Executive Summary

Pima County Health Department (PCHD) is experienced with delivery of the Health Start Program. The Scope of Work required for this grant has been successfully met over the past twenty years. The Health Start Program is staffed with experienced community health workers to provide education, support and advocacy services to pregnant and postpartum women and their families under the supervision of registered nurses. The community health workers live in and reflect the ethnic, cultural and socioeconomic background of the areas they serve. Women and their families receive home visits and case management at no cost with oversight by nurses, social workers and counselors during the pregnancy and through the child's second year of life.

Pima County Health Department plans to target both urban and rural areas of the county with this Health Start contract. The service area will include Tucson areas covered by the North, South and East Public Health Nursing (PHN) Offices. Green Valley, Catalina and Ajo PHN Offices areas serve the rural southern Arizona to be covered in this Health Start contract. The target areas have significant number of the populations that are of low income, minorities and births to single mothers. There were 11,965 births in 2013 with 1,067 being premature. The poverty level in the service area is 19.2%.

To implement the program, a total of 3.5 Full Time Equivalent (FTE) Community Health Workers will be employed. There will be 1.0 FTE Community Health Worker based at the North, South and East Offices, and a 0.5 FTE CHW based at the Green Valley office. PCHD will contract with a licensed Social Worker or behavioral counselor for a minimum of four hours a month for consultation and training. PCHD employs (19) Public Health Nurses (PHNs) who along with the Program Manager and Supervisor will provide at least four hours of RN consultation for the program. The PCHD Health Start staff will attend required training, and annual meetings.

The Health Start Program will collaborate with other home visitation programs to ensure clients are enrolled in the appropriate program to meet their identified need. The Public Health Nursing (PHN) division provides home visiting services through the Nurse-Family Partnership, Family Drug Court, and Human Resources and Referral and Health Start programs and generalized PHN services. In addition, PCHD has a Maternal Infant, Early Childhood Home Visitation (MIECHV) grant to develop and implement a centralized referral system and to conduct outreach to promote home visitation programs. This referral system has been a good source of Health Start referrals and staff works with the coordinator in conducting outreach activities and coordinating referrals to assure no duplication of services occurs. Public health nurses and

community health worker staff is experienced and able to perform the Ages and Stages Questionnaire (ASQ) and ASQ Social Emotional (ASQ-SE) assessments; they routinely use the Edinburgh perinatal assessment tool and provide education to women on pre-conceptual/inter-conceptual health issues. The Health Start staff piloted the Healthy@Home assessment tool and used the relationship screening tool with enrolled women.

It is anticipated that a minimum of one hundred eighty (180) prenatal and postpartum women will be enrolled in the program in the first year. PCHD will make 1,330 visits to enrolled women and families and conduct all required screenings. Staff will conduct ten classes for Health Start enrolled clients. Staff will participate in relevant continuing education activities. The staff will continue involvement with various community agencies to facilitate referrals to and from Health Start.

In summary, Pima County Health Department has successfully provided Health Start services for over twenty years. The PCHD program is frequently called upon to pilot proposed changes to the state-wide program and staff has taken a leadership role in training others and implementing these changes. PCHD is well situated to continue to provide Health Start services.

2.5 Method of Approach (Methodology)

2.5.1 Written narrative

PCHD has been awarded the Health Start program for over twenty years. This Program has been very successful, with annual site reviews showing few, if any deficiencies. In Calendar Year 2014, 257 unduplicated women received 1.090 home visits or classes. There have been very few low birth weight (LBW) and/or premature infants born to prenatally enrolled PCHD Health Start clients, with only three births 91.26%) out of 239 being Very LBW. PCHD has consistent staff: two of the CHWs have been with Health Start over seven years; the current social work consultant has been with the program for over twenty years and the program coordinator for five years.

To achieve the goals and objectives in the scope of work and policy and procedure manual referenced in Part 2 Scope of Work in the RFP, PCHD will provide a home visitation program with the current administrative, management, organizational systems and information and referral networks in place to support the Health Start program in the targeted, contracted sites in Pima County. Communities that have high rates of preterm, low birth weight and high infant mortality are specifically targeted (**SOW 4.1**). Monthly program documentation and quarterly reports detailing progress to achieving established quality improvement indicators are submitted to the Arizona Department of Health Services in a timely manner. PCHD program has been effective in meeting quality improvement standards (**SOW 4.2**)

2.5.2 Submit examples of prior projects with activities similar to those as described

Nurse-Family Partnership (NFP) is a proven public health program that works with mothers expecting their first child. The mothers are connected to a registered nurse in the Pima County Health Department NFP Program early in their pregnancy. The nurse home visitor and mother work together to improve pregnancy outcomes improve child health and development and improve families' economic self-sufficiency. Pima County Health Department NFP team began serving mothers in the rural parts of Pima County in January of 2014. To date, the Nurse-Family Partnership team has enrolled 35 high-risk mothers and has seen the birth of 16 healthy babies.

