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

Family Road, after consultation with its Advisory Council (Consortium), Service Provider Agencies and through an extensive Geographic Information System (GIS) with Louisiana State University, selected the 39-square-mile area in the central part of East Baton Rouge Parish as its project area. The project area embraced five zip codes, 70805, 70806, 70807, 70811 and 70812. The 39 square mile area had one of the highest concentrations of infant deaths in the Parish. Nearly half (49.4%) of the African American women of reproductive age living in East Baton Rouge Parish, resided in the project area. Similarly, during the years 1996-98, births to African American women in the area, accounted for 51% of all African American births in the Parish and 52% of the African American infant deaths (based upon a three year average years 1996-98).

The population in the project area included 22,803 women of reproductive age, of which 79% were African American. Between 1996-98 there were 4,634 African American births, or 85% of 5,475 total live births. By contrast, 93% of the infant deaths in the project area, 84 of 90 infant deaths, were African American. Fifty-seven of the 84 deaths were neonatal deaths. Eighteen percent (859) of birth mothers were under 19 years old. Fifty-four percent of all babies in the project area were born to mothers who did not complete the eleventh grade. Sixty-five percent of the birth mothers were unwed.

Infant Mortality
The African American infant mortality rate of 18 per 1000 live births in the project area was higher than the parish-wide rate for African American infants of 17. This rate was double the 7.5 infant mortality rate (IMR) for Caucasians in the project area and greater than three times the Caucasian IMR of 5 for East Baton Rouge Parish.

Among African Americans, 57 of 84 or 68% of the infant deaths occurred within 28 days of birth. Among Caucasians, three of the six infant deaths occurred within the first months after birth. The high concentration of African American infant deaths and the racial disparities in the infant and neonatal mortality rates, indicated that the proposed Baton Rouge Healthy Start project, would target a population of women and children most in need of services.

Premature Births
The data on premature births, initiation of prenatal care and causes of infant death, also highlighted the racial disparity in perinatal health. Over one quarter (26%) of babies born to African American women in the project area were premature. The 1,191 African American premature births in the project area between 1996-98 compared unfavorably, with the 117 (15%) Caucasian premature births in the area. The percentage of African American premature births in the project area was double the 13% of Caucasian premature births for East Baton Rouge Parish.

Low Birth Weight Births
The data on low birth weight births in the project area revealed a similar pattern, as the premature births. Fifteen percent or 232 African American babies weighed 2500 grams or less at birth, of whom over a quarter (26%) weighed 1500 grams or less (based upon the 1996-98 three-year average). There were 61 babies (4%) of African American live births in this very low birth weight category. By contrast, 7.4% of Caucasian babies weighed 2500 grams or less. Only 1% of the Caucasian babies weighed 1500 grams or less.
Inadequate Prenatal Care

One-third of the birth mothers (510) in the project area did not enter prenatal care during their first trimester of pregnancy. Thirty-six births (2.3%) were to African American women who had no prenatal care. This figure is considerably higher for African Americans than Caucasians. In the entire Parish of East Baton Rouge, only 31 of 8,664 birth mothers (0.4%), failed to initiate prenatal care during their first trimester of pregnancy.

The high percentage of women in the project area, who failed to get early and continuous prenatal care contributed to the high infant mortality and morbidity rates. A review of the causes of infant deaths between 1996 and 1998 revealed that at least 65% of the causes were attributable to perinatal conditions that could be treated, to reduce the probability of infant deaths or avoided through appropriate prenatal care. These causes included short gestation and low birth weight, respiratory distress, maternal complications of pregnancy, birth trauma, intrauterine hypoxia and birth asphyxia, respiratory conditions of fetuses and newborns, infections specific to the perinatal period, fetal and neonatal hemorrhage, perinatal disorders of the digestive system, fetuses or newborns affected by complications of the placenta, cord and membranes, conditions involving the integument and temperature regulation of fetus and newborn and other/ill-defined conditions originating in the perinatal period. In addition, sudden infant death syndrome (SIDS) accounted for 5% of the deaths, while 20% were due to congenital anomalies. An additional 10%, were due to accidents, homicide and unspecified causes (8%). Fortunately, accidents were not a significant cause of death of children, in the project area. In 1998, the major cause of accidental deaths for children under one year of age was suffocation. For children one to four years old, the major causes were drowning/submersion and fire/burns.

Poverty

Poverty in the project area created additional needs in the target population. The percentage of African American children under 18 years old, living in families with incomes below the Federal Poverty Level in the project area was 44.3%, almost three times greater than 17.8% for Caucasian children.

According to 2000 Census data, 105,172 people lived in the project area and 34.6% of children under age 18, lived in families with incomes below the federal poverty level. Approximately one-fourth of the population (25,358) was women of childbearing age (aged 15-44), of which 77% were African American.

Adolescent Mothers

Other socioeconomic data on birth mothers in the project area, both helps to explain the levels of child poverty and highlights the special needs of the project area residents. The African American teen birth rate, when nineteen-year-old mothers were added, rose to 26%. Approximately 65% of project area birth mothers were unwed. Ensuring that women in the project area received early and continuous prenatal care was hampered by the high percentage of birth mothers, who did not complete high school (approximately 54%), as well as the limited availability of quality employment opportunities.
Moreover, the data on birth mothers in the target population highlighted the need for the interventions proposed. In particular, the high percentage of births to teens suggested the need for targeted outreach, case management and education services.

**Child Abuse and Neglect/Domestic Violence**

Other data from the project area reflected the consequences of the demographics. In 1999, there were 240 valid cases of child abuse and neglect located in the project area, which accounted for 25% of the 970 cases in the Parish. The area also had more than its “share” of reported domestic violence cases. In 2000, 65% of the new cases were located in the project area. Of the 990 cases, 604 or 61% were African American women and children; 346 were Caucasian.

Single parenthood and domestic violence contributed to homelessness. In addition, 65% of the birth mothers in the project area were unmarried. In 1999, East Baton Rouge Parish had 364 children under five years old and 550 children ages five to seventeen, classified as homeless.

Data reported for a single day noted that of the 332 people receiving service, 54 sought assistance due to domestic violence (Louisiana Interagency Action Council on the Homeless, Needs Assessment Survey 1999). Specific data for the project area was not available, but anecdotal evidence from service providers in the area, indicated that some pregnant women in the area confronted problems of homelessness, particularly those who were victims of domestic violence or who had mental health or substance abuse problems.

**Immunizations**

Between 1997 and 1998, the percentage of African-American infants, ages two and under, who had received all age-appropriate immunizations, dropped from 45% to 43%. The comparable figures for the Caucasian children were 70% and 66%.

**Crime**

Project area residents also confronted problems of crime. Public safety in the area had been generally summarized by the APB Neighborhood Crime Check ratings, developed by CAP Index, a leading provider of crime risk assessment data to Corporate America. The ratings, which represented a resident’s risk of encountering violent crime, assigned areas a number from one to ten, with a “1” meaning the risk is one-fifth the national average and ten indicating the risk is 10 times or greater the national average. Four of the five zip codes comprising the project area, received ratings between “7” and “9.” Only zip code 70811, received a “6” deeming it a borderline moderate risk.

**HIV/AIDS**

One of the unique risk factors to women in the project area was HIV/AIDS. Given the prevalence of the disease in Baton Rouge and the high number of unmarried sexually active women, both prevention and treatment services were needed. The Baton Rouge Metropolitan Area had the 12th highest AIDS case rate, among metropolitan areas with populations greater than 500,000. (1999 Control and Prevention HIV/AIDS Surveillance Report, Centers for Disease Control 1999 edition, Volume 11, No. 2) Baton Rouge had a new AIDS case rate of 32.6 per 100,000 and a total case rate of 53 per 100,000, which was higher than New Orleans or Los Angeles.
In 1999, 135 of the 246, or 55%, of new cases of HIV/AIDS in East Baton Rouge Parish were in the project area. Of these, 87% were African American, of which 37% were female. For each year 1996, 1997 and 1998, 17 babies, 16 babies, and 18 babies, respectively, were born to HIV-positive mothers. In 1996, four of the babies were HIV positive, while one baby in each of the subsequent years was HIV positive.

**Immunizations**
In 1997, only 45% of African-American infants in the project area under the age of two, had received all age-appropriate immunizations, compared to 70% of the Caucasian children in the same area. In 1998, the figure for African American children was 43%. The comparable percentage among Caucasian children dropped to 66%. Percentage of all children two years and younger in the project area, who were up to date on their required immunizations in 1998 was 57%.

**Lack of Case Management Services**
While there are a limited number of health care providers serving women in the project area and several programs addressing sub-populations, there were significant service gaps. There was no system of Community Outreach, to bring pregnant women into prenatal care. The Case Management Services were limited in capacity, while the need for these services was substantial. The shortage of Community Based Prenatal Care Programs resulted in an excessive number of women initiating prenatal care after their first trimester.

**Transportation**
Family Road recognized that a key factor in a woman’s decision to seek health care and social services was the ability to get there. Most young women in the project area were unlikely to own cars. Public transportation was limited. Although all of the hospitals and prenatal care provider sites are located on a public bus line; weather, fear of crime, length of commute and cost are often barriers to care.

**Calendar Year 2001**
In 2001, the infant mortality rate (IMR) was higher, 15.4 (16.48 for African Americans, 4.7 for Caucasians) than it had been in 1998-2000 when it averaged 13.9 (15.6 for African Americans, 2.8 for Caucasians). The neonatal mortality rate (NMR) for 2001 was 10.9 (11.2 for African Americans, 4.7 for Caucasians), which is higher than the average 1998-2000 rates of 9.3 (10.5 for African Americans, 1.4 for Caucasians). The post-neonatal rate of 4.5 in 2001 (5.2 for African Americans, 0 for Caucasians) was about the same as compared to the 1998-2000 rate of 4.6 (5.1 for African Americans, 1.4 for Caucasians). The disparity in infant deaths among African Americans and Caucasians is very evident from the data. African American infant deaths occur at least three times more than Caucasian deaths in the project area.

The percentage of low birth weight babies for 2001 of 9.4% (10.2% for African Americans, 4.7% for Caucasians) was lower than the 1998-2000 average percent of 10.6 (11.1% for African Americans, 7.4% for Caucasians). The number of live births in the project area for 2001 was 1,561 (1335 for African Americans, 213 for Caucasians). This compares with the 1998-2000 average of 1,798 (1,563 for African Americans, 236 for Caucasians). In 2001, the percentage of births to teens 17 years of age or younger, was 8.5 (9.4 for African Americans, 2.8 for
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Caucasians) which was lower than the 1998-2000 average of 9.7% (10.8% for African Americans, 2.4% for Caucasians). In 2001, the number of live births with no prenatal care totaled 35. Of these, 32 (91.4%) were among African Americans. This compares with the 1998-2000 average of 42 live births with no prenatal care (40 for African Americans, 1.7 for Caucasians). There were 1042 (14.5%) pre-term births for 1998-2001 (15.4% for African Americans, 9% for Caucasians, 3% for other races). Of the total pre-term births, 957 (91.8%) were among African Americans. The data on socioeconomic status, infant deaths, premature births, low birth weight births and initiation of prenatal care highlight the racial disparity in perinatal health. Family violence is a significant problem, and there is a high prevalence of sexually transmitted disease including HIV/AIDS.

Consequently, by targeting this population, the Healthy Start Project aspired to implement measures to significantly reduce the disparities in perinatal health between the Caucasian and African American populations in East Baton Rouge Parish.

II. Project Implementation

In 2001, the Family Road Healthy Start (formerly Baton Rouge Healthy Start) Advisory Council (Consortium) proposed to structure its Project Plan around the Core Services of Outreach and Client Recruitment, Prenatal and Interconceptional Case Management and Health Education and Training, by creating a coordinated system of “teamwork.” Additional services were added in 2003, to include Depression Screening and Referral and Interconceptional Care as core service components.

At the center of the infrastructure was the applicant Family Road of Greater Baton Rouge, which facilitated the collaboration and communication among all service providers. Family Road provided supervision for team operation; including recruitment, training and oversight of the personnel/”team members.” These services were delivered to pregnant women and their infants up to age two, living in zip codes 70805, 70806, 70807, 70811 and 70812, of East Baton Rouge Parish.

The program design addressed the obvious barriers to women receiving adequate prenatal care, such as location of services, poverty and lack of information. In addition, the program design accounted for the emotional and psychological barriers that inhibited women’s willingness to take appropriate actions to care for themselves and their infants.

The location of services at one convenient location (Family Road), in a customer friendly environment, has been a very successful model of comprehensive care. Services such as Medicaid, Presumptive Eligibility, WIC, educational classes, childcare, transportation and counseling were provided at Family Road, with extended hours of operation.

Outreach and Client Recruitment

A. Approach to Service

Family Road and its Advisory Council (Consortium), due to the numerous years of experience with families within the community, decided to assign outreach workers to zip code areas in their same residential area. It was strongly believed, that employing current community members as outreach workers, would increase the community participants comfort level and trust with the
implementation of new program services, in their community. The other advantage to this approach was the advantage of outreach workers having a unique perspective regarding psychosocial issues impacting perinatal health and a personal commitment to explore and improve issues impacting their communities.

After the community was saturated with program information, Family Road Healthy Start decided to continue community representation and provide additional training to the outreach team, to utilize their capabilities in other ways. The outreach team was very successful in providing information in the community and providing community resource information. To increase the community’s awareness and knowledge of risks impacting positive pregnancy outcomes, training with the outreach team was provided. The training implemented distribution of literature on National Health Observance Topics in the community each month. This strategy solidified meeting the community’s need for education and increased awareness of infant mortality.

Community data provided through GIS, identified 33% of birth mothers in the project area, did not enter prenatal care during the first trimester; and 65% of infant deaths in the project area were preventable or treatable, confirmed the need for special outreach efforts, supportive services and counseling to program and community participants.

Challenges for the Outreach Team included: increasing the community’s awareness of infant mortality rates in the project area and increasing the community’s knowledge of psychosocial and medical risks, connected to infant mortality. Examples of the psychosocial risk factors addressed included Domestic Violence, Mental Health and HIV/AIDS. Another community challenge included encouraging community leaders and churches to open their doors to social services and other local churches and increase communication and collaboration among churches through the removal of turf issues. Family Road Healthy Start also focused on increasing the community’s response and commitment to be a part of the solution to lower infant mortality by accepting infant mortality as a priority. Many families in the community struggled to meet their basic needs and viewed infant mortality as a problem, but not a priority, when compared to their families’ daily survival. The community was overwhelmed with many other complex issues restricting the families’ response to infant mortality. Family Road Healthy Start emphasized to community leaders and members, the advantage of taking a holistic, collaborative approach to address problems in the community, instead of individual problems being addressed by individual leaders.

Family Road Healthy Start had a tremendous amount of collaboration between churches, private, public and government agencies and other grass root community organizations. This allowed Family Road Healthy Start to build upon these relationships and discuss critical issues facing the community. Family Road had an established relationship and offers supportive services through the collaboration with the Office of Public Health (OPH), Maternal Child Health (MCH), Capital Area Human Services District (CAHSD), the regional mental health and substance abuse agency), Department of Health and Hospitals, community participants, the Mayor of Baton Rouge, state legislators, Active Maternal and Child Health Coalition, March of Dimes, United Way, Perinatal Commission, and Human Services Consortium.
B. Components of Intervention and Resources

Family Road Healthy Start’s Outreach and Client Recruitment was offered to program and community participants through several venues. Outreach activities included door-to-door contacts for client recruitment, distributing Healthy Start literature to churches, schools, businesses, community centers and health care providers; participation in workshops and community health fairs. Community outreach and education included media campaigns, outreach workers, peer advisors, Advisory Council (Consortium) including sub committees-Project Area committee and Neighborhood Networks, in addition to working with FIMR teams and partners in Title V, MCH and the local perinatal health system. The media campaigns included advertisements on billboards, bus stops and facility posters, along with radio and television. Program brochures were also disseminated throughout the project area and to service providers to provide information about the Healthy Start services. The media materials were developed through subcontracts with advertising, printing and radio agencies. Media messages included topics related to early and continuous prenatal care and paternal involvement.

Comments from current program participants was encouraged and received through focus group and Mommy Hour Sessions.

Outreach was provided to potential program participants and community participants living in the service area. A Geographic Information System (GIS) was developed for the service area to locate areas of high infant mortality and to identify high risk factors such as no prenatal care, based on birth and death certificate information. The GIS also identified specific zip code areas, streets and apartment complexes, with the highest rates of infant mortality, low birth weight births, pre-term births, no prenatal care and psychosocial risks. Outreach staff targeted the geographic areas when conducting outreach and client recruitment activities for program participants. Outreach staff also targeted areas that women visited such as nail and beauty salons, grocery stores and laundry mats to perform outreach for program participants. Media advertisements, health fairs, events and workshops, targeted the community participants.

Neighborhood Network Teams were established throughout the four year period. The outreach team coordinated their efforts with a “neighborhood network support team” composed of recognized individuals who work with or encounter women of childbearing age. Neighborhood Network Support Team Members included community leaders and Healthy Start program staff, clergy, teachers, coaches, beauty parlor employees and others, in a position to help the outreach worker, identify pregnant women and locations to target. The Community Developer and outreach workers met regularly with the network groups and participated in network-scheduled activities. Neighborhood Network Team Captains would serve as representatives of the Network Teams and invited to participate on the Advisory Council (Consortium) and Project Area Committees, to provide input into program operations. The Neighborhood Outreach Captain, worked with the Community Developer and outreach workers to develop a strategic plan for community efforts and initiatives. The Outreach Team’s other goal, was to establish in each neighborhood, a men’s team to reach out to expectant fathers and encourage the father’s involvement in the pregnancy and child-raising process. Educational workshops were implemented, in collaboration with the Neighborhood Network Teams and other community groups.
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The Neighborhood Network Teams included the North Baton Rouge Coalition (community-based coalition of concerned citizens, businesses and organizations) which represented 70807; Greater King David Couples Ministry (which is a prominent African American Baptist Church that provides community outreach) represented 70806; Health Care Centers in schools (represented concerned citizens, service providers; Alpha Phi Alpha fraternity, 100 Black Men and Security Dads, a school based group) in 70805 and 70812 and the Neimiah Society (religious group).

During the program-planning phase, the need to create a Community Developer position was identified by Family Road Healthy Start. This need was determined after careful review of the specific program duties of the Social Work Supervisor and community dynamics. The Outreach Component of the program, required additional time, resources, collaboration and organization, than initially anticipated.

The Outreach Team was employed as Family Road Healthy Start staff. The outreach team members were recruited from the community and assigned to work in a specified neighborhood within the project area. Initially, there were four Outreach Workers who lived in the project area who were supervised by the Community Developer. A Community Developer and two outreach staff resigned from the program in 2004. Since client recruitment processes were well established in the community, the program considered the employment of two outreach staff sufficient to meet outreach needs and promoted the internal Healthy Start Program Assistant, to Community Developer. Additionally, there were two part-time male outreach workers, who recruited men from the project area into the Family Road Fatherhood Program (Dedicated Dads). Fatherhood outreach activities funded by Healthy Start were subcontracted. The male outreach workers were supervised by the Fatherhood Coordinator, a position funded through Temporary Assistance to Needy Families (TANF).

The Community Developer met with the Outreach Team individually, weekly and as a team on a monthly basis. These meetings discussed outreach strategies; upcoming assignments/events; health education on perinatal and women’s health topics; program issues and concerns, acknowledgment of outreach successes and brainstorming ideas for future outreach projects. All outreach staff were required to attend an orientation-training program upon employment. The In-Service Training included: recruitment strategies; perinatal and women’s health issues, personal safety, community profile information, community resources and accessibility.

A client contact reporting system and an outreach schedule were implemented to track client contacts and outreach activities. Program participants were not assigned to outreach workers, since case managers were responsible for working directly with participants and families, to access needed support and services.

C. Resources and Events Related to Initiation and Implementation
The Outreach Team collaborated and connected with other agencies in the target community, to coordinate outreach activities. The program was linked with the Louisiana Folic Acid Council, March of Dimes, Children’s Coalition, HIV AIDS Region 2, Catholic Community Services, Human Services Consortium, Fetal Alcohol Spectrum Disorders Task Force, Juvenile Justice Team, Child Watch, Camphor Memorial Church, Communities against Domestic Violence, the
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Neighborhood Network Teams, Mayor’s Office, Louisiana Department of Social Services and several community based organizations. The Mayor’s Youth council, an outreach initiative to middle and high school kids on coping with risky behaviors; “Kick Butts Day” a National Cancer Association initiative for smoking cessation was coordinated with Family Road. Other activities included health fairs and programs participated in, Healthy Family Fun Day, Halloween and Fall Festival.

The outreach services were coordinated with other core services, through established procedures for program referrals and sub-committee meetings to discuss program operations. The outreach services were coordinated with the Advisory Council (Consortium), including the Project Area Committee and Neighborhood Networks and other partners, to ensure that coordination was meeting the outline of the Local Health System Action Plan. The outreach team also distributed information in the community to interconceptional community participants and assisted with providing resources to community participants, on depression screening and referral resources. The Management Team met monthly, to problem solve and discuss coordination of services. Barriers existed in these areas due to limited provider assessment and treatment; referrals; and program participants not accessing services to address mental health, substance abuse and family violence issues, due to the social stigma.

Women who were uninsured relied on public health service agencies to meet their health needs. The new Governor of Louisiana, Kathleen Blanco, held a Louisiana Health Care Summit in March 3-4, 2004, to address health care issues including, the large proportion of uninsured citizens and access to care. In December 2004, a Poverty Summit was organized. Family Road and other agencies in East Baton Rouge Parish facilitated the sessions to get the community’s perception on factors related to the high rate of poverty in Louisiana and community needs due to poverty.

The funding sources used to provide Healthy Start and Nurse Family Partnership Core Services, included a combination of federal and state funds, in combination with in-kind support and insurance reimbursement. Specific sources included the Healthy Start HRSA Grant; Louisiana State MCH money to fund the nurse case management team and nutrition services; Medicaid reimbursement for nurse case management services; TANF funds to support the fatherhood program; and in-kind donations by community organizations, to provide classes and services at Family Road. Another source of funding pursued included Medicaid reimbursement for social work case management services. Unfortunately, social work case management services are not reimbursable; grant money from national, state and local foundations and public funding was also explored. Family Road implemented a membership drive and organized several fundraising events to support the services provided at the site.

Case Management  
A. Approach to Service  
Family Road had been in operation for three years and had experienced working with 30-40 expectant mothers each week, through two of its collaborating partners – Better Beginnings and March of Dimes. Family Road identified that women did not have support in establishing a medical home and identified that women were being released from their obstetricians, prior to giving birth. Pregnancy to Parenthood, a smaller version of Healthy Start, funded through the
March of Dimes was provided to program participants at Family Road. The program employed one case manager to assist mothers in the Better Beginnings Program and assess the family’s needs. Despite these efforts, infant mortality continued to increase and no immediate programs offered home visitation and case management. Existing programs for expectant mothers offered no home visitation or case management services. Other parenting programs in East Baton Rouge Parish, did not address the families needs in the project area. Many of the community participants in the project area, had more than one child, numerous psychosocial problems that were not assessed or addressed and lacked knowledge.

Family Road’s Advisory Council (Consortium) acknowledged the increase in infant mortality, low birth weight and preterm births. In addition, other psychosocial factors directly related to infant mortality, low and preterm births were continuing to increase and no additional assessments, treatment or supportive services were provided to women in the project area, who needed assistance. The Advisory Council (Consortium) searched for funds to expand Family Road’s capacity to provide services to women in the Baton Rouge area. Family Road and its collaborating agencies pursued funds with CityMatch, to facilitate research and data collection for the city of Baton Rouge. Once this information was gathered, Family Road along with the other entities, decided to pursue Healthy Start funds. As the team of collaborative partners reviewed case management models and reflected upon supportive service experiences, the David Olds Model was selected. Family Road was familiar with the David Olds Model and its history of working with first time mothers. The Office of Public Health made a commitment to provide funding for the nursing component of the program, if full funding was not secured. To address the numerous economic, mental health and relational challenges of parenting mothers and other psychosocial barriers associated with negative birth outcomes, the social work component was created. OPH’s decision to provide funding for the nursing component in collaboration with Family Road insured enough funding to accommodate the zip code areas identified with high infant mortality rates. Family Road was selected as the most appropriate site, due to its past history of working with expectant mothers. Family Road lacked the social stigma of “social services” and program participants were comfortable receiving services at Family Road. Family Road established a reputation as a “warm, welcoming environment,” in which social services were provided, childcare and extended business hours.

The social work team was also created, due to data identifying 65% of infant deaths in the project area, as treatable and preventable. The David Olds Program Model was selected for both teams, due to the duration and frequency of home visits; and emphasis on service provisions being adjusted to a family’s need and risk level; prenatal and early childhood intervention and effective results with impoverished parents, which was deemed as the best model of care, for East Baton Rouge Parish’s client population.

Women of any ethnicity and childbearing age, living in zip code areas 70805, 70806, 70807, 70811 and 70812, were eligible up to 28 weeks gestation for prenatal enrollment. The prenatal cut off of 28 weeks gestation, was established based on research demonstrating interventions applied after the 29th week of gestation, did not demonstrate the greatest impact on pregnancies.

A Multi-Disciplinary Team Meeting was established and chaired by the Medical Director for the Office of Public Health, Region II; to eliminate knowledge gaps for both teams, associated with
medical conditions and needs. Representatives from other social service agencies providing services to Healthy Start high-risk cases would be invited to attend and contribute to individualized care plans.

The strength of the case management program was the client-centered approach to care, which emphasized psychosocial needs. The medical providers could not spend as much time addressing basic needs therefore, case managers were able to support the medical plan of care; assess psychosocial needs; and develop a family support plan based on client priorities. Progress toward goals was monitored at every visit and plan of care is updated monthly.

Based on the lack of case management programs services for pregnant women in the area and the lack of transportation in the area, it was decided to provide the case management services in the home or in a location closer to home so that the services were easily accessible. Most young women in the project area were unlikely to own cars. Public transportation was limited. Although all of the hospitals and prenatal care provider sites areas are located on a public bus line; the weather, fear of crime, length of commute, and cost are often barriers to prenatal care. Family Road understood that insuring the adequacy of transportation for project area women was a priority.

Challenges that were faced by the case management component of the program included working with the David Olds Program. Although Family Road attempted to reach a compromise with the David Olds Program, the social work case management team could not implement their intervention strategies in a research based format. David Olds had devised very strict research guidelines and their case management model could not be comprised or revised. Another challenge included both case management teams utilizing two separate databases. A separate database existed for the nurse case management and social work teams. The two, separate databases required the nurse case management team to enter duplicative data, collected in both data base systems. Due to lack of physical workspace, the nurse case management team could not provide services at Family Road. The nurse case management team was located in the East Baton Rouge Parish Health Unit. The health unit was five miles away from Family Road, which restricted the nurse case management team’s use of easily accessible services at Family Road. In addition, the health unit did not understand the core components of Family Road or the psychosocial model, which required education to Health Unit staff. Separate physical locations and different program requirements created the challenges related to a weakened team. The Management Team was able to bridge the gap by providing team building activities and including nurses in all activities at Family Road. The project encountered delays in client enrollment, due to the length of time to hire qualified staff and development of a data collection system.

Other challenges included program participants’ non-compliance with the visitation schedule; client attrition prior to the child’s second year of life; a lack of community counseling resources, affordable and adequate housing. Many mental health disorders among the population, was undiagnosed and untreated. Southern families also believe family myths, old wives tales and antiquated remedies. Many families resisted applying research-based methods, proven as effective in areas such as feeding, co-sleeping and sleep positions related to SIDS. Other families, due to negative histories with social service agencies, were reluctant to trust program
staff and viewed home visitation as intrusive and suspicious. Families also struggled with social stigma related to receiving available community resources as a sign of incompetence or emotional instability.

Systematic barriers included poverty; limited public transportation services; program participants feeling intimidated and refraining from discussing medical issues with their medical providers; program participants’ reluctance to ask questions to clarify medical terminology; and delayed processing for Medicaid. Personal barriers included program participants viewing early prenatal care as unimportant; poverty; challenges of single parenthood; domestic violence; depression; substance abuse; lack of social support systems; younger and older maternal age, lack of male involvement with the pregnancy and parenting role; lack of child care and program participants assuming passive roles. Community Service barriers included limited provider screening and referrals.

B. Components of Intervention and Resources

Family Road implemented an intensive case management program for program participants to support positive birth outcomes and healthy children and families. The case management program provided risk assessments; home visitation; health education; referrals and utilization of appropriate community resources; supportive counseling; anticipatory guidance and to eligible community participants.

The Nurse Case Management Team employed eight Registered Nurses and a Nurse Supervisor. The Social Work Case Management Team employed four Masters Level Licensed Clinical Social Workers and Professional Counselors and a Social Work Supervisor. The Family Road Healthy Start Project Director, maintained oversight for program operations and reporting. Case managers from each team; a part-time staff nutritionist and infant mental health specialist; provided case management services.

Moms, who didn’t qualify for program services, were referred to community resources. Biological fathers and family members were encouraged to participate in the home visitation sessions. The program would reach capacity if each social work and nurse case manager had a caseload of 20 program participants. If capacity was reached, prospective program participants were referred to other community agencies, contingent upon their identified needs on the referral forms.

A Clinical Risk Assessment that included medical and psychosocial risk indicators was administered to all program participants. Clinical Risk Assessments were continual, throughout the mothers’ participation in the program. The Clinical Risk Assessment was administered during the initial assessment/enrollment phase (first four weeks of program participation); six weeks after delivery and annually thereafter.

Program participants and case managers shared a joint effort in establishing individualized case plans. Through this mutual process, program participants and case managers thoroughly explored and identified problems; the nature of their difficulties; devised goals; identified strategies for implementation; identified roles and responsibilities of the case manager, program
participant and clarified expectations. The family members and significant others of program participants were allowed to actively participate in the goals established for the service plan. Case conferences were utilized to evaluate progress, provide guidance to each individualized case plan; evaluated the effectiveness of interventions; identified personal and systemic barriers undermining progress and enhanced continuity of care. Case conferences and collaboration also included professionals from other disciplines involved in providing medical and/or social services to program participants.

After the first month, visits were conducted bi-weekly until delivery. During this time, the case manager worked with the family to meet goals established in the family support plan. Activities included prenatal and parenting education, referral to community resources. After delivery of the infant, visits were conducted weekly for 6 weeks. During this time activities included monitoring the care of the woman during postpartum period, completing the risk assessment, Edinburgh depression scale and newborn care. Visits were then conducted bi-weekly until the infants’ were 21 months of age. The primary focus was meeting client goals for interconceptional care including family planning, addressing mental and physical health, nutrition, infant care, bonding and attachment, child development and parenting. Well child visits (including immunizations) were monitored along with community referrals for services. The infants were screened using the Denver II Developmental Screening Tool and referred as needed, for additional evaluations. Visits were then conducted monthly until the child’s second birthday.

Risk assessments were administered to identify high-risk program participants. A Multi-Disciplinary Team of professionals was created to identify and discuss risks and develop innovative strategies to promote positive health outcomes for mothers, infants and toddlers. The Multi-Disciplinary Team included the Medical Director from OPH, Region II; Healthy Start Program Staff and professionals from other collaborating agencies. The Multi-disciplinary Team Meetings occurred at least monthly or bi-weekly, to accommodate individualized case plan reviews for high risk program participants.

The David Olds Curriculum and Partners for Healthy Babies Curriculum was incorporated into the program and documentation tools were created for the Healthy Start program. The Healthy Start Consent to Participate and Request to Release Confidential Information was developed to ensure confidentiality and a HIPAA compliance measure. The Initial Contact, Family Database and Service enrollment forms were created to collect demographic information. The Risk Assessment, Maternal Health Record, Edinburgh Depression Scale provided information on previous risk factors and an assessment of current risk factors, which could impact positive birth outcomes. The Case Management Visit Plan and Family Support Plan were created to identify each family’s identified needs, document the families commitment and responsibilities and appropriate interventions. The Labor and Delivery Record and Infant Birth Record provided birth data information. The postpartum risk assessment and Edinburgh depression scale assessed the program participants’ emotional health and risk factors, which could interfere with maternal-child bonding. The Infant Record and Denver Developmental Screening Tool, was created to document and assess infant/toddlers social, emotional, physical development and monitor the mothers’ feeding patterns, response to infants’ cues and identify possible deficits which might restrict child development, impede parenting skills or attachment. The closure form was created
to document the reasons for case closure. The Case Management Visit Form was created to document the health education topics provided, during home visitation sessions.

Policies and Procedures were created to ensure client confidentiality; outline the visitation schedule; case management expectations (i.e., boundaries, on call services, transportation, etc.) and case management responsibilities; define program guidelines and boundaries were identified as well as the program participants’ responsibility to the program.

The co-location of services at one convenient location (Family Road) in a customer friendly environment, was a very successful model of care and helpful in retaining program participants. Services such as Medicaid, Presumptive eligibility, WIC, educational classes, childcare, transportation, counseling and prenatal education were provided at Family Road with extended hours of operation. Housing services was a big demand among program participants and Family Road worked with the Human Services Consortium and East Baton Rouge Housing Authority to assist in meeting the demands. Gender specific care was very limited among public services agencies and the Dedicated Dads program filled the gap by addressing the significance of male involvement on child development and parental roles and responsibilities. Family Road offered substance abuse assessments and treatment and mental health assessment and counseling services, to fill the gaps of services identified in the community. Family Road provided “Family Road Bucks” for each Family Road class, program service and Healthy Start home visitation session. The Family Road bucks were used in the Family Road Store, to purchase donated items. Family Road maintained the Family Road Bucks and the store, with donated items located at the facility. Car seats are donated items maintained by Family Road.

The Healthy Start program had a well-developed incentive schedule (refer to attachment). Items such as digital thermometers, baby blankets and baby sip cups were provided to program participants based on the incentive schedule. A special recognition was provided to all program participants, who were enrolled in the program for one year and at the completion of the program. Healthy Start Case Managers provided the incentives to program participants during the home visitation sessions.

A “Mommy Hour” support/educational group was held on a monthly basis, which provided a format for sharing health education information. Mommy Hour also provided an opportunity for program participants to interact with each other and assisted with client retention. Mommy Hours were facilitated by Healthy Start Case Managers and invited collaborative partners. The barriers to client retention included the lack of motivation among program participants to stay engaged for the entire two year period, due to other priorities such as work or school commitments. The program held focus groups and surveyed program participants to explore and identify services and information viewed as useful and valuable among program participants, to continue their engagement in the program. Therefore, the health education information was provided during Mommy Hour and home visitation sessions. Program participants also indicated an interest in very practical interactive classes. Therefore, more interactive styles of teaching, one-on-one services and classes were offered, which included breastfeeding support, nutrition and practical parenting skills. Other barriers identified included transportation; physical location of services; childcare and customer service. Transportation needs were addressed by continuing transportation services. Childcare issues were addressed through working with Partnerships in
Child Care (which is a VOA organization that locates child care facilities capable of providing various levels of care to infants and toddlers and willing to accept child care assistance). Family Road had a quality improvement plan that was reviewed and analyzed, to address client and collaborative partners concerns and requests, in a timely manner. Other challenges such as, referral sources for substance abusing pregnant women; poverty; late entry into prenatal care; younger and older maternal age; depression; mental health issues and domestic violence was addressed by the Advisory Council ( Consortia), through the Local Health System Action Plan.

Case Management Services continued during the four year period, with some modifications of procedures, to improve efficiency, cost effectiveness and the program’s response to client needs and requests. Letters were mailed utilizing the standard mail delivery system, as opposed to certified mail. Certified mail was expensive and did not yield positive results. Program participants were hesitant to retrieve certified mail and suspected that the correspondence was a negative announcement, court document or bill collection notification. After the infant reached one year of age, the visit schedule for social work case managers, offered greater flexibility. The one year birth date for infants, served as the phase of highest attrition among program participants. The developmental screening tool used with infants changed from the Denver Developmental Tool, to “Ages and Stages”, a tool now encouraged to be used by the Louisiana Office of Public Health. This tool had the advantage of providing more objective measures related to the psychosocial components of infant development. An Infant Mental Health Specialist was hired in 2004 to address the mother’s and infant’s mental health needs and promote healthy attachment and bonding between mother and child. The incentive schedule for program participants was revised and offered more parenting and toddler items, as requested by program participants. Other Case Management changes included the provision of mental health counseling services.

