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Introduction:

Introduction: The Greater Englewood Healthy Start Initiative (GEHSI) aimed to improve the perinatal health of women and infants in the Greater Englewood Community (the Project Area or PA), thus reducing the infant mortality at the community level to 18.4 over the entire Project Period and to focus on a reduction in low birth weight to 10% for GEHSI participants and to 12% for the PA. The staff implemented the five required HRSA Healthy Start Core Services of Outreach and Client Recruitment; Case Management; Health Education and Training; Interconceptional Care, and Depression Screening and referral in collaboration with the Community-Based Consortium and a variety of community agencies. The staff also implemented the four Core System-building Efforts (Local Health System Action Plan; Consortium; Collaboration and Coordination with State Title V and other Agencies; and Sustainability. The specific objectives for each component were based on a community needs assessment, and were determined by the grantee staff and a selected number of community agencies who later formed part of the consortium. Data from the 1990 Census and other available data for the period 1996 through 2000 were used in the community assessment.

Community Assessment

The Population: Age and Race: In 1990, according to data from the US census, the Englewood and West Englewood communities had a combined population of 101,206 persons, 98.5% (99,688) of whom were Non-Hispanic Black. The remaining 1.5% were divided into .75% (759) non-Hispanic White, .5% (506) Hispanic, and .25% (253) Non-Hispanic other. This compares with the City’s percentages of 38.6%, 37.9%, 19.6% and 3.9% respectively for these populations. Overall, it was a young population with 30% of the population aged 15 years and younger, compared to 25% for the city of Chicago. Forty-six (46%) of the population were children and young adults aged 0-24 years. Children under age five years were 9.5% of the population and those aged 65 years and over were 9% of the population. This profile remains similar to today. According to the 2000 Census, more than 35% of the population was aged 18 years and younger. Children under five were almost 9% of the population, and children 0-2 years made up over 5% of total residents.

Identification of the Targeted Population, Women of Child Bearing Age (WCBA): The 1990 Census indicated that there were 24,805 women of child-bearing age (women aged 15 to 44) living in the PA. This was almost 25% of the PA’s total population. Based on the relative percentages of other racial groups in the population in the area, it is assumed that most of these were Non-Hispanic Black. In the targeted communities, 53.9% of adults over 25 years of age are high school graduates compared with the citywide percentage of 66.0%. Data for WCBA was not available, however, because this category of women comprise almost 25% of the population, it is assumed that a significant proportion of the uneducated adults are WCBA. An analysis of data from birth certificates in 1996-1997 showed that 41.7% of women had less than a high
school education, 37.5% had graduated high school and 20.8% had received some college education.

Information on Industry and Occupation is not available specifically for WCBA in the PA. Roughly, 25.4% of the labor force residents 16 and older, in comparison with the citywide rate of 11.3% were unemployed. The major work industries for women in the PA are health care, social assistance, educational services and retail trade. Sales and office occupations, service occupations, and management, professional, and related occupations were the major occupations both for women in the PA and other Chicago women. However, compared to other Chicago women, those in the PA, were more likely to be employed in service occupations, and less likely to be employed in management or professional occupations. The major employment opportunities in these communities were in services such as education, social services, health care, retail sales, and blue-collar type work, with fewer individuals in managerial and professional occupations. The major institutions providing employment were the St. Bernard Hospital (a small community hospital), the Kennedy-King College, built in 1971 as part of the Chicago Community College system, and three public high schools. Unfortunately, many employers and employees did not reside in the area.

**MCH Indicators:** For the PA and the then existing Englewood HSI Program, nearly 99% of clients were African American. In the current HSI program, one prenatal client was white, and one Hispanic. From 1996-1998, there were 5,953 live births in the PA. Of those live births, 1,215 (20.40%) were to women less than 19 years of age. During the same period, 3,807 (63.95%) of births were to women who entered prenatal care during the first trimester of pregnancy, and 388 (6.51%) were to women receiving no prenatal care. Of those women receiving prenatal care in the PA during the three-year period, 3,031 (50.91%) received adequate prenatal care. In the PA in 1998, the infant mortality rate (IMR) for black infants was 19.7/1,000 live births, the neonatal (IMR was 11.2./1,000, and the post-neonatal IMR was 8.6/1,000 per live births. The percentage of low birth weight infants born in 1998 was 16.96% (318 births). This number dropped to 253 in 1999. Table1 provides PA and city MCH related indicators.

**Childhood Immunizations:** In 1998, the CDC and the CDPH immunization program’s joint survey showed that the immunization rates in the PA, especially for measles were very low: 55% of children 19-35 months of age had received 4 DTP (Diphtheria, Tetanus and Pertussis) and one MMR (Measles, Mumps, and Rubella) vaccine. Immunization rates rose 6% from 49% in 1996 to 55% in 1999. In 1999, the measles coverage rate for children in Englewood 19-35 months of age was 65% compared to the national coverage level of 92% for the same year. The CDPH immunization division planned to implement a number of interventions to correct the deficiency. The CDPH Immunization program’s four-year-goal for the PA was to attain 90% compliance with measles for the 4:3:1 coverage.

**Perinatal Health Status:** Current trends in the PA based on 1996-1998 data, demonstrated that the perinatal health status of the project area was below the city overall. For example, the CDPH Vital Records data showed that from 1996-1997 approximately 37% of the women who delivered in the PA did not achieve adequate weight gain during pregnancy. The CDPH Epidemiology Department had conducted a needs assessment to determine the communities in Chicago with the greatest Maternal Child Health (MCH) needs showed that the PA was one of
those needy communities. The percent of low birth weight infants for all births in Chicago had remained relatively stable at about 10.4% during the past eighteen years, while in the PA from 1996-1998 in the PA, the annual average percent of low birth weight births was 16.8%. Englewood HSI women experienced a low rate of birth defects (2.67%). This may have been attributable in part to the high percentage of folic acid prescriptions written at the ENHC. They accounted for an average 79% of all CDPH folic acid prescriptions written in the year 2000.

Additional Health Educators: An expanded examination of the health status of the PA demonstrated that the domestic violence rate against women was 6,449/100,000 compared to the citywide rate of 3,480/100,000. The aggregate AIDS case rate for the PA during the period 1996-1998 was 47/100,000. The death rate due to HIV infection was 18/100,000. Other communicable disease rates such as tuberculosis and syphilis infection were also markedly higher in the PA than in the City as a whole.

Maternal Child Figures for the Englewood Neighborhood Health Center (ENHC) showed that in the year 2000, 241 of the 352 pregnant, postpartum and childbearing women who were identified received smoking cessation intervention for their use of tobacco/nicotine. At the Englewood Women Infant and Children (WIC) site for the same time period, 111 pregnant, postpartum, and childbearing women received the smoking cessation intervention.

Domestic/Family Violence: The City of Chicago’s Domestic Violence Help-line data presented below are reported by zip code, with a close match between the PA and the two zip codes shown in the Table 1. The data covers the time period from January 1999 through June 2000. While nearly 11% of all callers do not report their zip codes, these numbers demonstrate that domestic violence was an issue in the PA. These numbers also only reflected those victims who were willing, and able to reach out for assistance. With these limitations in mind, the Help-line data show that there were 334 callers from the PA, or slightly more than one percent of all households in the PA. In comparison, less than 1% of all households citywide called the DV Help-line for assistance.

<table>
<thead>
<tr>
<th>Table 2</th>
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<tr>
<td>Victim Callers to the Chicago Domestic Violence Help-line, January 1999 - June 2000</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th></th>
<th>Englewood (60621-60636)</th>
<th>Citywide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victim Callers</td>
<td>334</td>
<td>9,197</td>
</tr>
<tr>
<td>Victim Callers with Children</td>
<td>175</td>
<td>4,446</td>
</tr>
<tr>
<td>Number of children 0-5 living with victim callers</td>
<td>200</td>
<td>not available</td>
</tr>
<tr>
<td>Households</td>
<td>28,525</td>
<td>1,020,911</td>
</tr>
</tbody>
</table>

Nearly half of the callers requested assistance with legal aid and counseling. This showed a significant need that was more than emergency shelter or shelter-based. The DV staff interpreted this to mean that many callers (including those with children) did not want to go to a shelter, preferring to stay in their homes, and seek help with removing the batterer. About half of the
callers in those zip codes reported having children. Some gave the children’s ages. Data indicated that at least 200 children aged five years and less PA may have been exposed to domestic violence in their homes. In 2000, the CDPH received a five-year grant from the Department of Justice to launch the Chicago Safe Start (CSS) Project to reduce the impact of exposure to violence on children up to six years of age.

**Child Abuse:** The Illinois Department of Children and Family Services (DCFS) reported that during the fiscal years of 1999-2001 and current through March 9, 2001, 2,638 reports of alleged child abuse/neglect were reported in the PA. Of those reports, DCFS determined that 956 (36%) were founded. (Department of Children and Family Services, Division of Quality Assurance, Reported and Indicated Child victims for Select Zip Codes 2001.)

**Substance Abuse:** This was closely tied to crime in Chicago. In 1999, a sample of persons who were arrested was tested for drugs. Slightly over seventy-four (74.4%) of the 2,219 males and 76.9% of the 540 women who were arrested tested positive for drugs. All women arrested for prostitution, and for selling drugs tested positive for drugs. Cocaine was the most common drug used by those arrested. (National Institute of Justice, 1999 Annual Report of Drug Use Among Adult and Juvenile Arrestees, June 2000.)

Alcohol was the substance most commonly reported as being used by Illinois residents. Fifty percent of women aged 18-24 years reported using alcohol in the past month. Some 5.4% of women described themselves as heavy drinkers (4 or more drinks per day). Twenty-one percent (21.4%) of women aged 18-24 years and twenty-four (23.7%) of women aged 25-34 years had used tobacco in the past month. In the previous month, 8.1% of women aged 18-24 had used an illicit drug. (Illinois Household Survey on Alcohol, Tobacco, and other Drug Use, 1998, Cho Young Ik, and Johnson, Timothy: Survey Research Lab, University of Illinois at Chicago. IDHS: 1998.) The PA accounted for 3.7% of the drug discharges from hospital, the 8th highest in the city. In the whole city, 17% of drug discharges was with a primary diagnosis of substance use was related to pregnancy and birth. (Report of the Drug Use Prevention Project. Roosevelt University, Chicago: 2000.)

**The Perinatal Health Care Delivery System:**

**PA Providers:** Englewood and West Englewood were designated by HRSA as Health Professional Shortage Areas (HPSA) as recently as September 2000. The psychiatrist to population ratio was 1:4800, and in combination with another adjacent community, the area dentist to client ratio was 1:38,050 (Illinois Primary Health Care Association, 2001). In 1998 the area had a physician to population ratio of 1:12,651. While the CDPH and St. Bernard’s Hospital were the primary providers of outpatient and in-patient care, located in the community, there were four other primary health care sites outside of the PA that provided services to the residents. These sites were the New City Health Center, the University of Chicago Medical Center, the Cook County Hospital (managed by the Cook County Bureau of Health Services), the Holy Cross Hospital, and the Friend and Family Health Center. The majority of the PA women delivered babies at the St Bernard’s Hospital, the University of Chicago Medical center, and the Holy Cross Hospital.

**The CDPH Englewood Neighborhood Health Center:** The ENHC, the Chicago Department of Public Health, FQHC look-a-like facility has provided a full range of primary health services to
nearly 17,000 clients annually. In 1999, the ENHC generated 33,692 encounters. The ENHC services include the MCH clinic, pediatrics, family planning, Chicago Family case Management, HIV Counseling and Testing, Head Start exams, infectious disease screening, mammography, lead screening and treatment, Medicaid and KidCare application and assistance with presumptive eligibility for pregnant patients. According to the 1999 data, eighty-one percent (81%) of patients seen at ENHC reported being at or below the poverty level, and 12% reported incomes between 100-200% of poverty. Despite low poverty levels, only 35% of patient services were billed to Medicaid while 57.2% were categorized as self-pay. Women of childbearing age comprised thirty percent (30%) of the client population.

Maternal Patients: Historically, about 8% of the total practice activity at the ENHC has been prenatal patients. In 1999 there were 3,517 maternal visits, a 47% decrease from the 5,861 encounters in 1997. However, in 1999, maternal visits increased 12.4% to 3,517. In January 2000, the CDPH negotiated a cooperative agreement with the St. Bernard Hospital for their midwives to provide care for the maternal patients at the ENHC. The primary advantage to clients was the continuity of care that occurs from being delivered by the individuals who provided their prenatal care.

Family Planning Patients: In 1999, 1,855 women received services at the ENHC’s Family Planning clinic, for a total of 3,001 encounters. From 1997-1999, the average annual encounter total was 4,334. In 1999, (35.4%) of clients were less than 20 years of age, 2.1% less than fifteen years of age. Nearly 80% of all visits were covered by Title X funds. Approximately 18% of visits were billed to Medicaid or Medicaid Temporary Assistance to Needy Families (TANF).

Pediatric Patients: The pediatric patients up to age 0-10 years, represented 27% of the users at ENHC. Adolescents 11-19 years of age represented an additional 19% of ENHC clients, accessing care across all service lines. From 1997-1999, the average annual pediatric client total was 8,300. Fifty percent of children seen at the ENHC were Medicaid eligible, and the others were uninsured. Children who qualified for KidCare were being actively enrolled into that program.

Other Primary Care Providers in Englewood:

New City Health Center: This was formerly a 330 facility providing 50,000 patient visits to the New City, Greater Lawn and Englewood communities, but lost its designation in the late 1990's. The New City Center has been rebuilding its patient base under new management affiliated with physicians from St. Bernard Hospital and the Sinai Hospital. The New City Health Center holds a Chicago Family Case Management contract and serves clients in the PA and in other adjacent communities. Their case load of 550 Medicaid and 180 non-Medicaid, and 4 DCFS was served by a staff of two case managers, one case manager assistant, and one outreach coordinator. The New City had a WIC caseload of 2,500 clients served by two nutritionists and three clerks. The Illinois Department of Human Services (IDHS) evaluation of the WIC and case management programs demonstrated that pregnant women enrolled in either program had better pregnancy outcomes than those who were not in either program. The best results were achieved among clients who were enrolled in both programs. Their goal was to integrate services so that all eligible clients received both services. New City Program had achieved ninety-five percent (95%) integration in their WIC and ninety-seven percent (97%) integration in their case
management program. The New City Health Center is located outside of the PA.

The *Cook County Bureau of Health Services* had a small family practice at the ENHC that was used as a training site for the Family Practice residency program. Initially, only adult services were provided. In December 2000, the County relocated services to its new facility: the Cook County/Englewood Health Center (CCEHC), and expanded to include MCH services. The number of pediatric and maternal patients had increased as the community has become more aware of the services. Because they were unable to obtain permission from the State to open a site, their clients received WIC services from the ENHC and other WIC sites in the area. The County had representatives on the Englewood District Health Council (EDHC), one of the five regional Health Councils formed by the Bureau of Cook County Health Services and the CDPH.

*Private Physicians:* It was difficult to estimate the capacity of the private physician community. The CDPH’s Immunization Program suggested that there were at least twenty-four pediatric practices in the area. It was not clear how full time these practitioners were, or the size of their practices. From work underway with several prenatal providers in the Weight Gain in Pregnancy initiative, the applicant knew of several obstetricians and family practitioners in the PA who were affiliated with the St. Bernard Hospital.

*St Basil's Free People's Health Clinic* was a small community based free clinic holding a special niche PA. Its Director was the Co-Director of the Englewood District Health Council, one of the Consortium co-founding organizations.

*St. Bernard Hospital and Medical Center* is a Catholic, not-for-profit, general service hospital located in the PA. More women in the PA deliver at St. Bernard’s than at any other single hospital. The CDPH’s Greater Englewood Healthy Start Initiative (GEHSI) was located at the St Bernard’s Hospital, but relocated from there to the ENHC in March 2002.

*The Holy Cross Hospital:* is a Church affiliated not-for-profit Hospital slightly West of the PA. In 1999, the hospital had 1,339 deliveries, resulting in 1,337 live births. Five percent (689) of hospital admissions were pediatric clients aged 0-18 years. Of these, 260 (37.7%), were Medicaid, 417 (60.5%) were self-pay. The remaining 12 (1.74%) were covered by insurance.

*Friend Family Health Center, Inc. (FFHC),* is a 330 not-for-profit corporation affiliated with the University of Chicago Medical Center and the Cook County Bureau of Health Services. FFHC received the federal funding that had previously been awarded to the New City Health Center. FFHC provided care (including WIC services) for family planning, pediatric, and low-risk pregnant women. Medicaid and self-pay is the predominant payer classification. The FFHC received Title V funds from the CDPH to provide primary care to clients who had no other payment source. During the FY 1999-2000, 31,960 pediatric clients were serviced. In Calendar year 2000, 648 prenatal clients received services.

*Hospital Based Level I-III Care and Liaisons:* PA delivery patterns by hospital suggested both a high concentration at St. Bernard's hospital, a larger proportion of women from West Englewood deliver at Holy Cross Hospital, and a wide distribution of live births in a city with numerous hospital choices for women, except for those who are unemployed. Using
appointments or walk-ins, St Bernard’s Hospital delivered 25% of all live births for the PA. This was followed by the UCMC with (17%); Holy Cross with (12.25%), Humana Michael Reese Hospital and Medical Center (8%), and Holy Cross Hospital, Little Company of Mary with 4% each. Michael Reese and UCMC, both tertiary hospitals, have been traditionally used by CDPH for high-risk referrals from the south side. The number of deliveries by PA women at Holy Cross Hospital indicated the presence of Holy Cross physicians in the PA. Combined, these four hospitals performed approximately 66% deliveries in the PA, with the other 34% are distributed among 30 other hospitals scattered throughout Chicago land.

The CDPH had primary referral relationships with St. Bernard’s, UCMC and Michael Reese for women seen at ENHC who are in need of planned deliveries. The hospital linkages are part of the city’s longstanding Partnership-in-Health agreements by which hospitals sign agreements to accept maternal, pediatric and other patient referrals from the city clinics and health centers. Two CDPH Public Health Nurses (PHNs) performed liaison functions at the UCMC, St. Bernard’s, and the Jackson Park Hospitals, responding to requests for antenatal follow-up especially for infants with adverse outcomes before they were formally picked up through the Adverse Pregnancy Outcome Reporting System (APORS), a state reporting data base which then ensures an assignment to local health departments for follow-up. This additional coverage allowed for more timely referrals and follow-up for high-risk mothers and infants.

**Perinatal Networks:** The perinatal centers provide antenatal, neonatal and postnatal services for low and high risk clients; physician and nurse consulting services for high-risk clients; maternal, fetal and neonatal transport via ambulance and helicopter; physician and nurse education; and morbidity and mortality reviews. The perinatal centers monitor the quality of perinatal care in their system through combining morbidity and mortality reviews and data surveillance systems, examining both utilization patterns and client outcomes. The perinatal networks act as resources and provide technical support to the community.

The University of Chicago Medical Center, the closest Perinatal Network included more than 12 hospitals, but only three of them were located on the South side. The University of Chicago Perinatal Center was involved with the Greater Englewood Healthy Start Initiative Start through the Fetal Infant Mortality Review (FIMR) process and the intensive follow-up of substance exposed infants admitted to the HealthyFIT program. The FIMR program was discontinued following the loss of the Healthy Start funds. The HealthyFit program admitted ten (10) women over the two-year period. Services were discontinued as not being cost effective because most of the eligible clients discharged from the hospital were not from the PA.

