A REPORT
TO THE
ARIZONA LEGISLATURE

Performance Audit Division

Performance Audit

Department of Health Services

Health Start Program

December • 2002
REPORT NO. 02 – 11

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Debra K. Davenport
Auditor General

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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
AUDITOR GENERAL

WILLIAM THOMSON
DEPUTY AUDITOR GENERAL

December 23, 2002

Members of the Arizona Legislature

The Honorable Jane Dee Hull, Governor

Ms. Catherine R. Eden, Ph.D., Director
Department of Health Services

Transmitted herewith is a report of the Auditor General, An Evaluation of the Health Start program. This evaluation was conducted pursuant to A.R.S. §41-1279.08. I am also transmitting with this report a copy of the Report Highlights for this evaluation to provide a quick summary for your convenience.

As outlined in its response, the Department of Health Services agrees with all of the findings and plans to implement all of the recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on December 24, 2002.

Sincerely,

Debbie Davenport
Auditor General

Enclosure

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SUMMARY

The Office of the Auditor General has completed an evaluation of the Health Start Program. The evaluation was conducted pursuant to the provisions of A.R.S. §41-1279.08. This is the Auditor General's fourth evaluation of the Health Start Program.[1] This report includes information about the program and its statutory goals, recommendations for improving its administration, and demographic information on program participants.

Health Start is a community-based program that delivers health education and referral services to pregnant and postpartum women and their families in communities at risk for poor birth outcomes. Health Start is designed to increase the number of women who receive timely and adequate prenatal care and to promote primary healthcare for families. The program is required by statute to reduce the incidence of babies born with a very low birth weight, improve early childhood health, and increase awareness of the need for good nutrition, child developmental assessments, and preventive healthcare.

The program is administered by the Arizona Department of Health Services, Office of Women's and Children's Health, and is offered at 24 sites around the State through 15 contracted service providers. The Health Start program uses lay health workers to provide services. Health Start providers recruit lay health workers from within the community and trains them to provide education, support, and referrals to pregnant and postpartum women and their families. The lay health worker visits participants in their homes, and participants have the opportunity to attend prescheduled group classes.

Legislation outlines several areas the evaluation is required to assess, including the program's effectiveness in meeting its goals, the level and scope of services, and various characteristics of program participants. However, evaluators were unable to assess the program's effectiveness and can provide only limited information on some program participants because of inaccurate and incomplete program data.

1 Three previous evaluations were conducted on the Health Start pilot program in 1996 (Report No. 96-2), 1997 (Report No. 97-1), and 1998 (Report No. 98-3), and Laws 2002, Chapter 245 eliminated the evaluation requirement for the Health Start Program after December 31, 2002.

Information on program goals (see pages 9 through 13)

Health Start has five statutory goals related to healthcare for women and children. Although evaluators could not draw conclusions about the program's progress in achieving its goals because of incomplete data, where possible, evaluators used program data and supplemented it with vital statistics records to develop information on the program.

The program's first statutory goal is to reduce the incidence of infants who are born with a very low birth weight (less than 3 lbs., 5 oz.) and who require more than 72 hours in a neonatal intensive care unit (NICU). Using vital statistics records for program participants for whom data was available, evaluators found that in 2000 and 2001, the very low birth weight rate was about 1 percent. Specifically, 2 of 327 participants in 2000 and 8 of 680 participants in 2001 delivered babies who weighed less than 3 lbs., 5 oz. The state-wide rate for babies born at a very low weight was 1.2 percent in 2000 and 1.1 percent in 2001. However, because the program is focused on serving women at risk of poor birth outcomes, program participants may have different characteristics than the general population. Therefore, the program's progress toward reducing very low birth weight or other goals cannot be directly measured against the general population. Instead, measuring the program's impact would require a comparison group of individuals with characteristics similar to the program participants, and program data was not reliable enough to allow the formation of a comparison group. Evaluators also used vital statistics reports to establish that, for program participants for whom data was available, infant admission rates to the NICU were 6 percent in 2000 and 4 percent in 2001. State-wide, 5.8 percent of babies born in 2000 and 5.7 percent of babies born in 2001 were admitted to the NICU. However, because the vital statistics records do not include information about the length of stay in the NICU, evaluators could not provide information on this part of the goal. The Department did not develop a process for collecting NICU information until July 2002.

Some information is also available about the program's other statutory goals. Other goal areas include increasing the number of women receiving prenatal care, and the number of children appropriately immunized, as well as educating families on good healthcare and nutrition. For program participants for whom data was available, over 60 percent entered prenatal care in the first trimester. For the program participants for whom data was available, 74 percent reported that their children were appropriately immunized. In 2001, Arizona's state-wide immunization rate was 78 percent.

Program administration needs improvement (see pages 15 through 18)

The Department needs to make several improvements to help ensure the program is effectively administered. First, the Department needs to ensure that the program's limited resources are used for those women most in need of services. Evaluators found that providers are not using the required risk assessment tool to determine each registered client's risk level. However, providers need more guidance on how to do this, such as how to weigh the risk factors in terms of importance or their impact on eligibility. Second, the Department should more effectively monitor sites. The Department did not conduct 4 of the 15 required annual site visits in 2002. Further, the Department needs to develop a process for reviewing the quality of providers' program data during its site visits. Finally, the Department needs to strengthen current policies and procedures, or develop additional ones, to ensure contracted service providers understand how to correctly implement the program. Areas that need improved policies and procedures include postpartum enrollment, data quality and entry, and in-kind contribution reporting.

Information on program participants and services (see pages 19 through 23)

By statute, this evaluation must report information on program enrollment and disenrollment, demographic information on program participants, and information on the level and scope of program services. Because evaluators were unable to obtain reliable data for all program sites, the numbers presented in this chapter are based on those participants for whom data was available.

Data was available for over 3,300 women who registered for possible inclusion in Health Start in 2000 and 2001. Over 2,100 of these women eventually enrolled in the program. Most of the women who registered but did not enroll were not pregnant and thus not eligible to participate in the program. Of those women who enrolled, the overwhelming majority did so before they gave birth. In addition, most were relatively young, Hispanic, unmarried, and enrolled in or applying for AHCCCS.

Health Start policies require that participants receive an average of five prenatal and seven family follow-up home visits from lay health workers. Data on the number of visits was not reliable and therefore it was not possible to determine how well the program was doing in meeting the required number of visits. However, during home visits, lay health workers discuss educational topics with participants. Some of the most common topics discussed include immunizations, emotions and feelings, and prenatal care. Lay health workers are also required to assess each participant's

home for safety hazards and evaluate each child enrolled in the program for developmental delays. The program uses the Arizona Safe Home/Safe Child Assessment checklist and the Ages and Stages Questionnaire to conduct these assessments. When participants have needs outside the scope of Health Start, lay health workers refer them to other pertinent programs, such as AHCCCS.

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INTRODUCTION & BACKGROUND

The Office of the Auditor General has completed an evaluation of the Health Start Program administered by the Arizona Department of Health Services. The evaluation was conducted pursuant to the provisions of A.R.S. §41-1279.08. This is the fourth Auditor General evaluation of the Health Start Program.[1] This report includes information about the program and its statutory goals, recommendations for improving its administration, and demographic information on program participants.

Program description

The Legislature established Health Start as a state pilot program in 1994. Health Start is a community-based program that serves primarily pregnant women and their families by providing participants with health educational materials and classes, and referrals to healthcare providers and other community or governmental services. Health Start is designed to increase the number of women who receive timely and adequate prenatal care and to promote primary healthcare for families in order to reduce the incidence of babies born at a very low birth weight, improve early childhood health, and increase awareness of the need for good nutrition, developmental assessments, and preventive healthcare.

