Northern Manhattan Perinatal Partnership
127 West 127th Street, Third Floor
New York, NY 10027
212-665-2600
212-665-0495
mdrummonds@msn.com

Central Harlem Healthy Start IMPACT REPORT

Mario Drummonds, MS, LCSW, MBA
Chief Executive Office

Goldie Watkins-Bryant, MPH
Project Director

Dennis Ho Sang, MPH
Evaluation Director

Kathleen Francis, LMSW
Case Manager Supervisor

Ron Turner
Consortium Manager

Central Harlem Healthy Start
Impact Report
July 1, 2001 – May 31, 2005

September 30, 2005

John McGovern
MCHB
Parklawn Building
5600 Fishers Lane, RM 18-12
Rockville, MD 20857-0001

Re: Healthy Start Eliminating Disparities in Perinatal Health (General Population)
Project No: H49MC00134 **July 1, 2001 – May 31, 2005 IMPACT REPORT**

Dear Mr. McGovern:

Attached are three hard copies and three discs containing the Central Harlem Healthy Start Impact Report for July 1, 2001 – May 31, 2005.

We at Central Harlem Healthy Start are deeply grateful for the opportunity HRSA gave us to continue to provide Healthy Start Initiative services to the Harlem community over the past four years. We are pleased to share with you the improvements in birth outcomes delineated in Attachment I that have occurred in Central Harlem since the initiation of our Central Harlem Healthy Start program in 1990. Fifteen years of collaborating with the perinatal service providers, the stake holders and Central Harlem community residents has produced an 80% decline in infant mortality: from 27.7 infant deaths/1,000 live births in 1990 to 5.1 in 2004. Moreover, teen deliveries have slid from 467 in 1990 to 220 in 2003, some 53%.

If you have any questions, please contact Goldie Watkins-Bryant, Project Director, Central Harlem Healthy Start (212) 665-2600, x324.

Sincerely,

Goldie Watkins-Bryant, M.P.H.
Central Harlem Healthy Start Project Director

Mario Drummonds, CEO, ED
Northern Manhattan Perinatal Partnership, Inc.

Attachments: Summary Impact Report, 1990 – 2005

2001-2005 Impact Report (3 paper copies and three copies on discs)**NORTHERN MANHATTAN PERINATAL PARTNERSHIP, INC.**

CENTRAL HARLEM HEALTHY START

IMPACT REPORT

July 1, 2001 – May 31, 2005

TABLE OF CONTENTS

IX. Attachments

- **A. Project Accomplishments**
- **B. MCH Budget Details, Form 1**
- **C. Variables, Healthy Start Participants, Form 5**
- **D. Common Performance Measures and Intervention Specific Performance Measures, Form 9**
- **E. Characteristics of Program Participants, Table A**
- **F. Risk Reduction/Prevention Services, Table B**
- **G. Major Service Table, Table C**

X. Appendices

- ***a.*** **2004 Outreach Plan**
- ***b.*** **CHHS Newsletter*, Reaching Out***
- ***c.*** **CHHS Organization Chart**
- ***d.*** **Radio ads**
- ***e.*** **Forums Organized by CHHS/NMPP**
- ***f.*** **Promotional Flyers**

NORTHERN MANHATTAN PERINATAL PARTNERSHIP, INC.

CENTRAL HARLEM HEALTHY START

IMPACT REPORT

July 1, 2001 – May 31, 2005

XI. Overview of Racial and Ethnic Disparity Focused on by Project

Identify the racial, ethnic or other disparities that your project focused on. Highlight from your initial community needs assessment the data that led to your community's decision to focus on the identified disparities.

The Central Harlem target area incorporates the city Community Planning District 10 covering an area from 110th Street to 155th Street in the Borough of Manhattan of New York City and spanning zip codes 10026, 10027, 10030, 10037 and 10039. Target area population data presented at the start of the project period was based on the latest available census data of 1990. Accordingly, in the 1990 census, there were 40,711 women of childbearing age (i.e., aged 10-44 residing in the Harlem community), 30,402 or 75 % were Black, 6,364 or 15% were White, and 10% were of other racial backgrounds. Thirteen percent of the women (n=5,410) were Latino. About 25 % of the population in 1990 was under the age of 18.

Target area birth data at the start of the project period was based on available state and city vital statistics. Comparisons of upstate and downstate, especially New York City, areas are based on known racial disparities between those areas. The examination of perinatal outcomes in New York State and New York City provided us with a context for examining the level of need for perinatal care for Central Harlem residents. In order to frame our understanding of the perinatal needs in the Central Harlem community, the perinatal outcomes below were selected in accordance with the State's Title V priority areas for maternal and child health.

Birthrates in New York City (66.0 per 1000 females in 1998) tended to be slightly higher than rates for New York State (59.0 per 1000 females). The New York State pregnancy rate for teens was 81.3 per 1000 girls aged 15-19; the rates for Black and Latino teens were more than twice that of White teens (Maternal and Child Health in New York State Annual Report 1999). Twenty percent of moms had a birth interval of less than 24 months; the rate for New York City was 15%. The percent of unintended pregnancies in New York State was 35% in 1998 with women under 20, unmarried mothers, Black women, women on Medicaid, and women with less than a high school education more at risk for unintended pregnancies.

In 1998, 74 percent of the women in New York State received prenatal care during the first trimester. Women living upstate were more likely to receive early prenatal care (80%) than those residing in New York City (66%). Although the rates of early prenatal care increased for Black and Latino women, White women were still more likely to

receive early care. In addition, the adequacy of prenatal care (i.e. completing 80% of visits) was better for women living upstate and for white women.

In 1998, 7.9% of the births in New York State were low birth weight (under 2,500 grams) and 1.5% were very low birth weight (under 1,500 grams). Blacks were more than twice as likely as Whites to have a low birth weight baby (10.2 vs. 4.9). Latinos were also more likely to have a low birth weight baby than whites (6.5 vs. 4.9).

In 1999, the infant mortality rate (IMR) for New York City was 6.9 infant deaths per 1000 live births, which was lower than the Healthy People 2000 goal of 7.0. However, the overall IMR for New York City masks the persistent racial, ethnic and geographical differences that exist. In 1999, compared to infants born to White mothers (IMR=4.6), infants born to Black mothers were twice as likely to experience an infant death (IMR=10.6) (New York City Department of Health and Mental Hygiene). The rates for Latino mothers (IMR=5.6) was also higher than that of Whites although the rates for Asian mothers (IMR=4.0) was slightly less than that of Whites. In New York City, IMR also varied by health district with the poorest communities in the city evidencing the highest infant mortality rates. In 1999, Central Harlem had the highest IMR in the city with 15.5 deaths per 1000 births. According to the New York City Department of Health and Mental Hygiene Vital Statistics, during 1996 to 1998, the IMR for Central Harlem was 10.9. In 1990, Harlem also had the highest rate in the city (27.7) and during the Healthy Start project the rate evidenced a sharp decline.

The finding of disparities in health outcomes in New York City was mirrored in the Perinatal Periods of Risk approach to the analysis of birth outcomes by the New York City Department of Health and Mental Hygiene in 2002. The Perinatal Periods of Risk approach to determining the prevailing risk factor for birth outcomes in a population was developed by the Centers for Disease Control and Prevention in conjunction with the World Health Organization. It is an analysis of singleton births which plots birth weight against feto-infant deaths; i.e. fetal, neonatal or post nenonatal mortality. Based on the distribution of the data, the analysis reveals that the prevailing risk for poor birth outcomes within the population under study is maternal health/prematurity, maternal care, newborn care, or infant health. In addition, more insights are gained on birth outcomes when the feto-infant mortality rate is also computed {fetal deaths + infant deaths per 1000 (fetal deaths + infant births)}.

The Perinatal Periods of Risk approach when applied to birth outcomes in New York City for the period 1996 – 1998 showed that maternal health and prematurity accounted for 39% of the deaths and maternal care accounted for 30%. The feto-infant mortality rate in the city was 8.8 per 1000 fetal deaths plus live births. The rates and causes of death varied by borough and race/ethnicity with Blacks and Latinos having the highest rates. Among Blacks, the rate was 13.8 per1000 fetal deaths plus infant births with Blacks having two and a half times the feto-mortality rate of whites. The major causes of deaths for black infants were maternal health and prematurity (44%) and maternal care (28%). Compared to Whites, Blacks had four times the rates of deaths due to maternal health and prematurity and over two times the rates of deaths due to both maternal care and infant health issues. NYCDOHMH maternal and child health staff concluded that citywide interventions to decrease feto-infant mortality should focus on a mother's health prior to conception, maternal health behaviors and perinatal care.

Table A

Maternal and Child Health for Central Harlem Data: 1996-1998

Source: New York State, Bureau of Women's Health

Area	Total Births	LBW	Pre-term Births	Late or no Prenatal Care	Median IMR
10026	1760	12.2	27.8	14.1	15.3
10027	2238	11.3	24.3	14.9	4.0
10030	1253	14.0	25.8	16.3	11.2
10037	627	9.4	30.2	13.8	12.8
10039	1103	12.1	25.4	12.4	10.0
Central Harlem	6981	11.8	26.7	14.9	12.2
Manhattan	58,470	8.7	19.8	8.8	5.7

An analysis of infant deaths in Harlem for 1998 and 1999 (Office of Family Health, New York City Department of Health and Mental Hygiene 2001) showed that most of the deaths occurred in the neonatal period. Of the 30 deaths for 1999, 23 were neonatal deaths and 7 were postneonatal and for the 22 deaths in 1998, 16 were neonatal and 6 were postneonatal. Prematurity accounted for 67% of the infant deaths in 1999 and for 46% of the infant deaths in 1998.

Municipal maternal and child health services for Central Harlem and the city are coordinated by the Division of Family Health Services (FHS) of the New York City Department of Health and Mental Hygiene which includes maternity services and family planning, day care, immunization, school health, children with special health care needs and the Women's Health Line. In 1999, the department of health established the New York City Infant Mortality Task Force to develop an initiative that would reduce the infant mortality rate and address the racial, ethnic and geographical disparities that exist

for infant deaths in New York City with community based organizations. The Harlem Strategic Action Committee to Fight Infant and Maternal Mortality was organized in 2003 in response to task force recommendations. See the section on **Collaboration and Coordination with Title V and Other Agencies,** page 37, for a description of the work of the committee.

An important service initiative was the Healthy Start/NYC (HS/NYC) project conducted from 1991 through 2001. As a Health Resources and Services Administration (HRSA) demonstration project, the Healthy Start Initiative (HSI), it aimed at reducing the infant mortality rate by 50% in three low-income, medically underserved communities located in Manhattan (Central Harlem); Brooklyn (Bedford-Stuyvesant) and the Bronx (Mott Haven). The Medical and Health Research Association (MHRA), an independent non-profit health services and research organization, was the grantee for the project. It was administered centrally by a Project Area Office but locally by the three perinatal networks that cover those regions: Brooklyn Perinatal Network (BPN), Northern Manhattan Perinatal Partnership (NMPP), and Bronx Perinatal Consortium (BPC).

During Phase I of the Healthy Start Initiative, 1990 – 1997, infant mortality in the three communities showed a dramatic decrease of 53% compared to the 38% drop seen citywide. A recent report entitled *Reducing Infant Mortality: Lessons Learned from Healthy Start* indicated that Healthy Start/NYC impacted prenatal care utilization. Participating in the project was associated with greater utilization of prenatal health care services, earlier use of care and greater numbers of prenatal visits. The report was published by Medical and Health Research Association of NYC in August 2001.

To identify gaps in the maternal and child health system, a series of focus groups were conducted with professionals including the Executive Directors from the perinatal networks and representatives from Healthy Start/NYC, the March of Dimes, the Visiting Nurse Services of New York and educational institutions. They found that major weaknesses in the system included the competition for scarce financial resources for maternal and child health providers which fostered competition rather than collaboration. Barriers still existed for many clients including no or insufficient insurance, lack of transportation to access care and lack of linguistic or cultural sensitivity on the part of providers. The need for providers who could work with clients of different cultural backgrounds was also evident. Studies have shown that providers are not communicating the same information to their patients; only 48% of Black parents were instructed not to have their infants sleep on their stomach compared to 72% of white parents. Focus group participants noted that there were still gaps in the quality of care provided by private and public providers. Poor dissemination of information and lack of public awareness of existing services were also seen as weaknesses. These findings were applicable to the three Healthy Start/NYC communities and not all findings were applicable to the Central Harlem community.

The assessment of community needs described above took place at the start of the project period in 2001 and was based on the latest available 1990 U.S. Census data. By the 2000 census, Central Harlem had undergone significant demographic changes. The population rebounded, increasing by 8.4 percent from 99,183 in 1990 to 107,506 in 2000. The area underwent revitalization under a state economic empowerment zone designation which is attracting more population and development to the area. Central Harlem had 56,899

women of child bearing age (10 to 44 years) which is 53.1 percent of area women in 2000. The teenage population (10 to 19 years) was 15,316 or 14.3 percent of the population. The age distribution for the area is similar to that of the city only slightly younger.

Since 2000, Central Harlem continued to experience an influx of immigrants from West African countries including Senegal, Guinea, Gambia, Mauritania, Nigeria, Ghana, Mali, and the Ivory Coast. Immigrating to a new country can create cultural and language barriers to accessing health and social services. The changes in the composition of community residents in Central Harlem underscore the need for expanded services which are sensitive to the needs of each specific culture. Moreover, there are a large number of undocumented immigrants in these communities.

During the project period, disparities in perinatal outcomes in the Central Harlem target area, compared to city and national measures, underwent significant changes. The infant mortality rate for the area decreased from 15.5 to 13.0 deaths per 1000 live births (three year average from 1999 to 2001) which were 197.5% of the city rate of 6.6 and 184% of the national rate of 7.05. The disparity for the neonatal (less than 28 days) mortality rate was 9.8 for the area compared to 4.6 for the city, a disparity of 215%. The infant mortality rate due to birth defects accounted for 24.4% of infant deaths in the city compared to 20.1% nationally.

Notable gaps in access to health care services were observed during the project period. While there were adequate supplies of prenatal care services and providers in the area, many women did not use them. The late or no prenatal care rate for the three year average from 1999 to 2001 was 12.4%. A significant number of area women are uninsured and immigrant pregnant women who have not attained legal status find it difficult to access prenatal care, even though the only eligibility rule is household income. Some 57 percent of non-US citizens living in New York with income below the federal poverty level are uninsured. Underutilization of prenatal care may also be due to demographic factors such as poverty, homelessness, low education attainment, unmarried, race and extreme age. Social factors such as domestic violence and former incarcerated individuals also lead to the underutilization of prenatal care. Transportation as an access barrier is less of an issue in the area than might be in rural areas since the area has a good public and medical emergency transportation system. But practical problems such as cost, added time, discomfort during pregnancy, and traveling with small children become obstacles.

XII. Project Implementation

All five of the Healthy Start Core Services (Outreach and Client Recruitment; Case Management; Health Education and Training; Interconceptional Care; and Depression Screening and Referral) and the four Core Systems-building efforts (Local Health System Action Plan; Consortium; Collaboration and Coordination with State Title V and Other Agencies; and Sustainability)implemented by the CHHS project were reviewed and approved by the Northern Manhattan Perinatal Partnership, Inc., Board of Directors in

2001 prior to submittal of the CHHS competitive application to HRSA. Board membership included a former Executive Director of a substance abuse agency, a former Head Start director, a former director of midwifery services for a large non profit health and research organization, a former CHHS client, a current administrator of the municipal Health and Hospitals Corporation, as well as those with business and budgeting experiences.

Outreach and Client Recruitment

A. Describe how you decided on your approach to each service, and the rationale for your particular approach based upon your particular community's needs, its service system and challenges and assets.

As noted in Section I, above, CHHS was not undertaken as a new project in 2001. At the outset of the project in 1990, the Central Harlem infant mortality rate was 27.7 infant deaths per thousand live births and the late or no prenatal care rate was 24.2%; both rates were the highest for any health district in New York City at the time. Although for 1996-1998 the median infant mortality rate was 12.2 infant deaths per 1000 live births, a 50% decline; the average late or no prenatal care rate had declined by only 38% to 14.9%. (See Table1.) For this period, the Manhattan median infant mortality rate was 5.7 infant deaths per 1000 live births yielding a disparity with Central Harlem of 214% while the late or no prenatal care rate was 8.8% yielding a disparity of l69%. Thus, on average, from 1996-1998, 33 women experienced an infant death and 375 failed to obtain early and continuous prenatal care annually. The average percentage of Central Harlem births that were Latino was 7% and on average 40% were born to foreign mothers.

Most of the women experiencing an infant death and/or bearing a low birth weight infant were African American women; nevertheless, many foreign born women also experienced these poor birth outcomes. Although the late or no prenatal care rate had declined significantly, it continued to be excessive. Harlem has been a magnet for immigrants for many years. The most recent waves of new comers have been arriving from West Africa and Central America. Many of the West Africans are from French speaking Senegal, Guinea, Mali and the Ivory Coast. The Central Americans speak Spanish and the West Africans speak some French. Most of the immigrant women of reproductive age, 14-44 years of age, are not aware of the Prenatal Care and Assistance Program (PCAP) or the services provided by Central Harlem Healthy Start. Sponsored by the New York State Department of Health, PCAP provides free prenatal care to all women with incomes less than 185% of the Federal poverty level and are required to refer all eligible participants to WIC. In New York State, there is no penalty applied to citizenship applications for having utilized PCAP services. Unfortunately, many indigenous women are not aware of the PCAP program or CHHS, especially those using drugs, those who are homeless, those recently released from prison or those experiencing domestic violence. With large numbers of young non-English speaking residents and significant numbers of indigenous women not receiving care early in their pregnancy, outreach efforts were essential to reaching the most high risk residents of the Central Harlem community.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention.

CHHS employed one outreach worker who reported to the project director. Initially, the outreach worker reported to the health education and outreach supervisor. This worked quite well at the start of the project because of unspent funds rolled over from 2001 to support the 2002 budget. Without such funds available for 2003, the position was downgraded to a none-supervising health educator when the health education and outreach supervisor left CHHS during the spring of 2003. The funds freed up were used for increasing the child care, client incentives, health education materials and postage budget lines. The CHHS Project proposal had been submitted for a budget of one million dollars. The budget was approved for $875,000, a 12.5% cut without a proportional decrease in deliverables as outlined in the original application.

The target population in Central Harlem is primarily English speaking (70 %). Twenty percent of the community is Hispanic. Increasing numbers of French speaking West Africans now reside in south east Harlem who speak French and local African dialects. CHHS had the capacity to communicate with our participants in English, Spanish and French.

During each year of the project, an Outreach Plan was developed for the Central Harlem community that was informed by the most current infant mortality data mapped by zip code along with our historical successes. The outreach plan targeted community zip codes where infant deaths had occurred during the past few years and where large numbers of immigrants lived. Our outreach efforts were multilayered, targeting many levels for client and community engagement. The plan described the mechanisms and incentives to be used based on the outreach strategy being undertaken; street, door-to-door, homeless shelters, perinatal services agencies, local businesses and health fairs. The plan delineated the responsibilities of the outreach worker and other CHHS staff. Incentives were used to enhance the impact of our outreach work. These included pens, calendars, bibs, shopping bags, and first aid kits. They bore the name and telephone number of the CHHS project for future use.

The outreach worker conducted street, door-to-door, local business, agency and health fair outreach. Each year 25% of the streets in our catchment area were targeted for intense door-to-door and street outreach. Outreach material was distributed in English, French and Spanish. Most new immigrants are not aware of the New York State sponsored PCAP program nor CHHS support services. Street outreach along with distribution of promotional material were helpful in reaching out to all women of reproductive age with information about these programs. Hair braiding shops operated by women from West Africa were helpful in reaching immigrant pregnant women from French speaking countries. CHHS offered English as a Second Language to women from these shops and our French speaking African clients as a mechanism for reaching out to the African French speaking community. We had a male case manager from Cameroon

during 2003 that facilitated our work with the French speaking clients by providing education about the PCAP and CHHS programs. He was especially helpful in speaking with the heads of households of West African families about the benefits available through these programs. The men were advised that their citizenship application would not be jeopardized by family members utilizing the programs.

CHHS promotional flyers indicated the services provided, which included case management with referrals to WIC, PCAP, other health care services, and pantries and emergency supplies. The flyers indicated that pampers, formula, strollers and cribs were available to clients in emergency situations. The flyers also contained the zip codes for eligible residents and the number to call for assistance. There are at least seven homeless shelters in Central Harlem with some 1,000 residents from across the city; the shelters are visited regularly to recruit clients. We do not know the exact number of domestic violence shelters located in our targeted zip codes. There are no residency requirements for shelter residents.