**Child Health and other Child Care Services:** The La Rabida Children’s Hospital and Research Center is a teaching institution academically affiliated with the Department of Pediatrics of the University of Chicago Pritzker School of Medicine. Staff cares for children with chronic illnesses and victims of child abuse. The Hospital’s developmental pediatrics includes specialization in infant development, and services for children with Down’s Syndrome, failure-to-thrive, sickle cell disease, developmental disabilities, cerebral palsy, and those requiring early intervention for various reasons. Eighty-five percent of their services in 1995 were covered by public insurance. Three Healthy Start infants were receiving services at this hospital.
The UCMC’s facilities included a clinical laboratory and radiology area and a modern pediatric emergency department adjacent to, but separate from, the adult emergency department. A 54 bassinet Neonatal Intensive Care Unit, directly adjacent to the delivery suite in Chicago Lying-in Hospital, has enhanced facilities and life support systems for premature and critically ill infants, including ECMO (extracorporeal membrane oxygenation). The buildings were directly connected to The University of Chicago Children's Hospital, permitting cooperative work between pediatricians, obstetricians, surgeons, and emergency medicine physicians. The University of Chicago Children's Hospital has a teaching affiliation with La Rabida Children's Hospital and Research Center.

**Case Management:** Illinois has used some Title 19 and Title V funding to weave together a basic case management program (Family Case Management) for pregnant women and infants through the age of one year. The program targets families insured by Medicaid or income eligible up to 185% FPL. Pregnant women are eligible up to 200% of poverty. The goals of the Chicago Family Case Management (CFCM) Program are to: ensure that families have access to and receive medical care, especially well child visits, immunization and prenatal care; increase compliance with recommended prenatal care, and decrease infant mortality rates. The CFCM program supports individual and family acceptance self-responsibility for lifestyle choices and promotion of the family’s health. Staff of the CFCM program provides assessment, home visiting, monitoring and follow-up guidance, counseling, physical assessment of infants including Denver Developmental Testing, and the development of individual care plans and referrals as needed. Referrals are stimulated as by assignment from the State of eligible families in the catchment area of agencies receiving CFCM contracts. Most contractors are local health departments, FQHCs and other agencies that perform specialized case management services, e.g., a substance abuse agency or community-based social service agency.

The CDPH is a primary contractor under the CFCM program. The CDPH is unique in Chicago because it uses public health nurses as case managers, and staff with either community experience or some college as case manager assistants. The model has been integrated with the CDPH public health nursing division. Unlike other agencies in the city, the CDPH has the capacity to provide thorough nursing assessments, including developmental assessments of children. Caseloads were large at approximately 155 active cases per PHN throughout the statewide system. The CDPH had two locations for the CFCM program in or close to the PA. The CDPH public health nursing staff managed high-risk patients in the PA., and responded to other health care needs including children with high lead levels, genetic screening, follow-up for abnormal mammograms, and persons with a diagnosis of tuberculosis. PHNs also managed substance-exposed infants referred by the Department of Children and Family Services (DCFS). In calendar year 2000, case managers and PHNs provided services to 7,464 duplicated clients. The Healthy Start case management staff and outreach staff provided services to 870 families. The CDPH had achieved 84% integration of WIC and 94% integration in the case management program.

**The Adverse Pregnancy Outcome Reporting System (APORS)** was initially created by the Illinois Department of Public Health (IDPH) to collect data on adverse outcomes on pregnancy, and track children in need of special services to provide services and correct or prevent health problems and handicapping conditions. The APORS requirements mandate that all hospitals
report adverse events to the local health department for in-home follow-up visitation by Public Health Nurses. These visits occur for up to two years. PHNs assess the child and family for contributing factors such as lead poisoning, adequate housing, and domestic violence. In year 2000, CDPH received more than 5,000 infant and nearly 2,500 maternal high-risk referrals. Of the nearly 7,500 referrals received, 237 PA infants and 96 PA mothers were reported from 20 Chicago area hospitals. The leading causes of infant referrals were prematurity and respiratory distress syndrome. The most frequently used diagnoses for maternal referrals for the PA were pre-term labor, asthma, and gonorrhea.

Access and Enabling Services: The Dan Ryan expressway forms the eastern boundary of the PA, increasing the challenge of accessing services from the UCMC. For the most part, Englewood services are clustered in the community area west of the expressway and linked by major subways and bus routes. Public transportation routes are adequate on the main arteries, although service is much slower between the morning and evening rush hour periods. Public transportation is limited or absent on the smaller streets. The GEHSI often issued trip Chicago Transit Authority “Pass Cards” to enable clients to honor their Healthy Start appointments. In 2000, approximately 95% of Englewood Healthy Start Clients had requested such assistance. Other PA agencies who provided transportation included the department of Transportation, Catholic Charities, Haymarket, Tessler and Arts of Living Programs for pregnant and parenting teens, Community Mental Health Council, Safer Foundation, and MS Ford, a concerned Englewood citizen whose services were free to those who needed them.

Child Care: The GEHSI clients used services that were available at one of eight sites, including the Children’s Home and Aide Society, Catholic Charities, Day Care Action Council and Maria Garden Head Start. Services were insufficient to meet the needs of all children in the PA. The Chicago Public Schools (CPS) planned to open an Infant Toddler Center at the Englewood High School to serve the needs of high school parents and their children. Another church in the PA had planned to open a day care center.

II. Project Implementation

Outreach and Client Recruitment

A. Prior to the receipt of funding through the Healthy Start Program, the Chicago Department of Public Health had successfully implemented two outreach programs in communities with similar poor perinatal outcomes. Based on the CDPH experience, the women with the poorest birth outcomes were those who were unknown to any system; were likely to enroll for prenatal care late; or just arrive for delivery with no prenatal care. Similarly, these women frequently did not take their children for immunization. Many women had multiple social issues that contributed to their inability to seek health care. The CDPH selected and trained outreach workers from that community, and placed them under the guidance of a Public Health Nurse to try to correct this situation. One community, located in a Chicago Housing Development, was sufficiently compact to comprise a census tract. The CDPH epidemiologist analyzed the birth outcome data for that tract, and compared it with data for the surrounding community. On all counts (infant mortality, low birth weight, prematurity etc.) this population did better than its neighbors. Since then, the CDPH has been using a combination of nurses and outreach workers to provide services to the hard to reach clients in the community.
B. The Outreach staff consisted of three full-time Public Health Aides (PHAs), one full-time Public Health Nurse II Coordinator, and one full-time Male Responsibility Coordinator. The Male Responsibility Coordinator supervised the five part-time peer educators. The outreach workers used street outreach, door-to-door recruitment, visits to churches, laundromats, and other places where women assembled to identify women who were pregnant and not receiving prenatal care, and infants and children in need of immunizations and other healthcare services. Outreach activities also included marketing the program to other agencies and community residents and recruiting members to participate in the Consortium. Initially, the outreach workers had their own caseload of low risk clients. This was changed to an exclusive focus on recruitment when the caseload declined. Currently the outreach workers manage their own caseload of low-risk clients, and recruit clients for the program. The Outreach workers receive guidance from the Public Health Nurse (Outreach Coordinator).

The Male Peer education program was already in effect when the Healthy Start Program was initiated. This program provided training to male adolescents, who, following a period of education, shared health related information to their peers and the community residents. The Healthy Start funds allowed the program to provide outreach to target the male partners of the pregnant women to assist them in improving their roles in the family and in the lives of their children. Services provided to men included assisting them to receive health and social services; getting previous criminal record expunged, and preparing themselves for employment.

C. Resources: The proposed budget for the Outreach and Client Recruitment was $1,016,989 to be divided into personnel costs of $920,929 for one public health nurse, three outreach workers, and one staff assistant with approximately five stable peer educators per school year for the male program. The projected non-personnel costs were $96,060. The high-risk status of clients, and the need to provide additional assistance for women who were screened for perinatal depression highlighted the need to add staff with the expertise to handle this. The Social Worker and Public Health Nurse supervisor were therefore added to the Program in 2002 and 2003 respectively. They each worked fifty per cent of their time in Outreach and 50% in Case Management. Their average annual salaries were $54,096 and $54,373 respectively. Both were paid from the MCH Block Grant. The allocation for non-personnel items was gradually reduced towards the end of the project period as salary increases for staff impacted the program.

Case Management

A The CDPH has been providing Case Management services through the State-funded Chicago Family case Management (CFCM) Program since 1991. Over the years, the CFCM Program became loosely integrated with the Supplemental Nutrition Program for women, Infants, and Children (WIC), both of which are managed by the State. The CDPH has successfully used case management teams of nurses (Case Managers) and case manager assistants (non-nurses with some health or social service background) to provide the case management service. The HS Program followed this model, but assigned fewer cases to staff.
B. The Case Management staff consisted of: one full-time Case Managers/Public Health Nurse, two full-time Case Manager Assistants (CMA) and one Social Worker who spent 50% of his time with the Outreach Program. CMs are Baccalaureate prepared nurses. Staff changes during the Project Period included the addition of a Public Health Nurse Supervisor, and the Social Worker. The Case Management Core service activities included enrolling new women into prenatal care, screening and referring them for treatment for perinatal depression, and providing postpartum and interconceptional services. Services for infants included a focus on assisting parents/guardians to obtain EPSDT and immunization services for infants and two-year-old children. The case managers (CMs, case manager assistants (CMAs), and Social Worker made home visits to pregnant women and to women, infants, and children during the interconceptional period. They used the IL Department of Public Health’s Cornerstone System Adult and Child Assessment forms to collect information in the home. The CMs screened the woman for perinatal depression using the Edinburgh Depression Screening Tool. Staff analyzed and used the information to develop a plan of care with the family, and provided appropriate health education, counseling or guidance in the home or referred the client to an agency where the services were available. The Social Worker (SW) made home visits at the request of the CMs to assess clients and to provide services outside of the CMs’ professional capability. The SW also accompanied the CM team on home visits as needed, assessed and counseled clients, and linked those who need treatment, especially for depression, with services. The SW also provided technical assistance and education for staff, clients and community on psychosocial issues, especially with reference to perinatal depression.

C. Resources: The proposed budget for this core service was $1,013,823 to be divided into personnel costs of $955,263 for one public health nurse, two case manager assistants, one data entry operator, and one outreach worker. The high-risk status of clients, and the need to provide additional assistance for women who were screened for perinatal depression highlighted the need to add staff with the expertise to handle this. The Social Worker and Public Health Nurse supervisor were therefore added to the Program in 2002 and 2003 respectively. They each worked fifty per cent of their time in Outreach and 50% in Case Management. Their average annual salaries were $54,096 and $54,373 respectively. Both were paid from the MCH Block Grant. The non-personnel costs were $58,560. The allocation for non-personnel items was gradually reduced towards the end of the project period as salary increases for staff impacted the program.

Health Education and Training
A. Although a number of CDPH Programs had successfully conducted formal and informal health education programs for clients and professionals in this community, the weight of evidence suggested that professionals and clients alike preferred the “personal touch”. For example, during the launching of the Englewood Weight Gain in Pregnancy Initiative, staff provided most of the information to physicians and their staff and clients in the physicians’ offices. PHN staff had always provided health education to families in their homes. Nevertheless, it was decided to try to reach as many persons as possible using collaborations with other community partners. Staff and the Consortium members
benefited most from the sustained educational efforts, whereas the community profited from health and resource fairs.

B. The Health Education core services activities consisted of developing a schedule of topics that were shared with GEHSI staff, program and community participants, providers, and the Consortium members. The HE staff worked closely with the CM and Outreach teams to provide the scheduled, formal education to increase the knowledge capacity of program participants. Most presentations were in the lecture/discussion format supplemented by audio-visuals. Speakers provided program participants with handouts of presentations supplemented by other materials. Linkage agreements were developed with community providers to facilitate the referral of GEHSI program participants for services as needed. HE staff also coordinated activities with CDPH specialized programs; the Consortium; local, state, federal and similar agencies to provide education to program participants. During the Project Period, resource persons provided information subjects such as: the importance of early entrance into prenatal care; community resources; family planning; stress management; postpartum depression; STD/HIV prevention; well baby care; immunizations; dental care for children; the adverse effects of drugs/alcohol and tobacco on overall health; substance abuse prevention; the need for grief counseling and social support systems; the importance of providing a good reproductive history to medical providers for current and future pregnancies, and the prevention of SIDS and premature births. The GEHSI staff planned and implemented several Health and Resource Fairs. These health fairs included educational workshops on topics such as housing, employment, male health services, family planning and immunizations for program and community participants. Consortium providers contributed in-kind donations such as speakers, resource materials and incentives. Even when transportation and other incentives were provided, the program continued to experience challenges in maintaining client participation at workshops and health fairs. Most preferred instead to accept health information from the staff who visited them in their homes. Between 2001 and 2003, the Public Health Nutritionist and the Public Health Aide conducted most of the Health Education activities. The Program’s ability to hire a qualified health educator was delayed, so a contract was offered to Comprehensive Quality Care Incorporated, Inc to provide health education training for staff and clients. In Feb. 2003, a health educator joined the program, but then transferred to the CDPH Mental Health Program in September 2003. The current Health Educator joined the HS program in December 2004.

C. Resources: The proposed budget for this core service was $815,626 to be divided into personnel costs of $661,496 for two outreach workers, one nutritionist, and one health educator. The non-personnel costs were $154,130. One outreach worker (July 2002) and the nutritionist (December 2003) transferred to another program within CDPH

Interconceptional Care

A. The CDPH Public Health Nurses and WIC staff has always included elements of Interconceptional Care in their approach to clients. This has included encouraging women to return for family planning services, and to take advantage of educational and other opportunities to improve their welfare. Nevertheless, even in the APORS program
when children were required to be visited for up to two years of age, the emphasis was mostly on the needs of the child, with less focus on the mother. This was despite evidence from CDPH statistical data that showed that the women who were most likely to have adverse birth outcomes had health and social problem, that if corrected during the interconceptional period, might have led to a more positive outcome. The HS requirement enabled the Program to initiate a more structured approach to provide this service.

B. The CMs, the CMA, the Outreach Coordinator, the PHAs, the Social Worker, the Health Educator and the Male Program Coordinator provided the service. During the Interconceptional period, staff provided assessments, education, counseling, health and social service referrals, and care coordination to ensure that participants: had a medical home, followed-up with their 6-8 week post-partum check-up, and received family planning and other needed services. Because most IC program participants were in the program during the prenatal period, the IC review focused on: the women’s return to normal physiological and emotional functioning following the effects of delivery, adaptation to the parental role, and their decision-making skills in setting goals for their future. After the first postpartum examination, the HS staff made contact with the IC program participant at least 15 times during the two-year period. Over the Project Period, the staff gradually became more inclusive in their approach to the whole family and placed more emphasis on helping the mother to identify and achieve her personal goals.

C. Resources: The Interconceptional care Core service was not listed separately in the proposed budget. The CM staff was responsible for providing this service. The implementation was facilitated by the State’s expansion of KidCare to cover families, and its receipt of a family planning waiver that allowed Medicaid funds to cover services for women up to five years after having a baby.

**Depression Screening and Referral**

A The University of Illinois at Chicago evaluators provided the GEHSI with a final report of findings obtained during the budget year 2001 that highlighted the urgency to begin screening women for perinatal depression. The evaluators used a standardized depression scale (CES-D) and interviewed 174 prenatal women in the PA for symptoms of depression. Fifty-four percent (n=83) of the women were depressed. Furthermore, depression was significantly associated with physical abuse or violence (p<.001). CDPH invited experts to conduct a seminar on perinatal depression for nursing and PHA staff (including the GEHSI staff). The Title V agency (also a Healthy Start Grantee) included the GEHSI staff in its training on the use of the Edinburgh Depression Screening Tool. In January 2002, the staff began to screen and refer women for treatment if they showed evidence of perinatal depression.

B The CMs, CMA and the Social Worker used the Edinburgh Screening tool to assess women for perinatal and postpartum depression upon enrollment into the program. Before the women were screened, the CM staff explained the tool and assessed the woman’s level of understanding and her ability to read the test. When clients screened
positively for depression, the CMs referred them to the HS Social Worker for evaluation. If the Social Worker determined that further action was needed, he counseled the client or referred her to the primary care physician or a mental health specialist for care. The Social Worker and the CMs tracked the status and the outcomes of referrals that were made to the mental health providers to ensure that the clients followed through, and to receive information on the plan of care and the outcome. The Social Worker or the CMs made home visits and monitored the clients to ensure compliance with the treatment plan. If the woman did not follow through with the mental health treatment the Social Worker and/or the CMs visited the home or contacted the client by phone to identify barriers that may have prevented her from keeping the appointment.

The HS Program collaborated with several state and local programs that were focusing on the issue of perinatal depression. The HS staff participated in training sessions offered by experts from University of Illinois at Chicago. They utilized this information to educate program and community participants and consortium members about signs and symptoms of perinatal depression during scheduled workshops, meetings, health fairs and group activities. CM staff also continued to investigate the referral network where women who are experiencing depression could receive services.

C. Resources: The Perinatal Depression Screening Core Service was not listed separately in the proposed budget. The CM staff was responsible for providing this service. Because this was a new requirement for agencies, everyone (especially the State) collaborated to ensure that staff was adequately trained for the task. Everyone also shared known resources for treatment.

Core Service Building Efforts
Local Health System Action Plan (LHSAP)

A. Because of its integration within the CDPH, the Healthy Start Program did not develop its own Local Health Systems Action Plan, choosing instead to await the result of the revised program developed by the CDPH. Several years previously the CDPH, the Grantee, had developed a LHSAP. That plan had identified the need to reduce infant mortality and morbidity, and had included other MCH activities that would become the focus of the Healthy Start Program. The Englewood Neighborhood Health Council had also identified infant mortality, mental health, substance abuse and violence as areas requiring focus. The CDPH lead and immunization programs also gave the prevention of lead poisoning and the increasing of immunization high priority. In some ways this dependency of the CDPH process became a barrier for the HS Program.

B. During the Project Period, the Healthy Start staff collaborated with several agencies that were working on different activities to address the health care needs of the population. Most significantly, during the period October 2002 through September 2004, the Healthy Start Program collaborated with the planning, implementation and evaluation of the Healthy Communities Access Program (HCAP) that was funded by the Bureau of Primary Health Care. This project facilitated the expansion of insurance coverage uninsured and underinsured residents across Chicago’s diverse communities;
strengthened the partnership relationships between the various providers of family case management services in Chicago, and trained CDPH, HS, and other community agency case management on Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, and the more effective use of the Cornerstone System. More recently, the staff has been collaborating with the State in its implementation of the Closing the Gap Initiative (funded by HRSA) that is focused on the need to reduce premature births and SIDS as factors contributing to infant morbidity and mortality. Senior HS staff are also working with the multiple agencies comprising Teamwork Englewood, a collaborative that believes that there is a need to improve client access to a full range of mental and physical health services to address high infant mortality rates, teen pregnancy, drug and alcohol addictions, and health issues such as diabetes, heart disease and cancer. Since the original CDPH LHSAP was developed, the overall infant mortality rate in Chicago has decreased to the current rate of 8.6/1000 live births in 2002. However, the rate in the infant mortality rate in the PA remained at 17.2/1000 live births during the period 1999-2001.

C Resources: No specific HS monetary resources were budgeted for the LHSAP. The HCAP received funds from the Bureau of Primary Health Care to implement a citywide program. These funds paid for education of staff, for the marketing campaign to promote Family Case Management Services in the Community, and for increasing health insurance to the needy. The Healthy Start made in-kind contributions of staff time to the HCAP, Closing the Gap and Teamwork Englewood’s activities.

Consortium

A The Chicago Department of Public Health (CDPH) had an excellent history working with communities to develop and implement health improvement initiatives and leading community-wide planning processes in such areas as maternal and child health, violence prevention, HIV/AIDS prevention and treatment, substance abuse prevention and treatment, and Dental Care for the Under-served. The CDPH provided services in the PA at the ENHC. This Facility had an established volunteer board of providers and consumers who met monthly with staff to receive reports and to provide input into the running of the ENHC. They had already identified MCH issues that needed to be addressed in the community and were interested in the possibility of funds for the community. It seemed logical to ask for members to form the initial core of the Consortium. Our ultimate goal, however, was to increase the membership of consumers in the consortium.