The program is designed to increase the number of women receiving appropriate prenatal care.

The program is administered by the Arizona Department of Health Services, Office of Women's and Children's Health, and is offered at 24 sites around the State through 15 contracted service providers (see Table 1, page 2). The Health Start program uses lay health workers to provide services to communities considered high risk for poor birth outcomes, such as those with a high rate of babies born at a very low birth weight. Health Start providers recruit lay health workers from within the community and train them to provide education, support, and referrals to pregnant and postpartum women and their families. The lay health worker visits participants in their homes, and participants have the opportunity to attend prescheduled group classes. The lay health worker also works with the contractor's program coordinator, a nurse, and a social worker to ensure that participants receive needed care and services.

The program uses lay health workers to provide services.

[1] Three previous evaluations were conducted on the Health Start pilot program in 1996 (Report No. 96-2), 1997 (Report No. 97-1), and 1998 (Report No. 98-3), and Laws 2002, Chapter 245 eliminated the evaluation requirement for the Health Start Program after December 31, 2002.

Table 1 Schedule of Providers, Service Areas, and Amounts Distributed
Years Ended June 30, 2000, 2001, and 2002
(Unaudited)

Provider	Service Area	Amounts Distributed 2000	2001	2002
County Health Departments				
Apache	Round Valley, St. Johns, Springerville, and the Apache reservation		$ 60,000	$ 60,032
Cochise	Douglas, Sierra Vista, Bisbee, and Willcox		70,000	71,997
Coconino	Page and surrounding areas, and the Navajo reservation	$ 21,350	51,725	51,875
Gila	Globe and surrounding areas		9,270	28,865
Mohave	Kingman, Bullhead City, and Lake Havasu		34,395	55,940
Pima	Tucson, Green Valley, and surrounding rural areas	30,820	100,000	89,438
Pinal	Coolidge, Eloy, Stanfield, and Gila Bend		67,000	66,369
Yavapai	Prescott, Chino Valley, Prescott Valley, and Cottonwood	130,930	170,000	115,720
Yuma	Yuma, Sommerton, San Luis, and Wellton	85,273	110,000	97,729
Community Health Centers/ Behavioral Health Centers				
Centro de Amistad, Inc.	Guadalupe	69,640	101,925	87,625
Clinica Adelante, Inc.	El Mirage and Surprise	25,700	47,325	53,025
Mariposa Community Health Center	Nogales, Elgin, and Patagonia	80,683	115,000	85,000
Mountain Park Community Health Center	South Phoenix	34,110		
Native American Community Health Center	Phoenix-area Native Americans		44,286	53,175
North Country Community Health Center	Flagstaff, Leupp, and the Navajo reservation		79,088	84,455
Tempe Community Action Agency, Inc.	Tempe and South Scottsdale		82,050	80,000
Total		$478,506	$1,142,064	$1,081,245

Source: Auditor General staff analysis of information provided by the Arizona Department of Health Services and Health Start staff.

During the first meeting with a woman, the lay health worker finds out whether the woman is pregnant. If she is pregnant, the lay health worker screens the woman for risk factors for poor birth outcomes, such as high blood pressure, smoking, homelessness, previous low-weight birth, and previous miscarriage. Though the program primarily targets pregnant women and their families for enrollment, women are eligible to enroll during the postpartum period as well. Reasons given by the program manager for postpartum enrollment include poor maternal or infant health. Participants may continue in the program until their child is 2 years old.

Previous evaluation and program changes

Various aspects of the Health Start program have changed since the previous evaluation. The most recent evaluation of Health Start (Report No. 98-3) indicated that the program appeared to be meeting its goals regarding prenatal care and babies born at a low birth weight, but some birth outcomes showed no improvement. For example, the rate of babies born at a low birth weight for participants was lower than for a comparison group of mothers and infants not participating in the program (4.8 percent compared with 6.3 percent). However, participants' babies were placed in the NICU at rates similar to the comparison group. Therefore, the evaluation recommended that, in addition to low birth weight, the Legislature consider using other birth outcomes, such as a reduced need for care provided in neonatal intensive care units, to measure the program's success. The evaluation also included several recommendations to improve the program's cost-effectiveness, including reducing the family follow-up period to 2 years or less; allowing services to be provided through group classes, as well as home visits; and requiring all providers to meet their obligation to provide participants with an average of five prenatal visits or be eliminated from subsequent contracts.

Following that evaluation in 1999, the Legislature authorized Health Start as a permanent program and made several changes to the program. Statutory goals now require the program to reduce the incidence of babies born with a very low birth rate (under 3 lbs., 5 oz.,) and needing more than 72 hours in a NICU instead of requiring the program to reduce the incidence of babies born with a low birth weight (under 5 lbs., 8 oz.). Other changes include reducing the length of time a participant may continue in the program during family followup from 4 years after the child's birth to 2 years, allowing postpartum enrollment and offering prescheduled group education classes.

In 1999, the Legislature authorized Health Start as a permanent program.

Appropriations and contracted service providers

The Health Start Program's revenue source has shifted from the State's General Fund to the Tobacco Litigation Settlement Fund. Specifically, the program received $700,000 and $1.2 million from the State's General Fund during fiscal years 2000 and 2001, respectively. However, in fiscal year 2002, the program received $1.2 million from the Tobacco Litigation Settlement Fund, in accordance with Proposition 204. [1]

The Department is allocated three full-time employee positions to administer and oversee the program and currently has two positions filled. Health Start provides services through various contracted service providers, which include county health departments and community health centers (see Table 1, page 2). In fiscal year 2000, the Department had eight providers located in six counties. For fiscal years 2001 and 2002, the Department expanded to 15 providers operating in 12 counties. Providers are paid for services such as registering a participant in the program, providing prenatal home visits, or conducting group educational classes. Providers bill the Department on a monthly basis for these services based on fees determined at the time the contract is established. As shown in Table 1 (see page 2), $500,936 was distributed to Health Start providers in fiscal year 2000; $1,142,558 in fiscal year 2001; and $1,065,779 in fiscal year 2002.

Fifteen contracted service providers, including county health departments, provide services in 12 of Arizona's 15 counties.

Additionally, the Department currently contracts with Scientific Technologies, Inc. to provide computer program development and maintenance services for the Health Start client database. In fiscal year 2000, the Department contracted with Diversified Consulting Services to provide a database dictionary, reports, and training for the Health Start database, and in fiscal year 2001, the Department contracted with Community Resource Associates to plan program-wide trainings and meetings such as the annual coordinators' meeting.

Evaluation scope and limitation

Evaluators are unable to report fully on the statutorily required evaluation components. Problems with the accuracy and completeness of information in the Health Start database limited evaluators' ability to assess and provide information on each of the statutory components.

Evaluation scope is set by statute—A.R.S. §41-1279.08 B and C require the evaluation to examine and report on several items, including the program's effectiveness, the level and scope of services, the criteria used to establish eligibility, and the number and demographic characteristics of program participants. In addition, the evaluation must provide information on program costs, including the

[1] Originally the fiscal year 2002 program revenues included a $1.2 million appropriation from the General Fund and $2.2 million from the Tobacco Litigation Settlement Fund. However, the December 2001 budget reconciliation act eliminated the General Fund appropriation. In addition, because of budget constraints and no further expected Proposition 204 allocations, the Department chose to restrict the program's funding level to $1.2 million annually through fiscal year 2004.

average cost per participant and revenues and expenditures. For this report, evaluators focused on obtaining information primarily for calendar years 2000 and 2001.