When canvassing the community, the outreach worker distributed project flyers to community residents on the street, left multiple copies of promotional flyers in delis, laundromats, beauty salons, hair braiding shops and barber shops. In housing projects, she went door-to-door leaving flyers. She visited a variety of community health and social service programs across our catchment area to leave promotional materials and advise management that she was available to provide health promotion workshops to increase name recognition with clients and referrals from staff. She was regularly out stationed in several WIC centers and Prenatal Care and Assistance Program clinics.

There were several churches that routinely hosted community health fairs during the spring and summer where we distributed bags of dried beans and literature on folic acid from the March of Dimes. Our outreach efforts targeted pregnant and interconceptional women with high risk characteristics. These included the homeless, victims of domestic violence, teenagers, ex-offenders, substance abusers, older women and those suffering from depression that were pregnant or parenting.

CHHS outreach efforts were complemented by those of Sister Link, a CDC/NYSDOH Aids Institute funded Community Action for Prenatal Care (CAPC) program that conducts outreach to prevent transmission of HIV. Sister Link is housed at NMPP and includes a group of some 30 outreach workers based in clinics across the city. They target sex workers, ex-offenders the homeless, teenagers, immigrant women, substance abusers and others at high risk of contracting HIV, in order to refer them to services provided by some 75 agencies to prevent the transmission of HIV from mother to infant. During 2002, some 17% of our clients were referred by Sister Link. That number had dropped to 11% in 2004. The largest single source of clients in 2004, some 22%, were self referrals or referred by other clients.

CHHS and NMPP took advantage of invitations to speak about the importance of early prenatal care and health promoting behavior to good birth outcomes as well as the services we offered using various media and venues where presentations/discussions

could be held on maternal and child health topics/issues. These included radio talk shows, TV interviews and annual meetings of beauticians and church nurses. During Phase I, we also purchased ad time. See Attachment D for the script used for radio ads.

CHHS established linkages with the Renaissance Health Care Network which includes the Renaissance Community Health Center and Drew Hamilton and Grant community based clinics; the latter two are located in Central Harlem housing projects. We worked closely with the African Services Committee for referral of West African residents. We also executed Memoranda of Agreement (MOAs) with the Upper Manhattan Mental Health Center, the Helen B. Atkinson Community Health Center which includes dental care among the services provided, and the Harlem Hospital Center WIC program which has six sites; four are located in housing projects. The links with WIC programs and PCAP clinics made the sites available to the outreach worker to recruit referrals as well as assist provider agencies in referring appropriate clients to us.

As the Outreach worker obtained referrals through her outreach contacts, she completed a referral form and forwarded it to the Supervisor of Case Management. The supervisor reviewed the referral and assigned the case based on the needs of the client and/or the expertise/interest of the case manager to be assigned the client and/or case load. The case manager then attempted to reach the client by phone and to schedule a home or office visit. If the prospective client was unable to be reached by phone, an unannounced home visit was made by the outreach worker. In an emergency situation, the prospective client had the intake performed immediately by the outreach worker and escort service was provided or an emergency referral was made.

Our outreach included the efforts of our Consortium committees. These were our Health Education Committee that included health educators from a variety of agencies, our Case Management Committee that involved various levels of social workers and case managers from local partners, our Consumer Involvement Organization that consisted of current and former clients, and our Male Involvement Consortium with its annual job fairs that drew 738 participants in 2003. These committees of the consortium helped educate community providers, elected representatives, business leaders and residents on the importance of early and continuous prenatal care services and the impact of unhealthy behaviors, poor community health status and stress on healthy birth outcomes. Staff also presented workshops at churches, schools, daycare centers and other community venues on early entry into prenatal care services and health promoting behaviors and the unique health challenges to community residents that produce poor birth outcomes with strategies for behavior modification. CHHS promotional flyers were always left with participants.

During the past three calendar years, CHHS recruited and provided comprehensive social/health case management services to 398 unduplicated clients, serving at least 200 annually, per our HRSA target. One hundred eighty-six were pregnant. Twenty-two percent of these clients entered the case management program during the first trimester of pregnancy; 34% during the second trimester and 44% during the third trimester. The

average late/no prenatal care rate for all Central Harlem residents from 2001-2003 was 10.8%.

The Outreach worker routinely carried a small caseload of three to five low to moderate risk clients with the capacity of serving up to eight such cases, if necessary, based on the case loads of the case managers.

C. Identify any resources or events that either facilitated or detracted from successful initiation and implementation of each intervention.

The outreach worker benefited from her membership in the Sister Link Community Advisory Group (CAG) which met quarterly and the monthly Sister Link meetings with city-wide outreach workers. From the Community Advisory Group, she learned about hot spots of activity in Central Harlem where new or more intense drug dealing or prostitution was taking place or where pregnant teens were congregating, etc. The CAG represented its eyes in the community and it consisted of current and former clients. The outreach worker's participation in quarterly Sister Link meetings gave her the opportunity to go out with a group of outreach workers saturating a housing complex or homeless shelter in Central Harlem with promotional materials.

The City Council made a total or $27,000,000 available to fight infant mortality over the past five years. Of the funds allocated to CHHS, we were able to annually recruit from 42 to 75 additional clients, or an average of 56 per year, beyond our normal case load of 200 clients. CHHS homeless clients who moved outside of our catchment area could be included in this number when we continued to serve them. The flexibility of City Council funds also allowed us to serve high risk clients living outside of our CHHS catchment area who were referred for case management services or were walk-ins. Through the overtime accrued by staff in serving these additional clients, we were able to provide staff with cost of living raises in their salaries. The training we provided staff along with the raises helped to stabilize our staff over the past four years.

Please see the attached summary matrix of progress toward implementation of CHHS outreach objectives, Attachment A.

Case Management

A. Describe how you decided on your approach to each service, and the rationale for your particular approach based upon your particular community's needs, its service system and challenges and assets.

The birth outcome measures for Central Harlem from 1996-1998 as outlined in Table A led the managers of CHHS to use the traditional social/health case management model it had used since the beginning of the project to address the continued excess numbers of pregnant women who received little or no prenatal care, who experienced unacceptable large disparities in their rate of preterm deliveries and excess numbers of low birth weight infants. This decision was reinforced with the knowledge that some 5% of Central

Harlem residents had recently reported emotional distress and the fact that Central Harlem had 80% more mental illness hospitalizations than New York City in 2001. In addition there were at least seven homeless shelters in this community, housing some 1,000 families; many from other parts of the city who were pregnant and/or parenting young children with no knowledge of the service system in Central Harlem.

The support and education provided by the social/health case management model were viewed as key tools to addressing the lack of early and consistent use of prenatal care services as well as the mental health and homeless needs of many pregnant and parenting women in this community.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention.

In using the traditional social/health case management approach, we recruited clients from the Central Harlem community, offering them home and/or office visits for intake, assessment and support. We also referred participants to needed services and, as necessary, escorted them to appointments. We addressed the participant's immediate needs and then developed a service plan in collaboration with the participant to meet their long term needs. Although CHHS clients experienced a few fetal deaths, none experienced an infant or maternal death over the past four years.

We found that due to the transient nature of our client population there were many times when we were unable to locate participants because they had moved to another part of the city. Of the 398 clients enrolled in CHHS from 2001 – 2005, some 300 indicated the need for housing assistance when completing the assessment form; of this group five were living on the streets. We also learned how changes in welfare policy in 1996 and declining affordable housing in New York City impacted the participants' ability to return to school for additional training or gaining new skills and fed the homeless shelter system. Clients had to work for their public assistance grants which meant that they were not available during the day for pursuing their education and training goals. Housing assistance allowances are based on family size which means that a family may be entitled to a housing allowance; however, it may not be sufficient for renting an apartment in today's market.

Staff soon realized that most of our services had to be concentrated in the first three months following intake before we lost the client. Where necessary, case managers met with clients after work hours, while waiting for appointments with providers and/or through the use of telephone contacts. This, in part, led to the development of a combination Welcome/Health Education packet that was given to clients at intake with information on pregnancy, WIC centers, the signs and symptoms of depression with service sites, and other information that we felt might be beneficial to pregnant and parenting women that would be available for future use even if the participant lost contact with the CHHS project.

The case management team found the need to be flexible in our attempts to meet with participants. Staff worked after normal business hours, went to homes early, met participants at doctors' offices and during their lunch/or school break. We also found that

a large number of our participants would not attend agency functions although they would keep their appointments with case managers in the office or at home. There were some participants who never came to the agency and made no connection to Healthy Start or NMPP as the service provider. Some of our participants also tended to retreat when in crisis thus making it more difficult for staff to engage them. However, through repeated outreach efforts, many returned for emergency supplies and/or services.

In addition to depression and homelessness, Central Harlem is noted for its excess levels of unemployment and poverty. Many of our clients who were already burdened with these challenges when they also found themselves pregnant and alone or alone with young children seemed to benefit most from the sister-friend component of our social/health case management model. Our case management program used four college trained staff to provide social/health case management services. At times, we had assistance from outreach and supervisory staff that carried a small caseload. During 2004, the outreach position was filled with a case manager which greatly assisted us in providing service to larger numbers of participants. This occurred during a period when we were at capacity (25 to 29 clients per case manager) and did not need to focus on outreach.

C. Identify any resources or events that either facilitated or detracted from successful initiation and implementation of each intervention.

The CHHS case management program participated in the New York City Council funded Infant Mortality Initiative via a contract between NMPP and the NYCDOHMH. The additional funds allowed CHHS to serve high risk pregnant and parenting women outside the CHHS target area including homeless clients who moved outside of Harlem. Thus the case management team provided case management services to clients who found permanent housing in, or high risk residents of, the upper west side, Washington Heights, the boroughs of Brooklyn, the Bronx and Queens through City Council funds. This was done by staff extending their 35 hour work week as necessary to serve additional clients. Moreover, when homeless participants were permanently relocated outside of Central Harlem, we could continue to serve them. Thirty-one percent of the CHHS participant base enrolled with CHHS while residing in a homeless shelter; an additional 49% lived in unstable housing situations and requested housing assistance from CHHS. The increased salary for staff associated with the City Council funds helped us reduce staff turnover.

Please see the attached summary matrix of progress toward implementation of CHHS Case Management Objectives, Attachment A.

Health Education and Training

A. Describe how you decided on your approach to each service, and the rationale for your particular approach based upon your particular community's needs, its service system and challenges and assets.

At the time CHHS was funded in 1990, its initial charge was to conduct focus groups of residents, business persons and community leaders to assess the community's perception

of its needs. The results revealed that Harlem residents had become accustomed to sick and dying babies; they were more concerned with jobs and affordable housing. This meant that in addition to the CHHS project attempting to address some of the community's priorities it had to educate community residents on the meaning of poor birth outcomes and what could be done about them. As noted earlier, the infant mortality rate in 1990 was 27.7 infant deaths per thousand live births and the late or no prenatal care rate was 24.2%.

The 1996-1998 average infant mortality rate had declined to 12.2% and the late or no prenatal care rate had dropped to 10.3% as noted in Table A. Nevertheless, the breastfeeding rates at six months among our clients during Phase II remained stubbornly low at less than 30%; the risk for smoking while pregnant was excessively high with some 20% of our clients having a history of smoking and the average interconceptional period for repeat pregnancies remained below the national goal of 24 to 36 months. Therefore, CHHS continued to place emphasis on individual client and community education and advocacy.

B. *Identify the components of your intervention and the resources (including personnel) needed to implement the intervention.*

CHHS conducted its program participant health education activities during the last phase of the Healthy Start Initiative through our health educator, the outreach worker and our case managers. The health educator was employed exclusively by the CHHS Project and was supervised by the project director. The person filling this position either had a master's degree in health education or was a nurse midwife.

Health education topics for pregnant clients addressed pregnancy related issues, the importance of early and continuous prenatal care, the content of prenatal care (why various tests are conducted and what they mean), the importance of breastfeeding, contraception methods and use, nutrition for the pregnant and breastfeeding mom, the impact on the developing fetus from smoking, alcohol and illicit substance use, the signs and symptoms of perinatal depression and home and travel safety for the pregnant woman and for women with infants and toddlers. Interconceptional women were provided health education on the importance of the post partum visit and well baby care, infant development, feeding and safety, SIDS, the stages of infant development, the signs and symptoms of perinatal depression, pregnancy management with two year periods between pregnancies, weight management, exercise, diabetes, hypertension, smoking cessation, alcohol and substance abuse. All clients were provided information on family and home preparedness in the event of a major catastrophe such as a black out or a terrorist incident through one of our monthly mailings to clients.

When we determined that a client or client(s) needed health education in areas that we could not address such as infant CPR, the health educator frequently obtained a consultant who provided the service. In other situations, we provided the health educator with additional training; our health educator became certified in infant message. When it was determined that clients needed additional parenting skills, we referred them to the

Baby College, a program of the Harlem Children's Zone, Inc. that is located four blocks from our office. It provides nine weekly three-hour parenting sessions four times a year.

We learned from a client focus group that we would get larger numbers of clients to come to health education workshops when a presentation on a life-skills topic directly related to clients' daily needs was included. Some of the topics addressed were how to select an apartment and caregiver for your baby/toddler, how to keep your home safe for toddlers, budget management, cleaning up your credit history, stretching your grocery budget, etc.

The group health education workshops were complemented with appropriate health education pamphlets and activities designed to transmit health promotion messages such as how to reduce the risks of SIDS, food preparation demonstrations, visits to grocery stores to demonstrate maximization of limited food funds, and how to read food labels. Hands on infant massage was taught in four sessions to moms with infants up to six months of age. In addition, we sent all clients monthly health education packets which contained health education brochures tailored to the pregnant or parenting status of the client, a CHHS/NMPP monthly activities calendar, the NYC Human Resources Administration's quarterly publication Diets and Dollars and a copy of the CHHS quarterly newsletter, *Reaching Out*. Our newsletter included congratulations to recently delivered moms, tips on self care and infant/toddler care including stress management, procedures for developing and monitoring personal goals, exercise suggestions, and budgeting insights. A copy is contained in Appendix B**.**

CHHS continued to provide health education messages to community residents, consortium members, health care providers and the general population using a variety of strategies. Each was tailored to the educational level and interests of participants; all included promotional messages regarding the CHHS project.

For community residents, the health educator, the outreach worker, the project director and a health education consultant presented health promotion topics and promotional material about CHHS at health education forums located in the community. We spoke at schools, churches and Head Start parents' forums. We had a collaborative relationship with Public School 911, which exclusively served pregnant teens. A curriculum on pregnancy, self care, breastfeeding and infant development was developed and used to help the young women practice healthy behaviors during their pregnancy, and help prepare them for parenthood. They were encouraged to select and use a contraceptive method and to complete their high school training after delivery. It was implemented annually during 2002 and 2003. The school was consolidated with another one for pregnant teens and the board of education provided these services beginning in 2004. Most of the young women were not interested in becoming clients of CHHS.

We also worked collaboratively with Greater Zion Hill Baptist Church speaking to youth in its mentoring program and referring clients to enroll adolescent sons in the program. NMPP has a Head Start program where we frequently made presentations on asthma and health promotion topics for adults (smoking cessation, obesity, hypertension, diabetes and depression). The project director was the mistress of ceremonies for an annual

meeting of a statewide beautician's conference; she negotiated the use of ten minutes to discuss the signs and symptoms of depression and the role the beauticians could play in suggesting treatment for their clients. The health educator provided SIDS magnets as part of the handouts for a Baptist church nurses annual celebration of outstanding church nurses. The president of the group, a grandmother, had never heard of the SIDS "back to sleep" campaign. She was grateful for learning about the research on this important health promotion activity.

The health educator and specialists were used to enhance the awareness of professionals regarding the latest developments in various health promotion areas. For example, grand rounds were co-sponsored by CHHS and NYCDOHMH at Harlem Hospital Center, Renaissance Community Health Center, and Settlement Health Center to educate obstetricians, gynecologists, pediatricians, nurses, social workers and others on the importance of depression screening and referral for perinatal clients. Thirty-eight professionals participated in the three sessions. In addition, providers participated in a two day substance abuse training that included instruction on substance abuse screening and referral. Twenty seven providers from across the city attended and were presented certificates of instruction. The training was made possible through a HRSA consultant. Providers participated in CHHS Consortium meetings which included presentations on cultural sensitivity in serving immigrant populations, pregnancy and management of preterm delivery, lupus and pregnancy, and breast cancer and pregnancy.

For educating the general population about the causes of infant deaths, implementation of the CHHS objective of securing tax levy funding to fight infant mortality proved to be an excellent vehicle. During each of the past four years, CHHS conducted a massive public relations and social marketing campaign that made infant mortality reduction in Harlem and across NYC the number one public health and political issue. Some 250,000 fact sheets were distributed to community members from June 2001 through May 2005. Over fifty print and electronic media placements about the importance of addressing the infant mortality problem in Harlem and NYC's high-risk communities were secured.

CHHS held four citywide infant mortality conferences that mobilized MCH activists from across the city to address the problem. Staff sent out 75,000 direct mail letters to politicians, community leaders/members and the press educating them about the infant mortality problem and concrete solutions to end the problem. The advocacy team met with decisions makers from the Mayor's office and City Council leadership to educate them about the impact of infant deaths on families and communities as well as strategies for fighting infant mortality. Moreover, the role they should play in providing funds to support community efforts to combat infant deaths was emphasized. About nine press conferences were held with major print and electronic media contacts who broadcast these core messages across NYC. As the messages were absorbed by the community, the struggle to reduce infant mortality was transformed from an abstraction into a real and solvable problem.

By May 31, 2005, some three hundred thousand NYC residents, including members of the Central Harlem community, understood what infant mortality was, its impact on the

community and what they could do to combat the problem. Over the last four years, CHHS played an instrumental role in creating the Citywide Coalition to End Infant Mortality that led the advocacy campaign that secured twenty-seven million dollars from the Mayor's office and the New York City Council.

The NMPP health education team that included the CHHS health educator also conducted a number of highly visible community events, including breast feeding promotion day at a local park which drew some 600 participants on average in each of three successive years, a half day women's health conference in March of each year for clients and community residents that was highlighted by a mistress or masters of ceremony who was a local movie or radio celebrity. The team assisted the Federation of County Networks in mounting an infant mortality reduction conference each year in June featuring replicable effective interventions that included the participation of more than 400 local political leaders, clients, community residents and providers each year. In 2005, the conference related to the impact of stress on chronic diseases and depression. The topic of the conference was: **"Feeling the Strength of our Own Spirit…Developing a Plan to Address Comprehensive Approaches to Perinatal and Family Health."** The topics discussed were *All stressed out! Am I my Sister's Keeper? Moving Towards Community Wellness; Look at those Baby Blues-Is there a System to Address the Need?; and, Taking it to the Streets: Organizing, Planning – Action.* Each of the forums was partially supported with City Council funds; all took place in Central Harlem. A Winter Solstice Celebration was sponsored in December 2003 by NMPP staff during which some1,200 gifts were distributed to clients participating in all of the NMPP programs including CHHS along with some community residents. The team also distributed our quarterly newsletter, *Reaching Out,* to community residents. The newsletter contains pregnancy, infant/child and interconceptional health promotion articles.

Staff was provided health education on pregnancy related issues especially the signs and symptoms of pre term delivery, the content of prenatal care and how to conduct depression screenings and referrals . The training institute of the NYCDOHMH was used along with consultants, as necessary, to meet the health education needs of staff. Experts have spoken on complications of pregnancy, routine diagnostic tests conducted during pregnancy, breast feeding "how to's" and rewards, infant bonding, tailoring service delivery to the needs of immigrant clients, lupus and pregnancy, and breast and cervical cancer. Staff was also trained in "motivational interviewing" which involves working with clients so that their behavior is congruent with their personal goals.

During 2003, we added a "Beauticians for Healthy Families" initiative to our community health education efforts. We trained beauticians to teach their clients about SIDS. For each pre/post test they returned to us, they received a $4 metro card. Fifty clients were tested during the initiative. It was implemented in three beauty shops and hair braiding salons: one each English, Spanish and French speaking to penetrate the West African community with health information on SIDS prevention. All materials were developed in English, Spanish and French.

C. Identify any resources or events that either facilitated or detracted from successful initiation and implementation of each intervention.

The CHHS health educator was assisted in her duties by the NMPP agency health educator who for three of the past four years was a Ph.D. candidate in health education at Columbia University's School of Public Health. The NMPP health educator held bi-monthly meetings of health educators in the various programs managed by NMPP to coordinate agency trainings and provide technical assistance when needed.

