropolitan Health District/SAMHD guidelines, Community Outreach Advocates concentrated their outreach and client recruitment efforts on these 36 census tracts. It was later determined that Healthy Start should target an area consisting of 15 zip codes instead of 36 census tracts. In 2003-2004, the outreach and recruitment efforts changed to focus on these 15 zip codes. To this end efforts began to hire, five (5) Community Outreach Advocates to promote Healthy Start in these high-risk zip codes.

It was believed that outreach and client recruitment efforts should include active mobilization of outreach workers in the high-risk zip codes.

Many San Antonio residents were displaced from one of the main target areas due to Government Housing closures. These residents were scattered throughout the city making outreach efforts more cumbersome. Outreach staff recruitment efforts included block walks (door-to-door canvassing), health fairs, advertisements (neighborhood, age, and ethnic specific media/newspapers, street banners, public service announcements via radio and television). In addition, outreach staff conducted visits with community agencies, such as hospitals, doctor’s offices, clinics, schools, churches, WIC offices, SAMHD health clinics, school parenting classes, school nurses, social workers, counselors, drug and alcohol in-patient and out-patient treatment centers, and homeless shelters. Outreach staff also attended conferences with Healthy Start appropriate audiences and attendees.

Since the San Antonio Metro Health District Clinics were considered a prime source for potential Healthy Start clients, client recruitment started within these clinics. Outreach staff conducted in-services to educate clinic staff about Healthy Start services. They were provided with referral forms to refer clients who might be appropriate for Healthy Start service. (see Appendix A: San Antonio Healthy Start Referral Form) Information requested on the referral form included demographic, pre/postnatal information, specific maternal and infant risk factors, and the zip codes that we service.
The outreach and client recruitment process is a two-stage process. The Outreach Worker initiates client contact and completes the client referral document. The client referral document is then given to case management (a licensed Social Worker) for triage. Clients who are considered to be low risk clients are supervised by an outreach team member. Clients who are considered to be high-risk clients are supervised by a member of the case management team (a licensed Social Worker or a Registered Nurse).

If a client was served in one of the targeted areas and later moved, the client is eligible to continue to receive Healthy Start service at their new residence. It has been determined that clients are vested in Healthy Start services due to longevity and consistency of family service provided by this program.

In addition to the use of COAs, the project also uses other methods to reach out to the target community and recruit program participants. These methods include the SAMHD Healthy Start website, radio public service announcements, newspaper advertisements, and distribution of brochures and flyers by our community business partners. In addition, the COA’s, conducted door-to-door outreach, neighborhood walks, and participated in health fairs and other community events. Some of the material designed specifically for Healthy Start advertising/outreach/promotion can be found in Appendix B (List of Products).

B. Components and Resources used for Outreach and Client Recruitment:

Our first and most important outreach intervention consisted of surveying the target community. The approach used was designed to help make the outreach worker accepted by the area residents. The focus was to unite with the residents in the community in a non-intimidating fashion. During outreach, our attire was designed to be casual and mimic the attire worn by those residing in the target community (blue jeans and t-shirts). Outreach workers provide community education, which consisted primarily of infant mortality data, risk factors, and an explanation of Healthy Start services. The primary outreach targets included businesses that which were frequented by potential Healthy Start clients (beauty salons, laundry mats, liquor stores, grocery stores, bus stops, and dollar stores). With the approval of business managers, Healthy Start brochures and pamphlets were distributed. Healthy Start flyers, posters and street banners were also displayed in businesses that consented to this type of advertisement. (see Appendix B: List of Products)

This outreach and recruitment effort required the use of five outreach workers and numerous printed materials, some of which is displayed as exhibits with this report. This outreach and recruitment effort also utilized radio and television public service announcement, and community education.

C. Resources/Events which Facilitated or Detracted from Successful Outreach & Recruitment:

Over the last 6 years, SAMHD has closed four (4) inner city public health clinic locations. For many years, SAMHD operated small public health clinics within the multi-family housing area through no-cost or low-cost lease arrangements. Like most urban cities of its size, San Antonio began a housing movement away from dense public housing environments to more scattered housing, concentrating on
single-family homes. As the housing units were demolished, SAMHD was faced with closing public health clinics. The population that has moved out of these units is now located in areas of the City where there are minimal public health facilities. The population left behind in the inner city is one of low economic status, homeless or Mexican nationals without proper immigration status. This shift in economic demographics (movement of the targeted population to other areas of the city, including the most rural sections of the city) has created a need for more proactive client outreach and recruitment.

This proactive recruitment, as outlined above, has been very successful. The program averaged 40 referrals a week. This high number of referrals both facilitated and detracted from Healthy Start performance. The Healthy Start case management team was required to work both Healthy Start and Texas Department of Health (TDH) cases. Increased Healthy Start referrals caused the case managers to have a very large caseload. The program was restructured to allow case managers to work only the 14 zip codes in the Healthy Start target area. The demographic restructuring also facilitated internal program restructuring. The outreach and recruitment team was downsized from five (5) to one (1).

Case Management was also restructured, two (2) case managers were lost; and once again, the remaining case managers were left with a large client caseload. Referrals from the Texas Department of Health also decreased, as the remaining case managers were no longer dually responsible for TDH clients and Healthy Start clients. Outreach increased in big conglomerates (hospitals, schools and city departments). This revitalized the Healthy Start outreach and recruitment program. At the time of this report, the program has one (1) outreach worker. The goal is to increase this to three (3) outreach workers. An outreach worker will be paired with a Case Manager to work with the family throughout the duration of the client’s enrollment. This should prove to be successful due to the consistency it provides to the family. Currently, Healthy Start is experiencing a loss in staff causing our outreach efforts to be put on hold. This reduced staffing has not hindered incoming referrals or services. Healthy Start is known by many agencies and is being recommended to others by our own clients. We continue to work diligently on serving pregnant women and their babies and strive for healthier outcomes.

During the summer of 2004, it was determined that these outreach efforts were not adequate to recruit the substantial number of African American clients target by this project. Therefore, an action plan was implemented which was designed to enhance African American recruitment. As indicated in San Antonio Healthy Start Action Plan (see Appendix C: Healthy Start Action Plan 2004-2005 and Progress Report), the project began efforts to assign an indigenous African American to enhance outreach in targeted zip codes. At the time of this Impact Report, this outreach worker has been hired and the program is seeing an increase in African American recruitment. Efforts were also implemented to increase knowledge of Healthy Start Services within targeted African American communities. This included the use of print media, public health clinics and other community based agencies within the target area. Efforts were also made to increase local business awareness of Healthy Start services. This included the distribution of Healthy Start promotional materials in beauty salons, Laundromats, grocery stores, etc. Efforts were also made to have face-to-face visits with local health providers in the targeted African American communities. Pamphlets and brochures, specific to the African American Community were produced. (see Appendix B) Other Healthy Start communication, and outreach effort was revised to be more culturally appealing to
African Americans. The project is also implementing efforts to collaborate (or establish a mentoring relationship) with other Healthy Start sites that are using depression screening tools and procedures that have demonstrated effectiveness with African Americans.

**Case Management**

A. Procedure and Rationale for Use:

As indicated in the original grant application submitted in 2001, San Antonio Healthy Start incorporated case management as a required core intervention service. The case management staff was all hired prior to the end of 2001, and the component commenced on March 1, 2002.

The component design was developed based on research, and the needs of the targeted population. It acted as an intervention that addressed perinatal health disparities associated with high risk populations which included, but was not limited to, the reduction of infant mortality, post neonatal deaths and teen pregnancies. To maintain consistency among the SAMHD’s case management programs, the Healthy Start case management component followed the standards and policies established by the Texas Department of Health’s Pregnant Women and Children’s Program (TDH/PWI). From implementation and throughout the four-year grant period, case managers were required to abide by the following standards:

- To be Texas licensed and TDH certified registered nurse or social worker with one-year experience in providing case management services;
- To maintain continuous educational development;
- To be trained in the Florida State University Center, Partners for Healthy Baby Home Visiting Curriculum;
- To participate in multiple initiatives and coalitions to coordinate case management activities with other providers;
- To be client centered and flexible in assisting clients;
- To consider cultural and social environment/situation of the client when developing plans and goals.

The case management component provided support to pregnant and postpartum adolescents/women and children through two years of age. Case management staff comprised of social workers and registered nurses provided education and guidance to families ensuring that their medical, social and educational needs were met. Each case manager was responsible for managing their assigned caseloads and was expected to abide by policy, procedures and standards established by the program.

In preparation for the Healthy Start commencement date, case managers received training from administrative staff, and were trained and certified by the Texas Department of Health to provide case management services for pregnant women and children. Prior to commencement case managers worked together with outreach workers in the targeted areas, assessing the community and available resources, and piloting Healthy Start program forms.

B. Components and Resources Used:
The Social Services Manager and three (3) social workers were transferred from the SAMHD Nursing Division to implement the case management component for Healthy Start. Two final case managers, both social workers were hired in December 2001, completing the case management component. The program experienced a short but diligent first year focusing its efforts on creating a case management team capable of providing and ensuring standardized case management services with uniform criteria for equal access and culturally sensitive delivery of services to all participating program clients/families.

Prior to the end of 2001, Healthy Start case management consisted of the Social Services Manager and five (5) social workers. Incorporated into the component were two existing SAMHD case management programs consisting of registered nurses and social workers. One program was funded through University Health System’s tobacco funds and the second provided services in the entire county through the Texas Department of Health Title V program. Using both Registered Nurses and Social Workers in SAMHD’s case management programs offered a blend of the social sciences that complimented the care of the client. Nurses and social workers from all three case management programs exchanged case information and developed a respect for what each discipline brought to case management.

In 2002 the case management component consisted of eleven (11) case managers who provided services in Bexar County, including the designated 24 Healthy Start census tracts. The case management component consisted of the Social Services Manager and five (5) HRSA funded case managers, four (4) Title V and two (2) funded through University Health System’s tobacco funds. Throughout the second year, (1) HRSA case manager resigned, (1) one Title V case manager was transferred back to the SAMHD perinatal clinic system, and based on University Health System funding cuts, one (1) case manager was terminated. In order to continue providing the same standard of care, the one remaining University Health System case manager was transferred into Healthy Start and as of December 31, 2002 the case management program consisted of five (5) HRSA funded case managers and three (3) Title V funded. Additional cuts to SAMHD’s Title V Block Grant funding reduced Title V case management staff to one Registered Nurse. In 2004 one (1) HRSA funded case manager was transferred to the outreach and recruitment component and an additional social worker was hired through a contract with Family First, a project of Alpha Home Inc., funded through a grant with the Department of State Health Services (DSHS). Family First was incorporated as a sub-project in Healthy Start effective August 2004 with goals that included (1) to provide help in communities to reduce the number of children and families whose lives are affected by the use of alcohol and/or other drugs and (2) to facilitate locating assistance for substance abuse/use to reduce the incidence of fetal drug exposure. In 2005 and at the end of the four year grant period, two (2) HRSA funded social workers resigned, leaving two (2) HRSA funded social workers, one (1) Title V funded RN case manager, and one (1) Alpha Home funded case manager. Two social work positions are currently in the process of being posted.

Throughout the four year grant period, adjustments were made based on the reduction in workforce which included the use of outreach workers to provide a lower level of care and health education, the RN was used to provide intensive health education and a Denver Development Screening for all children under two and case manager caseloads were reduced from a maximum of 45 and minimum
of 35 to a maximum of 35 and minimum of 25. These changes allowed the program to maintain the same or an improved standard of care.

The case management component receives the majority of its clients through referrals. All referral sources are provided with Healthy Start case management referral forms identifying program services and target areas. Referral sources send referrals to the program via fax, which are then triaged to social work case management staff, based on their assigned zip code areas of responsibility. Each case manager is responsible for high-risk, mid-level and low-risk prenatal and postpartum/interconceptional clients residing in the case manager’s assigned zip code. The nurse case manager receives referrals from all social work case management staff for clients/families that require additional health and educational support services.

Throughout year one and two, each client/family received a minimum of one home visit per month, with visit frequency adjusted based on the level of risk/need. The services provided consisted of the case manager providing the following:

- An introduction and overview of the case management program;
- Completing a comprehensive assessment of the family’s overall needs;
- Completing the Edinburgh Postnatal Depression scale for mothers 6-8 weeks postpartum;
- Completing a goal oriented service plan which reflected priorities identified by the family;
- Providing coordination of services required to implement the plan;
- Providing monitoring, follow-up and assessment of the plan and barriers to completing goals;
- Completing periodic re-evaluation and revision of the plan;
- Providing advocacy on behalf of the client/family.

In addition, case managers were trained to use the Florida State “Partners for a Healthy Baby” home visiting curriculum and provided one-on-one health education based on client/family needs.

Year three included development and utilization of the “Monthly Home Visit Checklist” to be used with/ and in addition to the monthly service plan. The tool was developed by administrative staff to collect additional data needed for HRSA reporting purposes and to specifically monitor compliance with pre-natal, postpartum and well-child healthcare. The frequency of visits were maintained monthly; however, an increase in high-risk client/families created the need for more frequent crisis intervention by professional staff. Year three also incorporated use of the “Minimum Standards for Health Education” tool used to provide a required minimum standard of health education to each participating client/family. The tool required use of “Partners for a Healthy Baby” home visiting curriculum throughout the pregnancy and babies first year, and incorporated the “Healthy Beginnings” curriculum for months 13 through 24. During the same period HOGG Foundation for Mental Health provided funding to conduct research regarding use of an appropriate depression screening tool. In June 2003, the Edinburgh Postnatal Depression Scale was replaced with the Center for Epidemiological Studies Screening Tool for Depression (CES-D) and from that point forward, participating clients were screened for symptoms of depression once throughout the prenatal period, at 6-8 postpartum and as needed based on the case managers assessment of need.
In 2004, based on TDH eligibility restraints and after conducting extensive research, the case management component stopped providing services based on guidelines established by TDH and selected a model of care parallel to California Counties Department of Health “Comprehensive Perinatal Services Program (CPSP).” The CPSP was created in 1987 to reduce morbidity and mortality among low-income pregnant women and their infants in California. CPSP integrates nutrition, psychosocial and health education assessments, interventions and perinatal education with basic obstetrical care. CPSP was initiated following the success of the Obstetrical Access pilot project, which exhibited positive outcomes and a reduction in infant mortality and low birth weight. The program demonstrated that obstetrical care supplemented by nutrition, health education, and psychosocial services could reduce the incidence of morbidity and mortality, and reduce the incidence of low birth-weight in infants by more than one-third.

During the initial home visit a social work case manager orients the client to comprehensive perinatal care, which includes, but is not limited to:

- Where, when and how comprehensive services are provided;
- Client’s agreement to participate in services;
- Where to obtain prenatal care;
- Information about routine tests and procedures;
- How to use healthcare services (office hours, making and breaking appointments, etc.);
- Identifying danger signs and symptoms and who to contact if problems arise;
- Informed consent;
- Information about referrals
- Hospital pre-admission and availability of hospital tours, and a full orientation to the hospital;
- An opportunity to ask questions and express concerns the client may have about her perinatal care;
- Postpartum orientation to services and referrals (such as moms six week exam and care safety of her newborn)

An initial four-component assessment of the client’s medical, psychosocial, nutritional, health education and healthcare needs is completed by the case manager. This is the first step taken to determine the client’s individual strengths, risks, and needs in relation to her health and well being during pregnancy. The assessment provides baseline data and questions are asked which help to identify issues affecting the client’s health and pregnancy outcome, her readiness to take action, and resources needed to address these issues. Ideally, the assessment is completed at the initial visit together with the CES-D depression scale, but additional visits are sometimes needed to complete the initial paperwork. An Individual Care Plan (ICP) is also completed with the initial assessment. This Individual Care Plan is used as a tool for coordinating the client’s perinatal care. The ICP is developed using one form that combines the four components of care, obstetric/perinatal care, nutrition, health education, and psychosocial. The case manager and the client use the initial assessment to develop the ICP and identify interventions to meet the client’s unique needs. The ICP also serves to identify and document the client’s strengths and prioritize a list of risk conditions/problems, set goals for interventions, and identify appropriate resources and referrals. The ICP is used to build on the client’s strengths, and not simply identify her deficits. This empowers the client to make positive changes during her current pregnancy and in the future.
Prenatal reassessments are conducted at a minimum of each trimester together with the CES-D depression scale. These reassessments are used as a tool to check on the client’s progress on those issues she wants to change. Reassessment is also a time to see if new issues have risen for the client and her family, as well as an opportunity to get feedback about the client’s perceptions of the care she has received. Case managers also continue to conduct the “Monthly Home Visit Checklist” monthly to address new or existing needs, and to provide one-on-one health education based on the client’s current needs and in accordance with topics outlined in the programs “Minimum Health Education Standards for Families During Home Visits”. After the initial assessment is completed and the case manager determines that the client’s high risk and/or medical condition requires additional support, the case manager refers the client to the RN nurse case manager. The nurse case manager makes a minimum of six home visits and a maximum of eight to provide specific information and intense education regarding the client’s health risk. If the client has any children less than two years of age, the nurse case manager conducts developmental testing and makes appropriate referrals as needed.

The program’s choice to use licensed social workers and registered nurses is based on the fact that trained and educated staff can complete an immediate risk assessment on a wide spectrum of issues, and address those issues immediately and effectively on a case-by-case basis. Case management staff are capable of making well trained decisions, applying culturally sensitive methods, providing immediate crisis intervention and addressing care at all three levels: high-risk, mid-level and low-risk. Case management staff are also capable of providing immediate care without making additional trips back to the Healthy Start office for staffing assistance, which requires additional staff hours to help a client resolve issues. A standard caseload for each case manager, which includes high-risk, mid level and low-risk pregnant and postpartum clients, has been increased to 40 families. The average number of program clients served annually was approximately 200 families. The projected number of clients at each level of risk, based on an average of 200 active cases at any time was, 42% high risk, 31% mid-level and 27% low risk. The nurse case manager will provide support services for a caseload of approximately 21 clients/families at any given time.

Multidisciplinary case conferences were a key strength of the program throughout the four years. Year one and two included bi-weekly staffing conferences where client information was exchanged and analyzed to ensure all clients were provided with the most effective interventions to help achieve their goals. Other SAMHD case management program staff, outreach and recruitment, health education and other disciplines were invited to attend. Effective 2003, interdisciplinary case conferences were held every Friday from 8:30 to 9:30am. On occasion, leading the multidisciplinary team was the Director of Health in San Antonio, Dr. Fernando A. Guerra, MD, MPH, Director of Health and Pediatrician, who provide the staffing team with his expertise, direction and guidance. In addition, the staffing team included the case management staff, outreach and mental health component staff, the program manager, and STD clinic physician, prenatal and well child clinic registered nurses and nurse practitioners, and the WIC director and staff.
C. Resources/Events which Facilitated or Detracted from Successful Case Management:

Cuts in Title V and University Health System funding provided a challenge for case management; however, adjustments allowed for the level of care to be maintained. Research conducted targeting an appropriate depression screening tool improved services provided and also created funds to provide collaboration between The San Antonio Mental Health Association and Healthy Start to provide brief psychotherapy on site through the use of volunteer clinical staff. The new assessment tools also improved the delivery of comprehensive case management services. Due to the diverse cultures served by the project, it was recognized that in order to serve culturally and linguistically diverse groups effectively, the project needed to design services to meet the needs of the targeted population. This included flexible home visiting times and appointments, use of cultural brokers, traditional healers, interventions and treatment, culture specific assessments, and language access. Additionally culture specific data was collected and analyzed. This data included, but was not limited to, race, ethnicity, language, age, gender, geographic locale, religion, immigration status, literacy levels and other mitigating cultural factors. The project site employed and utilized staff that was indigenous to the communities served. All aspects of the program including case management, health education, and outreach operated under policies which were clearly written to incorporate cultural and linguistic competence.