Problems with data affected all areas of the assessment—Data quality problems limited evaluators' ability to assess and provide information on each statutorily required area. Evaluators received a download of the Department's database and compared the information in this download to information in client files and vital statistics records. Evaluators found problems with both the accuracy and completeness of the database information. For example, several of the fields were determined to be inaccurate because database records and file records did not match, or unreliable because no file records existed to confirm the accuracy of the database records. Data completeness problems included information in file records but not in the database and records in the database that had no identifying client information, such as a name or date of birth, to allow evaluators to determine whether the records were valid. Additionally, at Yavapai County Health Department, data problems were so extensive—including women being matched to babies they did not give birth to—that the entire data set had to be excluded.

Evaluators were able to assess and report on each of the required statutory areas to the following degree:

- **Information on the number and characteristics of program participants—** Information on the characteristics of all program participants cannot be provided because one site's data had to be excluded, and the records of approximately 300 other participants had to be eliminated due to missing identifying information. Therefore, this evaluation provides information for only those participants for whom complete data exists in calendar years 2000 and 2001 (see Finding 3, pages 19 through 23).

- **Information on contractors and program service providers and revenues and expenditures**—Information on contractors and revenues and expenditures can be provided because there are other data sources for this information (see Introduction and Background, pages 1 through 8).

- **Information on the number and characteristics of enrollment and disenrollment and information from participants on the reasons for each**—For the reasons already explained, this evaluation provides information for only those participants for whom complete data exists in calendar years 2000 and 2001 (see Finding 3, pages 19 through 23).

- **Information on the average cost for each participant in the program**—This amount cannot be determined because the incompleteness of the database could potentially inflate the cost per participant.

- **Information concerning the progress of program participants in achieving goals and objectives**—Conclusions cannot be drawn about the program's success in achieving its goals because the data is not complete, and some fields are not accurate enough to use. Problems with completeness prevented evaluators from developing a similar nonparticipant group with which participants' outcomes could be compared. Therefore, the prenatal care and birth outcomes are reported for only those participants for whom vital statistics data exists in calendar years 2000 and 2001. Immunizations and awareness of the need for good nutrition, developmental assessments, and preventive healthcare are reported using the available program data (see Finding 1, pages 9 through 13).

- **Information on any long-term savings associated with the program**—A dollar estimate of the program's long-term savings cannot be provided, but the Department has made some changes that were intended to increase the program's cost-effectiveness. To estimate any savings, as was done in the Auditor General's 1998 evaluation, complete information on program expenditures as well as the participants and services received is needed. While adequate information on program expenditures exists, information on participants and the number of prenatal and family followup visits is incomplete and unreliable.

  However, as recommended in the 1998 evaluation, the Department has made changes that were intended to increase the program's cost-effectiveness. Specifically, changes include offering group education classes and reducing the family follow-up period from 4 to 2 years. In addition, the program has made the family follow-up period more focused by scheduling visits when immunizations are due and developmental assessments should be completed.

- **Recommendations regarding program administration and informational materials distributed through the program**—Evaluators provide program administration recommendations (see Finding 2, pages 15 through 18) and one recommendation regarding information materials (see Finding 3, pages 19 through 23).

This report presents findings and recommendations in the following areas:

- The Department needs to collect complete and reliable data on and report its progress in meeting its five statutory goals.

- The Department should use its risk assessment tool to determine program eligibility, improve its monitoring efforts, and enhance its policies and procedures for such areas as postpartum enrollment.

- Demographic and enrollment information on program participants for whom data exists, and the need to require providers to use the *Arizona Family Resource Guide* or seek Department approval for substitute guides.

Methods

Evaluators used a variety of methods to conduct this review, including developing data from other sources that would shed light on the program's participants and the degree to which the program's goals were met. The methods used included the following:

- To obtain general information about the program, evaluators reviewed Arizona Revised Statutes; literature on research and programs aimed at improving birth outcomes for at-risk populations, and program materials, such as Health Start policy and procedure manuals.

- To determine the number and demographic characteristics of program participants and the number and characteristics of participants who enroll and disenroll from the program and reasons for each, evaluators analyzed Health Start program data, collected from January 2000 through December 2001, for the participants for whom reliable data was available.

- To determine birth outcomes of women enrolled in the Health Start program for whom data was available, evaluators analyzed Arizona vital statistics data collected from January 1, 2000, through December 31, 2001. In addition, this information was used to validate the completeness and accuracy of the Health Start database (see Scope Limitation, pages 4 through 7).

- To determine the unique aspects of each site's provision of Health Start services, such as the characteristics of the families served, the types of services provided, and special needs of families not served but targeted in outreach services, and to determine whether Health Start administrative procedures were carried out as contracted, evaluators reviewed contract documents, conducted site visits, and interviewed program coordinators and lay health care workers. Evaluators conducted site visits and interviews with contractor staff at 14 of the 15 sites. The Mohave County Health Department was not visited because the program coordinator's position was vacant during the period when site visits were conducted.

- To evaluate the effectiveness of program administration and monitoring, evaluators interviewed Department staff and reviewed key documents. Documents included contract documents such as the solicitation of proposals and contract awards; program administration documents such as annual site

review evaluations and end-of-year performance summaries; and billing and service monitoring documents.

Acknowledgements

The Auditor General and staff express appreciation to the director and staff of the Department of Health Services and the Health Start Program for their cooperation and assistance during this evaluation.

FINDING 1

Information on program goals

Evaluators could not draw conclusions about Health Start's progress in achieving its five statutory goals because data on program participants was inaccurate and incomplete. However, where possible, evaluators used program data and vital statistics records to develop information about the program.

Program has five statutory goals

Health Start has five statutory goals related to healthcare for women and children. These goals are in keeping with research that suggests a link between low birth weight, infant mortality, developmental problems, and other childhood difficulties.[1] In addition, research shows that babies who are born with very low birth weight—less than 3 lbs., 5 oz.—have more severe health problems and developmental delays. The program's statutory goals address these links by focusing on the following results:

Babies born with very low birth weight can experience severe health problems and developmental delays.

- Reducing the incidence of infants who are born with a very low birth weight (less than 3 lbs., 5 oz.), and who require more than 72 hours in a NICU,
- Increasing prenatal care services to women;
- Reducing the incidence of children affected by childhood diseases;
- Increasing the number of children receiving age-appropriate immunizations by age 2; and
- Increasing awareness by educating families on the importance of good nutritional habits, developmental assessments, and preventive health care.

1 Research on low birth weight and very low birth weight referenced in this chapter includes: Iyasu, S., Tomashek, K., and Barfield, W. "Infant Mortality and Low Birth Weight Among Black and White Infants—United States, 1980-2000." *Morbidity and Mortality Weekly* 51(27), July 12, 2002: 589-592; Andrulis, D.P., Duchon, L.M., and Reid, H.M., *Healthy Cities, Healthy Suburbs: Progress in Meeting Healthy People Goals for the Nation's 100 Largest Cities and Their Suburbs*. SUNY Downstate Medical Center, Aug. 2002; and Hack, M., Klein, N.K., and Taylor, H.G. "Long-Term Developmental Outcomes of Low Birth Weight Infants." *The Future of Children* (5)1, Spring 1995.