The health educator was also assisted by the participation of CHHS in the Downstate Consortium that included all of the healthy start projects in New York City (3) and Long Island (2). At the beginning of Phase III of CHHS, the Downstate Consortium met quarterly. Each meeting included an update on outstanding issues which facilitated the work of our health educator. It was during one of these meetings that the Periods of Risk Approach to analyzing birth outcomes was introduced by the NYCDOHMH. This gave our health educator more ammunition for focusing on healthy behaviors of interconceptional clients, including promoting annual checkups and compliance with physician recommendations. At least a third of our clients are overweight and happily so while excess weight is a major risk factor for both maternal and infant mortality. The NYCDOHMH Perinatal Depression Project undertaken at Kings County Hospital shared its depression screening, referral and treatment practices with the group with special focus on the infant bonding support groups that it ran for clients experiencing post partum depression. The health educator used the physician intern who worked with the group to provide a workshop on the impact of post partum depression on infant bonding to our case managers.

Stability in the health educator position was fostered by increasing the salary for the position with City Council funds. Additional work was done for additional pay beyond the traditional work day.

Please see the attached summary matrix of progress toward implementation of CHHS health education objectives, Attachment A.

Interconceptional Care

A. Describe how you decided on your approach to each service, and the rationale for your particular approach based upon your particular community's needs, its service system and challenges and assets.

Based on the community needs identified above, we decided to provide interconceptional care through social/health case management services. In particular, with 20% of our clients having a second child in less than 24 months and poor pre-pregnancy health of mothers being a major risk factor for poor birth outcomes in Central Harlem, we decided that the social/health case management model would provide the most support for assuring that moms selected and used a birth control method and had medical homes which were used appropriately. The level of documented depression in Central Harlem

when compared with the lack of perinatal mental health services re-enforced the potential value of this intervention.

B. *Identify the components of your intervention and the resources needed to implement the intervention.*

We discovered that to assure the receipt of appropriate interconceptional care we had to be creative in providing services. Our clientele was difficult to engage due to the many life challenges they faced. These included inadequate schooling, homelessness, depression, unemployment and the five year cap with work requirements associated with public assistance. Through the social/health case management model we provided office visits, home visits and support. We also provided referrals to medical care, ensured that children's immunizations were up to date, encouraged the use of a family planning method, provided escorts to family planning appointments, offered condoms and assisted participants with developing and reaching their personal goals. The health educator as well as the case managers provided child development education, parenting training and health promotion education. The case managers encouraged school completion or obtaining a GED, job training and additional education for employment. They also assisted clients with preparing/updating resumes and hunting for jobs. In so doing, our case management program instituted "Stepping Up" which was our attempt to focus participants on having and using their medical home appropriately and setting and reaching economic self sufficiency goals. A service plan contract was developed that was participant friendly; it was reviewed monthly. Moreover, we provided staff training in motivational interviewing to add power to their behavior modification persuasion efforts.

During our homecoming celebration in 2004 just before Thanksgiving, we honored the achievements of our clients. Fourteen had found employment, eight had found permanent housing, five had obtained a GED, 3 had made substantial progress in self improvement, two had finally joined the Consumer Involvement Consortium and three had returned to school.

There were times when we were unable to obtain updated immunization information directly from the participant due to their transient housing status. Fortunately, we were able to get the data from the city's Immunization Registry, thus we avoided recommending shots that were not needed. The health educator included life skills topics as part of the health education workshops in an attempt to increase participants' attendance. This strategy was recommended by the participants during a client focus group and it was successful. We added questions to our CHART client assessment tool to include four questions on the signs and symptoms of depression, medical risk factors, a question related to primary health care provider and last contact with the medical provider. The case managers learned from participants that while many refused a family planning method, repeatedly denying engaging in or planning to have sex or having the need for birth control, they were getting pregnant. Thus, we started offering condoms and reviewing birth control methods with clients as a routine part of case management

services. We learned that we had to not only ask if they were using a family planning method but when it was last used and how it was used.

The four case managers who provided service to our pregnant participants also provided service to our interconceptional participants. They were assisted by the case management supervisor and, at times, the outreach worker.

C. Identify any resources or events that either facilitated or detracted from successful initiation and implementation of each intervention.

Just as the case management program participated in NMPP's contract with the NYCDOHMH's City Council funded Infant Mortality Initiative to provide services to additional pregnant clients, it also provided interconception services to women who lived outside of the CHHS target area. This allowed us to provide services to women who were referred to us but resided beyond the Central Harlem catchment area or who moved outside the area while enrolled in our program. The case management team provided case management services to high risk interconception residents of the upper west side, Washington Heights, Brooklyn, the Bronx and Queens through City Council funds.

Please see the attached summary matrix of progress toward implementation of CHHS Case Management Objectives for those related to interconceptional activities, Attachment A.

Depression Screening and Referral

Describe how you decided on your approach to each service, and the rationale for your particular approach based upon your particular community's needs, its service system and challenges and assets.

With the excess rates of mental health hospitalizations and documented level of mood disorders in Central Harlem we felt that is was imperative that we assure that all clients were minimally screened for depression. We also instituted the use of the Edinburg Depression Screening Tool for a more thorough assessment of clients who appeared to suffering from depression.

In addition, in response to the shortage of mental health resources for treating perinatal mood disorders, we organized Sister Chat which met monthly and the Baby Mama's Club which met weekly at 5:30 pm. Both are support groups for mom's who feel overwhelmed to support and learn from each other.

Service system deficits led us to work enthusiastically with the Harlem Strategic Action Committee's Mental Health Work Group which was chaired by CHHS staff. The Harlem Strategic Action Committee was sponsored by the NYCDOHMH. The Mental Health Work Group sponsored grand rounds on perinatal depression at four hospitals and clinics in Central Harlem.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention.

In October 2003, we modified the CHHS Participant Assessment Form to include six questions on depression. All clients completed the Participant Assessment Form which was required for enrollment into CHHS social/health case management program. In addition, a depression screening flow sheet was developed to assist case managers in administering the Edinburg depression screening tool when indicated.

During Phase III, we were not surprised to find that a large proportion of our clients experienced some of the signs and symptoms of depression; 82% responded to at least one of the following questions indicative of a possible mood problem:
Have you been feeling happy: No, 76.7%
Have you been feeling sad? Yes, 52.8%
Have you been feeling confused? Yes, 20.1%
Have you been feeling nervous? Yes, 20.1%.
Have you been crying? Yes, 50.9%
Have you been wishing yourself dead? Yes, 14.5%
(From 10/15/03 – 08/25/05, N=159)

All of the mood difficulties indicated above may not be reflective of clinical depression yet they make it clear that the mental status for many of our clients could impact their day to day functioning. It should be noted that 80% of our clients enrolled in our case management program with unstable housing as risk factors. This helps explain the large number of clients showing some signs and symptoms of depression.

The case management program initially screened participants for depression through our assessment form which included the depression indicators listed above. We also used the Edinburgh depression screening tool for a more thorough assessment of about a third of our clients, 132. Of this number, the screening scores of some 25 to 30 clients each year indicated the need for additional diagnostic tests, however only 6 to 9 clients actually kept appointments with mental health providers.

Our biggest challenge was getting everyone screened who appeared to need a professional assessment to accept a mental health service referral. In addition, it was difficult to obtain timely services from mental health providers; sometimes clients waited four to six weeks for an appointment. This delay caused several of those who had initially accepted referrals to lose interest in receiving needed service. CHHS management held a breakfast for mental health providers in Central Harlem in 2002 to make them aware of the services we offered, to learn how best to refer clients to them, and to facilitate those referrals.

For clients who scored high on the Edinburg depression screening tool, the case managers reviewed material on depression with participants and gave them a hotline number. Participants who appeared at increased risk of depression driving them further into inaction were contacted at least twice a week by their case managers to monitor any

changes in their mental status. *Sister Chat* was organized by case management staff as a support group for clients who refused to accept referrals to mental health providers. It met monthly. The *Baby Mama's Club* was organized by a former client. It met monthly in the evening so that working moms could participate. It was supported with funds from the City Council. These groups served as a finger in the dyke; "you cannot fix what you cannot face."

Medical and Health Research Association of NYC, Inc., organized a forum for mental health providers in Central Harlem to introduce its new depression screening tool which had been tailored to the reality of the lives of perinatal women residing in this community. There were 30 to 40 clinicians in attendance; many were in private practice who did not have a sliding fee scale. Additional meetings will be held with this group to promote acceptance of Medicaid payments which would facilitate referring our clients for their services.

The project increased the community's awareness of depression through a consortium meeting; a presentation on signs, symptoms and treatment of depression was made by Dr. Margaret Spinelli, a noted expert in the field of perinatal mood disorders. The agency also sponsored a post Mother's Day celebration where participants received long stem red roses. Workshops on depression were held in both English and Spanish. A poster campaign is presently underway in Central Harlem sponsored by NYCDOHMH to encourage women with post partum depression to seek help.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention.

A depression screening flow chart was developed that guided the case management team in completing the assessment of participants and administering the depression screening tool. Participants who scored high on the screening tool or appeared to be at risk based on the assessment form and/or observation were offered referrals to mental health providers. Moms who appeared to be depressed but refused referral services were encouraged to participate in "Sister Chat," the CHHS support group developed specifically for these kinds of clients to keep them from suffering behind closed doors.

C. Identify and resources or events that either facilitated or detracted from successful initiation and implementation of each intervention.

Central Harlem Healthy Start did not obtain any additional resources to conduct its depression screening program. Unfortunately, we were not able to hire an on-site mental health provider to deliver treatment to the women once they were identified as having signs of depression. However, the Mental Health Work Group of the NYCDOHMH's Harlem Strategic Action Committee had funds for grand rounds to educate medical providers, social workers and nurses about perinatal depression. The work group also developed a media campaign to educate Central Harlem residents on the signs of depression that was geared to decrease the sigma associated with obtaining mental health

services. The committee also developed a roster of mental health experts in the area who treated mood disorders and postpartum depression for participants in grand rounds.

Local Health Systems Action Plan

Describe how you decided on your approach to each service, and the rationale for your particular approach based upon your particular community's needs, service system and its challenges and assets.

The CHHS project's LHSAP for Phase III was developed based on the maternal and child health needs assessment in Harlem that was a part of our 2001 application. The needs assessment informed the project team to organize several system-wide interventions to strengthen the maternal and child health system of care and fill programmatic gaps in the delivery system.

∆ **In 2001, we identified a need to persuade more obstetricians to practice in Harlem. The lack of sufficient numbers of nurses and obstetricians we believed could have a negative impact on the health of mothers and babies in the community.**

∆ **Our needs assessment revealed that Harlem-based women from a variety of ethnic and class backgrounds requested that a birthing center be build in the community so that they could birth their children within a low-tech, high-touch family environment that views pregnancy not as a disease but as an important family/community event over the life-course.**

∆ **The needs assessment focused on documenting the fragmentation of MCH services in Harlem so we selected as one of our systems building projects the regionalization of perinatal care within the borough of Manhattan which includes Harlem. Our efforts defined the unique perinatal needs throughout the borough of Manhattan. NYSDOH staff connected 47 level four, three, two and one hospitals within a network of care and included community based organizations as part of the decision making process alongside hospital executives to set the perinatal care agenda in the borough of Manhattan. We strongly believed that the development of the Manhattan Regional Perinatal Forum has begun to coordinate care throughout the borough of Manhattan including Harlem.**

∆ **Finally, we learned that many segments of the Harlem community identified within our needs assessment understood the concept of infant mortality merely as an abstraction. We documented that infant mortality was not the number one priority of the Harlem community and many residents, local politicians and businesspersons could not define the problem in laymen's terms or understand their role in combating it.**

During the early 2000/2001 planning and proposal writing period, we agreed to develop a social movement starting in Harlem and eventually impacting mothers and babies

throughout NYC where infant mortality would be understood and acted upon by all members of civil society.

Identify the components of your intervention and the resources needed to implement the intervention. Note any changes.

The project team, which included consumers decided on the above four projects that would set the systems building/policy agenda for our local planning process to bring about real change. The following performance objectives governed the local planning process:

By May 31, 2005, the general Harlem community will come to understand the causes of infant mortality. City government will allocate funding to reduce the problem and community groups will join the CHHS project to address the problem throughout Harlem.

By May 31, 2003, the Georgia McMurray Whole Life Birthing Center will open to the public at Harlem Hospital.

By May 31, 2005, the Central Harlem community will have developed a locally based pool of private practice doctors who have made a commitment to service the needs of mothers and babies.

By May 31, 2004, all hospitals operating throughout the borough of Manhattan and Harlem will have received their designation by the NYSDOH and they will have begun to work together along with community members to carry out a coordinated plan for perinatal care in Harlem through the development of the Manhattan Regional Perinatal Forum.

During the proposal development process, the project team believed that these performance objectives, if achieved, would concretely address the gaps in service delivery identified within our needs assessment. Each objective required a unique set of interventions and resources to implement.

Each year during Phase III, CHHS conducted a massive public relations and social marketing campaign that made infant mortality reduction in Harlem and throughout NYC the number one public health and political issue. We distributed over 250,000 fact sheets to community members during the period. We secured over fifty print and electronic media placements about the importance of addressing the infant mortality problem in Harlem and NYC's high-risk communities.

CHHS held four citywide infant mortality conferences that mobilized MCH activists from across NYC to address the problem. Staff sent out 75,000 direct mail letters to politicians, community leaders/members and the press educating them about the infant mortality problem and concrete solutions to end the problem.

The advocacy team met with decision makers from the Mayor's office and City Council leadership to inform them about their budget and policy development role in reducing infant mortality in Central Harlem. About nine press conferences were held with major print and electronic media contacts who broadcasted our core messages across NYC where the struggle to reduce infant mortality was no longer an abstraction but a real and solvable problem.

By May 31, 2005, three hundred thousand NYC residents understood what infant mortality was, its impact on the community and what they could do to combat the problem. Over the last four years, CHHS played an instrumental role in creating the Citywide Coalition to End Infant Mortality that has led an advocacy campaign that secured twenty-seven million dollars from the Mayor's office and New York City Council. Over this period, these funds were allocated to over forty community-based organizations across NYC. The infant mortality rate in NYC declined from 6.7 infant deaths per 1000 liver births in 2000 to 6.5 in 2003. The infant mortality rate in Harlem dropped from 12.2 (the average for 1996-1998) to 10.8 (the average for 2001-2003). The average rates were computed because of the small numbers involved. The public relations and social marketing campaign outlined above played a major impact on the vital statistics results mentioned above.

The planning to build a new birthing center in Harlem started during Phase I of the Healthy Start movement. During Phase III, the CHHS project achieved the goal by collaborating with our elected officials and senior staff from Harlem Hospital and the birthing center opened on September 7, 2003. To achieve this goal, the collaborative raised over two million dollars. We conceptualized a birthing center service model within a hospital setting. By early 2003, the architectural plans were approved and the construction began. During most of early 2003, two more midwives were hired and a formal midwife seniority compensation plan was developed to satisfy the needs of the senior staff who served mothers and babies at Harlem Hospital for over twenty years.

The birthing center has been open for the last two years and the center experienced a measurable increase in the number of women who gave birth at Harlem Hospital for 2003. During the summer of 2004, the NMPP executive director traveled to a HRSA-sponsored healthcare management training at the Anderson School of Business at UCLA for two weeks. He developed a comprehensive marketing plan for the birthing center. However, senior Harlem Hospital leadership has responded hesitantly to the new plan. The hospital leadership has prioritized developing plans for a new hospital. Over two hundred and thirty million dollars was allocated in 2004 to the hospital by NYC Mayor Bloomberg.

CHHS staff will continue to work with senior leadership to increase patient flow into the OB/GYN department. CHHS staff will work with senior hospital leadership to hire a new director of the OB/GYN department. Today, immigrant women from the Dominican Republic, Mexico and West Africa have a birthing option they requested several years ago that respects the healing nature of the birthing process. A new level of MCH care has

been built in Central Harlem giving all women the option to have a child in a drug-free, low-tech, family oriented clinical environment.

The numbers of private practice obstetricians in Harlem were miniscule in 2001. Over the last four years, CHHS staff attempted to create a movement to convince more medical students to make Harlem their home as it relates to private practice. We were unsuccessful in achieving this goal. CHHS staff was operating against economic forces that blocked the growth in the number of private practice obstetricians.

The number one economic force is the cost of malpractice insurance which forced obstetricians to practice within a clinic or hospital environment. Independent obstetricians have been forced to close their practices and join a group or hospital based practice because they were unable to afford private malpractice insurance. Some obstetricians in New York State pay more than $100,000 a year for insurance in locales where the number of doctors is declining. Medical malpractice reform in Albany and Washington simply was not a priority over the last four years. Many doctors have left New York State to locate in other areas around the country where they can practice and the insurance is affordable.

The second major challenge faced by the CHHS staff was the growing trend of independent hospitals and group practices consolidating into larger healthcare systems. There is only one private hospital operating in Harlem and this hospital is slated to close in the next few years due to operating losses and inability to attract enough patients to stay viable. If private hospitals are facing difficulties in this current operating environment, private practice obstetricians face an uphill battle to provide quality clinical care and stay afloat from a business perspective.

During fiscal year 2004, President Bush reduced the funding for HRSA's National Health Service Corps Scholarship and Loan Repayment program. This reality reduced the funding to provide incentives for medical students around the country to serve in Federally-Designated Health Professional Shortage Areas like Harlem, New York. The program provides scholarships and pays loans to physicians, dentists and other health professionals who decide to practice in designated underserved areas.

CHHS staff was unsuccessful in convincing various medical school students to complete their internships and practice in Harlem. The above political and economic forces were formidable and prevented the CHHS project from achieving our systems change objective regarding the number of obstetricians practicing in Harlem by May 31, 2005. Despite all of our interventions, we were only able to convince one doctor to set up a private practice in Harlem. We plan to continue our efforts to work on this problem during Phase IV.

Finally, the work to regionalize the perinatal system of care in New York State has been successful. Senior staff from the New York State Department of Health began this important work in 2000. By 2001, the NYSDOH began re-designating all the maternity hospitals throughout the state. They also mandated that all level four hospitals or

regional perinatal centers collaborate with the 16 NYSDOH Perinatal Networks across the state to develop Regional Perinatal Forums.

By early 2003, CHHS staff and NMPP's executive director began working with the four Regional Perinatal Centers in the borough of Manhattan. They are: New York Presbyterian Hospital Center, NYU Medical Center, Cornell Weil Medical Center and Bellevue Hospital Center. An election was held during the September 2003 forum meeting and the director of Presbyterian's nurseries was elected to co-chair the Manhattan Regional Perinatal Forum with NMPP's executive director.

By December 31, 2002, all maternity hospitals in the borough of Manhattan had received their designation and had begun working to develop protocols to refer sick babies to the Regional Perinatal Centers. Also, guidelines for clinical consultations and methods for clinical and administrative oversight of levels one, two and three hospitals in each network were discussed and finalized. Work quickly began to develop a Manhattan Regional Perinatal Action Plan that was submitted to the New York State Department of Health on January 1, 2005.

The plan focused on improving the reliability and validity of data submitted by all 47 hospitals in the borough of Manhattan to the New York City Department of Health and Mental Hygiene's Bureau of Vital Statistics. The plan also focused on pooling all of the borough's preconception care assets to work with health educators from the New York City Department of Education to educate the system's teen student body about the importance of preconception care.

From 2003 to 2004, the Manhattan Regional Perinatal Forum (MRPF) focused on convincing the NYSDOH and the NYCDOHMH to begin the slow process of consolidating their vital statistics data systems within a Statewide Perinatal Regional Data System. Several local and statewide meetings took place to achieve this objective. However, both health departments' vital statistics departments were very territorial and refused to even consider data system consolidation.

Based on the above reality, the MRPF refocused on improving the quality of data entered into the NYC DOHMH's Bureau of Vital Statistics data base. A citywide data conference was organized in 2004 that had as a goal the standardization of data entry and data analysis protocols related to entering and querying the vital statistics database. By September 2004, the five borough forums' data committees consolidated into one citywide data committee to speak with one voice with the NYCDOH.

As a result of the above work, a reliability and validity test of seven fields on the electronic birth certificate is currently being completed by seven major hospitals within New York City on 2% of their cases. This plan will take two years to complete. At the end of this quality assurance process, the quality of the data entered into vital statistics will be more reliable and valid. Therefore, vital statistics data used for program planning and assessment will help the MRPF and other public health professionals make the best decisions determining service gaps, gathering evidence on new positive or negative

clinical developments in the field, and completing reliable program and service needs analysis that could strengthen program planning.

The regionalization of perinatal care in Manhattan has concentrated clinical human resources that can be targeted to address specific problems in our care system. During Phase III of Healthy Start, the MRPF focused on disseminating best practices concerning preconception care throughout the NYC school system utilizing health educators hired by the NYC Department of Education.