Health Education and Training

A. Procedure and Rationale for Use:

Due to the astounding number of teen pregnancies in the target area it was obvious that current educational efforts were either ineffective or inappropriate. The average post neonatal mortality rate of this community was reaching 5% per 1000 live births. This number is twice that of the national average. 16% of all births within the target area were to mothers 18 years of age and younger. This is four times higher than the national average and it represents 30% of teen births in Bexar County. Moreover, one third of the births within the target area are to single women. The Healthy Start health education approach is based on the belief that many community influences (family, friends, organizations, community agencies and businesses) are critical to the success of women and their families in having a healthy pregnancy and ultimately a healthy baby. Examples of specific activities include: 1) developing a community information campaign that is culturally sensitive 2) sponsoring and participating in various community activities 3) carrying out specific education for health care providers that serve women and families in the targeted areas 4) partner with other community agencies to educate the women and families and the community as a whole. The goal of health education is to increase awareness about the issues related to infant mortality and to influence behavior that results in changes in knowledge, attitudes, and skills necessary to change or maintain a lifestyle that promotes overall health, and perinatal health, specifically.

To achieve the Healthy Start objectives the health education core service implemented the following strategies: target area assessment, public information campaign, and provider training of healthcare workers, client education and community-based education. The social marketing framework is the guiding principle behind the public information campaign while the theoretical model is employed in the design of the client, provider and community-based educational activities. A public information
campaign continues to be a key strategy of the health education core service. This intervention addresses project objectives while also raising awareness of Healthy Start services in general.

An assessment of the target area was critical in the design of community-based interventions. Knowing who is doing what regarding a given topic is crucial in ensuring optimal use of resources. Furthermore, the exercise of conducting the community survey is one of the first steps in building relationships among stakeholders. In conjunction with the community outreach advocates, the HEC coordinated a survey of the target area to identify existing health education resources and services that address perinatal health and teen pregnancy prevention as well as healthcare providers, community agencies, churches, schools, recreation centers and neighborhood associations. The assessment resulted in, among other things, a comprehensive list of service-availability for referrals. The HEC provided case managers and community outreach advocates with a target-area resource list of childbirth preparation classes, healthy pregnancy classes, breastfeeding support services and related activities. By identifying gaps in availability, the assessment also guided efforts to provide community-based education aimed at increasing positive birth outcomes in the target area.

The Health Education component has two facets, a case management facet and a Title V facet. The case management component consists of identifying gaps in health education through client assessment and one-on-one client interaction. The Title V component consists of identification of gaps in health education for the high-risk women/families in the targeted area via interaction with professionals in schools, community agencies, and parents. Many times, professionals, community agency providers and parents will contact the Healthy Start Title V officer and request specific educational training. While the case managers provide individualized health education to all of their clients, the Title V health educator uses various group and social marketing strategies to inform, educate and mobilize the community around the issues of infant mortality and prenatal care.

B. Components and Resources used for Health Education and Training:

The health education service plan for the four year period (2001-2005) took the steps necessary to increase awareness of issues related to infant mortality and to provide educational activities that promote overall health, with an emphasis on perinatal health.

At the onset of the program it was decided that case managers would provide both comprehensive case management services combined with one on one health education to each participating client. In order to do so, case managers and other program staff, received in house training on topics such as “Partners for a Healthy Baby” home-visiting curriculum, safety, and additional topics as deemed necessary. Guest speakers also provided special education on various topics as well as mechanisms for accessing resources from their individual agencies.

A major accomplishment was the initial stage of integrating health education into the case management component. Case managers are primarily responsible for providing client education during their home visits to pregnant and parenting women while the health education coordinator provides essential back-up support for that education. A comprehensive Case Management Client Education Checklist was developed. (see Appendix D: Case Management Client Education Checklist) This checklist includes priority topics by perinatal stage (e.g. before baby arrives, baby’s
first six months, baby seven plus months), and the titles of handout materials appropriate for each topic. The Partner’s for a Healthy Baby curriculum is the basis of the client education while additional pieces supplement this curriculum. Additionally, Healthy Start created a checklist for the caregiver to determine the correct developmental stage for those with babies between the ages of 13 months to 24 months. A standardized supply of health education materials was identified and maintained. Each piece has a moderate reading level, is available in both English and Spanish and with the exception of three pieces, is free of charge. The San Antonio chapter of the March of Dimes was extremely helpful and generous in providing several key client education pieces.

The campaign uses a variety of media to get the word out about Healthy Start, the importance of early entry into prenatal care. Healthy Start handbills were designed as a simple, straightforward overview of the program in English and Spanish. They are used as the project’s “calling card” and distributed by community outreach advocates in their outreach activities. Health educators and other project staff also use the handbills, distributing them at health fairs, presentations, meetings and elsewhere. A fact sheet that describes the project goals, objectives, process, and target area is used so that health care providers, community agencies, schools and churches have a more detailed description of Healthy Start. Posters containing the contact information were posted at important gathering points in the target community.

A few of the more significant promotional/educational pieces that were created are:

- San Antonio Healthy Start logo and tag line (Vamos juntos! To a bright tomorrow) was designed through a contest and significant group input.
- Healthy Start handbills, a low-cost, simple overview of the program in English and Spanish are used as the program “calling card”.
- A multi-color, bilingual booklet aimed at potential clients that describes the program more thoroughly and offers simple steps to have a healthy pregnancy and child.
- A straightforward, one-page Healthy Start overview that includes program goals, objectives, process and contact information was developed and distributed to professionals.
- A bi-lingual, laminated poster advertising Healthy Start in full-color on tabloid size paper was developed and disseminated to clinics, community centers, community-based agencies and other locations within the target area.
- A full-color, laminated referral flyer that lists the high-risk categories, eligibility criteria and contact information. Over 100 of these have been given to clinical personnel so that they have a ready reminder of why and how to refer women to Healthy Start case management.
- Two-color door hangers that are used by outreach workers and case managers during an unsuccessful home visits. The hangers are left on the door of the home and contain the workers’ name and contact information.
- Lapel pins, magnets, t-shirts and stickers were developed and are used for promotional purposes.

The strategy of utilizing health care providers in order to reach a greater audience was successful. Twice a year the HEC conducted a survey of Healthy Start staff to determine health education topics
that they feel in need of further training. Staff meetings were held to determine the topics identified as most crucial. The HEC or a guest speaker would present the topics. A copy of the curricula used for the trainings are maintained.

C. Resources/Events which Facilitated or Detracted from Successful Health Education and Training:

The traditional health education approach of delivering presentations was reevaluated in order to more effectively disseminate the educational requirements of the program a “Train the Trainer” curriculum was created. The “Train the Trainer” model was found to be more appropriate in that a single staff person would be able to equip a large number of people to deliver the health education message, thus expanding the impact.

Healthy Start funds one position for the health education core service. That individual, the health education coordinator (HEC), implements the Healthy Start strategies and also supervises a staff of health educators that are funded through the Title V Population-based program, among others. Unfortunately, the resignation of several key personnel in the Healthy Start education team caused a large impact on the activities that health education could promote. Currently, the Healthy Start program shares a health educator (.5 FTE) with the Title V Population based program.

By working in conjunction the numerous agencies within the community the request for presentations on healthy pregnancy topics continues to rise. Once the staffing situation is rectified and with the appropriate training period the program would be in a position to reach even more pregnant women and those that support them.

**Interconceptional Care**

A. Procedure and Rationale for Use:

The original grant submission in 2001 did not include/require interconceptional care as a core service intervention; however, the program was established immediately to provide services to pregnant mothers and children through two years of age. In preparation to provide interconceptional care to all participating clients, year one consisted of providing case management and outreach staff with the following training.

- All case management staff were referred to TDH for training regarding case management for Pregnant Woman and Children from January through March of 2002;
- Case Management and outreach received in-house training from Health Education staff on the Florida State University Center, Partners for a Healthy Baby Home visiting Curriculum in February 2002 and maintained throughout the four year grant cycle;
- Case management and outreach staff were provided with education and administration ensured case managers maintained continuing education and staff licensure beginning March 2002 and maintained throughout the four year grant cycle;
- Case management staff were training to use the Edinburgh Postnatal Depression Scale on all participating clients 6-8 weeks postpartum;
Throughout the first year, case management and outreach staff were required to provide anticipatory guidance at each prenatal home visit to prepare for the birth of the infant and the postpartum period. In addition, case management and outreach staff were required to provide anticipatory guidance after birth regarding developmental milestones, behavior issues and activities for parent and infant. Case management maintained services for high-risk and outreach staff maintained services for lower risk clients.

B. Components and Resources used for Interconceptional Care:

Throughout the second year of the project, interconceptional care services became a required core intervention by HRSA. At this point services were adopted using the same basic concept and philosophy as case management services. Clients were seen in the program until the infant was two (2) years old. This two-year intervention served to promote the spacing of subsequent pregnancies, improve the health of the client to improve pregnancy outcomes, and promote positive parenting skills. Based on the standards established by TDH, an Initial Assessment and Individual Care Plan were completed for each client referred to the program who accepted to participate in the Healthy Start Program. The case manager also assessed the client for any indication of depression and in June 2002 implemented use of the CES-D Depression Scale and based on symptoms of depression, made appropriate referrals. Home visits are made once a month but some clients require more frequent visits based on their needs.

Based on a high number of referrals received by the case management component throughout the second and third grant year, it was determined that case managers should not continue to provide intensive interconceptional care. Case managers were reduced to providing a minimum standard of Health Education which allowed them to focus on immediate clients needs and provide more efficient, effective case management services.

At that point, the new method for providing one on one health and interconceptional care to high-risk case managed clients/ families was based on strategies used by a prior successful SAMHD case management programs. Health Education for the high-risk population was provided by one (1) Title V nurse case manager. The nurse would manage a caseload of approximately 75 high-risk clients referred by case managers. Home visits were to be made based on level of need, pregnancy trimester, and immunization dates for children. In addition, the nurse case manager conducted developmental testing and provided referrals as needed.

In addition, year two through year three incorporated an interconceptional care policy, which was very specific regarding how participating clients would be managed by the program through the babies second year. The policy consisted of very high-risk clients continuing in case management which included providing a minimum standard of health education. Case managers referred clients who needed additional more intense health education to the nurse case manager. All high-risk clients were continued to be visited monthly by case management staff and provided with services based on TDH standards. When case management staff determined the clients risk/needs became low risk, files were transferred to case outreach advocates for care through the second year. Cases were transferred from case managers to their immediate supervisor who then provided the outreach...
coordinator with the charts for distribution among her staff. At any point during the two-year period the client’s needs became high risk, the process was repeated sending the case file back to the case manager to provide comprehensive services.

Monitoring visits provided by outreach staff during the interconceptional care period consisted of completing a monthly home visit checklist with progress notes if needed. In addition outreach staff were to provide health education and handouts based on identification of needs using Partners for a Healthy Baby Home Visiting Curriculum and a client education checklist.

Outreach staff client contact schedule was as follows:
- 3-5 days after birth;
- 2 months;
- 4 months;
- 6 months;
- 9 months;
- 12 months;
- 15 months;
- 18 months;
- 21 months;
- 24 months;

During the final year of the grant, three of the four outreach staff, were transferred to the SAMHD clinic system and new hires are still pending.

At the same time the program chose to use licensed social workers and registered nurses to provide the interconceptional care piece based on the programs experience that trained and educated staff can complete an immediate risk assessment on a wide spectrum of issues and address those issues immediately and effectively on a case-by-case basis. The case management staff are capable of making well trained decisions, applying culturally sensitive methods, providing immediate crisis intervention and addressing care at all three levels; high-risk, mid-level and low-risk. Case management staff are also capable of providing immediate care without making additional trips back to the Healthy Start office for staffing assistance, which requires additional staff hours to help a client resolve issues. At this point, interconceptional care for year four was completed using the CPSP standard of care as described in the case management piece.

Prenatal clients were provided services in four major components: obstetric care, nutrition, health education, and psychosocial issues. The case managers who completed an assessment identifying any deficiencies in these four areas used every resource available to insure that the client and her family had the opportunity to receive the care, education, and assistance needed to meet those deficiencies. This resulted in healthier mothers better prepared to care for their newborn. Case managers monitored prenatal clinic appointments on a monthly basis. If the client did not keep their appointment, the case manager would investigate and offer the client assistance to resolve the problem or eliminate any barriers. Clients who received appropriate prenatal care were generally less nervous about the anticipated outcome of their pregnancy, as observed by the case manager. The case managers also make certain that the client is maintaining a nutritional diet. If the client was not
eating healthy due to the inability to purchase food with the adequate nutritional values, the case managers made appropriate referrals to programs such as WIC, Food Stamps, and food pantries. In some cases, HEB grocery store gift cards are provided by the Healthy Start Program for immediate purchase of food. During the monthly home visits the case managers conduct with the clients, and after addressing the existing and any new needs, the case manager provides health education according to the topics outlined in the program’s “Minimum Health Education Standards for Families During Home Visits” The case managers routinely provide pamphlets, brochures, and other health education information needed by the client. When a client required more extensive health education the case manager referred her to the Healthy Start nurse case manager. The nurse (RN) case manager meets at least six times with the clients who are referred to her by the case manager and while maintaining a separate file on the client she uses the Initial Assessment and Individual Service Plan provided by the case manager. The nurse case manager completes a Denver Developmental Assessment on all infants and toddlers in the household who are under the age of two. The nurse and the case manager have referred some of these children to Early Childhood Intervention Programs as a result of this service. Psychosocial issues are also addressed at every home visit with the client. Any new issues/needs are noted in the monthly Home Visit Checklist and addressed at the same time. However, a Needs Assessment and Care plan are completed every three months. The case manager will advocate for the client when she feels powerless to complete goals. The case manager makes every effort to empower the client to take control of her situation. In some cases the case manager becomes the primary source of support for the client although family support is strongly encouraged. As the prenatal client approaches the due date, the case manager addresses the issue of family planning. All information available regarding family planning is provided to the client to enable her to make an informed decision on the method of family planning she selects.

Postpartum/Interconceptional care services are provided to Healthy Start clients whether they were enrolled at the prenatal period, or are enrolled after they delivered. The same four components of care are used during the postpartum period, although the focus is on the mother and the infant. During the initial PP home visit, the case manager specifically addresses the mother’s concerns during the labor and delivery, postpartum check, the infant’s NBS, immunizations, well child checks, and makes sure that the infant has health insurance, a medical home and is enrolled in the WIC program. The case manager has found that many clients who were not prenatal clients of the Healthy Start Program were lacking some or all of the items above. This is true mostly with clients who received late or no prenatal care. The case manager basically follows the same format with the postpartum client as with the prenatal client and the results have been better-informed mothers who are able to provide better care for their infants.

In 2003 the caseload for interconceptional care services was 270 clients. Based on a reduction in outreach staff and clients whose children turned two years or were lost to follow-up, the numbers for 2004-05 have been decreased to at least half that amount. And at this point are all being managed by the case management staff.

C. Resources/Events which Facilitated or Detracted from Successful Interconceptional Care:

The biggest setback, and one of the most important elements of the program was the loss of three
outreach workers, who are still in the process or being replaced. At this point the program is research oriented. The goal is to determine an appropriate depression screening tool improved services provided and also created funds to provide collaboration between The San Antonio Mental Health Association and Healthy Start to provide brief psychotherapy on site through the use of volunteer clinical staff. The new assessment tools also improved the delivery of comprehensive case management services. Due to the diverse cultures served by the project, it was recognized that in order to serve culturally and linguistically diverse groups effectively, the project needed to design services to meet the needs of the targeted population. This included flexible home visiting times and appointments, use of cultural brokers, traditional healers, interventions and treatment, culture specific assessments, and language access. Additionally culture specific data was collected and analyzed. This data included, but was not limited to, race, ethnicity, language, age, gender, geographic locale, religion, immigration status, literacy levels and other mitigating cultural factors. In 2003 the “Healthy Beginnings” curriculum was incorporated into the minimum standards for Health Education for the clients 13-24 months. On August 26 and 27, 2004, staff and community professionals were provided with training on “Promoting Maternal Mental Health” curriculum. The curriculum was also incorporated into the “Minimum Standards of Health Education” provided by staff to ensure that clients were receiving appropriate information and education regarding mental health issues.
Depression Screening and Referral

A. Procedure and Rationale for Use:

In September 2001 the coordinator for mental health services began work under the umbrella San Antonio Healthy Start program as an-kind position. The purpose of the position was to oversee activities established toward meeting the goals and objectives of the Depression Screening and Referral component. The original vision of the project included screening all Healthy Start patients for depression and referring those patients who showed evidence of depression and/or other mental health issues to appropriate agencies for care.

The screening instrument chosen at that time was the Edinburg Postnatal Depression Scale this at the strong encouragement of the Health and Resources Services Administration. Screening results from the Edinburg complimented with the observation of program case managers and outreach workers and client discourse help determine the needs of each client.

Client needs generated referrals to appropriate mental health service agencies such as the Center for Health Care Services (CHCS), the Mental Health Authority for Bexar County. The Center for Health Care Services and the San Antonio State Hospital are the primary resources for clients presenting with acute disorders and serious mental health problems including Major Depressive Disorder and Schizophrenia. Clients showing signs of less acute or serious problems could be referred to the University Health System psychiatry department and to other outpatient mental health facilities that accept Medicaid reimbursement.

Over four years the mental health component has grown to become an integral component together with Case Management, Outreach, Health Education and our Evaluation component. The process of this integration is described in Section B.

Currently, Healthy Start Case Management staff is responsible for administering the Center for Epidemiological Studies Screening Tool for Depression (CES-D) (see Appendix E: Center for Epidemiological Studies Screening Tool for Depression) which will be discussed in various sections in the narrative. A baseline scale is administered with the initial Prenatal Assessment and the initial Postpartum Assessment, with interval scales administered at trimester intervals through the prenatal period and at 90-day intervals through the postpartum and interconceptional periods.

If a client enters the program in her first trimester and stays with the program through her child’s second birthday, the CES-D will have been administered approximately nine times. All data are entered into the Healthy Start database for comparison purposes. During the period of January through June 2004, a total of 156 CES-D scales were administered by case managers, with 49% scoring 16 or above indicating moderate to severe symptoms of depression.

In addition to the screening, Healthy Start clients receive education regarding depression. This may take place in any number of ways including discussions between client and case manager, the distribution and interpretation of literature and other materials that are appropriate for the client.
Healthy Start staff from Mental Health, Health Education and Case Management designed a culturally sensitive, age appropriate, user-friendly brochure that spoke to the issues of Perinatal Depression. A thorough literature search had been done prior to its completion and no materials were found to be appropriate for San Antonio clients of Healthy Start. A copy of the brochure is submitted with this packet.

Case Management staff adheres to policy and procedure with regard to serving clients with mental health needs including but not limited to depression during the perinatal period (see Appendix F: Mental Health Policies). In August 2003, the CES-D was included in the case management policies and procedures which mandate its use for all perinatal participating clients. Staff responds to scores according to the established Mental Health Triage Decision Tree to be described in Section B.

All mental health referrals are documented in the client’s chart and progress toward completion is tracked using a monthly home visit checklist and reassessments. Completion of referrals is mostly self-reported by clients. As already stated, it is the case manager who is almost exclusively responsible for screening and referral of clients in need. Case managers, the Case Management Coordinator and Mental Health Coordinator work together to determine a course of action for needs considered outside the ability of the program.