Incidence of very low birth weight and stays in intensive care

The Department needs complete and reliable data to ensure that the program is meeting the goal of reducing the incidence of very low birth weight and extended stays in the NICU. Evaluators were able to develop data about very low birth weight for some of the program participants, but because one site was excluded due to extensive data problems and information on other sites was incomplete, the information was too limited to allow determinations of how successful the program has been in meeting this goal. Further, because the program is focused on serving women at risk of poor birth outcomes, program participants may have different characteristics than the general population. Therefore, the program's progress toward reducing very low birth weight or other goals cannot be directly measured against the general population. Instead, measuring the program's impact would require a comparison group of individuals with characteristics similar to the program participants, and program data was not reliable enough to allow the formation of a comparison group. More specifically:

- Babies with very low birth weights—Using vital statistics reports, evaluators identified 327 babies born to participants in 2000 and 680 born to participants in 2001. In each of these 2 years, the rate of babies born at a very low birth weight among program participants in the vital statistics reports was about 1 percent (2 of 327 in 2000 and 8 of 680 in 2001). Nine of these 10 babies spent time in the NICU. The statewide rate in 2000 was 1.2 percent, and in 2001 it was 1.1 percent.

- Newborn babies spending time in intensive care—Vital statistics data identifies whether babies were admitted to the NICU, but not how long they stayed. Among program participants identified in the vital statistics reports, admission rates to the NICU were 6 percent for 2000 (19 of 327) and 4 percent for 2001 (26 of 680). Statewide, 5.8 percent of babies born in 2000 and 5.7 percent of babies born in 2001 were admitted to the NICU. Because vital statistics information does not include information about the length of stay in the NICU, evaluators could not provide information about the program on this aspect of its statutory goal.

Without complete and reliable data, program administrators cannot provide meaningful information about the extent to which the program is meeting its desired outcome in this area. The Department needs to take steps to collect complete and reliable data and report data on both parts of this goal. The Department did not develop a process for collecting this information until July 2002.

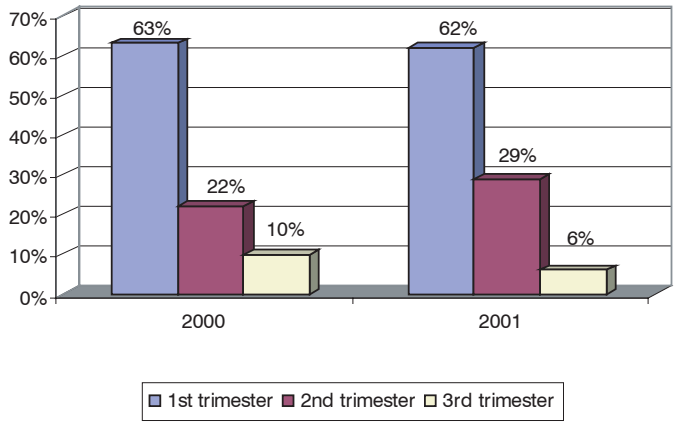
Vital statistics and program data provide some information about other goals

Some information is also available about the other four program goals set forth in statute. Evaluators used vital statistic records to report information on the goal related to prenatal care and used available program information on immunizations and education. For the program participants for whom data was available, evaluators found that over 60 percent of mothers entered prenatal care in the first trimester, and that participants report that nearly three-quarters of their children had appropriate immunizations for their ages. In addition, the available data indicates that immunizations are among the most common educational topics discussed.

Access to prenatal care—Health Start is statutorily required to increase prenatal care services to women. The Department has set more specific goals that 95 percent of participants will receive (1) prenatal care in their first trimester and (2) at least five doctor visits during their pregnancies. Using vital statistics records, evaluators were able to develop information for some Health Start participants related to these goals. Over 60 percent of the Health Start participants identified in vital statistics records received prenatal care during their first trimester of pregnancy (see Figure 1) in both 2000 and 2001, and nearly 90 percent received 5 or more doctor visits (see Figure 2, page 12). Although these amounts are not at the levels called for in the Department's program goals, on average, participants who entered prenatal care in the first trimester received 13 doctor visits, as recommended by the American College of Obstetricians and Gynecologists. In the 1998 evaluation, 62 percent of participants received prenatal care in their first trimester and on average received 10.2 doctor visits.

Several barriers, which are difficult for program participants and lay health workers to overcome, may influence the Department's success in increasing access to prenatal care.

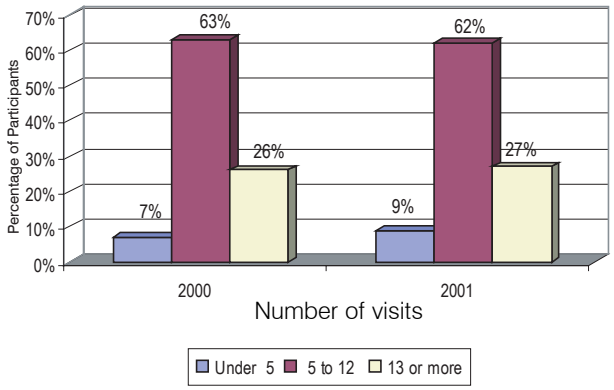
Figure 1 Trimester Prenatal Care Began[1]
Years Ended December 31, 2000, and 2001



1 In both 2000 and 2001, 2 percent of the cases in vital statistics indicated that the participant did not receive any prenatal care. In addition, 2 percent of cases each year could not be located in vital statistics records.

Source: Auditor General staff analysis of 2000 and 2001 Arizona Vital Statistics for Health Start participants. Data does not include all Health Start participants because Health Start data is incomplete.

Figure 2 Percentage of Participants [1] by Number of Prenatal Visits Years Ended December 31, 2000, and 2001



1 In both 2000 and 2001, 3 percent of the participants are missing information on prenatal visits in vital statistics.

Source: Auditor General staff analysis of 2000 and 2001 Arizona Vital Statistics for Health Start participants. Data does not include all Health Start participants because Health Start data is incomplete.

Table 2 Providers' Progress Toward Immunization Goal [1] January 1, 2000 through December 31, 2001

Percentage of Children Immunized	Number of Providers
90 to 100%	1
80-89	4
70-79	3
60-69	3
50-59	4
Total	15

1 The program-wide goal is to have at least 90 percent of participating children appropriately immunized for their age.

Source: Auditor General staff analysis of data provided by the Department of Health Services, Health Start Program. Data is incomplete and unreliable. It does not include all Health Start participants.

Program coordinators and lay health workers described barriers such as the following:

- Some participants at Centro de Amistad in Guadalupe do not have phones and cannot call their doctor's office to make an appointment.
- Participants in Springerville and Eagar in Apache County must travel 50 miles to get to the nearest hospital with an obstetrics department and some must rely on AHCCCS taxis to get them to the hospital when they go into labor.
- Participants in Cochise County face a shortage of medical care because the hospital in Bisbee closed, the Dougals hospital's maternity ward closed, and there are no obstetricians/gynecologists in Douglas.

Lay health workers take several steps to help ensure that participants overcome such barriers and receive the recommended amount of prenatal care. They encourage participants to make and attend their doctor visits and ask whether participants attended their last doctor visit. At some sites, they help clients arrange transportation or provide them access to telephones. Lay health workers also sometimes attend participants' doctor visits when requested by the participant to provide translation.

Immunization rates—The Department uses childhood immunizations as a way to measure its progress on both increasing immunization rates and decreasing childhood disease. The Department has set a goal of having 90 percent of participating children properly immunized. According to available program data, nearly three-fourths of Health Start participants reported to their lay health worker that their child was properly immunized. The percentage of children immunized varied somewhat by provider (see Table 2). In 2001, Arizona's state-wide immunization rate was 78 percent.