In collaboration with Tucson Fire Department, Public Health Nurses (PHNs) provide home visitation/case management to residents of Pima County who use the EMS/911 system inappropriately. In addition, case managers for collaborating partners are made aware of their clients' inappropriate use of the EMS/911 system and are able to address this with their client. Last fiscal year 47 adults were admitted through this program. Among those patients identified as frequent users of the system, there was a 60% reduction of calls to 911. The approach of this program is to meet regularly with collaborators to discuss program successes, areas of potential improvement, identify gaps in services and work together to solve problems identified.

2.5.3 Identify a neighborhood/community, city or county targeted service area
Pima County has medically underserved communities and the Tucson area has scattered pockets of need with poorer birth outcomes. These areas are where PCHD currently and will continue to concentrate outreach services. Staff will continue to work with health care and community service providers, outside agencies and hospitals to market Health Start services

The Green Valley office will use zip codes 85614, 85612 and 85629 as its defined service area for Health Start. This includes the communities of Sahuarita, Continental, Amado and Elephant Head, Helmet Peak, Wrangler, Curley Horn and McGee Ranches, Santo Tomas, Arivaca and Sasabe. Each of these communities has high rates of inadequate prenatal care, low birth weight, and/or infant mortality. All have significant populations of low income, minorities and births to single mothers. Arivaca is designated as a Federal MUA/MUP area with travel time to the nearest health care provider from 41 – 60 minutes. Of the people that live in this area, forty-three percent of them live at or below the poverty line. The availability of resources within the respective communities to maximize and support the work of the CHWs was a determining factor in choosing these target areas. PCHD will continue to work in close cooperation with school based programs and the United Community Health Center programs in the target areas.

The North Office area, will target zip codes: 85653, 85645, 85658 85705, 85719, 85735, 85737, 85739, 85743, 85745 and 85755. Clients who live outside these areas may be enrolled in Health Start on a case-by-case basis. St. Elizabeth's of Hungary Clinic, a sliding fee clinic, is located just to the east of this target area and provides prenatal care. Several churches in the area support local residents by providing food, clothing and other items. There are currently six WIC offices and two DES offices in this area. Marana Health Center has seven satellite offices and El Rio Health Center has several clinics in the north area that provide comprehensive health care to residents. Prenatal care is provided at some, but not all of the community health clinics.

The South Office area will target zip codes 85639, 85706, 85713, 85714, 85716 and 85736. The Tucson Police Department (TPD) has identified this area as among the worst sections of Tucson as evidenced by high levels of poverty, family isolation and crime. The TPD statistics show rates of domestic violence, child abuse and neglect and drug related offenses that are more than twice the citywide average. The neighborhoods are largely minority with 62.4% Hispanic and 8.9% African American. Included in this area is the town of Three Points. PCHD PHNs work with the Altar Valley School District (K-8) and the Serenity Baptist Church in case finding and referral. WIC services are available one time a month.

The Health Start activities at East Office will focus on zip codes 85601, 85707, 85708, 85710, 85711, 85712, and 85730. This area encompasses Davis Monthan Air Force Base, which does not provide prenatal care to military personnel and their families. There are many private physicians in this area and El Rio operates a sliding fee scale clinic, with limited prenatal care services available. WIC and DES both have offices in this area. This area tends to be very transient, with families frequently moving in and

out. This area has the highest rate of births to African American mothers, at 12.4%, compared to 4.3% for the entire county. There are increasing numbers of foreign born families in this area, including refugee families. Public transportation is limited south of the base; there are no major groceries or drug stores in the area and no sources of medical care. The closest facility is Banner University Medical Center, South Campus which is approximately four miles away. WIC services are located next to the medical center. There is no DES office in the area. Housing consists mainly of rundown mobile homes. The community of Littletown is located in this area, which is a geographically isolated area that consists of an elementary school, a County Parks and Recreation Facility, mobile homes and small houses, and truck stops. There is a group of homeless people who camp in the desert near this area. Limited health services are available in the area via the University of Arizona Rural Health mobile clinic.

Ajo is located 140 miles west of Tucson and is separated from the rest of Pima County by the Pascua Yaqui and Tohono O'odham Nations. There is a community health center, Desert Senita (DSCHC). DSCHC does not provide prenatal care, but their clients may obtain prenatal care from a clinic in Tucson. To receive these services women must travel two and ½ hours to Tucson. Those with health insurance must travel to Tucson, Phoenix, or Casa Grande for prenatal care. The closest OB/Gyn physicians are located in Phoenix and Casa Grande; both are approximately 100 miles from Ajo. The closest hospital offering obstetrics is West Valley Hospital in Goodyear, 94 miles from Ajo. See **Appendix A** for the zip code map of Pima County.