B. Components and Resources used for Depression Screening and Referral:

2001
Healthy Start did not have a clear estimate of the number of patients who might be diagnosed with depression or other mental health disorders within our target area. However, data extracted from a record review completed by the Mental Health Coordinator in October 2001 provided a snapshot of the mental health morbidity found in the SAMHD client population at large.

175 records were reviewed (75 of which were from prenatal clinics). Nearly one-third of these patients indicated current or past use of alcohol or other drugs. There was evidence suggesting that 5 percent of the women had experienced some mental health problems although not necessarily depression. Eleven percent of the women had been referred to outside agencies to address apparent symptoms of depression including suicidal ideation.

During 2001 and into 2002, the Mental Health Coordinator who was a Licensed Professional Counselor in the State of Texas received referrals from clinics throughout the Health Department including Healthy Start and he found that 43% of these clients had experienced sexual, physical or emotional abuse or a combination of two or more types of abuse. Other incidence of trauma within the families of clients receiving services through the SAMHD clinics ranged from suicide of family members to extra-marital affairs by husbands or partners. The implications of these findings were staggering but certainly not unexpected and suggested that our Healthy Start clients would present with many if not all of the same morbidity.

Objectives and strategies to be completed by the end of year one (May 2002) came to be based on the information described above. All clients would be screened for, at the very least, depression, and
all those who required ancillary services would be referred to them. Unfortunately, the Edinburg tool would not be of much value to assist us in our objectives since it had only been standardized with postnatal patients. Though “postnatal depression” was an important issue, perinatal depression was much more so because positive birth outcomes and client welfare were the goals of the project as a whole.

In order to address the wide variety of needs for our clients it was important to establish relationships with community-based agencies to which our staff could refer. The relationships had been established over many years however few written Agreements were in place to formalize a relationship. This also became an objective during year one.

Finally, in order to more effectively determine and consequently address the needs of our clients, training became of paramount importance. Our goals were as follows:

1) Train Healthy Start nursing, case management and outreach staff in the administration of the Edinburg Postnatal Depression Scale. (completed)
2) Implement screening utilizing the Edinburg. (completed)
3) Develop a mental health triage mechanism that would assist Healthy Start staff I making solid decisions about the need for referral. (completed)
4) Train staff in the use of the mental health triage mechanism. (completed)
5) Create a directory of public mental health providers with whom Healthy Start develops Memoranda of Agreement. (Partially completed but not particularly helpful)

2002 Calendar year 2002 became a benchmark year for the Depression Screening component of the program and Healthy Start as a whole. The premise for integration of our mental health component into all Healthy Start components became and continues to be “mental health is much broader than simply the absence of a mental illness.” Though all of our case management staff have been educated and trained in the basics of mental health we attempted to further integrate this training into their daily patient encounters by having them focus on assessment keys of mental triage in health and home settings including such keys as appearance, behavior, speech, thought content, mood and affect, perception, and cognitive capacity. Observations of these keys could lead to additional screening, assessment and ultimately treatment.

In addition to the above, the coordinator of the Outreach component wrote and was awarded a grant from the Hogg Foundation for Mental Health headquartered at the University of Texas in Austin. The grant was constructed to be completed in three separate and annual phases:

1) Phase One: Series of Focus Groups to understand consumer perspectives of post-partum depression and to evaluate the multicultural validity of current depression assessment instruments.
2) Phase Two: Prevalence assessment.
3) Phase Three: Counseling services to be delivered by practicum students (graduate and post-graduate) of the Department of Psychiatry of Our Lady of the Lake University (OLLU). These counseling services would be delivered from late 2003 through the
Indeed over a three-year period this project was successfully completed and became one of the hallmarks of not only Healthy Start but of the Health Department as well. Clients were referred from clinics throughout SAMHD including Healthy Start for short-term therapy offered by these practicum students and their supervising psychologist.

In August of 2002, San Antonio Healthy Start hosted a two-day community wide seminar on Perinatal Substance Abuse presented by Ira Chasnoff, M.D., President of the Children’s Research Triangle in Chicago. Dr. Chasnoff is the preeminent research physician in the field of perinatal substance abuse and the resulting birth outcomes. The following is a summary of his topics presented to approximately 100 community agency leaders and staff including case management and nursing staff of Healthy Start:

- Substance Abuse and Infant Mortality: Identifying the Women at Risk
- Women and Substance Abuse
- Medical Effects of alcohol and other drugs on the pregnancy outcome
- Psycho-Social issues for substance abusing pregnant women
- Co-occurring disorders during the pregnancy and postpartum periods (Moderator: Ed Baca; Mental Health Coordinator, Healthy Start)
- Linking Public Health and treatment providers (Moderator: Monica Trevino; Case Management Coordinator, Healthy Start)
- The Private Sector (Moderator: Frances Matt; Program Manager, Healthy Start)
- Primary Care (Moderator: Cynthia Henderson; Outreach Coordinator, Healthy Start)
- Strengths, Weaknesses, Opportunities and Threats (SWOT Analysis)

2003

Through the focus groups funded via the Hogg Foundation Grant we were able to determine the most appropriate depression screening tool for our population which turned out to be the Center for Epidemiological Studies Screening tool for Depression more widely known as the CES-D. (see Appendix E) The work completed through the Hogg Foundation Grant came to be known as the Maternal Depression Project and will be described in the Evaluation section of this narrative. The focus groups and research were completed by the Evaluation Team and contractors hired to facilitate the groups and perform assessments. The Mental Health Coordinator administratively supervised the practicum students who were also paid through the Hogg Foundation Grant. Work begun by the Outreach Coordinator, fashioned by the Management Analyst and Evaluation Team and integrated by the Case Management Team with assistance from the Mental Health Coordinator was a model of cooperation.

During 2002 and 2003 the coordinator for mental health services (depression screening) developed, finalized trained and retrained Healthy Start staff on a mental health triage mechanism created specially for San Antonio Healthy Start. The coordinator continued to tailor the mechanism to Healthy Start needs and to the coordinated use of the CES-D.
The purpose of the triage system and accompanying decision tree was to establish an efficient and effective mechanism to provide mental health services for patients and families in need. Research was completed in early 2002 and two resources became the basis of the triage system and resulting “Decision Tree”. (Triage Assessment, University of Maryland School of Nursing, 1997 and Mental Health Assessment, University of Maryland School of Nursing, 1997.) Triage was defined in terms of the acuity of the patient at the time of assessment: Emergent, Urgent and Non-Urgent. Each category was defined by the likelihood of harm to self or others and included observable behaviors that were suggestive of such harm. The Decision Tree provided a road map for staff to follow as a client’s acuity was determined including information about where resources may be found to assist a client with her needs.

In April 2003, the Mental Health Coordinator wrote a proposal in response to an RFP from the Mental Health Association of Greater San Antonio (MHA). The purpose of the proposed programs was to develop a community partnership supporting volunteer professionals in the mental health field (social workers, counselors, psychologists and psychiatrists) to provide pro-bono services to Bexar County residents who were in need of short-term therapy for non life threatening mental health problems. The Healthy Start proposal suggested that the site of the program could be the Health Start office in North Central San Antonio and would be supported by the social work staff and administrative staff of Healthy Start. Healthy Start was awarded the partnership by MHA and in October 2003, mental health professionals began providing free services in our offices as well as their own to all qualified clients. The program which came to be known as the Clinic without Walls continues at the time of the writing of this narrative.

Following the inception of the Clinic without Walls, the Mental Health Coordinator also wrote and was awarded funds to assemble a team who would attend training at the University of Washington in Seattle and help to form a database for the state of Texas of children diagnosed with Fetal Alcohol Syndrome. Though the Health District was the administrative lead in the program it was the University of Texas Health Science Center and its Village of Hope clinic that was the clinical lead. Physicians from the Village, together with social workers from Project Hope and nurse from Healthy Start made up the diagnostic team who would provide screening and assessment services to young children to be followed up by care in other institutions such as Our Lady of the Lake University’s Harry Jersig Center for the Learning Impaired. Again, the program continues to this day.

2004-2005
In May 2004 the Mental Health Coordinator was promoted into the Director’s Office of the Health Department and mental health direction was provided for by the Case Management Coordinator of Healthy Start. The transition was lengthy but successful since mental health services were already integrated within outreach and case management. The new coordinator was tasked with maintaining a successful mental health service delivery system and continually enhancing the established network of referral sources for all patients regardless of funding.

C. Resources/Events which Facilitated or Detracted from Successful Depression Screening and Referral:

There were no particular events that facilitated or detracted from successful depression screening and
referral however there are some local proclivities unique to San Antonio or perhaps the culture bias that one may find in San Antonio that detracted from this particular component.

First, the Hispanic and African American communities in San Antonio are generally not disposed to sharing their struggles (especially emotional) outside of family or close friends. As such these individuals are less likely to seek care from what might be considered traditional resources in other communities. In San Antonio, many Hispanic families have sought help (both medical and emotional) from the “Curandera” who without a deep and cultural understanding would be considered in a primarily Anglo community as a witch doctor. Though not all Hispanics seek services from a Curandera, she can be a deeply engrained inter-generational spiritual healer who if taken lightly or in jest in a biased community can turn away many from science and medicine. Little, if any research has been done to determine whether or not this Hispanic art and Anglo science can be successfully fused, however; the benefits would likely be tremendous.

A second barrier to care for women and family members who are depressed or experiencing other mental health problems is that too few resources are available for persons who are economically disadvantaged as the vast majority of program participants were.

Only Medicaid and CHIP funding made it possible for clients to find assistance in the traditional public or not for profit resources. Even these resources seem to be drying up with serious and devastating changes to the Medicaid funds in the state of Texas which eliminated mental health services for children and limited them for adults. Fortunately through the loud and united voice of providers, caregivers and clients the State Legislature was forced to change their position and refund the initiative. The economic picture has not particularly brightened in Texas for the immediate future and such resources are still not safe.

One must recognize that the public health arena has not been the traditional purveyor of mental health services although in San Antonio, the Health District has been partnering and leading other organizations in mental health and substance abuse efforts for over fifteen years. Even still the resources in public health shift again toward such things as bio-terrorism preparedness mental health has not fared well. The State of Texas ranks 48th out of the 50 states in state funding for mental health and substance abuse treatment. That is an abysmal statistic and it has not changed in over two decades. It is not likely to change in the future and as long as that trend continues, the economically challenged families in communities throughout the United States will find themselves in a more and more desperate situation. San Antonio is not immune.

**Local Health System Action Plan**

**A. Procedure and Rationale for Use:**

The local health system action plan was designed to facilitate ongoing collaboration with existing community service agencies to achieve an integrated system of care and service for the target population. The local health system action plan attempts to utilize resources and manpower allocations within the scope and budget of the San Antonio Healthy Start Project. The local healthy system action plan is spear headed through the San Antonio Metropolitan Health District. The San Antonio
Metropolitan Health District (SAMHD) administers the Healthy Start project. SAMHD is the single public health agency in San Antonio and Bexar County charged by State Law, City Charter and County Resolution with the responsibility for public health programs in San Antonio and the unincorporated areas of Bexar County. Although SAMHD is a City-County organization, current administrative control is under the City of San Antonio. In addition to funds received from City general funds, SAMHD also receives funds from private, state, and federal grants. The initial objectives of the Healthy Start project were link to and support several Texas Department of Health (TDH) Title V performance measures: reduction in teen births, early prenatal care, and children fully immunized by 2 years of age.

Since the SAMHD is a Title V provider as well as the administrator of the Healthy Start Project, Healthy Start began with a very good foundation. Using this foundation, the next step in the building of the local health system action plan was to formalize Title V relationships while establishing and formalizing collaborative relationships with other existing community care and service providers.

Work on the local health system action plan began at the time the initial Healthy Start grant application was developed. Barrio Comprehensive Family Health Center and El Centro del Barrio, both Federally Qualified Health Centers, were solicited to collaborate with the writing of the initial proposal. El Centro del Barrio operates a clinic in the southern section of Bexar County. El Centro del Barrio agreed to house a community outreach advocate to assist in reaching the isolated women in the rural areas. Barrio Comprehensive has a strong working relationship with public housing, San Antonio Housing Authority (SAHA), and views Healthy Start as an adjunct to assist with services to families residing in San Antonio Public Housing. Both of these clinics also house WIC clinics.

A portion of the Healthy Start targeted community is within the City of San Antonio (COSA) Enterprise Community/Empowerment Zone. The City of San Antonio Department of Community Initiatives was awarded a Department of Labor grant entitled “Youth Opportunity”, specifically targeted to at-risk youth aged 15–21. Additionally, the Department of Community Initiatives provided Healthy Start with many of the resources necessary to meet the needs of the Healthy Start “family” as opposed to the Healthy Start “individual client”. The Department of Community Initiatives provided literacy services, youth services, and resources for children, such as child care, family emergency services, such as assistance with utilities, rent, food, clothing transportation, and transitional housing. The Department of Community Initiatives also provides services for the Elderly and Disabled. The Healthy Start project determined that the Department of Community Initiatives would be an invaluable component of its local health system action plan.

San Antonio has multiple hospital health care systems providing perinatal health care. The health care delivery system is both public and private. Due to the large amount of perinatal health care provided by these hospital systems, it was determined that they too should be included in Healthy Start’s local health system action plan. The city has 4 major health care systems providing perinatal care, and a prestigious academic health science center. Two of the hospital systems are affiliated with religious organizations, Baptist Health Care System and CHRISTUS Santa Rosa. Each system has major hospital facilities in the inner-city area. CHRISTUS Santa Rosa also operates an acute care specialty children’s hospital with a Level III Neonatal Care Unit that serves as a central referral center for the city and South Texas. It also has a WIC project. University Health System (UHS), a tax supported hospital district, operates a teaching hospital in the Northwest section of the city. The inpatient perinatal services and diagnostic sonogram department is located at the hospital. UHS has outpatient perinatal services.
services at three sites: a Downtown ambulatory center, Southwest ambulatory center, and Southeast ambulatory center. The Southwest and Southeast centers are adjacent to the targeted community. UHS provides pre-natal care to a high percentage of our high-risk patients, through their complicated OB, diabetes and HIV clinics.

Methodist Healthcare System manages 2 major hospitals delivering perinatal services. The hospitals are located downtown, and in the northwest section of the city. The Methodist Healthcare System delivers approximately 35% of the city’s total births. Southwest General Hospital, a for-profit system, located in the Southwest section of the city, is a small community hospital strategically located in the Healthy Start Project target area, with a birthing center and other perinatal services. SW General Hospital is convenient for many of the women who live in the rural sections of the county. Also, with the targeted community, the Baptist system operates a hospital in the Southeast section of the city, with a high African American population. There is a Baptist pregnancy care center close to this hospital. The hospital provides perinatal services and is important to that section of the city. The birthing centers in the city are affiliated with the hospital systems and are adjacent to or within in the hospital. This being the case, it was determined that these hospital systems, especially the perinatal clinics should be a part of the Healthy Start local health system action plan.

In addition to these agencies, Healthy Start has determined that the local mental health system must be included in its local healthy system action plan. Collaboration with Clinic Without Walls provides mental health counseling. Alpha House provides perinatal services to women with chemical dependency problems. Additionally, partnerships with the following agencies are necessary for Healthy Start to provide a seamless, integrated care system for its clients: San Antonio Food Bank, Assistance League, Private Physicians, Texas Workforce Commission, and the University Health System.

B. Components and Resources used for Local Health System Action Plan:

As previously indicated, the Healthy Start Project began as an initiative of the Texas Department of Health, serving 36 census tracts. Over the course of the project, it was determined that serving 36 census tracts was not appropriate. The project was reduced to serving 15 targeted zip codes. As the project began to examine the data being collected related to participant characteristics, it was determined that the number of African American clients enrolled in the project and the number of clients enrolled during the first trimester of their pregnancy was not meeting the project’s targets. The project was later narrowed to better focus on the emerging needs of Healthy Start.

C. Resources/Events which Facilitated or Detracted from Local Health System Action Plan:

San Antonio Healthy Start is administered by the San Antonio Metropolitan Health District. This relationship has both facilitated and detracted from the establishment of a strong, effective local health system action plan. SAMHD manages nine (9) public health clinics located in areas of the City where racial and ethnic disparities exist. The clinics provide expert public health nursing leadership with an emphasis on prenatal, well child, family planning, and women’s wellness. SAMHD has been a leader in providing prenatal care without regard to patient funding source. The clinics offer free pregnancy
testing and assistance with the Medicaid application process. Besides the resident staffing previously discussed, contracted private obstetricians staff the clinics. SAMHD has been a provider of the Women’s, Infant and Children (WIC) nutrition program for over 25 years. SAMHD operates over 15 sites. SAMHD WIC project has a linkage with the City of San Antonio Immunization Registry that has been recognized nationally for its outstanding work. The linkage provides auto-telephone reminders to WIC clients concerning immunization status.

Healthy Start’s affiliation with the SAMHD has provided the project with a very fertile client referral base; however, a review of the Healthy Start data collected over the last four years of the project indicates that Healthy Start’s collaboration with the SAMHD may need to be a more targeted, purposeful collaboration. Healthy Start has received many client referrals from SAMHD; however, these referrals do not adequately reflect the African American target. The referrals also do not capture large numbers of clients in the first trimester of their pregnancy. In many instances, “Healthy Start” is overshadowed by the strong presence of the San Antonio Metropolitan Health District and clients (as well as other local health system action plan collaborators) do not recognize Healthy Start as a separate entity. Instead Healthy Start is viewed by many as “The Health Department”; and the local health system action plan is also viewed as “The Health Department” attempting to control other, independent agencies.

Severe budget cuts across the state and within the private and non-profit business sector also detracted from the local health system action plan. These budgetary problems caused changes in personnel within many of the agencies that made up the local health system action plan. This caused weakness and, in some cases, a complete breakdown in the seamless web of service the local health system action plan was designed to create.

**Consortium**

A. Procedure and Rationale for Use:

The development of the San Antonio Healthy Start Consortium began with a meeting of key staff from SAMHD, El Centro del Barrio and Barrio Comprehensive Family Health Care Center on September 7, 2001. All attendees are Title V providers for San Antonio and Bexar County and had partnered in writing the original request for funding. This meeting provided an opportunity for outlining the plans for implementation of San Antonio Healthy Start and confirming the commitment of the community agencies to the program. Further development of the Consortium was delayed until the Program Manager was hired and could define the direction of the group. The Director of Health for the SAMHD took a very active role in the creation of the Consortium and has provided considerable direction in deciding the community members who would be involved. Initially the Consortium was charged with the challenge of making equitable, accessible healthcare available for women and children in San Antonio and Bexar County.

The rationale for the Consortium was to have a group of culturally diverse members in a system in which consumers, community leaders and healthcare providers collaborated and coordinated efforts to reduce infant mortality. The Consortium was first established with the goal of building linkages, solving problems and/or enhancing leadership to address perinatal health concerns. The initial
proposed 5 stage plan to develop the Consortium was (1) getting together, (2) building trust, (3) developing a strategic plan, (4) taking action, and (5) going to scale. The involvement of consumers within the target area was an important expectation. This was to take place through activities that would empower citizens.

B. Components and Resources used for the Consortium:

Initially, all the Healthy Start management resources were involved in a structured and formal way in the Consortium. Each manager led one of the six standing committees: consumer advocacy, case management, evaluation, community education and mental health. These committees met regularly during 2002. As the Consortium evolved, input from Consortium members provided information that led us to believe that the six standing committees were not the most appropriate structure for the Consortium. This was also reinforced as the overall Healthy Start management team changed and evolved. Using input from Consortium members (consumers, providers, and community-based organizations), the Consortium adopted a structure that proved to be more inclusive, a structure that involved community partners as well as other Healthy Start staff besides management.