Awareness of the need for good nutrition, developmental assessments, and preventive healthcare—The Department is statutorily required to educate families on the importance of good nutritional habits, developmental assessments, and preventive healthcare. Statute does not set forth a more specific target in this regard, and unlike the goals described above, this goal has no Department-assigned target. Using available program information on the educational topics discussed during home visits, evaluators determined that immunization was among the most frequently discussed educational topics. In addition, the Department uses the Ages and Stages Questionnaire in order to help lay health workers identify developmental delays (see Finding 3, pages 19 through 23 for more information on educational topics and assessment tools).

Recommendation

1. The Department should collect complete and reliable data and report progress on its five statutory goals.

FINDING 2

Program administration needs improvement

The Department needs to make several improvements to help ensure the program is effectively administered. First, the Department should see that providers adequately screen program applicants and admit only those women at risk of poor birth outcomes. Second, the Department should improve its monitoring of providers, including reviewing the quality of providers' program data. Finally, the Department needs to strengthen current policies and procedures, or develop additional ones to provide guidance on postpartum enrollment, maintaining the quality of data on program participants, and reporting required in-kind contributions.

Providers need guidance on use of risk assessment tool

To ensure the program's limited resources are being used for the women most in need of services, contracted service providers need additional guidance on assessing each applicant's degree of risk for having a poor birth outcome. A 1996 statute required the Department to develop a screening method to determine the women most in need of program services. In response, the Department developed a risk assessment checklist that included over 30 risk items such as high blood pressure, smoking, homelessness, and previous poor birth outcomes, such as a baby born at a low birth weight or a miscarriage. The lay health worker is to gather information about a woman's risks during the initial screening visit.

Risk assessment tool not being used as intended—The program still does not use the risk assessment as originally intended. In 1998, the Auditor General's evaluation found that the tool was implemented in a way that resulted in virtually everyone being screened into the program, including women who did not appear to be at risk of poor birth outcomes. The 1998 evaluation recommended that the Department refine the instrument to screen into the program only women with risks of poor birth outcomes. The Department disagreed with the recommendation because it believed the communities were selected to provide program services due

to their high risk, and therefore, most of the women in the community would need services.

Risk assessment tool is not being used to screen participants.

This evaluation was unable to determine whether all women in the program were at risk of poor birth outcomes because the data on risk assessments was found to be unreliable. However, interviews with service providers found that the risk assessment tool is not being used as a screening tool. For example, 10 sites reported that any pregnant woman is eligible for the program, and two sites reported that AHCCCS eligibility or financial need were sufficient risks for including a woman in the program.

Additional guidance needed—To ensure the program's limited resources are used for those women most in need, the risk assessment tool should be used to help determine program eligibility. Although the Department disagreed with this recommendation in the previous evaluation, program resources have not increased, and most providers have waiting lists of clients they are unable to serve due to limited funding. Therefore, the Department should require providers to use the risk assessment tool to help determine program eligibility. However, to ensure the current risk assessment tool can be used to determine eligibility, providers need additional guidance on the purpose of the risk assessment tool and how to use it. Currently, the program's policies and procedures manual states that only 7 of the more than 30 risk factors, such as heart problems, diabetes, or sexually transmitted disease, automatically qualify a woman for enrollment. The manual does not provide instructions for how to weigh any of the other risks in terms of importance or eligibility. For example, the manual does not provide guidance on the minimum number of risks needed for program entry.

Monitoring efforts are insufficient

The Department should conduct annual site visits consistently and thoroughly.

The Department should improve its monitoring of the program by conducting an annual site visit with each contracted provider and making the visits more thorough. According to the program's policies and procedures, the Department must conduct an annual visit to each contracted service provider to monitor providers' program implementation and compliance. In fiscal year 2001, the Department conducted all but one site visit. In fiscal year 2002, however, the Department visited only 11 of the 15 providers because of limited staff.

The Department needs to develop a process for reviewing the quality of the provider's program data during its site visits. Currently, the Department reports that files are checked for items such as organization, use of correct forms, educational topics covered, and the appropriateness of referrals made. However, the Department does not verify any of the file information against the database to monitor data quality or identify potential data entry problems. As discussed in the Introduction and Background section of this report, evaluators identified numerous problems with data

quality, which resulted in the inability to draw conclusions about the program achieving its goals (see pages 1 through 8).

Additional program policies needed

The Department should also strengthen current policies or add additional policies to ensure service providers have appropriate guidance on how to implement the program. Evaluators identified several areas where new policies or stronger policies are needed:

- **Postpartum enrollment**—The Department needs to strengthen its policies and procedures guiding postpartum enrollment. In 1999, program legislation changed to allow providers to enroll a woman and her child postpartum. The Health Start policies and procedures manual states that "women who experience difficulty after delivery" are eligible to enroll. However, the manual does not define postpartum eligibility, or provide criteria to judge "difficulty after delivery." Currently, lay health workers use the same registration and risk assessment form used for prenatal clients, yet the tool is not designed to assess postpartum complications in women or infants. In addition, evaluators determined that not all providers understand that women can be enrolled in the program postpartum. For example, two providers do not enroll postpartum women because it is "not a goal" of the program. Another provider told evaluators that they were not aware that postpartum enrollment was allowed.

- **Data quality and data entry**—The Department needs to develop several policies and procedures to guide data quality and entry. First, although the Department requires providers to enter all their program data and ensure its accuracy and completeness, most providers do not have formal data quality procedures in place. Recently, the Department initiated the development of data quality assurance standards for use by all providers; however, the standards are not yet complete. Second, the Department needs to develop reliable data entry procedures for postpartum enrollment clients. Although the Department has been working to fix problems in this area, service providers indicate that they are unable to correctly enter data for women who enroll in the program postpartum.

Data quality assurance standards are needed.

- **In-kind contributions**—The Department needs to develop a policy for what constitutes reportable in-kind contributions and require providers to submit updated in-kind projections annually. Each contracted service provider is required to supplement state monies with in-kind resources. Providers that are awarded $60,000 or more annually must contribute resources valued between 20 to 26 percent of the state monies received, based on the amount of the contract award.[1] The Department's contracts provide no guidance on what type of in-kind contributions are allowable. Evaluators' review of service providers'

[1] Providers that are awarded less than $60,000 annually are required to contribute only computer hardware and software, and nurse and social worker assistance.

estimated in-kind contributions found that providers report a variety of items, including employee benefits, office furniture, and lice shampoo. Without a specific policy on what constitutes reportable contributions, it is not clear if all of these are allowable, and providers may measure program cost differently. In addition, since the contract period began in 2001, the Department has not required providers to update their budgets annually or revise in-kind projections when award amounts are adjusted during the year. Without updated budgets, the Department cannot ensure that providers' in-kind contributions are appropriate and that it has complete information on program costs.

Recommendations

1. To help ensure the program's limited resources are being used for women most in need of services, the Department should require providers to use the risk assessment tool to help determine program eligibility.

2. The Department should provide additional instructions to contracted service providers on the purpose of the risk assessment tool and how to use it to measure program eligibility.

3. The Department should ensure that all site visits are conducted annually as required.

4. The Department should develop a process for reviewing the quality of providers' program data during its site visits.

5. The Department should:

    a) Strengthen policies and procedures guiding postpartum enrollment.

    b) Ensure data quality and entry, both by continuing its efforts to develop data quality assurance standards and by developing additional procedures for how to enter postpartum clients.

    c) Develop a policy for what constitutes appropriate in-kind contributions and require providers to update their budgets and in-kind contribution estimates as award amounts change.