Family Road managed a prenatal clinic, with the collaboration of Louisiana Health Science Center/Earl K Long Medical Center (under Louisiana State University’s system). The clinic allowed women to receive earlier prenatal care during their pregnancy. The Title V MCH Program funded the full-time Nurse Practitioner and Registered Nurse positions. LSU/Earl K. Long Medical Center’s (LSU/EKLMC) primary goal was to increase the facility’s number of pregnancies. Earl K. Long and other entities discussed the possibility of Earl K. Long providing early prenatal care to program participants, with the possibility of those program participants, selecting another hospital who accepted Medicaid, as the birthing center for their pregnancies. LSU/EKLMC did not feel comfortable expending funds to provide early prenatal care to mothers who might select another birthing facility. Therefore the charity system did not view the operating costs of the prenatal clinic as a fiscally sound strategy, which resulted in the prenatal clinic being closed, after a year of operation.

C. Resources and Events Related to Initiation and Implementation

The funding sources that were used to provide Healthy Start Core Services included a combination of federal and state funds, along with in-kind support and insurance reimbursement. Specific sources included the Healthy Start HRSA Grant, Louisiana Title V MCH money to fund the nurse case management team, presumptive eligibility, part-time infant mental health and nutrition services; Medicaid reimbursement for nurse case management services; Administration for Children and Families, to support the Building Strong Families pilot program; Louisiana
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Department of Social Services and private foundation money to support the Dedicated Dads (Family Road Fatherhood Pilot Program) and in-kind donations of staff time from community organizations, to provide classes and services at Family Road. Other sources of funding pursued included Medicaid reimbursement for Social Work Case Management Services, if it became available; grant money from national, state and local foundations and public funding. In addition, Family Road implemented a membership drive and organized several fundraising events to support the services provided at the site.

Capital Area Human Services District provided free gender-specific assessment and treatment to substance abusing pregnant, postpartum and interconceptional women at Family Road. Case managers referred cases with mental health problems and bonding and attachment concerns, to the Infant Mental Health Specialist on staff (50% of this position was funded by OPH), for further assessment and/or treatment. The Battered Woman’s Program offered free individual counseling and group support for victims of Domestic Violence, at Family Road. Family Road continued to have a satellite Medicaid office on site and offered assistance with Medicaid applications and Presumptive Eligibility, funded through OPH. Family Road was selected as a pilot site for electronic applications, which significantly impacted the gestational age of entry into prenatal care. Counseling was provided to program and community participants through contractual arrangements, with a culturally sensitive, licensed marriage and family counselor.

Family Road managed a prenatal clinic, with the collaboration of LSU/Earl K Long Medical Center. The clinic allowed women to receive earlier prenatal care during their pregnancy. The charity system did not view the operating costs of the prenatal clinic as a fiscally sound strategy, if women received prenatal care at their clinic and delivered at other hospitals; especially when their Medical Residency Program depended on births for fiscal resources. Due to state budget cuts and differences in goals for the clinic, the prenatal clinic was closed after one year of operation.

Barriers to care due to lack of insurance was addressed through the LAMOMS program goal of expanding eligibility for Medicaid. Dental services were also included in 2003 for pregnant women. A central phone number was provided to program participants to call for dental providers in the community. RAD Training for staff was facilitated by Louisiana State University, due to high crime rates in the project area. Other in-services (refer to Staff Development Schedule). Nurse case managers attended three trainings in Denver on pregnancy, infancy and toddler phases.

Health Education and Training
A. Approach to Service
Various organizations in the community provided health education information. There were four entities reviewed, prior to developing Health Education and Training for the Community: (1) Community; (2) Social Services, Educational and Prison Systems; (3) Medical and Perinatal Health Systems; (4) Faith based Organizations

Part 1: Community of East Baton Rouge Parish
A review of health information distributed in the community, revealed fragmented sections of information, provided to specific groups of community participants. Community members only
received health education information, if they received services through a specific program. Family Road, not only provided health education information to program participants, but was established a reputation in the community, as a “one stop shop”. Some of the various entities (social, civic, business, faith-based, prison, educational, medical), were not aware of community resources and how to access the existing program services. Family Road also offered comprehensive training to Healthy Start Staff members, to increase their competency skills, confidence, compassion and cross-cultural sensitivity. Family Road used local and national experts, to provide in-service and service provider trainings.

Part 2: Social Service Agencies, Educational Institutions and Prison Systems
Family Road reviewed social service and educational institutions and agencies; including their own staff; knowledge about psychosocial stressors impacting pregnancy birth outcomes and its influence on the families’ daily functioning, in the community. Family Road reviewed the data from the Geographic Information System (GIS); and identified local and national experts, that could provide training and education, to improve the competency skills of social service agencies’ staff.

Part 3: Medical and Perinatal Health Community
Medical providers in the Greater Baton Rouge area had proficient medical training. The purpose of health education for the medical providers was to increase their knowledge regarding psychosocial issues and its impact on pregnancy; increase the medical providers’ knowledge and compassion in understanding the culture of poverty and challenges directly related to poverty, that influenced pregnancy outcomes. The rationale was to increase their understanding of how life stressors, significantly restricted the patients capacity to view and respond to the pregnancy, as a priority.

Part 4: Faith Based Organizations
Faith based organizations did not include discussion of prenatal care as a component of their religious education. Faith based organizations, did not have a comprehensive knowledge base, of the community services available and how to connect their congregations to those services. Family Planning was a taboo subject in the churches, for unmarried, single adolescents and adults, who were sexually active.
The importance of prenatal care and community resources for pregnant women and their families was provided to faith-based organizations, due to their direct contact with women in the pregnancy and interconceptional phases. Family Road created a strategy, that highlighted health education topics in the community by providing agency based workshops and classes.

Challenges for Health Education included: the low literacy level and high rates of high school drop-outs in Baton Rouge, influenced the comprehension reading level for community participants; the high rates of single mothers, restricted participation in health education activities, due to their dual role in the family unit and limited support systems; limited transportation due to location or costs; turf issues among various sectors related to individual entities having a separate established plan of action, to resolve the challenges, among the segregated population who received program services. Other challenges included the service providers’ negative attitudes and stereotypes of individuals in communities, based on their socio-economic status or ethnicity and the cycle of poverty. The culture of poverty in Baton Rouge,
provided a message of hopelessness, identified generational poverty as a “conditioned way of life”; acceptance of a passive role of community participants having no control over their current life circumstances; acceptance of illegitimate children as the “cultural norm”; did not encourage future planning or goal setting; and ingrained themes of behaviors, that perpetuated the cycle of poverty. Resistance from agencies with long histories within the community, to change their approach or perspective, created discriminatory acts toward certain ethnicities.

Community agencies; Hospitals, social services and perinatal and educational organizations were willing to collaborate. Staff members of the various agencies were eager to attend health education and trainings, to improve perinatal health in the Baton Rouge Community. The community’s desire for change, served as a catalyst for exploration of previous attitudes and practices. Community participants were willing to surpass cultural and economic boundaries, to improve perinatal health conditions, for women and children in their community. The Mayor’s office and other state and legislative delegates were supportive of the health education and training plan, created by Family Road and the Advisory Council (Consortium).

B. Components of Intervention and Resources
The health education component of the Family Road Healthy Start Project included four parts: (1) A diverse curriculum of classes, programs, and workshops on topics related to pregnancy, child birth, parenting and women’s and children’s health, at Family Road and community settings in the project area; (2) Addressed the special needs of women in the target population, through individual and small group, formal and informal instruction programs; (3) Conducted a public information media campaign on issues related to the importance of seeking prenatal care; avoidance of risky health behaviors and community resource information; and (4) Development and implementation of specialized training programs for medical and social service providers, who served women in the target population, to enhance the effectiveness of their service delivery and personal interaction with members of the target population.

Educational programs at Family Road included: prenatal and parenting education, fatherhood, car seat, home and general safety, job skills and education (GED), programs for children and adolescents, money management, counseling, wellness, nutrition and fitness and life skills development. The majority of the classes, transportation and childcare were provided free of charge to program participants. Family Road maintained registration and attendance.

Public information media campaigns and workshops were implemented in collaboration with other community organizations and included messages on the importance of prenatal care and child immunizations; the role of fathers and prevention of teen pregnancy.

All women in the target population contacted through the outreach program in the project area were encouraged to participate in the Healthy Start Health Education Component. Health Educators associated with collaborating agencies offered a variety of courses and workshops in project-area community settings. They also solicited input from community participants regarding topics for future topics of interest. Outreach workers, Project Area Committee, Neighborhood Network Team Members and other community leaders, were provided with an updated detailed description of courses, workshops and programs of potential interest to the target population.
Methods used to provide health education to program participants included one-on-one instruction during home visitation sessions with program participants and their families; group instruction through Family Road classes and the Healthy Start “Mommy Hour” sessions; health education literature; referrals to other providers as needed. When there was a need for classes not provided through Family Road, referrals to other agencies occurred. Educational topics during Mommy Hour Sessions included: Healthy Relationships, STDs, Establishing Trust, Identifying and Responding to Infant Cues, Nutrition, Self-Esteem, Roadblocks to Learning and Choosing A Childcare Facility.

The Medical Director of Region II, who chaired the Multi-Disciplinary Team Meetings, provided educational presentations related to obstetrics and gynecology, primarily to Healthy Start staff. Trainings were also provided to staff through Family Road on self defense with RAD training, Mace Training, Non-Violent Verbal Confrontation, Team Building, Identifying Work Styles (DISC Profile), Understanding the Culture of Poverty, Undoing Racism and on-going In-Service Trainings on service excellence and service delivery. Speakers for provider trainings were usually experts in the field that are invited to conferences.

Health education to community participants was provided through health fairs, events, workshops, mommy hour sessions and conferences. The majority of educational offerings were provided by Healthy Start staff in collaboration with other organizations, hosting educational activities throughout the community. The Healthy Start Program developed a Calendar of Monthly, Community Health Education Topics based on the National Health Observances Calendar (see attachment- Monthly Health Observances).

Health education services continued during the four year period, with few modifications. The Healthy Start program participated in the lecture and presentation of Ms. Marian Wright Edleman, Juvenile Justice System. Technical Assitances and Presentations including service providers and community members were provided in the areas of domestic violence, perinatal depression and perinatal substance abuse. The Healthy Start program collaborated with other community agencies to continue educational activities on the topic of perinatal substance abuse. In response to requests for additional breastfeeding information, Healthy Start obtained a video, produced by the WIC program in Mississippi, encouraging breastfeeding. A high prevalence of Syphilis infected and HIV infected pregnancies was identified in the project area. Due to the prevalence of STDs in the community and program participants’ requests for additional information, STD health education was included in the 2004 Family Road Calendar. Family Road Healthy Start, also participated in a HIV/AIDS Community Block Outreach Initiative, organized by OPH in 2004. Community health education initiatives were contingent upon themes and psychosocial risks identified through direct services to program participants, service providers and meetings with collaborating agencies and meetings.

C. Resources and Events Related to Initiation and Implementation
Healthy Start Staff coordinated a workshop provided by the Southeastern University School of Nursing. Nursing students targeted violence prevention for children and their families in October 2003, with the theme of violence prevention, “Hands Are Not For Hitting.” The Healthy Start program co-sponsored a conference on Perinatal Substance Abuse featuring a national expert on perinatal substance abuse and fetal alcohol syndrome. The Technical
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Assistance was attended by 250 health care and social service providers in the community. Dr. Ira Chasnoff, conducted presentations to provider groups and community groups on “perinatal substance abuse”, made possible by a technical assistance grant through Healthy Start. The Medical Director for Region II provided presentations to program staff on perinatal topics such as, Group B Strep and the HELLP Syndrome. The Healthy Start Contract Therapist, Project Director, Case Management Supervisors, provided television educational segments on perinatal depression, prenatal care and highlighted program services at Family Road. The Director of Operations/Dedicated Dads Program Manager and Healthy Start Managers, served on a panelist review regarding challenges with at risk families. The Executive Director served on the state and local March of Dimes, Stakeholders for Department of Social Services, Block Grant Needs Assessment Committee for the Office of Public Health, Children’s Coalition, Battered Women’s Committee and Prevent Child Abuse Louisiana. Louisiana Department of Health and Hospitals/Office of Public Health and Office of Maternal Child Health, provided instruction and background information on such topics as: “Bright Futures”; Denver Developmental Screening; Breast-feeding; SIDS; health status data on the maternal and child health population; training through the Nutritionist on personal health responsibilities including diet, nutrition and exercise; methods for assisting women to access medical and support services, including WIC, Medicaid and child health insurance (LACHIP); and immunizations. Capital Area Human Service District (CAHSD) offered instruction and information related to working with populations experiencing mental health and substance abuse difficulties; and free psycho-educational classes on tobacco cessation. In addition, they established the only substance abuse treatment program for pregnant and parenting women and provided free counseling services for families at Family Road; mental health and substance abuse screenings; and procedural information to assist women with accessing medical and support services, including WIC, Medicaid, child health (LACHIP), and immunizations. Family Road was deemed a satellite office of East Baton Rouge Health Unit, thereby allowing Family Road to provide Medicaid applications, including presumptive eligibility, which allowed pregnant women to receive temporary Medicaid within 7-10 days of the application. The Battered Women’s Program, offered individualized sessions, support groups and workshops on domestic violence to women and their families. In addition, Public Campaigns such as “Take Back the Night” which included a walk through the project area, highlighting efforts of the Battered Women’s Program and collaborating agencies for women murdered due to domestic violence; interventions and assistance for Battered Women.

The Early Intervention Clinic at the Earl K. Long/LSU Medical Center, provided information on HIV/AIDS prevention and treatment for pregnant women. In response to the high proportion of new HIV/AIDS cases and the highest Syphilis rate in the state, Family Services of Greater Baton Rouge, in collaboration with Family Road, offered an HIV/AIDS Prevention Program. This program offered free HIV counseling and testing to the public. Also, in conjunction with Family Services of Greater Baton Rouge and Volunteers of America, an HIV/AIDS Care Coordination and Direct Assistance Program was offered free to program and community participants. This program assisted HIV/AIDS program participants in accessing services and programs, including case management and support groups. Also, in collaboration with Metro Health Education, Family Road provided educational sessions on basic HIV/AIDS facts for pregnant women and women of child bearing age.
The Staff Development Department at Woman’s Hospital provided an in-service training on Birth Defects and the importance of folic acid; and supplied pregnancy wheels to the social work and nurse case managers. Family Road, in partnership with Woman’s Hospital offered “Special Delivery”, “After Baby Comes Baby Care” and “Child Birth Preparation for Teens throughout the four year grant period, for a nominal fee (funded by Woman’s Hospital). Participants gained basic information on the signs and symptoms of labor, infant care and teen parenting. Family Road, in collaboration with the Office of Public Health, continued to offer “This Side Up”; a free SIDS prevention class. Case managers emphasized placing infants on their backs to sleep during home visitation sessions.

Interconceptional Care
A. Approach to Service
Family Road adopted a holistic approach to improve healthy birth outcomes, by incorporating education that addressed factors, which influenced the infant mortality, low birth weight, preterm births in the project area. The women in the project area were giving birth in shorter intervals, without considering their future plans or their emotional and financial statuses.

Family Road Healthy Start’s two Case Management Components, was a response to mothers in the project areas having subsequent pregnancies with ongoing negative birth outcomes. Women in the project area were underweight, overweight, diabetic, hypertensive; not using birth control nor understand the problems and issues related to poor birth outcomes. Existing program services excluded the mental, physical and emotional well being of women, in between pregnancies.

Interconceptional care in the community, did not address the other aspects of women’s lives, which impacted positive pregnancy outcomes. Louisiana experienced budget cuts that reduced the amount of family planning service hours and reduced the number of women served.

East Baton Rouge Parish had several challenges during the grant period that included: limited family planning services, state budget cuts, a lack of education during the interconceptional period on Sexually Transmitted Diseases; no holistic approach with current service providers; biological fathers were excluded from family planning and interconceptional care phases; and religious leaders and churches did not believe in family planning and using family planning methods.

Healthy Start did not receive special funding for interconceptional care for high-risk women and infants. The grant submitted, only provided services to expecting mothers in the project area. Therefore, no mechanism was in place to provide outreach to recruit high-risk interconceptional women, who were not previously enrolled or recruit infants born to women without prenatal care. Program participants enrolled into the program were provided case management services to coordinate care of their infants born with complications or with special needs.

Family Road provided interconceptional care and family planning through the prenatal clinic.
B. Components of Intervention and Resources

Interconceptional care was a component of case management services, to include the core elements of risk assessment; health promotion and interventions; home visitation; substance abuse treatment; interconceptional planning and other workshops and resources. The program participants were referred to a medical provider after delivery of the infant, for ongoing interconceptional medical care services. Other children that were members of the family were also eligible for case management services. The infant was screened using the Denver II Developmental Screening Tool and referred as needed, for additional evaluations.

Reducing unplanned pregnancy among young adults continued to be a focus for prevention efforts. One minor change for interconceptional care was identified during home visitation sessions: to incorporate more services addressing psychosocial issues negatively impacting birth outcomes.

C. Resources and Events Related to Initiation and Implementation

Family Road assisted with providing interconceptional care services through case management and the prenatal clinic. The state had a major transition in the Family Planning Program, which included changes in management and budget cuts, which limited choices for interconceptional care. Two facilities provided family planning services to program and community participants. One facility, the East Baton Rouge Parish Health Unit, reduced program services, which reduced the number of program participants served. The limited program services increased waiting lists for family planning services to a minimum of six months. The other family planning clinic, Planned Parenthood, provided family planning services at a minimal cost. Medicaid restrictions also limited women’s access to free family planning services, eight weeks after delivery, which increased the risk of short interval pregnancies.

Depression Screening and Referral

A. Approach to Service

A high rate of mental health issues existed in the Baton Rouge Community. Family Road and the Advisory Council (Consortium) recognized that twenty percent (20%) or more of the population in the project area struggled with mental health problems. A trend was identified regarding mental health acuity levels increasing, without existing services or options of cost effective services for depression. Depression assessment, referrals and treatment were an identified need in the community, to address mental health issues. Services in East Baton Rouge Parish, were only for chronically mentally ill community participants. Services for community participants with minor mental health issues, were non-existent and few facilities provided outpatient treatment. Initially, there were only two private Medicaid providers in Region II who accepted Medicaid, for outpatient treatment not connected to a psychiatric center. Gaps in services were not gender specific and provided no treatment for pregnant women requiring inpatient treatment.

Many women in the project area did not view depression as a problem requiring treatment and therefore, did not access mental health services. Many community members expected those suffering from mental health disorders, to spontaneously alleviate depression symptoms. The community did not understand depression as a complex disorder that impaired individuals’ functioning and did not accept mental health disorders, as a health issue. Other challenges
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included: the fear of being “crazy”; social stigma, the fear of being diagnosed with a mental health disorder.

Family Road acknowledged that the community’s increased mental health needs, would need to be addressed to improve the health of women and infants. If women were identified early in pregnancy, then interventions could be implemented prior to the birth of the baby. Research literature explained that women who were depressed prenatally were at risk for poor prenatal care, low birth weight infants, preterm delivery, substance use and maternal suicide. Infants of depressed mothers were at risk for poor cognitive and motor development and insecure attachment.

B. Components of Intervention and Resources

A new objective was established to address the core service of depression screening and referral. The Healthy Start program incorporated depression screening as a routine part of risk assessments. The Edinburgh Depression Screening Tool was administered during the initial assessment, pregnancy, postpartum and interconceptional program phases. The Edinburgh Depression Screening Tool was also administered as needed, contingent upon significant life circumstances, level of functioning; or depression symptoms. The Healthy Start program worked collaboratively with agencies providing services for further evaluation and treatment of women with perinatal depression.

Edinburgh Depression Scale Scores of 9 to 12 were monitored and reassessed within two weeks after the initial screening. Scores of 13 and above on the Edinburgh Depression Scale, required further assessment and treatment by a mental health professional. Program participants with scores of 14 and above were referred to a mental health professional and/or a hospital emergency room immediately for additional assessment and possible treatment. Program participants, who preferred to be assessed by a mental health professional instead of emergency room services, were advised to receive an assessment within 24 hours. The Regional Mental Health Service Provider, Capital Area Human Services District, provided psychiatric evaluation and treatment on major affective disorders. Case managers collaborated with the treatment providers, provided transportation and recommended other community referrals, for non-medical needs. Primary referral resources included Family Service of Greater Baton Rouge; partial hospitalization programs; COPE Team of Our Lady of the Lake Regional Hospital and local hospitals. Program participants who needed long-term treatment, were referred to the psychiatric rehabilitation centers, local mental health clinics, Infant Mental Health Specialist and Licensed Professional Counselor at Family Road.

Case managers explored during the home visitation sessions, barriers influencing program participants’ non-compliance with recommendations and social stigmas associated with mental health treatment. In addressing those barriers, case managers discussed with participants, the benefits of further mental health assessment and treatment. Case managers emergency phone numbers for mental health resources and 24-hour crisis counseling services.

Collaboration with Family Service of Greater Rouge resulted in a self-help activity book for program participants entitled, “Kiss the Blues Goodbye” for program and community
participants; defined depression; reduced the social stigma of depression; identified signs and symptoms of depression; and suggested coping strategies.

CAHSD provided free counseling services that focused on families instead of individual needs. To accommodate the service gap, Family Road provided counseling services to program and community participants through contracted services.

C. Resources and Events Related to Initiation and Implementation
Family Road Healthy Start received a technical assistance grant for perinatal depression, Dr. O’Hara and Dr. Segre, focused on enhancing the infrastructure and depression screening among health care providers. Presentations were provided to community members, to increase their awareness of perinatal depression and treatment options available to improve access to care. A best practice model of mental health care was discussed with health care providers to improve systems of care in the community for perinatal depression. As mentioned previously, “Kiss the Blues Goodbye”, was a self-help book designed to assist with ameliorating depression.

Healthy Start program in the initial stages of increasing awareness among community members, participated in a television broadcast that highlighted the need for women to seek treatment for depression. The contract licensed counselor at Family Road, facilitated discussion among program participants, on the topic of “The Benefits of Mental Health Counseling”.

Interventions, through collaboration with CAHSD, the Fetal Alcohol Spectrum Disorder (FASD) Consortium, sought to alleviate barriers for pregnant women accessing inpatient mental health services. Community interventions included FASD, training Obstetricians and Gynecologists, on assessment and treatment of pregnant women experiencing multiple psycho-social challenges. There were also lobbying efforts to open an inpatient psychiatric unit for depressed pregnant women. The Healthy Start Program had a full-time staff member and lead evaluator for Healthy Start, as active Advisory Council (Consortium) members. FASD provided coordinated prevention and intervention services; and administered the 4 P’s Plus, a screening tool developed by Dr. Ira Chasnoff, a leading expert in the field of perinatal substance abuse with The Children’s Research Triangle in Chicago, Illinois. The 4 P’s Plus, was devised to identify women who needed further evaluation for substance abuse, domestic violence, smoking, depression. Woman's Hospital and six private obstetricians and the WIC site located at Family Road, administered the 4 P’s Plus screening tool to program and community participants.

Local Health System Action Plan
A. Approach to Service
Women seeking services at Family Road initiated prenatal care late, in the second or third trimesters. These women were at a greater risk of experiencing complications during pregnancy, labor and delivery. Other women were reluctant or intimated and did not feel comfortable, having a dialogue with prenatal care providers, regarding their pregnancies. Family Road reviewed and discussed how the system was operating with the Office of Public Health’s Regional Office. Other women weren’t aware that they were pregnant until their third trimester; and denied or ignored early pregnancy symptoms. The Office of Public Health provided processing services for temporary Medicaid cards, Presumptive Eligibility to pregnant women,
three hours a day, one time a week. Many women would not return to complete documentation requirements for their permanent Medicaid card, which resulted in inadequate medical coverage during pregnancy and delivery. Medicaid also had very stringent eligibility requirements. Family Road was recognized as a Satellite Site of East Baton Rouge Parish Health Unit for presumptive eligibility and WIC. Family Road was able to provide screenings 5-6 days a week and processed temporary and permanent cards simultaneously.

The Baton Rouge Community already had a Child Death Review. Due to the increased infant mortality rates identified through GIS, the Fetal Infant Mortality Review (FIMR), a former Infant/Child Death Review Panel, needed to be reestablished with a focus on the fetal-infant period. Infants in Baton Rouge were dying from SIDS, co-sleeping and overlays. The information that could be obtained from the fetal infant mortality review process was essential. FIMR provided accurate information on causes of death; circumstances surrounding deaths; and input from medical providers, mothers and other family members. FIMR would provide the missing data needed, to make evidence-based decisions about changes needed in the perinatal system.

Challenges – Baton Rouge had the largest regional birthing hospital in the area. The hospital wanted to ensure that their facility would not be identified as a facility that contributed to infant deaths. Other concerns included anonymity; inquiries regarding an objective investigation process; confidentiality, losing respect from their large client base in the community; and HIPAA regulations. Family Road worked with the Perinatal Commission to assure the community and medical facilities of a legal, legitimate program in the project area.

The major challenge to implementing the Local Health System Action Plan was the length of time required, to implement FIMR initiatives. Implementation of the FIMR process required several meetings among key leadership in the community over a period of 12 months, to gain support for the process. The HIPPA regulations created some additional challenges due to the heightened security related to privacy and confidentiality issues. There was also concern among organizations about accessing clinical records and how the data would be utilized in reports to the community. Family Road Healthy Start had difficulty retaining birth certificate and other records from Vital Statistics.

Other statewide priorities such as bio-terrorism and the small pox vaccination initiative were a challenge since the national and state agenda competed with staying focused on the LHSAP and diverted resources to these important activities.

The Baton Rouge community was very supportive of the Healthy Start Project and worked collaboratively to develop the LHSAP. All public and private agencies were equal stakeholders in planning improvements in the local health systems. Other assets included the collaboration of Family Road Healthy Start with the largest birthing hospital in the region; other hospitals in the area were compromising and willing to participate; and FIMR was recognized as a state wide initiative and all public and private agencies were equal stakeholders in planning improvements in the local health system.
B. Components of Intervention and Resources

Priorities for the LHSAP were identified during preparation for the initial Healthy Start Project proposal. A grant funded through CityMatch Data Institute, provided the opportunity to perform a formal needs assessment. Advisory Council (Consortium) members analyzed the data and determined areas to include in the LHSAP.

The major goals of the Local Health System Action Plan were to (1) reduce barriers for women concerning early entrance (First trimester) into prenatal care; (2) Increase and improve Presumptive Eligibility Services; and (3) Implement a Fetal Infant Mortality Review (FIMR) for Region 2 (Baton Rouge). Collaborative relationships were established with the Office of Public Health, Maternal Child Health, CAHSD and several local hospitals to achieve goals.

A committee of the Advisory Council (Consortium), the Healthy Start Project Area Committee, provided input into Healthy Start Program operations and assisted with implementation of objectives. A quarterly report to the Advisory Council (Consortium), provided updates on the status of the program, including LHSAP. The Family Road Board was responsible for the Family Road strategic planning process. The Board received regular reports regarding Healthy Start through the Family Road Executive Director.

Key people involved in the LHSAP included program and community participants, community partners, public agencies, state Title V staff; local university faculty (LSU and Southern); Baton Rouge Community College faculty; Family Road Staff including (Executive Director, Healthy Start, Dedicated Dads and Building Strong Families Program Staff), FIMR Teams (Case Review Team and Community Action Team) and Advisory Council (Consortium members- including Project Area Committee and Community Network Teams).

The LHSAP was used to establish priorities for the Advisory Council (Consortium) and Healthy Start. Local legislators were kept informed of the progress in addressing key issues in the community and were supportive of Family Road’s efforts. The Mayor of Baton Rouge was concerned about infant mortality in Baton Rouge and included the topic in his public forums. The Executive Director and Healthy Start Program Manager was a member of the planning committee of the March of Dimes and a member of the health committee for the Children’s Coalition, which facilitated coordination of MCH activities. The Louisiana Perinatal Commission issued a letter authorizing FIMR as an Office of Public Health initiative and state legal counsel provided clarification of the HIPAA requirements. Once these steps were completed, the FIMR program proceeded.

Medicaid Presumptive Eligibility Service; and agency and home-based nutrition services, were implemented in June 2002 at Family Road. The addition of Family Road as a Presumptive Eligibility Site, expanded the availability of this service in the community. The Family Road prenatal clinic began in October 2003 and provided prenatal care to any client in need of prenatal services, regardless of insurance coverage. The clinic was the result of the collaboration between the Office of Public Health, LSUMC/Earl K. Long Hospital and Family Road. A nurse practitioner, nurse and administrative support person ran the clinic with, oversight by a medical physician.
A new initiative called LAMOMs was effective January 2003, to expand Medicaid insurance coverage for pregnant women in Louisiana. The income guidelines were expanded to 200% of the Federal Poverty Level and coverage included prenatal care, delivery and 60 days after delivery. Medicaid covered the infants for one year. The expanded coverage had a positive impact on access to services during the perinatal and infancy periods. Community Care was a new Medicaid program in Louisiana, to promote access for all children to a medical home. A Pediatrician was assigned to each child before discharge from area hospitals. This effort improved the ability of families to meet the health care needs of infants in a more timely fashion.

The Fetal and Infant Mortality Review (FIMR) was implemented March 2004. The Louisiana Office of Public Health and the National FIMR program provided technical assistance for FIMR. The Community Action Team identified several areas of miscommunication, between hospital and consumer communication; and devised a plan of action for effective communication and a standard of care for bereaved mothers.

C. Resources and Events Related to Initiation and Implementation
Other statewide priorities such as bio-terrorism and the small pox vaccination initiative, were a challenge since the national and state agenda competed with staying focused on the LHSAP and diverted resources to these important activities.

The East Baton Rouge Health Unit was the only provider for Medicaid eligibility determination in the entire parish. Layoff of staff in the Health Unit occurred in December 2000 and thus services were reduced accordingly.

Advisory Council (Consortium)

A. Approach to Service
Family Road began with 40 agencies that were willing to participate in the initiative to provide services to women, infants and families, in one location and grew to 104 non-profit, private and government agencies working together to “lead the way to healthier families”. Family Road reviewed facets of life impacting families and pregnancy outcomes and decided to implement a holistic approach. Family Road decided to capture the audience around the “magic moment of birth”, because people were more amenable to change and considered new ideas. A careful review of program services revealed that community systems were not communicating effectively and services were disjointed and not coordinated; which confirmed the need for a co-location of services. After conducting surveys, focus groups and reviewing local statistics from March of Dimes, Kids Count and the United Way; Family Road desired to serve not only underprivileged families, but families from all socio-economic levels. The families’ decisions to access services, was contingent upon the life cycle of the family unit.

Community agencies had existing turf issues and duplication of services. These turf issues exacerbated the differences of opinion among agencies and restricted the timeliness of Family Road’s pursuit of topics. Developing the Advisory Council (Consortium) at the grass roots level, required significant time and resources. Collecting data and facilitating constructive feedback, took considerable time. Community agencies had to be convinced that collaboration did not include each agency abandoning their missions and goals. Suspicions from community agencies delayed the implementation of constructive solutions. At the same time, community agencies,
non-profit, private and government agencies were looking to “think outside the box”. Different approaches would need to be implemented. Several Town Meetings were sponsored by the Mayor’s Office, for community members to express their concerns and hopes for the future. Community leaders and organizations, including Family Road, Children’s Coalition, Maternal and Child Health Coalition, United Way, Business Report, Chamber of Commerce and Baton Rouge Area Foundation, began to assess the overall living conditions. The assessment of economic growth and potential in Baton Rouge provided a base for grass root development and allowed organizations to move forward and work together in addressing problems.

B. Components of Intervention and Resources
Family Road proposed the Healthy Start Program, as it was envisioned to provide coordination, community resource information and service access for pregnant women and their families.

Family Road established contacts with various racial/ethnic groups, business owners, Catholic Community Charities (main social service agency for new immigrants in the area); Louisiana State and Southern University, which connected various racial/ethnic organizations; and Baton Rouge Equity, which provided community outreach to all racial/ethnic groups in Baton Rouge. Family Road ensured that the committee membership was culturally representative for both providers and consumers, by reviewing the demographics of the project area; meeting with providers to ascertain their cultural sensitivity, and surveying the consumers concerning their views of the provider’s cultural sensitivity. Once this information was gathered and evaluated, the program made adjustments accordingly, which included meeting with providers and consumers to discuss concerns; addressed community issues; acted as a change agent to ensure that both providers and consumers had cultural representation.

Family Road planned to address community challenges through the quality improvement plan for the Advisory Council (Consortium). Family Road provided an annual survey to all Advisory Council (Consortium) members and received suggestions on program services, coordination, meetings and collaboration could be improved. In addition, members were able to provide their comments and concerns throughout the year through surveys. This information was collected, reviewed and presented to the Executive Director, Program and Administrative staff, Advisory Council and Board of Directors. These entities worked together on a quality improvement plan and implemented changes within the structure, to enhance collaboration and address operational concerns.

The Advisory Council (Consortium) met on a quarterly basis; identified gaps in services and created forums to increase the community’s awareness of existing problems and facilitated decisions at the administrative level. The Advisory Council (Consortium) met on a quarterly basis with sub committees such as a Project Area Committee and Community Network and Action Teams meetings, once or twice a month or more as needed. The Advisory Council (Consortium) also developed and offered several educational programs. Each year, the Advisory Council (Consortium) convened five public forums. The Advisory Council (Consortium) continued its efforts as the “Advisory Council (Consortium)” of the Family Road Healthy Start, working through an active committee structure and quarterly meetings. Healthy Start Project Area Committee, which was a sub committee of the Advisory Council (Consortium), began with subcommittees and limited participation. Healthy Start offered meetings in the evenings and
provided refreshments to increase community participation. The Advisory Council (Consortium) and the Project Area Committee worked with the local perinatal health system, Title V MCH staff and the community, to address goals in the local health system action plan. In addition, the Project Area Committee and it’s subcommittees which included the Neighborhood Network Teams and Men’s Teams, provided outreach and held public forums monthly, to identify zip code areas; raise awareness and provide education information on MCH topics. In addition, the Advisory Council (Consortium) provided training/conferences to program and community participants, key leaders, physicians, social services and others.

Case managers recruited and encouraged program and community participants to participate in the Advisory Council (Consortium). Surveys were done that were based on program priorities and services. Program goals were established and monitored continuously for quality assurance; program changes were identified and resources explored and established to address community needs.

C. Resources and Events Related to Initiation and Implementation

Funding opportunities were sought to fill gaps in resources. In-kind services were provided by Capital Area Human Services District (mental and substance abuse), Battered Women’s Program, Baton Rouge AIDS Society, Family Service of Greater Baton Rouge, the four major hospitals in the community and the other agencies, who were members of the Advisory Council (Consortium). In addition to the Healthy Start Grant, the Louisiana Office of Public Health, TANF, ACF and foundation grants were major contributors of resources for Family Road. Other Federal and State Grants were pursued to enhance resources. Family Road had strong political support from both parties and had a positive strong relationship with the Federal and State Legislature.

The barriers related to the Advisory Council (Consortium) were: time limitations of members due to other commitments; limited resources; the membership lacked critical stakeholders; attendance by key members was irregular; competing agendas of member organizations or unstable relationships among members; no history of collaborative efforts among community agencies; resources in the state or community were insufficient to support the goals of the Advisory Council (Consortium).