Table1. Demographic Characteristics and Health Status, Pima County, 2013

845 (7.1 %)	LBW babies in Pima County
688	Admissions to NICU
8.9%	Premature Births
4.8%	Infant mortality
	Birth Rates/per 1000 by Maternal Race and Ethnicity
6.5	American Indian or Alaska Native
6.8	Asian or Pacific Islander
13.1	Black or African American
6.6	Hispanic or Latino
7.0	White, non-Hispanic
	Low-Birth Weight by Mother's Race/Ethnicity and Age
4%	American Indian or Alaska Native
4%	Asian or Pacific Islander
9%	Black or African American
41.5%	Hispanic or Latino
41.3%	White, non-Hispanic
9%	15-19 years
29%	20 -24 years
27.5%	25 – 29 years
20.9%	30 – 34 years
9.1%	35- 39 years
3.4%	40 – 44 years
	Infant mortality rate by race (4.8deaths per 1000 live births)
18.7	American Indian or Alaska native
0.0	Asian or Pacific Islander

16.8	Black or African American
5.1	Hispanic or Latina
3.0	White, non-Hispanic
	Other Notable statistics for Pima County
53%	Births are paid for by AHCCCS
1.9%	Women with no prenatal care
5.8%	Had 1-4 prenatal visits
17.9%	Had 4-8 prenatal visits
73.8%	Had care begin in the first trimester
18.8%	Had care being in the second trimester
6%	Had care begin in the third trimester
46%	Births to unwed mothers
19.2	Pregnancy rates for women 19 years or younger per 1,000
16.4%	Births to women with less than a High School Education

Source: Arizona Department of Health Services Statistics (2013)

Table 2. Pima County Statistics on Crime, Education and Poverty

27%	Children living in poverty
39%	Children living in single parent households
447	Violent Crimes per 100,000
7.0	Unemployment rate
43	Teen births per 1,000

Source: County Health Rankings from Robert Woods Johnson Foundation (2015)

2.5.4 Projected enrollments, visits, classes and training

The projection of the number of proposed prenatal and postpartum clients to be enrolled in the program for the first year:

Table3. Type of visit and projected number for year 1

Type of Visit	Projected Number
Prenatal Enrollment	120
Post-Partum Enrollment	60
Total Enrollments	**180**
Prenatal Visits	380
Family Follow-up Visits	950
Multiple Child Visits	49
Proposed Trainings: Car seat tech trainings Health Start Annual Meeting/Training CPR training LATCH trainings Strong Families Conference	 2 people x 5 days 6 people x 1 day 6 people x 1 day 4 people x 4 days 6 people x 2 days
Pregnancy Tests	15
Birth Doula Support (optional)	0
Classes for clients	10

2.5.5- Strategies for outreach and to recruit new prenatal and post-partum clients on an ongoing basis:

PCHD Health Start receives the majority of new clients from word-of-mouth, that is, current or former clients telling family members and friends about the Health Start program. New clients will be recruited through:

- Participation in neighborhood health fairs and community events
- CHW "hours" at WIC clinics and PCHD immunization clinics
- Pregnancy testing "hours' established at the PHN offices
- Networking with community agencies e.g. Reachout Women's Center, Crisis Pregnancy, Tucson Diaper Bank, health care providers and hospital social workers
- Coordinating/collaborating with other PCHD programs such as family planning, STD/HIV, Tobacco Freeways, child care health consultation, oral health program etc.
- Outreach to local businesses/organizations such as grocery stores, child care centers, schools, churches and retail stores and local civic/service organizations such as the African American Wellness Coalition, Black Chamber of Commerce, Hispanic Chamber of Commerce, Kiwanis Club, etc.
- Participation on community advisory boards such as Healthy Families, Family Support Alliance, Refugee Primary Care Group, Head Start Health Advisory Board Nurse-Family Partnership etc.

Through the newly established Pima County Outreach Family Support referral system, agencies and medical providers within the community refer clients in need of home visitation and other services to a specified warm line or website. Referrals may also be faxed in. A coordinator reviews referrals and connects families to services that are needed. Health Start is part of the coordinated referral system and has received a larger number of referrals since its inception.

2.5.6 Describe Resources available to enroll clients

PCHD Public Health Nursing has an extensive network of community resources that are utilized in working with clients. This includes the Tucson Urban League, the African American Community Health and Wellness Coalition and other groups that work with and target the African American population in Pima County. PCHD also has close collaborations with several behavioral health organizations such as COPE and CODAC.

In the South Office target area, health care services are available at El Pueblo Neighborhood Clinic, Primeros Pasos and at Banner University Medical Center (BUMC South) South Campus. Prenatal care, labor & delivery are not offered at BUMC South. El Rio Health Center, which provides care on a sliding fee scale, is located in all but the greater Green Valley target area, with twelve clinics in the Tucson metro area and operation of the Desert Senita clinic in Ajo. El Rio provides prenatal care at several locations.

Neighborhood associations work to decrease the incidence of crime taking place in their neighborhoods. School based Family Centers provide school linked family support services in neighborhood locations. Each center offers a range of social, health and counseling services, as well as parenting and adult education. Several centers provide a neighborhood health clinic and a DES eligibility worker on site. Most provide a link with preschool programs for families with at-risk children including Parent and Child

Education and Head Start. PHNs and CHWs network with these and other groups to make referrals for services/resources to receive Health Start referrals.