FINDING 3

Information on program participants and services

By statute, this evaluation must report information on program enrollment and disenrollment, demographic information on program participants, and information on the level and scope of program services. Because evaluators were unable to obtain reliable data for all program participants (see scope limitation, pages 4 through 7) the numbers presented in this finding are based on those participants for whom data was available.

Enrollment and participant characteristics

In 2000 and 2001, Health Start enrolled over 2,100 women for whom data was available. Nearly one-third of these women left before completing the program. Most were relatively young, Hispanic, unmarried, and enrolled in AHCCCS.

Enrollment numbers and characteristics—Data was available for over 3,300 women who registered for possible inclusion in Health Start in 2000 and 2001. Over 2,100 of these women eventually enrolled in the program. The registrations were done by lay health workers attempting to identify women in the community who might be eligible for the program. These lay health workers canvass the community for pregnant women or women who recently gave birth. Lay health workers also take referrals from hospitals and clinics. Table 3 (see page 20) shows the number of registered women who enrolled and who did not enroll in Health Start for both 2000 and 2001. Using program data, evaulators were able to determine that the majority of women enrolled in the program before they gave birth. However, because the Department does not collect specific data on whether a woman enrolls as a prenatal or postpartum participant, evaluators could not determine an exact number for either of these types of enrollment. Most of the women who registered but did not enroll were not pregnant and thus not eligible to participate in the program.

Reasons for disenrollment—For those women for whom data was available, about one-third of those who enrolled in Health Start in 2000 and 2001 left before completing the program. As illustrated in Figure 3 (see page 20), most women who

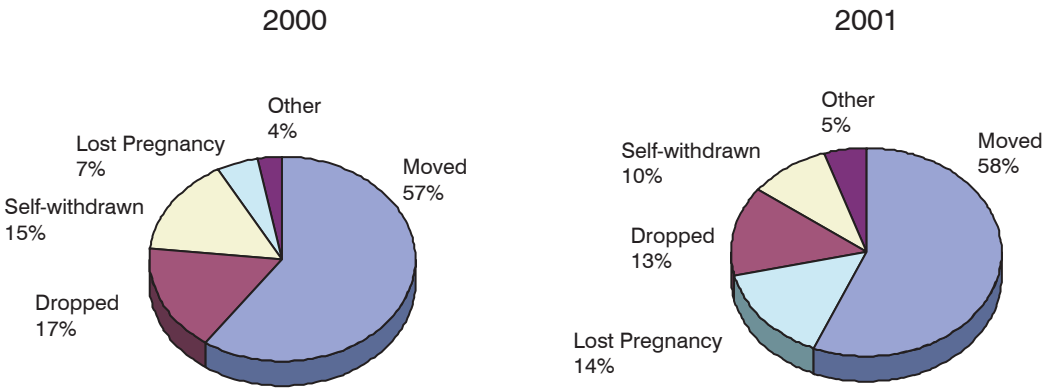
Table 3 Enrollment Results for Registered Women[1]
Years Ended December 31, 2000, and 2001

	2000	2001
Enrolled	855	1,328
Not enrolled		
Not pregnant	168	239
Declined enrollment	64	207
Other	5	10
Total	237	456

1 Enrollment data is missing for 24 women in 2000 and 405 women in 2001.

Source: Auditor General staff analysis of data provided by the Department of Health Services, Health Start Program. Data is incomplete and unreliable. It does not include all Health Start participants.

Figure 3 Reasons and Percentage for Disenrolling
Years Ended December 31, 2000, and 2001



Source: Auditor General staff analysis of data provided by the Department of Health Services, Health Start Program. Data is incomplete and unreliable. It does not include all Health Start participants.

left the program did so because they moved out of the site's program area. Besides moving, other reasons for disenrollments include pregnancy loss or being dropped from the program by the lay health worker. Health Start policies state that a woman should be dropped from the program if the lay health worker fails to make contact after four attempts. In 2000 and 2001, 17 percent and 13 percent of women, respectively, were dropped for this reason.

Characteristics of program participants—For those women for whom data was available, most of those enrolled in Health Start were relatively young and unmarried. While education and income information on program participants was determined to be unreliable, the majority of participants were enrolled in or applying for AHCCCS at the time they enrolled (see Table 4).

Table 4 Characteristics of Health Start Participants
Years Ended December 31, 2000, and 2001

	2000	2001
Average age	23.9 years	23.9 years
Married	35%	33%
First child	42%	42%
Enrolled in AHCCCS	42%	45%
Applying for AHCCCS	19%	17%

Source: Auditor General staff analysis of data provided by the Department of Health Services, Health Start Program. Data is incomplete and unreliable. It does not include all Health Start participants.

Of the women for whom information about race and ethnicity was available, most were white/Hispanic (see Table 5). The next largest categories were white/non-Hispanic, and Native American. African-Americans have a high rate of low-weight births and infant mortality, and they represented 3 percent of the women for whom data was available in 2000, and 2 percent in 2001.

Table 5 Percentage of Women in Program[1] by Race and Ethnicity
Years Ended December 31, 2000, and 2001

	2000	2001
White/Non-Hispanic	14%	17%
White/Hispanic	66	65
Native American	12	10
African-American	3	2
Asian	<1	1
Other/unknown	5	5

1 Numbers do not total 100 percent due to rounding.

Source: Auditor General staff analysis of data provided by the Department of Health Services, Health Start program. Data is incomplete and unreliable. It does not include all Health Start participants.

Program services

Lay health workers provide services to participants during prenatal home visits and family follow-up visits, and Health Start policies require that participants receive an average of five prenatal and seven family follow-up home visits from lay health workers. During these visits, they provide education and information, administer assessments, and provide referrals to other pertinent programs, such as AHCCCS, when participants have needs outside the scope of Health Start.

Providing education and information—The Department gives the providers a broad list of educational topics, and recommends that topics are discussed based

Common topics discussed include immunizations, emotions/feelings, and prenatal care.

on client need. The providers gather materials and information that address the needs and concerns of the women in their area, and the Department approves these materials for use in the program. Because data on the number of visits was not reliable, it is not possible to determine whether participants received the required number of visits. However, of the visits for which data was available, some of the most common educational topics discussed include immunizations, emotions and feelings, and prenatal care.

Six providers do not find the *Arizona Family Resource Guide* useful because it does not contain local phone numbers.

In addition, statute requires the Department to distribute the *Arizona Family Resource Guide* to hospitals state-wide for parents of newly born children, and the Department requires lay health workers to give one to each of their clients. The guide, which is available in both English and Spanish, contains toll-free phone numbers for public and private health, education, and family services organizations in all 15 Arizona counties. However, 6 of the 14 providers told evaluators that they do not find the guide helpful because it is not community-based. In addition, two providers were not even aware of the guide. While most providers continue to use the guide and some supplement it with a local resource guide, four providers are not using the guide at all. The Department should ensure that providers distribute the guide to all program participants or require service providers to develop and seek departmental approval for substitute guides.

Administering assessments—In addition to providing education and information, the Department requires lay health workers to assess the safety of the participants' homes and the development of the participants' children. To do this, the Department requires lay health workers to use the following assessment tools:

- The Arizona Safe Home/Safe Child Assessment—The checklist is designed to prevent in-home, unintentional injury to children under age 5, and the lay health worker administers it once during the prenatal period and again after the baby's birth, preferably within 2 months. If lay health workers detect a hazard, they must reassess the client's home within 30 days to ensure that the hazard was eliminated.