D. Additional Elements

1. Established and Identified Barriers

Family Road was initially established with the idea of serving families in a capacity, that addressed maternal and child health issues in the community and addressed other concerns. Agencies that represented diverse disciplines, had worked together under the “umbrella” of Family Road, to deliver comprehensive, culturally competent maternal and child health services to low income, high-risk families. Family Road reviewed how to enhance services for expectant and parenting mothers in the community and established more collaboration to meet the community need.

Barriers to the effectiveness of the Advisory Council (Consortium) were addressed in the following manner:
Insufficient staff time dedicated to assisting the Advisory Council (Consortium) in its efforts. Advisory Council (Consortium) committees with chairpersons were established with clear responsibilities. Priorities and timelines were developed. Reports from committees were done at every meeting.

Lack of other Healthy Start resources – Other Federal and State grants were pursued to enhance program services.

Membership lacked critical stakeholders – On a regular basis, the membership was reviewed to ensure that key stakeholders were included. Updates to the membership were completed at least annually.

Attendance by key members was irregular – The Advisory Council (Consortium) membership meeting reminders. Problems and concerns were identified through the LHSAP and MCH needs assessments and included as an agenda item for each meeting. This strategy enabled members to be aware of the issues and concerns in the community. The agenda provided time for each representative to provide group announcements and network, which provided a positive incentive to attend meetings. If members were unable to commit to regular attendance, then a replacement was sought.

Competing agendas of member organizations or unstable relationships among members – The chair of the Advisory Council (Consortium) facilitated meetings effectively, to encourage positive group dynamics.

No history of collaborative effort – Each meeting included to build rapport among the group. Members were encouraged to join committees, which provided opportunities to interact with each other.

Political environment – Issues were discussed using “Roberts Rules of Order” during meetings. In addition, the program had strong support from both parties and had positive strong relationships with federal and state legislature.

Resources in the state or community were insufficient to support the goals of the Advisory Council (Consortium) – Federal grants were sought to supplement funding of programs.

2. Working Structure of Advisory Council (Consortium)

The Healthy Start project has an Advisory Council (Consortium) of 104 agencies and 118 members that were broadly representative of East Baton Rouge Parish, including program and community participants, public and private provider agencies, community, civic and religious leaders and public officials. The Advisory Council (Consortium) had been active since 1998, when Family Road was established, to address the needs of pregnant women and their families. Meetings were held on a quarterly basis with sub committees such as the City Match Data Institute Project Area Committee, later referred to as the “Project Area Committee.” This Committee assumed responsibilities unique to the project area and represented the target population interests’, in policy and program activities of the Advisory Council (Consortium). Family Road’s Management Team, Executive Committee and Board of Directors, provided oversight to Healthy Start. Other Committees of the Advisory Council (Consortium) included:

CityMatCH Data Institute Committee ( Evolved as HS Evaluation Team) was responsible for collecting data, monitored and evaluated service effectiveness with programs and services provided by partner agencies; developed and analyzed survey responses.

A CityMatCH Data Institute Project Area Subcommittee focused on data collection in the target
area. Committee members reviewed and analyzed data; updated needs assessment and evaluation activities. *Mommy Hour*-a subcommittee and psycho-educational group for community and program participants provided suggestions for program improvement. Representatives from this subcommittee attended the Project Area Committee meetings.

*Media/Speakers Bureau* was responsible for public service messages regarding prenatal care and infant health; announcement of program services; developed a multi-faceted public relations plan for HS; monitored its implementation and effectiveness.

*Programming and Planning* Committee developed educational programs sponsored by the Advisory Council (Consortium); reviewed policies and procedures; developed the Family Road Calendar. A *Screening Sub Committee* reviewed applications from agency providers, developed policies and monitored collaboration and facility use. *Resource Development*: identified resources, including availability of grant funds, program operations.

Advisory Council (Consortium) members represented the following categories by percentage: State or local government 48%; Program participant 13%; Community participant 5%; Community based organization 25%; Private agencies or organizations (not community based) (PAO) 3%; Providers contracting with the Healthy Start program 4%; and Other Providers 2%.

Racial/ethnic breakdown of Advisory Council (Consortium) members by percentage: Caucasian 52%; African American 46%; Asian 1%; American Indian or Alaskan Native 0%; Native Hawaiian or Pacific Islander 0%; and Hispanic or Latino 1%.

The percentage of Advisory Council (Consortium) members currently active was 70%, with a meeting attendance of at least 50% of meetings.

Family Road ensured cultural representation for providers and consumers, by reviewing the demographics of the project area; meeting with providers to ascertain their cultural sensitivity; and surveying consumers regarding their views of the provider’s cultural sensitivity. Once this information was gathered and evaluated, the program made adjustments accordingly, which included meeting with providers and consumers to discuss concerns; addressing issues and making changes when appropriate, in order to ensure that both providers and consumers are being represented.

3. *Advisory Council (Consortium) Activities*

The Advisory Council (Consortium) utilized various activities to assess ongoing needs; identified resources; established priorities and monitored implementation. One activity included developing a work plan, based on the goals and objectives for Healthy Start; and the needs identified by the community. A quality improvement plan for the Advisory Council (Consortium) was adopted as part of the process, by reviewing the work plan with staff members, weekly; Project Area Committee, monthly; and Advisory Council (Consortium) quarterly. The Project Area Committee reported to the larger body, the Advisory Council (Consortium) on survey results; focus groups; and information gathered from outreach workers regarding community needs.
The Advisory Council (Consortium) met on a quarterly basis, identified gaps in services and created forums to increase the community’s awareness of existing problems and facilitated decisions at the administrative level. The Advisory Council (Consortium) also developed and offered several educational programs, which it proposed to expand as it assumed the role of Project Advisory Council (Consortium). Each year, the council convened five public forums. Family Road provided an annual survey to all Advisory Council (Consortium) members and received suggestions on how program services, coordination, meetings and collaboration could be improved. In addition, members were able to provide their comments and concerns throughout the year with surveys. This information was collected, reviewed and presented to the Executive Director, program and administrative staff, Advisory Council (Consortium) and the Board of Directors. These entities worked together on a quality improvement plan and implemented changes within the structure, to enhance collaboration and address operational concerns.

Several new programs were offered during the four grant period: Substance Abuse Assessment and Counseling Program for pregnant and parenting women, funded by Capital Area Human Services; Presumptive Eligibility and Medicaid Program; expansion of the WIC Program; Back to Sleep Campaign to: Reduce the Risk of SIDS was provided by the Louisiana Office of Public Health; Becoming Your Child’s First Teacher was funded by Southern University Cooperative Extension; Encouraging Language Development Through Reading and Play, funded by Louisiana State University’s Speech and Hearing Clinic; Parenting; Mission Impossible funded by Truancy and Assessment Services Center; Crisis Intervention Training funded by Baton Rouge Youth, Inc.; Goal Setting to Meet Family Needs funded by the Louisiana Agriculture Center – Baton Rouge Cooperative Extension Service; Intimate Partner Violence Counseling and Group Sessions, funded by the Battered Women’s Program; Dedicated Dads Pilot Program, funded through TANF; Fatherhood Outreach, Individual and Family Counseling funded through Healthy Start and Building Strong Families Pilot Program, funded through Mathematica.

The Healthy Start outreach program was linked to the Children’s Coalition, Louisiana Folic Acid Council, March of Dimes, Catholic Community Services, Fetal Alcohol Spectrum Disorders Task Force, Child Watch, Juvenile Justice Team, Communities Against Domestic Violence, Camphor Memorial Church, Glen Oaks Baptist Church, Security Dads, and the Neimiah Society. The Healthy Start program, through its Advisory Council (Consortium) of over 104 agencies, established connections with agencies that have a common interest in providing services to pregnant women and their families in the target community.

4. Community Major Strengths
Improving health services to mothers and infants was a primary goal for Family Road and a natural fit, to respond to community needs. Family Road reviewed how to enhance services for expectant and parenting mothers in the community and established more collaboration to meet the community need. Family Road had a history of connecting with people in the community to provide services and had established a good reputation. The community also had key leaders who had gained the trust of their peers and were able to provide messages that could reach the community participants and their families, in a culturally sensitive manner. In addition, community participants desired change and were willing to explore unfamiliar strategies. Family Road, Title V and other agencies already had an existing collaborative relationship. Several
agencies that provided services to the targeted population desired change; sought to improve negative birth outcomes and were willing to consider and implement innovative service system changes. The Advisory Council (Consortium) also had strong support from both political parties and a positive relationship with Federal and State Legislature.

5. Weaknesses and/or Barriers
A need existed for the community to assume ownership of the problem. Community participants were unaware of the psychosocial issues and challenges in Baton Rouge, until the service provider agencies revealed startling statistics from the Center for Disease Control and other entities including Kids Count and the Casey Foundation. The community was in denial about the psychosocial challenges in the Baton Rouge Area. Community members did not view infant mortality as “their problem” if it did not directly impact their nuclear families. Other community participants were not concerned about the infant mortality rate and the other psychosocial challenges because they did not reside in the project area. Other community participants, did not understand the connection of others’ health problems connected to their personal health or their families’ health and the overall community health.

Most of the program participants did not feel comfortable with the meeting format that included professionals and agency representatives. In response, Healthy Start encouraged program participant suggestions for program improvement; client recruitment strategies; media advertisement; enlisted insight on the psychosocial challenges which impacted infant mortality and possible community solutions during each Mommy Hour Session. Healthy Start also implemented an evening session in the community, at various locations, once a month. The goal was to increase client and community participation; increased the community’s awareness of the psychosocial risks associated with infant mortality; facilitate the community making a personal investment to resolve issues in their community; and encouraged the community to take an active approach to resolve challenges, impacting pregnancy outcomes.

Faith based, as well as community agencies had existing turf issues. Competing agendas of member organizations or unstable relationships among members had to be addressed, in order to move forward in addressing community problems. Community agencies were also comprised of more middle class Caucasian staff, which influenced their perspective of psychosocial challenges of the target population, which was primarily African American and poor Caucasians. Cultural competency and sensitivity was explored with the various entities.

6. Activities / Strategies
The Healthy Start Evaluation Team implemented a client satisfaction survey that was used to determine client perceptions of Healthy Start program and areas for improvement. Consumer meetings were conducted to provide input into the program. There were at least 20 participants at each meeting. Input was valuable and included suggestions on effective media messages; ways to decrease attrition among program participants; types of educational services that were of interest to program participants and their families and specific activities of interest focused on parenting issues. Feedback on the impact of the program services on program participants and their families; and gaps in services were helpful in planning program improvements. Case managers recruited and encouraged program and community participants to participate on the
Advisory Council (Consortium) to provide input into the project and become a stakeholder in the community.

The program also provided recognition of consumers and reinforced the positive impact of their involvement in the program. Two Family Road Newsletters were distributed in the community, which highlighted the Healthy Start program accomplishments and highlight quotes and pictures of program participants. To eliminate any barriers, free transportation and childcare was provided to meetings. The case managers of the consumers provided reminders and encouragement to keep them actively participating. At times, there were Legislators and Board member meetings that included consumers, to provide additional feedback about program successes. Role of the consumer in the Advisory Council (Consortium) activities included identification of MCH services and strategies that would be most successful; identified areas of priority for budgeting; identified key staff requirements for hiring/job descriptions. Special thank you notes were sent to consumers to recognize their important role in the program.

7. Consumer Input
Consumers were invited to participate on the Advisory Council (Consortium) to provide input into the program. As mentioned above, consumer groups, surveys, focus groups and one-on-one sessions were all used to gain consumer input, which influenced decision making.

8. Utilization of Consumer Suggestions
Feedback on the impact of program services on program participants and their families and gaps in services was helpful in planning program improvements. Consumers’ participation provided input on the following:
Developing the scope of Healthy Start services – Consumers identified gaps in community services such as mental health counseling; expressed concerns and issues in the community; and recommended programs and services which were needed to improve their community. Once needs were identified, Family Road worked with the social service and health community, to explore how identified community needs could be achieved.
Communication/media efforts – Consumers provided input on billboards, posters, brochures and radio advertisements for Healthy Start. Consumers also attended Breakfast with the Board” annually to describe program impact.
Data collection/evaluation – Client satisfaction surveys were conducted annually to identify areas of strength and needs for program improvements. Comments and suggestions were also solicited once a month, during the Mommy Hour sessions.
Sustainability – Fundraising ideas were sought from consumers.

Collaboration and Coordination with State Title V and Other Agencies
A. Approach to Services
Family Road was already established as a one stop shop to provide program services to women, infants and families in the community; and improve maternal and child health services to mothers and infants. Family Road had an established relationship and collaboration with Title V MCH for Medicaid and WIC; Title X for family planning; Title XXI for LACHIP and Early Head Start. Title V MCH was searching for an agency to assist with reaching the population and addressing community risk factors influencing maternal child health. Due to the high infant mortality; late entry into prenatal care; low birth weight and preterm births, there was a
significant need for Title V MCH and other agencies serving this population to respond to the
community need. Although the service system was connected, the perinatal health system was
not aware of the community’s needs; nor the rationale behind the community’s mentality and
individuals’ responses to seeking prenatal care late in pregnancies; and not having good nutrition
or other elements of good prenatal care. The issues were being addressed by the current service
system; but not with a holistic approach. Better Beginnings was the response to women entering
prenatal care late or receiving no prenatal care. Better Beginnings only provided medical care
with no follow-up or support for psychosocial factors influencing negative birth outcomes.

B. Components of Intervention and Resources
Family Road had a history of connecting with people in the community to provide services and
had established a good reputation. In addition, community participants desired change and were
willing to explore unfamiliar strategies. Several agencies providing services to the targeted
population desired change; sought to improve negative birth outcomes and were willing to
consider and implement innovative service system changes. Although the service system was
joined, there were still gaps in the service system of care to women and infants. Agencies and
systems were not innovative in their approach to resolving the community’s issues and thereby,
created a barrier for service provision and increased the system’s difficulty to connect with
program participants, due to the service system’s opposition to change or improve their service
delivery.

Family Road coordinated the services of 104 providers, who implemented clinical and
educational programs for women and families in the Greater Baton Rouge area. These
collaborative efforts included two local hospitals, non-profit agencies, public and private
agencies that provided prenatal and parenting classes, safety classes, job training and placement,
outreach and case management, counseling, substance abuse assessment and treatment and
prenatal care. Healthy Start program participants and their family members benefited from the
co-location of services at one site with expanded hours of operation, free child care and free
transportation. Program participants viewed Family Road as the preferred location to obtain
services due to the convenient location, customer friendly environment, and the comprehensive
array of services available.

C. Resources and Events Related to Initiation and Implementation
The Fatherhood Program- Dedicated Dads, was funded through TANF. The public agency
providing mental health and substance abuse services in Baton Rouge, Capital Area Human
Services District (CAHSD), was a lead agency for substance abuse assessment, treatment and
prevention efforts for pregnant and parenting women. East Baton Rouge Parish was chosen by
the SAMHSA Center for Substance Abuse Prevention to provide a public community education
program to prevent fetal alcohol syndrome and alcohol related birth defects “Partnership to
Prevent Fetal Alcohol Spectrum Disorders.” Billboards and brochures were developed for
distribution in the community. A group of professionals including staff from the Office of Public
Health, CAHSD and Healthy Start received health education training on FASD and facilitated
presentations in the community, to increase awareness of perinatal substance abuse.

The Early Childhood Supports and Services (ECSS) program was funded primarily through
TANF and coordinated by the Office of Mental Health to enhance the network of providers to
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support needed mental health services for children, birth to age 6 and family members. Healthy Start Staff Members attended the ECSS staffing meetings, which are now held at Family Road. Several Healthy Start program participants have benefited from this service.

Healthy Start collaborated with the LSU Agricultural Center, the American Dietetic Association, Blue Cross/Blue Shield and the Office of Public Health Nutrition Program to initiate activities related to childhood obesity. A regional conference was held in New Orleans, Louisiana in 2003, to share best practices in research and strategies devoted to prevention of obesity in children. Dr. William Dietz, from the CDC, provided a lecture on “Strategies to Prevent and Treat Childhood Obesity” sponsored by the LSU Ag Center Cooperative Extension Service. Blue Cross/Blue Shield had chosen childhood obesity as the 2004 health education focus and was interested in continued collaboration with Family Road on community projects. The Healthy Start Program co-sponsored a Nutrition Month Physical Fitness Activity, in March 2004.

The Healthy Start Program Manager, presented an overview of the program at a statewide meeting in November 2003, sponsored by the Louisiana Office of Public Health. The workshop provided an opportunity for regions in the state to share best practices and develop new strategies. Healthy Start staff also participated in a statewide workshop focused on program evaluation techniques.

Family Road changed the processing format for Medicaid and decreased service delivery increased service provision to women. Other changes included WIC services being provided to pregnant and lactating mothers; the prenatal clinic changed the WIC processing format, reduced the waiting period for services and increased the number of women served by 20%. The established prenatal clinic at Family Road, provided services for pregnancy and delivery regardless of insurance benefits and enabled women to receive prenatal care sooner. and Presumptive Eligibility allowed verification of coverage sooner for earlier prenatal care. Depression, substance abuse were noted challenges in the community. Implementation of the 4 P’s Plus Screening Tool by medical providers identified potential psychosocial risks related to perinatal birth outcomes.

Sustainability
A. Approach to Service
Family Road strived to receive reimbursement for both case management programs to enhance and sustain services. In addition, Family Road and the Advisory Council (Consortium) strived to increase the community’s awareness and understanding of the connections between perinatal health and overall life health indicators to perinatal outcomes, to increase community support of the Healthy Initiative. The community’s increased awareness and understanding would create funding opportunities in the Baton Rouge Community.

A need existed for the community to assume ownership of the community problems associated with infant mortality. Community participants were unaware of the psychosocial issues and challenges in Baton Rouge, until the service provider agencies revealed startling statistics from the Center for Disease Control and other entities including Kids Count and the Casey Foundation.
No reimbursement options existed for the social work case management team. The Nurse Case Management Team completed a rigorous application process for Medicaid reimbursement. The community was in denial about the psychosocial challenges in the Baton Rouge Area and did not view infant mortality as “their problem”, if it did not directly impact their nuclear families. Community participants were not concerned about the infant mortality if they did not reside in the project area; nor did they understand the connection of others’ health problems connected to their personal, families’ health or overall community health.

Prominent organizations and other social and civic organizations worked on the community challenge with infant mortality and were passionate about making changes in Baton Rouge. Baton Rouge Area Foundation was a local, fiscally sound organization that could provide funding to support Healthy Start initiatives. Several hospitals in the area were willing to provide some financial assistance in supporting services. The Baton Rouge area, also had a local March of Dimes and United Way which could provide financial assistance for community initiatives.

**B. Components of Intervention and Resources**

Family Road had a positive history of collaboration with Title V MCH, Title X Family Planning, Title XXI LACHIP, Early Head Start, etc. The Louisiana Title V MCH program provided funding for the nurse case management component of the Healthy Start project; part-time nutritionist; a portion of the salary for the infant mental health specialist and presumptive Medicaid eligibility. Family Road worked with Family Planning, to enhance interconceptional care services; Title XXI LACHIP program for reimbursement. A private foundation funded the other portion of the infant mental health specialist position. These funding sources increased enrollment and enhanced specific program services. Family Road provided in-kind donations to support administrative operations and implemented several fundraising events to increase funding sources. Community agencies provided in-kind donations of staff members time for meetings and training programs. Additional funding sources included funds from TANF, a federal grant for Strengthening Families initiative and other MCH grants. Healthy Start coordinated efforts with members of the Advisory Council (Consortium), including Community Centers, to review grant opportunities and worked with local foundations and Health Departments on collaboration for grant applications and contracts.

The major change that went into effect March 1, 2004 was the transition of Family Road to an independent non-profit agency. In the past, Woman’s Hospital provided in-kind administrative support in human resource management, accounting, information systems, building space/maintenance and materials management.

**C. Resources and Events Related to Initiation and Implementation**

Family Road utilized program staff to explore possibilities for reimbursement for case management services. The Board of Directors developed a financial plan to cover operating expenses and planned fund raising activities to support Family Road operations and specific program initiatives at Family Road, such as Healthy Start.

Family Road benefited from widespread community financial and in-kind support. Grants provided by The March of Dimes funded a prenatal coordinator; the Young Women’s Christian Organization funded a child care aide for children of women receiving services at Family Road;
United Way funded a family support coordinator; Junior League funded children’s programming; the German Protestant Orphan’s Asylum Foundation funded clerical assistance, and The Twilight Rotary Club funded infant car seats. In addition, several area foundations, community organizations and corporate funds, provided unrestricted grants for operating funds, including: The Pennington Foundation, Exxon, New Orleans Federal Reserve Board, Kiwanis Club, Rotary Club; and family funds administered by the Baton Rouge Area Foundation, including Manship, Coates, Saurage and Barbier Funds. Family Road also received $25,000 “sponsorship” donations for reimbursement of its start-up loan from Junior League, Hibernia, Woman’s Hospital Auxiliary, Baton Rouge New Car Dealers’ Association and the Greater Baton Rouge Health Forum.

Family Road received significant in-kind donations to assist with its operational and programmatic needs. Agencies delivered services, including education, counseling, screening and job placement assistance, at no cost to Family Road. The annual estimated value of this contribution was $350,000. Family Road estimated that it received $40,000 worth of in-kind contributions of clothing, baby items, toiletries, and other useful items, which it made available as an incentive to expectant and new mothers and fathers, who attended education classes at Family Road. Woman’s Hospital provided a variety of administrative and infrastructure in-kind resources. Among the most valuable were accounting services, human resources, technical assistance and free space for a period of five years, until the transition in March 2004. The Hospital provided discounts, in-kind printing services on special projects and sponsorship for special events.

Family Road had an extensive formal contract with MCH. Family Road received reimbursement for administrative services it provided to the WIC program, for which it served as a certification site. In addition, MCH provided employee training as an in-kind service, specifically for the Denver Developmental Screening Tool and WIC.

Family Road, its Board of Directors, the Advisory Council (Consortium) and Project Area Committee members, were committed to continuing the services initiated under the Healthy Start Project. Given its record of service and its success at securing funds from foundation and community resources, Family Road believed it could continue to provide services to the Healthy Start Project’s target population, once the grant period concluded.

The tragic 911 incidents was a major component related to philanthropic funding decreasing. Resources were limited in response to the 911 tragedy. The American Red Cross Scandal, which involved questionable allocations with donated funds, hindered funding efforts. The State of Louisiana also experienced budget cuts that limited available resources.

E. Additional Elements
1. Managed Care Organizations and Third Party Billing
Family Road applied for a Medicaid provider number to facilitate billing for nutritional services and received reimbursement for Medicaid applications. The Nurse Case Management Program, was approved for third party Medicaid, for the David Olds Home Visitation Model.
2. Identification and Development of Resources

Family Road had a positive history of collaboration with Title V MCH, Title X Family Planning, Title XXI LACHIP, Early Head Start, etc. The Louisiana Title V MCH program provided funding for the nurse case management component of the Healthy Start project; part-time services of a nutritionist; a portion of the salary for the infant mental health specialist and presumptive Medicaid eligibility. Family Road also worked with Family Planning and pursued funding, in order to enhance interconceptional care services. Family Road also worked with Title XXI LACHIP program and received a reimbursement application for the program. A private foundation funded a part-time position for an infant mental health specialist. These funding sources increased enrollment of program participants and enhanced specific program services. Family Road provided in-kind donations to support administrative operations. Community agencies continued to provide in-kind donations of staff members time for meetings and training programs. Family Road also implemented several fundraising events to increase funding sources. Additional funding sources included money from TANF, a federal grant for a Strengthening Families initiative and other MCH grants. Family Road Health Start coordinated efforts with members of the Advisory Council (Consortium), including Community Centers, to review grant opportunities and worked with local foundations and Health Departments on collaboration for grant applications and contracts.

Existing Title V Maternal and Child Health services were provided through the East Baton Rouge Health Unit, which also housed the regional clinic for Children with Special Health Care Needs. The Health Unit provided services for reproductive age women, including screening for Presumptive Eligibility for Medicaid; pregnancy testing and referral to prenatal care or family planning services; WIC food vouchers and nutrition/prenatal education. Infants and children served by the Health Unit received Medicaid/CHIP eligibility support services, preventive health screening (including EPSDT), WIC services, referral to early intervention services, Children’s Special Health Services and other health and social services as indicated.

Louisiana’s LaCHIP program was extremely successful in providing Medicaid coverage to uninsured children by increasing income eligibility levels to 200 percent of the federal poverty level. Through simplified eligibility applications, reducing eligibility requirements, translation services, and aggressive outreach over the past two years, 1 out of every 3 uninsured children in the state was enrolled in LaCHIP or Medicaid. Family Road played a lead role in the outreach for LaCHIP for children in the project area by maintaining its close working relationship with the Medicaid agency and outreach activities of the Title V Covering Kids Initiative. Each family enrolled in the project was assessed for Medicaid/LaCHIP eligibility.

In Baton Rouge, Title V also funded the Teen Advocate Program and funded in part, seven adolescent school based clinics. Title V and LSU Health Sciences Center funded prenatal clinical services, the nurse practitioner and registered nurse positions, hired and supervised staff at Family Road. A contract was developed for Title V support for the salaries of a Family Road Project Executive Director and a Medicaid Eligibility worker to be located in the Family Road facility.

Through the generous donation of funds from a Baton Rouge philanthropist in 2003, 50 cribs were distributed to needy families in the project area. Louisiana OPH, Greater Baton Rouge
Children’s Coalition, Family Road Healthy Start, the YWCA and other philanthropists in Baton Rouge, coordinated the event.

The Office of Family Services administered the Temporary Assistance for Needy Families (TANF) program and the Office of Community Services administered Child Welfare Services. Both agencies were represented on the Advisory Council (Consortium) and worked with Family Road to assure that referrals for services and mandatory reporting requirements were addressed and worked effectively in the project. Head Start and the Child Care Assistance Program were part of Family Road and the Project Area Committee. All families were referred for eligible services to meet their childcare needs. Volunteers of America and Partnerships in Child Care were active in Family Road and served on the Advisory Council (Consortium). Health and safety training was offered to all childcare centers in the project area by the Title V Healthy Child Care America program. Advisory Council (Consortium) members Child Net/Child Search, Early Intervention program and the early intervention providers serving the project area facilitated early intervention services. The Association of Retarded Citizens continued to provide services for families with special needs.

Families with substance abuse or mental health problems were referred to the Advisory Council (Consortium) member agencies including the Mental Health Association, Family Services of Greater Baton Rouge, Alcohol and Drug Abuse Council and the Capitol Area Human Services District, who administered Federal Substance Abuse and Mental Health Grants. The Baton Rouge Crisis Intervention Center continued to coordinate services with Family Road. Also represented on the Advisory Council (Consortium) was the Governor’s Office of Women’s Services, Job Placement Program, Job Service, Louisiana Delta Service Corps and East Baton Rouge School Board’s Adult Continuing Education. Baton Rouge Workforce Investment, Consumer and Credit Counseling Services and the Chamber of Commerce of Greater Baton Rouge, assisted families with budgeting and other financial and work related needs.

3. Barriers

The program was able to overcome several barriers. Reimbursement for the Nurse Case Management Component of the program was secured. The hospitals and vital statistics agreed to provide information for the FIMR process. The Board of Directors obtained sponsorships for its operating budget and continued to provide fundraising initiatives, to support program operations. Family Road was successful in the transition from Woman’s Hospital, as its fiscal agent and assumed complete responsibility for operation and management of the organization.

III. Project Management and Governance

A. Project Management

Family Road of Greater Baton Rouge, Inc. was governed by a 18 member voluntary Board of Directors that had 150 years of combined experience in perinatal care, public health, preconception planning, social services, business, management and accounting, among other disciplines. The Board of Directors was responsible for developing and implementing the annual financial work plan of the organization and the board, monitored the work of all board committees, evaluated and established compensation for the Executive Director. The Executive Director was responsible for overall administration of the organization, including all programming and financial development and reported directly to Board of Directors. The

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Executive Director had a total staff of 30, with 9 contract workers and provided direct supervision to 7 staff members including the Director of Operations/Dedicated Dads, Healthy Start Program Manager, Building Strong Families Program Manager, Community Developer, Office Manager, Accounting Clerk and the Nutritionist. The Director of Operations in conjunction with the Executive Director oversaw the consultants, program evaluators, and accounting services. The Healthy Start (HS) Program Manager was responsible for supervision of the program personnel; including case managers, outreach workers, educators and administrative support staff. The HS Program Manager was responsible for managing the coordination of services with the partner agencies providing services to the target population and collected data, which enabled the Project Area Committee, City Match Data Use Institute Committee and Project Area Infant Mortality and Morbidity Review Committee, to evaluate effectiveness of the various components of the program.

Connected to the operations of Family Road is the Advisory Council (Consortium), 104 non-profit, private, government agencies, which provided workshops, one-on-one sessions and classes to clients at Family Road. The Advisory Council officers included a Chair, a Co-Chair and several sub-committees, which each have chairs and co-chairs. The sub-committees of the Advisory Council met monthly, to provide assessment, input and implement plans and projects of Family Road. The sub-committees were Programming/Planning Committees, which provided input and reviewed programs and services offered at Family Road. This committee assisted in developing the calendar for Family Road and reviewed the schedule of programs. The committee acted as the review panel for new organizations, events and meetings held at Family Road. Another subcommittee was the Media/Resources Committee, which worked with Family Road’s PR Representative to gather resource information and disseminate information to print/broadcast media, service providers and the community. This committee developed the print and broadcast media plan for Family Road. The Media plan consisted of service providers that were highlighted each month on TV and print materials in the Greater Baton Rouge Area.

The City Match Data Institute Committee provided assistance in analysis, database management, geo-mapping and evaluation. This committee and its members became part of the Evaluation Team for Healthy Start. The Resource Development Committee acted as a Clearinghouse for grants and alerted the advisory council of new grants and coordinated work groups for grants. The committee also worked with service providers to identify possible funds that were available within the Greater Baton Rouge community. This committee transitioned into the Grants Committee. The Screening Committee developed policies and viewed applications of new agencies and programs interested in the collaboration at Family Road.

The sub-committees, which worked specifically on the Healthy Start programs, were the Project Area Committee and the Neighborhood Network Teams, which disseminated information to the community and provided insight community challenges regarding perinatal and women’s health. The multi-disciplinary Advisory Council (Consortium) Council met quarterly to review the effectiveness of Family Road’s service delivery.

The Executive Director, Director of Operations, Program Managers, and the Community Developer worked together as a team, to manage use of the Family Road site and delivery of services, by all providers. The Management Team prepared regular reports for the Project Area.
Committee, the Family Road Board of Directors and the Advisory Council (Consortium) detailed progress on achieving objectives in the project plan.

The Director of Operations in conjunction with the Executive Director oversaw solicitation, awards, fiscal and program monitoring of contracts and subcontracts. Family Road placed our bid among all possible providers through paper, state and local venues. Each contractor was required to submit a written proposal providing references, experience and program plan. This information was brought to the Finance Committee of the Board of Directors and reviewed. There must be at least 3 bids for every contract.

Family Road controlled all contracts, payroll, and personnel decisions. Since March 2004, Family Road assumed responsibility for accounting services, human resources and overall operations of Family Road. A contract CPA firm, Troy Jones CPA Firm, provided accounting services. The accounting services included: processing payroll, reconciling bank statements, recording and maintaining all necessary financial data in conformity with generally accepted accounting practices, preparation and presentation of monthly financial statements to the Board and consultation on development of the annual operating budget. While the following accounting functions were performed by an employee of Family Road, accounting clerk/bookkeeper, writing checks, deposits, reconciling bank statements and processing accounts payables and receivables. Family Road was subject to an annual external audit, as well as an annual internal audit conducted by Postlethwaite & Netterville CPA Firm.

B. Resources for Fiscal and Program Management

Family Road had an existing contract with MCH for coordination of maternal and child health services in Baton Rouge and WIC services. This relationship enabled Family Road to fund the nurse component of the Healthy Start program, which included eight nurses and a supervisor; funded a Presumptive Eligibility worker and nutritionist. Family Road also collaborated with Capital Area Human Services District for Substance Screening and Treatment for pregnant and parenting women; and a psychiatrist for multi-disciplinary team meetings for high-risk clients. Dedicated Dads enabled the program to gain assistance with expecting and parenting fathers whose partners were apart of the Healthy Start program. The Baton Rouge Area Foundation Medical Committee, provided funds for the infant mental health specialist. The Board of Directors also implemented a fund development plan to cover administrative expenditures of Family Road and programs. For the first three years of the program, Woman’s Hospital served as the fiscal agent and provided in-kind donations in the form of administrative support for human resource management, accounting, information systems, building space/maintenance and materials management.

C. Changes in Management and Governance

The major change in administration and management of the project was related to the transition of Family Road to an independent entity. Changes were implemented in a relatively short period of time, due to Woman’s Hospital shift in management/fiscal goals for the hospital. Family Road was notified in July 2003 that the transition was necessary and needed to occur within 4-5 months. The Family Road Board, Advisory Council (Consortium) and Family Road Management team, worked together very diligently, to implement essential changes to assure a
smooth transition. The major change in management and governance went into effect March 1, 2004.

With the transition of Family Road to an independent entity, a change in key staff included the Accountant and Director of Operations positions. Troy Jones, a contract C.P.A. replaced Amanda Hymel, Director of Accounting for Woman’s Hospital, for accounting services. Mike Tucker, former Human Resources professional with Woman's Hospital and current Program Manager of Dedicated Dads, was promoted to Director of Operations, to provide expertise in Human Resources, contract administration & negotiations and strategic planning. These changes became effective March 1, 2004 and July 1, 2004, respectively. Due to personal reasons, two outreach staff resigned. The infant mental health specialist became a full-time position (50% allocated to Healthy Start and 50% allocated to the Best Start Program). Vivian Gettys, former Healthy Start Program Manager, resigned her position in September of 2004. Charletta Montgomery assumed a dual role as Interim Healthy Start Program Manager/Healthy Start Social Work Supervisor and was transitioned into Permanent Status as Program Manager, June 1, 2005. Chavella Jenkins, former Community Developer resigned her position in September 2004. Tonya Hollins, Family Road Program Assistant II was promoted to the position of Community Developer in October 2004. Family Road reviewed the structure of administrative support for Healthy Start and decided that the FIMR analyst position, held by Ragan Canella, could be combined with the Program Assistant position.

D. Distribution of Funds

Family Road worked in conjunction with Woman’s Hospital and developed a method for appropriate distribution of funds. Expense Object Codes were developed to track the distribution funds as compared to the budget; a check request form was created to provide written documentation and receipts of any expense the program incurred, who made the request, description, code, signatures (Program Manager and Executive Director). Each month costs for salaries, benefits and expenses were drawn and an accounting of funds spent was reconciled with the PSC forms and the account. During the first year, Amanda Hymel served as the accountant for the program. Each month, the Accountant reported to the Board and Executive Director regarding the fiscal status of the program. During the second year, an accounting clerk was hired and was located at Woman’s Hospital under the supervision of Ms. Hymel. The clerk assumed the daily duties of Ms. Hymel and processed all check requests; data entry; completed PSC forms; provided reports and ran analyses requested by the accountant, program manager and the Executive Director. The Accountant continued to report to the Board and Executive Director regarding the fiscal status of the program. During the last two years, specific staff was designated to fill out check requests, specific days were identified to process requests and double signatures were required on receipts, bills as well as the check requests.

During the time mentioned above, Troy Jones CPA, assumed responsibility as the accountant for Family Road. Mr. Jones met with the Executive Director twice a month and the accounting clerk relocated to Family Road. Mr. Jones, the Executive Director and Director of Operations supervised the clerk. The Executive Director and Director of Operations meet with the Program Manager and Accounting Clerk monthly, to review the program budget to actual expenses and revenues. The transition enabled Family Road to have greater access to financials, thereby increasing efficiency in reviewing and revising financial information.
E. Additional Resources
Family Road of Greater Baton Rouge is a centrally located service site in the project area that coordinated services provided by more than 104 private, public and governmental agencies, to pregnant women, fathers and their families. This model attracted several governmental and private entities. Title V MCH for the past five years, provided funding for MCH initiatives such as coordination of prenatal and child health programs; presumptive Medicaid eligibility and nutrition consultations; infant mental health; assisted with obtaining funding for CityMatch which provided the opportunity to research infant mortality in Baton Rouge. Title V MCH also was instrumental in Family Road being a designated satellite location for the East Baton Rouge Parish Health Unit. This provided the opportunity for Family Road to provide WIC services and the full scope of Medicaid.