B The Consortium assisted with the planning, implementation, and evaluation of the Healthy Start Program. The Consortium revised the bylaws and reestablished the evaluation and membership committees. The chair of the consortium attended the National Healthy Start meetings, and shared information with the consortium and Executive Committee members. Consortium agency providers shared information about their services and assisted program participants in accessing these services. The consortium met monthly to discuss collaboration and ways to maximize and monitor resources and offer input on the implementation of the program. The Consortium took an active role in assisting in the distribution of health education materials to women of childbearing, particularly those
who met the criteria of high-risk pregnant women. The consortium assisted the HS staff in the planning and implementation of the “Side Walk Sale of Resources” Health Fair that also included providers from Housing, Employment and Recruitment. Consortium participants assisted in managing the informational table for GEHSI and provided direction to the providers who were either speakers or had a resource table. The Consortium participated in the workgroups for Closing the Gap Initiative. They provided input to the campaign posters and slogans that are used on the billboards and buses.

C Resources: The proposed budget for this core service was $107,528 to be divided into personnel costs of $77,828 for 50% of the Administrator Assistant to provide support and assistance to the consortium. Non-personnel costs were $29,700, and included travel, healthy snacks for meetings, and occasional incentives for consumers. Agencies such as the March of Dimes and SIDS of Illinois often provided cloths or other items that could be used as prizes for consumers.

D Additional Elements
1) The Greater Englewood Health Start Consortium evolved out of a meeting sponsored by the Grantee agency and attended by concerned community members, representatives, of social service agencies, hospitals, health clinics, businesses, block clubs, clergy and consumers. Several of the members were already serving on the Englewood Neighborhood Health Center Facility and the District Health Council, and were therefore familiar with the activities and services provided by CDPH. They had a vested interest in improving the health care available to the residents in the community. Prior to the funding of the HS Program, these groups had conducted community needs assessments and had identified multiple health and social problems that affected the community’s MCH population, but lacked the funds to affect change. They were therefore a logical group to form the core of the Consortium.

At first, defining a process for sharing advisory responsibilities and maximizing services created a barrier. The CDPH’s ENHC provided many of the services that clients needed, and some providers though they would lose clients if they referred them to the HS program. Staff was able to demonstrate how agencies and clients would benefit from building partnerships. Agencies ultimately developed agreements among themselves and with the HS program to have a mutual referral system based on client needs. The other barrier was to keep consortium members, especially consumers engaged. The program responded by providing transportation for consumers, and by adjusting hours to meet their needs. Finally, barriers to obtaining input for programs content, evaluation, case finding methodologies and consumer activities were partially overcome by sending materials to members prior to meetings, and using some meeting time to conduct “focus groups”, or to promote the discussion of objectives.

2) The GEHSI Consortium officers consisted of a chairperson (provider) and secretary (consumer and HS staff) during most of the program implementation. Within the last year, the consortium has been co-chaired by a program participant and a community resident. Evaluation, Membership, and Public Information committees were established. The Evaluation Committee was the most effective in that, along with other consortium
members, it reviewed continuation applications, and gave input into the grant application for 2005-2009. The diverse membership was predominantly African-American and reflected the population affected by the maternal and child health concerns in the PA. The GEHSI Consortium was 98% African American and 2% Caucasian. The GEHSI ensured that the membership of the Consortium was culturally representative of both providers and consumers by urging the current members to recommend and recruit others to serve on the Consortium. The Consortium currently has 35 members, consisting of 8 men and 27 women. Agencies represented on the Consortium include LaRabida, St. Bernard’s and John Stroger (formerly Cook County) Hospitals, Cook County Community Health, Planned Parenthood, March of Dimes, Rebirth of Englewood, Teamwork Englewood, SIDS of Illinois, Child Serv, and Little Feats. Male and female community residents are from various block clubs, the library, and the alderman’s office. Of the 35 members, 15 (42.9%) are program participants, 3 (8.6%) are community participants, and 17 (48.6%) are community-based health and social service providers and representatives from political and private organizations. One major change in the Consortium has been a higher ratio of consumers to providers.

3) Staff conducted formal and informal evaluations many times during initiative meetings to determine the ongoing needs of the Healthy Start Program. The consortium members participated in individual interviews, surveys, and focus groups. The consortium members voiced interest in becoming actively involved in recruiting clients for the program and for the Consortium. The Consortium meetings were essentially a forum where community agencies could meet each other and consumers to provide information on available resources, to receive or provide training on factors influencing the health and social conditions in the community, to discuss ways to improve the health needs in the community, and to provide community input into the implementation of the program.

4) Community Strengths: A multiplicity of churches and other organizations that have provided services to the residents for many years served to enhance consortium development. In many cases, the providers were also familiar with each other and the CDPH activities in the community. Government agencies and private foundations have also increased funding for programs and/or have introduced new initiatives to the community residents. Many workers have held their jobs for a long time, and are presumed to have an invested interest in helping uplift the residents.

5) Community Barriers. The Greater Englewood Community has been impacted by the gentrification of the project area. Clients and some staff have emigrated from the communities. This attrition of members affected the “institutional memory” of the Consortium and decreased its effectiveness. To address this issue, GEHSI requested that the agency rather than the individual be the Consortium member. Some consumers with school-aged children had difficulty attending the meetings or staying for entire meetings because of the need to be at home when the children arrived from school. The Consortium alternated monthly meetings from afternoons to the mornings to accommodate the need of those clients who wanted to attend the meetings. Staff provided consumers with bus passes, or used a CDPH van to transport consumers to meetings. HS staff also attended meetings to support the program participants.
6) In order to increase resident and consumer participation in the Consortium the GEHSI:
a) Provided transportation (CDPH van and bus passes) and modified the timing of
meetings to promote consumer attendance at the meetings; b) Welcomed children to the
meetings with their parents where they were provided with structured activities that
included arts and crafts and story reading; c) Provided training to help consumers to
understand the objectives of the GEHSI program; d) Allowed choice in programming by
asking consumers to make recommendations for subjects of interest to be discussed in the
meetings; e) Encouraged consumers to assume active leadership roles. During the
reporting period, consumers took on the role as co-chair and secretary. Currently, one co-
chair is a consumer and the other co-chair is a community resident; f) Provided Health
Education activities free of charge to promote community ownership of the problems and
solutions to poor infant and maternal health outcomes. The consortium worked with the
GEHSI staff to organize health fairs within the community. Finally, the consumers
helped to organize meetings by mailing flyers, and providing suggestions for speakers and
educational sessions.

7) Staff made it clear to consumers that their opinions were valid. Some meetings were
used as forums to solicit input from the consumers. Special attempts were made to
explain the nature of the Healthy Start Program, including the role of the MCH Bureau.
Consumers were given copies of the objectives for the Grant Proposal, and received
assistance in understanding them. An external evaluator analyzed the activities of the
consortium on two separate occasions. A summary of the most recent report is in
Attachment C. Five (5) consortium members participated in the focus group. They
credited the program with providing comprehensive health and social service for the
consumers. They said the program was doing well in helping consumers not only with
health care but also with other services such as employment, education and housing.

8) The consumers and the providers revised the bylaws and reestablished the various
committees. The consumers recommended the topics that were most important to them,
and many of these formed the basis for education and resources that were provided in the
meetings. They also organized speakers to address Housing, Child Support, SIDS, and
Domestic Violence.

Collaboration and Coordination with State Title V and Other Agencies

A. The Grantee Organization, the CDPH, has a long and successful history of collaboration
with local, and statewide public and private organizations. The State has entrusted the
CDPH to manage selected funds for the MCH Block Grant, the WIC and Immunization
Programs. Similarly, the CDPH subcontracts Ryan White Federal and Community
Development Block Grant Funds and supervises the agencies administering these funds.
The CDPH is the Title V agency for the City and collaborates with the State Title V
agency (IDHS) and other perinatal advisory groups on a variety of maternal and child
health issues. It assists the state in MCH planning activities, and contributes information
for and reviews the State’s application to the Maternal and Child Health Bureau for Title
V Block Grant funds. The CDPH is committed to assist the State in achieving the
required Federal and the negotiated performance measures such as: increase the
proportion of live births to women who receive adequate prenatal care as measured by the Kessner Index; births occurring following a short inter partum interval, and increase the number of families who receive genetic testing, counseling and follow-up services. The CDPH assists the State with the successful achievement of these measures through providing direct health care and enabling, population based, and infrastructure services. The CDPH and IDHS management staff meet approximately every two months to discuss and resolve MCH issues of mutual concern.

B. The HS maintained its role with the state through the activities of the CDPH. In addition, the GEHSI joined the IL HS Partnership. These programs have been administering the Family, High Risk infant and Targeted Intensive Case Management Programs Case Management jointly with the State's Title V Maternal and Child Health Program. The HS program used the state's Information Systems to input and to obtain data. For example, the HS program used data from the state's "Cornerstone" database to obtain an annual statewide portrait of psychosocial issues affecting pregnant women and services levels afforded through case management. Finally, the state's HS grantees also use the Tracking Our Toddlers' Shots (TOTS) system that provides an immunization registry to facilitate timely childhood immunization.

The GEHSI also continued to collaborate with agencies in and outside the PA to obtain services and make referrals for clients as needed. Some agencies provided health promotion, social services, and mental health, substance abuse and violence prevention counseling at the ENHC. HS clients who required services beyond those available at ENHC were linked with other CDPH and IDHS-funded providers located in and outside of the PA.

C. Resources: GEHSI collaborated with more than 25 agencies to provide services and referrals for HS clients. The HS consortium assisted in identifying agencies that should be at the consortium table. These agencies also participated in the health fairs during the project period. Many of the agencies provided in-kind donations by presenting at workshops for the HS staff, Consortium, program and community residents.

Sustainability
A. The CDPH has maintained ongoing relationships with multiple agencies including the State Title V MCH, Title X, Title XXI and Early Head Start. The CDPH receives Title V funds to provide case management and public health nursing services in the community, and Early Head Start Funds to provide a home based instruction program for pre-school youngsters and to conduct vision and hearing tests on three to five year-old children. The CDPH has a Title X grant to provide family planning services, and has hired staff with the exclusive function of enrolling clients in the State KidCare (Title XXI) program. Because of its success in implementing outreach and case management programs using its own staff, the CDPH decided to use the HS funds for staff salaries and not for primary care services. The GEHSI’s activities are integral to other CDPH revenue-generating functions, but the Initiative does not have access to spending its own funds. However, those collected in a general pool can be used to help sustain the HS Program.
B. The Federal HS funds were used for staff salaries and not for primary health services received by the clients. The social worker and the Public Health Nurse Supervisor positions were funded with MCH Title V funds. Currently in Illinois, physical assessments performed on pregnant women and Denver Developmental Screens and physical assessments performed on infants in the home by nurses are billable to Medicaid, so this form of revenue was solicited. All program participants were entered into the State’s Cornerstone System, and allowed the GEHSI to generate funds for these clients. The CDPH received $26.25 per month per client. Beginning December 2004, the Illinois Department of Public Aid also began to reimburse professionals approximately $15 to screen women for perinatal depression using the Edinburgh Screening Tool.
C. Resources: The HS Clients received primary health care services that were provided by CDPH and other clinics and physician’s offices. For the most part they were paid for by Title V, Title X and Title XXI funds. The HS Program referred clients to the CDPH ENHC. This helped to enhance CDPH (and indirectly) the HS Program revenue.

E. Additional Elements

1) Program staff used available avenues to leverage resources for the clients. (See section B). Clients were referred for primary health care services at the CDPH and other clinics and in physician’s offices. Staff completed assessments in the home and CDPH billed Medicaid for these services. Staff entered clients into the Cornerstone system where they were able to obtain a monthly stipend for the case management service. Finally, staff assisted clients to enroll for KidCare so that they would receive insurance for their children.

2) All of the delivery sites within or close to the PA are either Federally Qualified Health Centers (FQHCs) or public health department clinics. This structure has provided a set of agency and voluntary advocacy association contacts for the Partnership that is critical for program sustainability. Either in collaboration with others, or independently, the CDPH has been successful in obtaining grant funds to maintain programs. The presence of obstetrics and gynecology resources for high-risk women in underserved areas has resulted in sustainable provider practices, which can be enhanced by Healthy Start enabling services. CDPH anticipates that funders that support these health centers and clinics view the collaboration with Healthy Start as a key model for building programs for the underserved given limited funds for primary health care and enabling services.

3) Escalating staff salaries are the major concern for the program at this time. The goal of the program is to try to increase its revenue base to offset these raises. In the meantime, the CDPH has established partnerships with hospitals and community agencies to provide services to the community its own resources are limited.

III. Project Management and Governance

A. The GEHSI has remained in the Division of Women and Children’s Health Programs under the leadership of the Director Dr. Agatha Lowe, who reported to the Commissioner, Dr. John Wilhelm. The direct management of all day-to-day activities, including staff supervision (with the exception of the Male Responsibility Coordinator who reported to Dr. Lowe), consortium building, marketing the Program, collecting data and writing the reports, was handled by the project coordinator who reported to Dr. Lowe. The Public Health Nurse IIs (Case Managers) provided guidance the case manager assistants and the outreach staff. The Male Responsibility Coordinator handled all functions related to the development and maintenance of this aspect of the program.

B. The CDPH provided many in-kind resources that were essential for fiscal and program management. Dr. Agatha Lowe was the overall Director responsible for the Program. Carlos Barrios, Director of Finance, who was responsible for day-to-day management of CDPH’s financial activities, supervised the finance officer, Mr. Michael Asongwe who
donated 20% of his time to handle the financial administration of the project. Dorothy Kline, Voucher Coordinator for CDPH, who reported directly to the finance officer, was responsible for processing contractual vouchers. Linda Parks facilitated the execution of contracts through the City’s system. Finally, the CDPH and City’s Human Resources Division were responsible for facilitating the hiring of staff for the program.

C. Three changes in project management occurred. Dr. Patricia Daniels was with the project from 2001-2002. After her departure, Dr. Lowe and Wilma Lilly, Public Health Administrator III, co-managed the program. In August 2003, April Watkins, Public Administrator III, assumed responsibilities for the day-to-day operations of the program including collecting data, writing reports, and marketing it to other community area providers. The Nursing Supervisor, Gail Patton, PHN III was promoted from a PHN II during this time. With the exception of the Male Responsibility Coordinator and the Nurse Supervisor, all staff reported to the Project Coordinator who shared responsibility with the Nursing supervisor for monitoring the activities of the staff who were implementing the program. All contractors reported to the Project Coordinator. The local evaluator worked with the consortium and staff to ensure that the scope-of-services were carried out.

D. The GEHSI followed the City’s established procedure for allocating and distributing funds, and the process changed slightly over time. The City of Chicago’s budget office approved all proposed expenditures for personnel and non-personnel funds before the grant was submitted to the funding agency. The City Department placed the funds on the system according to the categories that were submitted with the proposal. The program proceeded to spend the funds once they were in the system. Approval for hiring staff was obtained from the City’s Department of Personnel since they are City employees. The City’s Law and Procurement Departments approved contracts. They also provided orientation to contractees and staff, and provided general oversight to the implementation of the Grant. The Program Director, Division Administrator, and Finance officer signed expenditure voucher requests before they were submitted for processing. The City’s Budget Office approved all out-of-town travel before plans to travel were initiated. Staff were reimbursed for travel expenses according to a set formula. Over time, the signature of the Director of Facilities Management and that of the Director of the Office of Management and Information Systems (OMIS) became requirements respectively for expenditures for furniture, fax machines and large shredders and for computer hard and software.

E. In addition to those mentioned in section B, the CDPH provided other in-kind resources to support with the implementation of the program. Dr. Sandra Thomas, Director of Epidemiology served as an internal consultant to the project and as a member of the evaluation team. Her staff provided vital statistical data to the evaluation team. The CDPH planning division staff to assisted with the writing of the grant proposal, and ensured that it was forwarded to Washington on time. The OMIS staff helped to ensure implementation and accurate functioning of the Cornerstone computer system), while Facilities Management provided assistance with the telephone system and the logistics for moving. The computer specialist also offered technical assistance to staff (data entry
operator, social worker, case managers, and case manager assistants) in to help in improving skills utilizing the Cornerstone database system. The CDPH’s fiscal officers provided the Project Coordinator with technical assistance in completing the budget, vouchers/invoices, and supply ordering. In-kind resources from other CDPH Programs and other external organizations were used for staff training and client education.

F. Linguistic competency was not a problem because the majority of clients, staff, and providers, spoke English. The community is 98% African American. The Healthy Start’s one Non-African American woman spoke fluent English. However, class and racial sensitivity were potential issues. Most evaluators were white whereas the population was predominantly African American. Open resentment was avoided by having the Project Manager introduce the group to the consortium, and by having the Consortium provide input for the evaluation survey. Class differences were avoided by recruiting outreach workers from the community, and by providing in-service that helped to focus on the effects of poverty on health seeking behaviors. In May 2004, the Healthy start Staff received a half-day training in Customer Care provided by two individuals who had participated in the Friendly Access Program (based on the Walt Disney Model for maintaining customer care loyalty) offered by the University of Southern Florida. One of the trainers had completed the full training offered by the Walt Disney trainers.

IV. Project Accomplishments
A. Please see Budget Period Objectives in Attachment A (See page 32)

B. The MCH Bureau paid Dr. Ira Chasnoff to provide technical assistance to the staff. They invited other CDPH and agency staff to share this opportunity. The Workshop participants were extremely impressed with Dr. Chasnoff’s depth of knowledge, and the simplicity with which he was able to present concepts. Staff has continued to use the tools that they received from him to evaluate clients for substance abuse. They have also shared the information at the Consortium.

The HS Program is a member of the Illinois Healthy Start Partnership. During the approximately monthly meetings, the members have shared information on strengthening all programs. They collaborated to provide training for consumers, and supported each other’s applications for the most recent HS funding cycle. The GEHS program provided technical assistance to the Access Healthy Start Program on the development of their Program’s male component.

V. Project Impact
A. Systems of Care

   Agency Collaborations to Provide Services.

1. The primary care system for the Greater Englewood community was highlighted in the assessment of community needs on page ?? The GEHSI’s location within the CDPH offered its clients access to and benefits from these providers. The GEHSI capitalized on the CDPH ENHC’s referral relationships with all perinatal systems to
include the Healthy Start clients. The GEHSI Program used community agency personnel to assist in developing the initial proposal, to provide letters of support, and to join the Consortium. During meetings of the Consortium Executive Committee, the members used the opportunity to share information about their services, to solicit referrals, and to develop Memoranda of Agreement to provide services. Healthy Start staff visited or contacted agencies to promote and seek their collaboration with the activities of the program, and participated in the activities or served on committees of other organizations. Staff organized or participated in many health fairs that were a unifying force and were well attended by providers. Other collaboration enhancing activities included shared educational opportunities for Healthy Start and other agency staff and clients.

2 The presence of perinatal screening for depression in the Healthy Start Program triggered the CDPH’s desire to make this a goal for field and clinic staff, and for the two delegate agencies that received MCH sub-contracts from CDPH. During the Project period, field staff and contract agency staff began screening women, and the numbers are reported to the State as part of its MCH Title V reports. The Healthy Start Program developed a protocol for the screening of women for perinatal depression that has been shared, modified and adopted by the CDPH. Most other policies and procedures used were already a part of the very vibrant Primary care and MCH services provided by the City. The Healthy Start Program also influenced the Mental Health to place emphasis on the needs of women experiencing post partum depression. Healthy Start client data was universally entered into the State’s Cornerstone System, a secure system that is accessed only by assigned passwords. The system however allows for the transfer of demographic data when clients change sites. The WIC program shares this server, and therefore is able to provide services for HS clients. Finally, HS clients who receive clinical care are entered into the CDPH Global information system. For many years the State and CDPH have had conversations re integrating these systems, but have been unable to make this happen.

3a) The primary mode for impacting relationships was through the Consortium because the CDPH and its many programs were already well known in the community. Prior to the initiation of the HS Program, the CDPH had had approximately 22 years experience collaborating with communities to develop and implement health improvement initiatives, and in leading community-wide planning processes. Most of these prevention and primary care services were in the areas of maternal and child health, violence, cardiovascular disease, Type 2 Diabetes, HIV/AIDS, substance abuse, and Dental Care for the underserved. Many CDPH divisions were already tied directly to the communities served or through contracts with community-based agencies, and they had formed relationships with over 530 community-based, nonprofit and private organizations to address health care issues for low-income and poverty level families throughout Chicago. The HS program served as a vehicle to expand the work of internal CDPH programs such as Safe Start and Family Planning, and that of social service and employment agencies.