The Family Literacy project is active in most of the target areas along with numerous literacy and adult education programs. PCHD has an active Reach Out and Read program which is a clinic based program that role models reading to young children. Books are available to give to families in clinic and on home visits. Healthy Families is active in all of the target areas except Ajo and the more remote areas of the greater Green Valley area. PCHD Health Start has always had a close working relationship with Healthy Families. The Health Start Project Manager is a member of the Healthy Families Advisory Board. Coordination of services between Health Start and Healthy Families will continue.

Health Start clients have access to a variety of services and personnel at the PCHD including the following: 1) PHNs who provide a variety of services in Pima County, including immunizations and well child clinics; health education classes and home visits to at-risk populations. 2) Family planning, sexually transmitted disease and HIV testing clinics, 3) Women, Infant and Children (WIC) nutritional services, 4) teen services and 5) Health Insurance enrollment assistance.

PCHD Health Start has worked closely with area Head Start programs, Arizona Early Intervention Program, DDD, Teenage Parent Programs, and postpartum depression support groups to provide services for clients. In the Green Valley areas, clients can be referred to United Community Health Center for prenatal and health care needs. Preventive health services are available through the University of Arizona's Rural Health mobile clinics. The CHWs utilize resources from the Directory of Human Resources, an online resource. This comprehensive publication provides information on community agencies that serve all of Southern Arizona.

As part of training, CHWs are required to visit local agencies, make contact with staff, determine eligibility requirements and needed paperwork to apply for assistance. This allows the CHWs to have accurate information to give to clients and helps CHWs to establish relationships with agency staff to facilitate referrals and client services. The CHWs are also kept up-to-date on changes in programs via their staff contacts. CHWs participate in community activities such as health fairs which allow them to make contact with other agency staff and provide outreach to agencies in the targeted communities. They attend community meetings such as The Mother and Baby Wellness Coalition, Pima County Parenting Coalition and Family Support Alliance to maintain relationships with other organizations.

2.5.7 Describe how the RN and CISW consultation will be provided

The Licensed Social Worker or Licensed Counselor will attend monthly staff meetings and provide consultation on cases presented. The counselor or social worker will be available by phone between meetings and may go on home visits with CHWs, to better understand client situations and give appropriate advice to the CHW. The counselor or social worker may provide training and may assist in orienting new CHWs. All

consultations will be documented in the Care Facts electronic charting system by the CHWs. The consultation time will also be detailed on the invoice submitted by the consultant as part of the monthly billing.

The Registered Nurse Consultation will be provided by the project manager, Gloria Barrett and program coordinator, Gabriela Arriaga. They will serve as resources for the CHWs on the Health Start program and be available to consult on client issues. Ms. Arriaga will provide direct supervision of the CHWs, conduct periodic chart audits, performance appraisals and advice on Health Start clients as needed.

The nineteen PHNs will also provide RN consultation to the CHWs. This is accomplished through: periodic joint visits with the CHW to Health Start clients; review of the CHWs documentation of client encounters; face-to-face meetings with the CHW about Health Start clients and provide input/feedback on interventions conducted by the CHW. All consultations, joint visits and chart reviews are recorded in the Care Facts electronic charting system by the CHW or PHN.

2.5.8 Similar home visiting programs

There are several home visitation programs in Pima County. The Health Start Program is unique in that the staff are community health workers and a Bachelor of Science (BSN) prepared registered nurse provides nursing assessments and consultation on client or CHW concerns. When it is discovered that duplicative services are being provided to a family, the family is told that only one agency can work with them. The family is informed of the services that each agency can provide and a discussion is held about which program best meets the family's needs. Ultimately, it is the family's decision as to which program they wish to continue with. This system has proved successful in minimizing any duplication of services.

Program Name	Program Goal	Services Provided
Nurse Family Partnership	Improve pregnancy outcomes, child health, development and self-sufficiency for eligible first time parents	In-home visitation to women residing in specific zip codes and at specific timing in gestational term
Teen Outreach Pregnancy Services (TOPS)	Provide education and support to pregnant teens	Classes and phone support to teen moms
First Steps	Improve parenting skills for parents of infants	Monthly home visits with parenting tips; birth to child age 1
Healthy Families	Enhance parent/child interactions, promote child health/development and prevent child abuse and neglect	Home visitation to pregnant women and families with children less than 3 months of age
Parents As Teachers	Provide parent education to enhance child development	Educate parents; group meetings, child development screenings, some home visitation
AZ Early Intervention Program	To provide eligible children and families access to services to support the child's development	In-home visitation for assessment and provision of therapies
Parent Aid	Increase parenting skills and knowledge of child development	In-home visitation and classes
Early Head Start	Enhance children's physical,	In-home visitation and day

	social, emotional and mental development	programs

2.5.9 Other Contracts that administer home visiting coordinator, Healthy Families, Nurse-Family Partnership etc. description and program coordination.

1. Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Grant. Funding for this grant comes from the Arizona Department of Health Services. Funding for the current fiscal year ending 9/2015 is $148,000. Staffing for the Family Support Program consists of 1 FTE Outreach Coordinator/Health Educator; 0.02 FTE Program Manager, Special Projects; 0.05 FTE Division Manager; and 0.05 FTE Administrative Assistant. Through a newly established referral system, agencies and medical providers within the community refer clients in need of home visitation and other resources. Referrals can be called in on a warm line, can be completed on-line at the Pima County Parenting Coalition web site or be faxed. The Coordinator reviews the referrals and connects families to appropriate home visiting programs and resources. Outreach via information sessions, trainings and presentations are provided to families throughout Pima County. In addition, the Coordinator attends/or presents at informational fairs and special events; and attends community meetings and participates in home visiting coalitions. Health Start, among other home visitation programs receives referrals from this referral system. The Coordinator ensures that services to each client unduplicated.

2. The Nurse-Family Partnership (NFP) is funded through the MIECHV grant, and totals $798,931for FY 14/15. NFP is staffed by one nursing supervisor, one administrative assistant and four PHNs. NFP staff, the MIECHV Outreach Coordinator and Health Start staff work together to conduct outreach, identify program eligible clients and to coordinate services and referrals. Referrals are made to either Health Start or NFP based on client eligibility and the needs of the client. Since Health Start and NFP have very different eligibility requirements (NFP only serves first time mothers less than 28 weeks gestation), the programs work well together to assure that all women receive services. For example, if a woman if 30 weeks gestation, the NFP staff would refer her to Health Start.

2.6. Experience and Expertise:

2.6.1 Description of Offeror's experience and expertise regarding the services offered.

The vision of the Pima County Health Department (PCHD) is "A Healthy Pima County: Every one. Every where. Every day". The mission is to ensure the health, safety, and well-being of our community through leadership, collaboration, and education. PCHD's operational tenets focus on leadership, assessment and assurance. Health Start's focus on helping women and families achieve healthier lifestyles fits well with PCHD mission and vision.

PCHD has a long history of community service, starting in 1930. Approximately 367 full and part-time employees work in six divisions to implement the agency's mission and vision. The six divisions include:

- Public Health Nursing has the three service components: clinics, case management and population based services
- Nutrition and Health Services comprised of Community Nutrition Programs, Consumer Health and Food Safety, Tobacco Prevention and chronic disease prevention
- Strategic Integration Team which includes Emergency Preparedness and Epidemiology
- Pima Animal Care Center consists of Veterinary Care and Disease Control, Enforcement, Animal Sheltering, Animal Licensing, and Public Education.
- Clinical Services includes Family Planning, Well Woman Health Check, STD/HIV services and mobile clinic services, tuberculosis program
- Business Operations which oversees financial operations, billing, procurement, Vital Records and the warehouse operations.

See **Appendix B** for the Pima County Health Department Organizational Chart.

The Abrams Public Health building is located at 3950 S. Country Club in Tucson, Arizona. PCHD administration, Public Health Nursing administration, Child Care Health Consultation, Oral Health Programs, WIC, Vital Records, Emergency Preparedness and Tobacco/Chronic Disease Prevention are located at this site. There are five Health Department offices:

- North office, 3550 N 1st Ave, Tucson; Public Health Nursing and Family Planning are at this site. A 1.0 FTE CHW is based at this office and covers the north targeted Health Start areas.
- East office, 6920 E Broadway, Tucson; Public Health Nursing, Family Planning and WIC services are co-located at this site. A 1.0 FTE CHW is based at this office and covers the east targeted Health Start areas.
- South office, 175 W Irvington, Tucson; Public Health Nursing and Family Planning services are co-located at this site. A 1.0 FTE CHW is based at this office and covers the east targeted Health Start areas. Ajo office, 120 E Estrella, Ajo is covered by the south office staff.

- Green Valley office, 601 N La Canada, Green Valley; Public Health Nursing is located at this site. A 0.5 FTE CHW will be based at this site.
- Teresa Lee Clinic, 332 S. Freeway provides Well Woman Health Check, STI/HIV services.

PCHD has provided Health Start or similar services for over twenty five years including as an ADHS contracted Health Start provider from April 1995 through the June, 1998. PCHD resumed providing Health Start services in September 1999 and has continued in that role until the present time. Prior to the 1995 Health Start contract award, PCHD operated a successful program called the Prenatal Care Initiative (PNI) for three years. The PNI was an outreach program to identify high-risk women in need of prenatal care and other services in targeted Tucson neighborhoods. This program utilized trained CHWs in areas with high rates of inadequate prenatal care, low birth weight and premature infants, and high percentages of infants requiring intensive care services at birth. Identified pregnant women were taught the importance of prenatal care, and were assisted in obtaining prenatal care and other needed resources. CHWs followed the families until their infants were three months of age, during which time they assisted families in obtaining health care and establishing a medical home. The families were referred to a Public Health Nurse if they required services beyond three months. In January 1994, PCHD received a small grant from ADHS to maintain the PNI as county support decreased.