Family Road is a partner with Title V MCH, in assessment and development of needs assessments and worked on several community initiatives including SIDS and HIV/STD outreach. Family Road was chosen as the site for the Louisiana Low-Income Fathers’ Pilot Demonstration Project by Louisiana Department of Social Services. In addition, a local Title V MCH program, committed to providing free space and IS services for the nurse case managers. Family Road was chosen by the Administration of Children and Families (ACF), as a pilot site for the Building Strong Families initiative. As a “co-location of the Baton Rouge Health Unit, Family Road offered certification opportunities to pregnant women. Family Road and the Evaluation Team, which included members from Louisiana State University Epidemiology and Geo-mapping Department, developed tools to ensure quality assurance, program monitoring and service utilization. In addition, the Healthy Start program database was connected to a Geo-mapping system. The Office of Public Health for FIMR, wherein the Title V MCH, provided the expertise of Dr. Acuna, for technical assistance regarding FIMR.

F. Cultural Competency
Cultural Competency was an issue for some contractors and staff of Family Road Healthy Start site. Issues included staff not understanding poverty and culture; everyone was put in the same category because of race and culture; and no desire to learn. Institutional issues were addressed with conferences and one-on-one sessions and training. Cultural competence was achieved in the organization with staff and contractors, through building awareness, cross-cultural sensitivity training, planning implementations and evaluating results. Family Road was a member of Equity of Baton Rouge. Equity of Baton Rouge served as a coordinating body whose mission was to create more equitable race relations by increasing awareness through dialogue and education within organizations, communities and individuals. A dialogue on race was coordinated by the YWCA, to facilitate a deeper understanding and insight about race relations. All employees at Family Road of Greater Baton Rouge are required to participate in cultural competence training. The Management Team was the first to be trained, followed by staff and contactors. As a result of these efforts, Family Road was able to identify a change in attitude and approach toward clients, as well as, a higher level of understanding and tolerance towards cultural differences.

IV. Program Accomplishments
A. Summary
Below is a detailed summary of Program Accomplishments for Healthy Start for the project period. Please see Appendix A for the Final Report/Implementation Plan.
Outreach

**Strategy: Contact pregnant women in the target population**

**2002**

A total of 630 pregnant women were contacted in the target population, which surpassed the goal of 530 contacts for 2002. Of the participants enrolled, 58% were recruited through outreach.

1 and 3. Four full-time outreach workers and two part-time male outreach workers were hired. The Community Developer was hired and supervised outreach staff; coordinated outreach activities in the community. Outreach staff completed an orientation program upon hire and were required to attend monthly in-services.

2. and 8. Neighborhood Network Teams were formalized and included: Neimiah Society; Security Dads; Health Care Center in Schools; 100 Black Men; Alpha Phi Alpha fraternity. Captains were representatives of the Network Teams and participated in the (Advisory Council) Consortium; Project Area Committee; and provided input into program operations.

4. A client contact reporting system and outreach schedule was implemented, to track client contacts and outreach activities.

5. The Outreach team attended in-service trainings as scheduled in 2002.

6. Refer to 1 and 3.

7. Outreach activities included door-to-door contacts; distributing healthy start literature to churches, schools, businesses, community centers, health care providers; participation in workshops and community health fairs. Advertisements were provided on billboards, bus stop posters, posters for mounting at facilities, radio and television advertisements.

9. Outreach activities were reported to the Project Area Committee and Advisory Council (Consortium), each month.

**2003**

There were four Outreach Workers who lived in the project area who are supervised by the Community Developer. Refer to Calendar Year 2002, Number 6,7.

1. Neighborhood Network Teams were formed with the following community groups: Neimiah Society; Security Dads; Health Care Center in Schools; 100 Black Men; and Alpha Phi Alpha Fraternity. The Community Developer and Outreach Workers coordinated activities with network groups. In 2003, 2724 contacts were made by outreach staff in the project area.

2. In-service trainings were scheduled on adolescents and STD’s and birth defects in 2002.

3. The Community Developer conducted Annual Outreach Worker Evaluations; provided supervision, with continual suggestions for skill enhancement. Outreach workers attended In-Service Trainings to improve their competency level in community outreach.
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4. A training manual obtained from the University of North Carolina at Pembroke, served as a reference to assist with creating an Outreach Training Manual.

2004
1. Family Road in collaboration with Consortium members provided a comprehensive array of educational offerings for pregnant, postpartum and parenting women and their family members. Recipients of educational services included program and community participants. Outreach staff provided Family Road and Healthy Start program information and community resource information. Nurses and Social Workers provided health education on community risks, influencing perinatal health; the nutritionist and Medical Director of Region II, provided educational sessions on perinatal and infant health topics. The Medical Director of Region II, provided educational workshops related to perinatal health. Speakers for provider trainings were usually local and national experts in the field.

The Health education curriculum “Partners for a Healthy Baby” was presented to program participants during home visitation sessions. In 2004, 90 program participants completed the prenatal curriculum; 142 program participants were completing the parenting curriculum. The parenting curriculum covered topics for infant care/parenting skills from birth to age 2 of the child. Educational classes offered at Family Road and other community agencies were based on client need and preference.

2. Health education services continued in 2004 with a few modifications. The Healthy Start program participated in technical assistance visits; Domestic Violence in June 2004 and Perinatal Depression in September 2004. Presentations were provided to community members and providers in 2004 on these topics. The Healthy Start program collaborated with other community agencies to continue educational activities on the perinatal substance abuse. Dr. Chasnoff returned to the community in March 2004, and provided additional provider training on assessment and treatment of substance abusing women. Program participants indicated the need for more breastfeeding information. The program obtained additional literature on WIC: a video produced by the WIC program in Mississippi, to encourage women to breastfeed. There is a high prevalence of STDs in the community and program participants requested additional information. Health education on the topic of STDs was included in the 2004 calendar.

3. The media campaigns included advertisements on billboards, bus stops, facility posters along with radio and television. The media materials were developed through previous subcontracts with advertising, printing and radio agencies. Based on comments from current program participants, print and media advertising were recommended to continue.

4. A Contract with A&J Transportation and Yellow Cab provided transportation to program participants. HS purchased bus tokens for program participants and encouraged self-sufficiency.

5. The Family Road prenatal clinic began in October 2003 to provide prenatal care to any client in need of prenatal care, regardless of insurance coverage. The clinic was the result of the collaboration between the Office of Public Health, Louisiana State University Medical Center/Earl K. Long Hospital and Family Road. A nurse practitioner, registered nurse and administrative support person operated the clinic with oversight by a medical physician.
Case Management
Strategy: Enroll pregnant women into case management services.

2002
1. A total of four Masters’ Level Social Work Case Managers and one licensed Social Work Supervisor provided the social work case management services. A total of eight registered nurses and one registered nurse supervisor were hired to provide nurse case management services.

2. In-service trainings were attended by all case management staff on a monthly basis. Trainings in 2002 consisted of five training sessions on Infant Mental health, Breastfeeding, Adolescents and STD’s, Denver II training, Birth Defects, Nutrition and Pregnancy.

3 and 4. Healthy Start policy and procedures were developed. A referral system was developed for program enrollment, contingent upon eligibility criteria and identified needs.

5. A manual documentation system was devised to maintain records and report on the performance measures for the nursing and social work model of case management. An electronic database was in the final development phase.

6. A list of medical providers was obtained from Medicaid and was provided to program participants as requested or needed.

7. The Family Road Program Committee evaluated client satisfaction with programs and service providers each quarter. A total of 24 surveys were distributed to participants enrolled in the program at least 3 months. There were a total of 17 respondents giving a 71% response rate for the survey. All 17 (100%) program participants responded positively to survey questions. On a scale of 1-5 (with 5 being best), the respondent’s opinion of their home visitor was on average 4.94. The top 2 ways respondents liked receiving information was through talking with someone (82%) and through pamphlets/brochures (53%). Respondents could check more than one answer. Of the respondents, 82% reported increased knowledge of self-care skills. Of the respondents, 82% stated that their needs were being met. All respondents (100%) stated that they would refer a friend to the program. Of the respondents, 94% stated that they set goals for themselves. On a scale of 1-5 (with 5 being best), respondents rated their opinion of the Healthy Start program on average as 4.82.

All respondents (100%) reported a good relationship with their provider/doctor. Of the respondents, 94% stated that their provider/doctor answered questions in a way they understood. Of the respondents, 88% stated the prenatal visits were an okay length of time. Of the respondents, 94% stated their doctor was friendly. All respondents (100%) stated that they thought their provider/doctor cared about them and their baby. Of the respondents, 94% stated that they would not change their provider/doctor. On a scale of 1-5 (with 5 being best), respondent’s opinion of their provider/doctor was on average 4.82.

8. Barriers to program participants receiving services included location of services in a convenient, customer-friendly environment, transportation, and childcare. The Family Road
model of care eliminated many barriers through co-location of services; provision of childcare and transportation.

2003
For 2003, a total of 248 program participants and their families were enrolled in the program; 191 were new program participants.
1. A nurse case manager was hired.
2. In-service trainings were attended by all case management staff on a monthly basis. Trainings in 2003 consisted of child safety, two sessions for domestic violence, substance abuse, child brain development, HIV/AIDS, depression, gestational diabetes, vaccine safety, perinatal Group B, preterm labor, smoking cessation in pregnancy and treatment of female cancers.
3. Additional Healthy Start policy and procedures were developed. These policies consisted of transportation, crib dissemination, counseling and mommy hour. In 2003, there were a total of 1,198 taxi trips and 200 bus tokens provided to program participants in the Healthy Start Program. Counseling services were also initiated at Family Road to meet client needs.
4. The Healthy Start program completed the annual client satisfaction survey. There were 92 respondents to the survey, which included questions about the case manager, the program, and the health care provider. On a scale of 1-5 (with 5 being best), the program participants rated the case manager as 4.93 on average. Of the respondents, 88% reported that they were more educated about how to take care of themselves and 95% reported that their needs were being met. On a scale of 1-5 (with 5 being best), program participants rated the Healthy Start program as 4.90 on average. The program participants most preferred method of receiving information was through talking with someone. Of the respondents, 95% reported that they had set goals for themselves. Of the respondents, 99% stated that they would refer a friend to the program. On a scale of 1-5 (with 5 being best), respondents rated their prenatal health care provider as 4.65 on average. Of the respondents, 88% stated that their provider/doctor answered questions in a way they understood.

2004
1. In-service trainings were attended by all case management staff on a monthly basis. Trainings in 2004 consisted of management of suicidal patients, non-violent crisis intervention, preterm labor, STD’s, adolescents and family planning, parenting enrichment, play therapy, professional ethics and confidentiality, depression in pregnancy and grief.
2. Additional Healthy Start policy and procedures were developed. These policies consisted of client boundaries, infant mental health and revisions to the transportation and mommy hour policies due to changes in the program.
3. The Healthy Start program completed the annual client satisfaction survey in 2004. There were 83 respondents for the survey, which included questions about the case manager, program operations and health care provider. On a scale of A-F (with A being the best), 90% of the program participants gave their case manager an “A”; 7% gave a “B” and 3% gave a “C”. Program participants felt that the most important things about their case manager was: (1)
descriptions of the case managers as friendly and approachable (94%), (2) case manager was helpful (84%), and (3) case manager was happy to come and see them (84%). Of the respondents, 76% reported that Healthy Start assisted with goal establishment for themselves and their families; 71% reported that Healthy Start helped them to be a better parent and 60% reported that the Healthy Start Program helped them cope effectively with their problems and to feel better about themselves. Of the respondents, 99% stated that they would refer a friend to the program. Of the respondents, the Healthy Start participants ranked the top three most important services to be, relationship with case manager (94%), home visits (78%) and Mommy Hour (52%). Of the respondents, 76% stated that their provider/doctor answers questions in a way program participants understood.

4. An Incentive schedule was incorporated into the Healthy Start program. See copy of incentive schedule in the Attachment Section.

5. Family Road Healthy Start staff worked very closely with the Louisiana Office of Public Injury Prevention Coordinator, in campaigns to prevent Sudden Infant Death Syndrome, especially deaths possibly linked to co-sleeping and overlays. Cribs were donated by a local philanthropist and disseminated to a total of 150 Healthy Start program participants in 2003. The crib dissemination campaign was discontinued in 2004 due to limited funding.

6. The Ages and Stages Developmental Screening Tool was utilized. The Office of Public Health encouraged case managers to use the “Ages and Staged.

7. An infant mental health specialist was available in 2004, to address mental health needs to promote attachment and bonding between mother and child. Referral procedures were established and included in the policy and procedure manual.

**Case Management**

**Strategy:** Identify causes of infant morbidity and mortality through review of infant deaths and focus group interviews.

**2002**

1. The Child Death Review process was established for East Baton Rouge Parish. MCH and Healthy Start collaborated to establish the FIMR process. Planning and development of FIMR, was initiated but was not been completed. An implementation plan was developed for timeline requirements beginning in 2003.

2. The Geographic Information System (GIS) provided additional information to the outreach and case management program to better serve the population. Birth and death certificate data for Region II was analyzed using GIS to identify areas of high infant mortality; areas with high rates or no prenatal care visits; areas with inadequate prenatal care visits; and areas with high rates of short gestation and low birth weight births. The analysis identified risks by project area (streets or physical addresses).

3. Case managers, the Community Developer and Outreach Workers interviewed identified women and surveyed their reasons regarding a lack of prenatal care visits.
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4. A focus group was conducted regarding the SIDS initiative, which initiated funding for the crib dissemination project.

5. A survey of 41 Healthy Start participants in 2002, revealed the top five reasons pregnant women seek prenatal care: they don’t think they need care, denial about being pregnant, don’t want people to know, no way to get there, fear of repercussions for drug and alcohol use. Respondents surveyed stated that the best ways to get women into prenatal care included: providing home prenatal visits, extended hours for appointments and advertisement about the importance.

6. Refer to Calendar Year 2002, Number 2.

7. Public information media campaigns and workshops were implemented in collaboration with other community organizations to include the importance of prenatal care and child immunizations, the role of fathers, and prevention of teen pregnancy. A survey of 41 Healthy Start participants revealed that the top three areas that the community needs to know more about involving pregnancy and having a healthy baby included: the importance of prenatal care, risks for delivering early or risks related to infant deaths, and sexually transmitted diseases.

2003  
1. Technical assistance for the FIMR was provided by the Louisiana Office of Public Health and the National FIMR program. The Louisiana Perinatal Commission issued a letter authorizing FIMR as an Office of Public Health initiative and state legal counsel provided clarification of the HIPAA requirements. Meetings among key leadership in the community continued in 2004 to gain support for the process and recruit members to both teams.

2. A Case Review team was established in May 2003. An orientation about the FIMR program was conducted in October 2003.

3. HIPPA regulations created some additional challenges due to the heightened security, related to privacy and confidentiality issues. There were concerns among organizations about accessing clinical records and how the data would be utilized in reports to the community.

4. The Community Action team was established in May 2003. An orientation about the FIMR program was conducted in October 2003.

5. Documentation tools and database provided by the NFIMR.

6. A Case Review Summary was used in the reporting mechanism provided by the NFIMR database. Modifications were made to the FIMR Case Summary, in order for the case information to be read easier and easily understood.

7. A FIMR fact sheet and letter was created and initiated for distribution. An article highlighting the purpose of FIMR was submitted to the Family Road Newsletter.
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8. The Case Review Meeting was delayed until March 2004, due to the hospitals’ reluctance and uncertainty on confidentiality, FIMR, community’s perception.

9. An evaluation was pending due to the program not reviewing cases.

2004
1. Refer to Calendar Year 2003, Number 1.

2. Refer to Calendar Year 2003, Number 7.

3. Four meetings were conducted in 2004 and seven cases reviewed. The Community Action Team (CAT) met in November 2004 for its first meeting. Discussion was conducted on the reporting process for CRT to initiate community awareness projects.

4. An evaluation was developed for the Case Review and Community Action Team. This evaluation will be issued in 2005.

Case Management
Strategy: Enroll pregnant women into the program early in pregnancy.

2002
1. Family Road in collaboration with Consortium members provided a comprehensive array of educational offerings for pregnant, postpartum, and parenting women and their family members. Recipients of educational services included program participants and community participants. Outreach staff provided Family Road and Healthy Start program information and community resource information. Nurses and Social Workers provided health education on risks identified in the community, influencing perinatal health. The nutritionist provided educational sessions related to perinatal and infant nutrition, including breastfeeding. The Medical Director of Region II, provided educational presentations related to perinatal health. Speakers for provider trainings are usually local and national experts in the field.

2. Workgroup convened to review adequacy of prenatal care providers serving the target population. Medicaid improved provider services. Ongoing work with hospitals and committees to increase medical providers. Medicaid introduced Community Care Program, which provided a medical home to assign all participants to medical providers.

3. An additional component of the outreach program was a media campaign to promote early prenatal care, healthy prenatal behaviors and the toll free information and referral hotline. This existing campaign entitled “Partners for Healthy Babies” will direct its television, radio, outdoor and transit advertising messages to the target population. The Louisiana Title V Maternal and Child Health (MCH) Program funded this program since 1993. The Baton Rouge Healthy Start Project had free access to the Partners for A Healthy Baby Campaign. In addition, MCH worked with focus groups of women in the target area, particularly those deemed high risk to elicit information for development of effective media messages.

4. The hotline for “Partners for A Healthy Baby” was advertised through radio and broadcast media.
5. Healthy Start developed a personal education packet for women in the target population. The packet contained information concerning preconception planning, perinatal care, parenting resources, and resources for basic needs (such as food, shelter, and clothing).

6. Providing an educational campaign with support from the Neighborhood Network Teams, Men’s Teams and other community organizations on the topics of early prenatal care and STDs were a major focus since consumers identified this as a need.

2003

1. For 2003, there were a total of 358 referrals into the program. There were 248 active program participants and their family members that received case management services. Including family members, there were a total of 784 program participants receiving services. There were a total of 2,723 case management visits conducted in 2003. The majority of program participants were in the age range of 18-24 years. Of the prenatal program participants, 49% initiated prenatal care in the first trimester. There were a total of 1004 prenatal care visits completed by program participants in 2003; and 80 male participants in the program. The majority received educational services and referral to resources. Of these 80 males, 12 were enrolled in the Family Road Dedicated Dads program. There were a total of 110 infants born to program participants enrolled in the program in 2003. There were a total of 276 well baby visits completed by infants in 2003. Of the infants, 82% had a birth weight greater than 2500 grams.

In 2003, there were a total of 88 client referrals to the nutritionist. There were 75 home visits provided by the nutritionist. The most common reasons for referrals included breastfeeding intent, dietary habits at risk, and overweight. Of the women who had a goal to breastfeed their infants, 71% initiated breastfeeding at delivery and were successful at breastfeeding more than 2 weeks. Several initiatives were focused on increasing awareness of the benefits of breastfeeding for the infant and woman and how family members could be supportive. Client education materials on breastfeeding were obtained. A child wellness fair was provided in the target community with a focus on breastfeeding. A seminar titled, “Breastfeeding-A Gift of Love” was provided for Healthy Start program participants and family members to provide information on breastfeeding and to hear from a couple who breastfed their infants successfully.

There were a total of 56 high risk program participants reviewed by the multidisciplinary team in 2003. The percentage of high-risk program participants based on a total of 248 program participants is 23%. Major risk factors included medical high risk, no prenatal care, depression, history of alcohol, tobacco, and drug use, anemia, incompetent cervix, pre-eclampsia, previous low birth weight baby, diabetes, HIV positive, STDs, and hypertension.

2. Public education programs in the form of workshops reached a total of 1,265 people. Workshops were held on topics such as: breastfeeding, nutrition, and immunizations. Technical assistance was provided on topics of perinatal substance abuse and depression.

3. Healthy Start funded billboards, posters, and radio broadcasting targeting the project population reached an estimated 519,000 people per day. Additional billboards were implemented with the message to seek early prenatal care.
4. A total of 1,198 taxi trips and 200 bus tokens were provided to assist with transportation.

5. The Family Road prenatal clinic began in October 2003 to provide prenatal care to any client in need of prenatal services regardless of insurance coverage.

**2004**

1. For 2004, there were a total of 302 referrals into the program. There were 291 active program participants and their family members, that received case management services. Including family members, there were a total of 730 program participants receiving services. In 2004, 3,022 case management visits were conducted; most program participants ranged in age from 18-24 years and 42% initiated prenatal care in the first trimester. There were a total of 1,854 prenatal care visits completed by program participants and 61 male participants in the program. Seventy-four infants were born in the calendar year, 91% of the infants born, had a birth weight greater than 2500 grams. Forty-nine high risk program participants were reviewed by the Multidisciplinary Team in 2004.

2. Community service providers that are part of the Healthy Start Consortium also implemented educational programs at the Family Road on various topics including prenatal care, parenting, life skills development, car seat and general safety, education and training classes, wellness and nutrition, fatherhood and counseling.

3. Media messages included topics related to parenting and women’s health using in-kind donations for television, newspaper, radio and billboard media. Healthy Start Program brochures were disseminated throughout the project area.

4. The Family Road model of care eliminated many barriers by co-locating services in a customer-friendly environment with the provision of transportation and child care.

5. Through a collaborative partnership with the Office of Public Health, LSU/Earl K. Long and Family Road the prenatal clinic provided prenatal care to any client in need of prenatal services, regardless of insurance coverage.

**Education Strategy:** Provide educational programs to the target population.

**2002**

1. The education component of the Family Road Healthy Start Project had four educational components: (1) A diverse curriculum of classes, programs, and workshops to deliver information and instruction on topics regarding pregnancy, nutrition, exercise, avoidance of risk reduction behaviors, child birth, parenting and pregnancy expectations.

For the period July 15, 2002 to December 31, 2002, a total of 3,329 participants from the target population participated in educational offerings through outreach efforts and community collaboration. Of the 88 program participants in case management services, 88 (100%) participated in at least one educational offering. These outcomes surpassed 2002 objectives for health education.
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2. A total of 6,855 Family Road calendars for January – June 2002 were distributed in the community.

3. Healthy Start Outreach workers, distributed Family Road calendars and program information to sites frequented by pregnant and parenting women in the project area.

4. Healthy Start Case managers assisted program participants with identifying useful and convenient course offerings.

5. Public information campaigns were provided through community events and community health fairs. Family Road sponsored a public meeting at a community church to improve awareness of infant mortality in Baton Rouge and to provide input to services offered through Healthy Start. Healthy Start participated in a total of 11 additional health fairs that were held at churches, health centers, and other community settings focused on providing health education to the public. Participation in community events and health fairs totaled 4,213.

6. A total of three consumers participated on the Family Road Healthy Start Consortium for 2002. Consumers provided suggestions on topics of interest during “Mommy Hour”, a subcomponent of the Consortium.

2003

1. In 2003, there were a total of 348 participants for the mommy hour sessions with an average of 26 participants attending each month. Educational topics included Healthy Relationships, STDs, Establishing Trust, Infant Cues, Nutrition, Self-Esteem, Roadblocks to Learning, and Choosing Childcare.

2. and 3. Family Road Calendars were distributed in locations, frequented by pregnant and parenting women.

4. Refer to Calendar Year 2002, Number 4.

5. In 2003, there were a total of 2,787 community participants that attended health fairs; 1,265 attended workshops and 5,065 attended events. The grand total of all educational offerings for community participants was 9,117. There were 1,230 providers that attended conferences that were co-sponsored by Healthy Start in 2003.

6. and 7. The Family Road Program Committee evaluated client satisfaction with program services, each quarter. In addition, Family Road also assessed the needs of the program participants through surveys to determine educational topics of interest.

2004

1. Refer to Calendar Year 2003, Number 1.

2. Refer to Calendar Year 2003, Number 2.

3. Refer to Calendar Year 2003, Number 3.
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4. Refer to Calendar Year 2003, Number 3.

5. In 2004, 28 workshops and fairs were held in the community with 1,321 community and program participants in attendance. Technical assistance was provided by Dr. Michael O’Hara and Dr. Lisa Segre on September 9, 2004 on the topic of perinatal depression. A total of 44 participants attended the event. Technical assistance was provided on the topic of Domestic Violence on June 14-15, 2004. Rebecca Whiteman, senior policy analyst from the Family Violence Prevention Fund, and Linda Chamberlain, a consultant for the Family Violence Prevention Fund conducted the site visit. A total of 103 participants attended the event. Technical assistance was also provided on the topic of Perinatal Substance Abuse on March 29-30, 2004 by Dr. Ira Chasnoff. A total of 180 participants attended the event.

6. The Healthy Start program completed the annual client satisfaction survey in 2004. There were 83 respondents for the survey, which included questions about the case manager, program operations and health care provider. On a scale of A-F (with A being the best), 90% of the program participants gave their case manager an “A”; 7% gave a “B” and 3% gave a “C”. Program participants felt that the most important things about their case manager was: (1) descriptions of the case managers as friendly and approachable (94%), (2) case manager was helpful (84%), and (3) case manager was happy to come and see them (84%). Of the respondents, 76% reported that Healthy Start assisted with goal establishment for themselves and their families; 71% reported that Healthy Start helped them to be a better parent and 60% reported that the Healthy Start Program helped them cope effectively with their problems and to feel better about themselves. Of the respondents, 99% stated that they would refer a friend to the program. Of the respondents, the Healthy Start participants ranked the top three most important services to be, relationship with case manager (94%), home visits (78%) and Mommy Hour (52%). Of the respondents, 76% stated that their provider/doctor answers questions in a way program participants understood.

7. Refer to Calendar Year 2003, 6 and 7.

**Education Strategy:** Provide educational programs to males of pregnant women in the case management program.

**2002**

1. Strategies were developed to recruit the Neighborhood Network Support Team members, Captains, and the Men’s Team members. Male support services included a fatherhood seminar at a community church and a series of workshops for teen males age 10-16 in the project area. Total males served were 97. The captain and outreach workers also consulted with network members to identify and recruit members of the men’s team. Family Road provided training to members of the men’s team adapted from its Facts for Fathers program developed for expectant fathers. Each neighborhood also established a men’s team to reach out to expectant fathers to encourage the father’s involvement in both the pregnancy and child-raising process.

2. Family Road Healthy Start with the assistance of Radiance Productions created radio clips which included two males discussing pregnancy and initial feelings men experience with unexpected pregnancies.
3. Refer to Calendar Year 2002, Number 1.

4. Planning meetings for the Fatherhood Program began in May 2002 with brainstorming on a curriculum to use and an incentive program to follow. A fatherhood conference was attended in July 2002. The strategic plan for the Fatherhood Program included recruitment activities: to recruit fathers in the target area; develop a system of contact and referral; how to receive and process referrals; develop a system of contact and referral; activities and incentives.

5. Family Road provided training to members of the men’s team adapted from its Facts for Fathers program developed for expectant fathers. Each neighborhood also established a men’s team to reach out to expectant fathers to encourage the father’s involvement in both the pregnancy and child-raising process. Completed instructor training and program planning using the “Quenching the Father Thirst” curriculum. Fatherhood curriculum sessions were scheduled to begin 2003.

2003

There were a total of 80 male participants in the program. The majority received educational services and referral to resources. Of these 80 males, 12 were enrolled in the Family Road Dedicated Dads program.

1. Networks have been formed with the Neimiah Society (religious group), Security Dads (school based group), Health Care Center in Schools, 100 Black Men (a civic organization) and the Alpha Phi Alpha fraternity.

2. A new brochure was developed and distributed regarding the Fatherhood Program. One of the three components of the Dedicated Dads program was to provide relationship-building & educational activities for Dads of and their families.

3. An incentive schedule was developed for the Fatherhood Program. Items such as ink pens, pencils, coffee mugs, umbrellas and calculators were included on the schedule and were provided to participants throughout participation in the program.

4. Dedicated Dads program provided ongoing support to fathers of babies in the case management program.

5. Dedicated Dads Program was expanded to include additional services. Surveys were conducted to measure client satisfaction by a third party evaluator and PSI.

2004

1. The Fatherhood brochure was distributed out in the community by the outreach team. The brochure was also included in the initial packet of information when a client enrolled in the Healthy Start Program.

2. Refer to Calendar Year 2003, Number 3.

3. Participants who graduated from the program were encouraged to return to various weekly sessions to serve as mentors for the program. They shared their experiences while being in the program and provided information on how the program influenced and impacted their lives.
4. Surveys were conducted to measure client satisfaction by a third party evaluator and PSI.

**Education**

**Strategy: Provide educational program for clinical providers on perinatal health.**

**2002**

1. Marion Wright Edelman of the Children’s Defense Fund provided a presentation on reducing disparities in the health of women, children and families. The Louisiana Juvenile Justice Commission held a presentation to review findings and recommendations to improve community support for at risk children and families. Dr. Karla Damus provided a seminar on the topic of Substance Abuse and Pregnancy using a multidisciplinary approach. A fair housing summit was held to discuss housing services to underserved populations. The “Caring Conference” provided information on community approaches in reducing violence among families in Baton Rouge. The Greater Baton Rouge Children’s Coalition Community Meeting provided a detailed Community Plan for Children which addressed issues concerning health, education, recreation, community linkage, youth leadership, development and service, basic needs, transportation, and family support. Women’s Council Women’s Week provided insight into women’s health and relationships and provided a variety of workshops and session conducted throughout the week. A series of five sessions were conducted on the topic of Infant Mental Health to enhance skills in promoting parenting by infant caregivers. A total of 155 members of the Consortium participated in training. Training was provided to 868 professionals and paraprofessionals serving the target population.

2. The service providers and women in the target population convened to address issues and ideas on an effective curriculum.

3. Family Road provided continuing education credits for professionals.

4. Woman’s Hospital provided programs and individual instruction on a variety of general and specialized medical topics such as introduction to fetal monitoring, HIV in pregnancy, STDs in pregnancy, diabetes in pregnancy, promoting breast-feeding in today's healthcare environment, “ABC’s” of pediatric assessment, critical choices in nutrition for the pre-term and low birth weight infant, spirituality and nursing, stress management: exercise, meditation, and music, among others. Woman’s Hospital personnel collaborated with Project staff in developing training programs for health care providers.

5. Healthy Start Case Managers and Staff contacted providers and encouraged them to participate in trainings.

**2003**

1. The Healthy Start program co-sponsored a conference on Perinatal Substance Abuse featuring national experts that was attended by 250 health care and social service providers in the community. Dr. Ira Chasnoff conducted presentations to provider groups and community groups on the topic of perinatal substance abuse that was made possible by a technical assistance grant through Healthy Start. There were 258 participants at the presentations by Dr. Chasnoff.
2. The service providers and women in the target population convened to address issues and ideas on effective curricula. Upon review of the curriculum, service providers and women in the target population suggested supplemental information to enhance selected curriculum.

3. Refer to Calendar Year 2002, Number 3.

4. Perinatal substance abuse training was provided at the major hospitals in the community.

5. Refer to Calendar Year 2002, Number 5.

2004
1. The Baton Rouge community participated in Healthy Start technical assistances, provided in the areas of substance abuse, depression, and domestic violence. The Healthy Start program participated in technical assistance visits in the areas of domestic violence in June 2004 and perinatal depression in September 2004. Presentations were provided to community members and providers in 2004 on these topics. Dr. Chasnoff returned to the community in March 2004, where he provided additional provider training on screening and treatment of women for substance abuse. Technical assistance was provided by Dr. Michael O’Hara and Dr. Lisa Segre on September 9, 2004 on the topic of perinatal depression. A total of 44 participants attended the event. Technical assistance was provided on the topic of Domestic Violence on June 14-15, 2004. Rebecca Whiteman, senior policy analyst from the Family Violence Prevention Fund, and Linda Chamberlain, a consultant for the Family Violence Prevention Fund conducted the site visit. A total of 103 participants attended the event. Technical assistance was also provided on the topic of perinatal substance abuse on March 29-30, 2004 by Dr. Ira Chasnoff. A total of 180 participants attended the event.

2. Consumers and providers provided input on the perinatal substance abuse, depression and domestic violence initiative. Evaluations were given to all participants who attended the technical assistance visits. A client satisfaction survey was conducted in 2004 where 83 participants completed the survey. In the survey, questions were asked regarding the healthcare provider. The program participants were asked how they would rate the service that they received from their OB/GYN: 57% gave a rate of excellent, 34% gave a rate of good and 7% gave a rate of fair. The program participants were asked how they would rate the service that they received from their Pediatrician: 57% gave a rate of excellent, 35% gave a rate of good and 7% gave a rate of fair. They were also asked did their doctor answer their questions in a way that they could understand: 82% said yes, 4% said no and 11% said sometimes. Questions regarding what prevented them from getting early prenatal care were asked. The top three reasons were: (1) needed a Medicaid card, (2) waiting time to get an appointment with a doctor, and (3) did not know that they were pregnant.

3. Refer to Calendar Year 2003, Number 3.

4. Refer to Calendar Year 2003, Number 1.

5. Refer to Calendar Year 2003, Number 5.
Education
Strategy: Provide education and referral for childhood immunizations in the project area.

2002
1. Information was compiled regarding opportunities to provide a public information media campaign regarding the importance of childhood immunizations. This media campaign was a collaborative effort among community agencies.
2. In collaboration with “Shots for Tots”, educational materials were distributed in the project area regarding immunizations.
3. Outreach workers disseminated information in the community regarding age appropriate immunizations. Services provided to mother and child by case managers included ensuring that both mother and infant attend scheduled medical appointments and that the child received all age-appropriate immunizations. Data was not yet available for the percentage of one year olds who have received age-appropriate immunizations since program infants had not reached one year of age.
4. Family Road compiled a list of the available sites where a child could get immunizations. The list was made available to program participants upon request.
5 & 6. Immunization information was not accessible at this time. Immunization rates were reported for year 1998 only. Data for 1999-2001 immunizations was not available. The Louisiana State contract for the LINKS immunization database was transferred to another organization, which created difficulties in obtaining the data. The only data available for immunizations was for the entire East Baton Rouge Parish. The project area data required more in-depth sorting using the LINKS database.

2003
1. Public information media campaigns and workshops were implemented in collaboration with other community organizations to include the importance of child immunizations. Immunizations were targeted in August. The Office of Public Health launched an immunization drive and provided immunizations at a variety of sites in the community.
2. Workshops on the topics targeted in the National Health Observances calendar were conducted in the project area at community based sites. These topics included immunization awareness. In collaboration with “Shots for Tots”, immunization information was provided at health fairs/workshops sponsored by Healthy Start.
3. Refer to Calendar Year 2002, Number 3. In 2003, there were a total of 53 infants out of 61 infants at the age of 5 months who completed age appropriate immunizations that resulted in an 87% rate.
4 & 5. Refer to Calendar Year 2002, Number 5 and 6.

2004
1. Refer to Calendar Year 2003, Number 1.
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2. Refer to Calendar Year 2003, Number 2.  

3. Refer to Calendar Year 2003, Number 3. Case managers recorded immunizations directly from the infant/toddler’s immunization record or medical provider record. Immunizations for infants/toddlers were recorded in the case file and database. Case managers during home visitation sessions, stressed the importance of immunizations.  

4. The Louisiana Office of Public Health has continued to establish a reliable mechanism to retrieve immunization rates by zip code using the new LINKS system. All of the private providers and non-health unit clinics were not using the system for immunization documentation. Therefore, many of the immunizations were not entered into the electronic surveillance system which limited the data analysis and interpretation. The LINKS data showed that the project area had a 21% rate of completion of age appropriate immunizations by age 2. See LINKS letter in attachments.  