The main components and resources of the Consortium consisted of consumers, Healthy Start Staff, community-based agencies and providers. Active consumer involvement in the Consortium was deemed one of the major priorities, to facilitate this component of the Consortium; an in-house leadership development program was formed. The goal of the program was to train interested consumers in attaining a level of self-esteem and sense of empowerment to prepare them for active participation in the Consortium. We had 2 “graduate” groups in 2003 and one in 2004. Participants met for 2 hours weekly, during an 18-week period, with the group facilitator, the Healthy Start outreach coordinator. The four major areas of development during the training were self-esteem, group work, leadership and self-evaluation.

Another component of the Consortium was member training on issues related to perinatal health. Sessions included topics such as: legislative updates on maternal and child health issues in the Texas state legislature, Family Drug Treatment Court, (an initiative to streamline getting offenders into treatment programs attempting to preserve families), complementary and alternative medicine during the perinatal period, cultural sensitivity training, information on Medicaid, Dangers of Lead, domestic violence, pre-term labor, mental health promotion, perinatal periods of risk model applied to our local community, and management of children with fetal alcohol syndrome.

C. Resources/Events which Facilitated or Detracted from Successful Consortium Building:

Events that facilitated successful consortium building included stability in consortium leadership. During the fourth grant year, the person facilitating the leadership group also took responsibility as the consortium coordinator. This change proved to be very beneficial to preserve consumer participation, because consumers enjoyed the continuity. For the first time, two of the leadership participants have continued to take an active role in the consortium for almost a year, and they have successfully helped in the recruitment of other consumers.

Events that detracted the implementation of Consortium interventions were:
Changes in Healthy Start Program Manager: The first program manager served as the Consortium leader, and led the process of establishing a formal structure for the Consortium, including by-laws. This person resigned after less than a year of service. Then there was a year of interim program management and a vacancy in the Consortium leadership, causing the group to lose its momentum. The committees ceased to meet and member participation dropped.

Staff cuts: Severe legislative changes mandated budget cuts and re-structuring at the Texas Department of Health. These changes triggered budget cuts in many agencies and programs previously funded by state grants. With the economic environment, in which the availability of health care dollars was significantly decreased, non-profit organizations had to reduce their staff, stretching those that remained into multiple responsibilities, including participation in many initiatives, community meetings and committees. The same people attended many different monthly meetings and already had an excessive burden of responsibilities. Existing groups were centered on topics such as mental health, child abuse, domestic violence, teen pregnancy and early childhood intervention, which were all related to maternal-child health. Efforts to consolidate these groups and meetings were ineffective, due to restrictions imposed by funding sources. This was also true of requirements imposed by Healthy Start. Additionally, in 2003 a Perinatal Periods of Risk (PPOR) workgroup was established, with the intention of it later becoming the Consortium’s steering committee. The management analyst position was cut due to re- restructuring, and the PPOR group could not continue functioning without the data analysis that was needed for such work.

Limitations in City of San Antonio hiring policies: Healthy Start attempted to hire one of its consumers, upon successfully completing the leadership training program. Unfortunately due to limitations in the City of San Antonio hiring policies, the consumer could not be hired. This event was very disappointing for the consumer as well as the Healthy Start program in general. The consumer had to move on, and pursue other goals, which did not allow her to continue Consortium participation.

D. Additional Elements for the Consortium:

1. The development of the San Antonio Healthy Start Consortium began with a meeting on September 7, 2001, which included key staff from San Antonio Metropolitan Health District, El Centro del Barrio and Barrio Comprehensive Family Health Care Center. All attendees were Title V providers for San Antonio and Bexar County and had partnered in writing the original request for funding. This meeting provided an opportunity for outlining the plans for implementation of San Antonio Healthy Start and confirming the commitment of the community agencies to the program. Further development of the Consortium was delayed until the Program Manager was hired on December 26, 2001, at which point the direction of the group was defined.

The Director of Health took an active role in creating the Consortium and provided considerable direction in deciding which community members should be involved. The first official Consortium meeting took place on February 25, 2002, in which approximately seventy-six members from the community, composed of service providers, businesses,
healthcare professionals, and consumers were invited; forty-nine, actually attended. The meetings were to be held monthly, extending to quarterly as projects were defined and subcommittees were formed. The Consortium was charged with the challenge of making equitable, accessible healthcare available for women and children in San Antonio and Bexar County.

The Consortium’s goals were broken up quarterly for 2002. In the first quarter, they were to solicit 40 additional participants, hold one Consortium meeting to discuss the launch of Healthy Start on March 1, 2002. During the second quarter, they were to solicit 50 members, hold 2 Consortium meetings with team building activities. They were to establish a task force to write by-laws for the Consortium. During the third quarter, they were to solicit 55 members, hold 2 Consortium meetings with team building activities, have an election for Consortium officers and approve by-laws. Establishment of the Consortium’s standing committees would follow. Finally during the fourth quarter, membership would increase to 60, hold 2 Consortium meetings with team building activities and meet with Consortium standing committees once a month or as needed.

Barriers to our Consortium’s success were active participation from the members. Although the Consortium had professional representation, it lacked consumer involvement. It was determined that lack of transportation, and daycare were deterrents from the consumer participation. Professional representation declined due to the lack of guidance the Consortium maintained. These barriers broke down membership to half its original size. Representatives would send alternates in their place causing a loss of continuity. Members had to be continually re-trained on Healthy Start and Consortium objectives, vision and mission. The foundation for Healthy Start’s management staff was not solidified, causing additional inconsistency to the group dynamic.

2. The Consortium met quarterly for the majority of the grant cycle. In 2005, at the consumers’ request, the Consortium moved from meeting on a quarterly basis, to monthly meetings, until solid consumer participation was established. This move was designed to enhance continuity of attendance and rapport among the members. The working structure initially was set up with by-laws, membership applications and standing committees. After the first year the standing committees were dissolved and the Consortium began to operate in a less formal manner according to the input and guidance of the Consortium members. Experience showed that the group was not ready to commit to by-laws, officers, and reporting. Emphasis was then given to training, with the goal of networking the available resources, and giving members a better understanding of what resources were available in the community and how to access them. There was open enrollment for members and fostering of an informal environment with which to network and seek support. The racial/ethnic breakdown of the Consortium was Latino 51%, African American 13%, Non-Hispanic White 36%. The program did not keep track of gender, but it is estimated that 75% of the active members were women. The type of representation was 10% government, 30% provider, 6% Consumer, and 54% other. There were 30 organizations participating in the Consortium, of which 50% were active participants.
3. In order to assess the ongoing needs and required resources for families and children, consumer participation and feedback was needed. This feedback provided us with information on the problems families were facing during their pregnancy and postpartum periods. We identified that consumer participation was our main information resource. The clients’ priorities were to receive information during the Consortium meetings that would address questions related to their ongoing needs. To satisfy their interest, it was decided to bring in a speaker, of the consumers choice, to every Consortium meeting. This interaction with other agency affiliates improved consumer attendance. The Consortium was not allotted any financial resources during the grant cycle. Healthy Start did partner with other community-based organizations and providers for grants and funding opportunities; however, these partnerships were not specific to the Consortium. (Refer to the sections on Collaboration, page 37 and Sustainability, page 40) A collaborative effort lead by the United Way and the University of Texas Health Science Center representatives developed a survey to assess problems consumers faced during their pregnancy and postpartum periods. Due to the lack of statistical resources and financial limitations, the survey could not be administered. Other consortia serving the same population includes the Bexar County Case Management Coalition, which Healthy Start was part of while receiving TDH funding. Healthy Start partnered with Family Service Association to distribute a parent resource book and video to all Healthy Start clients; partnered with the Center for Infant Loss to promote and provide client follow-up to a Safe Sleep Education Program; partnered with March of Dimes in their Prematurity Prevention Campaign, teaching “Educando Bien” curriculum and promoting use of folic acid. March of Dimes extended an invitation to Healthy Start, to participate in the “Start Healthy, Stay Healthy” Gerber bilingual tour; a mobile unit featuring “stations” with prenatal and post-natal education about newborn care, folic acid and newborn health. Healthy Start developed a partnership with University of Texas Health Science Center and was chosen as one of the five national sites participating in the NIH-sponsored Stillbirth Collaborative Research Network. This was a five-year research study, with the purpose of understanding the causes and scope of stillbirth. The study funded .5 FTE for the Research Coordinator position, who is the FIMR and past Consortium coordinator.

4. The community’s major strength is the link that many of our active members have with improving perinatal health outcomes. This problem is not an isolated one; therefore, the community was invested in the need for improvement in perinatal health outcomes. The blue ribbon task force, which was developed to bring community awareness to child abuse, strengthened our community’s relationship with law enforcement, government officials, and state legislators. This task force unified the community in providing better services to families. Healthy Start has a strong relationship with the target area schools and work closely with the school-aged parenting programs. This program has maintained strong representation in the Consortium.

5. Barriers to our Consortium’s success were active participation from our members, as it was very difficult to recruit and retain them. We found that lack of transportation and daycare were major deterrents to active consumer participation. Professional representation declined due to the lack of guidance the Consortium maintained. Representatives would send alternates in their place causing a loss of continuity. Healthy Start management changed
three five times during the grant cycle. Consortium structure was not solidified and, therefore, goals were difficult to achieve.

6. When the Consortium was established there were no consumer incentives. Even though we had the leadership program, something was missing. We could not keep consumers interested longer than 6-8 months. At the end of the grant cycle we had several incentives in place. Consumer attendance increased when they were provided with taxi vouchers, grocery store gift cards and meeting invitations were extended to include consumers’ children. A volunteer was recruited to do arts and crafts with the children during the meetings. All meetings were held at the same location, which was centralized for all participants.

7. Consumer input about the Consortium decision-making process was obtained through a variety of methods. A confidential suggestion box was utilized to facilitate honest and candid responses. Many of our consumers were Spanish speaking; it was our belief that we were missing some vital information from this group. A group was established for our Spanish-speaking clients so that their concerns and barriers could be validated and addressed. H.U.G.S (Holding Up Girls Spirits) was used to serve two purposes. The first being a peer support group that would be facilitated by two of our leadership graduates/consortium advocates. The second would be to mainstream any issues or problems faced by the clients to the Consortium by our two advocates. Other consumers, who felt more comfortable, could bring up issues during the meetings. Consortium members did not participate in the decision making for the overall Healthy Start program; however, they did participate in the decision-making process for the Consortium, itself.

8. Once changes were suggested and discussed by the members of the Consortium, they were implemented. Consumer suggestions helped the consortium grow towards a consumer driven initiative.

Collaboration and Coordination with State Title V and Other Agencies

The existing Healthy Start sites across the state created a strong alliance with the Title V staff at the Texas Department of Health (TDH). Two representatives from SAMHD and the program evaluator attended the Texas Healthy Start Project Strategic Planning Meeting on October 19, 2001 in Austin. During this meeting, TDH provided an update on TDH and Title V programs, and discussion continued regarding guidelines for collaboration between TDH and the Texas Healthy Start sites. The Strategic Planning Meetings are held quarterly and are attended by representatives from all parties. This group of individuals soon evolved into the Texas Healthy Start Alliance.

A. Procedure and Rationale for Use:

San Antonio Healthy Start has an advantage in collaboration with Title V in that San Antonio Metropolitan Health District is a Title V provider for San Antonio and Bexar County, providing both fee for service and population based services. The collaboration with the other Title V providers in designing San Antonio Healthy Start has continued throughout the Healthy Start project. The Community Outreach Advocates conduct case finding activities in the target areas surrounding
Barrio Comprehensive and El Centro Del Barrio (Title V providers). Healthy Start refers families to these agencies as appropriate. Additionally, the staffs of these agencies receive information regarding eligibility for Healthy Start services and refer clients to Healthy Start.

The most realistic approach to meeting the Healthy Start goals is to systematically solicit opportunities to establish collaboration with other agencies. The Texas Healthy Start sites value the partnership that it has established with Title V and other agencies and is committed to promoting cooperation, integration, and dissemination of information with statewide systems and with other community services funded under the Maternal and Child Health Block Grant.

Numerous networking activities were fostered in order to address maternal health problems in San Antonio. Examples of these collaborations and coalitions are the March of Dimes Programs Services Committee, Avance, Inc. Health Advisory Board, the San Antonio Folic Acid Council, and the Pregnancy and Newborn Task Force, among others.

B. Components and Resources used for Coordination with State Title V and Other Agencies:

Healthy Start has developed partnerships and plans to continue working collaboratively with various community agencies. One of the most notable is with the March of Dimes in their prematurity prevention efforts, dissemination of information regarding use of folic acid, and training of professionals. March of Dimes extended an invitation for Healthy Start staff to tour “Healthy Start, Stay Healthy”; a mobile unit featuring “stations” with prenatal and pregnancy content about newborn care. Healthy Start has incorporated education on preterm labor awareness in the participant and community health education activities while the March of Dimes has provided considerable amounts of materials and assistance free of charge. Together, the March of Dimes and San Antonio Healthy Start are reaching a broad range of women in the community with important preterm labor prevention messages.

Healthy Start also developed a collaborative with Any Baby Can in the Safe Sleep program to ensure parents and caregivers are practicing safe sleep practices. Healthy Start also co-sponsored a SIDS awareness seminar with the Alpha Kappa Alpha Sorority.

Another major collaboration of note is the project’s collaboration with the local Stork’s Nest, a program of the March of Dimes and the Zeta Phi Beta service sorority. The Stork’s Nest is an incentive-based program to promote healthy behaviors during pregnancy and is run by volunteers from the local chapter. The Nest includes a classroom-based educational component, which was not being implemented because there were no volunteers able to provide this piece. The project is now a member of the Stork’s Nest Advisory Board and will continue to be part of the effort to promote healthy behaviors among high-risk women. This stands as an excellent example of groups working together for a common goal and was a precursor to the project’s involvement as a community partner on the March of Dimes’ new Prematurity Prevention Campaign.

The Texas Healthy Start Alliance also meets with Title V representatives in Austin, Texas to discuss program updates and current issues including Healthy Start, Title V, Maternal and Child Health Legislation, and the Pregnancy Risk Assessment Monitoring System (PRAMS).
A special hallmark was the Texas Healthy Start Alliance/ Texas Department of Health Title V 2nd Annual Education Conference in San Antonio. The San Antonio Metropolitan Health District sponsored the day-long conference in San Antonio. The March of Dimes San Antonio Chapter and the San Antonio Healthy Start project also supported this event. The conference, Working Together to Prevent Preterm Births, provided participants with an overview of prematurity and specific training on related topics. A representative of each Healthy Start site and a TDH representative comprised the planning committee. There were a total of 105 participants, 47 were from Texas Healthy Start sites while the remainder were professionals from San Antonio and surrounding areas. On a 5-point scale, the overall quality of the event was 4.8, relevancy of topic to the job was 4.75, and contribution to professional effectiveness was 4.7. Presentations that were well received by the participants included Coping with the Loss of a Pregnancy, First-hand Experience with Prematurity, and Bringing the Message Home.

Healthy Start established a collaborative with Family Service Association to distribute a parent resource book and parenting videos to all of our clients. The resource book includes topics on depression, safety, health, crying, early learning and helpful phone numbers. The book is in the form of a 3 ring binder, so that information can be added, modified or deleted, as needed. Notebook content is reviewed, discussed and explained to the clients. Healthy Start also participates in co-sponsoring a “Walk to Remember”, with the hospital systems and community support groups. This is a community wide annual perinatal bereavement event.

Because resources for women suffering from maternal depression are scarce in our community, San Antonio Healthy Start partnered with the Mental Health Association of Greater San Antonio to launch the Clinic Without Walls, which provides free counseling services to any under served individual in the county. Beginning in September 2003, the clinic has been held Thursday evenings at the Healthy Start site and staffed by clinicians on a volunteer basis. Another collaborative effort to address maternal depression is the internship program with Our Lady of the Lake University Department of Psychology. Graduate and post-graduate students provide pro-bono counseling services to Healthy Start program participants. Together, these activities have made significant progress toward closing the gap on the availability of mental health services for women in need.

San Antonio Healthy Start joined the University of Texas Health Science Center at San Antonio’s Department of Obstetrics and Gynecology on a National Institute of Health grant to study stillbirths and to better understand the causes of fetal loss in our community. San Antonio Healthy Start partnered with the Texas Lawyer’s Committee for Civil Rights to sponsor a second workshop on clarifying doubts about immigration issues among service providers. Healthy Start held the first workshop in December 2002 to overwhelming interest in the community. The Lawyer’s Committee approached Healthy Start about teaming up to provide a second workshop, which was held in October 2003 and attended by 130 individuals from Bexar County.

Finally, Healthy Start supported the Educational Summit on Developmental Outcome and Interventions for the Premature Infant in November 2003, which was hosted by the Premature Infant Development Program of the University of Texas Health Science Center at San Antonio.
C. Resources/Events which Facilitated or Detracted from Successful Coordination with State Title V and Other Agencies:

The overriding best practice that this project has identified is the need to partner/collaborate with others. Collaboration between San Antonio Healthy Start, Project WORTH, March of Dimes, Rape Crisis Center, and Stork’s Nest was integral to service delivery, specifically, reaching a broader audience than would have been possible in its absence.

An important fact to consider about collaboration is that fostering partnerships requires a significant amount of time. It is difficult to quantify the many time-consuming activities required to build these relationships. In order to address this issue, a project database was designed to illustrate the myriad of contacts/activities that take place between the project and the partnering agencies. Although strong partnerships currently exist, improving on those and expanding to other service providers will be an ongoing project activity. The San Antonio Healthy Start project plans to retain the full scope of its thriving relationships with Title V and other agencies, both local and statewide.

Sustainability

A. Procedure and Rationale for Use:

San Antonio Healthy Start actively monitors grant opportunities. Our strong collaboration with Title V and other consortium members have been very helpful in identifying and developing funding opportunities. Title V is also a funding source that supports several key positions within San Antonio Healthy Start. The nurse case manager, health education supervisor and 2 health education specialists are funded through Title V. Within the Consortium, Healthy Start has a sustainability committee, which consists of influential community leaders who have broad contacts in business and philanthropic foundations. San Antonio Healthy Start and the Consortium have a vested responsibility to the community in developing and implementing a sustainability plan. The lack of perinatal case management services makes it imperative that continuation of Healthy Start is assured.

The Director of Public Health, Program Manager, Consortium Coordinator, and members of the Healthy Start Consortium are responsible for exploring funding opportunities through foundations and grant writing activities.

B. Components and Resources used for Sustainability:

San Antonio Healthy Start’s strong relationship with the San Antonio Metropolitan Health District (SAMHD) has been a major component and resource used for sustainability. SAMHD has a long-standing track record of public health excellence. Through the SAMHD, Healthy Start has exploited funding opportunities with universities and other community health agencies. San Antonio Healthy Start has been successful in being awarded grants to advance the program’s goals of reducing infant mortality. The program has received funding from the University of Texas Health Science Center at San Antonio, and the Hogg Foundation for Mental Health. In addition, the Texas Council on Alcohol and Drug Abuse has provided funding to support specialized training for Healthy Start staff.
In an effort to enhance the program and better serve the needs of the drug using and abusing population, Healthy Start entered into a contractual agreement with Alpha Home Treatment Facility. The contract funds one case manager to provide, in-home case management services, to Family First program participants and their family members. The services are provided primarily in three locations including the Healthy Start administrative offices, Family First Offices and the participant’s home if deemed appropriate.