A meeting was organized with officials from the Department of Education to introduce the plan in December 2004. Several clinical staff from the major hospitals and community-based organizations developed a preconception curriculum that was presented to the staff from the Department of Education for their review and approval. They reviewed the document and forwarded their approval to the MRPF in March 2005.

MRPF health education committee members began planning fund development activities to finance the project starting in February 2005. The NYC chapter of the March of Dimes reviewed the committee's concept paper and asked the body to submit a full proposal by July 29, 2005. The MRPF will receive grant notification by October 1, 2005 to begin this important work within the New York City school system.

Summary:
CHHS always believed that case management, health education and outreach activities alone could not reduce racial disparities in birth outcomes in Harlem. We hypothesized in 2001 that major transformations in the local health system had to be implemented before conditions would change for mothers and babies in this community.

As a result of our work over the last few phases of Healthy Start, Central Harlem has witnessed measurable improvements in our MCH delivery system. The community now has a five-suite birthing center that has been targeted to immigrant women migrating to the community. This new business/clinical entity completes the community's spectrum of care giving Harlem-based women a wider choice in delivery services.

Due to the successful public relations and social marketing campaigns during Phase III, all sectors of the Harlem community have a keen understanding of what infant mortality is and what they must do to combat the problem. Our public health message has achieved a high saturation rate where the message now is being adhered to as high-risk women are transforming their well-baby care behaviors.

The regionalization of maternity care throughout New York State and Manhattan is another important development planned for in our 2001 local health systems action plan. The service delivery system fragmentation identified in our earlier needs assessment has been addressed through our regionalization efforts. Hospitals and clinics who did not talk with each other are now beginning to meet and search for ways to coordinate care and save money through joint projects. We are making small improvements in our data system and many of the hospitals and clinics in Manhattan have joined forces to develop

a borough-wide preconception plan for all women. MCHB had invested in our ideas for the past fourteen years and the Central Harlem Healthy Start project has returned results!

Identify any resources or events that either facilitated or detracted from successful initiation and implementation of each intervention.

As noted above, during fiscal year 2004, President Bush reduced the funding for HRSA's National Health Service Corps Scholarship and Loan Repayment program. This reality reduced the funding to provide incentives for medical students around the country to serve in Federally-Designated Health Professional Shortage Areas like Harlem New York which impacted on our ability to attract new obstetricians to practice in Central Harlem.

Our plans to advertise the new birthing center to increase the use by the community were thwarted by Harlem Hospital Center's new reconstruction activities. The administrators have been entirely focused on this multimillion dollar undertaken. Thus, they have not been able to collaborate on implementing a marketing plan for the birthing center.

The congruence of the NYSDOH's neonatal regionalization plan with our need to have regionalized perinatal services in Central Harlem facilitated our work in addressing this need. The Manhattan Regional Perinatal Forum provided representatives from community based organizations and community residents with the opportunity to work with key hospital perinatal staff to create a perinatal safety net for community residents.

Consortium

For consortium, please address the following <u>additional</u> elements:
A. Describe how you decided on your approach to developing your consortium and the rationale for your particular approach based upon your particular community's needs, service system and its challenges and assets.
1) Highlight how the consortium was established and identify any barriers that emerged in its establishment and how they were addressed

In 1994, when the consortium was formed, the residents of and providers in Central Harlem were still being overwhelmed by the crack/cocaine epidemic that was devastating the community. The term "border baby" was coined to describe the growing number of infants born to women who were addicted to crack/cocaine who were left in the hospital, abandoned by their mothers. One New York City judge was quoted in the New York Times as having said: "I never thought I would wish for the 'good old days' of heroine. At least it never made mothers walk off and leave their babies." Perinatal service providers were overwhelmed by the needs of clients created by this epidemic; engaging and helping crack/cocaine addicts to keep their prenatal care appointments, eat nutritious food, take shelter in a safe environment and, most importantly, use less/no crack/cocaine while pregnant. Our municipal Health and Hospitals Corporation established a special substance abuse prenatal clinic at Harlem Hospital Center for these clients. Thus, providers had very little time for organizing another body to address birth outcomes. Nevertheless, it was in 1990 that the New York Urban League organized the Board of

Directors for establishing Northern Manhattan Perinatal Partnership. Many board members were agency leaders at the time: the Executive Director of a substance abuse agency, the director of the Harlem Branch of the Red Cross, the Director of Nurse Midwifery for a large health and research agency, the director of a Head Start program and other community stakeholders and residents. These individuals were joined by representatives from the state and city departments of health.

With the challenges posed by the crack/cocaine epidemic, there was little interest in organizing a new oversight body for a new project in 1994. Therefore, the consortium was organized as a forum for community residents, service providers, clients/consumers, religious and business leaders and other stakeholders to work together to find ways to address infant mortality without establishing a new formal organization. To overcome barriers to participation, a sustained effort was made to outreach to service providers as well as identify, recruit and cultivate those community members most receptive to the consortium mission. The major barrier for service providers was their feeling: "what's in it for me to participate?" For those providers with core competencies in case management, outreach and health education, subcontracting partnerships were developed. The major barrier for consumers was their feeling that they had little power within the consortium. This was addressed by creating the Consumer Involvement Organization that was expressly for consumers seeking more meaningful ways of providing input to the consortium on their concerns. Structured, *Leadership Training* workshops were offered annually to equip consumers with the tools to participate in the give and take dynamics of working to achieve mutually agreed upon goals in any meeting.

B. Identify the components of your intervention and the resources needed to implement the intervention.
2) Briefly, describe the working structure of the consortium which was in place for the majority of the implementation, its composition by race, gender and types of representation. Also, please describe the size of the consortium, listing the percent of active participants.

The working structure of the consortium included the following components:
The **Steering Committee** was comprised of consumers, service providers and stake holders who were co-chairs of the other consortium bodies; they played a strategic role in guiding the activities of the various components of the core CHHS interventions.

The **Health Education Committee** facilitated client and community health education activities by suggesting topics/issues for health education workshops/ forums and experts to address the topics. Members also reviewed health education materials for appropriateness for use with clients.

The **Case Management Committee's** goal was to improve access to social support and health services as well as develop strategies for the continuing challenges of client retention and motivating clients to reach stated goals.

The **Consumer Involvement Organization** worked to empower members to be proactive participants in its deliberations and in those of the consortium. It also served as a support group for participants.

The **Male Involvement Consortium** worked to address the social conditions impacting men's health and their access to care. It organized job fairs and workshops that addressed men's issues.

Collectively, these groups helped shape the activities of our community outreach, case management, health education and health promotion interventions within our target area. The goal was to promote client self sufficiency and involvement in leadership and community building activities that served as catalysts for change. To this end, the provider and community participants along with stake holders working through the consortium and its components played an integral role in impacting the lives of our clients. The consortium was also the impetus for the development of our Male Involvement Consortium.

At the end of Phase III, the consortium's ethnic/racial composition was 80% African-American and 20% Latina; 2% were state or local government representatives, 50% were current or former program participants, 15% were community participants, 20% were community-based organizations, 13% were providers. Finally, there were approximately 90 consortium members with about a third being active participants. We fully expect these participants to continue to support the work of the consortium and CHHS through Phase IV of the Healthy Start Initiative, June 1, 2005 – May 31, 2009.

CHHS employed a consortium manager to handle the day to day activities of the consortium. He was assisted by case managers and the health educator who consistently encouraged clients to attend consortia meetings. Child care was made available on site to client and community participants in the consortium. Over time, this became less important as an incentive as clients found the consortium forums of greater interest to them because of the influence they learned to exercise in advising CHHS staff on activities they felt would enhance the impact of CHHS in the community. Several of the interventions were implemented. Metro cards remained a consistent incentive to client participation in consortium and committee meetings.

C. *Describe the activities this collaborative has utilized to assess ongoing needs; identify resources; establish priorities for allocation of resources; and monitor implementation. 3) Describe your relationship with other consortia/collaboratives serving the same population.*

The consortium utilized its diverse components to continuously assess the evolving needs of Central Harlem. The Steering Committee met bi-annually. Staff provided the most recent data available on infant mortality, low birth weight births, the late/no prenatal care rate; the percentage of Latino births and births to women who were foreign born in Central Harlem. In addition, cumulative data was shared on our client base…the number of Latino and African families, homeless families, and rates of depression along with data on other services delivered. With this combined intelligence, suggestions were made to increase the effectiveness of our interventions. Recently members of the Steering Committee suggested that staff educate men in young fatherhood programs and job

training programs on the signs and symptoms of depression and treatments available. The suggestion was partially implemented earlier in 2005.

The Health Education Committee consisted of the following members: Harlem Hospital Center WIC program health educator, the Community Health Alliance health fair organizer, NYCDOHMH regional nurse supervisor, the NMPP Community Health Worker Program health educator, the CHHS health educator and two to three clients would participate in the meetings. The committee met quarterly to discuss strategies for enhancing the effectiveness of information sharing activities, to review new health education materials for their linguistic and cultural appropriateness, and other issues as they came up. In addition, topics and expert presenters for forums for clients and community residents were decided upon for at least two workshops a year based on member perceptions of client and community needs. Each agency representative on the committee invited clients from its programs to these forums. Community residents were also invited. The Health Education Committee sponsored the substance abuse training for providers in 2004. Twenty-eight providers participated in the training.

The Case Management Committee included representatives from the following agencies: the NYSDOH AIDS Institute, the Minority AIDS Task Force, Harlem United (a minority AIDS program), the Harlem Children's Zone's Baby College and NMPP's ACS foster care placement prevention program. The CHHS case management supervisor co-chaired the committee with a former client. Three to four clients usually participated in committee deliberations. The committee shared strategies on promoting client retention and client behavior modification and any challenges in client referrals. The Case Management Committee sponsored at least two forums annually for providers, clients and community residents on topics selected to address some of the needs focused on during committee deliberations. One of the more popular forums sponsored was "Everything You Need to Know About Entitlements. There were 34 attendees.

The Consumer Involvement Organization met monthly; it was comprised of current and former clients and community residents. Members of this group participated in leadership training workshops that introduced group dynamic processes and community organizing principals that prepared clients/consumers for active roles within the consortium and in the community. The training facilitated their participation in these venues. Following the 2004 training, clients organized a bake sale to raise funds for helping the homeless. Some $100 were raised and donated to a homeless shelter. They also held a fashion show featuring their children.

The Male Involvement Consortium consisted of men from young fathers' programs and representatives from agencies serving young men. In response to the excessive unemployment rates in Central Harlem, the Male Involvement Consortium sponsored an annual job fair. (The Community Service Society reported in 2004 that the unemployment rate among men of color across New York City in 2003 was 47%.) The job fair was held the Friday preceding Father's Day. It included recognition awards given to young fathers from fatherhood programs involved in the day-to-day lives of their children, workshops on job readiness, resume development, how to find a job using

the computer, and how to interview for a job as an x-offender—drawing some 500 participants from the community each year. The Male Involvement Consortium also presented workshops on relationships, legal issues for young fathers and men's health. In response to a grant from the Agency for Children's Services, the consortium sponsored a workshop for Head Start agencies on how to create a welcoming environment for male participation in activities sponsored by the agencies.

The consortium was not called upon to identify resources nor establish priorities for allocation of resources for CHHS. The NMPP Board, as noted earlier, was responsible for managing the financial resources of the agency. Moreover, this was too much to ask of providers whom we had encouraged to participate in the legislative education activities of the Citywide Coalition to End Infant Mortality which, in fact, raised some $27m over five years. It was also burdensome for clients who already participated in the Consumer Involvement Organization, legislative advocacy activities, health education and parenting training workshops and the many conferences and forums sponsored by NMPP. Nevertheless, the work of the consortium was facilitated by CHHS staff who reminded participants of scheduled meetings, maintained attendance lists, identified and created resources for consortium essentials such as snacks for meetings, metro cards, Path Mark food vouchers and child-care for consumer participants. This was accomplished by downsizing the health education and outreach supervisor position to a non-supervising health educator which freed up money to pay for these program essentials. Both the Male Involvement Consortium and Consumer Involvement Organization sponsored fund raising activities that provided each group with some operational capital that was supplemented with CHHS funds. Note that the Consumer Involvement Organization and the Male Involvement Consortium had their own internal structures—a governance body—which established priorities for resource allocation and monitored implementation.

The Healthy Start consortium maintained collaborative partnerships with a variety organizations serving similar "at-risk" populations in Central Harlem and environs. In addition to the agencies with representatives serving on the CHHS Consortium and its committees, we also had successful partnerships with the following groups:
The **African Services Committee** provides HIV education and preventive services to the African community in Harlem and advocates for professional language translation services for its clients by service sites frequented by them ;
STRIVE is a job training and skills development and job placement agency for the formerly incarcerated;
The **Greater Zion Baptist Church** provides mentoring services to young men in Harlem including the adolescent sons of some of our clients.
WE ACT for Environmental Justice (WE ACT) is an agency that acts to minimize the impact of historical environmental racism on Harlem residents and to prevent new environmental assaults on the Harlem community;
The **Northside Head Start Center** offers Head Start, therapeutic mental health services for children and child development assessments;
The **Manhattan Mental Health Center** is the largest non-hospital based mental health clinic in northern Manhattan;

The mission of the **Federation of County Networks** is to reduce the rate of infant mortality/maternal morbidity through educational activities on best practices; it regularly hosts forums on new case management practices, health education initiatives and outreach strategies;
The **City Wide Coalition to End Infant Mortality** is comprised of perinatal organizations and community residents working together to reduce infant mortality through government action, targeting the city council and mayor's office of New York City for tax levy funding for community based interventions;
The **Harlem Health Promotion Center** works to improve the health status of Harlem residents by assessing community health concerns, building health partnerships, promoting the adoption of wellness practices, improving community public health practices and advocating for the sustainability of demonstration programs;
The **New York City Breast Feeding Alliance** is focused on increasing the initiation and duration of breastfeeding among middle to low-income women, helping to eliminate racial and ethnic disparities in breastfeeding with culturally appropriate strategies, educating, promoting, supporting and encouraging breastfeeding in New York City.

Our collaboration with the **New York City Department of Health and Mental Hygiene** resulted in the successful mounting of the Harlem Strategic Action Committee to Fight Infant and Maternal Mortality. **(**See page 40 for a full description of the work of this body.) In particular, the goal of the Systems Work Group was to assess the adequacy and quality of clinical and social support programs/agencies in Central Harlem for meeting the perinatal needs of the community. A self administered questionnaire and interview survey was completed for each identified provider. The next steps are (1) to map the results to determine gaps in services, (2) to develop a survey instrument for clients to provide feedback on the quality of services provided by the existing agencies, and (3) assist participating agencies in improving services, where needed, and look for resources to fill the gaps identified by steps (1) and (2).

These collaborative relationships reinforced our commitment to the elimination of social, economic and cultural factors that lead to disparities in health outcomes. Moreover, the affiliations with these stakeholders helped us to raise public awareness of infant mortality issues. The collaborative relationships also served as mechanisms for sharing information, referring clients, promoting community involvement, and recommending strategies and policies to improve family health in Harlem.

c. 4) Describe the community's major strengths which have enhanced consortium development.

The community's major strengths which enhanced consortium development were numerous and complex. These included a concerned citizenry that had grown in strength as it has taken on community challenges such as inadequate housing, poor health care, a failing school system, and environmental pollution. It had done this in spite of the obstacles of poverty and economic and environmental racism with the achievement of being designated a federal empowerment zone. This became a two edged sword, bringing new businesses and residents into Harlem thus accelerating gentrification of the

community. Gentrification has priced many of our clients out of continuing to live in the Central Harlem community.

Central Harlem residents are also deeply attuned to their spirituality, manifested by a strong belief in our religious institutions and clergy, who exercise considerable power to insure that neighborhood issues get a hearing. It is noteworthy that the churches have established the *Community Health Alliance* which has successfully placed health educators in 15 of the largest churches in Central Harlem through a Kellogg Foundation initiative. Another community asset was the business community which joined with the Healthy Start consortium in co-sponsoring one of our annual job fairs. The consortium was therefore a conduit for productive relationships bringing together clients, consumers/community residents, policy makers, business and faith leaders and other stakeholders to address the needs of the community. In addition, these relationships enhanced community understanding of perinatal health needs, disparities in birth outcome, infant mortality and maternal morbidity risk factors. Finally, the community's rich and archived history provided the consortium with opportunities to engage, educate and unify the community through diverse music, art and cultural expressions. These cultural and linguistic manifestations were used as effective recruitment tools for the consortium. Community residents always knew that culturally appropriate food and occasionally music would complement our educational activities.

5) *Describe any weaknesses and/or barriers which had to be addressed in order for the consortium to be moved forward.*

Not insignificantly, consumer homelessness, depression and other mental health issues, were significant barriers to committed consortium participation. By creating dynamic and relevant topics that were both "consumer friendly" and related to the Healthy Start mission, we helped mitigate this barrier. Another potential barrier, lack of incentives and give-a-ways, became less of a problem when participants were provided information at consortium meetings that they felt directly impacted their day-to-day lives. Finally, enlisting consumers to participate in leadership roles was difficult; i.e., getting them to assume co-chair positions or to attend national Healthy Start activities in other cities. Leadership training workshops which introduced group dynamic processes and community organizing principals prepared clients/consumers for active roles within the consortium and in the community facilitated their participation in these venues.

6) *Discuss what activities/strategies were employed to increase resident and consumer participation. How did these change over time?*

Some of the activities/strategies that were employed to increase resident and consumer participation included on-going street outreach (leafleting and flier distribution), providing child care on a consistent basis, obtaining incentives that consumers valued and found meaningful (i.e., food vouchers, metro-cards, acknowledging achievements and milestones, etc.), and providing monthly mailings announcing events to members as well as prospective consortium members. Other recruitment activities included canvassing for participants at health fairs, job fairs, education/training facilities, town hall forums, block

parties and other neighborhood events. When appropriate, telephone follow-up was conducted to insure message saturation among partnering agencies/organizations and clients. Other strategies included dissemination of consortium information during client in-take and registration sign-ins prior to other agency events. Finally, linkage agreements with targeted community organizations were signed to formalize collaborative relationships as well as serve as a client recruitment strategy for CHHS.

Over time, as consortium topics became more relevant to the life of the consumer, there was less reliance on incentives (other than metro-cards) to encourage and engage participation. Finally, as consumers began to feel more valued (seeing their suggestions for program changes incorporated), the consumer became more invested in the Healthy Start mission, resulting in greater trust in the project as well as more consistent participation in consortium activities.

7) How did you obtain consumer input in the decision-making process?

Consumer input in the decision making process was obtained in several ways. As participants in the Steering Committee, we reviewed with committee members the CHHS logic model and proposed strategies for meeting our goals. Among the suggestions made by committee members was one to educate males involved in fatherhood and job training programs in the community on the signs, symptoms and treatment options for perinatal depression. This suggestion is currently in the process of being implemented after a failed attempt last year. As focus group participants, clients suggested that health education workshops include topics of interest to the daily life challenges of clients such as how to select an apartment and budgeting issues. Consumers also provided input through their participation in Title V collaboration meetings in Albany and National Healthy Start meetings in Washington D.C.

Consumers were helpful through their participation in marketing and outreach strategies via radio and television interviews to increase awareness of women's perinatal health issues within the community. A Central Harlem Healthy Start client currently serves on the Board of Directors of the National Healthy Start Association and a former client is secretary to the Northern Manhattan Perinatal Partnership's Board, two important forums where consumer input is actively sought. Consumers also made valuable contributions to the development and implementation of the Local Health Systems Action Plan as well as to the NYCDOHMH sponsored Manhattan Regional Perinatal Forum and Harlem Strategic Action Committee deliberations. (It was consumers who requested access to a low tech, family friendly birthing center in the Harlem community. It was during one of the Harlem Strategic Action Committee meetings that a former client advised the body about the challenges parents face placing infants to sleep on their backs: 1) During the winter, the heat is turned down to 55 degrees Fahrenheit in New York City apartments. If the infant kicks the covers off while on its back, it could catch cold. 2) African American parents are very concerned about the bald spot that frequently develops on the back of the infant's head as a result of sleeping on its back. Our presentations on SIDS now incorporate these concerns with recommendations for addressing them.) All of the venues described above provided consumers opportunities for participation where their input was greatly encouraged.

How did you utilize the suggestions made by the consumers?

Suggestions made by consumers were utilized programmatically in diverse ways. For example, in response to multiple discussions consumer had during Phases I and II of the CHHS program, regarding their on-going challenges securing marketable skills and employment the *Harlem Works Job Readiness Training Program* was developed. This program included hands-on instruction in computer technology training as well as education classes to prepare consumers to take and pass the GED Exam. Tutorial services were also included to improve math and reading comprehension skills. Interest in self-employment was responded to with a workshop on owning your own business that included as it's final exercise developing a marketing plan for your business. At least one of the participants implemented her business plan; she opened a beauty salon.