- Ages and Stages Questionnaire—The Department implemented the Ages and Stages Questionnaire in response to the Auditor General's 1998 recommendation that the program should devote more time to educating parents on child development. The questionnaire assesses a child's developmental milestones, and lay health workers administer it three times during the family follow-up period. If any developmental delays are suspected, the lay health worker refers the family to the Arizona Early Intervention Program (AZEIP) or another appropriate agency for further evaluation.

Providing referrals to other programs and services—Lay health workers provide referrals for clients to other services and programs from which they may benefit. Lay health workers can provide referrals to shelters for women who are

subject to domestic abuse, refer teenage participants to the Teenage Pregnancy Program, or refer new mothers to immunization clinics if a child needs immunizations. Additionally, providers that serve Native American populations might provide referrals to tribal chapters. Lay health workers can also help women apply to AHCCCS if they are not already enrolled. However, because the data on the number of referrals women received is unreliable, this information cannot be reported.

Recommendation

1. The Department should either require providers to use the *Arizona Family Resource Guide* or to develop a Department-approved substitute.

AGENCY RESPONSE

Arizona Department of Health Services

Office of the Director

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Fax: (602) 542-1062

JANE DEE HULL, GOVERNOR
CATHERINE R. EDEN, DIECTOR

Ms. Debra K. Davenport
Auditor General
Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85004

Dear Ms. Davenport:

Thank you for giving us an opportunity to respond to your office's evaluation of the Health Start Program. We agree with the report and all of its findings. In addition, we plan to implement all of the report's recommendations.

We regret that data limitations hindered the audit team's ability to definitively determine program outcomes, and we are already working to improve our data collection efforts.

While we concur with the Auditor General that Health Start participant screening could be further improved, it is important to note that the Health Start program operates in high-risk, vulnerable communities. Site selection is based on a variety of indicators, such as: low birth weights; percent of the population living below the federal poverty level; the teen birth rate; the rate of uninsured births; the ratio of the population to available community health providers; the infant mortality rate; and the rate of pregnant women receiving less than five prenatal visits in each geographic area.

As a result of this site selection process, Health Start serves over sixty of the most underserved and vulnerable communities in our state. Examples of communities served by Health Start include:

- Guadalupe, where the federal poverty rate is 25.6 percent (compared to 14.2 percent statewide), and the percent of residents with less than a 9th grade education is 38.8 percent;
- St. Johns, where the ratio of the population to health care providers is 8,091:1, compared to 770:1 statewide;
- Kaibeto, where the percent of women receiving no prenatal care is nearly three times the state average;
- Dateland, a rural Arizona community where no health care providers exist;

- Communities lacking local hospitals, such as Hayden, Wickleman, Arivaca, Ash Fork, and Bagdad.

In these high-risk communities, lay health care workers perform a variety of vital services, such as:

- Conducting risk assessments, and tailoring services based on individual client needs;
- Educating clients on prenatal care, breastfeeding, and nutrition;
- Monitoring clients for pregnancy danger signs and referring clients to medical providers when necessary;
- Educating women about child safety issues, such as proper use of car seats;
- Coordinating client transportation to health care providers;
- Delivering food baskets or taking clients to appointments for other support services such as WIC or employment services;
- Referring pregnant women lacking health insurance to KidsCare or AHCCCS;
- Educating and referring pregnant women or women with newborns to immunization services.

Enclosed please find letters from community health and service providers and program participants voicing their support for the Health Start program. Due to space limitations, all such letters were not included.

Thank you for giving us an opportunity to respond to the report. We appreciate your staff's professionalism and responsiveness in conducting this evaluation.

Sincerely,

Catherine R. Eden
Director

CRE:KV:lls

Enclosure

White Mountain Specialty Care
Eagar Plaza
367 N. Main Street
P. O. Box 1076 • Springerville, AZ 85938

Thomas B. Bennett, D.O.
Obstetrics & Gynecology

Phone: (520) 333-3543
Fax: (520) 333-3545

To: Dr. Catherine R Eden
Director of Arizona Department of Health Services

December 4, 2002

Regarding: Health Start necessity in rural Arizona

Our practice fully utilizes the Health Start program. Many of our patients require translation, transportation, and other Health Start services. Being located in a rural area means that there is limited access for many of our patients to these types of services. Without the help of Health Start we would be unable to offer adequate OB/Gyn care to most of our Spanish-speaking patients, meaning that many of these patients would end up going without any OB care, resulting in unnecessary perinatal morbidity and mortality along with the associated costs. Our patients currently have to travel one hour each way to attend Lamaze classes in another county. Health Start is now in the process of incorporating Prenatal/Lamaze classes in our area.

We cannot emphasize enough how very important Health Start is to our practice, the taxpayers of Arizona, and especially to our patients. If you should have any questions or concerns, please feel free to contact us at the number listed below.

Sincerely,

Dr. Thomas B.Bennett OB/GYN
White Mountain Specialty Care
Phone # (928) 333-3543
Fax# (928) 333-3545

YUMA REGIONAL MEDICAL CENTER

December 5, 2002

Catherine R. Eden, Director
AZ Department of Health Services

Ms. Eden,

I am writing this letter to support the Health Start Program. The community of Yuma County needs this wonderful program. With our diverse population and our towns so far spread apart, we need the promatoras to travel to the clients, because there is a problem with transportation. The individual attention given to these pregnant women is very important. The caring ways and role modeling that the ladies provide to the clients is a great way to provide education and information about services in Yuma County.

I teach several types of childbirth classes and other related subjects here at Yuma Regional Medical Center. However, the people in the outlying communities live too far to travel (45 minutes) to the center of town for the classes. The Health Start Program meets the needs of those people. Also, we currently do not offer classes in Spanish. I am very grateful for the promotoras for their hard work. The Health Start program is a bridge in the gap of services for this and other outlying communities.

I would love to see this program continue and grow to meet the needs of this growing area. If you have any questions please feel free to call me at: (928)336-7058.
Thank you very much.

Sincerely,

Donna M. Gradias, CCE
Childbirth Education Coordinator
Yuma Regional Medical Center

Yavapai County Health Department

Marcia Moran Jacobson, Director
Sandra G. Halldorson, Director of Nursing
Chris Sexton, E. H. Administrator

"Yavapai County Health Department will provide leadership, information, and services that contribute to Improving the health of Yavapai County residents."

December 11, 2002

Catherine R. Eden
Director, Arizona Department of Health Services

Dear Dr. Eden,

We are very proud of the impact the Health Start Program in Yavapai County is having on our clients and on our conummities. Our team of Health Start workers are gifted women who are mothers and native Spanish speakers. They are able to promote genuine communication because they are able to talk with their clients in Spanish and then translate questions and information to and for medical professionals and other resource people.

Health Start workers provide and explain handouts and information in both English and Spanish. They are able to encourage and demonstrate skills and techniques one-on-one. They live in the communities they serve, so they have connections and credibility in their communities. They are good mentors and role models for the pregnant women and new mothers they visit in their homes.

In a very large, rural county like Yavapai, many of the women are isolated and lack transportation. Periodic visits from Health Start workers give these women an opportunity to ask questions and demonstrate their parenting skills in their own homes and at a time when they are most receptive to sharing their experiences and learning new skills. Home visits over a period of time (through pregnancy and until children are two) create connections and closeness between workers and their clients, so clients are able to share joys and concerns, and workers know clients well enough to see changes that can indicate problems like depression or domestic abuse.