This contractual relationship has also helped to expand Healthy Start services beyond the program target area. The case manager funded by Alpha Home is able to serve these pregnant high-risk clients throughout the city, using the Healthy Start principles and philosophy. This step in collaboration and sustainability has been important to ensure this population is served appropriately.

2003 marked a productive year for San Antonio Healthy Start related to collaboration with community-based and other types of agencies. The year started off with the Maternal Depression Conference held in San Antonio and in partnership with Title V and the Texas Healthy Start Alliance. Over 140 professionals from across Texas participated in the conference. Due to scarce resources for women experiencing maternal depression in our community, San Antonio Healthy Start partnered with the Mental Health Association of Greater San Antonio to launch the Clinic Without Walls, which provides free counseling services to any under served individual in the county. Beginning in September 2003, the clinic has been held Thursday evenings at the Healthy Start site and staffed by clinicians on a volunteer basis. Another collaborative effort to address maternal depression is the internship program with Our Lady of the Lake University Department of Psychology. Graduate and post-graduate students provide pro-bone counseling services to Healthy Start program participants. Together, these activities have made significant progress toward closing the gap on the availability of mental health services for women in need.

Another significant relationship that was built upon during 2003 was that with the March of Dimes. Healthy Start became a full partner on their Prematurity Prevention Campaign. A major component of the partnership includes providing training on the signs of preterm labor with Healthy Start sponsoring/providing training for 295 providers in the community. Healthy Start has incorporated education on preterm labor awareness in the participant and community health education activities while the March of Dimes has provided considerable amounts of materials and assistance free of charge. Together, the March of Dimes and San Antonio Healthy Start are reaching a broad range of women in the community with important preterm labor prevention messages.

Project WORTH (Working on Real Teen Health) is a city-sponsored effort to reduce teen pregnancy in two target areas in Bexar County. Those target areas coincide with San Antonio Healthy Start’s target area. Since both projects work toward teen pregnancy prevention, a strong collaborative relationship has been developed and maintained. The Healthy Start health education coordinator supervises two Project WORTH health educators. Staff from both projects partner on outreach activities, health fairs and other educational efforts. This partnership is a solid example of programs working together to maximize resources.

Zeta Phi Beta, Inc. sorority sponsors the local Stork’s Nest, a program designed to increase the number of women who receive early, regular prenatal care and to provide education to expectant
parents about healthy pregnancies and infant care. The Nest is incentive-based, rewarding women who attend prenatal visits or educational sessions with points to use toward gifts like maternity clothing, layette items, baby supplies, etc. Volunteers from the Zeta Phi Beta sorority staff the Nest. Healthy Start Health educators assist them when they are in need of educators to conduct healthy pregnancy presentations.

San Antonio Healthy Start joined the University of Texas Health Science Center on a National Institute of Health grant proposal to study stillbirths. The proposal was awarded in October 2003. San Antonio was chosen as one of the five national sites participating in the NIH Stillbirth Collaborative Research Network, a five-year study. This network will identify stillbirths in Bexar County and provide state of the art, in-depth study of each case. It will include epidemiological, genetic, maternal disease, and placental studies. The patients will also have access to follow up visits for genetic counseling. We are pioneering this kind of in-depth study in the United States. In addition, NIH is considering the possibility of banking tissue, to facilitate further studies as technology improves and new funding is obtained. The network is funding .5 FTE for the study coordinator. This person also serves as the FIMR coordinator.

San Antonio Healthy Start partnered with the Texas Lawyer’s Committee for Civil Rights to sponsor a second workshop on clarifying doubts about immigration issues among service providers. Healthy Start held the first workshop in December 2002 to overwhelming interest in the community. The Lawyer’s Committee approached Healthy Start about teaming up to provide a second workshop, which was held in October 2003 and attended by 130 individuals from Bexar County.

Finally, Healthy Start supported the Educational Summit on Developmental Outcome and Interventions for the Premature Infant in November 2003, which was hosted by the Premature Infant Development Program of the University of Texas Health Science Center at San Antonio. The daylong seminar provided 85 healthcare professionals with vital information about outcomes of preterm births.

The above describes a few of the collaborations that have been initiated to enhance sustainability. All intentions are to continue with the intense collaborative efforts we have initiated and to increase them even more in the coming years. Through these partnerships, San Antonio Healthy Start is able to have a greater impact on the community than would be possible if we were to attempt to provide these services alone.

C. Resources/Events which Facilitated or Detracted from Successful Sustainability Efforts:

1. San Antonio Healthy Start has experienced a challenge in seeking third party reimbursement from the state’s Medicaid program. Effective September 1, 2003, the Texas Medicaid program underwent a significant change in eligibility services for recipients. Increased Medicaid procedural complexities in the eligibility guidelines have resulted in case management providers going out of business virtually overnight. This reform has had a severe economic impact on reimbursement for medical case management services. Over 90% of San Antonio Healthy Start’s client population, under the new guidelines, no longer meets eligibility criteria. These reforms in the state’s Medicaid program have drastically reduced revenue by 96.5%. These Medicaid and
SCHIP reforms resulted in a $1.6 billion overall savings to the State.

2. Major factors associated with the identification and development of resources to continue key components of Healthy Start funding are described above.

3. The barriers presented by Medicaid reimbursement were not overcome and these barriers were deemed to be distracting in Healthy Start goal accomplishment. Therefore, Healthy Start has ceased to seek Medicaid reimbursement at the time of this report.

III. Project Management and Governance

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

The original Healthy Start funding proposal was completed and submitted by members of the Nursing Division of the San Antonio Metropolitan Health District (SAMHD) in March 2001. Once the funding was awarded in June 2001, the nursing staff and SAMHD management were responsible for assembling the project staff. Over the next several months, SAMHD worked to realign several existing positions in order to create the initial Healthy Start staffing complement. To accomplish this, the San Antonio Metropolitan Health District utilized existing in-house positions from the Nursing, Case Management, and Health Education and Promotion programs. This infusion of positions and monies allowed for the creation of a new division within SAMHD that would be comprised of non-clinical, community-based services. To that end, the San Antonio Healthy Start program was created. In addition to utilizing existing staff positions, the Healthy Start program created and hired new positions including the Program Manager, Coordinators for Health Education and Outreach, the Social Services Manager, and the Management Analyst.

Over the course of the San Antonio Healthy Start Program the staffing compliment has undergone several changes, however the basic management structure of the project has remained consistent. This structure includes a program manager, social services manager, health education coordinator, outreach coordinator, mental health coordinator, consortium/FIMR coordinator, data management analyst, case managers, outreach workers, health educators, as well as necessary administrative support staff. The structure of the organization is depicted in the Healthy Start Organizational Chart. (see Appendix G: San Antonio Healthy Start Organizational Chart) The roles and responsibilities of each position are outlined in Table III-1 below.

<table>
<thead>
<tr>
<th>Title</th>
<th>Responsibilities</th>
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<tbody>
<tr>
<td>Program Manager</td>
<td>The program manager has responsibility and accountability for the project development, operations and evaluation. The program manager will hire staff and assure that appropriate training is done. The program manager will develop policies and procedures, monitor financial situation and enact a quality assurance program meeting federal and state regulations. The program manager assures continuation of the Consortium and the Fetal/Infant Mortality Review Board activities. The qualifications for the program manager include: experience in public health administration for five or more years; preferably a Master’s degree in public health or related fields; a Bachelor’s degree in Social Science area or</td>
</tr>
<tr>
<td>Role</td>
<td>Description</td>
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<tr>
<td>Social Service Manager</td>
<td>The social services manager is responsible for developing, implementing and evaluating the case management services of San Antonio Healthy Start. The social services manager is accountable for developing policies and procedures and maintaining the case management standards developed by the Texas Department of Health, and ensuring accurate documentation and billing of case management visits through direct supervision of staff. Requirements include a Bachelor’s or preferably a Master’s degree in Social Work; state licensure in social work and knowledge of targeted case management principles.</td>
</tr>
<tr>
<td>Health Education Coordinator</td>
<td>The health education coordinator is responsible for the development, implementation and coordination of all Health Education and Promotion program activities. Within the Healthy Start program, the health education coordinator is responsible for the design and implementation of linguistically and culturally appropriate health programs, educational materials and social marketing campaigns. Development of an extensive training course with frequent updates on new topics is also the responsibility of the education coordinator. The health education coordinator will also be responsible for evaluating the effectiveness of educational materials and programs.</td>
</tr>
<tr>
<td>Outreach Coordinator</td>
<td>The outreach coordinator is responsible for developing, implementing and evaluating the outreach efforts of San Antonio Healthy Start. Fundamental to this position is the ability to develop and train employees whose education backgrounds may be limited but viewed by the community as an advocate. The outreach coordinator will be responsible for assuring appropriate documentation and interaction with the clients. The qualifications for the outreach coordinator include a degree in nursing or social services; knowledge of perinatal and child health issues and previous experience in providing leadership and management to para-professional staff.</td>
</tr>
<tr>
<td>Mental Health Coordinator</td>
<td>The mental health coordinator is responsible for the development and implementation of all mental health initiatives within Healthy Start, including identifying appropriate mental health screening tools for use in the Healthy Start program, and the establishment of partnerships to provide mental health services to Healthy Start clients.</td>
</tr>
<tr>
<td>Consortium and FIMR Coordinator</td>
<td>This position is responsible for the development and coordination of FIMR and Consortium activities. Responsible for the development of a standard stillbirth postmortem protocol, to include review of clinical history, protocols for autopsies and pathologic examinations and, other postmortem tests to illuminate genetic, maternal, and other environmental influences.</td>
</tr>
</tbody>
</table>
| Management Analyst                        | The management analyst will work directly with the evaluator and program manager to analyze the demographic and outcome data of the San Antonio Healthy Start program. The management analyst will be responsible for the creation and maintenance of the database, provision of program data for required reports and will assist in creating a quality assurance program to measure the accuracy of the data entered. The management analyst will provide direct supervision to one full time
<table>
<thead>
<tr>
<th>Administrative Staff Position</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Assistant</td>
<td>Enables the efficient operation of personnel matters, purchasing and general office management. Assists the program manager in daily operations and program monitoring.</td>
</tr>
<tr>
<td>Senior Office Assistant</td>
<td>Assists the Management Analyst in the collection and accurate entry of program demographics and outcomes into the database and compiling program data for required reports. Provides clerical support as needed.</td>
</tr>
<tr>
<td>Case Manager</td>
<td>Responsible for providing intensive case management to high-risk families in the target area. Each case manager will provide goal-directed services, including linkages to social and medical services, to a caseload of 35-45 families. The case manager will follow the family until the child is two years of age.</td>
</tr>
<tr>
<td>Community Outreach Advocate</td>
<td>Responsible for implementation of outreach and recruitment activities directed toward potentially eligible participants, provision of health education, information and referrals for health and social services to program participants. Works in coordination with the Outreach Coordinator and case managers.</td>
</tr>
<tr>
<td>Health Educator</td>
<td>Responsible for delivering presentations on healthy pregnancies, adolescent health, and related topics within the community. Participates in the planning, production, implementation, and evaluation of events and activities. Coordinates with SAMHD nursing personnel, other departments and community agencies to ensure the dissemination of current health information as it relates to healthy pregnancy outcomes and adolescent health.</td>
</tr>
</tbody>
</table>

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

Since its inception in 2001, the San Antonio Healthy Start program has been a division of the City of San Antonio, San Antonio Metropolitan Health District (SAMHD), and has served under the direction of the SAMHD Director of Health. The San Antonio Metropolitan Health District (SAMHD) is the single public agency charged by State Law, City Code, and County Resolution with the responsibility for public health programs in San Antonio and unincorporated areas of Bexar County. Although the SAMHD is a City/County organization, administrative control is under the city of San Antonio and the SAMHD is operated as a City Department. In addition to the Healthy Start program, SAMHD services include: preventive health services, health code enforcement, clinical services, environmental monitoring, disease control, health education, dental services, and maintenance of birth and death certificates.

The San Antonio Healthy Start program has the distinct advantage of being part of the SAMHD due to its proven track record in managing complex accounting requirements on both the state and federal level. The SAMHD is annually awarded 35-40 grants totaling $15-20 million. These grants include, State Title V, Title X, Title XX, NIH, HRSA,
Bioterrorism, and HUD. The City of San Antonio, of which SAMHD is a department, has recently adopted a revolutionary way in which it does business. The Enterprise Resource Management (ERM) has been rolled out citywide and has transformed administrative functions such as budgeting, managing contracts, paying vendors, and hiring staff. This system allows the city to reduce operating costs and become more efficient in managing its resources.

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

The San Antonio Healthy Start program has undergone several staffing changes since its inception in 2001. The most devastating has been the high turnover in the position of Program Manager. Since 2001 there have been five different program managers, including three interim positions and two full time positions. This inconsistency in leadership has severely impacted the programs ability to move forward. The inconsistent program leadership has not only been a source of confusion for program staff, but has strained relations with potential partners in the public health system. This has severely hindered the development and growth of the consortium, and continues to be a barrier in establishing the FIMR. Although each new program manager brought positive strengths to the program, they also brought different approaches to program management. This has resulted in inconsistent record keeping and data management which has hindered the programs ability to fully demonstrate its quantitative impact. The changes in program manager can be attributed to continued organizational restructuring of the city and state health departments.

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

On August 30, 2001, in accordance with the policies and procedures of the City of San Antonio, the SAMHD presented the Healthy Start grant award to the Mayor, City Manager, and City Council for review. Upon review of the grant award, the City Council approved the funds, and the Healthy Start program was initiated. Since the Healthy Start program was established within the SAMHD, all accounting functions such as budgeting, managing contracts, and paying vendors has been handled by the SAMHD Accounting Department. The SAMHD has a proven track record in managing complex accounting requirements on both the state and federal level, and continues to upgrade and improve its business practices. The Healthy Start program was able to take advantage of the existing accounting and finance processes already established within the SAMHD. In addition, beginning in FY 2005, the SAMHD has established a new division for Contracts Management to provide objective oversight on all contracts.

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

Over the course of the program additional resources have been acquired through the HOGG Foundation as well as Alpha Home Treatment Facility. These resources have been utilized to expand and enhance the delivery of services to the Healthy Start clients. The HOGG

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Foundation provided additional resources to Healthy Start for the provision of two counseling interns through Our Lady of the Lake University, who provide in-home counseling/psychotherapy services for high-risk clients. The San Antonio Healthy Start program has also entered into a contract with Alpha Home Treatment Facility in which Alpha Home funds an additional case manager to specifically serve the Healthy Start population who are drug using/abusing. These additional funds have given the Healthy Start program more flexibility with its resources, and have helped to strengthen services through valuable technical assistance.

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

In June 2003, during a site review from the HRSA Project Officer, cultural competency of program staff was identified as an area of concern for the San Antonio Healthy Start program. In response to this concern, the management staff developed an Action Plan (see Appendix C) to address cultural competency in addition to other concerns. The Action Plan included 14 goals to improve the cultural competency of staff. Progress has been made on each of these items, and several steps have been taken to improve the cultural competency of the staff. The goals of the Action Plan, and the progress that has been made thus far can be found in Appendix C. In addition to this Action Plan, the San Antonio Healthy Start program has made it a priority to recruit contractors that represent the cultural diversity of our target population. This is evident in the long-standing contract in place with Our Lady of the Lake University who have provided African American counseling/psychotherapy interns to serve our high-risk clients, and with our local evaluator who is African American.

Another issue of cultural competency has been the large Spanish speaking population within the Healthy Start target area. Since 58% of the population in Bexar County is of Hispanic origin, there is a significant need to employ Spanish speaking case managers and outreach workers. In order to ensure appropriate delivery of services to this population, the Healthy Start program prefers to hire bi-lingual staff. In addition, the City of San Antonio offers a language pay incentive for qualified translators, of which many of the staff qualifies for. This has been a positive step toward fulfilling an unmet need.

IV. Project Accomplishments

Appendix H contains “Attachment A” tables, one for each year of project implementation.

V. Project Impact

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

1. Describe the approaches utilized to enhance collaboration.
Healthy Start has utilized mainly the Local System Action Plan, the Consortium and Outreach to enhance collaboration. As described in previous parts of this report, we have a strong network of hospital systems, public and private health providers, the SAMHD WIC and health clinics, community based and social services agencies that work together to enhance health services to our target population. We have developed strong relationships and enhanced collaboration through

- Holding regular consortium meetings
- Regularly attending meetings held by Consortium and Local Health Action Plan member organizations
- Supporting community initiatives initiated by other agencies related to perinatal and infant health
- Regular Healthy Start presentations at schools, social service agencies, hospitals and pre-natal care clinics, and other health care providers.
- Sponsoring free training and conferences to these organizations throughout the 4-year grant cycle.
- Participating in the Bexar County Child Fatality Review Team

2. Identify the extent to which structured changes, such as procedures or policies, have been established for the purpose of system integration.

Due to the holistic nature of the Healthy Start program, it is important that system integration between agencies, internal processes and our community be seamless. Our efforts to improve system integration have been based on working policies and procedures and contractual agreements. The policies and contracts have established accountability of time for the workers and services to our families in need. Contractual agreements include, Our Lady of the Lake University Psychology Department for free in-home counseling, the Alpha Home, a drug rehabilitation center, for our case management services and the Greater San Antonio Mental Health Alliance for counseling to our uninsured clients. Internal revisions have been made on the referral policies and how they are triaged. The policies have guaranteed efficiency and disposition to our referring agents so to acknowledge their recommendations for a potential client. Policies have redefined our service boundaries and incorporated a thorough assessment to mainstream our clientele towards self-efficiency. Another structured change to enhance system integration was the Case Manager/Outreach team system. The system was implemented with each of our families to ensure continuity of care. These approaches provided our project area and our workers with better services and reliability.

3. Describe key relationships that have developed as a result of Healthy Start efforts covering the following areas:

   a. Relationships among health service agencies; between health and social service agencies; and with community-based organizations;

   The Healthy Start Program has diligently worked towards developing strong
relationships with other health care, community based organizations, and social service agencies. These relationships are built based upon a mutual goal of serving a population that is at high risk of infant mortality and low birth weight: pregnant women and children under the age of two years.

Collaboration has been enhanced through the willingness of these agencies to establish agreements regarding the process that will be used to refer clients to each other. We have established an informal referral protocol to facilitate delivery of services. Contractual policies have been developed with some of these agencies in the cases where there are monetary agreements.

An example of a key relationship developed with community social services program is the non-profit organization of Ella Austin Community Center. This center is located in the East side of town and serves both the African-American community and the Hispanic community in equal proportion. This organization has demonstrated a willingness to collaborate with the Healthy Start Program and has helped Healthy Start consumers with emergency food, utility relief, school supplies, rent monies and prescription medicines relief.

Another agency that has enhanced services to our program is Any Baby Can. Their safe sleep program is contributing with bassinettes for our clients in exchange of attending an educational class about SIDS and safe sleep practices. Family Services Association has also enhanced our services by providing parenting classes at home to our teen consumers through their H.O.P.E.S program. The Assistance League program who generously provides the Healthy Start program with baby and toddlers clothing.

San Antonio Healthy Start collaborated with the San Antonio Mental Health Association and created the existing mental health Clinic Without Walls. Additional collaborative efforts included the Texas Department of Mental Health and Mental Retardation which created the Fetal Alcohol Spectrum Disorder team which operates monthly to raise FASD awareness and provide screening and assessments and Alpha Home treatment facility who funded an additional case manager, by contract, to specifically serve the Healthy Start population who are drug using/abusing clients. One final endeavor by the mental health coordinator generated funding through the HOGG Foundation for Mental Health. HOGG funded two counseling interns through Our Lady of the Lake University, who provided in-home counseling/psychotherapy services for Healthy Start clients.