3b) In reality, many of the most vocal community leaders are those employed by health
and social service agencies. The Healthy Start Program used the Consortium to recruit members from educational institutions, business, politicians, consumers and block club leaders. The program achieved success in all areas, but was unable to maintain membership. The current co-chairs of the Consortium are a Block Club leader and a former HS participant. HS staff and community agencies provided services for community participants that included helping them to find jobs, or actually employing them when possible.

**Comprehensiveness OF Services**

4a) The Healthy Start Program’s impact on eligibility and or intake for health or social services rested in its ability to free the other case management agencies of the need to try to provide services to the higher risk clients. The HS Program had a lower client to staff ratio. Services provided by HS were more intense and flexible and were based on client need rather than being prescribed. The HS program was thus viewed as a resource to which high-risk clients could be referred.

4b) The activities of the Consortium members have already been described. All Healthy Start staff, but especially the outreach workers, canvassed the community and provided information for clients and agencies. The HS staff organized several health and community resource fairs that allowed agencies to share information about their resources, and to recruit clients for those services. HS staff advocated with social service agencies for clients and shared information that empowered clients seek assistance. The HS Program was often a source for the newest information on changes in state policies that affected women and children.

4c) For the most part HS staff used existing CDPH duplicated written referrals for clients. Agencies, internal staff and other primary care providers would use the return portion of the referrals to provide information on the result of the visit. The HS staff used accessed the ENHC clinic and the WIC Cornerstone records to schedule and clients for services and to follow-up on the results of contacts. When reports were not received, staff called physicians and social service agencies for reports, or checked with the client in the home. On-the-whole, the referral system appeared to be working satisfactorily.

4d) The Cornerstone System pre-existed the HS program, and is used by all CDPH Case Management and WIC staff. The HS program used, but did not significantly influence this system. The State controls access to the different data fields. Staff not involved with the client is able to access all information except specific case notes.

**Enhancing Client Participation in the System**

5a) HS staff was partially successful in maintaining client participation in the system by using incentives, by making home visits and telephone calls to clients, and by providing transportation for those who needed this. The HS program had a Male Responsibility Program since its inception. The male high school adolescents trained by the program became well known in the ENHC and in the community. They facilitated enrollment of male clients at the ENHC. More recently, they were asked to assist the ENHC to educate and enroll clients for Prostate Cancer Screening. The Male
Coordinator was especially resourceful in obtaining social services for men that included training for jobs, obtaining support for children, and having criminal records expunged. This program is well known to HS and other staff and agencies. They often request technical assistance from the Coordinator.

5b) Consumers involved in the Consortium critiqued and offered suggestions for the development of materials that are currently used in the Healthy start program. Consumers suggestions about places to visit to recruit clients, and their ideas of what would attract clients to the program was also used by the Program

B. Impact to the Community

1. See Health Resource Fairs. The most popular fairs were for housing and jobs.

2. The HS Program did not conduct any significant activity in this area.

3. The Program has developed many positive relationships in the community, to the extent that HS staff was asked by the University of Illinois at Chicago to help to organize providers for its training on Perinatal Depression. The event was so well attended that a second session was planned. Similarly, staff organized large numbers of community agency personnel and consumers to participate in a town-hall focus group to brainstorm about the Closing the Gap Initiative.

4. A portion of the PA was designated as a Tax Increment Financing District and funds became available for job creation and for improving housing, businesses and educational institutions. The HS program was active in promoting attendance at these job creation programs. While the program had no significant funds to employ residents, staff actively sought out job training and job opportunities for clients. As a result several residents are now gainfully employed. All HSI outreach workers live in the community, as do the peer educators who receive stipends from the program. GEHSI staff has worked with Teamwork Englewood (a group of over 115 residents, business owners, and institutional leaders) to develop an action plan for the community that included the creation of jobs.

C. Impact on the State: The GEHSI maintained membership in the IL HS Partnership that administers several programs jointly with the state's Title V Maternal and Child Health Program, and collectively they were able to expand the number of clients in the Chicago-land area who received enhanced Family Case Management Services, with the resultant positive effect on infant mortality and morbidity. The group jointly conducted customer-training workshops for Healthy Start Consumers. The Director of the Project participated on an IDPA Task force to improve the Health of Women. One result from this was the decision by IDPA to fund Perinatal Depression Screening.

D. Local Government Role: The CDPH, the grantee is the local government entity. The CDPH fully supported the program as is attested to by the in-kind resources provided.
E. Lessons Learned:

The HS program offers communities a unique opportunity to introduce innovative programs that would not otherwise find root in those localities. Without the presence of the HS Program, our CDPH Programs would probably not have begun to screen Women for Perinatal Depression. Certainly the experience of the HS Program facilitated the process. By far the most rewarding experience for staff has been the opportunity to work with some of the male counterparts of their clients, and realize that, contrary to what has been said, African American men, (even when they are unemployed) do want a relationship with their children. Also instructive for staff were the prejudices men face in trying to get custody for their children, or in securing financial aid when they are unemployed, but are the sole caretakers for the children.

VI Local Evaluation: Please see Attachment B page 67.

VII. Fetal Infant Mortality Review (FIMR).

The original Healthy Start Grantees in Illinois received funds that were used to initiate a FIMR process in 2000. The Coordinator from the University of Chicago Perinatal Center was contracted to implement the program. It consisted of identifying women who had suffered fetal or neonatal losses, seeking permission to review their medical records, and to contact them. Mothers who agreed were visited in the home, and interviewed to obtain their perceptions concerning the possible factors that contributed to their loss. During the visit the interviewer would provide the woman with literature or referrals for health or social services as needed. Following the visit, an interdisciplinary team comprised of health professionals, the police and the ministry reviewed the cases to determine the potential social factors that contributed to the loss, and determine if the loss was or was not avoidable, and make recommendations for further action. The HS funded program was discontinued because of lack of funds. The State Title V agency then applied to the Federal Government and received funds to continue the FIMR program and expand it beyond the Healthy Start areas. The perinatal coordinator from the University of Chicago Medical Center (UCMC) has continued to manage the process. Oversight is shared jointly by the CDPH and the State Title V agency. The GEHSI is still included in this FIMR activity through the Director of Women and Children’s Health Programs. The results from the report were released late last year, and indicated that stress was a significant factor that contributed to fetal loss. A specific Community Action Team has not been identified. Instead, the original review team plans to organize community groups and professionals to address and find solutions to the issues that were revealed in the report.

VIII. Products. Please see under a separate cover.

IX. Project Data. Please see Attachment D.
ATTACHMENT A
### BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Outreach, Pregnant Women

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
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<tr>
<td>O1 By 5/31/2005, 65% (500) women who are not receiving prenatal care will be recruited and will receive adequate prenatal care.</td>
<td><strong>Strategy:</strong> Aggressive case finding of pregnant women to identify and enroll them in prenatal care.</td>
<td>587 pregnant women were recruited and enrolled into the HS program. Of them 398/587 (68%) received adequate prenatal care.</td>
</tr>
<tr>
<td>Baseline: During the CY 2000, 268/500 women were admitted and 71/268 (26.5%) of HSI women received adequate prenatal care.</td>
<td><strong>Activities (with Implementation Time frames):</strong> 1a. Review and if needed modify strategies, activities and protocols for outreach activities which focus on assessing women, and if eligible, enroll them in prenatal care with the provider of their choice. (continued from CY 001 and continuing throughout the Project Period).</td>
<td>1a. Completed.</td>
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<td>1b. Train Outreach Workers (Public Health Aides [PHAs]) on the strategies, activities and protocols. Include information on the need for continuous and accurate record keeping and logs. (continued from CY 001 and continuing throughout the Project Period).</td>
<td>1b. Completed.</td>
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<td>1c. Collaborate in the reassessment of all PHAs in the Chicago Department of Public Health (CDPH) with respect to the need for and content of prenatal care. They will jointly provide or arrange for training sessions to maintain the competence of the PHAs. (continued from CY 001 and continuing throughout the Project Period).</td>
<td>1c. The Outreach Workers (PHAs) received training on Breast Feeding, SIDS Prevention, WIC, Immunizations, Perinatal Depression, Domestic Violence, HIV/STD, Birth Defects, Family Planning, The Effects of Drugs and Alcohol during Pregnancy, and Neutral Tube Disorders of Folic Acid.</td>
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<td>1d. Contract with the Daley Community College to provide Adult Education Classes for PHAs as a transition to their qualifying for College Credits. (continued from CY 001 and continuing throughout the Project Period).</td>
<td>1d. 2 PHAs enrolled at Kennedy King College. One is attending the Registered Nursing Program and the other is in the Child Development Program.</td>
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<td>1e. Assure that Consortium Members, providers and community agencies receive information on the criteria for selecting clients into the program. (continued from CY 001 and continuing throughout the Project Period).</td>
<td>1e. Completed. The consortium referred 10 pregnant women who were enrolled into the HS Program.</td>
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</table>
**Project Period Objective**

| O1 | By 5/31/2005, 65% (500) women who are not receiving prenatal care will be recruited and will receive adequate prenatal care.

**Baseline:** During the CY 2000, 268/500 women were admitted and 71/268 (26.5%) of HSI women received adequate prenatal care.

**Source:** HSI Outreach and Case Management records

**Project Performance Indicators:** Increased Percentage of HSI women who keep scheduled prenatal care visits.

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**Strategy and Activities**

| Strategy: | Aggressive case finding of pregnant women to identify and enroll them in prenatal care. |
| Activities with Implementation Time frames (contd.): |
| 2a. | PHAs will combine door-to-door canvassing and visits to beauty parlors and churches with visits to fixed sites such as malls and public aid offices to recruit clients into the program. **(continued from CY 001 and continuing throughout the Project Period).** |
| 2b. | The Outreach Coordinator will hold end of day discussions with the outreach workers to assess facilitators and barriers to client recruitment, the numbers and types of contacts that were made, and make provision for the referral of clients as needed. **(continued from CY 001 and continuing throughout the Project Period).** |
| 2c. | The Outreach and Case Management teams will meet weekly to discuss: new outreach clients who are eligible for case management, the success of outreach and case management efforts, clients who need of more extensive services, community resources and staff support needs. **(continued from CY 0001 and continuing throughout the Project Period).** |
| 3. | Outreach workers will facilitate community resident linkages with social services by sharing information with senior Outreach and Case Management staff. When necessary they will accompany families to assure that connections are made. **(continued from CY 0001 and continuing throughout the Project Period).** |
| 4. | Organize at least one annual Health Fair to promote the HSI and to allow other agencies to market their services to community residents. Participate in Health Fairs held by other agencies. **(continued from CY 0001 and continuing throughout the Project Period).** |

** Accomplishments**

| 587 pregnant women were recruited and enrolled into the HS program. Of them 398/587 (68%) received adequate prenatal care. |
| 2b. | Completed. |
| 2c. | Completed. |
| 3. | Completed. |
**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Outreach, Infants and Children

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| O2 By 6/1/2005 at least 75% of HSI infants (475 infants) will receive appropriate EPSDT services (minimum of 5 well child visits). | **Strategy:** Active case finding to identify and enroll infants into care. **Activities (with Implementation Time frames):**  
1a. Review and if needed modify strategies, activities and protocols for outreach activities which focus on assessing infants, and if eligible, enroll them in well baby prenatal care with the provider of their mothers choice.  
(continued from CY 001 and continuing throughout the Project Period).  
1b. Train Outreach Workers (Public Health Aides) [PHAs] on the strategies, activities and protocols. Include information on the need for continuous and accurate record keeping and logs. (continued from CY 001 and continuing throughout the Project Period).  
1c. Collaborate in the reassessment of all PHAs in the Chicago Department of Public Health (CDPH) with respect to the need for assess the training needs of all PHAs in the CDPH with a focus on well child care including the meaning of the acronym EPSDT. Jointly provide or arrange for training sessions to maintain the competence of the PHAs. (continued from CY 001 and continuing throughout the Project Period).  
1d. Contract with the Daley Community College to provide Adult Education Classes for PHAs as a transition to their qualifying for College Credits. (continued from CY 001 and continuing throughout the Project Period).  
1e. Provide Consortium Members, providers and community agencies with information on the criteria for selecting infants for the program. (continued from CY 001 and continuing throughout the Project Period). | 489/566 (86%) infants received well child visits 2-4 weeks after birth.  
445/566 (79%) infants received appropriate well-child visits by one year of age.  
1a. Completed.  
1b. Completed.  
1c. The Outreach Team received training on: Breast Feeding, Well Child Services and Immunization, Second Hand Smoke/SIDS, Infant Nutrition & Health Education, Immunization Workshop, eight sessions for Bright Futures.  
1d. 2 PHAs enrolled at Kennedy King College. One is attending the Registered Nursing Program and the other PHA is enrolled in the Child Development Program.  
1e. Completed. The consortium referred 10 pregnant women that was enrolled into the HS Program. |

**Baseline:** During the Calendar Year 2000 24% (236/982) HSI infants received appropriate EPSDT Services Source: HSI Program Logs and case reports.

**Project Performance Indicator:** The number and percentage of HSI infants who receive EPSDT services.
# BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Outreach, Infants and Children

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<td>O2 By 6/1/2005 at least 75% of HSI infants (475 infants) will receive appropriate EPSDT services (minimum of 5 well child visits).</td>
<td><strong>Strategy:</strong> Active case finding to identify and enroll infants into care.</td>
<td>1154 infants and children were enrolled into the HS program. 566 were born in the project period. 489/566 (86%) infants received well child visits 2-4 weeks after birth.445/566 (79%) infants received appropriate well-child visits by one year of age. 2a. Completed. 2b. Completed 2c. Health care provider selection was arranged before or shortly after the birth of the baby. 2d. HS Program provided 1124 families with transportation tokens/cab vouchers and made reminder calls to encourage clients to keep their appointments. 3a. Completed. 3b. Completed.</td>
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<tr>
<td><strong>Baseline:</strong> During the Calendar Year 2000 24% (236/982) HSI infants received appropriate EPSDT Services Source: HSI Program Logs and case reports.</td>
<td><strong>Activities (with Implementation Time frames):</strong> 2a. Use Cornerstone Assessment tool to triage infants for management by a) the Outreach Workers; b) the Case Management team; or c) the local Public Health Nurses. (Continued from CY 001 and continuing throughout the Project Period). 2b. Inform all care-givers/parents about the effect of keeping all well-child visits on the health of their infants. (Continued from CY 001 and continuing throughout the Project Period). 2c. Refer infants for well-child visits at the Englewood Neighborhood Health Center (ENHC) or other Health Care Providers of their choice. (Continued from CY 001 and continuing throughout the Project Period). 2d. Provide transportation tokens, reminder recalls and staff if necessary to accompany clients to help them keep appointments. (Continued from CY 0001 and continuing throughout the Project Period).</td>
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<tr>
<td><strong>Project Performance Indicator:</strong> The number and percentage of HSI infants who receive EPSDT services.</td>
<td>3a. Hold end of day discussions with the outreach workers to assess facilitators and barriers to client recruitment, the numbers and types of contacts that were made, and make provision for the referral of clients as needed. (Continued from CY 001 and continuing throughout the Project Period). 3b. The Outreach and Case Management teams will meet weekly to discuss: new outreach clients who are eligible for case management; the success of outreach and case management efforts, clients who need more extensive services, community resources and staff support needs. (Continued from CY 001 and continuing throughout the Project Period).</td>
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**BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN**

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Outreach, Male Support

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| **O3.1** By 6/1/2005, 90% of the males who enroll in peer education will complete the Peer Educator program, and share the information with students and others in the school and community. | **Strategy:** Continuous recruitment of peer educators to replace those lost through high school graduation or relocation.  

**Activities (with Implementation Time frames)**  
1a. The Male Program Coordinator (MPC) will recruit and retain 10 students per year in the program. With a focus on attracting male students partners of pregnant or parenting females in the school. *(Continued from CY 01 and throughout the Project Period).*  
1b. The MPC will use a structured curriculum to provide 120 hours of instruction to new recruits on topics such as (self esteem, human sexuality, communication, family planning, pregnancy STD/HIV prevention, the prevention of dating and domestic violence, parenting and health education techniques. *(Continued from CY 01 and throughout the Project Period).*  
1c. The MPC will provide refresher courses for continuing students, and use them as coaches for the new students. *(Continued from CY 01 and throughout the Project Period).*  
2a. The MPC will supervise the peers as they develop skills in making presentations to approximately 500 persons (50 per peer educator) to include other students and community individuals. *(Continued from CY 01 and throughout the Project Period).*  
2b. The MPC will market the program to community organizations, other health care providers and social service agencies in the community. *(Continued from CY 01 and throughout the Project Period).* | 53/75 (71%) completed the program. At 10 students per year, the 53 exceeded the anticipated enrollment.  

1a. Completed. 13 students are currently enrolled.  
1b. Completed.  
1c. Completed  
2a. Peers provided information to 5,525 individuals.  
2b Completed. Many organizations continue to request the Coordinator’s assistance.  