To address consumers on-going concerns regarding the disproportionately high number of unemployed and unskilled residents of the Harlem community, the *Male Involvement Consortium* sponsored annual job fairs where some 20 prospective employers offered diverse employment and job training opportunities to those who attended. Workshops on job readiness, resume development, how to find a job using the computer, and how to interview for a job as an x-offender—drawing some 500 participants from the community each year.

Another example of how consumer suggestions were utilized programmatically occurred when members of the *Consumer Involvement Organization* indicated their challenges raising male children without the benefit of an adult male living in the household. These consumers understood the advantages of the adult male presence and sought ways to engage men meaningfully in their children's lives. Through sustained outreach to Greater Zion Hill Baptist Church, the Healthy Start project staff was able to collaborate with members of their male mentoring program, successfully teaming adult male mentors from this church program with the adolescent sons of consumers.

The birthing center at Harlem Hospital Center was a direct result of consumers requesting a less intrusive medicalized birthing experience. The request was made during Phase II; it was implemented in Phase III.

Finally, utilizing skills learned during their annual *Leadership Training/Skills Development* workshops, the *Consumer Involvement Organization* membership sought to assert their independence by raising its own funds for group activities. To this end, the membership developed a fund raising plan based on neighborhood resources, deciding to raise money through a baked goods sale (that would also promote the importance of healthy eating within the community). This plan was fully endorsed by Healthy Start project staff, in conjunction with the health educator, an herbalist and holistic practitioner provided suggestions on healthy alternatives to traditional ingredients. A successful baked goods sale took place totally organized and run by the CIO members themselves.

C. Identify any resources or events that either facilitated or detracted from successful initiation and implementation of each intervention.

Pursuant to its mandate, CHHS reaches out to engage and enroll high risk families, usually women without a partner who are pregnant or parenting, who are living in a homeless shelter, are abusing drugs and/or alcohol, are unemployed, are on public assistance, have few family supports or have not been successful in school. For some of the women who head these families to be willing to provide the most intimate details of their personal lives to a stranger, including for a few how they misjudged the staying power of the partner who impregnated them, they are in a serious crisis. It is the nature of the crises they face that serve as barriers to participation in any activities offered by CHHS beyond those of our case managers. Nevertheless, we find many who participate in the Consumer Involvement Organization and other consortium activities once their lives have been stabilized; they are then eager to give back to the program. Frequently, this is after their children have entered school.

The numerous conferences and workshops sponsored by CHHS and NMPP have created among our clients and community residents a sense of ownership and belonging to the program: "A home away from home!" Moreover, the value providers, clients/consumers and stakeholders find in being kept up to date on the latest perinatal issues and best practices served to facilitate participation in the consortium's activities. People appreciated informative content that was presented effectively and efficiently. See Appendix E for the various forums we have organized over the past four years.

The establishment and work of the Citywide Coalition to End Infant Mortality served as a catalyst to engage clients and community residents, providers and stakeholders in our work. Once these groups saw the results of our efforts through millions of dollars allocated to fight infant mortality by the mayor and City Council members, they became more enthusiastic and engaged in our work.

Please see the attached summary matrix of progress toward implementation of CHHS Consortium Objectives, Attachment A.

Collaboration and Coordination with State Title V and other Agencies

Describe how you decided on your approach to each service, and the rationale for your particular approach based upon your particular community's needs, its service system and challenges and assets.

New York State Department of Health

Based on the historical experience of CHHS linking perinatal clients to needed services, staff identified fragmentation of services in Central Harlem as a major concern when submitting its application to HRSA to participate in for Phase III of the Healthy Start Initiative. In 2001, the NYSDOH had been working on designation of regional perinatal care centers for several years; however, the work had been delayed. CHHS planned to use the designation in northern Manhattan as a platform for organizing the delivery of

clinical and hospital based perinatal services in Central Harlem. There was adequate capacity for prenatal care in the hospitals and clinics in this community; however, linkages between community based and hospital based providers, where it existed, was weak at best. The establishment of the Prenatal Care and Assistance Program by the state department of health in 1986 to provide free prenatal care to all pregnant women with family incomes less than the Federal poverty level, irrespective of immigration status, facilitated the availability of clinic based prenatal health care in poor, underserved communities across the state.

NYSDOH has supported a Comprehensive Prenatal-Perinatal Services Network (CPPSN) initiative through 16 perinatal networks in high risk communities throughout the state. This was done over the past 16 years with Title V funds. The networks worked to improve the perinatal health system and reduce infant mortality and morbidity in the communities they serve. NMPP is one of the networks established to identify gaps in perinatal services and work to fill those gaps. It is responsible for doing so in Washington Heights, Central Harlem and East Harlem, the communities comprising northern Manhattan . With its "finger on the pulse" of these communities, NMPP serves as the eyes and ears of the Title V program supplying it with information on the perinatal needs and assets of each community. Therefore, it was poised to capitalize on the regionalization of neonatal intensive care unites (NICUs) when the state department of health announced the designations. The announcement included a requirement that regional perinatal forums be established around each local level III NICU. The director of the level III NICU was required to co-chair the local forum in conjunction with the director of the local CPPSN program. Thus, the Manhattan Regional Perinatal Forum was initially co-chaired by the director of the New York Presbyterian NICU and the executive director of NMPP. The director of the Bellevue Hospital Center NICU now co-chairs the Manhattan Regional Perinatal Forum with Mr. Drummonds.

Identify the components of your intervention and the resources (including personnel) needed to implement the intervention.

The most significant collaborative activity over the past four years between NYSDOH and NMPP occurred through the formation of the Manhattan Regional Perinatal Forum sponsored and funded by the NYSDOH. Similar forums were organized in the 15 other communities with perinatal networks. The Manhattan Regional Perinatal Forum is composed of the local Regional Perinatal Care Centers, NMPP, other perinatal/prenatal service providers, stake holders and consumers who are charged with developing and implementing a strategic plan to improve maternal and child health throughout Manhattan. The Executive Director of NMPP co-chairs our forum with the director of the Bellevue Hospital Centers NICU director. For the first time, physicians from 47 hospitals in Manhattan were required to play a leadership role in addressing community based issues that impact birth outcomes.

The Education Committee of the forum developed a proposal for preconception education for high school students that focuses on adequate folic acid intake. The proposal was submitted to the March of Dimes for funding. The Data Committee hosted a symposium to improve the quality of birth data that is reported to the Vital Statistics Division of the New York City Department of Health and Mental Hygiene

(NYCDOHMH). In addition, it has been working tirelessly to get the city department of health to collaborate with the state department of health by allowing online submission of birth data by city hospitals to improve timely reporting of annual summaries of birth outcomes. This lack of collaboration on birth data submissions to the state is a historical problem dating back to the establishment of the New York City Department of Health in the eighteen hundreds.

With regard to the collaborative activities encouraged by HRSA among the Healthy Start projects in New York (5) and our Title V agency, the projects meet bi-annually with Title V Maternal and Child Health Staff to identify opportunities for mutual support and collaboration. Initially, the meetings were used to educate the Healthy Start projects on the services provided through Title V funds locally and statewide. In turn, the Healthy Start projects provided Title V staff with the strategies employed by each to implement the core healthy start initiative services. We were seeking opportunities to reinforce each others work.

More recently, meetings have focused on enhancing women's health from "girlhood to granny hood", improving immigrant families' access to care, and depression screening. The state department of health collaborated with the Association of Perinatal Networks in presenting a couple of one day conferences on women's health. Dr. Peter van Dyck spoke at the first one in 2002. In 2002 and 2003, NMPP conducted focus groups in New York City and in Suffolk and Nassau Counties on the challenges various immigrant groups face in seeking health care. The groups included Arabs, Indians from India, American Indians on a local reservation, Latinos and African Americans. The Healthy Start projects are now collaborating on a campaign to reduce the stigma associated with getting services for perinatal depression. Focus group work conducted by NMPP under the umbrella of the Harlem Strategic Action Committee funded by the NYCDOHMH on perinatal depression has been shared with the state for use in developing copy ready public service announcements on depression. The Healthy Start projects along with the perinatal networks will obtain local radio and TV time for the PSAs.

During one of the Title V/ Healthy Start Initiative collaborative meetings, client participants expressed interest in communicating some of the useful information they learned at the meetings to the community. The CHHS project initiated a newsletter, *Reaching Out (*See Appendix B), in response to this request. *Reaching Out* educates clients and community residents on current issues affecting their health and well being.

Identify any resources or events that either facilitated or detracted from successful initiation and implementation of each intervention.

As noted above, the regionalization of neonatal intensive care units by the New York State Department of Health is facilitating our work in developing a broad based system of perinatal health care in Central Harlem.

Although we are working to get the city department of health to work with the state department of health to have all hospitals submit birth outcomes data to the centralized

electronic state data base, the fact that the state data base still has function glitches provides the city with ammunition to not work with the state on this issue.

During phase II of the Healthy Start Initiative, 1997 – 2001, the healthy start projects sought support from the state department of health to develop a Medicaid perinatal case management funding stream to sustain and broaden the work of the healthy start projects. A commitment was made by the director of family health to have the economic advantages of perinatal case management assessed by an economist. However, the administration of the department changed before the study took place. A decision on Medicaid funding for perinatal case management was to have been based on the results of the study. Nevertheless, CHHS continued to advocate for establishing such a funding stream. We were advised that the current administration was not interested in pursuing this suggestion because New York State already had the most costly Medicaid program in the nation.

New York City Department of Health and Mental Hygiene

A. Describe how you decided on your approach to each service, and the rationale for your particular approach based upon your particular community's needs, its service system and challenges and assets.

In response to recommendations made by the New York City Infant Mortality Task Force to work with local community based organizations to address community challenges that contribute to excess infant morbidity/mortality and maternal morbidity/mortality the New York City Department of Health and Mental Hygiene organized a Harlem Strategic Action Committee to Fight Infant and Maternal Mortality in July 2003. The committee consisted of perinatal medical and social support providers located in Central Harlem or serving Central Harlem residents. It had three goals: 1) to improve the general health of women of reproductive age in Central Harlem; 2) to reduce maternal and infant death and disparities in Central Harlem by improving the quality of maternal and infant mortality surveillance; 3) to improve pregnancy-related and infant health care in Central Harlem; and 4) to improve the quality of the physical and social environment in Central Harlem for pregnant and parenting families. We were delighted with the assistance this intervention brought to the work of CHHS. We, therefore, became the driving force behind the work of the committee.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention.

The goals of the Harlem Strategic Action Committee were addressed through the following work groups: Women's Health, Male Involvement, Mental Health, Surveillance, Systems and Environmental Improvement. The Male Involvement and Mental Health Work Groups are chaired by CHHS staff. CHHS provides the staff for the Services Work Group. The Male Involvement Work Group used focus groups of African American and Latino men to develop a poster message on male involvement. The Mental Health Work Group used focus groups to create the message for a poster on perinatal depression to help de-stigmatize the issue. The focus group work and art work

were accomplished by NMPP's Social Health Marketing Group. Twenty-five thousand posters in English and Spanish were produced of each poster for display in East and Central Harlem during the month of August 2005. Larger posters were placed at the entrance of subway stations in Central Harlem. The Mental Health Work Group also sponsored grand rounds at hospitals and health centers in Harlem on perinatal depression screening and treatment to increase service capacity in anticipation of positive responses to the posters.

As noted above, the Systems Work Group through staff support provided by CHHS, worked to assess the adequacy and quality of clinical and social support programs/agencies in Central Harlem for meeting the perinatal needs of the community. A self administered questionnaire was mailed to providers and telephone interview surveys were completed for each identified provider. The next steps are (1) to map the results to determine gaps in services, (2) to develop a survey instrument for clients to provide feedback on the quality of services provided by the existing agencies, and (3) assist participating agencies in improving services, where needed, and look for resources to fill the gaps identified by steps (1) and (2).

In addition to this work, NMPP has received funds from the New York City Council to work with other community based organizations to fight infant mortality through a variety of community driven strategies, including case management, health education, and advocacy for women's health. As a part of this initiative, each mother who delivers at Harlem Hospital receives a home visit within six weeks of delivery to assure that mother and infant are well, the environment is safe, and that both the mother and infant have a medical home. The visits are being made by VNS staff. Mothers needing additional support are referred to Harlem Hospital Center's perinatal case management program or to CHHS.

The City Council funds were the direct result of the NMPP inspired legislative education campaign by the Citywide Coalition to End Infant Mortality. Over the past five years, $27m of City funds have been made available to some 40 community based agencies to fight infant mortality.

Identify any resources or events that either facilitated or detracted from successful initiation and implementation of each intervention.

The generation of City tax levy dollars to support the fight against infant mortality facilitated the establishment and work of the Harlem Strategic Action Committee. Without the base CHHS HRSA grant that supported core CHHS staff, the work of the Harlem Strategic Action Committee could not have been accomplished.

The fact that the New York City Department of Health and Mental Hygiene siphoned off at least 50% of the funds for the work of its Division of Family Health Services that we worked so hard to secure from the city council and mayor reduced the potential impact community based organizations could have made had they been allowed to use all of the funds their efforts generated.

Sustainability

For sustainability, please address the following additional elements
Describe how you decided on your approach to each service, and the rationale for your particular approach based upon your particular community's needs, its service system and challenges and assets.
1) Describe your efforts with managed care organizations and third party billing.

When HRSA quadrupled the number of Healthy Start Initiative projects during Phase II (1998-2001) with essentially the same amount of funding that had been availability to the demonstration projects in Phase I (1991-1997), it became imperative that CHHS look for opportunities to assure sustainability. Although the infant mortality rate had dropped substantially since the initiation of CHHS in 1990, the average infant mortality rate for 1996-1998 indicated that much work remained to be done during Phase III. During the latter period of the 1990's, the New York State Department of Health was rigorously moving Medicaid clients into Medicaid Managed Care plans. Therefore, it appeared logical to attempt to market our services to these plans.

Although the staff of CHHS made several attempts to identify managed care organizations that would be willing to meet and listen to our pitch to offer outreach and case management services to their clients. Initially, staff was not prepared to make the best clinical and business presentations to these representatives. After receiving various managed care trainings that helped us develop business logic for our pitch, many of the Healthy Start projects in NYC were still unsuccessful in convincing various managed care organizations to do business with Healthy Start. There major compliant was that our services were not clinical enough and they could not see where they would save money and save lives at the same time.

CHHS and the other two Healthy Start grantee agencies in NYC selected a different strategy during Phase III. We decided to negotiate directly with the New York State Department of Health to see if they would sustain the cost of our case management and outreach functions through direct Medicaid funding. Several pitches were made at Healthy Start/Title V Collaboration meetings. Health department officials revealed that accessing Medicaid funding was not a viable or reliable objective during the current funding climate and would have to be revisited two to three years into the future.

CHHS was not able to overcome this barrier due to the fact that New York State has the most expensive Medicaid program in the United States costing tax payers over forty-five billion dollars a year. The NYSDOH would not consider adding another cost center like Healthy Start to the ledger despite the concrete cost saving proposals we presented in terms of the reduction of very low birth weight babies throughout New York State.

As a result of the failure of our managed care sustainability strategy, CHHS developed a hospital strategy that produced several new funded program initiatives that built upon the Healthy Start foundation. This was in direct response to several Request for Proposals that had been released by government agencies and foundations to address the disparities

in health status that had persisted in high risk communities since the founding of this country.

Finally, as HRSA was continuing to increase the number of Healthy Start Initiative projects, the funds to support CHHS and the other demonstration projects was continuing to decline. It was now timely to call on our local government to do its share toward improving the health status of its most vulnerable residents. The executive director of CHHS rigorously promoted the formation of the Citywide Coalition to End Infant Mortality to press the mayor and City Council of New York City for municipal fund to help fight infant mortality.

Identify the components of your intervention and the resources (including personnel) needed to implement the intervention.

2) Describe the major factors associated with the identification and development of resources to continue key components of your interventions without HS funding.

Several opportunities to collaborate with local hospitals to provide foot soldiers in the community arose from Requests for Proposals from both government and foundation sources. From 2000 to 2003, NMPP collaborated with the NYC Health and Hospitals Corporation to submit a HRSA Community Access Program grant to fund our Birthing/Doula Projects in Harlem and the South Bronx with an annual budget of $250,000 for three years.

From 2002 to 2004, NMPP collaborated with New York Presbyterian Hospital where they funded a second community health worker program in East Harlem at $240,000 a year. Finally, during Phase III of the Healthy Start Initiative, CHHS built a strategic alliance with Harlem Hospital to raise over two million dollars to build the first birthing center in Harlem at the hospital.

CHHS has experimented with a variety of fund development strategies all designed to build new MCH case management, clinical, outreach and maternal psychiatric screening and treatment capacity for pregnant and parenting women who live in Central Harlem. The delivery system is well on its way to building a permanent infrastructure of services that will be in place whether or not Healthy Start services are funded by MCHB. However, MCHB funds were used to leverage other public and private funds to expand the level of care in Central Harlem as well as deepen the intensity of case management and outreach services delivered to mothers and babies in this community.

During Phase III, the CHHS project implemented a variety of fund development interventions that expanded, supported and helped to sustain the programmatic functions of the CHHS service delivery system. CHHS has also developed a national sustainability reputation assisting other projects around the country to develop sustainability plans and prepare local projects for when federal dollars are discontinued. The fund development expertise of the staff ranges from proposal writing, direct mail, advocacy/legislative policy interventions and income producing business ventures that relate to the mission of the grantee agency, the Northern Manhattan Perinatal Partnership, Inc.

HRSA/MCHB defines sustainability as the following: "Projects should foster community partnerships and build capacity and/or program resources that continue as needed in that community after federal funds discontinue. A sustained project is one that demonstrates the continuation of key elements of program/services components started under the MCHB supported project." CHHS staff sustainability strategy addressed securing financial resources to make permanent each one of the key components of the Healthy Start model as well as deploying fund development strategies that supported the program overall.

The advocacy strategy supported our plan to develop financial resources not only for Central Harlem Healthy Start but the entire MCH movement in New York City. New York City government had not previously allocated resources to community-based maternal and child health organizations to reduce infant mortality. CHHS staff believed that a social movement could be built in NYC through which municipal government would allocate millions of dollars to support programs like Healthy Start.

In late 2000, Mr. Drummonds met with City Councilman Bill Perkins to conceptualize the possibility of building a citywide movement to end infant mortality in high-risk communities throughout NYC. Mr. Drummonds first completed a political climate analysis that determined the feasibility of a movement. His analysis revealed the following:

HRSA'S GUIDANCE FOR PHASE III PUBLISHED WITH ONE MILLION DOLLAR CAP
NYCDOH HAD NEVER ALLOCATED FUNDS TO CBO'S TO REDUCE INFANT MORTALITY
MHRA, THE INITIAL CONTRACTOR FOR THE HSI IN NYC, DECIDED TO EXIT THE HEALTHY START BUSINESS
CENTRAL HARLEM HAD THE HIGHEST INFANT MORTALITY RATE IN NEW YORK STATE
DURING THIS PERIOD THERE WAS LIMITED POLITICAL DISCOURSE ABOUT PUBLIC HEALTH ISSUES IN NYC

Mr. Drummonds and Councilman Perkins hypothesized that a public health social movement could be built throughout NYC that could raise mass awareness of the infant mortality problem in Central Harlem and across other high risk communities in NYC and that city government could be persuaded to allocate millions of dollars to address this problem. Both men also believed that there was political and market space to begin talking with the media, community members and public officials about the problem of infant mortality in Harlem and other hot pockets in the city and they would listen and act to solve the problem. In February 2001, the ***Citywide Coalition to End Infant Mortality*** was organized by advocates, clinicians, community residents, and elected officials from all five boroughs. A consensus was reached on the following campaign goals:

*Demystify the issue of infant mortality to consumers, elected officials and the media

*Create a state of emergency about the high infant mortality rates in Harlem and other poor communities in NYC
*Demand five to ten million dollars a year for the next five years to combat the problem
*Magnify through the media the high infant mortality rate in Central Harlem to secure federal Healthy Start funds

To achieve the goals outlined above, the coalition communicated the following messages through a variety of means (press conferences, media appearances, town meetings, news articles, fact sheets, mass demonstrations, etc.) to make infant mortality reduction the number one public health and political issue in NYC. The first campaign message that we communicated across the city was that while the infant mortality rate was declining over the last five years in NYC, the problem was still an issue in Central Harlem and within ten communities where the rate was double the city average.