Program Evaluation  

Strategy: Administer satisfaction survey to program participants in program  

2002  
1. The Healthy Start Evaluation Team implemented a client satisfaction survey that was used to determine client perceptions of the Healthy Start program and areas to improve.  

2. A total of 24 surveys were distributed to participants who had been enrolled in the program at least 3 months.  

3. The Family Road Program Committee evaluated client satisfaction with programs and service providers each quarter. Refer to “Case Management” Strategy: Enroll pregnant women into case management services; Calendar Year 2002, Number 7.  

2003  
1. Client satisfaction surveys were used to identify areas of strength and needs for improvements for the Healthy Start program. The Healthy Start program completed the annual client satisfaction survey for 2003.  

2. Refer to “Case Management” Strategy: Enroll pregnant women into case management services; Year 2003, Number 3.  

2004  
1. Client satisfaction surveys were used to identify areas of strength and needs for improvements for the Healthy Start program. The Healthy Start program completed the annual client satisfaction survey for 2004.  

2. Refer to “Case Management” Strategy: Enroll pregnant women into case management services; Calendar Year 2004, Number 3.  

Case Management
Strategy: Screen women receiving case management services for depression and make referrals as needed.

2002
1. All case management staff received training upon hire on the topic of perinatal depression, use of the depression screening tool and referral resources. Case management staff was provided orientation to use of the Edinburgh Depression Screening Tool and referral agencies in the community.

2. Intervention strategies included the use of the Edinburgh Depression Tool to screen program participants during the prenatal period for past histories of depression.

3. Using the Edinburgh Depression Screening Tool, all pregnant women enrolled in the program were screened for depression during the post-partum period.

4. Based on screening results, referrals were made for further assessment and treatment to community agencies providing mental health services. For the period July 15, 2002 to December 31, 2002, a total number of 70 program participants were screened for depression. Of these, 15 (21%) were referred for further evaluation and treatment.

5. & 6. Case management staff monitored services provided to program participants for depression to ensure needs were met. The number of completed referrals totaled 6. Two of the program participants who completed referrals were receiving treatment.

7. Healthy Start developed record keeping systems in order to track performance measures for depression screening and referral.

8. Program development phase continued during 2002. Program participants were enrolled starting in July 2002.

2003
1. Refer to Calendar Year 2002, Number 1.

2. Refer to Calendar Year 2002, Number 2.

3. Refer to Calendar Year 2002, Number 3.

4. Of a total of 125 Edinburgh depression screens with a score available, 34 (27%) program participants required a referral for further evaluation and treatment. Of the total of 61 postpartum screen scores available, 11 (18%) program participants required a referral for further assessment and treatment.

5. Case managers track the status and outcome of referrals to mental health providers through a client referral and appointment database. In 2003, of the prenatal program participants that were screened for depression, 27% required a referral for further evaluation and treatment.
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6. The client’s family support plan was supported through health education and counseling. Family Road offered family counseling services by a licensed clinical social worker through a subcontract that started in March 2003. In 2003, there were a total of 134 counseling sessions conducted by the counselor.

7. The Healthy Start program received a technical assistance grant for perinatal depression that focused on enhancing infrastructure and depression screening among health care providers. Presentations were made to community members to increase awareness of the problem of perinatal depression and treatment. Best practice models of mental health care were discussed with health care providers to improve systems of care in the community.

**2004**

1. Refer to Calendar Year 2003, Number 1.

2. Refer to Calendar Year 2003, Number 2.

3. Refer to Calendar Year 2003, Number 3.

4. Of a total of 93 Edinburgh Depression screens with a score available, 30 (32%) of the program participants required a referral for further evaluation and treatment. Of the total of 69 postpartum screening scores available, 14 (20%) of the program participants required a referral for further assessment and treatment.

5. Of the Family Road Healthy Start prenatal program participants that were screened for depression using the Edinburgh Depression Screening Tool, 32% of women required a referral for further evaluation and treatment. For postpartum program participants, 20% required a referral for further evaluation and treatment.

6. Case managers continued to monitor program participants depression through utilization of the Edinburgh Depression scale; self report and provided resources specific to the program participants depression symptoms.

7. Family Road collaborated with Family Service of Greater Rouge and devised a self-help activity book to reduce/ameliorate depression.

8. Technical assistance was provided by Dr. Michael O’Hara and Dr. Lisa Segre on September 9, 2004 on the topic of perinatal depression. A total of 44 participants attended the event.

**Education**

**Strategy: Provide educational programs to the target population on perinatal health.**

**2003**

1. Through the collaboration with Community service providers health education topics to improve healthy birth outcomes were provided to program and community participants.

2. The outreach team distributed over 24,000 calendars in the community during 2003.
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3 & 4. Refer to “Education” Strategy: Provide educational programs to the target population; Year 2003, Number 5.

5. Health education to community participants was provided through health fairs, events, workshops, and conferences. The majority of educational offerings were provided by Healthy Start staff in collaboration with other organizations hosting educational activities throughout the community.

6. and 7. Evaluations were given to participants after educational programs to identify the areas that were in need of improvement. Client satisfaction surveys were used to identify areas of strength and needs for improvements for the Healthy Start program. The Family Road calendar was updated to reflect any changes.

**2004**

1. Family Road offered health education on risk reduction topics to program participants and community participants.

2. The Family Road calendar of classes and services was updated based on the evaluations and needs assessment. The outreach team distributed 34,165 calendars in the community during 2004.

3. In 2004, 28 workshops and fairs were held in the community with 1,321 community and program participants in attendance.

4. Refer to “Education” Strategy: Provide educational programs to the target population: Calendar Year 2002, Number 4.

5. Through community outreach and case management, health education on risk factors influencing infant mortality was provided in the project area to program and community participants.

6. Program participants completed an evaluation for Mommy Hour sessions comments included a rating on the health education content and an increase in knowledge.

7. Refer to Calendar Year 2003, Number 7.

**Education Strategy:** Provide educational programs and support services for the project area, including adolescents, focused on the impact of risky behaviors on physical, social and emotional health.

**2003**

1. The Baton Rouge community participated in Healthy Start technical assistance provided in the areas of smoking, substance abuse, depression, and family violence.

2. Various types of media included print, radio and television in the project area on risk reduction topics.
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3. Family Road provided health education information on risk reduction topics.

**2004**
1. Refer to Calendar Year 2003, Number 1.

2. Refer to Calendar Year 2003, Number 2.

3. Refer to Calendar Year 2003, Number 3.

4. Technical assistance was provided on the topic of Domestic Violence on June 14-15, 2004. Refer to “Health Education and Training Section.”

**Case Management**

**Strategy:** Provide educational programs and support services for HS participants focused on the impact of risky behaviors such as smoking and substance abuse on physical, social and emotional health.

**2003**
1. In addition to Family Road, affiliated agencies provided services included the YWCA Early Head Start program, Health Care Centers in Schools, Family Service Teen Advocate Program, Riz Up Louisiana (formerly known as Inner Reflections Too), Word-Up Foundation and the Mayor’s Youth Advisory Commission.

2. Various types of media included print, radio and television on risk reduction behaviors. Refer to “Health Education and Training” Section. Media advertisements, health fairs, events and workshops targeted community participants.

3. Family Road offered substance abuse treatment and mental health counseling services to fill the gaps in services identified in the community. Counseling services were offered at Family Road and were utilized by community and program participants.

4. For 2003, there were a total of 157 risk assessments completed for prenatal program participants, a total of 71 risk assessments completed for postpartum program participants and 2 annual risk assessments to program participants. The top 5 risks identified among prenatal program participants included STDs, dental problems, tobacco, hypertension, and depression. Among postpartum program participants, the top 3 risk factors included STDs, alcohol, and hypertension. There were no risks identified among program participants on the annual assessments.

**2004**
1. Refer to Calendar Year 2003, Number 1.

2. Refer to Calendar Year 2003, Number 2.

3. Focus groups were held in the community during the Family Day Extravaganza where a pre test and post test were given to measure an increase in knowledge of risky behavior reduction.
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Family Road offered substance abuse treatment and mental health counseling services to fill the gaps in services identified in the community.

4. There were a total of 49 high risk program participants reviewed by the multidisciplinary team in 2004. The percentage of high-risk program participants based on a total of 248 program participants is 17%. Major risk factors included medical high risk, no prenatal care, depression, history of alcohol, tobacco, and drug use, anemia, incompetent cervix, pre-eclampsia, previous low birth weight baby, diabetes, HIV positive, STDs, and hypertension. Of the prenatal program participants that were screened for depression, 27% required a referral for further evaluation and treatment. For postpartum program participants, 18% required a referral for further evaluation and treatment.

5. Healthy Start collaborated with Capital Area Human Services District of Baton Rouge on a 4P’s plus screening tool that was administered.

6. A member of the social work case management team represented the Healthy Start Program on the team that attended the planning meeting at the Leadership Institute at Children’s Research Triangle. A strategic plan was finalized for Baton Rouge to address the issues of perinatal substance abuse.

**Case Management**

**Strategy:** All HS participants will be provided interconceptional services by a licensed health care provider and monitored through the HS case management service.

**2003**

1. The majority of educational offerings were provided by Healthy Start staff in collaboration with other organizations, which hosted educational activities throughout the community. Topics that were covered in the health fairs, events, workshops and conferences included the importance of receiving interconceptional care.

2. In conjunction with Metro Health, the Office of Public Health and pregnancy clinics, media campaigns included the importance of interconceptional care.

3. Healthy Start contracted with A&J Transportation and used Yellow Cab as an alternative method for transportation. Healthy Start purchased bus tokens for program participants who chose to use the bus line. In 2003, there were a total of 1,198 taxi trips and 200 bus tokens provided to program participants in the Healthy Start Program. Policies and procedures were developed for transportation.

4. The prenatal clinic at Family Road in collaboration with the Office of Public Health, LSUMC/Earl K. Long Hospital and Family Road provided interconceptional care to program and community participants.

5. Through Community Outreach, the outreach team continued to provide information on the importance of interconceptional care. Program participants were given information and resources, referred to appropriate providers, and referred to appropriate classes at Family Road.
and to collaborating agencies. For 2003, there were a total of 109 referrals for postpartum/interconceptional clinical care. Of these, 101 women completed the referrals at a rate of 93%.

**2004**
1. Refer to Calendar Year 2003, Number 1.,

2. Refer to Calendar Year 2003, Number 2.

3. Refer to Calendar Year 2003, Number 3. In 2004, there were a total of 1,587 transportation trips and 200 bus tokens provided to program participants in the Healthy Start Program.

4. Refer to Calendar Year 2003, Number 4.

5. Refer to Calendar Year 2003, Number 4. For 2004, there were a total of 75 referrals for postpartum/interconceptional clinical care. Of these, 61 women completed the referrals or 81%.

**Case Management**

**Strategy: Improve completed referrals through education and increased access to services.**

**2003**
1. There were a total of 9,117 community participants in Healthy Start sponsored educational activities and health fairs. Another 40,000 participants were reached through Family Road sponsored education.

2. Various types of media included print, billboard to increase awareness of substance abuse during pregnancy. Mental health issues were addressed through Contract Counseling and collaboration.

3. Provided transportation to health education classes and medical appointments.

4. Family Road services were expanded to include substance abuse treatment/counseling and mental health counseling services.

5. The outreach and case management teams continued to provide health education information on interconceptional care through distributing literature in the community, home visitation sessions and community health fairs.

6. A total of 68 infant developmental screens were conducted. Of these, 61 (90%) fell within the normal range. A total of 7 infants were referred for further evaluation and received services.

**2004**
1. There were a total of 3,132 community participants in Healthy Start sponsored educational activities and health fairs. Another 1,321 participants were reached through Family Road sponsored education.
2. Refer to Calendar Year 2003, Number 2

3. Refer to Calendar Year 2003, Number 3.

4. Refer to Calendar Year 2003, Number 4.

5. Refer to Calendar Year 2003, Number 5. For 2004, there were a total of 75 referrals for postpartum/interconceptional clinical care. Of these, 61 women completed the referrals at a rate of 81%.

6. A total of 117 infant developmental screens were conducted. Of these, 111 (95%) fell within the normal range.

**Consumer Participation**

**Strategy: Provide an avenue for consumer involvement in the Healthy Start Program 2003**

1 & 2 & 3. Surveys were conducted in the community regarding ways to spread the word about the Healthy Start Program and the subcommittees formed to help aid in its functioning. Community participation was welcomed at all Healthy Start functions. Community participants were invited through fliers placed in the project area by the Outreach team to take part as a consortium member and attend the Project Area Committee. A total of 3 consumers attended the Project Area Committee and consortium meetings on a regular basis in 2003.

4. Transportation, childcare and other incentives such as refreshments and Family Road bucks were provided to consumers for attending these meetings.

5. At times, there were Board member meetings that involved consumers, which provided additional feedback about program successes.

**2004**

1 & 2 & 3. Refer to Calendar Year 2003, Numbers 1, 2 & 3.

4. Transportation, childcare and other incentives such as refreshments and Family Road bucks were provided to consumers for attending these meetings.

**Birth Outcomes**

**Strategy: Provide outreach, case management, and education services to program participants enrolled in the program to improve birth outcomes.**

**2003**

1. Please see objectives titled outreach, case management and education for described services and activities.

2. There were a total of 110 infants born to program participants enrolled in the program in 2003. Of the infants, 82% had a birth weight of greater than 2500 grams.
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2004
1. Comprehensive services of core efforts encompassing interconceptional care and depression screening played a major role in outcomes for program participants and their infants. Services provided an outlet for program participants to focus on healthy birth outcomes for the babies.

2. There were a total of 74 infants born to program participants enrolled in the program in 2004. Of the infants, 91% had a birth weight of greater than 2500 grams.

Education
Strategy: Provide educational programs for adolescents focused on prevention of unwanted pregnancy.

2002
1. Ongoing collaboration with Community agencies, included Health Care Center in Schools. Services to adolescents in the project area included pregnancy prevention, services to pregnant and parenting teens, adolescent health services and youth empowerment programs. In addition to Family Road, affiliated agencies provided services included the YWCA Early Head Start program, Health Care Centers in Schools, Family Service Teen Advocate Program, Riz Up Louisiana (formerly known as Inner Reflections Too), Word-Up Foundation and the Mayor’s Youth Advisory Commission. There were 4,222 participants in pregnancy prevention programs, 1,383 participants in services for pregnant teens, 1,089 participants in parenting teens programs, 4,413 participants in adolescent health services, and 1,209 participants in empowerment programs.

2. Outreach team provided information in the community to pregnant adolescents and connected them to the requested resources.

3. Teen pregnancy prevention information was provided to agencies in the target population to be distributed.

4. In addition to Family Road, affiliated agencies provided services included the YWCA Early Head Start program, Health Care Centers in Schools, Family Service Teen Advocate Program, Riz Up Louisiana (formerly known as Inner Reflections Too), Word-Up Foundation and the Mayor’s Youth Advisory Commission.

5. Youth leadership was completed through the collaboration with the Mayor’s Office Youth Advisory Commission and other community programs targeting teens.

6. Report completed through Health Care Centers in Schools which identified common adolescent risk behaviors. Efforts initiated to address identified needs.

Case Management
Strategy: Provide referrals to medical providers for all children born to women in the program.

2002
1. Project staff provided a list of medical providers to program participants, as requested.
2. The case managers ensured that each program participant was connected to a Community Care provider.

3. During home visits, case managers followed up on medical appointment; attended Pediatrician appointments; requested medical records; documented immunizations and well baby visits.

4. A list of medical providers was compiled and available for the outreach team. This list of medical providers was provided to community participants in the project area, if requested. The New Louisiana Program also provided this service.

5. Case Managers and outreach teams worked together to ensure that Medicaid eligible children born to women in the project area had a medical home.

B. Technical Assistance for Sites
Family Road Healthy Start provided technical assistance to several sites during the project period. The sites included Texas, N. Carolina and Lafayette, Louisiana. Each site identified, participated in a site visit with Family Road, to discuss the Healthy Start Program. Of particular interest, was the collaboration of services; program design and implementation; incentives; program participant profiles; staff development; database design and function; Geographic Information System; documentation tools; program challenges and lessons learned. Family Road Healthy Start, also participated in a site visit, with Great Expectations of New Orleans, Louisiana. The site visit included a brief overview of database design and function, program operation and incentives.

V. Project Impact
A. Systems of Care
The Family Road Healthy Start Program has had a great impact and has enhanced collaborative interaction among community organizations and services involved in promoting maternal and infant health and social services in the city of Baton Rouge. There were few entities besides those who worked in the medical and social service field that even knew Baton Rouge had one of the highest infant mortality rates in the country. The first efforts of the Family Road Advisory Council (Consortium) CityMatch Data Committee, brought together both of the major Universities in town (Southern and Louisiana State Universities) and the major Nursing University- Southeastern University as well as the Regional Mental Health and Substance Abuse Office- Capital Area Human Services District, AHEC, Office of Public Health, Title V MCH, WIC and 4 major hospitals- Woman’s Hospital, General Hospital, LSU Health Sciences Center/Earl K. Long and Our Lady of the Lake Regional Hospital. These entities were the first to actually study the problem by using Geo-mapping of birth/death certificates and overlays information which identified psychosocial problems.

1. Approaches Utilized to Enhance Collaboration-
Several approaches were used to enhance collaboration among community organizations and service providers. The FR Healthy Start program identified key figures and stakeholders in local and state government, health care, social services, education, community, faith based and business and met with these figures and their staff to discuss the issue of infant mortality and provided the statistics and geo-mapping regarding the identified areas of focus in the Baton Rouge community. Another approach, was communication through the Advisory Council,
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which represented all segments of service delivery in the community, thereby allowing the intent and focus of Health Start program to be spread to various social service areas in the community. The program developed brochures, fliers and handouts that were culturally sensitive on an elementary reading level, for program participants and service providers. The Healthy Start program also developed print and broadcast media messages including advertising, billboards in the community and buses, radio messages and announcements. The Healthy Start outreach team was able to reach people at the grass root level, by focusing on door-to-door outreach, developing relationships with business in the community. A major factor, which enhanced collaboration was using the approach of enhancement and control. There were small efforts in the community by individual organizations and people. Family Road Healthy Start program worked with existing efforts and focused on enhancing what people were doing. If the project that the group was working on was not related to maternal and infant health then it was framed around the topic that service providers and community was focused on, for example if the issue was substance abuse, Family Road Healthy Start would fit in by providing information and insight into pregnant and parenting women who are substance abusers.

2. Structure Change for the Purpose of System Integration
Several procedures and policies were changed for the purposes of system integration. Changes covered several areas including HIPPA guidelines, FIMR and referral methods. HIPPA guidelines affected how people were identified for resources in a public setting. Instead of being called by full names, individuals were called by last name and/or by number. In addition, privacy and HIPPA notices were distributed to all program participants regarding the service they received at Family Road and through Family Road Healthy Start. HIPPA had tremendous impact on FIMR. In the past the hospital would call the FIMR analyst to provide information on deaths. The implementation of HIPPA, Family Road Healthy Start had to receive clearance from the Perinatal Commission deeming the program a public health initiative, so that hospitals could release information and be in compliance. Referral methods were changed so that referrals could be tracked. Outside entities added Family Road Healthy Start to their registrations and needs forms so that their staff could discuss Healthy Start program and provide options for program participants in need of perinatal services.

3. Key Relationships
   a. Healthy Social Services and Community
Health Service Agencies- Among health agencies Family Road Healthy Start developed a presence in the community as a program providing expertise, education and services to the Baton Rouge community. The Geo-mapping, research on the project area, the core services being provided and technical assistance visits enabled staff to enhance the relationships with all four major hospitals in Baton Rouge including Woman’s Hospital, LSU Health Sciences Center/Earl K. Long Hospital (Charity), General Health Systems and Our Lady of the Lake. There was also an established relationship with the Greater Baton Rouge Health Forum, which was composed of the CEO’s of all the hospitals in the Greater Baton Rouge region. Relationships were also enhanced with East Baton Rouge Health Unit and its individual clinics including WIC, Family Planning, STD clinic, Well-Baby Clinic and Special Needs Services. Relationships were also forged with LSU Health Science Center/Earl K Long and its specialty clinics including Early Intervention Clinic (NICU babies, HIV/AIDS and clinic Women’s Clinic). Other relationships included Community Health Centers such as Capital City Health Center, Health Care Centers in
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Schools and health centers at both major Universities-Southern and LSU. University programs in nursing from Our Lady of the Lake, Southern and Southeastern were also developed. The entities listed above served on the Advisory Council, Project Area Committee, and FIMR Committees and on technical assistance committee, which were formed to coordinate visits from experts in the field of perinatal health. In addition, Family Road Health Start also had developed relationships with the local OB/GYN and Family Practice Associations, Louisiana American Academy of Pediatrics, Perinatal Commission, Child Death Review Panel and the Maternal and Child Health Coalition.

**Between Health and Social Services**  
Between health and social services Healthy Start was able to bring together the entities mentioned above and the 104 social service organizations in which Family Road coordinated. Strong Relationships developed among the Office of Public Health and Capital Area Human Services District (Regional Mental Health and Substance Program), as well as Department of Social Services (Office of Family Support and the Office of Community Services). Family Road Health Start was able to develop relationships between Medicaid and the hospitals.

**Community based organizations:**  
Relationships were strengthened among the 104 existing and new service providers coordinated by Family Road of Greater Baton Rouge. Education and training provided through Healthy Start was welcomed and raised awareness and the skill level of community based organizations. Due to the holistic approach entities such as the education system and business, which had community based organizations became more active and supportive of perinatal health issues and understood the connections and importance of perinatal health.

**b. Relationships that Focus on Involvement of Consumers and Community Leaders**

**Consumers**  
These relationships were formed in various settings and using several methods. Family Road Healthy Start engaged consumers through focus groups, surveys and Mommy Hour (which provided a medium for consumers to receive health education information and provide input into the Healthy Start program). FR Healthy Start found that even though consumers were asked to participate in the Advisory Council many discussed discomfort because of the organizations and their level education at the meetings. We were gradually able to bring on consumers on to the Advisory Council by first having surveys and having focus groups. We also highlighted achievements among consumers with their participations in community presentations, workshops and press conferences. Then introduced them to Mommy Hour, which provided for the first time a forum for expecting and parenting women to voice their opinions and concerns surrounding perinatal health. Consumers were also approached in their own neighborhood settings in established social/civic groups, churches and faith-based organizations, Neighborhood Network Teams and school-based organizations.

**Community Leaders**  
These relationships were formed through outreach efforts in the community including attending and becoming involved in council district meetings, neighborhood association meetings, church and faith-based organization meetings. In addition, Family Road program held board positions and committee positions on all major health and social service topics in the community.
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Including the Children’s’ Coalition, Mayors Youth Advisory Commission, Governor’s Office of Women’s Services, ECSS, Human Services Consortium (Basic Needs Organization), Council on Human Relations, Baton Rouge Equity, Baton Rouge Housing Authority Stakeholders, Maternal and Child Health Needs Assessment Committee, Baton Rouge Coalition on HIV/AIDS, FASD (Fetal Alcohol Spectrum Disorder Committee, School Board, Literacy, Prevent Child Abuse Louisiana, Department of Social Services Stakeholders meeting, Baton Rouge Leadership (Chamber of Commerce), Mayor’s Commission for Social Services, Coalition on the Homeless, Juvenile Justice Commission, LSU and Southern Cooperative Extension Services, etc. This enabled the Healthy Start program to have access to community leaders who were active in various venues in the community.

4. Impact on Comprehensive Services
   a. Eligibility and/or intake requirements for health and social services
      Healthy Start project made an impact on health and social services by identifying the zip codes, which had the highest rates of infant mortality in the city. This enabled health and social services to concentrate their efforts in these areas and provide additional services to consumers who lived in these areas. Providers who served expecting and interconceptional women were able to incorporate Healthy Start eligibility requirements into their own forms making it easier to provide referrals for program participants who meet the requirements.

   b. Barriers to access and service utilization and community awareness of services
      Family Road of Greater Baton Rouge was created to address the barriers that the community faced in receiving social services. Thereby, childcare, transportation and hours of operation were addressed in order to reduce barriers to obtain services. Childcare was provided free of charge to program participants during the time they attend classes at Family Road. Family Road was located on three-bus line and also provided transportation for families in the Healthy Start program for medical and social service programs. Family Road was open 12-13 hours Monday-Thursday, 8 hours on Friday and on various weekends to provide services. An incentive program was also established at Family Road. Program participants would earn Family Road bucks (monopoly money) by having a home visit, attending class/one-on-one sessions and programs. These bucks could be used at our store (located inside Family Road) to buy items that they may have needed or wanted. Family Road also coordinated over 104 non-profit, private and government agencies to its location thereby providing the setting for maximum use of services. The Healthy Start program advanced those services by providing home visitation wherein mothers had the benefit of receiving a program which catered to their needs and their time constraints as well as providing them a location to receive comprehensive services. By having case managers, consumers were able to address problems with health care providers and other social services with the support and knowledge of professionals, thereby assisting them in creating a voice for the needs of their child(ren) and themselves. Case managers were also able to link consumers to services to assist them in addressing concerns and needs they had identified. Community awareness of the program was increased through Neighborhood Network Meetings, Project Area Community Meetings, Health Fairs, Job Fairs, Print and broadcast media and other public forums held in the community. Brochures and health education workshops were held in the communities increasing their awareness and knowledge of health problems in the community.
c. Care coordination
Several mechanisms were put into place to assure continuity of care, quality improvement and follow-up systems for client referrals. All case managers received an orientation-training program upon hire and were supervised to be sure that high quality care was provided. In-services were provided on perinatal health topics and several staff attended national Healthy Start meetings every year. Annual performance evaluations were conducted for all staff. Any needed performance improvements were identified and an improvement plan was initiated as appropriate.

Program participants were recruited into case management services through referral from outreach activities, providers or self-referral. Case management programs providing services to the target population included Family Service of Greater Baton Rouge (HIV/AIDS), Friends for Life (HIV/AIDS), and the Teen Advocate Program (closed in 2004). Referrals were made between case management service providers based on client eligibility and need. Verification of referral completion was through the use of a referral form that documented when a referral was received, the case manager assigned to the case, contacts of program participants to set up a home visit and final disposition of each referral received.

The case manager visited the client and family primarily through home visitation. Other sites for visits such as the doctor’s office, school, work, etc. were acceptable for some visits. The case manager visited program participants weekly during the first month of enrollment. Consent for the program, assessment for needs including a risk assessment, and the development of a plan of care was completed during the first month. Depression screening was conducted prenatal, postpartum and annually thereafter using the Edinburgh Depression Screening Tool. Women were referred for additional evaluation of depression based on the score of 9-13. If a client received a score of 14, then the client was at high risk for Depression and the case manager took steps to secure an immediate referral. Referrals to a nutritionist on staff were made as appropriate to address nutritional needs. Barriers to program participants receiving services included location of services in a convenient, customer-friendly environment, transportation, and childcare. The Family Road model of care eliminated many barriers by co-locating services and provision of childcare. Transportation services were well utilized by program participants, which improved participation in services. Counseling services were also initiated at Family Road to meet client needs. Barriers to care due to lack of insurance was addressed through the LAMOMs program of expanding eligibility for Medicaid. Dental services were included in 2003 for pregnant women. A central phone number was provided for program participants to call for dental providers in the community. In Louisiana, the LAMOMs program allowed women to qualify for Medicaid coverage up to 200% of poverty to assist with access to care for pregnant women. Upon enrollment, all program participants were assessed for needs including the need for a health care provider. Case managers provide information and support to secure a medical provider during pregnancy and interconception as needed. Medicaid provided transportation services for medical appointments. Case managers provided support of program participants by attending medical appointments with the client to decrease communication barriers between the provider and client. Physicians and program participants commented that this assistance was very helpful.

After the first month, visits were conducted bi-weekly until the infant delivers. During this time, the case manager worked with the family to meet goals established in the plan of care. Activities
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include prenatal and parenting education, referral to resources in the community, and ongoing support.

Visits are then conducted monthly until the child reaches 24 months. Activities include preparing the family for case closure. The strength of the case management program was the client-centered approach to care, which emphasizes psychosocial needs. The medical provider many times could not spend as much time on addressing issues related to basic needs such as housing, transportation, childcare, relationship issues, etc. In addition to supporting the medical plan of care the case manager assessed the psychosocial needs and developed the plan of care based on client priorities. The client then signed the plan and a copy was provided. Progress toward goals was monitored at every visit and plan of care was updated monthly.

All high-risk client cases were reviewed by a multidisciplinary team (MDT) including an OB/GYN physician, nurses, social workers, nutritionist, outreach staff, and service providers as needed. High-risk cases were determined by the risk assessment that included an assessment of medical, psychosocial and home/neighborhood risks. Recommendations were made by the team and implemented by the case manager. The MDT monitored progress through follow-up reviews. All high-risk cases received one additional visit by the case manager per month.

All client cases were reviewed during conferences between the case manager and supervisor to discuss progress toward goals on a weekly basis. Client record audits were conducted to determine areas for improvement. Internal audits were conducted by administrative staff and the external auditors regarding follow-up system for client referral in the Healthy Start program. Supervisors conducted internal audits of charts, database and all records on a monthly basis to ensure consistency in documentation and database management. Healthy Start staff meetings also provide a forum for staff to discuss needed improvements in the program. For example, after reviewing several cases, it was determined that there was very few counseling services available to women in the community. Therefore, counseling services to address family issues, substance abuse, and relationships were recommended to be considered for new services at Family Road and were implemented.

d. Efficiency of agency records systems and sharing of data across provider
Family Road Healthy Start Case Management and Evaluation Teams worked together to create forms in which documentation could be shared among service providers working with the client with their consent. This information was obtained during the initial visit wherein the case manager explained and provided documentation of the need to share information with physicians and other social service providers on their behalf, when necessary and identified for consent. The Healthy Start program with this consent was able to share records with the organization concerning educational offerings and classes provides. It was also able to work with the Better Beginnings program, WIC and Medicaid by obtaining consent with program participants from the beginning of the process, thereby cutting down on duplication and repetition.

5. Enhancing client participation in evaluation of service provision
a. Provider Responsibility in maintaining client participation
Provider responsibility in maintaining client participation in the system and provider sensitivity to cultural, linguistic and gender needs of the community was an on-going task of Healthy Start
program, which had a great impact on how service providers viewed and treated consumers and the problems that they faced. Maintaining client participation when faced with other daunting problems was an issue in which case managers and service providers had to develop an incentive program as well as meet the basic needs of program participants and developed a trusting relationship in order to sustain the program. Cultural, linguistic and gender needs were addressed with on-going in-services for staff and service providers. These concerns allowed Family Road Healthy Start to increase the awareness and provide opportunities for staff and service providers to enhance their knowledge and skills in working with different cultures, including race and poverty. In addition, service providers were provided educational workshops with national speakers such as Joe Jones and worked with Fatherhood Initiatives to assist providers in understanding the importance of the father’s role and how as providers it is our responsibility to include them in the process and to change the mentality around fathers being involved in the lives of consumers. Family Road also developed a strong relationship with Administration for Children and Families and their efforts in Healthy Marriages/Building Strong Families, which provided even more research concerning working families and families living in poverty that are headed by single mothers. Information from this arena dispelled the myth that these women and the men in whom they had relationships with were not interested in the lives of their children as a couple. In fact it showed that these couples had the desire and potential to be supportive of each other but due barriers such as poverty, education, job stability, not having examples of “good” parenting among other problems, decreased their possibilities of sustaining a relationship. However, when these issue were addressed, especially during pregnancy the outcomes of pregnancy as well as the likelihood of the couple staying together increased. This information provided yet another mechanism to reach providers in regards to their standards, policies and process of working with client

b. Consumer participation in developing assessments and interventions

Through surveys, focus groups and Mommy Hour consumers were able to assist in developing brochures, media messages through billboards and radio, simplify assessment tools and implement interventions such transportation, counseling, substance abuse treatment in order to enhance services provided by Family Road Healthy Start program. There was full implementation and utilization of the ideas, concerns and comments presented by the consumers. Surveys provided documentation of their ideas, problems and concerns on maternal and child health. Focus groups provided an outlet for them to speak to these issues and Mommy Hour provided the setting to discuss ideas and develop materials, which could reach present and potential consumers in the community.

B. Impact to the Community

1. Residents

Before Family Road Healthy Start the amount of information regarding resources/service availability and location and how to access these resources was disjointed. After the implementation of Healthy Start service providers and health entities have solidified their efforts in having a comprehensive understanding as well as documentation of how services operate. Residents have an increased knowledge of Family Road and the services provided due to the outreach in the community and the home visitation and case management provided to consumers. Family Road also prints a 6-month calendar, which provides an outline of all of services that are available at the Family Road site (description, dates/times, location). In addition, these free
calendars are available throughout the community in various settings. Family Road has a no wrong door policy and is connected to all state programs, so that residents are able to identify their needs and are either served at Family Road or are able to have a direct referral to services that are need. Case managers and out reach workers not only ensure that residents have this information but teach them how to be resourceful in working in different systems and understanding how to be advocate for their children and themselves.

2. Consumer participation in Establishing or Changing Standards and/or Policies
The Family Road Healthy Start program truly raised the awareness among service providers, local government and the community concerning infant morality and its impact on the community. Service providers have held focus groups in every arena around Baton Rouge and have sought out national speakers and models with the focus being on expecting and interconceptional mothers trying to understand and provide services, which meet the needs of the community. This includes areas such as substance abuse, mental health, domestic violence, HIV/AIDS and other STDS, child abuse/neglect, education and workforce development. Service providers who use to group expecting mothers and serve them with the general population in dealing with these issues developed new programs and services which specialized in serving women who were pregnant and parenting. New assessments tools were developed as well as procedures in screening women for the problems mentioned above. Local government placed infant mortality as a priority on their list as they participated in local forums and received information from focus groups on the concerns in the community, thereby establishing committees and initiatives to increase awareness and understanding among all citizens in the Baton Rouge area and the State as to how infant mortality is connected to the health of the community as a whole.

3. Community Experience in Working with Divergent Opinions, Resolving Conflicts and Team Building Activities
The community was able to work together on many of the programs and services being provided by Family Road Health Start and the Advisory Council. The community, as a whole, had to reestablish trust with social service organizations and health care organizations in the community. Many community members before the Healthy Start program had built a wall of suspension, frustration and mistrust due to programs coming in and out their communities and not leaving anything behind in which communities could build upon. Economic and educational statuses were large problems that the community faced. The Baton Rouge community had a history similar to many southern cities. Once thriving economically with a community represented evenly among African-Americans and Caucasians, the school system provided a source of stability for the community. Unfortunately, the undertone of poor race relations had Baton Rouge under the longest running federal mandate to desegregate schools in the country. This along with ‘white flight’ played a major role in relationships developed with the health and social service community. In the past representation of minorities in roles of power and influence were minimum and the connection between the community and systems were strained. Therefore, Family Road Health Start had to face these challenges and worked on developing team building activities centered around race relations, health care and youth among service providers and community members. Family Road Health Start went into communities as a partner in working on the issues that were facing the people. Divergent opinions were heard and information and data from community members as well as social services were presented.
allowing people to questions and come to their own understanding of programs and how they impact the community norms and behaviors. Conflicts were resolved in the same manner, which enabled community members to be empowered in making decisions and having voice concerning the health of their community.

4. Creation of Jobs within the Community
The Baton Rouge community like the rest of the country is struggling regarding the creation of jobs. The Health Start program was able create jobs for 20 staff people and provide contracts to consultants and contractors for services needed in the community. The program was also able to work with consumers in preparing them for job placement. Many had not finished their GEDs and had none to little work experience. Family Road Healthy Start program was able provide resume preparation, education and job training through other programs at Family Road. Family Road was also able to work with agencies in job placement for consumers and their families.