Prior to the PNI, PCHD implemented a grant-funded project called the Pregnancy Outreach Program (POP). This program-utilized neighborhood volunteers to seek out pregnant women and assisted them to receive prenatal care and other resources. Many of the materials developed for the POP program are still in use by pregnancy outreach programs in Arizona, including Health Start.

PCHD's family planning division has utilized lay workers to target young women at-risk of cervical and other cancers and to reach homeless teens. PCHD also manages the Well Woman Health Check Program that targets older women in need of breast and cervical cancer screening. The Health Start CHWs have coordinated services with these programs by conducting joint outreach at health fairs and other community events, and have benefited from reciprocal referrals with these programs.

2.6.2 Resumes for key personnel responsible for delivery of services (see Attachment D for resumes and job description)
The Project Manager position is filled by Gloria Barrett, RN, MS. Ms. Barrett has served as the Health Start Program Manager for the past year. She has been responsible for the development, implementation and evaluation of the Pima County Health Start program. Both the program manager and program coordinator (Gabriela Arriaga) prepare for, attend and lead meetings, trouble shoot and correct problems; designate an alternate contact when Ms. Barrett is unavailable; both provide administrative oversight of all contracted activities. They have or will:

- hire, train and supervise community health workers
- ensure that contracted activities were carried out in accordance with the Health Start policies and procedures and **SOW 5.29**

- carried out quality assurance activities i.e. quarterly chart audits and implementation of a client satisfaction survey
- provide input to the ADHS on various aspects of the program
- pilot tested and implemented the Healthy@Home assessment
- trained other Health Start staff on the use of the Ashline referral screening
- served on community advisory boards to network, assure non-duplication of services (e.g. Healthy Families Advisory Board, Family Support Alliance)

Ms Barrett will serve as the primary contact for the ADHS Project Manager; oversee implementation of the program and monitoring of program activities as required in the Health Start Policy and Procedure Manual. A minimum of 0.25% of her time will be spent on Health Start related activities. Gabriela Arriaga, PHN will work as the Health Start Program Coordinator and serve as Ms. Barrett's alternate. She has 10 years of experience as a Public Health Nurse and is a certified child birth educator. She has experience working in a program similar to the NICP, making home visits to high-risk infants in the state of Illinois. She is bilingual/bicultural.

Community Health Worker (CHW) positions will be filled by currently hired staff including:

- Patricia Lopez has worked with the Health Start program since 2002. Patricia is bilingual/bicultural, has car seat technician certification and is a certified lactation counselor. She has had previous experience with the Women, Infant's and Children's (WIC) program. One hundred per cent of Patricia's time will be spent on Health Start.
- Lilly McCauley has worked with the Health Start program since 2011. She is bilingual/bicultural. She is a certified car seat technician. One hundred per cent of Lilly's time will be spent on Health Start.
- Erika Ramirez has been employed with Health Start since 2009. She is bilingual/bicultural, is a certified lactation counselor and is certified as a community health advisor through Pima Community College. She has previous experience with the WIC program. One hundred per cent of Erika's time will be spent on Health Start.
- To Be Hired. Will be assigned to the Green Valley office as a 0.5 FTE Community Health Worker.

All CHWs currently employed have completed the Health Start orientation and training. They have completed training on the Edinburgh perinatal depression screening tool, the Ages & Stages 3 (ASQ 3) and the ASQ Social Emotional Questionnaires, Healthy@Home assessment, Alcohol, Tobacco and Other Drugs screening tool and brief interventions and relationship screening tools. CHWs utilize these tools currently in their work with Health Start clients as they implement the Life Course Theory Conceptual Framework with clients.

Community Health Nurses (CHN) positions will be filled by PCHD Public Health Nurses (PHN). All PHNs are Bachelor's prepared registered nurses with a variety of work experiences and backgrounds. All PHNs have been trained on and are utilizing the

Healthy Steps approach with all maternal-child clients. All PHNs employed by PCHD serve as nurse consultants for the Health Start program and have received orientation to the Health Start program. Three PHNs are certified car seat technicians; two have worked in hospital NICU's; one is a certified child birth educator; two are lactation specialists, one is certified in infant massage and one is a certified diabetes educator.

2.6.4 Offeror must describe how the Health Start Program Coordinator will be selected and how the Community Health Workers will be hired, trained and supervised.

The Health Start Program Coordinator was selected from the PHNs currently employed by the PCHD, Public Health Nursing division. The coordinator has maternal-child experience, an established network of community resources, and experience in working with CHWs. She is bilingual and has program development experience.

There are plans to hire an additional 0.5 FTE CHW for the Health Start Program. This position will be recruited from the target community via word of mouth, advertising on the Pima County website and in local publications. Interviews will be conducted to select the best candidate. The previous CISW will no longer be available to provide services. A notice of bid will be distributed to recruit a licensed social worker or behavioral health consultant. Bids will be reviewed and the bid will be awarded to the person best able to meet program needs.