Secondly, it was noted that Federal Healthy Start funding in NYC was reduced by 45% from 1997 to 2001. Infant mortality rates increased in ten high risk communities during the same period of funding decline. This message helped CHHS to leverage funds from MCHB as a new grantee for Healthy Start beginning in 2001 as well as secure funding from the Mayor's office that same year.

The Citywide Coalition to End Infant Mortality constantly kept before the public the need to reduce infant mortality in Central Harlem below six deaths per one thousand live births by 2005. It was very important to communicate a positive vision as it related to Central Harlem's infant mortality rate which in 1990 was 27.7 infant deaths per one thousand live births. CHHS made a commitment to significantly reduce the infant mortality rate if funding was secured over a multi-year period from city government.

Finally, the movement communicated to the media, the Mayor's Office and the Commissioner of the New York City Department of Health and Mental Hygiene that city government had a responsibility to help to fund infant mortality reduction activities across NYC supplementing state and federal funding. From June 30, 2000 to May 31, 2005, CHHS staff and the Citywide Coalition to End Infant Mortality created a media firestorm where every week a story was dropped on television or the newspapers about the high infant mortality rate in Central Harlem and within ten other communities in NYC. Over 75,000 fact sheets were distributed to the media, community members and elected officials. Hundreds of meetings took place with city officials, the editorial boards of the major newspapers, television and radio stations throughout NYC. Testimony was given at New York City Council hearings and at least four citywide infant mortality conferences were held over this period. Mass demonstrations were held at City Hall where women breastfed their babies and demanded that city government deliver human and financial resources to combat the problem of infant mortality.

The advocacy team met several times with Mayor Giuliani and his successor, Mayor Bloomberg, to state our case and both of them responded to several news articles supporting our campaign messages by stating that they would do something about the

high infant mortality rate in Central Harlem. From July 1, 2001 to May 31, 2005, the Citywide Coalition to End Infant Mortality secured twenty-seven million dollars as a result of our advocacy activities.

The movement was successful in creating a state of emergency concerning the status of mothers and babies in Central Harlem and across NYC. CHHS was able to create a political situation where funding and action around infant mortality were recommended by elected officials from both parties.

Over forty community-based agencies throughout NYC along with the CHHS project received these funds to supplement their outreach, case management, and health education activity. On June 30, 2005, the Citywide Coalition was able to secure 7.5 million dollars from the City Council and the Mayor's Office to continue to expand/sustain the work of CBO's including CHHS from July 1, 2005 to June 30, 2006. Funds secured through the successful implementation of our advocacy strategy went to add capacity/support to CHHS outreach, case management, health education and consortium interventions.

Functional Sustainability Activities
Outreach and Case Finding:

Starting in 2000, NMPP secured a CDC/New York State Department of Health AIDS Institute grant entitled ***Community Action for Prenatal Care (CAPC).*** This $240,000 a year grant assisted NMPP in paying for the services of thirty perinatal outreach workers whose job was and is to locate, persuade, educate and enroll high-risk pregnant women into the NYC care system which included the services provided by CHHS. Through the use of funds from this grant, NMPP developed the Sister Link Coalition which is a network of providers, consumers and outreach workers who are dedicated to servicing the needs of high-risk pregnant women throughout northern Manhattan.

All outreach workers were trained to utilize a best practices outreach strategy and approach to motivate pregnant prostitutes, homeless women, HIV-infected women, teenagers, immigrant women and substance abusers to enter prenatal care and situate themselves with a medical home. It is based on intense, one-on-one engagement of clients. CHHS has utilized funding from our CAPC/Sister Link Coalition to expand the outreach and case finding operation. Our CDC funding is assured through 2009.

Case Management
Starting in 2003, the New York City Department of Health and Mental Hygiene began the start up process of deploying a ***Nurse Family Partnership*** (NFP) team within Central Harlem to address low birth weight babies and infant mortality. The program was based at Harlem Hospital and five registered nurses have been trained to case manage 100 high-risk pregnant mothers in Harlem. They are subcontracted from the Visiting Nurse Service of New York.

Over $450,000 was allocated from last year's City Council Infant Mortality Initiative to pay for this intervention. Starting on July 1, 2005, NYC Mayor Bloomberg base lined funds to make the NFP intervention a permanent component of Central Harlem's case management spectrum of care.

NMPP responded to a RFP from the New York State Office of Children and Families in 1999 to start-up a Healthy Families America Home Visiting Program in Harlem. The proposal was approved in 2000 and NMPP has been operating the ***Baby Steps Home Visiting Program,*** one of the programs sponsored by Healthy Families of America, with a staff of thirteen workers responsible for recruiting and visiting at the prenatal stage, high-risk women in the western sector of Central Harlem. The addition of this $500,000 a year program places more boots on the ground and saturates Central Harlem with a variety of perinatal case management programs to reduce infant mortality and low birth weight rates.

On September 7, 2003, the first birthing center in Central Harlem opened at Harlem Hospital. Please review the local health systems action plan segment of this report to learn more about the planning of this unit of service. Over two million dollars was secured to build five 750 square foot birthing rooms. Two new midwives (that brought the total to five) and three more obstetricians (that brought the total to thirteen) were hired to fully staff up the new physical plant.

On January 7, 2005, NMPP submitted a $750,000 proposal to the NYC Administration for Children's Services to staff up an intensive preventive and aftercare services program to address the needs of pregnant and acting out teenagers currently stepping down from congregate care to a foster boarding home level of care in Central and East Harlem. The program utilizes the multisystemic therapy (MST) treatment modality.

The MST model is an effective family and community-based modality that has historically proven to be successful in the treatment of complex deviant and antisocial behaviors in youth who have been exposed to substance abuse and other dysfunctional family situations. MST has a proven track record to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers as well as empowers teens to cope with family, peer, school, and neighborhood problems. NMPP will learn whether they will be awarded this grant by October 30, 2005.

Health Education

NMPP strengthened our teen services division in 2000 when we were awarded a grant to deliver adolescent pregnancy prevention services in Central Harlem by the New York State Office of Family and Children Services. Annually since 2000, NMPP's ***Club Moms Program*** has served over 100 pregnant and parenting teenagers with a flexible curriculum that prepares teens for the full expectations of parenting and internatal care and non-pregnant teens learn the benefits of delaying sexual behaviors and engaging in a number of positive life-skills activities. On October 1, 2005, NMPP will start-up its HRSA/NYSDOH-funded teen abstinence program that is geared up to service another 100 teens to motivate them to abstain from sexual behaviors.

Perinatal Mood Disorder Screening and Marketing Activities

Starting on September 6, 2003, the New York City Department of Health and Mental Hygiene initiated the ***Harlem Strategic Action Committee on Infant and Maternal Mortality*** (HSAC). They decided to make an investment in Central Harlem by mobilizing all of the MCH stakeholders and concerned community residents to develop a collective definition of the MCH problem in Central Harlem and develop a set of interventions to resolve the community's infant and maternal mortality problem. Over forty hospitals, clinics, case management programs, consumers and academics form the HSAC.

During 2003, the NYCDOHMH and NMPP allocated $75,000 from the City Council Infant Mortality Initiative funding stream to fund the work plans of several HSAC workgroups in the areas of Male Involvement, Clinical Care, Environmental Health, Surveillance, Systems, Mental Health and Women's Health. During 2004, $150,000 was allocated to the above workgroups to carry out a second year of activities.
Over the last two years, staff from CHHS led the ***Mental Health Workgroup***. Over ten grand round training sessions were organized at medical facilities and clinics where doctors, midwives, community health workers, and social workers learned the state of the art to screen, diagnose, and treat various maternal psychiatric disorders. Some of the best clinicians were secured and paid to complete the above trainings sessions.

Two group work sessions called the ***Baby Mama's Club*** targeted depressed pregnant women. Each group of 12 women was motivated to develop an informal social network of support to address the root causes of their depression through testimonials, reflective thinking and self-help action projects. Now, into the third year, participants are charged with developing their own groups within beauty parlors, community centers or in their homes to expand the number of perinatal social support networks of poor and working class women attempting to gain control over their lives. The HSAC plans to continue funding this work from July 1, 2005 - June 30, 2006.

The Mental Health Workgroup developed a maternal depression anti-stigma social marketing poster campaign from July 1, 2004 to June 30, 2005. Focused groups were organized to understand working women's perspective of mental health providers and the social and economic sources of their depression during the pregnancy period and beyond. A final report was produced and NMPP's ***Social Health Marketing Group*** was hired to develop three maternal depression anti-stigma poster drafts for review by staff from the NYCDOHMH.

One "book" was reviewed and selected from June 16, 2005 until September 30, 2005; over 50,000 English and Spanish campaign posters are being mailed to community-based providers and placed in transportation hubs, bodegas, beauty salons and on subway and bus stops. The campaign will help redirect the Harlem community's views about maternal mental health services and motivate more women to admit that they are depressed and come in to seek services. Starting on July 1, 2005 to June 30, 2006, over

$200,000 in City Council funds will be allocated to continue the above work in Central Harlem by the NYCDOHMH and CHHS.

C. Identify any resources or events that either facilitated or detracted from successful initiation and implementation of each intervention.
3) Describe whether or not you were able to overcome any barriers or to decrease their negative impact.

The CHHS project learned that a persistent, on message advocacy campaign can produce new financial resources to supplement Healthy Start funding and educate thousands of community residents, civic leaders and stakeholders about the problem, consequences and solutions to infant mortality. We learned that a robust media campaign and targeted political work can create a state of emergency concerning high infant mortality rates within an urban setting.

Creating a state of emergency (high level of consciousness and concern related to infant mortality problems and interventions) was a necessary condition before our sustainability and advocacy goals could be achieved. CHHS staff and consumers learned that believing in and adhering to the social movement's political will and following the vision can create new opportunities for mothers and babies. CHHS project staff and the Citywide Coalition to End Infant Mortality achieved the above objectives over the last four years despite hard fiscal times and two Republican mayors in office. We also learned that Healthy Start projects which utilize community mobilization tactics to achieve advocacy/sustainability objectives must secure a legislative champion of their cause.

This elected official has the task of broadcasting your message throughout municipal government and the media. The legislative champion makes the case for new funding and actually secures funding utilizing external political pressure coming from the community and media placements and expert negotiating skills with his or her colleagues in government to achieve the fundraising objective. The combination of media intensity, message concentration, community mobilization and political savvy won the day in Central Harlem and New York City. CHHS staff strongly believes that this formula can be replicated in other cities looking to sustain their projects after MCHB funding ends.

III. Project Management and Governance

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

Implementation and management of CHHS during Phase III was guided by its management structure during Phase II, 1997-2001: The Executive Director, Mario Drummonds, MS, LCSW, MBA, was responsible for administrative and fiscal oversight of the project and the management of all staff on the project. Mr. Drummonds has ultimate responsibility for the successful implementation of the project and accountability for agency funds. He reports to the board of directors. The Project Director, Goldie

Watkins-Bryant, MPH, was responsible for the day-to-day management and implementation of the project. All internal Healthy Start staff and subcontractors reported to her. She was responsible for the conduct of all project services, ensuring maximum coordination and integration with other NMPP projects and those of other organizations in the perinatal health and social services systems, maintaining community ownership of the consortium, assessing and addressing the training and technical assistance needs of staff, monitoring project performance, assuring the attainment of performance objectives, and providing HRSA with all required data and reports. She reported to the Executive Director. The Fiscal Director, Diomedes Carrasco, was responsible for managing and monitoring the expenditures of the CHHS project. He was responsible for working with the Executive Director and the Project Director to develop the CHHS budget and budget modifications, the preparation of fiscal reports, submitting the Financial Status Report to HRSA, overseeing the annual audit contract and responding to auditing queries. Human Resources Director, Michelle Arthur, was responsible for implementing all personnel policies, facilitating the hiring process for the Project Director, managing benefit packages, and ensuring the timely completion of staff evaluations. She was also responsible for helping to develop opportunities for staff training. We fully expect these staff members to apply the expertise gained to date in the implementation of the interventions developed for Phase IV of the Healthy Start Initiative, June 1, 2005 – May 31, 2006

The HRSA field office tested a Healthy Start Initiative project monitoring tool on the CHHS project. The tool included an exhaustive review of project management, implementation of project services, project impact and fiscal accountability of the project. The project review was summarized as follows:

"**It is clear from the interviews conducted of the Management Team and the review of the supporting documents; the policy and procedure manual for case management, the personnel manual, the quality assurance documents, board minutes that the grantee's work towards achieving the outcomes and results is in place and is being evaluated comprehensively and consistently. The GPRA national measures are clearly understood by all of the grantee's employees. The CEO leads the project with a corporate integrity and consistent message about the mission, vision and values of the organization. There is an entrepreneurial culture at NMPP that similar programs could benefit from having. This consistent message is reflected in the expertise of the staff that has been hired for this grant, the comprehensive staff evaluation and performance, the review of the client charts as a component of the grantees quality assurance program and the quality of the health education and case management that is being provided to the CHHS clients and the general community of Northern Manhattan. The Project Director and the rest of the management team of the grantee are equally as clear and consistent in their understanding of the perinatal care needs of the community ad how to meet those needs within the guidelines of the Healthy Start project."**

A copy of the CHHS Organization Chart is in Appendix C**.**

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

In order to enhance project management of CHHS, the Evaluation Director tailored a Program Monitoring Tool (PMT) created during Phase I of the Healthy Start Initiative with three subcontractors in New York City to the single site CHHS project. The PMT was completed quarterly and annually on staff changes, staff training, consultant contracts released, and outreach, case management, depression screening, interconceptional care and health education program achievements, obstacles and plans for the next reporting period. He also provided monthly statistical reports on project performance by service area.

The Evaluation Director also extracted case management, health education service data, and consortium activities from weekly staff reports and from CHART, our case management data management system.

These performance tools proved to be invaluable in managing the project with few surprises as to how each staff member was working to meet the expectations of his/her position. Also, the data provided for adjustments in outreach activities to reflect case management case load.

The Fiscal Director provided the CHHS Project Director with monthly expenditure reports for each line in the CHHS budget. This facilitated the Project Director carefully monitoring the rate of spending by line item and provided the basis for timely budget modifications for funds accumulated from under spending in various line items.

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

The most significant changes that occurred in management and governance of the project related to staffing of the project. The Healthy Start Initiative application submitted to HRSA for continuation of CHHS requested a budget of $1m; however, $875,000 was received. No adjustment was made in staffing or deliverables for this 12.5% reduction in funding. In order to retain the initial staffing proposal, other budget lines were reduced. However, this proved to be a handicap to the project as the need arose for increasing the child care, client incentives, health education materials and postage budget line allocations. When the Health Education and Outreach supervisor resigned, this position was replaced.is The outreach worker was first placed under the supervision of the Case Management Supervisor which led to better coordination of outreach activities with case management capacity. The position was vacated at a time when referrals from providers and self referrals were effectively filling case management capacity. The next outreach worker was placed under the supervision of the Project Director to conduct more community based health education activities. The Health Educator was also placed under the supervision of the Project Director who had a history of providing education services tailored to client needs through her four years of volunteer activities as a tutor for high school students.

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

As the Phase III application was being developed, the CHHS project and budget reflected the $1M cap on applications as well as the 10 years of experience gained with staffing and managing the project since 1990. The budget reflected the staff and other supports

required to provide core services to 200 pregnant and parenting high risk families from Central Harlem. Based on the 12.5% reduction in the $1m requested to manage the project and the $875,000 grant award, changes in the budget were made as noted in Item C, above.

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

Beginning in July 2001, the New York City Council made around $5m available annually for a City-wide initiative to fight infant mortality. The budget allocation was the result of legislative education and advocacy accomplished by the Citywide Coalition to End Infant Mortality. The NYCDOHMH managed the funds through contracts with some 40 community based organizations for the delivery of specified services. NMPP received $250,000 annually in City Council funds to serve additional clients with outreach, case management and client and community health education activities beyond other contracts for these services. No additional staff was hired for the City Council initiative; existing staff worked additional hours. The funds were crucial to the project retaining staff which had been a problem during Phase II because the HSI budget did not provide funds for annual staff raises. We were able to give increased salaries to staff for working additional hours to meet the deliverables of the NYCDOHMH contract. For clients who enrolled into the case management program as homeless families and who found permanent housing in other boroughs of the city, we were able to use some of the additional funds allocated to CHHS to retain them in our case management program. Moreover, when individuals were referred by local providers who lived outside our catchment area or when such individuals inquired about our services that were walk-ins we served them.

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

Cultural competency was never an issue with this project, at the outset, we were able to hire bi-lingual English/Spanish staff. In addition, we were able to hire a male case manager from Cameroon who was helpful in attracting and retaining clients from among the West African immigrant population in Harlem who came from French speaking countries. It was especially helpful having a male case manager who could persuade the male African heads of households to permit companions to participate in the CHHS project. West African households in Central Harlem are usually male dominated.

All CHHS staff participated in workshops on Latino and West African health seeking behaviors and cultural mores to enhance our outreach efforts and to assure appropriate respect for client behaviors. Also, English as a second language was provided to French speaking West African clients and community residents to enhance referrals; however, we attracted no more than five or six West African clients each year for a total of 25 over the project period.

IV. Project Accomplishments are delineated in Attachment A.

V. Project Impact

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

1. Describe the approaches utilized to enhance collaboration.

The Manhattan Regional Perinatal Forum was established by the NYSDOH in 2003 to enhance collaboration among hospital based and community based perinatal health and social support providers. The executive director of NMPP co-chairs this body. The

forum has facilitated the involvement of hospital based obstetricians and other professional staff in addressing community based challenges to good birth outcomes. Members of the forum are collaborating to improve the quality of birth outcome data reported to the city department of health and educating high school students about the importance of consuming an adequate amount of folic acid. Through these collaborations, we are gaining trust in each other and insights into the challenges each faces in utilizing best practices to optimize birth outcomes.

The Harlem Strategic Action Committee (HSAC) was organized by the NYCDOHMH to address both the excess infant and maternal morbidity and mortality in Central Harlem. Membership includes hospital, clinic, social support agencies and consumer representatives. The staff of CHHS was crucial to the success of the work of the committee. Staff chaired the Mental Health and Male Involvement Work Groups and conducted the agency survey for the Systems Work Group. The city department of health brought representatives of groups to the table that CHHS had not previously been able to engage. The representative from Hunter College manages an ex-offender community re-entry program for adolescents released from our local jail, the executive director of Harlem Hospital Center along with his public relations director routinely participate in the deliberations of the HSAC, the medical consultant who conducts infant mortality reviews for the city has been an invaluable contributor to our work.

Our participation in the Manhattan Regional Perinatal Forum has provided the opportunity to negotiate Memoranda of Agreement (MOA) with three of the hospital based PCAP providers located outside of our catchment area that deliver about 10% of our clients. We had already negotiated MOAs with three community based PCAP providers that are used by many of our clients.

We have also developed MOAs with the largest community based mental health provider in our community, a Head Start program that is available to our clients, an HIV-AIDS prevention and education program that is located across the street from our office, and a community food pantry that many of our clients use.

When the project initiated depression screening in 2002, a breakfast was held for the mental health providers in the Central Harlem community to inform them of the role of CHHS in improving birth outcomes in this community and to learn how best to refer clients for their services.

Because of a shortage of mental health providers, grand rounds were held for physicians, nurses, social workers and other professionals at Harlem Hospital Center, the Renaissance Community Health Center (includes three clinic sites based in local housing projects) and the Settlement Health Clinic on perinatal depression screening and treatment. The insights provided by Dr. Margaret Spinelli, an expert in perinatal depression from New York State Psychiatric Institute, will expand the pool of individuals trained to assist in this area. The grand rounds were sponsored by the Mental Health Work Group of the Harlem Strategic Action Committee chaired by A CHHS employee and sponsored by the NYCDOHMH.

NYSDOH provides free prenatal care services to all pregnant women residing in households where the income is less than 185% of the federal poverty level through the PCAP project. All individuals eligible for PCAP are also eligible for WIC services. PCAP is available to low income households irrespective of immigration status of the pregnant woman. CHHS sponsored a three hour forum in 2004 on depression screening and treatment for PCAP providers across the city. This was done to promote the

screening by all PCAP providers serving Central Harlem residents regardless of their risk and socioeconomic status. The PCAP risk assessment tool does not require depression screening of all patients; it is required for those who exhibit signs or symptoms of depression.

We collaborated with the Coalition to End Smoking in NYC to bring the smoke free homes initiative to our clients. We will work with the New York Presbyterian Hospital staff to initiate education on the prevention and management of diabetes for our clients and the residents of a local housing project beginning later in 2005. Our collaboration efforts with the Prevention Center of Harlem, a CDC funded program, led to the development of a proposal concept that is in the process of being flushed out for submittal to a foundation for funding case management and health promotion activities for men. Asthma prevention and immunizations services were provided to our clients through collaboration with NMPP staff hired with funds from Columbia University grants.