C. Impact on the State
Family Road Healthy Start program had a strong relationship with Title V program. Family Road Healthy Start coordinated the first meeting among Healthy Start programs in the state of Louisiana. Through that meeting and several others the programs were able to share information, ideas and concerns in working in the perinatal health. Title V established a statewide initiative of FIMR among Healthy Start programs and other health related entities in the community. In addition, efforts such as campaigns on SIDS and co-sleeping were also launched. Family Road was also able to share their experiences received and provided in-services for sites on program implementation, geo-mapping, evaluation and systems management. In addition, Family Road Healthy Start shared information regarding their experience with Special Needs, Medicaid, LAChip and Early Intervention Program. The Family Road Healthy Start Program Manager presented an overview of the program at a statewide meeting in November 2003 sponsored by the Louisiana Office of Public Health. The workshop provided an opportunity for regions in the state to share best practices and develop new strategies in an effort to improve maternal and child health in Louisiana. Representatives from each of the Louisiana regions participated in the discussion and planning sessions for MCH needs assessment. Healthy Start staff also participated in a statewide workshop focused on program evaluation techniques that can be applied to MCH programs in Louisiana. The Healthy Start FIMR Program Coordinator also presented at the statewide FIMR conference. Nurse case managers presented at the Statewide Nurse Family Partnership Conference in New Orleans. Technical assistance visits were planned in coordination with key stakeholders in these areas. Dr. Chasnoff, Dr. Segre, Dr. O’Hara, Rebecca Whiteman and Lisa Chamberlin continued to work with the community to improve prevention efforts and systems of care related to perinatal substance abuse, depression and domestic violence. Benefits and lessoned learned from the collaboration including understanding the rural versus urban settings and the barriers and techniques which could be used in working with those populations. In addition, information and insight were gained into case management, psychosocial stressors, database management, outreach that provided opportunities to review systems and improve or change aspects of the programs to meet the needs of the communities we served. Family Road of Greater Baton Rouge was the recipient of the Healthy Mothers, Healthy Babies Coalition 2004 Community Impact Award. This award recognized Family Road’s innovative community strategies to improve maternal and child health.
D. Local Government Role

Family Road Healthy Start was linked to the State and local Title V MCH block grant agencies through the needs assessment/health plan and the implementation of perinatal initiatives. The Louisiana Office of Public Health MCH program provided funding of the Healthy Start nurse home visitation program in the health plan. MCH funding for services including Medicaid presumptive eligibility, a prenatal clinic and nutritional consultation were co-located at Family Road to improve access to these services. The WIC program was also located at Family Road to improve nutritional resources available to pregnant women and infants. Promotion of breastfeeding was an important component of the WIC program. Referrals were made among the programs located at Family Road to create a seamless continuum of care for all services.

Family Road Healthy Start worked closed with the Mayor’s Office, councilmen and school board officials, assisting in working with citywide events for youth. These events included pregnancy prevention among all teens, male and female mentoring programs, youth leadership and development and peer advisors in school. Family Road Healthy Start was also Senior Commissioner for the Mayor’s Youth Advisor Commission.

Family Road Healthy Start staff worked very closely with the Louisiana Office of Public Injury Prevention Coordinator, in campaigns to prevent Sudden Infant Death Syndrome, especially deaths possibly linked to co-sleeping of family members. Healthy Start program participants were eligible for a crib dissemination and car seats campaign after completion of several classes focused on parenting, safety and SIDS prevention.

Family Road coordinated services of 104 providers who implemented clinical and educational programs for women and families in the Greater Baton Rouge area. These collaborative efforts included four local hospitals, non-profit agencies, public and private agencies that provide prenatal and parenting classes, safety classes, job training and placement, outreach and case management, counseling, substance abuse assessment and treatment and prenatal care. The fatherhood program called, Dedicated Dads, was funded through DSS and private foundations. Healthy Start program participants and their family members benefited. Program participants viewed Family Road as a preferred location to obtain services due to the convenient location, customer friendly environment, and the comprehensive array of services available. This was demonstrated by several agencies, which surveyed program participants on location of services.

The public agency providing mental health and substance abuse services in Baton Rouge, Capital Area Human Services District (CAHSD), was the lead agency for substance abuse prevention efforts. East Baton Rouge was chosen by the SAMHSA Center for Substance Abuse Prevention as a site to develop a public education program to prevent fetal alcohol syndrome and alcohol related birth defects. The collaboration among agencies including Family Road, “Partnership to Prevent Fetal Alcohol Spectrum Disorders” was instrumental in beginning prevention efforts through community education. Billboards and brochures were developed for distribution in the community. A group of professionals including staff from the Office of Public Health, CAHSD, and Healthy Start were trained in FASD to make presentations in the community. CAHSD collected data based on screening of pregnant women in a public maternity clinic that showed approximately 40% of pregnant women screened positive for substance abuse. The Healthy Start
project collaborated with CAHSD to host a technical assistance visit with Dr. Ira Chasnoff in July 2003 made possible by a Healthy Start grant. CAHSD has also implemented a substance abuse screening and treatment program for pregnant and parenting women, the only one of its kind in the region and state. In addition, Dr. Chasnoff and the Children’s Triangle worked with CAHSD and other members of the collaboration, including Family Road Health Start, to implement the 4P’s plus screening tool (screens for domestic violence, substance abuse and depression) in private/public physicians offices to expecting mothers in the Baton Rouge area, in order to provide early intervention to women in need of services.

The Early Childhood Supports and Services (ECSS) program was funded primarily through TANF and coordinated by the Office of Mental Health to enhance the network of providers to support needed mental health services for children birth to age 6 and family members. East Baton Rouge was one of six parishes in Louisiana where ECSS was being implemented. Healthy Start staff attended staffing meetings that were held at Family Road including a team of psychologists, psychiatrists, infant mental health specialists, and agency representatives to provide input into development of family care plans. Several Healthy Start program participants benefited from this service.

Family Road Healthy Start collaborated with the LSU Agricultural Center, the American Dietetic Association, Blue Cross/Blue Shield and the Office of Public Health Nutrition Program to initiate activities related to childhood obesity. A regional conference was held in New Orleans, Louisiana in 2003 to share best practices in research and strategies devoted to prevention of obesity in children. Dr. William Dietz, from the CDC, provided a lecture on “Strategies to Prevent and Treat Childhood Obesity” sponsored by the LSU Ag Center Cooperative Extension Service. Blue Cross/Blue Shield has chosen childhood obesity as the 2004 health education focus and is interested in continued collaboration on projects. The Healthy Start program co-sponsored a Nutrition Month physical fitness activity.

E. Lessons Learned
Several lessons learned that were not addressed above included understanding the culture of the community (behavior and involvement), the degree of mental health and substance abuse and attrition.

Community Involvement and Behavioral Changes
During the process of developing the program geo-mapping information and statistics were gathered concerning the community, which were indeed helpful to pinpoint the problems that were facing the community. The enormity of the problem and how the values and the morals of the community had changed over the past ten years was eye opening at the street level. Without that information we would not have been as prepared to deal with the program participants and the issues that they presented. Still those issues were challenging. The community was faced with a lack of jobs, lack of education/training, lack of fathers and a decline in values. Program participants and the communities they lived in did not have strong support at the street level concerning safe sex, pregnancy out of wedlock, multiple partners and pregnancies from different men. There were several occurrences where there were women in the program who were pregnant by the same man. The image of fathers being “sperm donors,” and “players, pimps, etc.” and women being “sex objects” had a great influence on how women and men saw each
other, themselves and their children. First time mothers were easier to work with because it was their first pregnancy and they were interested in learning. However, second time mothers who had smoked or used substances during pregnancy and had a “normal” baby were very hard to convince that they should not practice those habits with their present pregnancy. Constant conversation/reminders, medical intervention, videos, educational materials had to be provided in order to evoke change among these women. We found that unless you had community members and family members who lived in the community and interacted with the program participants on the daily basis speaking the same language of the program it was challenging to change the mind set and behavior of the program participants. Community based and faith-based organization along with Family Road provided the educational resources and information, but case managers and peers had a greater influence on changes.

Community involvement was also an area in which the Family Road Healthy Start program learned that community leaders had to be sold the program, buy into the initiative and have ownership in order to see participation. Even with the information provided concerning the community it was a challenge to get people involve in yet another project or priority for the community. Many had several other priorities lined up for their platforms and this was yet another. We found that we had to be involved at every level concerning streets, garbage pick up, crime, etc. before we could introduce infant mortality. We had the support of high-ranking officials and key stakeholders, but getting the grassroots level took persistence, constant contact, scheduled events/planning and good communication.

Mental Health, Substance Abuse and STD’s
There is a widespread long-standing notion that pregnancy is a time of happiness. For many of our program participants, pregnancy created additional emotional and financial stress; abandonment by their current partner; ridicule or rejection from family members; or escalated relational conflicts. Program participants, struggled with co-occurring disorders such as, schizophrenia, bi-polar disorder, borderline personality traits, depression and substance abuse. Due to the social stigma, many women decided to discontinue their medication and/or medication management with a physician; refused to seek treatment; failed to recognize their behavioral and emotional symptoms as atypical; or did not understand the mental illness etiology and discontinued their medications prematurely.

The co-occurring disorders posed risks to the mother and fetus. Mothers who exhibited symptoms of the aforementioned psychiatric illnesses, had poorer prenatal care (fewer visits and sought prenatal care later in the pregnancy); inadequate nutrition; impulsive behaviors; substance abuse; histories of postpartum depression; increased incidences of postpartum depression; mood instability; and frequent sporadic periods of disengagement from the program. Family Road Healthy Start provided increased emotional and social support by increasing the intensity of home visitation sessions and care calls; provided education to mothers’ on their specific mental illness to increase their awareness and serve as a catalyst of change, for their specific behaviors; increased the community’s awareness of mental health and substance issues and it’s impact on the fetus (short and long term). The goal of the community health education was to increase the community’s support, knowledge, awareness and hopefully, acceptance of mental illness. Family Road Healthy Start provided a stable support system; discussed and encouraged treatment options and provided child care assistance during the prenatal, postpartum and
interconceptional periods. The program participants were also concerned about taking medications during pregnancy. The goal for case management was to minimize risks for the mothers and fetuses/infants through reduction and management of symptoms. The goal during the interconceptional period, was to increase mothers emotionally stability and coping skills, prior to the next conception, to improve the mother’s ability to handle stresses of both pregnancy and motherhood.

Routine obstetric care often does not identify women with co-occurring disorders. Most of the program participants did not have access to a perinatal psychiatrist. Implementation of the 4 P’s Plus Screening Tool among medical providers and WIC services, assisted with early detection and intervention of early risk factors for many of the program participants.

**Attrition**
As program participants developed their goals and delivered their babies, we had many program participants who were following through on their plans and goals that they had set forth for their family. The program started to suffer from some attrition due to the fact they the program participants were too busy for home visitation. Therefore, the standard method of having home visitation and attending doctor’s appointments had to be turned into meeting at school or job on the lunch break or meeting the program participants on the weekend or later in the evening. We had to be creative and flexible to keep program participants who were meeting their goals involved in the program. Therefore for the in the new grant we modified our visit schedule based on the assess need of program participants and the amount of support they need to be successful in their lives.

**VI. Local Evaluation**
Below is an explanation of the local evaluation reports. The evaluation attachments are located in Appendix B.
Family Road Healthy Start
Project Number H49MC00107

TITLE OF REPORT: The identification of Infant Mortality, Low Birth Weight, Very Low Birth Weight, Short Gestation, Very Short Gestation Births and Poor Prenatal Care Hotspots in East Baton Rouge Parish
AUTHOR: Andrew Curtis

Section 1: Introduction
Local Evaluation Component
The Baton Rouge Healthy Start local evaluation team involving the World Health Organization’s Collaborating Center For Remote Sensing and GIS for Public Health, and the Department of Geography and Anthropology at Louisiana State University analyzed birth and infant death certificate data for the period 1996 to 2001, with additional analyses of 1990 to 1996 as part of a graduate student theses. These analyses help determine the risk surface in the Healthy Start Program Area.

Key Questions / Hypotheses
Are some neighborhoods more vulnerable to high proportions of infant deaths, low birth weight, short gestation deliveries, and women receiving poor prenatal care?

Section II: Process
Methodology / data sources, instruments used
This analysis comprised the geocoding of electronic records, meaning each address was matched to a street file in a Geographic Information System (GIS). Once inside the GIS, different forms of spatial analysis were performed to identify neighborhood patterns and hotspots. A spatial filter analysis was applied to the addresses. This technique, developed to identify hotspots of infant mortality, has been widely used in the analysis of infant risks. For every year (1996 to 2001), a filter grid is overlaid onto the study area (East Baton Rouge Parish) and a filter (in effect a circle) is fixed on each grid intersection. Filter sizes are set by the user, with large filters producing smoother more generalized surfaces. For each filter, a rate (the numerator being deaths, the denominator being births) is calculated. As these filters overlap, the resulting rate surface, which is generated by interpolating the rates assigned to all filter centers, creates a smooth surface with no abrupt drop-offs as would be experienced by mapping political units. A test of statistical significance is then generated by applying a known probability of each birth location becoming a death event (or a low birth weight or short gestation delivery). In this way a simulated infant death surface is created. By repeating this simulation 1000 times, an infant death distribution is generated, against which the real death surface can be compared. For example, if the actual infant mortality rate is higher within a filter than occurs in 950 of the simulated runs, it can be said that there is a 95% confidence of identifying the area as a hotspot. These confidence percentages can also be interpolated to create contours of statistical significance.

These birth outcome risks, along with others extracted from the birth certificate were also analyzed using a difference of proportions t-test. The purpose of using this test is to determine whether mothers in one neighborhood have higher prenatal risk occurrences than all repeat mothers. The difference of proportions test is defined as:

\[ Z = \frac{p - \bar{p}}{\sigma_p} \]

where \( Z = \frac{p - \bar{p}}{\sqrt{P(1-P) / n}} \)

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\[ Z = \text{sample statistic} \]
\[ P = \text{sample proportion (for example proportion of low birth weight births in the neighborhood)} \]
\[ p = \text{population proportion for the year under investigation (for example proportion of low birth weight births in East Baton Rouge Parish)} \]
\[ \sigma_p = \text{standard error of the proportion} \]

The following variables will be included in the analysis:
1. Proportion of mothers having no prenatal care
2. Proportion of mothers making seven or less prenatal visits (less 7 visits)
3. Proportion of mothers making a first prenatal visit in the fifth month or later (After 4th)
4. Proportion of mothers giving birth in the 32nd week of gestation or less (classified as a very premature birth) (less 32)
5. Proportion of mothers giving birth in the 36th week of gestation or less (classified as being a premature birth) (less 36)
6. Proportion of babies weighing less than 1500 grams (classified as a very low birth weight baby) (less 1500)
7. Proportion of babies weighing less than 2500 grams (classified as being low birth weight) (less 2500) See Wilcox 2001

A further analysis involved the extraction of all birth certificate information for a 0.25 mile radius around a woman entering the healthy start program so that the local neighborhood risk surface could be identified.

Section III: Findings / Discussion

Results

The spatial filter analysis, when performed over different time periods, identified certain sections of the healthy Start service region that had elevated levels of infant mortality. For example in the figure below, different colored contour lines identify those areas with infant mortality rates exceeding 40/1000. See Evaluation/Attachment A: Spatial Filter Analysis I. Similarly the next figure shows a neighborhood with a high proportion of low birth weight deliveries See Evaluation/Attachment B: Spatial Filter Analysis II. The difference of proportions test can also be used to identify multiple risks in a neighborhood. For example, see Evaluation/Attachment C: Infant Mortality Table I shows a table of output where in one neighborhood the infant mortality rate never dropped below 43 / 1000. This analysis approach can also be applied to health care providers, such as the school based health care centers shown in Evaluation/Attachment D: Health Care Centers. In this way we identify what are the primary risks in the population being served. Returning to the difference of proportions results table, a further analysis of all birth outcomes was performed See Evaluation/Attachment E: Difference of Proportions Table. See Evaluation/Attachment F: Analysis of Birth and Death Certificate - it shows a typical analysis of birth and death certificate data in an area surrounding a Healthy Start program participant.
Discussion / Limitations of findings
There of course data quality issues associated with Birth certificate data. Many fields are simply estimated or self reported (especially those detailing known risks such as alcohol use). Data input errors are also possible within the certificate. It is therefore important to view any results attained with caution.

It is all very well to perform these analyses in a GIS environment, but the results need to be transferable to outreach workers. This was achieved by having mini-presentations and creating a simple information system in PowerPoint allowing anyone to navigate through different slides showing neighborhoods and the information inside. The next few slides show examples of this information system for “women receiving no prenatal care”. See Evaluation/Attachment G: GIS Analysis and Information Systems.

Section IV: Recommendation
Policy, program, and other recommendations
The results of the analyses have help direct outreach efforts into specific neighborhoods, and to prioritize outreach efforts in those neighborhoods.

Section V: Impact
Changes in perinatal system, community, etc
This approach was used to understand the risks faced by program participants in their neighborhoods, and as such helped direct outreach workers and their messages.

There have been four major outputs of this GIS approach of Birth and Death Certificate Data. Firstly, the results have been used to apply for other research funding. Although two grants were unsuccessful (one was accepted but was not funded to a shortfall in the budget), there has been one successful grant for approximately $100,000:

Receiving Grants for Further Research:
A successful grant was obtained from the Louisiana Board of Regents to fund a Ph.D. student at Louisiana State University to investigate The funding provided by this assistantship will support a Ph.D. student to continue the work in Baton Rouge, and extend the GIS analyses to three other Louisiana cities; Lafayette, New Orleans and Shreveport, which also have active Healthy Start programs. These programs do not have GIS capability, and the ability to be able to target risk neighborhoods with this technology will prove an invaluable contribution. It is estimated each low birth weight delivery (2500 grams or lower) costs the taxpayer $30,000. Most low birth weight births (which are one of the leading causes of infant mortality) are to minority and low-income households. The $30,000 cost includes expensive medical interventions at time of birth, and subsequent medical, educational and criminal costs associated with developmental problems. The doctoral student could easily reduce total costs to Louisiana in the hundreds of thousands of dollars by effectively targeting resources. The effectiveness of this approach can be measured by reducing trends in targeted neighborhoods.

The specific goals are:
To identify infant mortality and low birth weight hotspot surfaces for the period 1999 to 2003 (and continuing on as data becomes available) for Baton Rouge, Lafayette, New Orleans and Shreveport.

2. To compare these surfaces to identify temporally stable hotspots, and rank the neighborhoods falling into these hotspots based on priority (an already developed measure combining rate level, and years of achieving that level).

3. To present these results to the local Healthy Start programs, which by definition will be centered on the highest problem zip codes of each city.

4. To liaise with the current governors initiative of developing statewide GIS connections designed at improving services and reducing costs for all departments and agencies.

In addition, two grants are currently pending for an analysis of nutritious food availability through the food stamp network in the program area. These grants were prepared in consultation / collaboration with the Department of Social Services.

This leads to the second major output. Members of the evaluation team have worked with several other state agencies (Department of Education, DSS, Baton Rouge Mayors office), federal agencies (NIH discussing a new direction for drug abuse), local charities and health care providers (Woman’s Hospital, Mary Bird Cancer Center, YWCA all working on breast cancer proposals) all of which are not directly related to the Healthy Start program, but work on issues that will benefit program participants. These contacts have been made because of the widening knowledge of what is being achieved under the evaluation components of Health Start in Baton Rouge.

The third major output is a contact with other Healthy Start programs in the state with results and approaches being shared through presentations. GIS approaches have been shown at state level presentations, to groups from Monroe, New Orleans and Lafayette visiting separately, at the National Healthy Start association meeting as well as other professional meetings.


In addition, the evaluation work was presented at different community and University presentations:


“Utilizing GIS to Eliminate Disparities in African American Infant Mortality in Baton Rouge Louisiana”, Department of Geography, University Of North Carolina, Chapel Hill, February 2005

Finally, the work was presented at a Congressional Breakfast:


Section VI: Publications
Several publications have also focused on the results of the Baton Rouge Healthy Start evaluation. These include:


A Masters thesis has also been written on the analysis of data relevant to the Baton Rouge Healthy Start
Finally, and most importantly, a book has been written (currently at press) that describes how GIS can be used in the evaluation of a Healthy Start. This book is intended to help other organizations across the country.


At Press

The purpose of this book is as follows:

This book is designed to introduce a community health group to the potential of using a Geographic Information System to improve birth outcomes. The book is aimed at novice to intermediate level GIS users, though even advanced researchers will gain from the detailed health examples. Chapters in this book provide an overview of why geography is important in the investigation of health, the importance of the four main components of a GIS (data input, manipulation, analysis and visualization), how important neighborhood context is when using a GIS, and the general differences found between urban and rural health environments. In addition, the reader is introduced to the importance of GIS and confidentially, how a mobile urban population may impact GIS findings, and why pregnant mothers should be catered for when making disaster response plans. Examples are drawn heavily from the Baton Rouge Healthy Start program, with one chapter providing an overview guide as to how GIS can be incorporated in the initial grant writing stage for such a program.

The GIS involvement in the Baton Rouge Healthy Start is also presented on the World Health Organization’s Collaborating Center for Remote Sensing and GIS for Public Health website, at www.whocc.lsu.edu
Section 1: Introduction
Local Evaluation Component
Farrell Jones, Associate Director of the CADGIS lab at Louisiana State University built the Baton Rouge Healthy Start database. The purpose of this database was to create a system that allowed Healthy Start to keep control of its data, and at the same time perform whatever GIS analysis was needed. Although other database systems are available (often at considerable cost), these are often inflexible in terms of what can be requested. These external database options provide excellent alternatives for the generation of end-of-year evaluation reports, but if the program wants to investigate a particular issue, the lack of flexibility can be frustrating.

The initial “brainstorming” meetings was to construct a system that captured all data required to write reports on the objectives we had listed in the initial proposal, along with any additional MCH required data. Other data was collected to satisfy program or research needs, for example a mechanism was included to track address changes through the duration of the participants attachment to the program.

From a GIS perspective, spatial analyses can be performed on any of the attributes collected about the program participants. Data could include neighborhood stressors, quality of housing, number of family members residing in the same unit, psychosocial stresses, domestic abuse, problems with diet etc. All of these variables could be analyzed spatially for the program area. If program participants were considered to be samples of the neighborhoods in which they reside, then outreach intervention can be planned if particular risks were identified.

This database allows high quality and relevant data, with checks, to be collected for the program.

See Evaluation/Attachment H: Data Sheet I
From a GIS perspective, these databases can easily be imported by geocoding the initial address on the client contact form. All other data sheets can be joined using the unique program participant identifier. In this way maps can be made based on queries for any single record, or combinations of multiple records. Examples can be found in the results section.

See Evaluation/Attachment H: Data Sheet II.

Key Questions / Hypotheses
The creation of the Healthy Start Database capturing many different data fields has allowed us to ask several pertinent questions, such as: In which neighborhoods are women facing a high load of stressors?, What are those stressors? What are the neighborhood / community risks?, How frequently do women move?

Section II: Process
Data Input
Data input for the Baton Rouge Healthy Start was originally supposed to be via laptop and secure wireless uploads. The current system is still laptop based, but requires monthly data dumps. As with all technology, things change rapidly. It was soon found that laptops were too intrusive and sometimes created distrust between program participant and caseworker. PDAs provide a possible alternative, but their limited viewing screen may prove too problematic. A possible alternative is moving to a computer tablet, though this could also be viewed as being too intrusive.

It is hoped that eventually all data will be uploaded to a secure server via a wireless connection. This is obviously the way data collection is moving for all agencies. Just as with the initial database construction, the development and maintenance costs of these web portals will not be cheap. This cost impediment has so far hindered its development in Baton Rouge.

Section III: Findings / Discussion
Results
There have been several investigations of program participant’s patterns, and neighborhood level effects, made possible by this database. A few examples include: How different neighborhood stressors impact low birth weight, See Evaluation/Attachment J: Stressors Impact Low Birth Weight. How stress can be caused by local crime and the perception of crime, See Evaluation/Attachment K: Safety Fears. In relation to the neighborhood mentioned in Report One with high risks as identified through birth and death certificate analysis, how did Healthy Start program participants fare inside? See Evaluation/Attachment L: Stress During Pregnancy. How do multiple risks combine within the neighborhoods in the program area? See Evaluation/Attachment M: Neighborhood Complexity.

Discussion
This flexibility in data manipulation has also been important as MCH reporting requirements change. Anecdotal evidence suggests that other Healthy Start programs sometimes face data crises when asked to report on a new variable from a previous year of their program. To extract these data from paper records is time-consuming and usually full of errors. A well-constructed database provides an excellent alternative.

Limitations of findings
Developing the database was a slow process, and to this day still requires constant tweaking. A recent MCH push has been to address interconceptional care – this will again require a modification of our existing database. Even something simple like the changing of “client” to “program participant” requires data base maintenance.

Of course there were also problems, two of the trickiest being program participants that enter the program, leave the program, and join again later. Also clients can become prenatal, then postpartum, then interconception, and again become prenatal. There were also problems with caseworkers incorrectly filling in information. We still have to go back through cumulative reports and check why some program participants have information missing, or why two dates
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don’t make sense, and though each round sees more validation and quality control checks entered into the system, it is likely this system (as with any computer system) will never be perfect.

What should be remembered is that the construction of the database is a time-consuming process, and expensive unless a computer programmer is found who also believes in the mission of the program. The construction of the database is not the end of the story though. As has been mentioned, new data entries will need to be programmed, reports will need to be generated, and mistakes/crashes will have to be salvaged.

Section IV: Recommendation
Policy, program, and other recommendations
As was previously mentioned, apart from allowing the evaluation team to investigate important issues associated with the program, the database allows for the Baton Rouge Healthy Start to control the quality of its data collection. The interface itself was designed with caseworkers in mind, the data forms being easy to follow and complete. Date stamps were automated, meaning when a first contact was made, the initial date was recorded. Each program participant had a unique identifier, as does every baby born. Many data pages comprised of “click” boxes, some of which opened a further data collection window. As many validation checks were placed in the system as possible, for example if the date meant a child was born before the initial contact, or that the mother was over 100 years old, the entry was flagged. Other automation included flagging datasheets when entries were missed, posting reminders when the program participant was expected to make a visit, and prompting the caseworker to make a referral when a threshold was reached.

Section V: Impact
Changes in perinatal system, community, etc
The success of using GIS in the Baton Rouge Healthy Start has not been lost on other community health groups. Other Healthy Starts around the country have requested additional information about how to implement a GIS, usually after seeing a presentation at an MCH meeting. The same interest has been generated at the local level, with other health groups, such as the YWCA, asking for help in identifying patterns of alcohol use during pregnancy, breast cancer screening deficiency, and identifying teenage pregnancy risks around Early Head Start Centers. Most groups, once they have seen what a GIS can do, realize the potential of the technology.

Section VI: Publications
Many of the presentations listed for Report One also contain output from the database. The book also contains a section on how the database was constructed.
Section 1: Introduction
Local Evaluation Component
Birth certificate data were analyzed in a similar fashion to that presented for Report One. In addition Healthy Start Participant data were extracted from the Database. Finally, an additional survey tool was analyzed in collaboration with an Alcohol based investigation through an area health unit using the 4P’s plus screening tool. The questions asked on the screening tool include:

4P’s Plus:
1: Does your partner have a problem with drugs or alcohol?
2: Do you consider one of your parents to be an addict or alcoholic?
3: What is your prior smoking history?
4: How much alcohol, drugs or tobacco have you used in your past?
5: How much alcohol, drugs or tobacco have you used during this pregnancy?

Key Questions / Hypotheses
Are some neighborhoods more prone to alcohol, tobacco and illegal substance use during pregnancy?

Section II: Process
Methodology / data sources, instruments used
The GIS approaches explained in Report One were used to identify hotspots for each of the three factors.

Section III: Findings / Discussion
Results
Some neighborhoods were identified as having increased proportions of these risks. In addition to the type of contour surface generated in the results section of Report One (for women who use alcohol or smoke during pregnancy), the following analyses outputs were generated to create neighborhood profiles. From the Healthy Start database See Evaluation/Attachment N: Smokers. From the 4P’s plus screening tool See Evaluation/Attachment O: Parents with Drugs/Alcohol

Discussion
Limitations of findings
Self-reporting smoking (or any substance use) on birth forms, or through more sophisticated tools such as the 4P’s Plus which is asked at the first prenatal visit can be linked to a residence to produce a GIS analysis. However a problem with using self reported data on the birth certificate is the stigma associated with admitting using any drug during the pregnancy. The 4 P’s Plus hopes to reduce this bias by asking multiple interlinking questions. The Healthy Start Database should create far more accurate datasets because of the relationship an trust developed over time between program participant and caseworker.
Section IV: Recommendation
Policy, program, and other recommendations
Education approaches designed to warn about the risk of alcohol, tobacco and drug use should obviously be universal, yet the results of these analyses can help direct outreach education initiatives into those neighborhoods most at risk.

Section V: Impact
Changes in perinatal system, community, etc
By working with other health groups. Such as those administering the 4P’s Plus program, which involve screening at multiple point-of-contacts, early understanding as to a likely at-risk pregnancy can be identified.

Section VI: Publications
Many of the presentations listed for Report One also neighborhood results involving alcohol, tobacco and drug use. The book also contains a section on these risks.
Section 1: Introduction
Local Evaluation Component
During any disaster / terrorist event, whether real or perceived, it is important for “at-risk” populations to be identified and accommodated. The obvious way of achieving this is by using a GIS to identify specific at-risk cohorts. Arguably the most at-risk cohort is pregnant women, and specifically pregnant women in traditionally high birth-risk areas. These hot-spot areas (as identified in Report One) often have other compounding problems (such as lack of transport). It is therefore important to identify these areas of high birth risk so that accommodations can be made during the hazard event, ranging from providing adequate transportation, to providing informed education as to the dangers being faced, to simply providing suitable medical help depending on the individual pregnancy. It is therefore important, when considering hazard preparedness, to have already identified those sections of a city that traditionally suffer from poor birth outcomes.

Generally, the more stress added during a pregnancy the greater the likelihood of a poor birth outcome. Not understanding the situation, not having transport, being told what to do by culturally (and racially) insensitive responders can all lead to stress.

Vital records are available for any city in the United States, however, to maximize the protection of this at-risk cohort, an active surveillance system is needed. An objective of the Healthy People 2010 initiative is to “Increase the proportion of all major national, State, and local health data systems that use geocoding to promote nationwide use of Geographic Information Systems (GIS) at all levels.” This increase is targeted to include 90% of all health units, which means that such active surveillance will be available at some point in the future. Baton Rouge Healthy Start database could be used to make contacts with program participants during such an event.

Key Questions / Hypotheses
Neighborhoods vulnerable to traditional birth risks are also those most vulnerable to any disaster. This vulnerability not only occurs during the event, but also in the post-event situation.

Section II: Process
Methodology / data sources, instruments used
The techniques and approaches used in Report One, in combination with specific risks such as “women as head of household”, “no transport” “other young children in the home” extracted from the Healthy Start database were used to identify neighborhoods of most risk.

Section III: Findings / Discussion
Results
See Evaluation/Attachment P: Heads of Households

Discussion
Limitations of findings
Section IV: Recommendation
Policy, program, and other recommendations
It is recommended that pregnant women are treated as a special vulnerable population, especially those that originate in neighborhoods with traditional high risk pregnancy occurrences.

Section V: Impact
Changes in perinatal system, community, etc

Section VI: Publications
Additional presentations to Report One that focused on pregnant women include:

"Utilizing GIS, Spatial Analysis and a Real-Time Pregnancy Surveillance System to Identify and Serve At Risk Populations During a Bioterrorism Event" 2004 International Conference on Emerging Infectious Diseases. CDC March 1-2 Atlanta 2004

“Utilizing GIS, Spatial Analysis and a Real-Time Pregnancy Surveillance System to Reduce African American Infant Mortality in Baton Rouge: Implications for Bioterrorism?” Colloquium, Department of Environmental Studies, Louisiana State University, April 2004

Utilizing GIS, Spatial Analysis and a Real Time Pregnancy Surveillance System to Reduce African American Infant Mortality in Baton Rouge: Implications for Bioterrorism?, School of Human Ecology, Louisiana State University, March 2005

The book also contains a section on pregnant women as a vulnerable population.
Section 1: Introduction
Local Evaluation Component
If an at-risk population is analyzed using a GIS, it is assumed that the population is stable. If this population frequently moves between residences, doubt might be cast on the revealed patterns and spatial processes. This in turn casts doubt on intervention / outreach strategies designed as a result of these analyses. In addition, a population that is mobile is also more likely to suffer stress and have negative birth outcomes.

Key Questions / Hypotheses
How mobile are pregnant women in the Healthy Start Program Area and how mobile are program participants?

Section II: Process
Methodology / data sources, instruments used
Mobility patterns of an at-risk population were revealed by birth and death certificate analysis, and by drawing from the Healthy Start database. Four sets of neighborhoods within East Baton Rouge Parish were analyzed (three inside the Program Area, one as a control). Each one of these neighborhoods comprised six 0.25 mile areas of analysis. The first set of neighborhoods was identified using a combination of a spatial filter analysis and a moving window to identify high rates of women receiving no prenatal care during the period 1996-1998. The second set of neighborhoods was located proximate to the first set. The third and fourth sets of neighborhoods were located some distance from sets one and two to provide a geographic comparison. Birth certificate data for the period 1999-2001 were used to validate the findings of the first analysis. Finally, the program participant dataset was overlaid onto these neighborhood groups to provide an indication of the amount of underlying mobility. Results suggest that in this study mobility is not a predictor of spatio temporal stability and is in reality another symptom of a high neighborhood risk load.

Section III: Findings / Discussion
Results
The analysis of birth and death certificates found a high percentage of deaths had a different address on the certificates. See Evaluation/Attachment Q: Percentage of Deaths.

An analysis of repeat births also found that a high proportion of mothers moved between pregnancies in the program area, the following table showing how far those moves were.

<table>
<thead>
<tr>
<th>Birth Years</th>
<th>97&amp;96</th>
<th>98&amp;96</th>
<th>98&amp;97</th>
<th>All Moves</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distances</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-0.5</td>
<td>47%</td>
<td>44%</td>
<td>65%</td>
<td>51%</td>
</tr>
<tr>
<td>0-1</td>
<td>57%</td>
<td>47%</td>
<td>71%</td>
<td>56%</td>
</tr>
<tr>
<td>0-1.5</td>
<td>64%</td>
<td>54%</td>
<td>79%</td>
<td>63%</td>
</tr>
</tbody>
</table>
The Healthy Start database was constructed to capture all moves made by program participants. The figure, See Evaluation/Attachment R: Program Participant Moves and Distance, shows how many moved, and how many made multiple moves.

**Discussion**
It is important to keep a close check on mobility as this both impacts any neighborhood level analysis, and should be considered a risk factor in itself due to the stress it causes.

**Limitations of findings**
Only a few years worth of data have been collected, and there are problems with the way birth and death certificate data are collected. This problem has not gained much attention in the literature and yet it is an issue. The Baton Rouge Healthy Start will hopefully find insights that will be useful for the entire United States.

**Section IV: Recommendation**
**Policy, program, and other recommendations**
It is recommended that other Healthy Starts begin to capture mobility data. It is also important to start to conduct focus groups to determine why these mothers are so mobile.

**Section V: Impact**
**Changes in perinatal system, community, etc**

**Section VI: Publications**
The previous mentioned book has a section on issues of mobility.
Section 1: Introduction
Confidentiality is usually associated with individual information recorded as text, in a table, or in a spreadsheet format. This information can be referred to as statistical or attribute information. It may include generic information (age, date of birth, marital status, religious affiliation, etc.) and more specific information of interest (tobacco or alcohol use, pregnancy outcome) to the collecting organization (hospital, police, university registrar, etc.). For this type of information, standards and rules have been developed in order to protect individual’s privacy. For example, the U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

The Privacy Rule clearly states how individual and statistical health information should be protected. No guidelines are offered of how to protect health information visualized in maps generated by a GIS. If the same Privacy Rule established for attribute health information (see above) is also applied to locational data, highly generalized maps would be produced which would not reveal insight into the problems of specific neighborhoods. For this reason, better and more appropriate privacy rules for map displays need to be established.