The Health Start project manager and program coordinator will work with the ADHS program manager to insure that additional training of Health Start staff is completed, as needed. See **Appendix C** for the Health Start Program Organizational Chart.

The project manager is very familiar with the Health Start Policy and Procedure Manual (HSPPM), has been responsible for assuring that staff follows the HSPPM and are compliant with contract requirements. The program manager and coordinator will be responsible for the recruitment and training of new Health Start staff and the consultant, as needed; annual evaluations and supervision of the CHWs. They will conduct quarterly audits of Health Start records to insure compliance with contract requirements and review audit results with the CHWs. The project manager, coordinator or their designee will make a minimum of one home visit per year with the CHWs to directly observe their interactions with clients. The project manager or coordinator will elicit feedback from the Public Health Nurses (PHNs) that work closely with the CHWs in providing care to Health Start clients. Monthly staff meetings will be held with Health Start staff to provide program updates, including changes in the HSPPM, discuss issues/problems, case conferences and educational updates for staff. Meetings may be held more frequently or with individuals as needed. Since both the project manager and program coordinator are RNs, they will serve as nurse consultants for the program.

Training of the 3.5 FTE CHWs will follow the requirements as listed in the HSPPM. Training will be conducted by the Health Start project manager and coordinator, consultant, other PHN staff and community subject matter experts. CHWs will have a minimum of 16 hours of training to ensure adequate knowledge of pregnancy, prenatal care, maternal nutrition, women's and child's health, infant massage, immunization requirements, preconception and inter-conception health, reproductive health, birth spacing, multivitamins, male involvement and life plans, screenings regarding alcohol,

tobacco, other substance use, interpersonal violence, perinatal depression, home assessments, child safety, injury prevention, safe sleep and car seat safety and how to facilitate referrals **(SOW 5.9).** Training will also include topics specific to Pima County. An example of contractor specific training would include local resources that are available to assist Health Start clients.

In the event that it is necessary to replace a current CHW, recruitment of possible candidates would take place within the communities in which the CHW would be working. Every effort would be made to hire a worker from the targeted communities and who is representative of the population of that community. The hired CHW would be culturally sensitive to the residents and every effort will be made to accommodate language barriers. This will be true for the 0.5 FTE Community Health Worker that will be hired.

2.6.5 Technical Qualifications:

The Project Manager position will be filled by Gloria Barrett, RN, MS who currently is in this position. The project manager will be responsible for the overall implementation and evaluation of the PCHD Health Start program. She will serve as the primary contact person for the ADHS Program Manager. Ms. Barrett has attended, led and prepared materials for meetings under the current Health Start contract and will continue to do so. Ms. Barrett is familiar with the Health Start contract and the HSPPM. She will oversee orientation/training of Health Start staff on all aspects of the contract and HSPPM. She will review all materials to be submitted for the monthly billing to assure that all forms are completed accurately and all required documentation is included prior to submitting to the ADHS. She will insure that billing materials are submitted to the ADHS on a timely basis. She will prepare and submit the required quarterly reports in an accurate manner and within 30 days after the end of each quarter and assure timely response to the Health Start manager if there are questions **(SOW 5.24)**. Quality assurance activities such as quarterly chart audits and client satisfaction surveys will continue. The project manager will advertise for and recruit either a licensed social worker or behavioral health consultant for the program. She will work with the contracted Social Work or behavioral health consultant to assure that all job tasks required are fulfilled. Ms. Barrett will work closely with the program coordinator to assure that all the tasks required under the **Scope of Work 5.2 to 5.28.6** are completed. The program coordinator will serve as her alternate contact when Ms. Barrett is not available. Ms. Barrett will maintain the background checks on the currently hired CHWs and assure that a background check is completed on new hires with a copy placed in their personnel files. **(SOW 5.3)**

Ms Barrett will investigate any problems that arise in the implementation of the Health Start program and a solution to any problems will be implemented, in consultation with the ADHS program manager. Measures will be taken to insure that no further problems arise.

The Program Coordinator, Gabriela Arriaga, RN, BSN will work with Ms. Barrett to recruit and train CHWs **(SOW 5.2, see above for SOW 5.9).** She will have primary supervisory responsibility for the 3.5 CHWs as they identify, screen, and enroll pregnant and postpartum women in the Health Start program. She will monitor the CHW

caseloads to assure that each full time CHW maintains a caseload of at least 60 women and families, the majority being prenatal clients. The 0.5 CHW will maintain a caseload of at least 30 women and families, the majority being prenatal clients. Ms. Arriaga will work with Ms. Barrett and the CHWs to develop an outreach plan to achieve and maintain the minimum number of clients **(SOW 5.4).** The Program Coordinator, manager and CHWS will attend all Health Start sponsored annual meetings and trainings **(SOW 5.5, 5.6).** Ms. Barrett and Ms. Arriaga will provide or facilitate the CHWs receiving a minimum of 12 hours of continuing education/training annually **(SOW 5.10).**