**Baseline:** 1999-2000, 100% Peer Educators completed the program, and 60% shared the information with others.  

**Source:** Coordinator’s Report.

**Project Performance Indicator:** The percentage of males completing the peer education program and sharing the information with others.
### BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN

**Grantee:** The Chicago Department of Public Health (CDPH)  
**Intervention:** Outreach Male Support

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| **O3.2** By 6/1/2005, 80% of the males who enroll in the community program will complete the program, and actively participate in the care of their children or pregnant partners. | **Strategy:** Expand the program at the Englewood High School; market the program; provide outreach to males.  
**Activities (with Implementation Time frames)**  
1. The Male Program Coordinator will market the male program to community organizations, other health care providers and social service agencies in the community. (Continued from CY 01 and throughout the Project Period).  
2. The Male Program Coordinator will recruit at least 25 fathers who are identified by pregnant women or parenting women with children under one year of age for voluntary enrollment in the program. (Continued from CY 01 and throughout the Project Period).  
3. The Male Program Coordinator will collect data from participants (demographic, education, employment, occupation, health, knowledge of child care, parenting experiences). (Continued from CY 01 and throughout the Project Period).  
4. The Male Program Coordinator will provide group (all male), couple (male/female), individual, and parent-child sessions for males using the expanded CDPH curriculum mentioned above. (Continued from CY 01 and throughout the Project Period).  
5. The Male Program Coordinator will encourage men to form support groups for mutual sharing of challenges, information and concerns. (Continued from CY 01 and throughout the Project Period).  
6. The Male Program Coordinator will assure that the men in the program who need the support groups are referred, linked to and receive health, educational, social and job training services. (Continued from CY 01 and throughout the Project Period). | 168/237 fathers were enrolled in the program and received services. All became more involved in the lives of their children and/or their partners.  
1. Completed.  
2. 3 & 4 Completed.  
57 of those completing the program had a child < 1 year of age.  
Most men were unemployed, and had several children. Over half of the men were ex-offenders.  
229 referrals were made. 23 for health care, 74 for social services and 132 for employment and training. 41 individuals obtained employment. Other assistance provided included: assistance in establishing paternity; help to obtain food (WIC) and support from Public Aid and counseling and referral for domestic violence. Challenges include providing services such as housing and employment for ex-offenders (57% of the male clients).  
The program provided assistance to males who, although not enrolled, sought help from the program. Referrals were made for social services, health care; education, and for employment and training. |
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| CMT1 By 5/31/05, 900 new pregnant women will be enrolled in prenatal care. | **Strategy:** Enroll and refer women for prenatal care and assure that they keep at least 90% of their prenatal appointments.  
**Activities (with Implementation Time frames)**  
1a. Assess and enroll clients referred from the Outreach Program, PHNs in the community, and the CDPH Central Intake for High Risk Clients.  
(Continued from CY 01 and throughout the Project Period).  
1b. Assess and appropriately refer women to prenatal care, nutrition services, mental health, social services, substance abuse prevention (including cigarette smoking) and treatment programs, domestic violence and HIV counseling and treatment programs.  
(Continued from CY 01 and throughout the Project Period).  
1c. Obtain consents and develop a plan of care with each woman within one week of admission to the program.  
(Continued from CY 01 and throughout the Project Period).  
1d. Maintain telephone communication with the woman’s primary health care provider to obtain information about her prenatal regime, and share information (as approved by the client) about other services that she is receiving that may impact the outcome of her pregnancy.  
(Continued from CY 01 and throughout the Project Period).  
1e. Make home visits, conduct face-to-face contacts with the women in the WIC and maternal clinics, or telephone them to ensure that women adhere to their prescribed regimes.  
(Continued from CY 01 and throughout the Project Period). | 587 pregnant women were enrolled. 274 (47%) were in the first trimester, 200 (34%) were in the second trimester, 92 (16%) were in the third trimester 21 (4%) had no prenatal care on entry into the program.  
1a. All referrals were triaged by the case management coordinator and/or the nursing supervisor.  
1b. Staff referred clients for services. 115 clients were referred for nutrition, 196 were referred for parenting, 72 were referred for childbirth education, 59 were referred for substance abuse counseling, 41 referred for DV, and 102 referred to the smoking cessation class.  
1C. Completed.  
1d. Completed. All pregnant women were encouraged to carry their cards with them to each prenatal visit.  
1e. The outreach and case management staff make home visits, make telephone calls to the women and their providers to ensure that they adhere to their prescribed regime. |
## BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Case Management, Pregnant Women

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| **CMT1** By 5/31/05, 900 new pregnant women will be enrolled in prenatal care. | **Strategy:** Enroll and refer women for prenatal care and assure that they keep at least 90% of their prenatal appointments. **Activities with Implementation Time frames (Contd.)**  
2a. The Outreach and Case Management teams will meet weekly to discuss: new outreach clients who are eligible for case management; the success of outreach and case management efforts, clients who need more intensive services, community resources and staff support needs. (Continued from CY 01 and throughout the Project Period).  
2b. The Case Management staff will conduct biweekly case conferences with all agencies providing care to clients at highest risk to improve the effectiveness of care coordination. (Continued from CY 01 and throughout the Project Period).  
3a. The Case Management staff will attend education/training opportunities provided specifically for them, or being offered through the CDPH for all staff. Education will include cultural sensitivity training; HIV counseling of pregnant women; domestic violence counseling and prevention; promoting adequate weight gain in pregnancy; smoking cessation strategies, and prevention of low-birth weight and Pre-term births. (Continued from CY 01 and throughout the Project Period).  
4a. The Case Management staff will maintain up-dated and accurate client records demonstrating: all services that were provided; failed attempts to provide services and reasons for this; client outcomes resulting from services received or not received. (Continued from CY 01 and throughout the Project Period). | 587 pregnant women were enrolled. 274 (47%) were in the first trimester, 200 (34%) were in the second trimester, 92 (16%) were in the third trimester 21 (4%) had no prenatal care on entry into the program.  
2a. The Outreach and CM teams met weekly to discuss cases, resources and client needs.  
2b. It was difficult for the agencies to meet bi-wkly for case conferences. Therefore the cases were discussed once a month at the Englewood facility Board meeting.  
3a. Completed.  
4a. Records were maintained in the Cornerstone Computer system. Logs, daily and monthly activity sheets, and the hard copy of the client’s chart were maintained. |
BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Case Management, Infants and Children

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<td>CMT2: By 5/31/05, 95% of infants enrolled in the Project will receive appropriate EPSDT services (minimum of 5 well child visits).</td>
<td><strong>Strategy:</strong> Coordinate and manage client services to assure that the objectives are met. &lt;br&gt;<strong>Activities (with Implementation Time frames) for EPSDT</strong> 1. The CM or CMA will assure that HSI infants receive primary health care at the ENHC or another community provider. (Continued from CY 01 and throughout the Project Period). 2. The CM or CMA will maintain communication with health care providers to ensure that children receive appropriate EPSDT screens, and that they are referred for other services as needed. (Continued from CY 01 and throughout the Project Period). 3. The CM will perform developmental screening on at least 80% of children, provide instruction to care-givers regarding stimulating their children, and referring children for remediation of identified problems. (Continued from CY 01 and throughout the Project Period). 4. Children with special health care needs will be referred LaRabida, the University of Chicago, or the University of Illinois at Chicago pediatric units for services as needed. (Continued from CY 01 and throughout the Project Period).</td>
<td>1154 infants and children were enrolled into the HS program. 546 were born during the project period. 472/546 (86%) infants received EPSDT services. 432/546 (79%) infants received appropriate well-child visits by one year of age. 1. Health care provider selection was arranged before or shortly after the birth of the baby. 2. Providers are contacted and information is recorded in the Cornerstone Computerized database and in the clients records. 3. Denver Development screening tests were completed on 100% of infant and children. Follow-up instructions were provided as needed. 4. 11 special needs infants. 6 referred and accepted treatment at LaRabida, 4 received and accepted treatment at UIC. 1 was referred and accepted treatment at Cook County Hospital</td>
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**Baseline:** During the Calendar Year 2000 (40.6%) 203/500 HSI infants received appropriate EPSDT Services <br>**Source:** HSI Program Logs and case reports.

**Project Performance Indicators:** The number and percent of HSI infants receiving EPSDT services.
**BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN**

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Case Management: Children with Special Health Care Health Needs (Objective Created in 2002)

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| **CMT2** By 6/1/05, 95% of Healthy Start Infants with Special Health Care needs will be referred for services. At least 90% of them will receive Services. | **Strategy:** Coordinate and manage client services to assure that the objectives are met. **Activities (with Implementation of Time Frames) for EPSDT**  
1. The CM will perform developmental screening on at least 80% of children, provide instruction to care-givers regarding stimulating their children, and referring children for remediation of identified problems. *(Continued from CY2001 and throughout the Project Period).*  
2. Children with special health care needs will be referred to LaRabida, the university of Chicago, or University of Illinois at Chicago pediatric units for services as needed. *(Continued from CY2001 and throughout the Project Period).* | 10/566 (10%) of infants had needs for special health care. |

**Baseline:** During the Calendar 2002 (5.1% of 117 infants were identified as needing special care. All 6 (100%) were referred to special care hospitals.  
**Source:** HSI Program Logs and case reports 2002.

**Project Performance Indicators:** The number and percent of HSI infants receiving Special Health Care Services.

1. Denver developmental screening tests were completed on 100% of children by the CMs and CMAs. Follow-up instructions were provided to their caregivers.

2. 11 children were identified as needing special care services and were referred to: LaRabida hospital (6), UIC (4), Cook county Hospital (1).
# BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN

**Grantee:** The Chicago Department of Public Health (CDPH)  
**Intervention:** Health Education

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<td><strong>HED1</strong> By 5/31/05, at least 2,016 public information/educational sessions will be conducted.</td>
<td><strong>Strategy:</strong> Provide intensive training to Health education Staff regarding the Englewood HSI and means to improve the pregnancy outcomes for women in the PA.</td>
<td>All staff participated in multiple educational sessions provided through the State, CDPH, the HCAP Program, and by invited speakers. Presenters included the IL Maternal and Child Health Coalition, the March of Dimes, Dr. Ira Chasnoff, and the SIDS Alliance of IL. 1a. Completed</td>
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</tbody>
</table>
| **Baseline:** In calendar year 2000, HSI staff (not including Male Responsibility Program) provided public information to 1,716 people. **Source:** Staff Records. | **Activities (with Implementation Time frames)**  
1a. The Project Coordinator will work with CDPH programs such as the divisions of Violence Prevention and STD/HIV AIDS to schedule training for the Health Education Team on health issues that may impact pregnancy outcomes. **Beginning July 2001 and throughout Project Period.**  
1b. The Health Education Team will receive training from CDPH and external sources to ensure that each staff member understands the following subjects: perinatal and post-partum depression; the prevention of STD/HIV especially syphilis; congenital anomalies; SIDS; improving weight gain in pregnancy; increasing the availability of immunizations; smoking, alcohol and other substance use prevention, and the provision of family planning counseling and services. **Beginning July 2001 and throughout Project Period.**  
1c. HE staff must score at least 90% on post-test evaluations following each training session received. **Beginning July 2001 and throughout Project Period.**  
1d. HE staff scoring less than 90% on post-test evaluations will receive appropriate, streamlined education and re-testing of the information. **Beginning July 2001 and throughout Project Period.** | 1b. Completed  
1c. CQC Inc and the Trainers for the Bright Futures Curriculum gave pre and post tests. Staff post test scores ranged between 80-90% on most tests.  
1d. Not implemented. |
**Grantee:** The Chicago Department of Public Health (CDPH)

**Health Education (Continued)**

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<td><strong>HED1</strong> By 5/31/05, at least 2,016 public information/educational sessions will be conducted.</td>
<td><strong>Strategy:</strong> Launch an aggressive program to educate the PA health professionals, consumers, Consortium members, business owners, and other government agencies on the Englewood HSI and MCH issues relevant to increasing positive pregnancy outcomes. <strong>Activities (with Implementation Time frames)</strong> 2a. HE Staff will work with the Project Coordinator and Consortium to identify providers, business owners, and other government agencies in the PA interested in, and in need of education regarding the perinatal health status of families of the PA and the role HSI plays in improving pregnancy outcomes. <strong>Beginning July 2001 and throughout Project Period.</strong> 2b. The Project Coordinator and Consortium will identify providers, business owners, and other government agencies in the PA to schedule educational sessions regarding health and environmental factors that may impact pregnancy outcomes. <strong>Beginning July 2001 and throughout Project Period.</strong> 2c. HE staff will coordinate with outreach workers and case managers to determine educational needs of HSI clients. <strong>Beginning July 2001 and throughout Project Period.</strong> 2d. The HE team, in concert with the ENHC staff, will provide weekly group educational sessions at the ENHC. <strong>Beginning July 2001 and throughout Project Period.</strong> 2e. Each HE staff will provide at least three educational sessions per week during the Project Period. <strong>Beginning July 2001 and throughout Project Period.</strong></td>
<td>Staff provided public information and educational sessions to 3,150 individuals, but did not meet the target of providing 2,016 public educational sessions. 2a. Completed 2b. The program conducted 45 sessions for providers and doctors. 2c. Clients readily identified their needs, but preferred to obtain Health Education on an individual basis. 2d. Sessions were not well attended. 2e. Staff provided 184 educational classes for consumers, 24 for providers, and 4 for doctors.</td>
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</table>

**Baseline:** In calendar year 2000, HSI staff (not including Male Responsibility Program) provided public information to 1,716 people. **Source:** Staff Records.

**Project Performance Indicators:** The number of consumers, providers, and others vested in the PA receiving education.
Grantee: The Chicago Department of Public Health (CDPH)  
Intervention Service: Interconceptional Care

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| **IC.** By 5/31/05 the proportion of women who receive one or more of the following interconceptional services will increase to 89% (623/700women): a) Post-partum Examinations b) Family Planning services c) STD/HIV education, screening, treatment d) Screening, counseling & referral for treatment for the inappropriate use of drugs, alcohol and tobacco e) Screening and counseling for domestic violence f) Assistance with social services such as housing, education, job training and education.  
Baseline: 56.6% (211/373) of HSI women received documented post-partum examinations 2000. Source: Healthy Start Records. | **Strategy:** Identify and refer women who have recently given birth, and other non-pregnant HSI women to a health care provider for post-partum and family planning services, and promote health and development of women and their families by providing or facilitating their access to a comprehensive array of health and social services that include: the prevention and treatment of STD/HIV and substance abuse (including alcohol and tobacco use); counseling for domestic violence; education and job training, and the prevention of congenital anomalies.  
Activities (with Implementation Time frames)  
Post-Partum Examinations:  
1a. During the third trimester of the woman’s pregnancy, staff will collaborate with the woman’s health care provider to reinforce information about the health value of a post-partum examination six weeks after delivery. *(Continued from CY 2001 and ongoing throughout the Project Period).*  
1b. Staff will collaborate with the women and their health care providers to ensure that women receive and keep their appointments for post-partum exams six weeks after delivery. *(Continued from CY 2001 and ongoing throughout the Project Period).*  
2a. Recruit and refer post-partum clients previously unknown to the HSI staff for check-ups within six to eight weeks after delivery. *(Continued from CY 2001 and ongoing throughout the Project Period).*  
2b. Case manage clients who experience barriers and facilitate their return for the visit to ensure compliance with medical examinations. *(Continued from CY 2001 and ongoing throughout the Project Period).* | 816 women were postpartum. Of those 735/816 (90%) received documented postpartum exams within 8 weeks after delivery therefore the Objective was met. 424/576 (74%) of women >18 had an interconceptional period of two years. 188/240 (78%) of women 17 years of age had an interconceptional period of > two years.  
1a. Completed.  
1b. Completed.  
2a. Outreach Staff recruited and referred postpartum clients for check-ups. 105 community- participant women were recruited. They received 6-8 weeks postpartum exams. 3 community participants women who had miscarriages were recruited and connected for their postpartum exams.  
2b. Staff assisted clients to making appointments and provided those needing this with transportation and support services to enable them to keep their appointments. |
**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention Service:** Interconceptional Care

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<td>a) Post-partum Examinations</td>
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<td>b) Family Planning services</td>
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<td>c) STD/HIV education, screening, treatment</td>
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<td>d) Screening, counseling &amp; referral for treatment for the inappropriate use of drugs, alcohol and tobacco</td>
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<td>e) Screening and counseling for domestic violence</td>
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<td>f) Assistance with social services such as housing, education, job training and education.</td>
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<td><strong>Baseline:</strong> Calendar Year 2000, 44.9% (288/641) of HSI women received Family Planning Services. <strong>Source:</strong> HSI Reports.</td>
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<td><strong>Project Performance Indicator:</strong> Number and percentage of post-partum women who are linked with and are using an effective method of family planning.</td>
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<td><strong>Interconceptional Care (Cont’d) (Activities and Implementation Time Frames)</strong></td>
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<td><strong>Family Planning:</strong></td>
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<td>1a. The HSI staff will collaborate with staff from the ENHC and the Cradle-to-Classroom program, the Consortium, and the Planned Parenthood Association to recruit teens, (especially those who have had a previous pregnancy) as well as other females who obtain negative pregnancy tests results, and who do not desire a pregnancy and refer them for family planning services. <strong>(Ongoing since December, 1999 and will continue through the Project Period).</strong></td>
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<td>1b. Refer non-pregnant sexually active women and their partners to the ENHC, the Planned Parenthood Clinic, or to the provider of their choice for family planning services. <strong>(Ongoing throughout the Project Period).</strong></td>
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<td>1c. Screen clients and minimally provide palm cards to all clients indicating sources of assistance for domestic violence. Refer clients who report episodes of domestic violence and are willing to accept assistance.</td>
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<td>**2a. Provide culturally appropriate and accurate information on family planning methods to women and their partners, verify their family planning status, refer those who needed linkages, and assist them in keeping all appointments. <strong>(Ongoing throughout the Project Period).</strong></td>
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<td>2b. Collaborate with the Coordinator of the Male Program to provide education, support and training to encourage male support for the family planning efforts. <strong>(Ongoing throughout the Project Period).</strong></td>
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<td>2c. Expand the distribution network for Family Planning literature to assure that families receive community support to obtain family planning information and services. Leave materials in accessible locations such as barber and beauty shops, libraries, parks, community agencies, and with Consortium members and other health care professionals for easy access by families. <strong>(Ongoing throughout the Project Period).</strong></td>
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<td>740/816 (91%) of HSI clients received family planning services.</td>
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<td>1a. Cradle to Classroom staff referred 3 pregnant teens to HIS. In 2004 after the Cradle to Classroom program was discontinued, the CMs recruited 13 pregnant teenagers from Harper, Robeson and Englewood HS.</td>
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<td>1b. Completed.</td>
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<td>1c. The HSI staff provided palm cards to 41 clients who were referred for DV assistance. 35 clients refused assistance, 6 were referred to a shelter and accepted.</td>
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<td>2a. Completed.</td>
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<td>2b. Completed.</td>
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<tr>
<td>2c. Completed.</td>
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Grantee: The Chicago Department of Public Health (CDPH)

**Intervention Service: Interconceptional Care**

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<td><strong>Interconceptional Care (Cont’d)</strong> Activities (with Implementation Time frames) <strong>Family Planning:</strong> 3 The Project Manager and CDPH Family Planning Consultant will develop training for the staff which minimally includes: a) effective strategies for working with adolescent family planning clients b) an overview of family planning methods, method usage, side effects, etc. c) focus on community cultural beliefs and values re control of ones own fertility; d) issues of domestic violence, especially sexual coercion as they affect family planning (Ongoing since December, 1999 and will continue through the Project Period). 4. In collaboration with the Planned Parenthood Association, provide quarterly educational sessions within organizations serving the target population. (By June 2002 and ongoing throughout the Project Period). 5. Supply the network providers and family planning clients with access to free condoms, handouts on proper utilization, and consumer education information on prevention of STD/HIV. (By June 2002 and ongoing throughout the Project Period). 740/816 (91%) of HSI clients received family planning services. 3. Consortium members and the clients received 2 trainings on family planning, from Planned Parenthood Association and CDPH. Staff and clients received 2 trainings on DV and Sexual Assault from the Chicago Police Dept. and CDPH staff. 4. Completed. 5. The HSI Program provided condoms and literature to family planning clients, along with literature on HIV/STD. Condoms were also distributed at health fairs and by the PHAs during outreach.</td>
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### Intervention Service: Interconceptional Care

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Genetic Counseling:  
1. Provide community wide education to women concerning the recommended intake and the benefits of folic acid to theirs and their infants health, and the hazards of chemicals such as mercury, drugs and alcohol. **By June 2002 and ongoing during the Project Period.**  
2. Provide nutritional assessments and counseling for women of child-bearing age. **By June 2002 and ongoing during the Project Period.**  
3. Refer clients who need these to the genetic counseling services offered at the ENHC. **Ongoing during the Project Period.**  
4. Distribute the March of Dimes information on Folic Acid through a variety of venues, including a) churches, b) provider’s offices, c) hospitals, d) barber shops, e) beauty parlors, f) grocery stores, etc. **Ongoing during the Project Period.**  
5. Collaborate with the Park District, the Boy’s and Girl’s Clubs, the Local School Council and St. Sabina’s job training program to offer alternatives such as recreation, job training, and tutoring for clients (especially adolescents) as a means for reducing pregnancies.  
6. Maintain monthly records of: a) the number of clients who were identified as needing interconceptional services; b) the number who were referred and connected with this service; c) the reasons for non-referral and lack of connection with services; d) successful/unsuccessful strategies used to connect clients with services; e) resource gaps for clients; and f) the number and types of educational materials distributed. **Continued from CY 2001 and ongoing throughout the Project Period.** | 39 clients needed and received genetic counseling.  
1. Completed.  
2. 2214 persons received Nutrition education classes. 546 were HSI Clients. All HS clients received WIC nutrition services.  
3. 39 clients received genetic counseling. 6 of the client’s partners accompanied them to the ENHC.  
5. Completed. 235 clients were assisted with and/or received jobs. 37 completed the GED training. 22 teen moms returned to school.  
6. Completed. |
## BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN

**Grantee:** The Chicago Department of Public Health (CDPH)  
**Intervention:** Perinatal Depression

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| PD By 5/31/05, 90% of pregnant/post partum women will be assessed for depression; 70% of those who experience symptoms will be referred and 10% will accept treatment | **Strategy:** Select and enroll clients in an appropriate level of care based on identified risk factors.  
**Activities (with Implementation Time frames):**  
1a. Provide training to staff, community providers and the Consortium on: a) risks and contributing factors (including inadequate nutrition) to perinatal depression; b) the correct methods for assessing women for perinatal depression using the Edinburgh Depression Screening tool; c) potential resources including social support to cope with perinatal depression. **Continued from November /02 and continuing throughout Project Period.**  
1b. Collaborate with health care providers to assess pregnant and post-partum women for risk factors associated with perinatal depression. For example, negative birth outcomes: pre-term, low, and very low birth weight births; stress; inadequate social support; drugs and alcohol use; poor nutrition, previous history of depression. **By January 2002 and continuing throughout Project Period.**  
1c. Using the Edinburgh Depression screening tool, select and assign women to different levels of Case Management as follows: **Score of 12 or above:** Refer to the social worker for further assessment and referral for more intensive services. Refer positive responses to question 10 to the social worker. **Score 9-11:** Re-screen in one month and assess for possible follow-up by the case manager, case manager assistant or the PHA. **Depressed Clients under age 18 years:** Refer to the CDPH Greater Lawn Mental Health Center. **Depressed clients over age 18 years:** Refer to the CDPH Mental Health Clinic at the ENHC. The case manager or the social worker makes weekly home visits to assure compliance with treatment. **By January** | 587 (100%) prenatal clients were screened. 127 (22%) were re-screened. 26/127 (20%) referred for treatment. 19/26 (73%) accepted treatment and services with their primary provider, mental health specialist or healthy Start social worker. 816 (100%) interconceptional clients were also screened  
1a. The staff and community providers received 4 trainings on Perinatal depression.  
1b. Completed. 8 clients received psych medications by their providers.  
1c. The nurse or the social worker made the initial assessments. 127 women were re-screened. 26 referrals for treatment are made to the ENHC Mental Health or to Mental Health services in the community. 19 women accepted treatment. The social worker makes at least 2 follow-up home visits per week. |
### Grantee: The Chicago Department of Public Health (CDPH)

### Intervention: Perinatal Depression

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| PD By 5/31/05, 90% of pregnant/post partum women will be assessed for depression; 70% of those who experience symptoms will be referred and 10% will accept treatment | **Strategy:** Select and enroll clients in an appropriate level of care based on identified risk factors.  
**Activities (with Implementation Time frames):**  
2a. Screen women upon admission; 3-6 weeks post-partum; prior to discharge from the HS program. Obtain consents and develop a plan of care with each woman within one week of admission to the program. **BY January 02 and continuing throughout Project Period.**  
2b. Maintain telephone communication with the woman’s primary health care provider to obtain information about her treatment regime, and share information (as approved by the client) about other services that she is receiving that may impact the outcome of her depression. **BY January 02 and continuing throughout Project Period.**  
2c. Make home visits, conduct face-to-face contacts with the women in the WIC and maternal clinics, or telephone them to ensure that they are adhering to their prescribed regime. **BY January 02 and continuing throughout Project Period.**  
2d. Ensure that women receive the support they need to enable them to keep their visits for service, and manage (tokens; child care, company). **BY January 02 and continuing throughout Project Period.**  
3a. Develop short messages that all staff can use to provide consistent information to women and their support system about aspects of their care. **BY January 02 and continuing throughout Project Period.**  
3b. Identify and participate in the variety of MCH workshops on perinatal depression provided through the Title V Agency and the Universities of Chicago and Illinois. Obtain a copy of the videotape developed by the Title V Agency to assist health professionals in their understanding of perinatal depression. **BY January 02 and continuing throughout Project Period.**  
4. Maintain up-dated and accurate client records demonstrating all services provided; barriers to providing services; and, client outcomes resulting from services received or not received. **BY January 02 and continuing throughout Project Period.** | 2a. All postpartum women were screened upon entry into the program using the Edinburgh screening tool. 127 (15.5%) were re-assessed. 19 accepted treatment.  
2b. Completed.  
2c. Completed.  
2d. Completed.  
3a. Completed.  
3b. Completed.  
## BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN

**Grantee:** The Chicago Department of Public Health (CDPH)  
**Intervention:** Immunization of 2-year-olds

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| CM1. By 06/1/2005 increase the proportion of infants that are age appropriately immunized to 80% (2000 children). | **Strategy:** Identify inadequately immunized infants and implement aggressive follow-up measures to improve levels.  
**Activities (with Implementation Time frames):**  
1a. The CDPH Immunization Division will: a) share with the community the results of the 2000 CDC survey highlighting the low immunization; b) assess and discuss staff personal vs professional reaction to the importance of a completed series of immunization; c) respond to concerns about vaccine side effects; d) provide one educational session for health care providers, WIC staff, consortium members and community agencies re the importance of the completed immunization series for 2 year old children *(Continued from CY 2001 and throughout the Project Period).*  
2a. All HSI staff will distribute literature provided by the CDPH Immunization Division, and at each visit to an infant review them with care givers to reinforce the need for completing the immunization series. *(Continued from CY 2001 and throughout the Project Period).*  
2b. All HSI staff will collaborate with parents/care givers and health care professionals to verify child immunization records, remind parent/care givers of pending appointments and support them in securing immunization. *(Continued from CY 2001 and throughout the Project Period).* | Not Accomplished., but greatly improved. As of May 31, 2005, 865/1154 (75%) of infants and 2 year-olds were appropriately immunized. |

**Baseline:**  
In 2000, 1767 (55%) 18-35 months had received either the 4:3:1:3 or 4:3:1 series of immunizations. *(CASA audits conducted by CDPH Staff)*

**Project Performance Indicators:**  
The number and percentage of infants who are appropriately immunized.

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<tr>
<td>2a. Staff distributed approximately 5800 brochures and immunization schedules and discussed the information with clients.</td>
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</table>

2b. Population is very transient. Staff needed to improve on the review immunization records for compliance and updated them at WIC appointments, well-child visits, CM/Outreach and at home and office visits.
**BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN**

**Grantee:** The Chicago Department of Public Health (CDPH)  
**Intervention:** Immunization of 2-year-olds

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<tr>
<th>Project Period Objective</th>
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</table>
| CM1. By 06/1/2005 increase the proportion of 2-year-olds that are age appropriately immunized to 80% (2000 children). | **Strategy:** Identify inadequately immunized infants and implement aggressive follow-up measures to improve levels.  
**Activities (with Implementation Time frames):**  
2c. The Outreach and Case Management staff will promote the Fast Track Immunization program and refer clients there for immunizations. *(Continued from CY 2001 and throughout the Project Period).*  
2d. During outreach efforts, staff will locate clients with delinquent appointments and assist them to make and keep their appointments. *(Continued from CY 2001 and throughout the Project Period).*  
1c. Staff will maintain and submit accurate client immunization records to the Project Manager. These would include: a) the number of infants who were identified as needing immunizations; b) the number who were referred and connected with immunization services; c) the reasons for non-referral and lack of connection with services; d) successful/ unsuccessful strategies used to connect clients with services, and e) the number and types of educational materials distributed. *(Continued from CY 2001 and throughout the Project Period).* | 865/1154 (75%) of infants and 2 year olds have been appropriately immunized.  
2c. 416 community participants were referred to the Fast Track Immunization Program. The HSI staff distributed 3245 Immunizations information and schedule brochures to community participants  
2d. Staff made home visits, sent reminder letters, and made follow-up telephone calls to assist the clients in keeping their appointments  
1c. The staff submitted a monthly report to the Project Manager with immunization information. a) 92 infants were identified as needing immunizations. b) 86 were referred and connected with immunization services. |
BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN

Grantee: The Chicago Department of Public Health (CDPH)
Intervention: First Trimester Prenatal Care

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<th>Project Period Objective</th>
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</table>
| CM2. By 6/1/2005 the proportion of pregnant women who initiate prenatal care in the first trimester will be increased to 75% (427 women) | **Strategy:** Provide outreach and case finding to identify and enroll pregnant women in prenatal care during the first trimester of pregnancy.  
**Activities (with Implementation Time frames)**  
1a. Provide two in-service sessions for PHAs and Case Management Assistants on the health benefits for mothers and babies of early entry into prenatal care. Review this information with them on a quarterly basis.  
(Continued from CY2001 throughout the Project Period).  
1b. Assist the PHAs (community residents) to identify barriers to obtaining prenatal care, and suggest strategies for overcoming them to allow mothers to participate in prenatal care.  
(Continued from CY 2001 throughout the Project Period).  
2a. Establish an agreement with the Englewood Neighborhood Health Center (ENHC) and the Planned Parenthood clinic to obtain the names of women who received positive pregnancy tests but did not register for prenatal care.  
(Continued from CY 2001 throughout the Project Period).  
2b. Visit the ENHC and the Planned Parenthood clinic weekly to obtain lists of women who received positive pregnancy tests but did not enroll for prenatal care. Assign the PHAs to locate and encourage clients to make appointments with providers of their choice.  
(Continued from CY 2001 throughout the Project Period).  
2c. Assess the needs of the women, and triage them according to risk status into Case Management, the Outreach Program, the CDPH Public Health Nurse Program other coordinating agency for care.  
(Continued from CY 2001 throughout the Project Period). | Improved but not accomplished. 283/587 (48%) of pregnant women began prenatal care in the first trimester of pregnancy.  
1a. 2002 the Outreach Workers and the CM staff attended an 8 session “Bright Future Training”. 2004 the HSI staff attended a “SIDS and Infant Mortality training”.  
1b. This was ongoing in weekly team meetings.  
2a. The ENHC, WIC, and FCM programs referred clients to the GEHSI program. The Data Entry Operator also identified pregnant women who lived in the target area, but were unconnected to services.  
2b. The Outreach team talked to 552 women at the Public Aid and WIC offices. 105/552 (18%) pregnant women were recruited from these offices. Of those 85/105 (89%) initiated prenatal care in the first trimester of pregnancy.  
2c. Referrals were triaged by the Nursing Supervisor and/or the CM Coordinator to determine risk status and needs. |

Baseline: In 2000, 53/268 (19.4%) of Healthy Start received prenatal care in the first trimester of pregnancy.  

Project Performance Indicator: The percent of women receiving care from the first trimester.
## BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** First Trimester Prenatal Care

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| CM2. By 6/1/2005 the proportion of pregnant women who initiate prenatal care in the first trimester will be increased to 75% (427 women) | **Strategy:** Provide outreach and case finding to identify and enroll pregnant women in prenatal care during the first trimester of pregnancy.  
**Activities (with Implementation Time frames)**  
2d. Maintain telephone communication with the woman’s primary health care provider to obtain information about her prenatal regime, and share information (as approved by the client) about other services that she is receiving that may impact the outcome of her pregnancy. *(Continued from CY 2001 throughout the Project Period).*  
2e. Make home visits, conduct face-to-face contacts with the women in the WIC and maternal clinics, or telephone them to ensure that women adhere to their prescribed regime. *(Continued from CY 2001 throughout the Project Period).*  
3a. The HSI staff will use culturally specific material to promote the value of early prenatal care. The Consortium members will help distribute this material to community residents, social agencies, businesses and community and religious organizations. *(Continued from CY 2001 throughout the Project Period).* | Improved but not accomplished. 283/587 (48%) of pregnant women began prenatal care in the 1st trimester of pregnancy.  
2d. Primary care providers were contacted monthly or as needed to discuss the client’s medical status  
2e. 454/587 (77%) of pregnant women received prenatal care at the ENHC. Face to face contacts were made during WIC and Prenatal clinic visits. 98/587 (17%) of pregnant women received prenatal care with outside providers. Home visits were made at least twice monthly on all pregnant women.  
3a. All literature and brochures were culturally sensitive. Literature and brochures were in English and Spanish. |

**Baseline:** In 2000, 53/268 (19.4%) of Healthy Start received prenatal care in the first trimester of pregnancy.  
**Source:** HSI Outreach and Case Management Reports, 2000.

**Project Performance Indicator:** The percentage of women receiving care from the first trimester.

**Comment.** Given their many issues, clients in this community still do not see prenatal care as a priority. Also women, especially teens do not want to readily admit to their pregnancy.
# BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** First Trimester Prenatal Care

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<tr>
<td>CM2. By 6/1/2005 the proportion of pregnant women who initiate prenatal care in the first trimester will be increased to 75% (427 women)</td>
<td>3b. The Outreach, Case Management, and Health Education staff will reinforce each others efforts to encourage local supermarket managers, and vendors of food to stock or serve more fresh fruits and vegetables and less high fat, high sodium and processed foods. They will provide vendors with information for display that would promote healthy food choices. <em>(Continued from CY 2001 throughout the Project Period).</em></td>
<td>3b. HSI staff distributed posters and other literature to 45 local grocery stores and supermarkets to display. The HSI and HE staff encouraged vendors to display healthy food choices. The Healthy Start Nutritionist and Health Educator implemented 4 healthy food preparation demonstrations in the clinic to encourage pregnant women to select and prepare healthy foods.</td>
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<td>3c. The Outreach, Case Management, and Health Education staff will reinforce each others efforts to encourage local supermarket managers and other vendors of alcohol and cigarettes to advise pregnant women to refrain from smoking and using alcohol. <em>(Continued from CY 2001 throughout the Project Period).</em></td>
<td>3c. The Outreach and Case Management staff distributed 4600 pieces of literature and brochures on the effects of smoking cigarettes and drinking alcohol during pregnancy to the local supermarket and other vendors</td>
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**BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN**

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Postpartum examinations

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| CM3. By 5/31/05 the proportion of women who receive postpartum examinations will increase to 89% (801/900 women). | **Strategy:** Enroll women with a health care provider post-delivery to receive post-partum care and family planning services.  
**Activities (with Implementation Time frames)**  
1a. Work with the provider network to establish a protocol for follow-up of clients who miss their post-partum appointments. *(Continued from CY 2001 and ongoing throughout the Project Period).*  
2a. During the third trimester of the woman’s pregnancy, collaborate with the woman’s health care provider to reinforce information about the health value of a post-partum examination six weeks after delivery. *(Continued from CY 2001 and ongoing throughout the Project Period).*  
2b. Collaborate with the women and their health care providers to ensure that women receive and keep their appointments for post-partum six weeks after delivery. *(Continued from CY 2001 and ongoing throughout the Project Period).*  
2c. During outreach activities recruit and refer post-partum clients previously unknown to the HSI staff for check-ups within six to eight weeks after delivery. *(Continued from CY 2001 and ongoing throughout the Project Period).*  
2d. Case manage clients who experience barriers to facilitate their return for the visit to ensure compliance with medical examinations. *(Continued from CY 2001 and ongoing throughout the Project Period).* | Achieved. 736/816 (90%) HS postpartum women received postpartum examinations within 6-8 weeks after delivery.  
1a. CMs made appointments, home visits and telephone calls to clients. Data Entry staff review new postpartum list via the computer for follow-up.  
2a. Completed. During the third trimester of the women’s pregnancy the CM and the CMA collaborated with the health care provider to reinforce the importance of the 6-8 week postpartum visit.  
2b. Home visits and telephone calls are made to the women and their health care providers. Reminder letters are also mailed to the women.  
2c & d. Outreach Staff recruited and referred postpartum clients for check-ups. 105 community participant women were recruited and connected for their 6-8 week postpartum exams. 2 community participants who had miscarriages were recruited and connected for their postpartum exams. |

**Baseline:** 56.6% (211/373) HSI women received documented postpartum examinations in 2000. **Source:** HSI records, 2000.

**Project Performance Indicator:** The percent of women who receive postpartum examinations.
**BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN**

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Percent of HSI Women who use an Effective Method of Family Planning

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| CM4 By 5/31/05 the proportion of sexually active HSI clients who use an effective method of family planning will increase to 75% (675/900 women). | **Strategy:** Identify and refer post-partum and non-pregnant HSI women to a health care provider for family planning services.  

**Strategies (with Implementation Time frames)**  
1a. Work with the local hospital’s discharge team to identify and enroll client who are discharged without family planning information or methods with an appropriate provider. *(Continued from CY2001 throughout the Project Period).*  
1b. Refer non-pregnant sexually active women and their partners to the ENHC, the Planned Parenthood Clinic, or to the provider of their choice for family planning services. *(Ongoing throughout the Project Period).*  
1c. Provide culturally appropriate and accurate information on family planning methods to women and their partners, verify their family planning status, refer those needing linkages, and assist them in keeping all appointments. *(Ongoing throughout the Project Period).*  
1d. Provide support to new contraceptive users, explaining and assisting them to deal with common side effects. *(Ongoing throughout the Project Period).*  
1e. Collaborate with the Coordinator of the Male Responsibility to provide education, support and training to encourage male support for the family planning efforts. *(Ongoing throughout the Project Period).*  
2a. Seek in information from the community about the most effective and culturally appropriate methods to disseminate family planning information including locations for service. *(Ongoing throughout the Project Period)*  
2b. Through the ENHC an the Planned Parenthood Clinic, provide in-service education for the community organizations bi-annually for the community organizations that do not offer family planning services, and encourage them to refer clients for care. *(Ongoing throughout the project period).* | 736/816 (90%) HS women received family planning services.  
1a. Staff reinforced family planning information and provided follow-up to clients.  
1b. The Outreach and Case management staff referred non-pregnant sexually active women and their partners to a provider of their choice for family planning.  
1c. Completed.  
1d. Completed.  
1e. All HSI clients and their partners were educated on the importance of family planning. 4 in-services were provided for the clients and their partners.  
2a. The HSI Staff attended one outside Family Planning in-service.  
**BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN**

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Percent of HSI Women who use an Effective Method of Family Planning (continued)

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| CM4 By 5/31/05 the proportion of sexually active HSI clients who use an effective method of family planning will increase to 75% (675/900 women). | **Strategy:** Engage in aggressive case finding of women who have delivered, and encourage enrollment for post-partum and family planning visits.  
**Strategies (with Implementation Time frames)**  
2c. Assign a PHA to visit the Public Aid Office weekly to identify women who might need referrals for services. | 736/816 (90%) HS women received family planning services.  
2c. PHAs visited the Public Aid and WIC Offices weekly. They identified and recruited women appropriate for HSI services. 120 women were recruited for the HSI services. 15/120 (13%) of them were postpartum women needing postpartum exams and family planning services. |

**Baseline:** Calendar Year 2000, 44.9% (288/641) of HSI women received Family Planning Services. **Source:** HSI Reports.