The San Antonio Healthy Start Program as part of the SAMHD has an exceptionally close relationship with the WIC program. This includes the direct involvement of WIC staff with Healthy Start clients in providing nutrition education and participating in case management client staffing. WIC staff do not hesitate to refer their clients to the Healthy Start Program when they deem it appropriate. Healthy Start staff screen every single mother/infant and other children in the household who
may be eligible for WIC. The WIC clinic staff will do anything they can to accommodate Healthy Start clients and enroll them in the program. WIC clinic Registered Dietitians have participated in Healthy Start Program educational presentations to the community. WIC staff and Healthy Start staff routinely communicate any client issues, which may arise in order to provide a more comprehensive service to the clients.

b. Relationships that focus on involvement of consumers and/or community leaders (who are not employed by a health or social service agency) with any of the agencies/organizations listed above or any additional agencies.

Relationships that focus on consumer involvement have been fostered through the Consortium, HUGS and the Participant Leadership Program. The Participant Leadership Program has been open to clients referred by any other agency or organization in Healthy Start’s target area. The first two leadership programs were co-facilitated by one of our consortium member agency.

4. Describe the impact that your Healthy Start project has had on the comprehensiveness of services particularly in the following areas:

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

As an agency that advocates strongly for its clients, the Healthy Start Program has seen a decrease in the barriers to health and social services for its clients. These barriers in previous years had prevented eligible clients from obtaining the services they needed. Improving access to services was accomplished by having formal and informal discussions with agency representatives explaining them on an individual basis what challenges each consumer was facing.

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

A random telephone survey of 1000 Bexar County adults was conducted in 1998 to identify specific health needs of area residents. Although the survey did not specifically focus on perinatal health, the overall results spoke to the needs of women and families. According to this study, there is an estimated 261.2 physicians per 100,000 residents. This is higher than the national rate of 235.9 per 100,000. There are approximately 3000 health care providers, the majority whose offices are located in the Northwest, North Central, Northeast and Central sections of the City. The targeted area for the Healthy Start project is located in the inner city and southern semi-rural sections of the county. In analyzing the number of health care providers specifically serving this population, less than 100 have offices within or near the targeted area.
Barriers and challenges to enrolling and retaining both prenatal and postpartum/interconceptional clients included unstable housing, domestic violence, perinatal depression and teenage non-compliance. Based on previous experience, the primary challenge in retaining clients is unstable housing, making our clients highly mobile and easily lost to contact. Another challenging barrier is domestic violence, which tends to make clients fearful of accepting and maintaining contact with the program. Another barrier faced by clients is the lack of transportation to get to and from providers’ offices and language barriers, which tends to delay their health care, as many providers do not speak their language and do not exhibit cultural sensitivity/competence. Perinatal depression is another barrier faced by clients, thus reducing client retention. An additional barrier, specific to our undocumented prenatal client, is their lack of healthcare insurance and inability to register for complicated obstetrical care through the county’s health care system without proof of residence or income. Intimidated by the system, mothers leave and do not return for prenatal care. In order to ensure that clients receive on-going care, Healthy Start and University Health System staff maintains an on-going relationship, which helps our program staff advocate on behalf of our clients and get them into continued care.

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

San Antonio, a large urban metropolitan city, has multiple health care systems providing perinatal health. The health care delivery system is both public and private. The City has 4 major health care systems providing perinatal care and a prestigious academic health science center. Two of the hospital systems are affiliated with religious organizations, Baptist Health Care System and CHRISTUS Santa Rosa. Each system has major hospital facilities in the inner-city area. CHRISTUS Santa Rosa also operates an acute care specialty children’s hospital with a Level III Neonatal Care Unit that serves as a central referral center for the City as well as South Texas. These two hospitals accounted for a large number of births in San Antonio. University Health Systems, UHS, a tax supported hospital district, operates a teaching hospital in the Northwest section of the City. The hospital has a closed medical staff under the direction of the University of Texas Health Science Center. The inpatient perinatal services and diagnostic sonogram department is located at the hospital. UHS has outpatient perinatal services at three sites, a Downtown ambulatory center, Southwest ambulatory center, and Southeast ambulatory center. The Southwest and Southeast clinics are adjacent to the targeted communities.

The travel time between the far edges of the County to UHS Hospital is over 45 minutes. Methodist Health System manages 2 major hospitals delivering perinatal services. The Methodist Health hospitals are located on the north side of downtown, the far northwest section of the city. Again, since the expansion of Medicaid, this traditionally private provider has been providing more perinatal care to Medicaid recipients. Southwest General Hospital, a for-profit system, is located in the
Southwest section of the City. This small community hospital is strategically located in the Healthy Start Project service area. It has a birthing center and other perinatal services. The hospital is convenient for many of the women who live in the rural sections of the County. Also, within the target area, the Baptist system operates a hospital in the Southeast section of the city. The birthing centers in the city are affiliated with this hospital system and are adjacent to or within the hospital. Obstetricians deliver the majority of the babies. Recently, CHRISTUS Santa Rosa has allowed Family Practice physicians with Obstetrical backup to do deliveries.

As a state supported academic institution, the University of Texas Health Science Center (UTHSCSA) offers many different residency training programs, including Obstetrics and Gynecology, Family Practice, and Pediatrics. The Obstetrics (OB) and Gynecology (GYN) department is affiliated with UHS and area Obstetricians. The department provides outpatient services at UHS downtown ambulatory center. The Department of Family Practice is affiliated with UHS but also has agreements with Santa Rosa and the Federally Qualified Health Center. The Family Practice Department has established agreements with CHRISTUS Santa Rosa to provide delivery services. The Family Practice Department operates outpatient services at UHS downtown ambulatory clinic and a downtown CHRISTUS Santa Rosa ambulatory center. SAMHD has agreements with the Department of Family Practice to provide prenatal services at two of the public health clinics. CHRISTUS Santa Rosa has established a Family Practice Residency Program with ties to the UTHSCSA Department of Family Practice. The CHRISTUS Santa Rosa Program also has agreements with SAMHD for resident rotations at one public health clinic and for a general public health rotation. The UTHSCSA Department of Pediatrics is affiliated with CHRISTUS Santa Rosa providing an extensive inpatient and outpatient management of acute and chronically ill children. The UTHSCSA Department of Pediatrics provides inpatient services at UHS, specializing in trauma, transplant, and cardiac care. SAMHD also has affiliation agreements with several clinical departments of UTHSCSA including the nursing school to provide student rotations and electives in public health.

An unmet need within the entire community and the Healthy Start project area was the lack of available health care for a woman who was not pregnant. The woman often times delayed her own preventative care for the needs of the family. In Texas, Medicaid benefits are only paid through 6 weeks of post-partum care. After six weeks, the woman must find funding for family planning or other preventive services. Planned Parenthood clinics are located throughout the City, but all require a co-pay for services and often have waiting lists for available appointments. SAMHD has family planning services at the public health clinics. Funding allows for 7 of the 9 clinics to provide family planning services. The goal is to have all nine clinics provide this valuable service. SAMHD cares for over 7000 women a year with no-cost family planning services. Again, the demand for such services requires the program to triage the woman with the most need. In most situations this is the teen with a child. For the woman who is no longer practicing contraception but
requires an annual examination, SAMHD began a no-cost woman’s wellness clinic. In the last year, the clinic has documented abnormal findings in over 50% of the women including obesity, anemia, thyroid disorders, depression and undetected diabetes. The nursing staff works with UHS to have the woman followed in one of the ambulatory care clinics. A benefit to the community is UHS’ CareLink system, a payment plan for the member based on financial eligibility. This program offers the uninsured woman and families a type of health insurance based on the financial situation of the family.

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

In order to maximize efficiency with our records and our data across providers, we first provide dispositions on the referrals we receive to the referring agents. The disposition includes the results of the referral such as enrollment, client declined, ineligibility, unable to locate and resources/referral intervention only. The dispositions are done by telephone and/or fax. Confidentiality is a priority. A release of client information is needed when detailed information is passed between providers.

Effective April 14, 2003 the Health Insurance and Portability and Accountability Act (HIPAA) requires that The Healthy Start Program maintain the privacy of protected health information and provide participants with a notice of their legal rights regarding disclosure of protected health information. The Healthy Start Program has developed and implemented for HS-SAMHD/NS27, Authorization for Release of Medical Records form. Before any information is exchanged between the collaborating agencies the authorization form must be completed and signed by the client. This form is a bilingual form, English on one side and Spanish on the other side, if the client requires reading the information in Spanish. This form is provided to the referring agency when requesting and or submitting information about the participant.

Record information usually is shared between Healthy Start and the school systems, the hospitals, the primary doctor and the mental health provider if there is one, housing, and private agencies. Information is usually brief and pertains to securing records from the agencies to Healthy Start to better manage the client.

The information most often requested is immunization records, history and physical, lab reports, referrals, rental records, treatment and medications, nurses notes, X rays reports, ultrasound reports, consultation reports, and other. Sometimes the patient will bring her own copies of these records.

Healthy Start case managers have not been successful in obtaining data from the
mental health providers when it pertains to Child Protective Services clients or from state agencies.
Records requested from Healthy Start for legal purposes need to be addressed to the privacy officer of the San Antonio Metropolitan Health Department.

5. Describe the impact on enhancing client participation in evaluation of service provision in the following areas:

a. Provider responsibility in maintaining client participation in the system and provider sensitivity to cultural, linguistic and gender (especially male) needs of the community;

Healthy Start assumes the responsibility of establishing and maintaining client participation through the case managers. Many of our families lack consistency in their lives; it is their need for us to be consistent advocates and informants to their families. Healthy Start staff and the consortium member organizations have participated and been trained on cultural sensitivity and provide services that are specific to language and gender. Families are paired to the Case Manager that can fit the profile the family can adapt to the easiest. A strong and respectful relationship enhances and maintains client participation in our program.

When the consumer is enrolled in the program, case managers are responsible for completing an Individual Care Plan with the client. Needs and goals are recorded by stating what the case manager will provide to the client (i.e. case manager will bring monthly prenatal information) and what the client is responsible for in return (i.e. client will keep monthly appointments with case manager), engaging the client with pertinent prenatal or postpartum information, and in “selling” the program to the client in such a way that the client feels their input is valuable to the program. The program being holistic and comprehensive in nature gives the case managers the opportunity to address the whole family issues and involves all members of the household. Great care is taken to try to involve the male members of the household, i.e. husband, boyfriend, father and/or sons, and providing them with useful information for the care of the pregnant client or the baby, and giving them referral forms or notices, (i.e. job searches). This information is given in the family’s language of choice (English or Spanish), and in the cultural (African-American, Black, Hispanic, Asian) mode.

b. Consumer participation in developing assessment and intervention mechanisms and tools to serve perinatal women and/or infants, and the extent of implementation and utilization of these tools or mechanisms.

Consumer participation in developing assessments and intervention mechanisms to serve perinatal women and infants has not been implemented as of yet. Currently, our priority is not consumer participation in developing interventions to serve our perinatal women and infants. Our priority is to increase the interests of our client’s in
the program to take initiative to want to help.

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

1. In assessing the client’s needs and with the client’s input we are able to provide referrals, information and education to our consumers and their families on the resources available to them in the community. We provide them with the location of these resources and the telephone numbers so the consumers themselves will learn how to access such resources. In some instances, where the consumers encounter difficulties accessing these services we intervene in the client’s behalf by making the appointments for them or we will teach the consumers how to access the transportation system by going over the busses schedules, routes, times and connections to transfer from point A to point B. We know we have made an impact in the lives of our consumers because they let us know and/or they refer our program to the other relatives in the family and in many cases we have sisters, cousins, and friends in our caseloads. We will represent the client’s interests and translate for them in some instances, when their native language is not English; in problems they are encountering with landlords, or agencies as in Housing, Human Services, Doctor’s offices and such.

2. We inform and encourage our consumers to attend public Hall Town Meetings in their community so they will become more knowledgeable of the policies that govern the local governments and that affect their health or welfare issues, as well as informing them of free Health Fairs available to their community. We also encourage our consumers in participating in our Consortium meetings where they have the opportunity to interact with leaders in the community and upper management of agencies that affect their lives.

3. Through monthly brown bag meetings with other agencies, such as the Council of Drug and Alcohol; the Community Clinics; the Mental Health Community; the Family Violence Prevention Services Agency, we have been able to work in team building activities which affect the community as a whole, representing Healthy Start.

4. By working in conjunction with the Texas Work Program in the community we have been able to provide timely information to our consumers and their families in upcoming Job Fairs, and job opportunities.

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

Part of the Healthy Start-Title V collaboration has consisted of planning a Healthy Start/Title V Region V1 conference, updating the Region V1 Three Year Strategic Plan, and quarterly meetings designed to serve as a forum of discussion concerning Texas Healthy Steps (Title XIX-EPSDT), Children’s Health Insurance Program (Title XXI-CHIP), Children With Special Health Care Needs (Title V), Family Planning (Titles X, XXI), Breast and Cervical Cancer Control Program, HIV/STD Program, and WIC. In addition, the Title V program solicited input from the San Antonio Healthy Start program regarding the Maternal and Child Health Block Grant Application and Annual Report. The Title V program has conducted annual conference calls with the San Antonio Healthy Start program to strengthen the collaboration between Title V and Healthy Start at the local level.

The San Antonio Healthy Start program has established a strong working relationship with the other Healthy Start programs within Texas. Monthly meetings and conference calls, and repeated instances of mutual assistance and support have promoted the Texas Healthy Start programs to establish the Texas Healthy Start Alliance (TXHSA). The Alliance includes all the federally funded sites in Texas, currently at Brownsville, Dallas, Fort Worth, Houston, Laredo, and San Antonio. The mission of TXHSA is to address community-based maternal and child health issues focusing on promoting healthy life styles for women of child bearing age, maximizing participation in prenatal care, reduction of infant mortality, low birth weight, racial, ethnic and border area specific disparities in perinatal outcomes.

The TXHSA has joined together to review several standardized curricula in an effort to ensure consistency in the provision of health education to program participants throughout the state. After review and discussion, TXHSA has chosen the following topics of health education as priorities in this program component: family planning; childbirth preparation; postpartum care; breastfeeding; child development; child safety; well-child care; immunizations; nutrition and exercise; alcohol; drugs and tobacco; STDs/HIV; SIDS and shaken baby syndrome; discipline; toilet training; empowerment; communication; relationships and support; problem-solving and decision making.

San Antonio’s involvement with TXHSA has allowed it to develop extended collaborative working relationships not just with agencies within the immediate service area of Bexar County, but across the State of Texas.

The SAMHD has a history of working to establish and strengthen relationships with state funded Title V providers in order to ensure efficient delivery of services to individuals and families in San Antonio. Managed Medicaid for pregnant women and children began in San Antonio in 1995. The participants in San Antonio/Bexar County could
select from four (4) organizations, 3 HMOs and 1 Primary Care Case Management Program administered through Birch and Davis. The participant could change providers monthly and change Medicaid Managed Care organizations quarterly. Most HMO’s provided health education, transportation, and telephonic case management services. All participated in County collaborative efforts aimed at improved access for participants. This collaboration would eventually benefit many of the Healthy Start clients.

Over the course of the Healthy Start program, the clients have benefited from the extensive network of services provided by the SAMHD state funded programs. As a provider of public health within the community, SAMHD manages nine (9) public health clinics located in areas of the City where racial and ethnic disparities exist. The clinics provide expert public health nursing leadership with an emphasis on prenatal, well child, family planning, and women’s wellness. SAMHD has been a leader in providing prenatal care without regard to patient funding source. The clinics offer free pregnancy testing and assistance with the Medicaid application process. Residents from local post-graduate training programs and contract private Obstetricians, staff the clinics. This allows the Medicaid women to be seen in the clinic in their neighborhood and to have a private physician who delivers her at a hospital agreeable to both. Title V, fee for service, grant is used to provide care to the un-funded women. Through the Title V grant, SAMHD is reimbursed for services and subcontracts for ultrasounds through UHS. Complicated Obstetrical care, genetic counseling, substance abuse treatment, and mental health counseling are not covered by the grant funds. SAMHD has maximized Title V funding for the last five (5) years and has provided over $500,000 in non-reimbursed care. In 1999, SAMHD saw over 4000 prenatal patients from all funding sources for a total of 24,000 visits.

SAMHD has been a provider of the Women’s, Infant and Children (WIC) nutrition program for over 25 years. SAMHD operates over 15 sites with a current caseload of over 51,000 participants. El Centro del Barrio and Barrio Comprehensive Family Health Center also are WIC providers. CHRISTUS Santa Rosa has a WIC project. All four WIC providers are collaborating in outreach efforts to enroll more women and children. Breastfeeding is strongly encouraged in the community by the WIC providers. A “warm-line” was established to help new mothers with breastfeeding problems. To date, there are over 55,000 WIC participants in Bexar County. SAMHD WIC project has a linkage with the City of San Antonio Immunization Registry that has been recognized nationally for its outstanding work. The linkage provides automatic-telephone reminders to WIC clients concerning immunization status.

There are approximately 91,000 children within the community receiving Medicaid and an additional 50,000 eligible for Children’s Health Insurance Plan (CHIP) or Medicaid but not enrolled. In 2003, Vision for Children, a not-for-profit local group, began efforts to secure funding for CHIP outreach and continue to focus on health care for every child. Through their on going efforts, approximately 50% of the children have had outreach services and enrollments in CHIP have increased daily. The outreach efforts are coordinated through a coalition of providers meeting regularly to improve efforts. El
Centro del Barrio is coordinating a pilot program for presumptive eligibility for Medicaid, Project Alberto. This project works with Texas Department of Human Services to have on-site enrollment for children.

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

The San Antonio Healthy Start program operates within the City of San Antonio, San Antonio Metropolitan Health District (SAMHD). The SAMHD is the single public agency charged by State Law, City Code, and County Resolution with the responsibility for public health programs in San Antonio and unincorporated areas of Bexar County. Although the SAMHD is a City/County organization, administrative control is under the City of San Antonio and the SAMHD is operated as a City Department. The Healthy Start program has realized many advantages by being part of the SAMHD. The SAMHD and the City of San Antonio maintain a strong organizational infrastructure that provides accounting, purchasing, human resources, contract management, information technology, legal services, and administrative oversight. This infrastructure has provided the Healthy Start program with several valuable in-kind services, and has allowed the program to focus its energy on serving the clients.

Although the City of San Antonio has provided much valuable infrastructure to Healthy Start, it has also hindered program development in several ways. Due to the strict rules and regulations that govern the City of San Antonio municipality, certain activities/incentives typically provided by other Healthy Start programs are not allowable within the City of San Antonio budget structure. The City of San Antonio does not have a mechanism to support certain allocation of funds. Examples of unallowable expenses include providing monetary incentives to consumers to participate in the consortium, providing monetary incentives to involve consumers in outreach activities, and being able to financially support consumers in attending national Healthy Start meetings. These restrictions have become a significant barrier to engaging consumers in the San Antonio Healthy Start program.

The San Antonio Healthy Start program established a connection to the Texas Department of Health through the program’s case management component, as indicated in the original grant application submitted in 2001. The case management component initially followed the standards and policies established by the Texas Department of Health’s, Pregnant Women and Children’s Program (TDH/PWI). In preparation for the Healthy Start commencement date, case managers were trained and certified by the Texas Department of Health to provide case management services for Pregnant Women and Children. In addition, the case managers were required to maintain the TDH certification. In 2004, the case management component stopped providing services based on the TDH guidelines, based on TDH eligibility restraints and extensive research. Healthy Start selected a new model of care parallel to California Counties Department of Health “Comprehensive Perintal Services Program (CPSP). As a result, the case
management component went through significant revisions. Healthy Start has considered reinstating the TDH guidelines in order to resume Medicaid billing, but the decision is still under consideration.