The Program Coordinator will oversee the CHWs to assure that they implement the Life Course Theory Conceptual Framework by providing education, including information on enrollment into Health Start, prenatal care and the importance of taking multivitamins with folic acid and education to women who have a positive pregnancy test. They will also provide preconceptual/inter-conceptual education, including information on healthy behaviors, recommended birth spacing and the importance of taking a multivitamin with folic acid education to women with a negative pregnancy test **(SOW 5.7, 5.8).** The program manager and coordinators will instruct CHWs on how to screen and enroll clients, utilizing the enrollment form, with a health risk assessment, visit and contractor referral form, how to provide home/office visits of a minimum of 30 minutes duration, conduct developmental assessments, screenings, and referrals, and optional educational classes of at least one hour duration, completion of forms, the identification and utilization of referral sources available **(SOW 5.11, 5.14, 5.17).** A minimum of eight (8) supervised home visits will be conducted with CHWs within 90 days of hire and at least minimally annually thereafter. Supervised visits will be documented utilizing the Home Visiting Checklist and the completed checklist will be saved in the personnel file **(SOW 5.12, 5.13).** During the orientation and training of new staff, the Health Start training curriculum is utilized. Pre and post tests are administered to determine baseline knowledge and the areas for the most concentration. All CHWs must pass the posttest with 90% or better. The post tests are sent to the ADHS Health Start Program Manager and a certificate of completion is issued. To assure the CHWs' compliance with the contract, a quarterly chart audit is conducted on randomly selected clients. The audit checks to assure forms are placed in client record and signed/dated by clients in blue ink on the bottom of the form **(SOW 5.23.2).** Audit results are reviewed with each CHW. In addition, the program coordinator assures that the monthly staff follow-up visit checklist is completed. The coordinator also calls two randomly selected clients per CHW to ask about services that were provided and to determine satisfaction with services. The checklist is kept on file for review **(SOW 5.26).** The coordinator reviews the CHW outlook calendars for scheduled home visits, classes and other Health Start related activities. These are available for review at contractor site visits **(SOW 5.27).** Program forms are reviewed monthly to assure completeness and accuracy prior to submission to the ADHS within 15 days of the billing period **(SOW 5.22, 5.23.1).** The PHN staff consults with the CHWs on a regular basis and reviews the CHW documentation in the client record.

Ms. Barrett and Ms. Arriaga will identify and develop two Quality Improvement (QI) Indicators as described in the HSPPM and assure progress towards achievement on a

monthly and quarterly basis **(SOW 5.25).** For example, one QI could be to improve the rate of return on client surveys. Activities to monitor progress would be tracking of how many surveys are distributed and returned. The surveys could be coded to indicate which CHW distributed them and their approach to the families. This information would be used to identify areas of improvement as well as strengths **(SOW 5.15).** Ms. Barrett will respond in a timely manner to the Health Start data quality specialist or Health Start Program Manager if there are any questions about billing forms or encounter data. This is a QI measure from ADHS **(SOW 5.23.3).**

As part of training, CHWs are required to visit local agencies, make contact with the staff, determine eligibility requirements and needed paperwork to apply for assistance. This allows the CHWs to have accurate information to give to clients and helps the CHWs to establish relationships with agency staff. This relationship then serves as a means to continue outreach and case finding activities. The CHWs are also kept up-to-date on changes in programs via their staff contacts. CHWs also participate in community activities such as health fairs which allow them to make contact with other agency staff and provide outreach to agencies and the community. They attend community meetings such as The Mother and Baby Wellness Coalition (MBWC) and Family Support Alliance (FSA) to maintain relationships with other organizations. These activities provide for continuous updating of knowledge and awareness of health, behavioral and other community resources **(SOW 5.16).** CHWs will be assisted with referrals and complete all encounter form documentation as needed **(SOW 5.18).**

The program manager and coordinator will provide the required four hours/month of RN consultation and PCHD will contract with a licensed social worker or behavioral health consultant to provide four hours/month, including training activities. All will attend the monthly Health Start staff meetings/case conferences and provide reflective supervision and guidance regarding difficult client situations **(SOW 5.19.1, 5.19.2).** Ms. Barrett will monitor the work of the Social Worker or behavioral health consultant to assure that required duties and responsibilities are fulfilled as described in the HSPPM and the Contract **(SOW 5.21).**

The program manager/coordinator will communicate with and work closely with ADHS to implement any program changes and program development, notification of changes in personnel and daily operations as issues arise, share information with ADHS and other Health Start coordinators about resources, forms, reports, challenges and barriers **(SOW 5.28.1, 5.28.2, 5.28.3, 5.28.4).** The program manager/coordinator will be responsive to ADHS for requests for information or clarification in a timely manner **(SOW 5.28.5).** The program manager/coordinator collaborates with community based agencies through participation in the Healthy Families Advisory Board, Family Support Alliance, Pima County Parenting Coalition and other community organizations **(SOW 5.28.6)**.

2.6.6 See **Attachment D** Key/Essential Personnel