CHHS was successful in raising the funds to construct a five unit birthing suite at Harlem Hospital Center. The low tech, family friendly birthing suit rounds out the birth options available to residents of Central Harlem. Because of our roll in securing the funs for the birthing suite, our relationship with the obstetrics staff at Harlem Hospital Center has been enhanced.

NMPP quarterly staff meetings also provide a forum for the perinatal programs operated by NMPP in the Central Harlem, East Harlem and Washington Heights communities to collaborate and benefit from each others best practices. These programs include outreach, case management, health education, infant development, Head Start, and prevention of teen pregnancy and foster care placement.

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

CHHS was among many agencies and hospitals pressing the NYSDOH to finalize the regionalization of neonatal intensive care units (NICUs). Once completed, regional perinatal forums were organized around the Level III NICUs. The Manhattan Regional Perinatal Forum, organized in 2003, has served as a forum for pressing the city department of health to integrate its paper driven birth outcomes data into the electronic data base managed by the state department of health. Our efforts to this end are on going.

The breakfast for depression providers sponsored by CHHS as it was initiating its depression screening activities has facilitated referrals for clients willing to access the services. A MOA has been executed with the largest free standing mental health service provider in our community; nevertheless, our clients must wait four to six weeks for an appointment.

Memoranda of Agreement have also been developed with the WIC and PCAP providers in Central Harlem to assure that CHHS clients have ready access to these services.

The NYCDOHMH developed a prenatal history card which providers are encouraged to use. With the card, clients have up to date results on the various tests they have received which can be kept with them at all times in the event that the client has an emergency delivery in a situation where the providers do not have access to her chart. This was done by NYCDOHMH to facilitate emergency care because of the mobility of high-risk clients. CHHS staff reinforced with clients the importance of keeping up with the prenatal care card.

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

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

Relationships with health service agencies

CHHS secured the services of Dr. Ira Chasnoff, Director, Children's Research Triangle, Chicago, Il. in 2004 to provide instruction to health care providers on screening for substance abuse. The two day workshop included an in depth presentation on the impact of alcohol, tobacco and illicit substances on the developing fetus. In addition, CHHS participated in quarterly meetings hosted by the NYS Office of Alcohol and Substance Abuse for substance abuse providers that served women. Relationships developed from

these activities facilitated cross referral of pregnant and parenting women who needed substance abuse treatment.

Memoranda of Agreement were negotiated with three Prenatal Care and Assistance Providers that facilitated referral to CHHS of a prenatal health care client from our catchment area who missed two or more prenatal care appointments.

NMPP and CHHS worked with the NYC Health and Hospitals' Corporation, our Congressman and the Manhattan Borough President to build a Birthing Center Suite in Harlem Hospital. On September 8, 2003, the five bed birthing suite was opened. Each room includes a delivery bed and a small refrigerator, microwave oven and sofa for the family to participate in and support the mother during the delivery process. We now have a supportive relationship with the obstetric staff at Harlem Hospital Center. This staff facilitated other hospital staff participation in grand rounds on depression screening and treatment sponsored by the Mental Health Work Group of the Harlem Strategic Action Committee.

Relationships with community based organizations

Head Start Programs

We worked with local Head Start programs to refer clients, receive referrals and provide speakers on child safety, parenting, immunizations and other topics upon request. During the presentations, we addressed reproductive health issues and advise participants of the services provided by CHHS. In addition, because of the success of our Male Involvement Consortium, the consortium was hired by the city Agency for Children's Services to organize a half day workshop on how to create an inviting atmosphere in Head Start centers for the fathers of clients. Consortium members will continue to assist the centers in developing successful male involvement strategies. There were 79 Head Start programs represented at the workshop.

Community Planning Boards, the Harlem Chamber of Commerce, and the Community Health Alliance

The CHHS outreach worker participated in at least six health fairs sponsored by local churches during the spring and summer of each year. In addition, we provided health promotion presentations in at least twelve community forums each year. We also conducted outreach activities at the annual Harlem Day Festival sponsored by the Harlem Chamber of Commerce which attracts thousands of participants.

Community Based Mental Health Programs

We had a breakfast for the community based mental health programs in 2003 in preparation for referring clients with symptoms of depression for screening and treatment, as needed. However, to date, we have not been successful in getting many of the women who scored high enough on the Edinburgh scale for referral for further work up to accept a referral. The Mental Health Work Group of the Harlem Strategic Action Committee developed posters to help de-stigmatize depression because so many of our

clients have refused referral for further assessment that obviously needed help. CHHS organized *Sister Chat* for clients who scored high on the Edinburg depression screening tool. The Mental Health Work Group also organized the *Baby Mama's Club* as a support group. It accommodates working moms who can only meet after normal work hours, 5:30-7:30 pm.

The Baby College

When clients need more intensive parenting assistance than we can provide, CHHS refers them to the Baby College which is sponsored by the Harlem Children's Zone, a program affiliated with the Brazilton Institute at Harvard University that promotes healthy infant development. The Baby College provides nine weekly three hour workshops per week for young mothers with infants. Four sessions were offered a year to residents of the Central Harlem community. A client was referred to the Baby College by the case manager based on case manager and/or client identified needs. The case manager followed up with the client to assure that the client had made contact with the Baby College to enroll in the next class. The Baby College, in tern, referred clients in need of more intensive case management than it provided to CHHS.

Miscellaneous groups

A Memorandum of Agreement was negotiated with the male mentoring program of the Greater Zion Hill Baptist Church for current and former clients to refer adolescent sons.

Case management staff had a close working relationship with the Yorkville Common Pantry. We referred clients there who either had not yet started receiving public assistance benefits or who had run out of food prior to the end of the month.

We routinely collaborated with the New York City Breast Feeding Alliance in hosting its annual Breast Feeding Promotion Day in one of our local parks. Last year, some 600 community residents participated in the event.

There are two agencies that provide GED and job placement assistance that we routinely worked closely with: The GED program sponsored by the Minority Task Force on Aids which is located on the fourth floor of our building and STRIVE which works with ex-offenders.

In 2003, CHHS collaborated with 100 Black Women to present a seminar on SIDS for health care providers from across the city. It was given at Harlem Hospital Center.

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

In 2004, CHHS added a "Beauticians for Healthy Families" initiative to our community health education efforts. We trained beauticians to teach their clients about SIDS. For each pre/post test they returned to us, they received a $4 metro card. Fifty clients were tested during the initiative. It was implemented in three beauty shops and hair braiding salons: one each with predominantly English, Spanish and French speaking staff. French was added to penetrate the West African community with information about preventing SIDS. All materials were developed in English, Spanish and French. A bi-lingual French

speaking interpreter from West Africa administered the pre/post test verbally in the hair braiding salons.

As a result of our "Beauticians for Healthy Families" initiative, the CHHS project director served as moderator for an annual scholarship luncheon sponsored by the State Beauty Culturist Association of New York, Inc. She introduced the work of CHHS to attendees and spoke briefly on the role beauticians can play in recognizing the signs and symptoms of depression and referring clients for assistance. There were some 250 beauticians and guests in attendance at the luncheon.

The CHHS Male Involvement Consortium, in response to a contract from the city Agency for Children's Services, provided a symposium on creating male friendly atmospheres in Head Start facilities to engage more fathers. As a result of the symposium, CHHS staff developed working relationships with several Head Start programs in Central Harlem, We offered the centers health promotion workshops on topics of interest to the parent advisory groups which consisted of many parents who were of child bearing age.

CHHS provided SIDS refrigerator magnets as handouts at the annual appreciation luncheon of the local Baptist Church Nurses Association. Many of the nurses were grandmothers and were not aware of the national "back to sleep" initiative. They were grateful for the magnets. There were about 85 church nurses at the luncheon.

CHHS participated on the Community Board # 10 Inter-religious Committee which offers health promotion presentations at local churches. This group was recently organized; we expect to work with it in meeting the goals of our public community education activities.

As active members of the Citywide Coalition to End Infant Mortality, we have been involved in educational advocacy with the elected officials representing Central Harlem in the City Council. In addition, we have engaged United States Congressman Rangel and United States Senators Clinton and Schuman in our educational advocacy activities.

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

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

During Phase II of the HSI, 1998 – 2001, the NYSDOH funded PCAP program, was at risk of undocumented immigrants being excluded from the program. CHHS staff and clients were among the educational advocates that worked to maintain coverage for undocumented immigrants. We were successful!

In addition, it was during Phase II that CHHS along with other perinatal health advocates worked to simplify the public assistance, WIC and PCAP applications. Ultimately, the eligibility for WIC and PCAP were made congruous. A single application can now be used to enroll in both programs.

Through the funding provided by the City of New York, CHHS served some of our homeless clients who moved outside our target area along with some 60+ high risk clients each year from outside our target area.

We used our West African case manager from Cameroon to educate African heads of household in southwest Harlem about the availability of free prenatal health care services for families earning less than 185% of the Federal poverty level. They were advised that CHHS services were free as well and utilization of either of these services would not jeopardize their immigration status. Some 40% of the Prenatal Care and Assistance Program clients at Harlem Hospital Center are now West African.

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

Unfortunately, many indigenous African American women are not aware of the Prenatal Care and Assistance Program or CHHS, especially those who are young, using drugs, are homeless, recently released from prison or those experiencing domestic violence. In addition, most immigrant families are not aware of these services or the fact that are free to low income families.

As noted above, when canvassing the community, the Outreach worker distributed project flyers to community residents on the street, left multiple copies of promotional flyers in delis, laundromats, beauty salons, hair braiding shops and barber shops. In housing projects, she went door-to-door leaving flyers. She visited a variety of community health and social service programs across our catchment area to leave promotional materials and advise management that she was available to provide health promotion workshops to increase name recognition with clients and referrals from staff.

CHHS used its male West African case manager from Cameroon to educate French speaking West African men about the availability of the PCAP program which when utilized does not penalize participant's efforts in securing citizenship. They were further advised of the PCAP services available at Harlem Hospital Center. At this time, some 40% of the PCAP clients at Harlem Hospital Center are West African women from both English and French speaking countries.

As noted above, when the Project Director spoke at an annual meeting of the State Beauty Culturist Association of New York, Inc., she introduced the work of CHHS to attendees and spoke briefly on the role beauticians can play in recognizing the signs and symptoms of depression and referring clients for assistance. The major mental health providers in Harlem were mentioned.

Fortunately, in 2003, when a community resident decided to give her new born away by leaving it in a "safe place," she chose the reception area of NMPP which speaks to community perceptions of who we are and what we do.

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

Continuity of care

CHHS and NMPP staff were founding members of the Federation of County Networks (FCN) that was created through a CISS grant from HRSA in 2000. Two years ago FCN received a Community Access Program grant from the Health and Hospitals Corporation to create a virtual network. The virtual prenatal perinatal network reduced paper work flow by facilitating cross referrals from one perinatal network to another in New York City as clients moved from one borough to another. It was constructed to operate in compliance with HIPAA requirements.

As a result of one of our annual consumer "speak out" agency accountability forums, the NYC Commissioner of Homeless Services made several changes the homeless system. Among them, one relates to continuity of care: pregnant women are now moved to the front of the waiting list for placement in stable temporary housing where they can reside until delivery as apposed to frequent moves from shelter to shelter while searching for an apartment.

At yet another one of our annual consumer "speak out" agency accountability forums, the deputy commissioners of the New York City Department of Health and Mental Hygiene (NYCDOHMH) and the Administration for Children's Services (ACS) were brought together in a forum to discuss the role each plays in protecting children. Based on questions generated by the presentations, the NYCDOHMH and ACS are now collaborating to obtain a grant from the State Office of Children and Family Service to jointly implement a Healthy Families America case management program in the City. The program will assure that any biological parent with children in foster care who delivers a new baby will receive case management services to support the mother in keeping the infant. Moreover, the two agencies are now working to share data bases on family services in order to coordinate services when they are both involved with the same family.

When the PCAP program was created in 1987 by the NYSDOH many individuals who are now members of the Board of Northern Manhattan Perinatal Partnership assisted in advocating that eligibility levels be the same as those for WIC and that WIC be required to refer pregnant women to PCAP programs and vice versa which assures that high risk women have access to needed nutrition programs as well as good prenatal care services.

CHHS executed Memoranda of Agreement with the community based Prenatal Care and Assistance Programs and WIC programs in our community to expedite referrals and maintain continuity of care. The Manhattan Regional Perinatal Forum provided the opportunity to develop Memoranda of Agreements with hospital based PCAP clinics. The MOAs provide for the clinics to refer to CHHS any clients eligible for our services who miss two or more clinic appointments.

A breakfast was held by CHHS for depression providers in our community to introduce them to us and vice versa in order to expedite referrals.

The credibility of CHHS along with the quality of services we offered in the Central Harlem community over the past 15 years brought us wide spread name recognition which facilitated referrals.

Quality improvement

During Phase II of the HSI, clients from West Africa, the Caribbean and holistic practitioners from Central Harlem recommended to us that a birthing center be developed in the community for delivery services that were less intrusive than those normally available in hospital settings. As a result of the efforts of our leadership, a five suite birthing center was opened in Harlem Hospital Center in 2003. The funding package for the birthing suite included the services of additional nurse midwives. When combined, the birthing suite and additional nurse midwifery services increased the quality of maternity services offered to residents of Central Harlem.

By insisting that CHHS prenatal clients carry with them at all times their NYCDOHMH Prenatal Care Card that contained the results of most of the tests required for pregnant clients the tests did not have to be repeated when clients changed providers. Many of our young pregnant clients were homeless or lived in unstable situations that resulted in them frequently moving from place to place.

The training CHHS provided to physicians, nurses and social workers over the years on substance abuse screening and treatment, the signs, symptoms and treatment of perinatal depression, and SIDS have increased the quality of services provided in Central Harlem.

Follow up system(s) for client referrals

The Memorandum of Agreements developed with the WIC and PCAP programs in Central Harlem facilitated client referrals.

The goodwill CHHS developed over the years with the many health promotion forums it offered to providers promoted name recognition which facilitated client referrals.

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

The virtual prenatal perinatal network developed in 2003 by the Federation of County Networks (FCN) facilitated the sharing of data across perinatal network providers. It was designed to assure compliance with HIPAA requirements. NMPP and CHHS staff participated in the organization and development of FCN.

A relationship was developed with the NYCDOHMH Immunization Program which permitted staff to check on the immunization status of infants and toddlers in our case management program. This reduced the redundancy of immunizations and allowed us to provide appropriate follow-up when clients were not fully immunized in accordance with to their age. All communication with NYCDOHMH regarding the immunization status of our clients was done with respect to HIPAA guidelines.

CHHS encouraged clients to make sure their prenatal care cards were kept up to date and carried with them at all times. This was especially important for our homeless clients who may live in several shelters before finding permanent housing. If the shelters are located several miles from their initial PCAP provider, they might seek out a new provider nearer to them. This was also helpful to our transient clients who moved around among relatives and friends. By keeping their prenatal care cards up to date; duplicate tests were avoided.

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

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

Our Consumer Involvement Organization (CIO) was created to provide CHHS and other perinatal social support programs implemented by NMPP feedback on the services NMPP provides as well as the services provided by other agencies. Giving consumers this opportunity to speak out about concerns they may have, has empowered them and challenged us to be responsive to their concerns. The establishment of the birthing suites at Harlem Hospital Center was a direct result of some of our immigrant clients requesting a more culturally appropriate birthing experience that reflected the view of their home countries: delivery is not a disease but a celebratory occurrence involving the extended family. Also, the Harlem Works program which included GED training and computer skills development was established in response to requests from clients for help finding jobs with decent wages.

The Male Involvement Consortium grew out of concerns expressed by both our CIO members and CHHS staff about the need for men to be more supportive of partners while pregnant. The Male Involvement Consortium was organized in 1997. It continues to provide workshops focused on the involvement of men in the lives of their children as well as men's health. They were always well attended. In March 2003, 16 men showed up during a snow storm for a men's health workshop even though the guest speaker couldn't make it. CHHS staff hastily outlined a presentation and duplicated relevant health education materials on the importance of annual physicals and good nutrition and prostate, colon and lung cancer screening. A lively discussion followed the presentation.

Recently, the Helen B. Atkinson Community Health Center began advertising the availability of primary care services for men. The promotional flyers are now included in the CHHS case management introductory packages for partners of clients. The flyers were also made available to the participants in our Male Involvement Consortium.

In 2003, CHHS staff submitted a proposal to the Kellogg Foundation to provide outreach, case management and health education services to men in Central Harlem. Unfortunately, it has not been funded yet. Currently, CHHS is collaborating with the Harlem Health Promotion Center to develop a proposal to provide case management and health services to the men in this community.

Each year of the CHHS project, the CHHS Consortium included a presentation or a panel discussion on cultural sensitivity during one of its quarterly meetings. The presentations covered both Latino and West African health seeking behaviors and use of alternative practitioners. They were made by representatives from advocacy groups for these populations: Alianza Dominicana and the African Services Committee.

Memorandum of Agreement with PCAP providers included provisions for referral of clients from our catchment area to CHHS when the client missed two or more prenatal appointments. In addition, clients earned Healthy Start Bucks as they kept their prenatal care appointments. The Healthy Start Bucks were traded in for dollars used to order merchandise from a comprehensive retail catalog.

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

Current and/or former clients served as Co-chairs of the CHHS Consortium and its committees: Case Management and Health Education, the Consumer Involvement Organization and the Male Involvement Consortium. The Co-chairs and chairs made up the Steering Committee of the Consortium. The Steering Committee recommended that we educate young fathers on the signs and symptoms of perinatal depression. Arrangements were made to implement the suggestion; however, the agency we worked with closed before the workshop on depression could be presented to participants in its young fatherhood program. Nevertheless, four support group meetings were held for young fathers earlier this year; staff took the opportunity to discuss signs and symptoms of perinatal depression along with community resources with the participants.

NMPP maintains a Consumer Involvement Organization for current and former clients of all of its perinatal programs. It is a support group. Participants asked that we seek out

mentoring programs for their young sons. A Memorandum of Agreement was negotiated with the Greater Zion Baptist Church sponsored mentoring program for referrals of these adolescents.

During one of our annual Valentine's Day celebrations, a focus group was conducted to determine what we needed to do to enhance client participation in group health education workshops. We were advised to include with each health promotion workshop a topic relevant to the day-to-day lives of the clients such as how to select an apartment, budgeting, cleaning up your credit history, etc. After implementing the recommendation, client participation in health education workshops climbed from two or three clients to 11 to 15 clients per workshop. Eight clients participated in our infant message workshop series this year.

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

1. Residents' knowledge of resource/service availability, location and how to access the resources

NMPP sponsored forums during which speakers addressed resources available in the community. These included: (1) our annual women's health conferences for clients, community residents and providers that drew from 75 to 100 attendees; and (2) our annual conferences on **"Linking Women to Health, Power and Love Across the Lifespan,"** which were regularly attended by some 350 to 450 providers, clients, community residents and stake holders. They participated in various workshops including ones on racial disparities, treating perinatal mood disorders, public assistance and housing, teens speak out, and the Midwife crisis in NYC.

The Citywide Coalition to End Infant Mortality, through its advertisement campaign, educated residents across the city on the causes of infant mortality and what could be done about it. The campaign employed newspaper articles, radio and TV stories, and the distribution of several hundred thousand pieces of informational material. Some 300,000 city residents were touched by the campaign. The messages both educated the community on the problem and drew community residents to the fight for city funds to help fight the problem. Participants were empowered by the success of the campaign which served to draw more community residents each year. All ad material included the telephone number for the Federation of County Networks; staff referred callers to the appropriate perinatal network for responses to caller requests.

A resource guide for local GED and job training and placement programs for young men was developed by CHHS staff and distributed to the partners of all case management clients. It was included in the introductory materials to the CHHS case management program. It was also provided to participants of the Male Involvement Consortium.

During community based health promotion presentations, local resources were noted and copies of the Sister Link Resource Guide which delineates the services provided by 124 agencies and organizations that are available to CHHS clients was available for distribution. It includes the telephone number and address of each provider.

2. Consumer participation in establishing or changing standards and/or policies of participating service providers and local governments, that affect the health or welfare of the community, and have an impact on infant mortality reduction.

In 2001, the Citywide Coalition to End Infant Mortality, inspired by NMPP leadership, successfully organized clients and consumers across the city in a massive legislative education and advocacy effort which resulted in the City Council and the Mayor allocating $5m for use by community based organizations to fight infant mortality at the community level. Leaflets were distributed across the city, and we were successful in getting articles by local new papers and paid and public service announcements made on the radio on the fact that infant deaths reflected a variety of deficits in the community that could be addressed if the city had the will to do so. Moreover, collaborations with our city council representatives led to us organizing a demonstration by breast feeding moms on the steps of City Hall. When the first funds were placed in the budget by the Mayor and City Council at a time when the City was plagued by deficit spending, community residents became more willing to work with us on other advocacy issues. To date, $27m in tax levy resources have been allocated by municipal officials to fight infant mortality at the community level.