The San Antonio Healthy Start program has also maintained a strong connection to the state Title V program, through the Title V Population-Based Services, and Title V Nursing Services. The initial San Antonio Healthy Start program included several Title V positions within the outreach, case management, and health education components. Over the course of the program many of the Title V positions that were utilized to support Healthy Start were moved to support other programs within SAMHD. Currently, Healthy Start utilizes one full time position, and one part time position funded by Title V Population Based program, as well as one full time registered nurse funded by Title V. This collaboration and cooperation with the Title V positions has significantly enhanced the Healthy Start program.

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

VI. Local Evaluation

Exhibits found in the following Local Evaluation Reports are found in [Appendix I.]

**HEALTHY START LOCAL EVALUATION REPORT 2002**

**PROJECT NAME:**  
San Antonio Healthy Start Program

**TITLE OF REPORT:**  
Local Evaluation Report: 2002

**AUTHORS:**  
Steve Blanchard, PhD, MPH (Contractor)

Section I: Introduction

A. Impetus for the Local Evaluation:

- To learn about the needs of pregnant women in the community.
- Assess the effectiveness of current marketing efforts.

B. History of Local Evaluation:

The San Antonio Healthy Start Project officially began March of 2002. A number of activities
took place during the first year of operations. What follows is a narrative of those activities:

1. Service coordination between the three components, Outreach, Case Management and Health Education. Staff of the three components assessed their respective roles in Healthy Start service delivery and how those roles fit together. Outreach staff was charged with the task of recruiting clients and referring them to Case Management. As the relationship evolved, a set of client risk indicators were devised whereby Outreach referred high-risk clients to Case Management and retained low risk clients for basic referral and follow-up. Clients who received Case Management services and whose risk profiles dropped were referred back to Outreach for additional follow-up. For some clients, both Outreach and Case Management held joint case responsibilities. Health Education developed materials that promoted perinatal health for distribution by Outreach and Case Management staff and provided training on the materials. This included the development of a flowchart (which is attached at the end of this document), to facilitate in the collection of data for the project. An Access database was developed in October of 2002 to collect project participant data.

2. Targeting areas of the city for program intervention. At the time that the program got underway in March 2002, staff had decided to use selected census tracts as geographical target areas for outreach, case management, and health education activities. The 24 target tracts were identified by calculating rates of infant mortality and low birth weight, the target tracts being those tracts with the highest rates. Outreach conducted door to door campaigns in the target areas and sweeps in residentially dense locations such as apartment houses. Health education provided the outreach workers a set of materials for distribution that promoted behavior related to improved perinatal health. Individuals who accepted service from the target areas were referred as Healthy Start clients to Case Management.

Two issues emerged by late 2002 that prompted staff to want to evaluate continuing with the original 24 target tracts. First, there was growing concern about an emerging disparity in perinatal health between immigrant and non-immigrant Hispanic women. The former, a clandestine population in the city with respect to the health care system (If they present themselves at all to the system, it is generally at the moment of delivery), tend to reside in the Southwest portion of the city away from most of the target census tracts. Secondly, a more program management concern was that the existing 24, predominantly non-contiguous, census tract target areas were too dispersed. Staff was becoming too stretched geographically to be effective. Program staff suggested a consolidation to two or three geographical areas of the city that have historically proven to be areas of high need of services of the San Antonio Metro Health Department. It was felt that a consolidation would not only allow for a greater focus on three key population groups (African Americans, Mexican immigrants, and adolescent mothers), it would be a more efficient use of staff personnel and project money. As a result of program discussions, two new target areas were defined effective with the calendar year 2003. The areas were defined by Healthy Start program managers and with a multicultural perspective by aggregating zip codes and paying attention to the predominance of such factors as African Americans (the Eastside Target Area), immigrant populations (Southwest Target Area), and adolescent pregnancy (both target areas). The Eastside Target Area retains within its boundary the former Census Tract Target Areas that pertained to infant mortality in the African American
population. The Eastside Target Area also includes the larger geographical area to the northeast where African American families of the inner Eastside residentially migrate. The Southwest Target Area has become one of the main geographical entry points for residential living by recently arrived Hispanic immigrants. Outreach coordinated program recruitment activities with other Metro and non-Metro agencies in the two areas, particularly indigenous community based faith and service organizations. The areas also facilitated Health Education activities by providing geographical containers for education saturation.

3. Cultural responsiveness of Health Education. One of the Special Concerns of the Healthy Start Program Guidelines was that local projects were responsive to cultural and linguistic diversity. To that end, in late 2002, Health Education with the assistance of the project data manager, held a series of focus groups and key informant interviews with Healthy Start consumers to evaluate the effectiveness of the program’s health education materials for content and text. Suggestions for materials revision were incorporated in early 2003. The methodology, materials and final report itself are included in this document.

4. Sustainability of postpartum depression screening. Program staff successfully wrote a proposal to the Hogg Foundation for Mental Health for monies to conduct a study of the prevalence of postpartum depression among clients attending the clinics of the San Antonio Metropolitan Health Department. The Hogg Foundation is a Texas-based private foundation that supports activities related to improving mental health services. There are three phases to the postpartum project in the first year. The first was a series of focus groups in March 2003 with Healthy Start and clinic consumers to understand consumer perspectives of postpartum depression and to evaluate the multicultural validity of current depression assessment instruments. The second phase was the prevalence study during April and May. The third phase was the development during the summer of a counseling protocol. The second year included the delivery of the counseling by PhD candidates in a psychology program at a local university. The project included the plan to coordinate with the local state-funded provider of mental health services in the county in an effort to gain funding for a community-wide program that could be sustained into the foreseeable future.

In addition, The Healthy Start project sponsored a daylong symposium on postpartum depression in December. Presenters were providers from various service locations in the city, including the Department of Psychiatry at the University of Health Science Center at San Antonio.

5. Coordination with local Mobilization for Action through Planning and Partnerships project (MAPP). The city of San Antonio is one of the pilot sites for the national MAPP initiative. MAPP is a mechanism for community coordination in the development of a community health plan. Healthy Start program management staff, advocating for improved perinatal health programs, have become regular participants in MAPP. Activities such as this are consistent with the ‘infrastructure building services’ recommended by HRSA to be undertaken by local Healthy Start programs.

II: Process
A. Type of Evaluation:

A formative evaluation was conducted to help formulate and reformulate the program during the initial, formative, phases of the program. As indicated in the history above, many components were implemented; but evaluation was necessary to determine if the program was doing what needed to be done to meet the program goals.

This formative evaluation consisted of two focus groups* among Hispanic and African-American pregnant women and women with young children from two San Antonio Metropolitan Health District clinics. One group was conducted entirely in English at the Barbara Jordan Community Center among four (4) women recruited from the East Side Branch clinic, while the second group was conducted in both English and Spanish at the Salinas clinic among seven (7) WIC participants. Those women who agreed to participate were given a $10 H.E.B. food voucher as a token of appreciation. Please refer to EXHIBIT A for a demographic profile of focus group participants. A moderator and two note-takers sat in each focus group to collect participants’ responses and observe each group’s dynamics. EXHIBIT C represents the focus group script.

Another phase of the formative evaluation consisted of six (6) key informant interviews. Key informants were chosen by three Healthy Start Health Education staff members based on each informant’s experience with Healthy Start’s target population. EXHIBIT B represents the key informants’ profiles.

Two focus groups were conducted among Hispanic and African-American pregnant women and women with young children from two San Antonio Metropolitan Health District clinics. One group was conducted entirely in English at the Barbara Jordan Community Center among four women recruited from the East Side Branch clinic, while the second group was conducted in both English and Spanish at the Salinas clinic among seven WIC participants. Those women who agreed to participate were given a $10 H.E.B. food voucher as a token of appreciation. A moderator and two note-takers sat in each focus group to collect participants’ responses and observe each group’s dynamics. Six key informant interviews were also conducted. Key informants were chosen by three Healthy Start Health Education staff members based on each informant’s experience with Healthy Start’s target population. Please refer to Appendix A for a demographic profile of those interviewed, along with sample copies of the instruments used.

To determine the adequacy of current Healthy Start marketing materials, respondents and key informants were given a Healthy Start handbill, brochure and poster and asked several questions regarding their content and look.

Section III: Findings/Discussion

Handbill (see Appendix J: Handbill 2002)

Overall, the handbill was favorably received by both focus group participants and key informants. Slightly more than half of both focus groups combined had not seen the handbill, while most of the

* Focus group and key informant participants were selected from a convenience sample. Some participants had working relationships with Healthy Start staff and were aware of the program and its services.
key informants mentioned having come across it.

Both key informants and respondents noted the physical aspects of the handbill, such as its “eye-catching” color and uncluttered look. Most felt the information provided to be simple, concise and to the point. Some felt that the handbill was easy to read and liked that it was written at a level everyone could understand and provided in both English and Spanish. Other “likes” included the following:

- the logo which implied a family-oriented program;
- a single number to call for further information; and
- a listing of the services Healthy Start provides.

Overall, most felt the instructions on the handbill to be clear, although one key informant felt that this would be dependent on a woman’s educational level. Another stated that anyone who comes across the handbill might expect direct services instead of referrals from the program.

**Intended Audience**

An issue that arose during the course of the interviews and focus groups was the question of who the intended audience was. This was especially true among those informants who work with “high risk” women, such as those who abuse substances or are infected with HIV.

Some of the individuals interviewed felt that because the handbill did not picture a pregnant woman, one might not know that she was the intended audience. Others pointed out that the words “free” or “free healthcare” do not appear anywhere on the handbill, nor does any mention of a woman needing to be pregnant. Some participants questioned whether a single father would be eligible, although all agreed that the handbill appeared to be speaking to women.

**Section IV: Recommendations**

Respondents and key informants were very forthcoming with suggestions for improving the handbill. The following suggestions were offered:

- change “Let us help you”, with “Do you need?”;
- change “Let us help you”, with “We can help you get”;
- define what the letters WIC stand for;
- state clearly that the services provided are free;
- highlight the lines that mention Doctor, Dentist and Health Insurance;
- add the line “Free, discrete and confidential” and “You have questions, we have answers”;
- highlight the phone number in larger font; and
- set-up a Healthy Start hotline with a friendly voice.

One suggestion that was repeated by both respondents in one group and a few of the key informants was the suggestion that pictures of a mother and her infant be included. Some focus group participants suggested the handbill be a full-sized sheet in a brighter color, along with placement of the handbills near the Healthy Start poster.
Dislikes pertaining to the handbill focused on the lack of pictures of pregnant women and/or infants. Also, one of the key informants interviewed found the line “Find health insurance”, to be unrealistic and suggested the line “If you qualify…”, be added.

Another dislike that seemed to come up was the mixing of the languages on the logo. This point was mixed; some found it offensive, while others did not have a problem with it. Among those who found it offensive, the suggestion was to stick with one language.

**Further Information**

Respondents and key informants were asked whether or not they felt a pregnant woman would know where to call for more information about the program. Both respondents and key informants agreed that a woman would know where to call, but were split as to whether or not she would call. Both groups felt that a pregnant woman would call to find out what services were available. On the other hand, key informants were not so sure a woman would call. Two informants who work with “high risk” populations felt that this would be dependent on whether or not a woman was in treatment or as a last resort in a crisis situation. Again, the discussion surrounding the intended audience resurfaced.

**Brochure**

Among both focus groups, none of the participants indicated having seen the Healthy Start brochure. Among the six key informants, half had not come across the brochure. As with the handbill, response to the brochure was favorable. Participants in both groups appeared to like the amount of information provided. One group that had reviewed the other Healthy Start materials (handbill and poster), felt the brochure provided the most information about Healthy Start: “I think this is better because it gives you more information.” The brochure’s colorful appearance was seen as a positive.

Both focus group respondents and key informants found the brochure’s colorful appearance and the fact that it was written in both English and Spanish to be appealing. Some key informants mentioned the brochure’s book-style format, bolded letters and simple sentences as a “like”. Lines such as “If you are pregnant” and “free” were seen as being helpful when it came to clarifying who was eligible for services, while one informant pointed out that the brochure did not contain any information pertaining to other criteria for eligibility, such as income, living/residential status, etc.

**Clarity of Content**

Response to the clarity of instructions was mixed. While some felt the instructions on the brochure to be clear, others again questioned who the brochure was targeting. This opinion was very strong among those key informants who work with “high risk” populations, such as women who abuse substances and those who are homeless.

Another point that came up repeatedly in both focus groups and interviews was the order of the pages in the brochure and the level of language used. Page two in particular, which provides an overview of the program’s components and a brief description of each, was agreed to be confusing and difficult to understand by both focus group respondents and key informants.
Again, in reference to page two, some participants felt that too much information was provided and that a person might not continue reading the brochure. This coincided with some key informants who felt that the words chosen were too “high level” and would therefore be difficult to understand by those who may not have much education. Another pointed out that words such as “home visit” and “case management” may not make sense to the general population as they would to professionals who work in the social service arena. One key informant questioned who the intended audience was, whether it was professionals or pregnant women in need of services.

Virtually everyone interviewed suggested a reordering of the pages. Most indicated a preference for moving page two to the last page, while keeping the order of the remaining pages. Another suggestion included adding a baby or a pregnant woman to the logo found on the front cover and increasing the font size of the phone number so as to make it stand out. One key informant also suggested replacing the dots with dashes in the phone number so as to make the number more legible. Another suggested other “tips” a woman should know, such as staying away from cat litter and x-rays while pregnant. Participants from one group suggested a Healthy Start table, where one could pick and choose from the materials (handbill, brochure, poster).

While most of the criticism centered on page two of the brochure, the rest of the pages were well received. The word “Confidential” was seen as being important by informants, although one felt the word might not be well understood by those individuals with a low literacy level.

**Poster**

Respondents from one focus group and all six key informants agreed to having seen the Healthy Start poster. Only one focus group (conducted at the Salinas clinic) failed to recognize the poster. Some stated that it looked somewhat familiar, having possibly seen it at a local doctor’s office. Three of the six key informants interviewed had the poster located somewhere in their offices.

Response to the poster was favorable, as it was seen to provide pertinent information in one location and in a simple format. Informants mentioned the “Free and Confidential” line as being important. All in all, the poster was seen as being colorful and simple and would interest someone to pick-up a handbill.

**Participant Criteria**

Both focus group participants and informants pointed out the lack of criteria for receiving services. One group of participants stated that “just about anyone” was eligible, while also feeling that only pregnant women would be eligible. According to these respondents, women with children and men were seen as being ineligible for services, according to the information provided on the poster.

One of the focus group respondents voiced her opinion of feeling overwhelmed with the amount of information provided at clinics and suggested other locations where the poster could be located. The following locations were suggested:

- community centers, such as the Claude Black Center,
- WIC clinics,
- Department stores such as Wal-Mart,
- Homeless shelters,
- Medicaid offices.
A couple of the informants interviewed questioned how Healthy Start was being marketed, i.e. whether or not enrollment was necessary in order to receive services.

**Language**

The mixing of both English and Spanish on the poster was seen by some as being a positive, while others saw it as being a negative. One key informant had such a strong negative reaction that she reported wanting to throw away the poster. Another commented about the poster appearing “very generalized”.

One group of participants suggested the inclusion of pictures of the program divisions on the four corners of the poster, along with the name of someone to speak with directly when one calls the 299-5035 number. Another suggestion made by a couple of the key informants was to have two separate Healthy Start posters, one in English and a second in Spanish.

**Media Habits**

**Internet**

Focus group participants were asked about their usage of the internet for information pertaining to clinic sites and medications. While participants felt that this would be a good way to advertise a program, such as Healthy Start, most did not use this as an avenue for gathering information. When asked as to where they received such information, respondents indicated phone books and family (word of mouth).

While most key informants indicated that their clients did not utilize the internet, some felt that teens would “surf” the internet for information while at school. With respect to the internet being a good medium for advertising, this was seen as being dependent on the target audience. Teens and health care professionals were seen as utilizing the internet for information, while informants’ clients were not seen as having access to the internet.

**Newspapers and Other Media**

Focus group respondents were asked which newspapers they read and key informants were asked about their clients’ reading habits. The following newspapers and magazines were named:

- Express-News,
- La Prensa,
- The Current,
- Recorder and Reporter, Southside Reporter,
- Parent/Baby Magazines,
- Baby Talk,
- Parenting American Magazine.

Respondents were also asked which radio stations they liked to listen to. The following radio stations were named:

- 92.9, 96.1, 98.5, 99.5,
- 102.7, 107.5, and 1480 AM.
Respondents named the following television stations as those they most like to watch:

- NBC, CBS, PBS and ABC,
- Channel 41 (Spanish-language),
- Cartoon Network and the community channel (CHIC-21).

Suggestions for Advertising

Both respondents and key informants were asked to suggest ways that Healthy Start could get the word out in the community. The following places to advertise were suggested:

- Doctors’ and dentists’ offices,
- Schools, including nurses and counselors’ offices,
- DHS offices,
- Substance abuse groups, such as Alcoholics’ Anonymous meetings, Narcotics Anonymous meetings, Club 12, Winners’ Club and Goliad Groups,
- Libraries,
- Pregnancy testing centers,
- Planned Parenthood Centers,
- Shopping malls,
- Hospitals, targeting nurses and social workers,
- Health department clinics, such as STD clinics for high-risk women,
- Hospital waiting rooms.

Respondents from one group had other suggestions for promoting the Healthy Start program. Suggestions included the following:

- advertise in the phone book,
- advertise in the Thrifty Nickel,
- advertise in the newspaper (Express-News),
- distribute Healthy Start stickers,
- place Healthy Start flyers on car windshields,
- mass mail the Healthy Start marketing materials,
- advertise inside VIA buses,
- distribute pencils and pens with contact information,
- distribute toys for children with contact information.

Other suggestions included having a case manager visit women at the hospital following a crisis event; offering a stipend to those women who participate in the Healthy Start program; speaking with teen girls at local schools; and conducting a network blitz of hospital personnel for awareness purposes.

Finally, it was suggested that the following individuals be interviewed for their input regarding the Healthy Start program:

- pregnant women,
- women from different age groups,
- San Antonio Birth Doulas,
- WIC administrators.
Section V: Impact

All three marketing materials were well received by both focus group participants and key informants. The materials’ physical aspects were seen as appealing, while suggestions appeared to focus on the intended audience and clarification of eligibility requirements. Among all three items, the brochure elicited the most suggestions for revisions.

The issue of the program’s “target audience” came up repeatedly among both focus group respondents and key informants, particularly among those informants who work with “high risk” groups, such as the homeless, substance abusers and individuals infected with HIV. Suggestions for improving the marketing materials centered on this issue, as noted in the previous paragraph.

Focus group participants repeatedly suggested the addition of photos to the logo and materials. Most suggested the addition of a mother and her infant, along with photos of the program divisions on the poster. Personalizing the phone number by adding the name of a person people can speak with was also seen as being helpful for anyone wanting further information.

The use of both English and Spanish on the marketing materials received some negative response, particularly among a few key informants.

Recognition of Healthy Start materials appears to be split, while most key informants recognized them, many focus group participants did not recognize any of the marketing materials.

Both respondents and key informants were very forthcoming with suggestions for advertising the Healthy Start program. The internet was not seen as being very useful for this purpose unless the intended audience was teens or healthcare professionals.

Section VI: Publications

There were no publications from this local evaluation.