Local Evaluation Component
Research conducted by evaluators of the Healthy Start program have developed ways to “mask” spatial information so GIS results can be presented.

Key Questions / Hypotheses
How to balance between using a GIS to gain insight into the neighborhoods of a program area while not violating confidentiality.

Section II: Process
Methodology / data sources, instruments used
Two approaches have been adopted by the evaluation team. The first is to change the actual residences on a traditional map in order to mask true locations. See Evaluation/Attachment S: GEO Map

Secondly, use a Thiessen polygon based on the centers of traditional political units, such as census tract, a new background is created so that all traditional geographic reference points are lost. See Evaluation/Attachment T: Confidentiality.

Section III: Findings / Discussion
Results
(See the paper listed at the end of this section)

Section VI: Publications
In addition to a section in the book, the following presentation has been made, and paper published on this issue:
Paper presented:

VII. Fetal and Infant Mortality Review (FIMR) Program

The FIMR Program in Baton Rouge began in March 2004, due to technical assistance offered by the Louisiana Office of Public Health and the National FIMR Program. Implementing the FIMR Program required several meetings among key leadership in the community, over a period of 12 months to gain support for the process. The FIMR Program only emphasized fetal and infant mortality in the cases that it reviewed. It conducted a chart review and attempted a home interview on each case that was presented.

A Case Review Team (CRT) and Community Action Team (CAT) were established in 2004 and have worked diligently to identify trends in the cases reviewed and are in the process of planning and implementing community awareness projects in the areas, from the trends identified. The CRT had four meetings and reviewed a total of seven cases. The 22 members who represented the CRT Team: local hospitals, Early Childhood Supports and Services, OPH, Social Services, Department of Health and Hospitals, Maternal Fetal Medicine, LSU, Maternal Child Health Coalition, the CRT Team met bi-monthly. From the reviews of the CRT, recommendations included enhancing prevention efforts; improving systems of care and decreasing infant mortality in Baton Rouge and Region II. The CAT held one meeting and identified several areas with hospital and consumer communication which needed to be improved and worked on a plan, that provided a standard of care for expectant mothers who have lost a fetus/child. There were 40 members who represented the team and they met bi-monthly. While the two teams continuously met, the Louisiana Fetal and Infant Mortality Review Program continuously worked on a reporting mechanism, with the East Baton Rouge’s Coroners office and hospitals located in the region.

Since the FIMR Program began, Family Road Healthy Start has increased awareness in the community concerning fetal/infant deaths and has a strong commitment from the physicians and the medical community, to address the concerns and impact of fetal/infant deaths on the community and families. Family Road Healthy Start and FIMR have also strengthened the relationship between the hospitals, community organizations and government entities, by utilizing a team approach to address issues/trends identified by the cases reviewed. The CRT and CAT Teams have increased their knowledge on the community resources, risks and psychosocial issues associated with fetal/infant deaths and identified ways to assist bereaved mothers and their families. Both teams are working together to address the Perinatal Local Health System Action Plan by developing universal tools regarding the FIMR process for the region/state and looking at developing a Maternal Death Review.

Since the inception of FIMR, several risk factors were identified in the CRT meetings. The risk factors included: sexually transmitted diseases; late entry into prenatal care; poor nutrition; obesity; lack of family planning (no birth control methods); poor service utilization; (WIC, Office of Family Support, etc.); short interval pregnancies and adolescent pregnancies. In response, CAT identified several hospital and consumer communication patterns which needed to be improved and began working on a strategy, to provide a standard of care for bereaved mothers and their families. Other goals included developing a specific resource manual for pregnant and parenting women and their families.
Family Road Healthy Start  
Project Number H49MC00107

VIII. Products  
Please see attached materials located in Appendix C.  
- Healthy Start Program Materials  
- Documents Referenced in Program Accomplishments  
- Co-Sponsored Events  
- Media

IX. Project Data  
Please see attached forms located in Appendix D.  
- MCH Budget Details – Form 1, Year 2001  
- MCH Budget Details – Form 1, Year 2002  
- MCH Budget Details – Form 1, Year 2003  
- MCH Budget Details – Form 1, Year 2004  
- Variables Describing Healthy Start Participants – Form 5, Year 2002  
- Variables Describing Healthy Start Participants – Form 5, Year 2003  
- Variables Describing Healthy Start Participants – Form 5, Year 2004  
- Variables Describing Healthy Start Participants – Form 5, Year 2005  
- Common Performance Measures and Intervention Specific Performance Measures – Form 9, Year 2001-2004  
- Characteristic of Program Participant – Table A, Year 2002  
- Characteristic of Program Participant – Table A, Year 2003  
- Characteristic of Program Participant – Table A, Year 2004  
- Characteristic of Program Participant – Table A, Year 2005  
- Risk Reduction/Prevention Services – Table B, Year 2002  
- Risk Reduction/Prevention Services – Table B, Year 2003  
- Risk Reduction/Prevention Services – Table B, Year 2004  
- Risk Reduction/Prevention Services – Table B, Year 2005  
- Major Service Table – Table C, Year 2002  
- Major Service Table – Table C, Year 2003  
- Major Service Table – Table C, Year 2004  
- Major Service Table – Table C, Year 2005
Appendix A

Final Report/Implementation Plan
**Final Report/Implementation Plan**

Grantee: **Baton Rouge Healthy Start**  
Intervention: **Outreach**

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>02  By 05/31/05 the outreach workers will have contacted at least 2130 of the African American pregnant women in the target population; participated in the case management conferences of the women living in her assigned area, and maintained an outreach panel for follow-up of up to 50 women not receiving case management services. (Baseline: 1,545 pregnant women in the target population based on three year averages of live births 1996-1998. Source: Office of Public Strategy: Contact pregnant women in the target population.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities (with Implementation Timeframes):</td>
<td>As of 12/31/02, 630 pregnant women have been contacted in the target population.</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td></td>
<td>Completed.</td>
</tr>
<tr>
<td>1. Family Road will employ a Social Work Case Manager Supervisor to oversee outreach activities and consult with Family Road staff and Project Area Committee (PAC) to identify boundaries of five outreach areas. (April 2002)</td>
<td></td>
<td>Completed.</td>
</tr>
<tr>
<td>3. The captains will recruit six outreach workers from their assigned areas. (April 2002)</td>
<td></td>
<td>Completed.</td>
</tr>
<tr>
<td>4. Family Road will implement a client contact reporting system to monitor work activities and progress towards achieving this objective. (April 2002)</td>
<td></td>
<td>Completed.</td>
</tr>
<tr>
<td>5. Family Road will initiate the first training program for outreach workers. (April 2002)</td>
<td></td>
<td>Completed.</td>
</tr>
<tr>
<td>7. Outreach workers will develop activity plans with Captains, including schedules for door-to-door inquiries and community presentations. (April 2002)</td>
<td>Completed.</td>
<td></td>
</tr>
<tr>
<td>8. Outreach workers will work with Captain to recruit members of the Neighborhood Network Support Team and Men’s Teams. Outreach activities will be planned, implemented and evaluated with consultation from these teams. (April 2002)</td>
<td>Completed.</td>
<td></td>
</tr>
<tr>
<td>9. Reports of outreach efforts will be made to the PAC and Consortium to determine areas for improvement. (July 2002)</td>
<td>Completed.</td>
<td></td>
</tr>
</tbody>
</table>

**2003**

| 1. The Community Developer will coordinate formalizing 3 additional Neighborhood Network Support Teams and Men’s Teams from the project area and initiate regular consultation regarding outreach activities. (July 2003) | Completed. |
| 2. Family Road will conduct two outreach worker continuing education training programs. (June-December 2003) | Completed and ongoing. |
| 3. Outreach worker evaluation will continue to improve knowledge, skills, motivation and confidence in providing outreach services as needed. (ongoing) | Completed. |
| 4. Outreach workers, Captains, Case Managers and others will consult on | Completed. |

There were a total of 2,724 contacts made in the target community by outreach staff.
the development of a “best practices” outreach manual based upon outreach worker’s field experiences. (November 2003)

| 2004 |
|---|---|
| 2. Family Road will hold workshops in conjunction with community organizations in the project area to focus on perinatal health topics including the importance of early prenatal care. (Jan. – Dec. 2004) | Completed. |
| 3. Expand publicity campaign including radio, television, billboard, etc. to increase awareness of the importance of early prenatal care. (May 2004) | Completed. |
| 5. Continue to provide prenatal care services at the Family Road clinic that will provide consistent providers and a friendly atmosphere for clients to obtain services. (Jan.-Dec. 2004) | Completed. |

There were a total of 3,132 contacts made in the target community by outreach staff.
Family Road Healthy Start  
Project Number H49MC00107

**Grantee:** Baton Rouge Healthy Start  
**Intervention:** Case Management

<table>
<thead>
<tr>
<th>Project Period</th>
<th>Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
</table>
| 02 | By 05/31/05 the Baton Rouge Healthy Start Project will provide case management services to 480 pregnant women in the target population; it will provide case management services to 432 of these women in the year following birth of their babies (90% program retention rate beginning in year 3); and provide case management services to 388 women during year 4 of the program. The case manager will insure that all women receiving services will have an annual comprehensive primary/preventive medical examination and will receive family | Strategy:  
Enroll pregnant women into case management services.  

**2002**  
Activities (with Implementation Timeframes):  
1a. Family Road will hire eight nurse case managers and three social work case managers and two supervisors. (May 2002)  
2. Family Road and partner case management agencies will conduct training programs for case managers who will serve target area women and their infants. (June 2002)  
3. Case Manager Supervisors and Project Staff will consult with PAC and area providers to develop procedures for referring a client for medical care and social services, following up referrals, and convening a client’s case management team. (May 2002)  
4. Family Road will develop and implement protocols for intake procedures and case management assignment. (May 2002)  
5. Family Road will develop reporting and record keeping systems to monitor the number of women receiving case management services, their compliance with their personal care plan, and the length of their participation in the program. (May 2002) | Case management client enrollment began July 2002. During the period of July 15-December 31, 2002, case management services have been provided to 88 pregnant women. A total of 134 referrals into the program were received.  
Completed.  
Completed and ongoing  
Completed  
Completed |
Family Road Healthy Start  
Project Number H49MC00107

<table>
<thead>
<tr>
<th>Planning counseling.</th>
<th>6. Family Road will identify medical providers who will conduct comprehensive primary/preventive medical examinations; Family Road will consult with providers to define an examination protocol. (June 2002)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family Road will fill one vacant position for a nurse case manager. (Feb. 2003)</td>
<td>7. Evaluation results of the effectiveness of the case management services will be used to improve the system. (December 2002)</td>
</tr>
<tr>
<td>2. Family Road will arrange the appropriate initial and continuing education training for case managers. (June – December 2003)</td>
<td>8. Case management supervisors will work with case managers, outreach workers, the PAC and Consortium to identify barriers to client’s receipt of needed services and develop proposals for reducing these barriers. (December 2002)</td>
</tr>
<tr>
<td>3. Case Management supervisors and Project Staff will develop</td>
<td></td>
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</table>

2003

<table>
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<tr>
<th></th>
<th>Completed</th>
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<tbody>
<tr>
<td>A total of 191 new clients enrolled in the Healthy Start case management service. There were a total of 248 active clients and their families for 2003. Of the 248, a total of 190 (76.6%) clients were retained in the program. Reasons for closure included lack of contact for 60 days and client refusal of services. Including family members, there were a total of 784 program participants.</td>
<td>Completed.</td>
</tr>
<tr>
<td>Completed and ongoing.</td>
<td></td>
</tr>
</tbody>
</table>
additional required procedures, including identifying any new services necessary. (March 2003)

4. Family Road and the Project Area Committee will ensure that the appropriate data collection, satisfaction surveys, and evaluations are being conducted to continuously improve the program. (January – December 2003)

**2004**

1. Family Road will arrange the appropriate initial and continuing education training for case managers. (Jan. – Dec. 2004)

2. Case Management supervisors and Project Staff will develop additional required procedures, including identifying any new services necessary. (March 2004)

3. Family Road and the Project Area Committee will ensure that the appropriate data collection, satisfaction surveys, and evaluations are being conducted to continuously improve the program. (January – December 2004)

4. Healthy Start will maintain the client incentive program based on length of time of client enrollment into the program. (Jan.-Dec. 2004)

Completed.

A total of 127 new clients enrolled in the Healthy Start case management service. There were a total of 291 active clients and their families for 2004. Of the 127, a total of 106 (83.4%) clients were retained in the program. Reasons for closure included lack of contact for 60 days and client refusal of services.

Completed.

Completed.

Completed.
<p>| | |</p>
<table>
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<tbody>
<tr>
<td>5.</td>
<td>Healthy Start will continue to implement the distribution of cribs based on program criteria. (August 2004)</td>
</tr>
<tr>
<td>6.</td>
<td>The Ages and Stages developmental screening tool will be implemented in the case management service after staff training is completed. (April 2004)</td>
</tr>
<tr>
<td>7.</td>
<td>Referrals will be made to the infant mental health specialist according to procedures. (Jan.-Dec. 2004)</td>
</tr>
<tr>
<td></td>
<td>Completed.</td>
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<td></td>
<td>Completed.</td>
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<td>Completed.</td>
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</table>
Family Road Healthy Start  
Project Number H49MC00107  

Grantee: Baton Rouge Healthy Start  
Intervention: Case Management

<table>
<thead>
<tr>
<th>Project Period</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 02  By 5/31/05 project will have identified the causes of infant mortality and morbidity for babies born to women in the target population and developed a plan to address the needs of women at highest risk for such birth outcomes that are preventable; the evaluation team will develop a profile of women who are most likely not to seek adequate prenatal care. Project staff will direct special efforts to identify and assist these women to seek continuous care through intensive case management services. | Strategy: Identify causes of infant morbidity and mortality through review of infant deaths and focus group interviews

Activities (with Implementation Timeframes):

**2002**

1. Convene a Fetal and Infant Mortality Review Committee and Infant/Child Death Review Panel for East Baton Rouge Parish; begin review of cases of infant deaths in the target population. (June 2002)

2. Using birth certificate data and Geographic Information System, identify women who had two or fewer prenatal medical visits during a previous pregnancy. (November 2002)

3. Utilize outreach workers to interview the women identified. (November 2002)

4. Convene one focus group of such women under the auspices of the Title V MCH Healthy Babies Campaign. (November 2002)

5. Examine responses to determine common characteristics among women who fail to seek to seek adequate prenatal care (December 2002)

6. Develop plan for outreach workers to identify and seek to contact women who are unlikely to seek care without assistance. (December 2002)

| FIMR Pending. Infant/Child Death Review Panel has been initiated through OPH. | Completed. |
| Completed. |
| Completed. |
| Completed. |
| Completed. |
| Completed using Geographic Information System |
Birth certificates indicate that the three year average of birth mothers prenatal history and infant morbidity and mortality for the project area is:
- Number receiving no prenatal care prior to birth is 36
- Number receiving one or two visits is 43
- Number of women in the target population receiving fewer than seven visits is 330
- Number of premature births to women in the target population is 397
- Number of low birth weight births to women in the target population is 232
- Number of infant deaths (under 1 year) is 28 (including neonatal deaths)
Source: OPH vital statistics

<table>
<thead>
<tr>
<th>7. Design public information campaign with messages targeted to these women, including dissemination of messages about the importance of prenatal care and where to go to find help. (December 2002)</th>
<th>Completed and ongoing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The first FIMR review was conducted in March 2004.</td>
<td></td>
</tr>
</tbody>
</table>

### 2003

- 1. Continue to build community support for FIMR through contacting hospitals, community leaders, medical providers, coroner, medical examiner, and pathologists regarding the initiation of FIMR activities. (March 2003)
- 4. Establish the Community Action Team. (April 2003)
- 5. Establish a tracking method for actions, recommendations follow-up and evaluation. (May 2003)
- 8. Initiate a review of cases. (May 2003)
- Pending – a timeline was established. (May 2003)
<table>
<thead>
<tr>
<th>Year</th>
<th>Task Description</th>
<th>Completion Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2004</strong></td>
<td>Continue to build community support for FIMR through contacting hospitals, community leaders, medical providers, coroner, medical examiner, and pathologists regarding the initiation of FIMR activities. (June 2004)</td>
<td>Completed.</td>
</tr>
<tr>
<td></td>
<td>Develop a FIMR fact sheet for distribution to the community. (September 2004)</td>
<td>Completed.</td>
</tr>
<tr>
<td></td>
<td>FIMR was continued in 2004 with seven cases being reviewed.</td>
<td></td>
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</tbody>
</table>
Family Road Healthy Start  
Project Number H49MC00107  

Grantee: Baton Rouge Healthy Start  
Intervention: Case Management  

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
</table>
| 02 By 5/31/05 increase the percentage of women in the target population who initiate prenatal care in the first trimester of pregnancy from 67% (1035 women) to 80% (1236 women)  
(Baseline: The working figure is 1545 live births to women in the project area, based on three year averages 1996-98. Data shows that presently only 67% initiate prenatal care in the first trimester of pregnancy, 2.3% (36) receive no prenatal care. Source: OPH vital statistics) | Strategy: 
Enroll pregnant women into the program early in pregnancy.  

Activities (with Implementation Timeframes):  

2002  
1. Outreach and case management service implementation as described in previous objectives.  
2. Family Road and PAC will convene a work group to evaluate the adequacy (number, location, types of services, acceptance of Medicaid) of prenatal care providers serving the target population (particularly the uninsured); Work group will develop a plan for expanding available providers based upon the needs of the target population and for taking steps to lower barriers to access. (April 2002)  
3. Initiate “Partners for Healthy Babies” media campaign and hotline in the project area to deliver messages encouraging women to seek early determination of pregnancy and immediate prenatal care following a positive pregnancy test. (April 2002)  
4. Advertise “hotline” for women who seek to learn what to do if they suspect they are pregnant. (April 2002)  
5. Family Road will develop the personal information packet for case | During the period July 15-December 31, 2002, 88 clients were enrolled in the program. Of the 63 clients who had the month prenatal care initiated information, 33 (52.4%) had received prenatal care during the first trimester.  
Completed and ongoing.  
Completed.  
Completed and ongoing.  
Completed.  
Completed. |
workers to give to women they contact, including information about the importance of seeking prenatal care early in pregnancy. (April 2002)

6. Outreach workers will consult with community organizations and leaders who work with young women to disseminate messages about the importance of early prenatal care to women of child-bearing age. (April 2002)

<table>
<thead>
<tr>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Outreach and case management service implementation as described in previous objectives. (Jan. – Dec. 2003)</td>
</tr>
<tr>
<td>2. Family Road will hold workshops in conjunction with community organizations in the project area to focus on perinatal health topics including the importance of early prenatal care. (Jan. – Dec. 2003)</td>
</tr>
<tr>
<td>3. Expand publicity campaign including radio, television, billboard, etc. to increase awareness of the importance of early prenatal care. (March 2003)</td>
</tr>
<tr>
<td>4. Provide transportation services to eliminate barriers to accessing prenatal care. (March 2003)</td>
</tr>
<tr>
<td>5. Expand Family Road services to include a prenatal clinic that will provide consistent providers and a friendly atmosphere for clients to obtain services. (June 2003)</td>
</tr>
</tbody>
</table>

Completed.

Of the 106 women in the program with prenatal care initiation information, 52 (49%) received care in the first trimester.

Completed

Of the 87 women in the program with prenatal care initiation information, 37 (42%) received care in the first trimester.
<table>
<thead>
<tr>
<th><strong>2004</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Outreach and case management service implementation as described in previous objectives. (Jan. – Dec. 2004)</td>
<td>Completed</td>
</tr>
<tr>
<td>2. Family Road will hold workshops in conjunction with community organizations in the project area to focus on perinatal health topics including the importance of early prenatal care. (Jan. – Dec. 2004)</td>
<td>Completed</td>
</tr>
<tr>
<td>3. Expand publicity campaign including radio, television, billboard, etc. to increase awareness of the importance of early prenatal care. (May 2004)</td>
<td>Completed</td>
</tr>
<tr>
<td>4. Provide transportation services to eliminate barriers to accessing prenatal care. (Jan.-Dec. 2004)</td>
<td>Completed</td>
</tr>
<tr>
<td>5. Continue to provide prenatal care services at the Family Road clinic that will provide consistent providers and a friendly atmosphere for clients to obtain services. (Jan.-Dec. 2004)</td>
<td>Completed</td>
</tr>
</tbody>
</table>
Family Road Healthy Start  
Project Number H49MC00107  
Grantee: Baton Rouge Healthy Start  
Intervention: Education

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 By 5/31/05 90% of women participating in the Healthy Start Project (432) will participate in at least one educational program.</td>
<td>Strategy: Provide educational programs to the target population.</td>
<td>For the period July 15-December 31, 2002, a total of 3,329 participants from the target population have participated in educational offerings through outreach efforts. Of the 88 clients in case management services, 88 (100%) have participated in at least one educational offering.</td>
</tr>
<tr>
<td>02 By 5/31/05 90% of the 2130 outreach target population (1,917) will participate in at least one educational program.</td>
<td>Activities (with Implementation Timeframes):</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>2002</strong></td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>1. Family Road will offer educational programs on having a healthy baby (nutrition, exercise, avoidance of risk behaviors) parenting, and pregnancy expectations. (April 2002)</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>2. Outreach workers will disseminate the Family Road calendar listing educational offerings. (April 2002)</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>3. Family Road will initiate a plan for regularly disseminating to outreach workers, providers, community groups and sites frequented by women in the target population updated information about Healthy Start educational offerings. (April 2002)</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>4. Case Managers and outreach workers will help each pregnant woman to identify the programs of interest and value to hear and encourage her attendance. (April 2002)</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>5. Family Road will offer educational programs at community sites in the project area. (June 2002)</td>
<td>Completed</td>
</tr>
</tbody>
</table>
whom 162 will participate in at least one educational offering in the first year of receiving case management services. Outreach efforts are expected to make contact with a total of 2130 pregnant women of whom 1,917 is expected to attend an educational offering. Source: Healthy Start case management referral log and outreach program participation rosters.

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<tbody>
<tr>
<td></td>
<td>6. Educational programs will be evaluated by participants to identify areas to improve. (June 2002)</td>
</tr>
<tr>
<td></td>
<td>Completed</td>
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<tr>
<td></td>
<td>Of the 191 new clients that were enrolled in the program, 191 (100%) have participated in at least one educational program.</td>
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<td></td>
<td>Completed.</td>
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<tr>
<td></td>
<td>2003</td>
</tr>
<tr>
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</tr>
<tr>
<td></td>
<td>1. Family Road will continue to offer educational programs on having a healthy baby (nutrition, exercise, avoidance of risk behaviors) parenting, and pregnancy expectations. (Jan. – Dec. 2003)</td>
</tr>
<tr>
<td></td>
<td>Completed.</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>2. Outreach workers will continue to disseminate the Family Road calendar listing educational offerings. (Jan. – Dec. 2003)</td>
</tr>
<tr>
<td></td>
<td>Completed.</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>3. Family Road will continue to disseminate to outreach workers, providers, community groups and sites frequented by women in the target population updated information about Healthy Start educational offerings. (Jan.- Dec. 2003)</td>
</tr>
<tr>
<td></td>
<td>Completed.</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>4. Case Managers and outreach workers will help each pregnant woman to identify the programs of interest and value to her and encourage her attendance. (Jan.-Dec. 2003)</td>
</tr>
<tr>
<td></td>
<td>Completed and ongoing.</td>
</tr>
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</tr>
<tr>
<td></td>
<td>5. Family Road will offer educational programs at community sites in the project area. (Jan. – Dec. 2003)</td>
</tr>
<tr>
<td></td>
<td>Completed and ongoing.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Educational programs will be evaluated by participants to identify areas to improve. (Jan. – Dec. 2003)</td>
</tr>
<tr>
<td></td>
<td>Completed and ongoing.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Family Road will survey the target population to determine educational</td>
</tr>
</tbody>
</table>
Family Road Healthy Start  
Project Number H49MC00107

<table>
<thead>
<tr>
<th></th>
<th><strong>2004</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Family Road will continue to offer educational programs on having a healthy baby (nutrition, exercise, avoidance of risk behaviors) parenting, and pregnancy expectations. (Jan. – Dec. 2004)</td>
<td>Completed</td>
</tr>
<tr>
<td>2.</td>
<td>Outreach workers will continue to disseminate the Family Road calendar listing educational offerings. (Jan. – Dec. 2004)</td>
<td>Completed</td>
</tr>
<tr>
<td>3.</td>
<td>Family Road will continue to disseminate to outreach workers, providers, community groups and sites frequented by women in the target population updated information about Healthy Start educational offerings. (Jan.- Dec. 2004)</td>
<td>Completed</td>
</tr>
<tr>
<td>4.</td>
<td>Case Managers and outreach workers will help each pregnant woman to identify the programs of interest and value to her and encourage her attendance. (Jan.-Dec. 2004)</td>
<td>Completed</td>
</tr>
<tr>
<td>5.</td>
<td>Family Road will offer educational programs at community sites in the project area. Educational programs targeting perinatal substance use, STDs, and breastfeeding will continue. (Jan. – Dec. 2004)</td>
<td>Completed</td>
</tr>
<tr>
<td>6.</td>
<td>Educational programs will be evaluated by participants to identify areas to improve. (Jan. – Dec. 2004)</td>
<td>Completed</td>
</tr>
<tr>
<td>7.</td>
<td>Family Road will survey the target population to determine educational topics of interest in order to modify the educational program as needed. (Jan.-Dec. 2004)</td>
<td>Completed</td>
</tr>
</tbody>
</table>

Completed and ongoing.

Of the 127 new clients that were enrolled in the program, 127 (100%) have participated in at least one educational program.
Family Road Healthy Start  
Project Number H49MC00107  
Grantee: Baton Rouge Healthy Start  
Intervention: Education

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
</table>
| 02 By 05/31/05 50% of the male partners of women participating in the case management component of the Healthy Start Project will participate in an education program focusing on fatherhood, health issues (including STD, HIV/AIDS prevention), family planning, and relationship issues. (Baseline: Family Road is relying upon its target of initiating case management services for a total of 480 pregnant women. Thus, the men’s program will be expected to reach 240 men during the project period. Source: Case management files and... | Strategy: Provide educational programs to males of pregnant women in the case management program. Activities (with Implementation Timeframes):  

**2002**  
1. Convene a Men’s Team for at least two of the project area’s subdivisions. (April 2002)  
2. Develop outreach and publicity campaign to inform men about their responsibilities as fathers. (May 2002)  
3. Work with Men’s Teams and community leaders and counselors who work with young men to involve them in encouraging expectant fathers to participate in the education program. (May 2002)  
4. Develop a three-year plan for recruiting men as students and retaining their participation through the entire course, including the offering of appropriate incentives. (June 2002)  
5. Provide a training for male leadership in the project area who will work with young men on how to counsel and encourage them to assume pregnancy support and fatherhood responsibilities including referral to education and support programs. (June 2002) | For the period July 15, 2002- December 2002 a total of 97 male participants have received an educational program.  
Completed.  
Completed.  
Completed and ongoing.  
Completed.  
Completed |
Add two Men’s Team serving the target population to support the Fatherhood program. (April 2003)

Continue the outreach and publicity campaign to inform men about the Fatherhood program. (Feb. 2003 and ongoing)

Implement an incentive program to encourage expectant fathers to participate in the education program. (Feb. 2003)

Implement a male mentor program using men who have completed the Fatherhood Curriculum as mentors to fathers of babies in the case management program. (March 2003 and ongoing)

Evaluate the effectiveness of the Fatherhood program to determine areas to improve. (quarterly beginning March 2003)

There were a total of 80 males of women enrolled in the program who attended at least one educational session. Of these 12 participated in the Dedicated Dads program.

Completed.

Completed.

Completed.

Completed.

Completed.

There were a total of 76 males of women enrolled in the program who attended at least one educational session. Of these 1 person participated in the Dedicated Dads program.

Completed.

Completed.

Completed.
<p>| 4. Evaluate the effectiveness of the Fatherhood program to determine areas to improve. (annually 2004) | Completed. |</p>
<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 By 5/31/05 four training programs will be held for medical providers including physicians, nurses, office staff, nurse practitioners, and midwives, serving or potentially willing to serve women in the target population. (Baseline: No precise baseline is available. There are fifty private medical providers conveniently located to the project area who accept Medicaid. Source: Local community resource directory of medical service providers.)</td>
<td>Strategy: Provide educational program for clinical providers on perinatal health. Activities (with Implementation Timeframes):</td>
<td>As of 12/31/2002, a total of 868 providers serving the project area have participated in educational programs.</td>
</tr>
<tr>
<td></td>
<td><strong>2002</strong></td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>1. Healthy Start project staff, PAC members, OPH MCH staff, and the evaluation team will collaborate in developing a training session for providers to familiarize them with the particular difficulties that women in the target population experience when seeking medical care. (July 2002)</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>2. Women in the target population as well as providers currently serving them will participate in the creation of a useful and effective curriculum. (June 2002)</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>3. Family Road will consult with appropriate licensing agencies to designate these trainings as programs that qualify towards meeting a provider’s continuing education requirements, thus creating an incentive for provider’s to participate. (July 2002)</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>4. Family Road will work with medical education personnel and physician training supervisors at hospitals operating prenatal clinics serving women in the Project (a) provide training to clinic staff at the hospital site; (b) to incorporate the training into the hospital’s training curriculum; or (c) to encourage the hospital to send their clinic personnel to one of the Healthy Start training sessions. (August 2002)</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>5. Case managers will contact providers who serve their clients to encourage them to participate in the training. (July 2002)</td>
<td>Completed</td>
</tr>
</tbody>
</table>
2003

1. Healthy Start project staff, PAC members, OPH MCH staff, and the evaluation team will collaborate in developing a training session for providers on perinatal health. (July 2003)

2. Input from women in the target population as well as providers currently serving them will participate in the creation of a useful and effective curriculum. (July 2003)

3. Family Road will consult with appropriate licensing agencies to designate these trainings as programs that qualify towards meeting a provider’s continuing education requirements, thus creating an incentive for provider’s to participate. (July 2003)

4. Family Road will work with medical education personnel and physician training supervisors at hospitals operating prenatal clinics serving women in the Project (a) provide training to clinic staff at the hospital site; (b) to incorporate the training into the hospital’s training curriculum; or (c) to encourage the hospital to send their clinic personnel to one of the Healthy Start training sessions. (July 2003)

5. Case managers will contact providers who serve their clients to encourage them to participate in the training. (July 2003)

There were a total of 2,541 providers who attended training programs. A major area of focus in the community is the perinatal substance abuse initiative.

Completed.

Completed.

Completed.

Completed.
<table>
<thead>
<tr>
<th>2004</th>
<th>There were a total of 1,437 providers who attended training programs. A major area of focus in the community is the perinatal substance abuse initiative.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Healthy Start project staff, PAC members, OPH MCH staff, and the evaluation team will collaborate in developing a training session for providers on perinatal substance abuse, perinatal depression and violence prevention. (March-August 2004)</td>
</tr>
<tr>
<td>2.</td>
<td>Input from women in the target population as well as providers currently serving them will participate in the development of effective care strategies. (September 2004)</td>
</tr>
<tr>
<td>3.</td>
<td>Family Road will consult with appropriate licensing agencies to designate these trainings as programs that qualify towards meeting a provider’s continuing education requirements, thus creating an incentive for provider’s to participate. (March-August 2004)</td>
</tr>
<tr>
<td>4.</td>
<td>Family Road will work with medical education personnel and physician training supervisors at hospitals operating prenatal clinics serving women in the Project (a) provide training to clinic staff at the hospital site; (b) to incorporate the training into the hospital’s training curriculum; or (c) to encourage the hospital to send their clinic personnel to one of the Healthy Start training sessions. (March-August 2004)</td>
</tr>
<tr>
<td>5.</td>
<td>Case managers will contact providers who serve their clients to encourage them to participate in the training. (March-August 2004)</td>
</tr>
</tbody>
</table>

Completed.

Completed.

Completed.

Completed.

Completed.
Family Road Healthy Start
Project Number H49MC00107

Grantee: Baton Rouge Healthy Start
Intervention: Education

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 By 5/31/05 the percentage of two-year old children in the project area who have received their full schedule of age-appropriate immunizations will increase from 57% to 85%. (Baseline: In 1998, 66% of the white infants and 43% of the African American infants under the age of two in the project area had received the full set of age appropriate immunizations. Source: PH-9 data received from the OPH)</td>
<td>Strategy: Provide education and referral for childhood immunizations in the project area. Activities (with Implementation Timeframes): <strong>2002</strong> 1. Implement public information media campaign re: childhood immunizations. (April 2002) 2. Collaborate with the “Shots for Tots” program to disseminate printed educational material about child immunizations to locations in the project area frequented by pregnant women and mothers of young children. (July 2002) 3. Outreach workers and case managers will assist new mothers in the case management program in arranging immunizations and follow-up to verify and document immunizations. (ongoing) 4. Family Road will identify all locations convenient to women in the project area where they can have their child immunized. (April 2002) 5. Utilize the immunization Registry (LINKS) which is being planned and developed by the OPH. (July 2002) 6. The evaluation team will analyze and map immunization data in an</td>
<td>The percentage of fully immunized two year old children in the project area was 66% for Caucasians and 43% for African Americans in 1998. Data for the project area for 1999-2001 is pending access to the state database. Completed and ongoing. Completed. Completed. Completed. Pending.</td>
</tr>
<tr>
<td></td>
<td>attempt to identify “low coverage” areas for targeted interventions. (November 2002)</td>
<td>The Louisiana Office of Public Health is continuing to establish a reliable mechanism to retrieve immunization rates by zip code using the new LINKS system. This process is not completed at the present time. All of the private providers and non-health unit clinics are not currently using the system for immunization documentation. Therefore, many of the immunizations are not currently entered into the electronic surveillance system which limits the data analysis and interpretation. The LINKS data currently shows that the project area has a 21% rate of completion of age appropriate immunizations by age 2. A detailed report can be found in Appendix F. Rates that have been compiled for the program include a total of 53 infants (87%) at age 5 months out of a total of 61 infants at 5 months of age have completed age appropriate immunizations.</td>
</tr>
<tr>
<td>---</td>
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<tr>
<td></td>
<td>2. Continue to collaborate with the “Shots for Tots” program to disseminate printed educational material about child immunizations to locations in the project area frequented by pregnant women and mothers of young children. (July 2003)</td>
<td>Completed.</td>
</tr>
</tbody>
</table>
3. Outreach workers and case managers will assist new mothers in the case management program in arranging immunizations and follow-up to verify and document immunizations. (ongoing)

4. Utilize the immunization Registry (LINKS) which is being planned and developed by the OPH. (July 2003)

5. The evaluation team will analyze and map immunization data in an attempt to identify “low coverage” areas for targeted interventions. (June 2003)

<table>
<thead>
<tr>
<th>2004</th>
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<tbody>
<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
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</table>

Out of a total of 161 infants, by age 3 months, 139 (86%) of infants had received their recommended immunizations.
Family Road Healthy Start  
Project Number H49MC00107  
Grantee: Baton Rouge Healthy Start  
Intervention: Program Evaluation

<table>
<thead>
<tr>
<th>Project Period Objective</th>
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</tr>
</thead>
</table>
| By 05/31/05 survey 100% (480) of those enrolled in Healthy Start to determine their satisfaction with the services received and the program. Commit to realistic program modifications based upon survey responses on an annual basis. | Strategy: Administer satisfaction survey to clients in program.  
Activities (with Implementation Timeframes):  
**2002**  
1. Finalize survey instrument. (May 2002)  
2. Administer survey according to protocol. (October 2002)  
3. Evaluation team to analyze results. (November 2002) | As of 12/31/02 a total of 24 satisfaction surveys were administered to women who have been in the program at least 3 months. Of these, 17 respondents (71%) participated in the survey. Results of the survey indicated excellent satisfaction with case managers, the program, and the health care provider. On a scale of 1-5 (with 5 being best) averaged ratings were as follows:  
Case Manager – 4.94  
Healthy Start Program- 4.82  
Health Care Provider- 4.82  
Completed.  
Completed.  
Completed. |
<table>
<thead>
<tr>
<th>Year</th>
<th>Action</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2003</strong></td>
<td>1. Administer survey according to protocol. (Survey clients at 6, 12, 18 and 24 months in the program 2003)</td>
<td>Completed.</td>
</tr>
<tr>
<td></td>
<td>2. Evaluation team to analyze results and make recommendations for program improvements. (June and December 2003)</td>
<td>Completed.</td>
</tr>
<tr>
<td></td>
<td>2. Evaluation team to analyze results and make recommendations for program improvements. (December 2004)</td>
<td>Completed.</td>
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</tbody>
</table>

There were a total of 92 respondents to the Healthy Start program client satisfaction survey.