**Project Performance Indicator:** Number and percentage of post-partum women who are linked with and are using an effective method of family planning.

| 2d. Expand the distribution network for Family Planning literature to assure that families receive community support to obtain family planning information services. Leave materials in accessible locations such as barber and beauty shops, libraries, parks, community agencies, Consortium members, other health care professional for easy access by families. **(Ongoing throughout the project period).** | 2d. Outreach and CM staff distributed literature on family planning in barbershops/beauty shops, parks, libraries, gas stations, and grocery stores. They also gave them to Consortium members and other health care providers to distribute in the community.  
2e. Outreach staff made linkages with Englewood HS, Roberson HS, Harper HS, and The Rebirth of Englewood for job training placement, GED training and testing and other alternatives for clients. 235 clients were assisted with and/or received jobs. 37 completed the GED training. 22 teen moms were assisted in returning back into school. |
| 2e. Collaborate with the Park District the Boy’s and Girl’s Clubs, the local School Council and St. Sabina’s job training, and tutoring for clients (especially adolescents) as a means for reducing pregnancies. | 2e. Outreach staff made linkages with Englewood HS, Roberson HS, Harper HS, and The Rebirth of Englewood for job training placement, GED training and testing and other alternatives for clients. 235 clients were assisted with and/or received jobs. 37 completed the GED training. 22 teen moms were assisted in returning back into school. |
| 3. Maintain accurate monthly records of: a) the number of clients who were identified as needing family planning services; b) the number of clients who were referred and connected with family planning and other services; c) the reasons for non-referral and lack of connection with services; d) the method of family planning being used; e) successful/ unsuccessful strategies used to connect clients with services; f) resource gaps for clients; g) the number and types of educational materials distributed; and h) the names of the most cooperative community agencies, health care organizations and businesses. **(Continued from CY2001 and ongoing throughout the project period).** | 3. Weekly and monthly data were collected and maintained by the PHAs and CMs. Clients were assisted with making appointments and obtained follow-up services. |
**BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN**

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Reduction of the Percentage of LBW, VLBW, Pre-term and SGA Infants

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<td><strong>CM5</strong> By5/31/05, among HSI infants, decrease the percent of a) LBW infants from 12.4% to 10.4% b) VLBW infants will decrease from 8.5% to 6%; c) pre-term births will decrease from 19.4% to 17.4%; and, d) SGA infants will decrease from 5.8% to 3.8%. <strong>Baselines:</strong> In calendar year 2000, a) 12.4% of HSI infants were LBW; 8.5% were VLBW; and, 19.4% were pre-term. In the PA for 1996-1998, 5.8% of infants were SGA. <strong>Source:</strong> CDPH Vital Records, 2000. <strong>Project Performance Indicators:</strong> Decreased percentage LBW, VLBW, pre-term infants, and SGA HSI infants.</td>
<td><strong>Strategy:</strong> Select and enroll clients in an appropriate level of care based on identified risk factors. <strong>Activities (with Implementation Time frames)</strong> 1a. Provide training to staff, community providers and the Consortium on topics such as: a) adequate weight gain in pregnancy; b) smoking cessation; c) freedom from infection such as STDs, HIV, bacterial vaginosis, periodontal disease; d) non-use of alcohol, marijuana and cocaine; e) birth spacing; and f) the importance of prenatal care in the first trimester of pregnancy. <em>(Begin CY 2001 and continuing throughout the Project Period).</em> 1b. Collaborate with health care providers to assess pregnant women for risk factors associated with adverse pregnancy outcomes: previous Pre-term births and low and very low birth-weight births; abuse of drugs and alcohol and cigarettes; short interconceptional periods, age less than 15 years, and precarious housing. <em>(Begin CY 2001 and continuing throughout the Project Period).</em> 1c. Select and assign women to different levels of Case Management as follows: Level I: Those with no exceptional risk factors to the CDPH PHNs program. Level II: Clients whose history suggest the a possible LBW, VLBW, Pre-term birth or SGA infant (100 women) to the Healthy Start Case Management team. Home visits should be conducted every one to two weeks. Level III: Women who are abusing drugs to the Healthy Fit Program for treatment during the prenatal period. Home visits will occur weekly to assure compliance with treatment. <em>(Begin CY 2001 and continuing throughout the Project Period).</em></td>
<td>546 HS infants were born. Among singletons a) 40/546 (7%) were LBW, b) 11/546 (2%) were VLBW, c) 29/546 (5%) were pre-term, d) 22/546 (4%) were SGA. 1a. Training was provided for staff, providers and consortium members on: HIV/STD, Nutrition, DV/Sexual Assault, The Effect of Smoking and Smoking cessation, Perinatal Depression, Periodontal Disease during pregnancy, Drugs and alcohol, Interconceptional Case Management, prenatal care in the first trimester of pregnancy and pre-term infants. 1b. The HSI program collaborated with the community Health care providers who were invited to attend all the trainings that were mentioned above in 1a. 1c. Women who demonstrated a history of risk factors were assigned to HSI CM and home visits were arranged. Women with issues of substance abuse were referred to the social worker for social services. 146 women were counseled for drug and alcohol use. 123 admitted to drug and alcohol use, 82 women referred treatment. 27 completed treatment. 64 stated they drank one to two beers wkly and reported that they stopped on their own and refused treatment. 64 refused treatment.</td>
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**BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN**

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Reduction of the Percentage of LBW, VLBW, Pre-term and SGA Infants

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| **CM5** By5/31/05, among HSI infants, decrease the percent of a) LBW infants from 12.4% to 10.4% b) VLBW infants will decrease from 8.5% to 6%; c) pre-term births will decrease from 19.4% to 17.4%; and, d) SGA infants will decrease from 5.8% to 3.8%. | **Strategy:** Select and enroll clients in an appropriate level of care based on identified risk factors.  
**Activities (with Implementation Time frames)**  
2a. Obtain consents and develop a plan of care with each woman within one week of admission to the program. *(Begin CY 2001 and continuing throughout the Project Period).*  
2b. Maintain telephone communication with the woman’s primary health care provider to obtain information about her prenatal regime, and share information (as approved by the client) about other services that she is receiving that may impact the outcome of her pregnancy. *(Begin CY 2001 and continuing throughout the Project Period).*  
2c. Make home visits, conduct face-to-face contacts with the women in the WIC and maternal clinics, or telephone them to ensure that women adhere to their prescribed regime. *(Begin CY 2001 and continuing throughout the Project Period).*  
2d. Ensure that women receive the support they need to enable them to keep their visits for service (tokens; child care, company. *(Begin CY 2001 and continuing throughout the Project Period).*  
3a. Develop short messages that all staff can use to provide consistent information to women about aspects of their care. *(Begin CY 2001 and continuing throughout the Project Period).*  
3b. Identify and participate in the variety of MCH workshops available in the City through the University Chicago, the University of Illinois at Chicago, and the March of Dimes. *(Begin CY 2001 and continuing throughout the Project Period).*  
4. Maintain up-dated and accurate client records demonstrating: all services that were provided; failed attempts to provide services and reasons for this; client outcomes resulting from services received or not received. *(Begin CY 2001 and continuing throughout the Project Period)* | 546 HS infants were born. Among singletons: a) 40/546 (7%) were LBW, b) 11/546 (2%) were VLBW, c) 29/546 (5%) were pre-term, d) 22/546 (4%) were SGA.  
2a. Completed by the CMs and CMAs.  
2b. Completed. Pregnant women are encouraged to carry their cards with them to each prenatal visit.  
2c. Completed by the outreach and case management staff.  
2d. Families received bus tokens or cab vouchers to encourage them to keep their appointments.  
3. Completed.  
3b. Completed.  
Grantee: The Chicago Department of Public Health (CDPH)

Intervention: Change in Prevalence of Risk Behaviors such as HIV

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<td>Education, Counseling, and treatment for HIV</td>
<td><strong>Strategy:</strong> assure education of providers and clients. Refer clients for counseling, testing and treatment as needed.</td>
<td>587 (100%) of pregnant women were educated and screened for HIV/STD. 56 clients were treated for std. 3 clients tested positive for HIV and received treatment. 1. Two trainings on HIV/STD were provided at the consortium</td>
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</table>
| RI By 05/31/05, 100% of pregnant women will be counseled, 95% will be tested for HIV during pregnancy, and 95% of those identified as HIV Positive will receive drug therapy to prevent Progress of their disease, and transmission to the infant. | **Activities (with Implementation Time Frames)**  
1. The HSI will educate care-givers regarding the standards for STD screening, including HIV counseling as a standard for prenatal care. (July 2000)  
2. CDPH will offer HIV counseling and testing services for all clients who receive prenatal care at the ENHC. (March 2000)  
3. The HSCM or HSMA will verify the counseling and testing status of all women admitted to the program. (Began April 2000)  
4. The Maternal Cluster at the ENHC will continue to refer all women who are HIV Positive for care at the Cook County Hospital or the University of Chicago to continue their prenatal care, and to receive treatment for their infection. (As identified)  
5. The HSCM or HSCMA will: 1) determine the primary care giver, and the treatment regime, and will contact the woman prior to each appointment to assist her to keep the appointments; 2) assure that the woman receives the supportive services needed to assist in coping with the infection. (As identified)  
6. Supply the network providers and family planning clients with access to free condoms, handouts on proper utilization, and consumer education information on prevention of STD/HIV. (By June 2002 and ongoing throughout the Project Period) | 2. 511 pregnant women received their prenatal care at CDPH. All women were counseled and tested for HIV.  
3. The CM and CMA used the women’s medical records to check their HIV/STD status.  
4 The 3 women who tested positive for HIV were and accepted treatment at the Cook County Hospital Core Center.  
5. The primary care providers were contacted on a monthly basis or as needed to discuss the client’s medical condition and/or changes. Staff provided the women with tokens to keep their appointments.  
6. The emphasis in the program was on abstinence as the preferred safety method. However, the HIS staff provide network provider and clients with free condoms and literature on HIV/STD. HS staff also provided information on prevention of HIV/STD to clients. The Peer Educators distributed condoms daily at the ENHC. All staff distributed at health fairs and during outreach. |

Baseline: In 2002, 134 (100%) clients received education about the prevention of HIV; all clients were treated.  
Source: HS records 2002.
## BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN

**Grantee:** The Chicago Department of Public Health (CDPH)  
**Intervention:** Change in the Prevalence of Risk Behaviors such, Substance Abuse, and Family Violence

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<td><strong>Smoking Reduction</strong></td>
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<td><strong>R1</strong> By 5/31/05 at least 70% of Healthy Start women will abstain from tobacco use (630 will be enrolled in the brief smoking intervention program).**</td>
<td><strong>1. The Director of Behavioral Health Staff (DBHS) and members of the private provider network have modified the brief smoking intervention for use within the private provider network, and will continue to provide in-service training for members of the provider network (Consortium providers, public health nurses, WIC nutritionist, case managers, case manager assistants, private providers, hospital clinic staff, etc.) On the revised protocol. (Ongoing since FY 2000 and will continue through the Project Period.)</strong></td>
<td>587 pregnant women were assessed for smoking. 128 received counseling. 102 were referred to the smoking cessation. 15 attended and completed the smoking classes.</td>
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<td><strong>Baseline:</strong> In CY2002, 27/120 (22.5%) Healthy Start women were assessed for smoking, and received counseling for smoking. One client stopped smoking. **</td>
<td>2. <strong>Purchase and distribute: a) 1,000 copies of <em>It’s Time</em> smoking reduction/cessation educational material and program support materials, and b) 40 <em>It’s Time</em> posters and mountings. (June 2000).</strong></td>
<td><strong>2. The social worker distributed more than 800 <em>It’s Time</em> Booklets and related anti-smoking education materials. He conducted pre/post test before/after educational training sessions.</strong></td>
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<td>3. Distribute culturally appropriate information on smoking cessation in the community. (Began CY2001 and will continue through the Project Period).</td>
<td>3. Smoking cessation material was culturally sensitive. The booklets and brochures were in Spanish and English.</td>
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<td>4. Continue to provide telephone support for women who desire to stop smoking. (Began CY 2001 and will continue throughout Project Period)</td>
<td>4. 67 women quit smoking during their pregnancy. 35 admitted to decreasing their cigarette intake The HSI staff provide encouragement and support to the clients.</td>
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*Source: Healthy Start Records 2002.*
## BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Change in the Prevalence of Risk Behaviors such as smoking, Substance Abuse, and Family Violence

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illicit Substance Abuse Prevention.</td>
<td><strong>Activities (with Implementation of Time Frames)</strong></td>
<td>587 pregnant women were assessed for substance abuse. 59 of them admitted to abusing substances 8 were referred and successfully completed treatment.</td>
</tr>
</tbody>
</table>
| R1. By 05/31/05, 80% of women who are using illicit substances will be identified. 70% will be referred for treatment and 50% will complete drug treatment. | **Substance Abuse**
1. The HSI and the Director of Substance Abuse Prevention & Treatment @ CDPH will use the Alcohol Screening tool with the health care team to: a) orientate them to the screening tool; b) develop strategies for implementing the tool into the home and in their practices. c) orientate them to community resources for treatment. (By May 2002 and continuing through the project Period) | **Baseline:** In 2002, 24/42 (54.7%) of women received counseling. Two were referred for impatient services. One person kept her appointment. **Source:** Healthy Start Case Management Report 2002. |
| | 2. HS Case Managers and Social Worker will collaborate with the Mental Health Staff at ENHC and providers, and will refer 95% of identified substance using women to the appropriate treatment modalities. (By May 2002 and continuing through the Project Period) | 2. 59 women were referred to the following treatment Centers: Haymarket (31), HRDI (10), Interventions (10). |
| | 3. The Healthy Start case management team will provide intensive case management services to ensure that at least 30% of the referred women complete treatment. (By Sept. 2000 and continuing through the Project Period). | 3. The women who received treatment were followed-up via home visits, telephone calls and HSI office visits. |
| | 4. The Health Educator and Social Worker will organize/provide a minimum of three educational sessions for police officers at the local Police District that serves the target area. The in-service will include information regarding: a) identification of substance using women; b) community resources; c) referring women to HSI staff for case management. (Begin June 2002 and continue through the Project Period). | 4. Not completed. |
| | 5. The Healthy Start Case Manager will work with hospital liaison nurse to determine if the infants are born substance exposed, and will provide case management to ensure that they receive treatment as needed. (Begin June 2002 and continue through the Project Period). | 5. Infants testing positive for drugs were referred to the HSI program through the high risk APORS program and followed by the Case Manager. |

**Project Performance Indicator:** % of women referred and who received treatment.
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<tbody>
<tr>
<td><strong>Prenatal Alcohol Abuse Prevention.</strong></td>
<td><strong>Strategy:</strong> Identify pregnant women who are abusing alcohol through screening and clinical observation and enroll them in treatment.</td>
<td>587 pregnant women were assessed for alcohol use. 87 women used alcohol. 59 reported they stopped when found out they were pregnant. 23 were referred for treatment. 64 refused treatment.</td>
</tr>
<tr>
<td><strong>RI</strong> By 05/31/05, 800 pregnant women will be screened for alcohol abuse, 50% of those with the problem will be referred to treatment, 50% of those referred will be followed by the Healthy Start. 30% will complete treatment.</td>
<td><strong>Activities (with Implementation Time Frames)</strong></td>
<td>1. The CMs and the CMAs use the substance abuse screening tool that is part of the admission package. In 2004, Dr. Ira Chasnoff provided updates for the HSI Staff and community providers on how to assess a woman for drugs and alcohol use during pregnancy.</td>
</tr>
<tr>
<td><strong>Baseline:</strong> In 2002, 8 pregnant women were referred. 6/8 (75%) completed treatment. One is still in treatment. <strong>Source:</strong> Healthy Start Case Management Report 2002.</td>
<td></td>
<td>2. 23 women were referred for treatment. 64 refused treatment. 19 successfully completed treatment</td>
</tr>
<tr>
<td><strong>Project Performance Indicator:</strong> % of women not using alcohol, or treated for alcohol use.</td>
<td>3. The Healthy Start case management team will provide intensive case management services to ensure that at least 30% of the referred women complete treatment. (BY May 2002 and continuing through the Project Period).</td>
<td>3. The women who received treatment are followed-up via home visits, telephone calls and HSI office visits.</td>
</tr>
</tbody>
</table>
**BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN**

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Change in Prevalence of Risk Behaviors such as Smoking, Substance Abuse, and Family Violence.

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</thead>
<tbody>
<tr>
<td><strong>Family Violence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>R1. Project period Objectives:</strong> By 5/31/05, 100% o clients (4% of 900:N=36) who experience partner abuse will receive screening, counseling and referral for services.</td>
<td><strong>Strategy:</strong> Assure education of providers. Provide screening and referral of clients.</td>
<td>41 women were referred for assistance for domestic violence. 35 refused DV assistance and were monitored by the CM. 6 were referred to a shelter and accepted.</td>
</tr>
<tr>
<td></td>
<td><strong>Activities (with Implementation of Time Frames) for Domestic violence</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1a. The HSCM or HSCMA will use the CDPH screening tool for all pregnant women in the program to identify those who are experiencing domestic violence in their relationships. (Began April 2000).</td>
<td>1a. Screening for DV screening is part of the admission risk assessment. Additional screening is conducted periodically.</td>
</tr>
<tr>
<td></td>
<td>1b. The HSCM or HSCMA will provide all women with the City of Chicago Domestic Violence Help line (1877-863-6388) or TTY 1-877-863-6339. (Began April 2000).</td>
<td>1b. This has been a CDPH practice. Two agencies provide on-site domestic and rape crisis counseling at the ENHC.</td>
</tr>
<tr>
<td></td>
<td>1c. The HSCM or HSCMA will counsel and/or refer women who are experiencing violence for the appropriate counseling and shelter as needed. (Began April 2000).</td>
<td>1c. Women who experience DV or who are suspected of DV are give palm cards and are referred to the social worker for consultation. 6 women were referred to a shelter.</td>
</tr>
</tbody>
</table>
**BUDGET PERIOD OBJECTIVE/IMPLEMENTATION PLAN**

**Grantee:** The Chicago Department of Public Health (CDPH)

**Intervention:** Consortium

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CI</strong></td>
<td><strong>By 5/31/05 enhance consumer participation in the HSI so that 25% of members (8/32) are consumers who regularly attend and actively participate in HSI Consortium meetings and activities.</strong></td>
<td></td>
</tr>
</tbody>
</table>
**Strategy:** Consortium participation in the HSI will increase through knowledge enhancement and development of an operating structure that promotes involvement  
**Activities (with Implementation Time frames)**  
1. The HSI will each bring at least two consumers to every Consortium meeting. *Continued from BY 01/02 and throughout Project Period.*  
2. Work with the Consortium to identify and recruit and expand its membership in the targeted areas. *Continued from BY 01/02 and throughout Project Period.*  
3. Work with the community businesses and clergy organization, and the community alternative policing strategy (CAPS) to recruit additional members for the Consortium. *Continued from BY 01/02 and throughout Project Period.*  
4. Provide funding for the following services to support consumer participation in the Consortium: a) babysitting; b) transportation (tokens, cab vouchers). *Continued from BY 01/02 and throughout Project Period.*  
5. The Project Coordinator and CDPH Public Information will work with the Consortium on the following community education strategies: a) the impact of infant mortality on the community; b) risk factors (smoking, substance abuse, adequate nutrition and weight gain) and the importance of prevention; c) the importance of well-child services and immunization; d) SIDS prevention – Back to Sleep Program e) the importance of genetic screening as a prevention strategy. d) impact of perinatal HIV transmission and effective prevention/treatment strategies. *Begin July 2001 and throughout the Project Period.* | 1. Completed although stable membership was not achieved.  
2. Completed by staff  
3. Outreach was completed.  
4. Completed. Most Consumers were transported by the CDPH van.  
5. Completed |
Section I: Introduction

Local Evaluation Component

A. The evaluation of the Chicago Department of Public Health’s Greater Englewood Healthy Start Initiative was a multi-level (individual and community) designed to assess the effectiveness of GEHSI in meeting its stated goals of reducing infant mortality, reducing infants born with low birth weight, and reducing the number of infants born prematurely. The evaluation design called for interviewing 240 Healthy Start clients, with an equal number being prenatal and postpartum. The GEHSI staff was responsible for introducing the evaluation and obtaining contact information on potential participants in the evaluation study. The evaluation was contracted out to the University of Illinois at Chicago.

B. The evaluation plan included measurements of specific performance indicators specifically from the core services of the program objectives. The main reasons for not participating (18%) was that the woman could not reached, telephone disconnected or no telephone number was provided on the contact information. Another reason was that if changes were modified to the recruitment strategy, that would have required changes to the Institutional Review Board (IRB) protocol which is through the University of Illinois at Chicago.

C. The evaluation was a combined outcome and process evaluation intended to assess both the impact of the Healthy Start Intervention (Core Services and System Efforts) among program participants in the targeted communities. The clients involved were either pregnant women or postpartum women. Some of the women who participated in the evaluation may have also been involved in the Consortium, however this was not mentioned in the evaluation.

II Process

A. Procedures for evaluation

Prenatal Care and Postpartum Survey

The purpose of the prenatal care and postpartum survey was to collect information from pregnant women in the HS program in order to assess the extent to which GEHSI objectives were achieved.

A1. Data Collection Procedures

The Evaluation Team interviewed 26 pregnant women and 20 postpartum women from 1/1/02 through 12/31/03. The interview was a 30 minute questionnaire that was read to the women by a trained research assistant. Criteria for participating in
the survey included: a) being pregnant or postpartum; and a b) HS participant. Women were recruited from the GEHSI program. Case managers and outreach workers introduced the study to the Healthy Start client and obtained permission for the research team from the University of Illinois at Chicago to contact the client. The client’s name and phone number were recorded on a form that was mailed to the evaluation team, usually within a week of obtaining permission.