Recommendations

The fact that many focus group participants did not recognize any of the Healthy Start marketing materials reflects a general lack of awareness about the program and its services. Most of the key informants interviewed have a professional relationship with Healthy Start staff members. As a result, awareness of Healthy Start services was high among this group.

The issue of the target, or intended audience needs to be clarified. Among those key informants who work with “high risk” individuals, it appears that the Healthy Start marketing materials may not be as effective in enticing women to learn more about the program. Along this vein, materials targeted to healthcare professionals should be different from those targeting the general population.
Suggestions regarding the inclusion of photos of pregnant women and infants, and language in the marketing materials should be considered, particularly the suggestions surrounding page two of the brochure.

The use of both English and Spanish in the logo and on the poster can be seen as potential “red flags” based on the strong negative reactions some key informants reported. It may be worth investigating the possibility of providing materials, particularly the poster, in both English and Spanish rather than combining both languages on one material.

Respondents and key informants’ suggestions for helping Healthy Start to “get the word out” in the community should be considered in light of the fact that awareness of the program appears to be low among the general population.
Section I: Introduction

A. Impetus for the Local Evaluation:

- Evaluate perinatal depression by establishing the prevalence of depression among pregnant and postpartum women in SAMHD clinics.
  - Selection of an appropriate perinatal depression screening instrument that captures depressive symptoms and is culturally sensitive to the overwhelmingly Hispanic population.
- Establish a triage and treatment system for women identified with depression or other mental health conditions.
- Identify any potential barriers (transportation, language, etc.) that may prevent women from accessing mental health services prenatally or during the interconceptional period.

B. History of Local Evaluation:

The major evaluation activity that took place in 2003 was the incorporation of new data elements collected on program participants. Based on the information presented at the February 2003 National Data Conference, the Healthy Start database was updated to reflect proposed changes in reporting requirements, as per HRSA. This Access database was also tailored to provide monthly reports to the Outreach and Case Management Supervisors, for the purposes of tracking all Healthy Start clients. In addition, reports were also provided to the Healthy Start Program manager and any member of the management team for general management of program efforts.

In 2003, the San Antonio Healthy Start program was selected to take part in the National Evaluation Survey. Members of the management team, including the evaluator for the project, Dr. Steve Blanchard, participated in the numerous teleconferences held so as to develop a national evaluation strategy for all Healthy Start grantees.

In an effort to address perinatal depression, San Antonio Metropolitan Health District developed a Perinatal Depression Project Team consisting of members of the Healthy Start and Nursing Divisions, an independent evaluator and members of the health care community. The Perinatal Depression Project Team was accepted for participation in the 2003 City Match Data Use Institute (DUI). They attended the DUI in the fall of 2003 and continued to work on the project through the winter and spring. The team had a goal to gather data that would quantify the prevalence of maternal depression during pregnancy as well as in the postpartum period among the SAMHD population. Accurate data will allow the team to move forward in critically analyzing the problem of maternal depression.

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depression and; with the involvement of community partners, design a plan to address this health issue and implement effective community-based intervention strategies. The Healthy Start Maternal Depression Project was presented at the City Match 2003 conference as a Promising Practice and at the 2003 Healthy Start Grantee Meeting. This Promising Practice Report is summarized in EXHIBIT E.

Section II: Process

Type of Evaluation:
The evaluation plan for 2003 was very extensive and consisted of a process evaluation, an outcome evaluation, and a formative evaluation. Revision of the Healthy Start database to incorporate new data elements as outlined in the HRSA 2003 National Data Conference has provided Healthy Start with the data necessary to determine program efficacy. This quantitative data is summarized in Tables A, B, C, and Forms 5 and 9.

A process evaluation in 2004 indicated that the project was not progressing well in some areas (African American client enrollment) a plan of correction was implemented.

A formative evaluation was conducted to help identify the most appropriate depression screening instrument. Among consideration were the Beck Depression Inventory, the CES-D and the Edinburgh Post Natal Depression Scale. Focus groups among current SAMHD female patients were conducted to learn how this population views and interprets depression and depressive symptoms during the perinatal period. Prenatal and Interconceptional women were recruited from SAMHD clinics and collaborating agencies, such as El Centro del Barrio As an incentive, a $25 gift certificate from a local department or grocery store was offered. To prepare for these focus groups, staff were trained in the recognition and acceptance of cultural beliefs and practices. The interviewers received information regarding cultural attitudes and practices with regard to pregnancy and mental health issues.

A total of 7 focus groups were conducted. The results of these focus groups are presented in EXHIBIT D.

Section III: Findings/Discussion

Depression during pregnancy is indicated as a significant factor leading to poor perinatal outcomes related to decreased nutrition, poor sleep, substance abuse and inadequate perinatal care. Anecdotally, we know that a significant number of the women and teens seen by the case managers have symptoms of depression for which they are not receiving treatment. The reasons reported for not seeking treatment include undocumented immigration status, lack of insurance or Medicaid, lack of daycare and the client's own reluctance to admit to the need for mental health assistance. A chart review of 377 case management clients revealed 86 (23%) of the young women reported symptoms of depression or had a positive Edinburgh Post Natal Depression Scale result. All 86 were referred for counseling or treatment. Of those referred, 10 (12%) received the necessary treatment. The remaining 76 (88%) did not receive treatment, with 19 (22%) of the women reporting the reasons for non-compliance being lack of funding and/or immigration status.
SAMHD clinic staff have also observed that a significant proportion of the women and teenagers seeking prenatal and birth-related care have symptoms of depression for which they are not receiving treatment. Currently, no source of hard data exists within the SAMHD system to quantify the scope and character of depression within the clinic population. While we do understand and recognize the signs and symptoms of depression, we do not know the prevalence of depression in the pregnant women seeking care from the clinics, nor the prevalence of postpartum depression (depression typically occurring within a six week window following birth). As such, the San Antonio Healthy Start and Nursing Divisions propose to gather data which can quantify the prevalence of perinatal depression with the intent to develop and implement appropriate community-based intervention.

Section IV: Recommendations

See EXHIBIT D

Section V: Impact

See EXHIBIT D

Section VI: Publications

These local evaluation efforts yielded no publications.
Section I: Introduction

A. Impetus for the Local Evaluation:

- Use PPOR (Perinatal Periods of Risk) to address perinatal disparities in the community. The objectives of PPOR and San Antonio Healthy Start in implementing PPOR are:
  o to develop the PPOR approach as a community tool to improve the health of women and infants;
  o to describe and encourage best practices in using PPOR as a community tool;
  o to develop easy-to-use materials and services to support communities interested in using PPOR; and
  o to assure the strategic linkage of the PPOR approach with related existing efforts (e.g. FIMR, Healthy Start).

B. History of Local Evaluation:

In 2004, the Healthy Start Management Analyst introduced the Perinatal Periods of Risk approach to Consortium members as a tool for addressing perinatal disparities in the community. A working group comprised of members from the healthcare, social service and community arenas met a total of three times in 2004 as part of the PPOR workgroup.

Section II: Process

Type of Evaluation:
There was not enough time in 2004 to implement all of the phases of PPOR and evaluate Healthy Start according to the PPOR model; however, a certain amount of quantitative data was collected in preparation for the implementation of PPOR. These data are summarized in EXHIBIT F.

Key Questions/Hypotheses:

The key questions/hypotheses addressed in 2004 were those posed by the PPOR:
- No simple, standardized, widely accepted approach for communities to examine infant mortality.
- Current approaches don't readily identify potential gaps in the community for further
reductions.

- Current approaches don't directly lead to action to targeted studies, investigations or prevention activities.

- Current approaches are not simply and easily communicated to community partners, which can inhibit mobilization.

Section III: Findings/Discussion

See EXHIBIT F

Section IV: Recommendations

Due to staffing changes within the project, participation in the PPOR was suspended.
HEALTHY START LOCAL EVALUATION REPORT 2002-2004

PROJECT NAME: San Antonio Healthy Start Program


AUTHORS: Vanessa Miller, DrPH, APRN (Contractor)

Section I: Introduction

A. Impetus for the Local Evaluation:

- To determine effectiveness of Healthy Start Services as perceived by the Healthy Start Clients.

VI. History of Local Evaluation:

Throughout the tenure of Healthy Start, efforts have been undertaken to assess the effectiveness of the project from the clients’ prospective. It has been determined that this can best be done through the administration of client satisfaction surveys.

Section II: Process

Client satisfaction surveys are a method of collecting formative and process data which will help us to formulate and reformulate the program. It helps us to determine if the program is progressing as expected from the clients’ viewpoint. Several approaches have been tried in the distribution of client satisfaction surveys. Initially, the surveys were left with the clients and Healthy Start staff requested that they complete them at their discretion. The return rate for these surveys was very low. Staff then elected to request that they clients complete the surveys in the presence of the staff person. This increased the return rate; but staff acknowledged that this may have also inhibited the clients’ responses to some questions.

Section III: Findings/Discussion

The findings from one of the client satisfaction surveys are indicated below.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you find on your visits that staff was friendly and helpful?</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Were you pleased with the services you received from our program?</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Did you have a part in making goals for your service plan?</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>
Were the Case Manager's home visits helpful for you and your family?  100%

Did our program help you meet your needs throughout your pregnancy  92.3  7.7

Were the referrals to other agencies and programs helpful to you?  92.3  7.7

Has the program been able to provide you and your family with information on nutrition, child/infant care, child birth, and other information concerning your prenatal care?  100%

Overall, how would you rate our services

<table>
<thead>
<tr>
<th>Rating</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>85%</td>
</tr>
<tr>
<td>Good</td>
<td>15%</td>
</tr>
</tbody>
</table>

Another client satisfaction survey was administered specifically to assess the effectiveness of Case Management services. These results are summarized below.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Case management services were helpful for me or my child.</td>
<td>79%</td>
<td>21.20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case management helped me with the needs I feel are important.</td>
<td>76%</td>
<td>24.20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was given referrals by my case manager that helped me.</td>
<td>72%</td>
<td>28.10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case management helped me access some needed medical services.</td>
<td>66%</td>
<td>34.30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using what I learned from Case Manager, I believe I am more able to access medical services on my own.</td>
<td>69.70%</td>
<td>30.30%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section IV: Recommendations

As previously indicated, it is felt that the method in this the client satisfactions surveys were administered decreased response rate (only 46 surveys were returned). It is also felt that respondents may not have felt free to fully express themselves when Healthy Start staff looked on as the client completed the survey. The lack low response rate and the lack of variability in the responses is an
indication that other methods must be implement to elicit client feedback regarding the effectiveness of the program.

Section V: Impact

Unable to assess at the present time.

Section VI: Publications

This local evaluation effort yielded no publications, however, the information was presented on several occasions to public health partners within the community.
VII. Fetal and Infant Mortality Review (FIMR)

The San Antonio Healthy Start Program is in the process of developing a FIMR program. In 2002 we held 3 initial meetings with a diverse group of members of the community that were involved in various aspects of maternal and child health. We presented the goals and objectives of the Healthy Start Program and asked for support in starting a FIMR program for San Antonio and the Bexar County community. In 2003 the progress was slow, due to resignation of FIMR coordinator, vacancy and training of the new hire. We continued efforts to meet with hospital administrators and educated them about the program, to encourage their buy in. In 2004, a team composed of the San Antonio Metro Health Director, Healthy Start Program manager, FIMR coordinator and city attorney, convened a meeting with all San Antonio hospitals that offer obstetrical services and children’s services. Hospital administrators and representatives from health information management were invited. There was only one hospital that expressed reservations about sharing their medical records. We worked with this hospital providing them with information about HIPAA, consultation with the legal department, and the sharing the willingness of other local hospital systems to work with us. After a year of discussions, this hospital agreed to participate. During 2004 we also convened a Texas Healthy Start Alliance FIMR legislative committee, with the objective of getting legislation passed in Texas that would mandate providers to open their medical records for FIMR reviews. The San Antonio FIMR coordinator served as chair for this committee. We gathered legislation passed in 5 other states, drafted Senate Bill 1183, which passed in the Senate, was approved by the House Public Health Committee, but unfortunately, due to lack of time, never got to the Full House floor. During 2005, as we worked on the legislative effort, we convened a Community Review Team (CRT), which has met regularly since March. The agendas for the meeting have included general orientation on FIMR, results of other FIMR programs in the country, infant mortality data for Bexar County, case selection criteria and pilot case review.

The emphasis of our FIMR program is child mortality. There is an adult mortality review program in our community, of which Healthy Start is a member. Healthy Start also participates in the Bexar County Child Fatality Review Team (BCCFRT) which is very supportive of our FIMR efforts.

Healthy Start plans to continue having regular CRT meetings. Once enough cases are reviewed, and trends can be identified, we will expand the FIMR effort to develop the Community Action Team (CAT). Our FIMR process follows the guidelines of the NFIMR and, as suggested by NFMIR, has a home visitation component. During this grant cycle the only funding source was Healthy Start.

The major challenges that have affected the development of the program FIMR in the past four years have been:

- Provider participation is voluntary. This is why we worked on the legislation initiative.
- Hospital personnel changes frequently and we have to re-educate and convince the new person to endorse FIMR.
- Funding is very limited. Healthy Start is the only source of funding. During most of the grant cycle the FTE allocation varied from .5 to .25 to perform the duties of director, coordinator, interviewer, and case abstractor. This made it very difficult to accomplish all the groundwork and legwork that needs to be done to implement this kind of program.
VIII. Products

The materials produced under the Healthy Start grant funding are being sent under separate cover, as many of them do not conform to the digital format of this report. Please refer to Appendix B for a list of all of the products including brochures, posters, flyers, and promotional items.

IX. Project Data

Progress Report, July 1, 2001 through December 31, 2001

The San Antonio Metropolitan Health District (SAMHD) received notification of funding for the Healthy Start Initiative on July 6, 2001. The first six months of the program was dedicated to recruiting and hiring staff, developing policies and procedures and working extensively with the evaluator to insure the creation and implementation of a program that would meet all expected goals.

The date for the initiation of San Antonio Healthy Start was March 1, 2002. For this reason, there was no demographic data or performance indicators related to program participants during this period of time.

The original Healthy Start funding proposal was completed and submitted by members of the Nursing Program of the San Antonio Metropolitan Health District (SAMHD). The nursing staff and SAMHD management conducted the initial program implementation. The first step for any grant-funded program is review by the City Council, Mayor and City Manager. When this review is completed and the program has been approved, the funds may be accepted and program activities may be initiated. The Healthy Start Initiative was approved by City Council on August 30, 2001.

Two program supervisors were asked to participate in the implementation of the Healthy Start Initiative. The process was initiated with weekly meetings including the Nursing Program Manager and a consultant in mid-August and continued through late October. The meetings were targeted toward the most basics of project start-up - budget and staff revisions, procuring office space and accommodations for staff, and writing job descriptions and posting positions. In late October, the two program supervisors initiated weekly meetings with the Program Evaluator. The focus of the meetings was the analysis of the process needed to create a viable program. These discussions led to the creation of policy and procedure and the basis for the data collection system. (see Appendix K: Data Collection Flow Chart)

San Antonio Metropolitan Health District had existing Case Management and Health Education and Promotion programs prior to receiving funding for the Healthy Start Initiative. The infusion of Healthy Start monies allowed for the creation of a new division within SAMHD that would be
comprised of non-clinical, community based services. To that end, the Healthy Start Division was created and many of the staff members transferred from similar positions within the Nursing Division, including case managers, clerical staff and case aides who would serve as the Community Outreach Advocates. New positions created for the Healthy Start division included the Program Manager; Coordinators for Health Education and Outreach; Social Services Manager and the Management Analyst. With the exception of the Management Analyst, the new positions were posted on September 10 and closed on September 24, 2001. The recruitment of the Program Manager included advertising the job posting in the newspaper. The screening process for all positions involved initial interviews by a panel headed by the Nursing Program Manager with finalists advancing to an interview with the Director and Assistant Director of Health. Ultimately, the Social Services Manager and the Outreach Coordinator transferred from the Nursing Division on November 3, 2001 and November 17, 2001, respectively. The Health Education Coordinator and Program Manager were subjected to the City of San Antonio's new employee screening process. Therefore, they did not join the team until December 10, 2001 and December 26, 2001, respectively. The Management Analyst position was posted on November 20, 2001 and closed on December 4, 2001. The same screening process applied, with the Management Analyst coming on board January 14, 2002.

Initially the Case Management staff was comprised of three social workers that transferred from the SAMHD Nursing Division in mid-November and two social workers that were newly hired in mid-December. Although the implementation date for San Antonio Healthy Start was March 1, 2002, the Case Managers began working in the targeted areas, assessing the community and available resources and piloting Healthy Start forms in mid-November 2001. The Outreach staff was comprised of four Community Outreach Advocates who also transfer from the SAMHD Nursing Division in early February, 2002. One additional outreach person was to be hired from the targeted areas. Table IX-1 outlines the roles and responsibility of the staff initially Hired by Healthy Start.

<table>
<thead>
<tr>
<th>Title</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Manager</td>
<td>Responsible for project development, operations and evaluation. Accountable for personnel, financial management, policy and procedure requirements and conforming to all federal, state and city regulations. Responsible for development and implementation of the Consortium and the Fetal Infant Mortality Review Board.</td>
</tr>
<tr>
<td>Social Services Manager</td>
<td>Responsible for development and implementation of policies and procedures, direct supervision of Case Management staff, oversees billing for Medicaid reimbursement. Accountable for compliance with all federal, state, county and city regulations and submission of required reports. Serves on the Consortium and FIMR.</td>
</tr>
<tr>
<td>Health Education Coordinator</td>
<td>Responsible for the development, implementation and coordination of Healthy Start education programs and social marketing and direct supervision of Health Education and Promotion staff. Accountable for compliance with all federal,</td>
</tr>
<tr>
<td>Role</td>
<td>Responsibilities</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Outreach Coordinator</td>
<td>Responsible for development and implementation of training curricula for outreach and case management staffs, development and implementation of policies and procedures, direct supervision of Outreach staff. Accountable for compliance with all federal, state and city regulations and submission of required reports. Serves on the Consortium and FIMR.</td>
</tr>
<tr>
<td>Management Analyst</td>
<td>Responsible for development and maintenance of database, provision of program data for required reports, conducting management studies to meet program goals and objectives. Assists with grant writing and preparation and monitoring of the annual budget.</td>
</tr>
<tr>
<td>Case Manager</td>
<td>Responsible for working with high-risk women and their families through a goal-oriented service plan to improve the health status of the family. Accountable for following Texas Department of Health guidelines and accurate documentation of visits. May exercise direct field supervision over Community Outreach Advocates.</td>
</tr>
<tr>
<td>Community Outreach Advocate</td>
<td>Responsible for implementation of outreach and recruitment activities directed toward potentially eligible participants, provision of health education, information and referrals for health and social services to citizens of San Antonio and Bexar County. Works in coordination with Outreach Coordinator and Case Managers to insure coordination of services for families.</td>
</tr>
</tbody>
</table>

**Project Data Reporting Forms**

Project Data Reporting Forms can be found in the following Appendices. Each Appendix contains a report for each year.

- **Appendix L - FORM 1**: MCHB Project Budget Details
- **Appendix M - FORM 5**: Number of Individuals Served (Unduplicated) Program Participants By Type of Individual and Source of Primary Insurance Coverage
- **Appendix N - FORM 9**: Tracking Discretionary Grant Healthy Start-Specific Performance Measures #7, 10, 14, 17, 20, 21, 22, 35 36, 50, 51, 52, 53, 54, and 55
- **Appendix O - Table A**: Characteristics of Program Participants
- **Appendix P - Table B**: Risk Reduction/Prevention Services
- **Appendix Q - Table C**: Healthy Start Major Service Table