Health Start workers are able to focus on prevention, encourage healthy nutrition, promote child safety, follow immunizations, and spot concerns. We have had numerous situations where our presence over time enables moms (and sometimes dads) to follow through with social and emotional care for themselves and their children, i.e. getting out of a bad living situation, acknowledging mental health issues and accessing care, helping moms connect with their babies and other children.

This program is of high value to the families in our community. When individuals and families succeed, the community is successful too!

Sincerely,

Elly Yost
Eileen Ruddell
Veronica Rollins
Genny Barker
Julia Naig
Robin Olson
Alice Vera
Jonnie Nava

Yavapai County Health Start Staff

PRESCOTT
930 Division Street
Prescott, AZ 86301-3868
(928) 771-3515 Appointments
(928) 771-3122 Administration
(928) 771-3369 FAX

PRESCOTT VALLEY
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Prescott Valley, AZ 86314
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COTTONWOOD
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(928) 639-8130 Nursing
(928) 639-8179 FAX

COCHISE COUNTY HEALTH DEPARTMENT

December 4, 2002

Dr. Catherine R. Eden, Director
Arizona Department of Health Services

Dear Dr. Eden,

I am writing in support of the Health Start Program here in Cochise County. Because we are geographically isolated, the Health Start Program bridges the gaps in our communities that have only one birthing center. At the beginning of this year, 2002, the birthing centers in Bisbee and Douglas closed their services due to high insurance rates. The community of Willcox has not had a birthing center for quite some time and must travel to Tucson for services. The communities of Bisbee and Douglas must travel to Sierra Vista. Thus the Health Start Program serves the communities of Douglas, Sierra Vista and Willcox with five "Promotoras" (lay health workers) who help pregnant women and teens get into early prenatal care to insure a healthy pregnancy outcome.

These Promotoras are all trained as lactation consultants and are able to present classes on prenatal care and childbirth. Two are also Car Safety technicians. The aspect of being a home visitor program gives the lay health workers a unique forum for education, referrals and personal insight to their clients needs.

This program also serves as a vehicle to promote the Folic Acid Program, ADHS Child Health Block Grant and Adolescent Maternal and Child Health Program.

I can further attest that because of Health Start other agencies welcome the collaboration to provide a smooth continuum of support services for pregnant and post-partum families.

Sincerely,

Maureen Kappler RNC
Program Manager
Health Start

DIANE C. CARPER, DBA, CHE
Director

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(520) 384-0309

Apache County Health Department
Health Start Program

Don Foster, Director
Box 697
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Lisa McCall, Program Coordinator
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Springervllle, AZ 85938
(928)333-0203

December 4, 2002

Arizona Department of Health Services
Catherine R. Eden, Director
2927 North 35th Avenue
Phoenix, Arizona 85017

Re: Importance of the Health Start Program in southern Apache County.

Dear Catherine R. Eden:

I would like to inform you of the vital role the Health Start program plays in southern Apache County. The program does a tremendous job of linking pregnant women and mothers of infants to the care they need through the use of lay health workers. These workers provide prenatal outreach and education, translation services for Spanish-speaking women, limited transportation, and advocacy to interface with public assistance programs for pregnant women. The lay health workers also provide developmental screening, immunization education, ear safety seats and education for families with infants up to two years old. No other agency in southern Apache County offers these services.

Southern Apache County, including Springerville, Eagar, St. Johns, Concho, Vernon, Alpine and Sanders, has been identified as a HPSA and a MUA. The local hospital does not offer OB services. With only one OB service provider and no pediatric healthcare provider in the area, the risks to pregnant women and young infants are great. Health Start's lay health workers fill a void created by the lack of providers by offering the services mentioned earlier.

If Health Start did not exist, the impact on our communities would be incredible. This year, the lay health workers have provided an average of 103 client visits per month. These include registration and risk assessment, prenatal, birth outcome and family follow up visits.

Sincerely,

Don Foster, RS, MPH

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621 S. 5TH STREET
GLOBE, ARIZONA 85501
TELEPHONE: (520) 425-3189
FAX: (520) 425-0794
TDD: (520) 425-0839 **(FOR THE HEARING IMPAIRED)**

NORTHERN COMPLEX:
107 W. FRONTIER SUITE A
PAYSON, ARIZONA 85541
TELEPHONE: (520) 4741210
FAX: (520) 4747069

GILA COUNTY HEALTH DEPARTMENT

1400 ASH STREET, GLOBE, ARIZONA 85501

December 4, 2002

Dr. Catherine R. Eden

Director, Arizona Department of Health Services
Phoenix, Arizona

Dear Dr. Eden:

The Health Start Program in Gila County is unique. There are no other programs available in the community that is comparable in nature. This program has become an important source of support and education for our clients and the community at large. Maternal and Child Health needs assessment indicated that there was no method of follow up for women post partum. There were no resources available for them after their six week post partum visit. This was a serious gap in service that the Health Start Program has been able to fill.

Since its inception, this program has been a support system for pregnant women who have had some unusual circumstances. We have had clients who were experiencing domestic violence, clients who have had drug abuse issues, clients whose infants have had serious diagnoses in utero, and a client who died from an overdose. We have received referrals from Child Protective Services and from Probation as conditions of their involvement. (Gila County does not have a Healthy Families Program, or any similar program. Health Start is their only resource.) By using the Ages and Stages Questionnaire, we have been able to identify children that needed to be referred to AZEIP at a very early age. Clients have verbally reported that the SafeHome Check has made them realize what needs to be in place for optimal safety for their infant/toddler. The local hospital sporadically provides prenatal classes. Our program has been able to provide education for those families, who solely speak Spanish, do not have availability to attend a class, or who require additional support.

The Health Start Program has provided much needed resource and support to our community members. We hope to expand our program to include additional locations. The transition to parenting one or more children can sometimes be difficult. This program enables our community members to have an objective knowledgeable person to turn to during this time. If you would like additional information regarding our program, please feel free to contact us.

Sincerely,

Carolyn M. Haro, BSW
MCH Program Director
Gila County Health Department

Jendean G. Sartain, RNC
Director of Nursing
Gila County Health Department

Performance Audit Division reports issued within the last 12 months

01-20 Department of Public Safety—Highway Patrol
01-21 Board of Nursing
01-22 Department of Public Safety—Criminal Investigations Division
01-23 Department of Building and Fire Safety
01-24 Arizona Veterans' Service Advisory Commission
01-25 Department of Corrections—Arizona Correctional Industries
01-26 Department of Corrections—Sunset Factors
01-27 Board of Regents
01-28 Department of Public Safety—Criminal Information Services Bureau, Access Integrity Unit, and Fingerprint Identification Bureau
01-29 Department of Public Safety—Sunset Factors
01-30 Family Builders Program
01-31 Perinatal Substance Abuse Pilot Program
01-32 Homeless Youth Intervention Program
01-33 Department of Health Services—Behavioral Health Services Reporting Requirements
02-01 Arizona Works
02-02 Arizona State Lottery Commission
02-03 Department of Economic Security—Kinship Foster Care and Kinship Care Pilot Program
02-04 State Parks Board—Heritage Fund
02-05 Arizona Health Care Cost Containment System—Member Services Division
02-06 Arizona Health Care Cost Containment System—Rate Setting Processes
02-07 Arizona Health Care Cost Containment System—Medical Services Contracting
02-08 Arizona Health Care Cost Containment System—Quality of Care
02-09 Arizona Health Care Cost Containment System—Sunset Factors
02-10 Department of Economic Security—Division of Children, Youth and Families, Child Protective Services

Future Performance Audit Division reports

HB2003 Children's Behavioral Health Services Monies

Department of Health Services—Office of Long Term Care