A2. Methodology
The prenatal care and postpartum surveys contained items that were intended to capture data about the GEHSI objectives, as well as to obtain demographic characteristics of the target population. Specifically, women were asked about their satisfaction with prenatal care. Postpartum women were also asked questions about the outcome of their most recent pregnancy, whether they received information on health topics such as: breast-feeding, family planning, domestic violence, immunizations, “Back to Sleep”, and the importance of involving the baby’s father. A sampling design was not used in this evaluation.

B. Identifying and describing data sources
A set of questions designed to measure clients’ satisfaction with their prenatal care providers is included in the survey. The women were generally satisfied with the various aspects of their prenatal (Table 2).

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received a rating of very good or excellent for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helpfulness of advice</td>
<td>20</td>
<td>77%</td>
</tr>
<tr>
<td>Would definitely recommend provider to a friend</td>
<td>19</td>
<td>73%</td>
</tr>
<tr>
<td>Level of concern</td>
<td>19</td>
<td>73%</td>
</tr>
<tr>
<td>Explanation of procedures</td>
<td>19</td>
<td>73%</td>
</tr>
<tr>
<td>How comfortable made to feel</td>
<td>18</td>
<td>69%</td>
</tr>
<tr>
<td>Level of respect</td>
<td>17</td>
<td>65%</td>
</tr>
<tr>
<td>Thoroughness of check-up</td>
<td>17</td>
<td>65%</td>
</tr>
<tr>
<td>Technical skill</td>
<td>16</td>
<td>62%</td>
</tr>
</tbody>
</table>

Postpartum study participants were asked a number of questions about the outcome of their most recent pregnancy. Nineteen women (95%) gave birth to single live infants who came home with the mother when she was discharged from the hospital. Most women (n=14, 70%) reported that their infants were born within a week of the infants due date. However, some (n=3, 15%) infants appeared to have been premature, being born more than three weeks before the due date. One woman (5%) was unsure of her due date and one woman (5%) did not answer the question.
Postpartum women also were asked whether or not they received information on a number of topics related to pregnancy and infant care. The results are summarized in Table 3.

Table 3

<table>
<thead>
<tr>
<th>Yes did receive information about these pregnancy and infant care topics</th>
<th>Number</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information about breast feeding</td>
<td>18</td>
<td>90%</td>
</tr>
<tr>
<td>Where to go for family planning services</td>
<td>17</td>
<td>89%</td>
</tr>
<tr>
<td>Importance of treating vaginal infections</td>
<td>16</td>
<td>80%</td>
</tr>
<tr>
<td>Importance of STD treatment</td>
<td>15</td>
<td>79%</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>15</td>
<td>79%</td>
</tr>
<tr>
<td>Information about douching during pregnancy</td>
<td>15</td>
<td>79%</td>
</tr>
<tr>
<td>Importance of involving the baby’s father</td>
<td>14</td>
<td>70%</td>
</tr>
<tr>
<td>Recommended number of visits</td>
<td>14</td>
<td>70%</td>
</tr>
<tr>
<td>Appropriate weight gain</td>
<td>14</td>
<td>70%</td>
</tr>
<tr>
<td>Folic acid</td>
<td>13</td>
<td>68%</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>12</td>
<td>60%</td>
</tr>
<tr>
<td>Importance of family planning</td>
<td>6</td>
<td>32%</td>
</tr>
<tr>
<td>Importance of spacing pregnancies</td>
<td>6</td>
<td>32%</td>
</tr>
<tr>
<td>“Back to Sleep”</td>
<td>19</td>
<td>100%</td>
</tr>
<tr>
<td>Immunizations</td>
<td>17</td>
<td>89%</td>
</tr>
</tbody>
</table>

A. **Instruments**

The prenatal and postpartum questionnaire contained items to reflect the GEHSI objectives, as well as to obtain demographic characteristics of the target population. This included a set of questions designed to measure clients’ satisfaction with their prenatal care providers. To a large degree, the items in the prenatal survey were parallel to those included in the postpartum, although questions were added in postpartum to reflect health information and breastfeeding.
Findings and Recommendations

Pregnant Women. The women interviewed were predominately AA (96%; n=25) and unemployed (81%; n=21). Over half of the respondents had only received a high school education or less (76.9%; n=20). The women ranged in age from 6.4 years old to 33.8 years old, with an average age of 21 years old. Three of the women interviewed were 17 years old or younger. Women initiated prenatal care at between 3 weeks to 22 weeks gestation. Sixty-one and a half percent (n=16) initiated prenatal care during the first trimester, and 38.5% (n=10) begun prenatal care during their second trimester. At the time of the interview women had received between one and 13 prenatal care visits, with a mean of 6 prenatal visits (Table 1).

Postpartum Women. The women interviewed were AA, had a high rate of employment, and had an education level of high school or less (Table 1). The women ranged in age from 15 years to 27 years old, with an average age of 21 years old. There were 3 women interviewed who ranged from 2 weeks to 28 weeks gestation, with an average of 10 weeks. Seventy-four percent of the women (n=14) began their prenatal care in the first trimester and five women the second trimester (n=26%). The women had received between zero and 30 prenatal care visits, with a mean of 15 prenatal visits.

Table 1 Demographic Characteristics of the Women Interviewed 2002

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Prenatal (n=26)</th>
<th></th>
<th>Postpartum (n=20)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>25</td>
<td>96%</td>
<td>19</td>
<td>95%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>21</td>
<td>81%</td>
<td>15</td>
<td>75%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HS or less (12 or less)</td>
<td>20</td>
<td>76.9%</td>
<td>19</td>
<td>100%</td>
</tr>
<tr>
<td>Some college or more</td>
<td>6</td>
<td>23%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gestational age in weeks at</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st PNC visit</td>
<td>11</td>
<td>5.4</td>
<td>9.9</td>
<td>7.6</td>
</tr>
</tbody>
</table>

Findings related to Prenatal Grant Objectives. Table 4 is a summary of the objectives for pregnant women as stated in the Healthy Start grant proposal. For each objective, the corresponding 2002 evaluation results are presented along with the summary assertion of whether or not the grant objective appears to have been met, based on the available data. For one objective, it was not possible to determine whether or not an objective was met because no baseline data was provided. Overall, it does not appear that GEHSI met its objectives for pregnant women.
Table 4. Achievement of Grant Objectives According to prenatal Survey Results, 2002

**Prenatal Survey**

<table>
<thead>
<tr>
<th>Grant Objectives</th>
<th>Evaluation results</th>
<th>Met Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the proportion of completed referrals among prenatal clients (CMT2 &amp; CMT 4)</td>
<td>Case managers provided from 0 to 8 referrals to their clients. % of women who received services as the result of case managers’ referrals: 30.0% (n=8) received one type of service 3.8% (n=1) received 2 types of services 7.7% (n=2) received 3 types of services 7.7% (n=2) received 4 types of services 3.8% (n=1) received 5 types of services</td>
<td>Unable to determine</td>
</tr>
<tr>
<td>Increase the proportion who receive prenatal care in 1&lt;sup&gt;st&lt;/sup&gt; trimester to 67.4 measured as weeks pregnant at 1&lt;sup&gt;st&lt;/sup&gt; prenatal care visit (CMT2)</td>
<td>% of women beginning PNC: 61.5% (n=16) began PNC in the 1&lt;sup&gt;st&lt;/sup&gt; trimester 38.5% (n=10) in the 2&lt;sup&gt;nd&lt;/sup&gt; trimester</td>
<td>Not met</td>
</tr>
</tbody>
</table>
| Increase the proportion of adult women who have an interconceptional period of 2 yrs. Or more measured as importance of using a contraceptive method to space pregnancies and pregnancy wanted-ness (CMT3) | Importance of contraception: 77% (n=20) of respondents reported using a contraceptive method to space pregnancies was very important; 11.5% (n=3) said it was somewhat important  
*Pregnancy Intendedness:* 19.2% (n=5) wanted their pregnancies at this time 65% (n=17) wanted the pregnancy at sometime in the future 11.5% (n=3) did not want to become pregnant at all 3.8% (n=1) wanted this pregnancy at an earlier time | Partially met |
| Increase the proportion of infants who are age appropriately immunized to 65% measured as age at which you plan to take your baby in for immunizations (CMT1) | Percent reporting when to take baby for first shots: 19% (n=5) didn’t know 7.7% (n=2) in less than 2 weeks of age 26.9% (n=7) between 2 wks and 1 month 19.2% (n=5) between 1-2 mo 19.2% (n=5) between 2-4 mo 3.8% (n=1) between 4-6 3.8% (n=1) after the baby’s 1<sup>st</sup> birthdays | No |

*Findings related to Postpartum clients.* Table 5 provides a summary of objectives for postpartum women as stated in the GEHSI grant proposal. For each objective, the corresponding 2002 evaluation results are presented along with the summary assertion of whether or not the grant objective appears to have been met, based on the available data. For objectives for which no baseline data were provided, a practice based approached was used to determining whether the objective had been met. Of the objectives for beginning prenatal care in the first trimester and
importance of contraception appear to have been met.

Table 5. Achievement of Grant Objectives According to Postpartum Survey Result, 2002: Postpartum Survey

<table>
<thead>
<tr>
<th>Grant Objectives</th>
<th>Evaluation results</th>
<th>Met Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the proportion of completed referrals among prenatal clients (CMT 2 &amp; CMT 4)</td>
<td>Case managers provided from 1 to 9 referrals to their clients. % of women who received services as the result of case managers’ referrals: 10% (n=2) received one type of service 20% (n=4) received 2 types of services 10% (n=2) received 3 types of services 20% (n=2) received 5 types of services</td>
<td>No</td>
</tr>
<tr>
<td>Increase the proportion of pregnant women who receive prenatal care in 1st trimester to 67.4 measured as weeks pregnant at 1st prenatal care visit (CMT 2)</td>
<td>Percent of women beginning PNC: 74% (n=14) began PNC in the 1st trimester 26% (n=5) in 2nd trimester</td>
<td>Met</td>
</tr>
<tr>
<td>Increase the proportion of adult women who have an interconceptional period of 2 years or more measured as importance of using a contraceptive method to space pregnancies and pregnancy wanted-ness (CMT 3)</td>
<td>Importance of contraception 85% (n=17) reported using contraceptive method to space pregnancies was very important; 5% (n=1) somewhat important Pregnancy Intendedness: 20% (n=4) wanted to be pregnant at this time 65% (n=13) wanted the pregnancy at sometime in the future 10% (n=2) wanted to be pregnant at an earlier time 5% (n=1) did not want to become pregnant</td>
<td>Partially Met</td>
</tr>
<tr>
<td>Increase the proportion of infants who are age appropriately immunized to 65% measured as age at which you plan to take your baby in for immunizations (CMT 1)</td>
<td>Percent reporting up to date immunizations: 35% (n=7) reported that her baby had received its first shots and were told that the baby was up-to-date with shots. Other infants had not yet received immunizations.</td>
<td>No</td>
</tr>
</tbody>
</table>

Section V. Impact of Evaluation: Although the level of information provided to clients was better than on the previous evaluation, it was disconcerting to learn that only 32% of clients had received information on Family Planning and child spacing. Staff subsequently received training sessions provided by Planned Parenthood and the CDPH Family Planning consultant, and have been encouraged to counsel clients on the need plan their family carefully. Similarly, staff will focus more on the need for women to use folic acid, and to comply with obtaining prenatal care. The level satisfaction with care improved, but still fell short of the goal. Staff has since received one half-day training on customer care (focused on treating each client as a guest). Staff used this information to continue to reinforce their educational messages and health education efforts in the community. The evaluators did not have access to the database, and therefore they were unable to evaluate the achievement of objectives. Nevertheless, staff redoubled efforts to enter data into the system. The Cornerstone Computer Specialist was asked to and completed a refresher/training for all staff.
Section VI. **Publications**: No information was published.
HEALTHY START LOCAL EVALUATION

PROJECT NAME: Greater Englewood Healthy Start Initiative

TITLE OF REPORT: Focus Group Analysis and Report

AUTHORS: Dr. Nagesh Kolisetty, Indiana University

Section I: INTRODUCTION

Local Evaluation Component

A. The Evaluation of the Chicago Department of Public Health’s Greater Englewood Healthy Start Initiative was designed to assess the effectiveness of the core services and consumers’ satisfaction with the GEHSI program. The evaluation consisted of questions pertaining specifically to the activities related to the Core Services: Case management, Outreach, Health Education, Interconceptional Care, Depression and Referral, and the Consortium. The data collection approach was implemented through group interviews to collect qualitative data. The Evaluation was contracted out to Dr. Nagesh Kolisetty, a professor at the Indiana University Northwest, Division of Social Work.

B. The focus groups consisted of 10 groups: four prenatal; four postpartum; one male group; and one consortium group. An additional group was added to the prenatal and postpartum because of few participants attending the initial focus groups.

The male group consisted of seven males ranging from 20 to 33 years of age. The prenatal group on an average represented three to five participants. A total of 18 women participated in the focus groups. The postpartum group had a total of 12 participants on an average of 3-5 participants. The consortium groups represented (3) program and community participants and (2) providers, totaling five members in attendance.

C. The evaluation was a process evaluation intended to assess both the implementation of the Healthy Start Intervention Core Services objectives and consumers’ satisfaction with services.

Key Questions
Each focus group was guided by a questionnaire to moderate discussion and obtain information. The questions for the focus groups are at the end of the document.
II Process

A. The focus group interviews were from February 1st through February 10th, 2005. A moderator guided the group, but the participants’ statements during the discussions was the essential data collected in the focus groups. Criteria for participating in the focus groups included: being pregnant, postpartum, male involved in the HS program, and a consortium member. Each focus group included an hour of participation in discussions on the implementation of the GEHSI program. GEHSI staff prepared and distributed flyers announcing the focus groups and encouraging clients to participate. GEHSI staff also provided input to the questions being discussed in the focus groups. Transportation was arranged by utilizing the CDPH van and providing bus passes. Nutritional snacks were provided during each focus group. Participants in the focus group were informed about the purpose, confidentiality and their voluntary participation. At the completion of each focus group, participants received a $10 gift for their participation. The Evaluator conducted (10) focus groups: one male group, four prenatal, four postpartum, and one group representing the GEHSI consortium.

II The Evaluator reviewed data from the previous HS evaluation (CY 2002), Program Narrative, objectives and accomplishments for CY 2002 and CY 2003.

II The instruments used for the focus groups included:
- Questionnaire Guide for the Male group (11 questions);
- Questionnaire Guide for the Prenatal group (15 questions);
- Questionnaire Guide for the Postpartum group (16 questions); and
- Questionnaire Guide for the Consortium group (13 questions)

Section III FINDINGS/DISCUSSION

Limitations:
1. The number of participants in the focus groups was small.
2. Many participants did not show up for the focus groups.
3. There was a wide variation in the participant’s involvement with the program.
4. Temperature in the meeting room was not conducive to discussion.
5. Consortium participants were not clear about the role of the consortium.
6. There was a sense of dependency by the consortium that staff members should be doing more outreach activities.
7. The consortium did not take any responsibility in helping the staff with outreach activities.
8. There seem to be more of a need for the community agencies’ participation in consortium meetings.
9. A referral sources and resource directory may need to be developed.

Strengths:
1. Overall the focus groups indicated a total satisfaction with the program.
2. Participants’ expression of total satisfaction with the program.
3. Program is very comprehensive and is providing a great service to the community.
4. Program has dedicated staff.
5. Good referral network and follow-up mechanisms
6. The participants seem to feel that no changes are needed for the program.

**Section IV RECOMMENDATIONS**

1. The participants felt that there is a lot more need in the community
2. That HS should expand the Program by doing more work in outreach
3. There is a need for more community agencies participation in consortium meetings.
4. Employment resources and job placement were of concern for some of the consumers.
5. Housing was another need expressed by some consumers.
6. There seem to a need to integrate other services from the city economic development activities to bring community change.

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

A. The evaluation findings were presented to the Consortium. Members of the Consortium felt that they needed to take an active role in the Consortium by outreaching to the community. Both co-chairs expressed enthusiasm in outreaching in the community and perhaps even communicating more with HS staff. One of the co-chairs stated that she knew several block presidents, alderman, and pastors in the community. Consortium providers distribute HS flyers and brochures within their agencies. One of the providers suggested that the agencies represented at the Consortium recruit one other agency to attend the monthly meetings.

B. The emigration of emigrating clients from the community area because of housing issues has impacted it. There has also been a fluctuation of staff changes at various agencies and thus information about the monthly consortium meetings is not always communicated. There have been no significant changes in management or administration that could have impacted the evaluation. There may have been changes in the implementation of the project whereby the Consortium and program participants have become more involved in the discussion of the objectives of the program and assisting HS staff in reaching the goals of the program.

**Section VI Publications**

There were no publications resulting from the local evaluation.
HEALTHY START FOCUS GROUP FOR MALES
QUESTIONNAIRE GUIDE
1. What does the Healthy Start Program mean to you?
2. What are some aspects of the program you like?
3. Are you satisfied with your Case Manager’s home visits?
III. Do you feel you are better informed about health care during the prenatal and postpartum as a result of the Healthy Start Program?
5. Have you been involved in any educational activities such as: childhood immunization, family planning, domestic violence, substance abuse?
6. Did you receive any information on prenatal and postpartum depression?
7. Do you feel healthy start program provided a better understanding of your partner?
8. How would you describe your experience with the provider?
9. Are there any aspects of the program you like to be changed?
10. Have you been participating in the male responsibility program?
11. Would you recommend this program to others?

HEALTHY START FOCUS GROUP FOR PRENATAL WOMEN
QUESTIONNAIRE GUIDE
1. What does the healthy start program mean to you?
2. What are some aspects of the program you like?
3. Are you satisfied with your case manager’s home visits?
4. Are there any aspects of the program you would like to be changed?
5. Are you are better informed about prenatal health due to healthy start program?
6. Have you been involved in educational activities such as: childhood immunization; family planning; domestic violence; substance abuse
7. Did you receive any information on prenatal depression?
8. Do you feel healthy start program provided a better understanding of your partner?
9. When did you enter into healthy start program? (Trimester)
10. Have you ever received any bus passes or cab coupons?
11. Any time during your pregnancy have you been diagnosed as a high-risk in your pregnancy?
12. Have you received nutrition information from the healthy start program?
13. Have you received information and/or testing for HIV and aids?
14. Would you recommend this program to others?

HEALTHY START FOCUS GROUP FOR POSTPARTUM WOMEN
QUESTIONNAIRE GUIDE
1. What does the healthy start program mean to you?
2. What are some aspects of the program that you like?
3. Are you satisfied with your case manager’s home visits?
4. Do you feel you are better informed about health care during the postpartum period as a result of the healthy start initiative?
5. Have you been involved in any educational activities such as: childhood immunization; family planning; domestic violence; substance abuse
6. Did you receive any information on postpartum depression?
7. Do you feel healthy start program provided a better understanding of your partner?
8. How would you describe your experience with the primary health care provider?
9. Did you ever receive any bus passes or cab coupons?
10. Have you received needed nutrition information from the healthy start program?
11. Have you received information on HIV and aids?
12. Have you been helped with well child visits?
13. Did you have any other referrals from the healthy start program?
14. Did you have follow up calls and post-partum visits from healthy start program?
15) Are there any aspects of the program that you like to be changed?
16. Would you recommend this program to others?

HEALTHY START FOCUS GROUP FOR CONSORTIUM
QUESTIONNAIRE GUIDE

1. What does the healthy start program mean to you?
2. What are some aspects of the program that you like?
3. Have you made any changes in any aspects of the program?
4. Has there been any consumer needs assessment done for this program
5. What type of community agencies are involved in the consortium?
6. How do you ensure consumer participation in your consortium?
7. Have you done any educational activities for the consumer on topics such as housing, sids, and domestic violence?
8. How do you conduct your outreach program?
9. What types of agencies are utilized for consumer referrals?
10. How do you identify and utilize community resources?
11. Do you have some kind of memorandum of understanding with the other agencies to provide services to your clients?
12. What are some of the decisions you made and implemented during the past year?
13. What type of health education topics was provided to various groups such as: community residents consumers; community-based organizations; churches; public agencies; local businesses; school personnel; students and others

Attachment D