- Completed.

There were a total of 83 respondents to the HS Program client satisfaction survey. 75 (90%) of the clients surveyed graded their case manager as excellent; 89% of the clients ranked the overall quality of services received while in Healthy Start as excellent.

- Completed.
Grantee: Baton Rouge Healthy Start  
Intervention: Case Management

<table>
<thead>
<tr>
<th>Project Period Objective</th>
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</thead>
</table>
| 02 By 5/31/05  100% (480) of those enrolled in Healthy Start will be screened for depression and referred for further assessment and treatment as necessary. | Strategy:  
Screen women receiving case management services for depression and make referrals as needed.  

Activities (with Implementation Timeframes):  
**2002**  
1. Case management staff will be provided orientation to use of the Edinburgh Depression Screening Tool and referral agencies in the community. (April 2002)  
2. Using a general risk assessment tool, all pregnant women enrolled in the program will be assessed for past history of depression during the prenatal period to identify women who may be at risk for postpartum depression. (April 2002 and ongoing)  
3. Using the Edinburgh Depression Screening Tool, all pregnant women enrolled in the program will be screened for depression during the postpartum period. (April 2002 and ongoing)  
4. Based on screening results, referrals will be made for further assessment and treatment to community agencies providing mental health services. (April 2002 and ongoing)  
5. Case management staff will monitor services provided to clients for depression to ensure needs are being met. (April 2002 and ongoing)  
6. Case management staff will support the personal care plan established | For the period July 15-December 31, 2002 a total of 70 depression screenings have been conducted. Of these 15 (21%) have been referred for further evaluation and treatment.  
Completed  
Completed  
Completed  
Completed  
Completed  
Completed |
<table>
<thead>
<tr>
<th>2002</th>
<th>2003</th>
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</thead>
<tbody>
<tr>
<td>to address identified needs related to postpartum depression. (April 2002 and ongoing)</td>
<td>completed and ongoing</td>
</tr>
<tr>
<td>7. Family Road will develop a record keeping system in order to track performance measures for depression screening and referral. (April 2002)</td>
<td>completed</td>
</tr>
<tr>
<td>8. Family Road and partner agencies will conduct a training program on postpartum depression for community providers based on a needs assessment. (June 2002)</td>
<td>pending. training being planned for 2003</td>
</tr>
<tr>
<td>1. New case management staff will be provided orientation to use of the Edinburgh Depression Screening Tool and referral agencies in the community. (ongoing)</td>
<td>completed.</td>
</tr>
<tr>
<td>2. Using a general risk assessment tool, all pregnant women enrolled in the program will be assessed for past history of depression during the prenatal period to identify women who may be at risk for postpartum depression. (January 2003 and ongoing)</td>
<td>completed.</td>
</tr>
<tr>
<td>3. Using the Edinburgh Depression Screening Tool, all pregnant women enrolled in the program will be screened for depression during the post-partum period. (January 2003 and ongoing)</td>
<td>completed.</td>
</tr>
<tr>
<td>4. Based on screening results, referrals will be made for further</td>
<td></td>
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</tbody>
</table>
Family Road Healthy Start
Project Number H49MC00107

assessments and treatment to community agencies providing mental health services. (January 2003 and ongoing)

5. Case management staff will monitor services provided to clients for depression to ensure needs are being met. (January 2003 and ongoing)

6. Case management staff will support the personal care plan established to address identified needs related to postpartum depression. (January 2003 and ongoing)

7. Family Road and partner agencies will conduct a training program on postpartum depression for community providers based on a needs assessment. (June 2003)

<table>
<thead>
<tr>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. New case management staff will be provided orientation to use of the Edinburgh Depression Screening Tool and referral agencies in the community. (ongoing)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>2. Using a general risk assessment tool, all pregnant women enrolled in the program will be assessed for past history of depression during the prenatal period to identify women who may be at risk for perinatal depression. (Jan.-Dec.2004)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>3. Using the Edinburgh Depression Screening Tool, all pregnant women</td>
</tr>
</tbody>
</table>

| Completed. |
| Completed. |
| Completed. |

Of a total of 93 Edinburgh Depression screens with a score available, 30 (32%) of the clients required a referral for further evaluation and treatment. Of the total of 69 postpartum screening scores available, 14 (20%) of the clients required a referral for further assessment and treatment.
enrolled in the program will be screened for depression prenatally and during the post-partum period. (Jan.-Dec. 2004)

4. Based on screening results, referrals will be made for further assessment and treatment to community agencies providing mental health services. (January-Dec. 2004)

5. Case management staff will monitor services provided to clients for depression to ensure needs are being met. (Jan.-Dec. 2004)

6. Case management staff will support the personal care plan established to address identified needs related to depression. (Jan.-Dec. 2004)

7. The client guide, “Kiss the Blues Goodbye” will be developed and distributed to clients in the program and community. (June 2004)

8. Family Road and partner agencies will conduct a training program on postpartum depression for community providers during the perinatal depression technical assistance visit (August 2004)
Family Road Healthy Start  
Project Number H49MC00107  
Grantee: Baton Rouge Healthy Start  
Intervention: Education

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
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</thead>
</table>
| 02 By 5/31/05 Outreach efforts are expected to make contact with a total of 2130 pregnant women of whom 1,917 is expected to attend an educational offering.  (Source: Healthy Start outreach program participation rosters) | Strategy:  
Provide educational programs to the target population on perinatal health. | There were a total of 2,724 women from the target population who participated in community educational programs sponsored by Healthy Start. |
| | Activities (with Implementation Timeframes):  
**2003**  
1. Family Road will continue to offer educational programs on having a healthy baby (nutrition, exercise, avoidance of risk behaviors) parenting, and pregnancy expectations. (Jan. – Dec. 2003) |  
Completed and ongoing. |
<p>| | 2. Outreach workers will continue to disseminate the Family Road calendar listing educational offerings. (Jan. – Dec. 2003) | Completed and ongoing. |
| | 3. Family Road will continue to disseminate to outreach workers, providers, community groups and sites frequented by women in the target population updated information about Healthy Start educational offerings. (Jan.- Dec. 2003) | Completed and ongoing. |
| | 4. Case Managers and outreach workers will help each pregnant woman to identify the programs of interest and value to her and encourage her attendance. (Jan.-Dec. 2003) | Completed and ongoing. |
| | 5. Family Road will offer educational programs at community sites in the project area. (Jan. – Dec. 2003) | Completed and ongoing. |</p>
<table>
<thead>
<tr>
<th>Year</th>
<th>Activity Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6. Educational programs will be evaluated by participants to identify areas to improve. (Jan. – Dec. 2003)</td>
<td>Completed and ongoing.</td>
</tr>
<tr>
<td></td>
<td>7. Family Road will survey the target population to determine educational topics of interest in order to modify the educational program as needed. (February 2003)</td>
<td>Completed and ongoing.</td>
</tr>
<tr>
<td>2004</td>
<td>2004                                                                ------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>Completed.</td>
</tr>
<tr>
<td></td>
<td>1. Family Road will continue to offer educational programs on having a healthy baby (nutrition, exercise, avoidance of risk behaviors) parenting, and pregnancy expectations. (Jan. – Dec. 2004)</td>
<td>Completed.</td>
</tr>
<tr>
<td></td>
<td>2. Outreach workers will continue to disseminate the Family Road calendar listing educational offerings. (Jan. – Dec. 2004)</td>
<td>Completed.</td>
</tr>
<tr>
<td></td>
<td>3. Family Road will continue to disseminate to outreach workers, providers, community groups and sites frequented by women in the target population updated information about Healthy Start educational offerings. (Jan.- Dec. 2004)</td>
<td>Completed.</td>
</tr>
<tr>
<td></td>
<td>4. Case Managers and outreach workers will help each pregnant woman to identify the programs of interest and value to her and encourage her attendance. (Jan.-Dec. 2004)</td>
<td>Completed.</td>
</tr>
<tr>
<td></td>
<td>5. Family Road will offer educational programs at community sites in the project area. (Jan. – Dec. 2004)</td>
<td>Completed.</td>
</tr>
</tbody>
</table>

There were a total of 3,132 women from the target population who participated in community educational programs sponsored by Healthy Start.
|   | 7. Family Road will survey the target population to determine educational topics of interest in order to modify the educational program as needed. (Jan.-Dec.2004) | Completed. |
Family Road Healthy Start  
Project Number H49MC00107

Grantee:  Baton Rouge Healthy Start  
Intervention:  Education

<table>
<thead>
<tr>
<th>Project Period Objective</th>
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<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>02  By 05/31/05  85% of members of the target population will report an increase in knowledge regarding risky behaviors such as smoking, substance abuse, family violence, lack of health care after an educational program. (Baseline: According to the Health Care Center in Schools Annual report for 2000-2001 school year the top risk factors were identified for students in grades 6-12 which included family/personal change, poor dietary habits, physical inactivity, tobacco use, gun at home, carried a weapon, physical</td>
<td></td>
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</tr>
<tr>
<td>Strategy: Provide educational programs and support services for the project area, including adolescents, focused on the impact of risky behaviors on physical, social and emotional health.</td>
<td></td>
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</tr>
<tr>
<td>Activities (with Implementation Timeframes):</td>
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</tr>
<tr>
<td>2003</td>
<td></td>
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</tr>
<tr>
<td>1. In conjunction with community organizations, provide three workshops in the project area on the topic of risky behavior reduction. (March, June, September 2003)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed.</td>
<td></td>
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</tr>
<tr>
<td>2. Conduct a media campaign targeting reduction of risky behaviors in the project area. (April 2003)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed and ongoing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Family Road in conjunction with community agencies will provide educational and support services focused on risky behavior reduction. (Jan. – Dec. 2003)</td>
<td></td>
<td></td>
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<tr>
<td>Completed and ongoing.</td>
<td></td>
<td></td>
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<tr>
<td>2004</td>
<td></td>
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</tr>
<tr>
<td>1. In conjunction with community organizations, provide workshops in the project area on the topic of risky behavior reduction. (Jan.-Dec. 2004)</td>
<td></td>
<td></td>
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<tr>
<td>Completed.</td>
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<tr>
<td>2. Continue to provide media messages targeting reduction of risky</td>
<td></td>
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<tr>
<td>Completed.</td>
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<tr>
<td>Activity</td>
<td>Completion Status</td>
<td></td>
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<tr>
<td>conflict, exposure to violence, risk of suicide/child abuse, alcohol/other drug use, and sexually active/unprotected sex. The range of the percentage of students reporting these risk factors was between 7% and 59% with an average of 25% reporting risk behaviors. Source: East Baton Rouge Health Care Centers in Schools Annual Report)</td>
<td>Completed.</td>
<td></td>
</tr>
<tr>
<td>behaviors in the project area. (June 2004)</td>
<td>Completed.</td>
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<tr>
<td>3. Family Road in conjunction with community agencies will provide educational and support services focused on risky behavior reduction. (Jan. – Dec. 2004)</td>
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<tr>
<td>4. With assistance from consortium members, plan and implement the technical assistance visit targeting violence prevention among families in the community. (June 2004)</td>
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</tbody>
</table>
Grantee: Baton Rouge Healthy Start  
Intervention: Case Management

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 By 05/31/05 the percentage of clients receiving HS funded health education and treatment in:</td>
<td>Strategy: Provide educational programs and support services for HS participants focused on the impact of risky behaviors such as smoking and substance abuse on physical, social and emotional health.</td>
<td>There were a total of 8 women who reported use of alcohol (3), tobacco (3), and illicit drugs (2) prenatally that were referred for services. Of these, 3 (38%) reported no use of substances in the postpartum period.</td>
</tr>
<tr>
<td>- Smoking Cessation</td>
<td>Activities (with Implementation Timeframes): <strong>2003</strong> 1. In conjunction with community organizations, provide three workshops in the project area on the topic of risky behavior reduction. (March, June, September 2003) 2. Conduct media campaign targeting reduction of risky behaviors. (April 2003) 3. Family Road will provide educational and support services focused on risky behavior reduction for Healthy Start clients. (Jan. – Dec. 2003) 4. Case Managers will conduct a risk assessment during the prenatal and postpartum period and annually thereafter to identify smoking and substance abuse risks. Educational services will be provided by the case</td>
<td>Technical assistance was provided on perinatal substance use in July 2003. Additional activities are being planned for 2004 to improve effectiveness of strategies.</td>
</tr>
<tr>
<td>- Substance Abuse</td>
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<tr>
<td>who self report lowered frequency or elimination of each risk behavior will be 75%.</td>
<td>(Baseline: According to 2002 Healthy Start program data, there were a total of 4 clients who were referred for smoking cessation and 6 clients referred for substance abuse counseling. Of the clients referred for</td>
<td>Completed and ongoing.</td>
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<td>Completed and ongoing.</td>
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<td>Completed and ongoing.</td>
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<td>Completed and ongoing.</td>
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</table>
smoking cessation, 1 (25%) received the service and reported reduction in use of tobacco in the postpartum period. Of the clients referred for substance abuse, 4 (67%) received counseling and reported no use of substances in the postpartum period. Source: HS program files.)

<table>
<thead>
<tr>
<th>2004</th>
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</thead>
<tbody>
<tr>
<td>1. In conjunction with community organizations, provide workshops in the project area on the topic of risky behavior reduction. (March, July, October 2004)</td>
</tr>
<tr>
<td>2. Continue to provide media messages targeting reduction of risky behaviors. (July 2004)</td>
</tr>
<tr>
<td>3. Family Road will provide educational and support services focused on risky behavior reduction for Healthy Start clients. (Jan. – Dec. 2004)</td>
</tr>
<tr>
<td>4. Case Managers will conduct a risk assessment during the prenatal and postpartum period and annually thereafter to identify smoking and substance abuse risks. Educational services will be provided by the case manager re: the harmful effects of smoking and substance abuse. Referrals will be made for further education and/or treatment as needed. (Jan. – Dec. 2004).</td>
</tr>
<tr>
<td>5. Conduct provider trainings on the use of the 4P’s plus screening tool for substance use during pregnancy and provide referral resources. (March 2004)</td>
</tr>
<tr>
<td>6. In collaboration with consortium members, a group of key stakeholders will be identified to attend the Leadership Institute at Children’s Research Triangle to develop a strategic plan addressing the perinatal substance abuse system of care in Baton Rouge. (August 2004)</td>
</tr>
</tbody>
</table>

There were a total of 8 women who reported the use of tobacco prenatally. Of these, 6 (75%) reported no use of tobacco in the postpartum period.

Completed.

Completed.

Completed.

Completed.

Completed.

Completed.
**Family Road Healthy Start**  
**Project Number H49MC00107**

**Grantee:** _Baton Rouge Healthy Start_  
**Intervention:** _Case Management_

<table>
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<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
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</thead>
</table>
| 02 By 5/31/05 the percentage of HS participants who receive interconceptional services will be 100%. (Baseline: Healthy Start Program data for 2002 shows that all 8 postpartum women received interconceptional services. Source: Healthy Start client case management files) | Strategy:  
All HS participants will be provided interconceptional services by a licensed health care provider and monitored through the HS case management service.  
Activities (with Implementation Timeframes):  
**2003**  
1. Family Road will hold workshops in conjunction with community organizations in the project area to focus on perinatal health topics including the importance of interconceptional care and availability of community resources. (Jan. – Dec. 2003)  
3. Expand publicity campaign including radio, television, billboard, etc. to increase awareness of the importance of interconceptional care. (May 2003)  
4. Provide transportation services to eliminate barriers to accessing care. (beginning Feb. 2003)  
5. Expand Family Road services to include a prenatal clinic which will provide interconceptional care to HS clients enrolled in the clinic. (June. 2003)  
6. Continue outreach and case management services to increase access to | All interconceptional clients have a provider for ongoing care. Based on referral logs there were a total of 109 referrals for interconceptional care services. Of these, 101 (93%) completed the referrals.  
Completed and ongoing.  
Completed and ongoing.  
Completed and ongoing.  
Completed and ongoing.  
Completed and ongoing. |
<table>
<thead>
<tr>
<th>Care, including interconceptional services for postpartum women. (Jan.-Dec. 2003)</th>
<th>All interconceptional clients have a provider for ongoing care. Based on referral logs there were a total of 75 referrals for interconceptional care services. Of these, 61 (81%) completed the referrals.</th>
</tr>
</thead>
</table>
| **2004**  
1. Family Road will continue to hold workshops in conjunction with consortium members to focus on perinatal health topics including the importance of interconceptional care and availability of community resources. (Jan. – Dec. 2004) | Completed. |
| 2. Continue to provide publicity campaign including radio, television, billboard, etc. to increase awareness of the importance of interconceptional care. (June 2004) | Completed. |
| 4. Continue to provide prenatal care services at the Family Road clinic which will provide interconceptional care to HS clients enrolled in the clinic. (Jan.-Dec. 2004) | Completed. |
| 5. Continue outreach and case management services to increase access to care, including interconceptional services. (ongoing) | Completed. |
Grantee: Baton Rouge Healthy Start
Intervention: Case Management

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
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</thead>
<tbody>
<tr>
<td>02 By 5/31/05 the percentage of completed referrals among case-managed:</td>
<td><strong>Strategy:</strong> Improve completed referrals through education and increased access to services.</td>
<td>Based on program participant referral logs, there were a total of 3,155 client/family referrals to resources in the community. Of these, 2,855 (90%) completed the referrals. There were 12 referrals for children to the early intervention children’s clinic. Of these, 12 (100%) completed the referrals. There was one child in the program that was born with a birth defect that required referral to a CSHCN clinic. This child receives ongoing services.</td>
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<tr>
<td>HS participants will increase to 80%.</td>
<td>Activities (with Implementation Timeframes):</td>
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<tr>
<td>HS infants with special health care needs will be at least 90%.</td>
<td><strong>2003</strong></td>
<td></td>
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<tr>
<td>(Baseline: Healthy Start Program data for 2002 shows that there were a total of 113 referrals. Of these, 47 (42%) case-managed HS participants completed the referrals. There were no infants identified with special health care needs requiring referral for 2002. Source: Healthy Start</td>
<td>1. Family Road will hold workshops in conjunction with community organizations in the project area to focus on perinatal health topics to increase awareness of available services and decrease barriers to care. (Jan. – Dec. 2003)</td>
<td>Completed.</td>
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<tr>
<td></td>
<td>2. Expand publicity campaign including radio, television, billboard, etc. to increase awareness of the importance of abstaining from alcohol and illegal drugs during pregnancy, addressing mental health issues and availability of community resources. (March 2003)</td>
<td>Completed.</td>
</tr>
<tr>
<td>Client Case Management Files</td>
<td>4. Expand Family Road services to include substance abuse and mental health counseling, and support groups. (Feb. 2003)</td>
<td>Completed.</td>
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<td></td>
<td>5. Continue outreach and case management services to increase access to care, including interconceptional services for postpartum women. (Jan.- Dec. 2003)</td>
<td>Completed.</td>
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</tbody>
</table>

**2004**

1. Family Road will continue to hold workshops in conjunction with community organizations in the project area to focus on perinatal health topics to increase awareness of available services and decrease barriers to care. (Jan. – Dec. 2004)

2. Continue publicity campaign including radio, television, billboard, etc. to increase awareness of the importance of abstaining from alcohol and illegal drugs during pregnancy, addressing mental health issues and availability of community resources. (June 2004)

Completed.

Based on program participant referral logs for 2004, there were a total of 3,245 client/family referrals to resources in the community. Of these, 2,581 (80%) completed the referrals. There were 11 referrals for children to the early intervention children’s clinic. Of these, 11 (100%) completed the referrals.

Completed.

Completed.
3. Provide transportation services to eliminate barriers to accessing care. (Jan.-Dec. 2004)

4. Continue to provide Family Road services to include substance abuse and mental health counseling, and support groups. (Jan.-Dec. 2004)

5. Continue outreach and case management services to increase access to care, including interconceptional services for postpartum women. (Jan.-Dec. 2004)


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<tr>
<th>Task</th>
<th>Status</th>
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<tbody>
<tr>
<td>Continue to provide Family Road services to include substance abuse and mental health counseling, and support groups. (Jan.-Dec. 2004)</td>
<td>Completed.</td>
</tr>
<tr>
<td>Continue outreach and case management services to increase access to care, including interconceptional services for postpartum women. (Jan.-Dec. 2004)</td>
<td>Completed.</td>
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</tbody>
</table>
### Project Period Objective

02 By 05/31/05 the percentage of consumers participating in the work of the Consortium PAC will increase to 90%.

(Baseline: During 2001, the consortium consisted of community agency representatives only. Source: The consortium roster and meeting sign-in sheets will be utilized to track the degree of consumer participation)

### Strategy and Activities

**Strategy:**
Provide an avenue for consumer involvement in the Healthy Start Program.

**Activities (with Implementation Timeframes):**

- **2003**

  1. The chair of the PAC will invite interested consumers to take part in the Healthy Start program as a member of the Consortium subcommittee overseeing the Healthy Start program, Project Area Committee. (Jan. 2003)

  2. Consumers will be invited to participate in a consumer subcommittee of the Project Area Committee. (Jan. 2003)

### Accomplishments

Consumer meetings were held in conjunction with monthly “Mommy Hour” and “Dad’s Day Out” sessions to gain input into the program. Survey information was tabulated and shared with the Project Area Committee and Healthy Start staff. There are 3 consumers who attend the Project Area Committee and Consortium meetings on a regular basis. Transportation, childcare, and other incentives were provided free of charge to consumers for the meetings. Consumer participation is 61% based on the data elements in performance measure #7. Consumers attended a “Breakfast with the Board” event, a legislators meeting, and educational workshops.

Completed.

Completed.
### 2004

1. The chair of the PAC will continue to invite interested consumers to take part in the Healthy Start program as a member of the Consortium subcommittee overseeing the Healthy Start program, Project Area Committee. (Jan.-Dec. 2004)

2. Consumers will continue to be invited to participate in all Healthy Start events. (Monthly Jan. – Dec. 2004)

3. Interested consumers will be invited to attend Consortium meetings to assist in policy and program decision-making. (Feb. 2003)

4. Consumers will be provided incentives for their active participation in the PAC and Healthy Start activities. (Beginning Feb. 2003)

5. All consortium members including consumers will be invited to participate in Healthy Start sponsored community activities

---

**Completed.**

**Completed.**

**Completed.**

**Completed.**

Consumer meetings were held in conjunction with monthly “Mommy Hour” and “Dad’s Day Out” sessions to gain input into the program. Survey information was tabulated and shared with the Project Area Committee and Healthy Start staff. There are 8 consumers who attend the Project Area Committee and Consortium meetings on a regular basis. Transportation, childcare, and other incentives were provided free of charge to consumers for the meetings.

**Completed.**

**Completed.**

**Completed.**
<table>
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<tr>
<th>Task Description</th>
<th>Status</th>
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<tbody>
<tr>
<td>Family Road Healthy Start Project Number H49MC00107</td>
<td></td>
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<tr>
<td>assist in policy and program decision-making. (Jan. – Dec. 2004)</td>
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<tr>
<td>4. Consumers will be provided incentives for their active participation in the PAC and Healthy Start activities. (Jan.-Dec. 2004)</td>
<td>Completed.</td>
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</tbody>
</table>
Family Road Healthy Start  
Project Number H49MC00107  

Grantee: Baton Rouge Healthy Start  
Intervention: Birth Outcomes  

<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
</tr>
</thead>
</table>
| 02 By 05/31/05, for women receiving prenatal Healthy Start services, decrease the percentage of: | **Strategy:**  
Provide outreach, case management, and education services to clients enrolled in the program to improve birth outcomes.  

**Activities (with Implementation Timeframes):**  
**2003**  
1. Provide outreach, case management, and education services to clients enrolled in the program as described in previous objectives. (Jan. – Dec. 2003)  
2. Collect and analyze data on birth outcomes of clients enrolled in the program along with program services data to determine areas for improvement. (monthly data collection as births occur in the program 2003) | According to client birth records, there were 110 births. Of these, 13 (11.8%) were low birth weight, 3 (2.7%) were very low birth weight and 14 (12.7%) were preterm infants. There were 2 sets of twins born which may have contributed to an elevation of the low birth weight rate. Completed. Completed.  

(Baseline: Three year average 1996-1998 statistics for the project area show the rates as follows:  
Low birth weight infants – 13.8%  
Very low birth weight infants – 3.5%) |  

According to client birth records, there were 74 infants born to clients enrolled in the program in 2004. Of the infants, 91% had a birth weight of greater than 2500 grams. Monthly database downloads were conducted to determine the birth outcomes each month. |
| Preterm births – 24.1% Source: State vital statistics | 2004  
1. Provide outreach, case management, and education services to clients enrolled in the program as described in previous objectives. (Jan. – Dec. 2004)  
2. Collect and analyze data on birth outcomes of clients enrolled in the program along with program services data to determine areas for improvement. (monthly data collection as births occur in the program 2004) | Completed. | Completed. |
<table>
<thead>
<tr>
<th>Project Period Objective</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
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</thead>
<tbody>
<tr>
<td>02 By 05/31/05 reduce the number of babies born to teens 18 years and younger over the project period by 149; percentage of teen births in the target population will decrease from 18% of live births to no greater than 14%. (Baseline: The number of births to teens 18 years and younger at the inception of the project is 283, 18% of the total live births, based upon three year average 1996-98. Source: OPH vital statistics)</td>
<td>Strategy: Provide educational programs for adolescents focused on prevention of unwanted pregnancy. Activities (with Implementation Timeframes): <strong>2002</strong> 1. Create a pregnancy prevention program including messages specific to adolescents in the target population. (May 2002) 2. Include in outreach training specific information on identifying pregnant adolescents and linking them to services; recruit Neighborhood Support Network Team members who work with teens. (May 2002) 3. Family Road, Teen Advocacy Program and other partner agencies will disseminate information to parents in the target population on talking to adolescents about pregnancy prevention. (May 2002) 4. Teen Advocacy Program and Family Road will collaborate to provide two training programs for counselors and youth leaders in the project area to enlist their efforts in educating young people about pregnancy prevention. (June 2002)</td>
<td>For the period July 15-December 31, 2002, a total of 4,222 adolescents received educational programs focused on pregnancy prevention through Family Road classes and affiliated organizations. A total of 1,209 participants attended youth empowerment programs and 4,413 youth participated in adolescent health services to promote health and well-being. Completed. Completed. Completed. Completed.</td>
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<td>5.</td>
<td>Develop a program of youth leadership to serve as mentors and counselors to teens deemed most at risk of becoming pregnant. (July 2002)</td>
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<td>Completed.</td>
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<td>6.</td>
<td>Identify characteristics of youth in the project area most likely to become pregnant and formulate a plan to target these youth in pregnancy prevention efforts. (October 2002)</td>
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<td></td>
<td>Completed.</td>
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</table>
Grantee: Baton Rouge Healthy Start  
Intervention: Case Management

<table>
<thead>
<tr>
<th>Project Period Objective</th>
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<th>Accomplishments</th>
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</table>
| 02 by 5/31/05 65% of the children in the Healthy Start project will be linked to a medical home. (Baseline: The annual baseline will be the number of babies born each year to Medicaid eligible women. Source: OPH vital statistics) | Strategy: Provide referrals to medical providers for all children born to women in the program. Activities (with Implementation Timeframes):  
**2002**  
1. The project staff will identify all potential medical homes available to women in the target population. (April 2002)  
2. Case managers will consult with each client and assist her to make the necessary arrangements to insure that her child has a medical home by the time of delivery. (ongoing)  
3. Case managers will follow up to insure that the infant continues to receive medical care at the medical home. (ongoing)  
4. Outreach workers will follow up with pregnant women not receiving case management services to assist them in locating a medical home. (ongoing)  
5. Family Road will implement procedures for learning of births to women in the project area. They will arrange for an outreach worker to contact the mother to insure that, if Medicaid eligible, the child has a medical home. (May 2002) | During the period July 15-December 31, 2002, there were a total of 10 births. All children (100%) have a medical provider. The Community Care Program initiative in conjunction with the Children’s Health Insurance program in Louisiana has been implemented to assign all newborn babies a medical provider.  
Completed.  
Completed.  
Completed.  
Completed.  
Completed. |
Appendix B

Local Evaluation Attachments
Evaluation - Attachment A - Spatial Filter Analysis I
Evaluation - Attachment B - Spatial Filter Analysis II
### Evaluation - Attachment C - Infant Mortality Table I

<table>
<thead>
<tr>
<th>Year</th>
<th>Cat</th>
<th>Risk</th>
<th>Birth</th>
<th>Death</th>
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<th>u&lt;sub&gt;18&lt;/sub&gt;</th>
<th>u&lt;sub&gt;1500&lt;/sub&gt;-u&lt;sub&gt;2500&lt;/sub&gt;</th>
<th>#Prep</th>
<th>Opren</th>
<th>Mpre</th>
<th>u32</th>
<th>u36</th>
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</tbody>
</table>

**Risk Neighborhoods are Defined As:**

- **A:** Stable High IMR, Stable High Risks
- **B:** Unstable IMR, Stable High Risks
- **C:** Unstable IMR, Unstable High Risks
- **D:** Stable High IMR, Unstable High Risks
- **E:** Low / No IMR, Stable High Risks
- **F:** High IMR, No / Little High Risks
Difference of Proportions Test

Using health care centers as the neighborhood center
Evaluation - Attachment E - Difference of Proportions Table

Some neighborhoods have much higher infant mortality rates....

<table>
<thead>
<tr>
<th>Neighborhood X</th>
<th>1.1 by 1.28 miles (1.41 square miles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births</td>
<td>Deaths</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>57</td>
<td>4</td>
</tr>
<tr>
<td>63</td>
<td>4</td>
</tr>
<tr>
<td>69</td>
<td>3</td>
</tr>
</tbody>
</table>
Evaluation - Attachment F - Analysis of Birth and Death Certificate

No Births

19 3 vlbwt

17 1 vlbwt

22 2 Deaths 2 vlbwt
A Data Sheet With Referral
Family Road Healthy Start
Project Number H49MC00107

Evaluation - Attachment H - Data Sheet II

Image of a computer screen showing various windows:
- Immunizations Summary
- Infant Record (Discipline)
- Family Database Directions
Evaluation - Attachment J - Stressors Impact Low Birth Weight
Evaluation - Attachment K - Safety Fears

Program participants with fears for safety

19 out of 26 HS PP

High-risk area

Homicides at above 3SD

Property built Before 1950

8.5 miles

Neighborhood X
Evaluation - Attachment L - Stress During Pregnancy
Evaluation - Attachment M - Neighborhood Complexity
Evaluation - Attachment N - Smokers
Did either of your parents have any problem with drugs or alcohol?

Is your partner’s temper ever a problem for you?
Program Participants who are the heads of their households, and had a Child

- Head of Household & With a Child Under 4
- And No Transportation
Evaluation - Attachment Q - Percentage of Deaths

211 deaths between 1996 and 1998

45 had different Addresses from Birth to Death Certificate

Death Residence Birth Residence

Which is the correct one to use?

Address on Birth Certificate
Address on Death Certificate
### Evaluation - Attachment R - Program Participant Moves and Distance

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Program Participants</td>
<td>320</td>
<td></td>
</tr>
<tr>
<td>Total making &quot;2&quot; moves</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Total making &quot;3&quot; moves</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Total making &quot;4&quot; moves</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Total making &quot;5&quot; moves</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total making moves</td>
<td>73</td>
<td>23%</td>
</tr>
<tr>
<td>Total having birth</td>
<td>157</td>
<td></td>
</tr>
<tr>
<td>Total making moves</td>
<td>53</td>
<td>34%</td>
</tr>
<tr>
<td>....before the birth</td>
<td>30</td>
<td>19%</td>
</tr>
</tbody>
</table>

12 moves were less than 1 mile
16 moves were between 1 and 2 miles

Spatial distribution of 1st and 2nd addresses

Can this vary spatial analysis results?
## Evaluation - Attachment S - GEO Map

<table>
<thead>
<tr>
<th>Information</th>
<th>Census tract boundaries as base map information</th>
<th>Street network as base map information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original, geographically unmasked point pattern</td>
<td><img src="image1.png" alt="Image" /></td>
<td><img src="image2.png" alt="Image" /></td>
</tr>
<tr>
<td>Geographically masked by flipping point locations about the vertical central axis of the map</td>
<td><img src="image3.png" alt="Image" /></td>
<td><img src="image4.png" alt="Image" /></td>
</tr>
</tbody>
</table>
Evaluation/Attachment T: Confidentiality
Appendix C

Products Summary
Family Road Healthy Start
Project Number H49MC00107

Products

Summary of Documents

**Healthy Start Program Materials**
- Healthy Start Program Brochure
- Healthy Start Initial Survey
- Healthy Start Pregnancy Survey
- Healthy Start Program Information Card
- Healthy Start Program Flier
- Healthy Start Monthly Health Observances
- Healthy Start Client Satisfaction Survey
- Healthy Start Staff Development Schedule
- Healthy Start - “Kiss the Blues Goodbye” booklet
- Healthy Start – FIMR Letter
- Healthy Start - Family Day Extravaganza Flier- 2002
- Healthy Start – Family Fun Day - 2004
- Healthy Start – Halloween Party Flier
- Healthy Start – Thanksgiving Invitation 2002
- Healthy Start – “Turkey Fry” Flier 2003
- Healthy Start – Christmas Open House 2003
- Healthy Start – Focus Group Flier (Prenatal Care)
- Healthy Start – Focus Group Flier (SIDS)
- Healthy Start – Focus Group Flier (Couples)
- Healthy Start – Dad’s Day Out Flier
- Healthy Start – Child Wellness Fair Flier
- Healthy Start – Mommy Hour Invitations
- Healthy Start - Project Area Committee Flier
- Family Road Healthy Start – “Quenching the Father’s Thirst” Flier
- Family Road Healthy Start - Counseling Flier
- Family Road Prenatal Clinic Flier
- Healthy Start - Breastfeeding Flier

**Documents Referenced in Program Accomplishments**
- Office of Public Health – LINKS letter – Immunizations
- Healthy Start Incentive Schedule

**Co-Sponsored Events**
- Prenatal Exposure to Drugs/Alcohol/Tobacco and Perinatal Outcome by Ira Chasnoff, M.D. Flier - July 2003
- Drug Use During Pregnancy: Mother and Child by Ira Chasnoff, M.D. Flier – March 2004
- Domestic Violence as a Perinatal Health Issue by Rebecca Rae Whiteman Flier – June 2004
- Perinatal Depression by Michael O’Hara, Ph.D. Flier – September 2004
Family Road Healthy Start
Project Number H49MC00107

**Media**
Billboard Advertisements (Pregnant)
Bus Shelter Advertisements (Prenatal Care)
Billboard Advertisements
Billboard Advertisements (Prenatal Care)
Billboard Advertisements (Prenatal Care)
Bus Shelter Advertisements (Pregnant)
Radio Advertisement Script - General Information
Radio Advertisement Script- Man to Woman
Radio Advertisement Script - Man to Man
Radio Advertisement Script – Woman to Woman
Appendix D

Project Data Forms