NMPP sponsored a consumer "speak out" agency accountability forum with the NYC Commissioner of Homeless Services where clients and community residents raised concerns on how the homeless shelter system was managed. Based on the information and concerns the commissioner heard from this forum, several changes were made in the system. Pregnant women are now moved to the front of the waiting list for placement in stable temporary housing where they can reside until delivery as apposed to frequent moves from shelter to shelter while searching for an apartment. In addition, the commissioner has announced plans to decentralize the Emergency Assistance Unit where all homeless individuals must not go to enter the shelter system. She is planning to place one in each borough where each will serve clients from its local communities. Moreover, the Homeless Services agency now has underway a major shift in funding from investments in the shelter system to investments in permanent low cost housing inspired by advocates from across the city including the voices of our clients and community residents.

Yet another forum organized by NMPP in response to community concerns over an infant being accidentally killed when it suffocated while sleeping with its mother brought together deputy commissioners of the New York City Department of Health and Mental Hygiene (NYCDOHMH) and the Administration for Children's Services (ACS) in a forum to discuss the role each plays in protecting children. NYCDOHMH discussed its best practices in teaching parenting to new moms while the Human Resources Administration spoke of the strategies it mounts in keeping older children safe. Based on questions generated by the presentations, the NYCDOHMH and ACS are now collaborating to obtain a grant from the State Office of Children and Family Service to jointly implement a Healthy Families America case management program in the City. The program will assure that any biological parent with children in foster care who delivers a new baby will receive case management services to support the mother in keeping the infant. Moreover, the two agencies are now working to share data bases on

family services in order to coordinate services when they are both involved with the same family.

Mobilization of clients and community residents in response to immigrant families requesting a low tech family friendly birthing center resulted in the Borough President, our Congressman and the municipal Health and Hospitals Corporation pooling together several million dollars to construct a five unit birthing center at Harlem Hospital Center.

Community residents also mounted a movement to restore the midwifery delivery services at New York Presbyterian Hospital. Unfortunately, these efforts ran up against reimbursement methodology challenges. Nevertheless, the movement continues.

In addition, our consumers, through the Sister Link Community Advisory Group, contributed to the development of a strategy for pregnant and parenting women to be provided with the Sister Link sponsored "1-800" hot line telephone number as they are released from our local jail.
our local jail to refer pregnant and parenting women to perinatal services in the community utilizing t

Many of the systems changes our clients and community residents fought for were successful because of the historical activism of the Harlem community and the advocacy capitol CHHS added to the community through the training provided to clients and community residents on community organizing and advocacy. Each successive success built on earlier ones. People readily ally themselves with winning teams.

As noted earlier, our Consumer Involvement Organization and our Male Involvement Consortium were direct outgrowths of concerns expressed by clients.

At the service level, CHHS added GED classes and a computer training laboratory to the services it provided in 1998 in response to clients' requests for assistance in finding decent paying jobs. Harlem Works provided GED and/or computer training to some 450 clients and community residents and assisted most of the computer laboratory graduates in finding employment from 1999 through 2003. By the end of 2003, seven proposals had been developed to continue to provide staff for Harlem Works. Unfortunately, none was funded.

During the 2003 fall meeting of the New York State based Healthy Start Initiative projects with the NYSDOH Title V program representatives, CHHS clients expressed concerns about some of the cutting edge information shared at the meeting not getting to clients and the community. In response to this concern, *Reaching Out*, the CHHS newsletter for clients and community residents was created. Some 2,000 copies of the newsletter have been distributed in the community. A copy is attached in Appendix B.

3. Community experience in working with divergent opinions, resolving conflicts, and team building activities:

The community organizing and advocacy training CHHS provided in an annual series of four weekly three hour workshops was open to current and former clients and community residents. The workshops served as team building exercises to increase organizing and consensus building skills of participants. Following the 2004 training, clients organized a bake sale to raise funds for helping the homeless; after considerable give and take, the group decided to prepare the food consistent with heart healthy principals. This view

won out over those who wanted to maximize profits by baking traditionally prepared cakes, pies, cookies, etc. Some $100 was raised and donated to a homeless shelter.

Clients and community residents worked with the Citywide Coalition to End Infant Mortality to secure funding from the City. Decisions were made each year on strategies for press conferences, newspaper articles and education advocacy meetings with elected officials. These deliberations gave all participants experience in problem solving to reach consensus on approaches to be used.

The Sister Link Community Advisory Group (CAG) meetings which included former NMPP and CHHS clients and community residents and the CHHS Outreach worker met quarterly to update staff on any new issues arising in the community that might adversely impact birth outcomes. Some of the concerns brought to the attention of the (CAG) included new prostitution sites or drug dealing sites in the community that needed to be targeted for recruiting women at risk of exposure to HIV. Recommendations were developed for outreach strategies for new hazardous areas in the community which required consensus building. Moreover, the Community Advisory Group contributed to the development of a strategy for pregnant and parenting women to be provided with the Sister Link sponsored "1-800" hot line telephone number as they were released from our local jail.

4. Creation of jobs

In 1997, in response to clients' requests for assistance in finding decent paying jobs, CHHS added a computer training laboratory and GED classes to the services it offered. Harlem Works provided GED and/or computer training to some 450 clients and community residents and assisted most of the computer laboratory graduates in finding employment from 1997 through 2003. By the end of 2003, seven proposals had been developed to continue to provide staff for Harlem Works. Unfortunately, none was funded.

A GED and Employment Training resource guide for men was created in 2004 for use by the partners of CHHS clients. In addition, staff provided assistance to at least 24 clients or their partners in creating or updating their resumes for job searches over the past year.

The annual Male Involvement Job Fair became so large, reaching 738 participants in Job Fair 2004, that CHHS hired young men from local programs to serve as security guards to assure an orderly experience for all. Each year as the job fair grew mounting it became a more complex exercise in conflict resolution and team building. The Job Fair included the following workshops: how to find a job through the Internet, preparation of resumes, and interview practice for formerly incarcerated men. The later workshop demonstrated how to interview with a focus on the positive aspects of the prison experience such as: increased self management skills and interpersonal skills and any other skills acquired in brick laying, electrical wiring, plumbing, and HIV and substance abuse prevention and education.

Over the years, CHHS hired former clients as Outreach Workers. In addition, we hired one of the Welfare-to-Work interns in our office as an Outreach worker.

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

The context for benefits and lessons learned from the CHHS relationship with the State Title V program appears on page 8 under Item E. *Collaboration and Coordination with State Title V and other Agencies.* NYSDOH received funds from HRSA to create copy ready public service announcements to help de-stigmatize perinatal depression. CHHS/NMPP leadership provided the state with the results of focus groups held with its clients and community residents on perinatal depression by the Mental Health Workgroup sponsored by the NYCDOHMH's Harlem Strategic Action Committee. When the copy ready PSAs are distributed state wide they will have been informed by the experiences of women residing in CHHS. Each of the Healthy Start Initiative projects will be expected to secure print space, and radio and TV time for the PSAs to assure statewide coverage.

Although the state department of health has been attempting to get the city department of health to consolidate its vital statistics data collection activities with those of the state for some forty years it has not been successful. The collective voices of the four regional perinatal forums in New York City have now been brought to bear on this effort. So far, we, too, have been unsuccessful; nevertheless as the pressure mounts on the city, we look forward to the inevitability of the success of our efforts. When accomplished, New York City hospital electronic reporting of birth outcomes data to the state will expedite the collection and analysis of the data. More timely reporting of the vital statistics data will then support more timely responses to infant and maternal morbidity and mortality summaries by community based organizations in New York City.

As noted above, the most significant collaborative activity over the past four years between NYSDOH and CHHS/NMPP occurred through the formation of the Manhattan Regional Perinatal Forum sponsored and funded by the NYSDOH. The Forum is composed of the local Regional Perinatal Care Centers, NMPP, other perinatal/prenatal service providers, stake holders and consumers who are charged with developing and implementing a strategic plan to improve maternal and child health throughout Manhattan. The Executive Director of NMPP co-chairs our forum with the director of the Bellevue Hospital Centers NICU director. For the first time, physicians from 47 hospitals in Manhattan were required to play a leadership role in addressing community based issues that impact birth outcomes. The state department of health had attempted a number of strategies to get hospital based staff to collaborate with community based organizations to address common issues of concern. CHHS/NMPP staff played a significant roll in organizing the forum, moving it to develop a plan of action and now implementing the plan.

CHHS has not had a collaborative involvement with the State Children with Special Health Care Needs Program nor the State Early Intervention Program. Nevertheless, when a pregnant client with developmental issues or one with a newborn with developmental challenges was encountered, the mom was referred to one of these programs.

We have not had a collaborative relationship with the state Medicaid or SCHIP programs either. However, NMPP has a contract with the Managed Care Consumer Assistance Program which offers community residents education and information about managed care plan options, applying for medical insurance, filing exemptions from choosing a Medicaid Managed Care plan, and filing a grievance against any health insurance company. The program offers walk in hours and a helpline to assist consumers. CHHS case managers worked with clients to assure that all family members had a medical home and used it appropriately. When necessary, they drew on the staff of the Managed Care Consumer Assistance Program to help find a medical home for a client. In addition, when homeless clients needed assistance in changing PCAP or primary care providers the staff of the Managed Care Consumer Assistance Program helped them do so.

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

The Association of Perinatal Networks in which our staff played a major role presented a couple of conferences on women's health, one included Dr. Van Dyck, the Director of the HRSA Bureau of Maternal and Child Health, as the guest speaker. The two conferences along with Dr. Michael Lu's ground breaking work on the impact of pre-pregnancy health status on birth outcomes gave us the insight to work harder with our interconceptional clients. We were successful in getting 91% enrolled in medical homes for themselves and their infants. We had always worked with interconceptional clients to accept a birth control method and enroll their infants in a medical home; however, now we harass them about not only having a medical home but using it appropriately. This includes getting annual physicals and following the doctors' recommendations for self care.

As noted above, in 2003, the NYSDOH initiated Regional Perinatal Forums. The Manhattan Regional Perinatal Forum facilitated the involvement of hospital based obstetricians and other professional staff in addressing community based challenges to good birth outcomes. We had not been successful in engaging obstetricians from New York Presbyterian, Mount Sinai and St. Luke's-Roosevelt Hospital Centers in our community based work in the past.

Also, in 2003, the NYCDOHMH organized the Harlem Strategic Action Committee to engage clients and community residents along with community based social and medical perinatal providers in developing community based solutions to the disparities in both infant and maternal morbidity and mortality in Central Harlem. The committee was funded with resources from municipal funds generated by the Citywide coalition to End Infant Mortality. For the first time, we had local academicians adding their insight and wisdom to maternal and child health issues. The successes of this group are described in Section b. *New York City Department of Health and Mental Hygiene*, above.

Back in 1998, the NYSDOH was interested in supporting intensive prenatal case management with Medicaid funds which would have provided the healthy start projects with a sustainable source of funding. However, the costs of Medicaid in New York State precluded adding a new cost stream to its budget. Although we have not been able to remount support for such a funding stream we continue to advocate for doing so. There are many high risk enclaves in the state of New York whose residents would benefit from comprehensive social/health case management services.

Historically, the State of New York has had two vital statistics systems: one for New York City and the other for the remainder of the State. In New York City, birth outcome data is reported by hospitals through the birth certificate, a paper document; whereas, upstate, the state hospitals use an electronic reporting system which facilitates data collection and compilation of vital statistics reports. Thus, the most significant barrier to our work was posed by the NYCDOHMH with its historical insistence that birth outcome data be submitted directly to its Office of Vital Statistics. With the paper system it used, reports from NYCDOHMH were delayed up to a year or more. Although annual summaries of birth outcomes data are provided by NYCDOHMH within nine months of the end of the calendar year; we do not have access to zip code specific data until another 12 months later. This lack of timeliness in the receipt of community based data delays us in effectively targeting the most high risk communities in our catchment area on a timely basis.

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

It is notable that HRSA designed the Healthy Start Initiative for local communities to ultimately take ownership of the program through the skills residents acquired from training in community organizing and advocacy and by participating in the consortium. However, NMPP is unique in several ways. There is no question about the leadership role the NMPP board has provided the agency through its campaign to effectively address many of the perinatal community based needs of the Harlem community with many of the services its needs. The agency has grown from one with a budget of $800,000 to just under $5m with all funds devoted to improving the health status of the residents of Northern Manhattan which includes Central Harlem. We found that there was no need for CHHS to organize another oversight body through its consortium.

It is extremely important for policy makers to hear the concerns of community residents articulated by those impacted by their policies. NMPP organized forums for several policy makers to hear directly from their constituents the barriers their policies posed. Based on complaints from clients the Commissioner for Homeless Services worked with us to develop a system for us to track our homeless pregnant clients when they were moved to another shelter. In addition, the Commissioner is now working to decentralize the Emergency Assistance Unit, an office for all homeless families to report to for assistance with housing. Shortly, there will be an Emergency Assistance Unit in each borough providing assistance to its local residents. Moreover, following a forum in which the Deputy Commissioner of the Human Resources Administration and the NYCDOHMH spoke on their respective roles in protecting infants and children, a collaboration evolved between the two agencies to better protect and serve children in

foster care. This is discussed in detail in section V. Project Impact, subsection 4. c., page 59.

Our awareness of the importance of stable housing to good birth outcomes was reinforced through our work with homeless clients and clients boarding with a variety of relatives and friends. We have relearned the essential nature of stable housing to families adopting health promoting behaviors, especially smoking cessation. The stress of unstable housing led women to smoke and/or abuse other substances.

We learned that it will take more than referrals of depressed clients to services before they are willing to keep an appointment. We are attempting to address this challenge in Central Harlem through a poster campaign targeted to women who have recently delivered and may be experiencing post partum depression.. The stigma of "I'm not crazy" will take much work to mitigate in this community and across the country to effectively address the high rates of depression and other mental illnesses found in poor, underserved communities with high unemployment and homelessness rates.

Other lessons learned by the CHHS team while implementing the Healthy Start Core Services and the Core Systems-building Efforts have been incorporated into the body of the report under each service and systems building activity discussed.

VI. Local Evaluation

A. Introduction

The purpose of Central Harlem Healthy Start local program evaluation was quality improvement and assessment of the value-added contribution of MCHB/HRSA investments. The main emphasis is on measuring whether the program achieved its stated objectives. As a mature program, in its third phase of operation, the original program design has been validated and demonstrated effective. It was assumed that if the program is faithfully implemented then desired outcomes and impact will be assured.

Local evaluation was conducted in-house and on-site (not contracted) by a full-time evaluation manager, a part-time management information system manager and a data-entry clerk. A computer-based client data gathering system was employed and supported by a computer consultation firm on a contract basis. Prior evaluation experience was gained from the program's participation in the Phases I and II evaluation activities as well as the national HRSA Maternal and Child Health Bureau evaluation. The Phases I and II evaluation activities were incorporated into the Phase III evaluation model.

The three components of our evaluation plan were (1) utilizing the Program Monitoring Tool (PMT) and Client Health Assessment Reporting Tool (CHART) data base to monitor progress in meeting program year objectives; (2) surveying client profile and satisfaction with services; (3) testing the theory and assumptions of our program concept using the Logic Model Protocol.

We utilized mainly process evaluation techniques to measure whether the program achieved its program year objectives. We also studied maternal and infant health outcome in relationship to program implementation. Our local evaluation program measured whether our interventions helped reduce infant mortality and other adverse birth outcome in the target area. It assessed program implementation and the relationship of the program model to local maternal and infant health outcomes.

Overall, the local evaluation program attempted to measure whether the interventions helped reduce infant mortality in the target area by fifty percent by the end of the project period. Specifically, at the start of the period our working hypotheses were:

> Hypothesis I: It is hypothesized that the high-risk women who participate in our case management and other service modules will have lower infant mortality rates, fewer low birth weight births, and fewer pre-term deliveries during each year of the project than Central Harlem resident women who do not participate, while controlling for the risk factors associated with being recruited into case management. Over the last ten years, the Central Harlem Healthy Start program serviced the needs of low-risk and high-risk women in Harlem who were pregnant or parenting. We have reached a stage where the infant mortality rate in Harlem of 15.5 infant deaths in 1999 reflected the underbelly of the problem: women who we defined as high-risk. These women were teens, substance abusers, immigrants, HIV-infected, homeless, prostitutes, older women and those who experience domestic violence. To reduce infant mortality by 50% by May 31, 2005, these women had to be located, encouraged to enter care, treated with respect, given case management, health education and job readiness skills and discharged into the Harlem community with well-baby care and women's health lessons learned that prepared them to have another healthy baby if they decide to do so.
>
> Hypothesis II: It is hypothesized that to reduce infant mortality our local perinatal health care system must be transformed: the general public in Harlem must come to an understanding that infant mortality is the number one social problem in Harlem and everyone in the community, clergy, tenant leaders and teachers must concretely know what they must do to transform this problem. Infant mortality has been described as a problem that is a barometer or predictor of other social and economic problems in a region or civil society. We understand that by just providing case management, health education and outreach services will not help us achieve our public health goal of reducing infant mortality in Central Harlem by 50% by March 31, 2005.

B. Process

1. Program Implementation

The main program implementation evaluation tool used was the Program Monitoring Tool (PMT), a quarterly reporting format, which was adapted from a format used during the previous phase of the project but expanded to include other core service areas and project period objectives. Statistical data tables were generated from the CHART database computer program and from self-reports submitted by workers. The PMT format incorporated quarterly data and narrative reports on each core service and systems areas aimed at demonstrating and documenting measurable progress toward achieving stated project goals. Calendar year objectives were included as a measurement tool to determine how the project was doing in achieving stated objectives. The PMT tracked and monitored the project on different aspects of the project's administration, fiscal and contract management, consortium, service delivery, collaboration/partnerships, impact on the perinatal care system. These reports were produced quarterly by the evaluation team and distributed to managers and service coordinators. The reports revealed the extent to which program implementation had occurred, the degree to which the interventions were reaching the clients as expected, and participants' reactions to the interventions were evaluated and presented in a report. PMT reports were used by program managers to monitor program implementation and to prepare annual project reports.

CHHS used the Client Health Assessment Reporting Tool (CHART) computer database software to gather client level data on core service components. It was first developed under Phase I of Healthy Start/NYC and has been used by CHHS since then as a case management tool. In Phase II of Healthy Start/NYC the computer application was upgraded from a DOS Revelation platform to a Windows-based Fox Pro platform, a more current software package. CHART contains nine data forms - participant intake, infant intake, enrollment status, participant assessment /reassessment, infant assessment and reassessment, service plan, daily report of referrals and appointments, daily encounter and client closure. Case managers completed these forms and submit them to a data entry clerk for input in the CHART computer database, which resides on a local area network server and is available to case managers in real time at their individual workstation through screen forms and 17 pre-programmed reports. The management information system manager generated quarterly management reports and as requested by others for various purposes. The computer system was supported by Data Link Technology Support and Training, Inc. The MIS manager monitored data entry activities and produced reports on missing and inaccurate data.

Program implementation monitoring incorporated 18 local program specific performance measures following the format utilized by the HRSA national performance measurement system. Each core service area has several project and budget period objectives which include strategies and activities, person responsible and progress. Each also has a timeframe, baseline data, data source, numerator and denominator. Some measures require client data from the CHART system, others rely on rating scales. The evaluation team collaborated with project staff to collect data to measure whether each program

intervention - case management, health education, outreach, local health system plan – were achieving their performance objectives.

The PMT report compared the planned project timeline of implementation to the actual dates that goals are achieved. If needed, a revised timeline was developed and presented in the report. Project staff stated reasons for delays in implementation and suggested ways to avoid similar delays in the future. The program director met periodically with the service coordinators to monitor barriers to achieving objectives, reviewed a small sample size of cases enrolled, provided direction to staff in implementing new strategies and communicated updates from HRSA.

2. Client Satisfaction and Profile Study:

During each calendar year, the evaluation director conducted a survey of case management clients to assess consumer satisfaction with the quality of services. The survey instrument used was developed during the Phase I project and was written at the third to fourth grade reading level in both Spanish and English. The survey was administered in one of two ways: either as part of the informational packet distributed to each client, with postage prepaid; or at the site, where the client was provided a private area to complete it, and place it in a box by the receptionist.

The survey instrument contained ten items with variables covering demographic information, referral source and length of program-stay. Some satisfaction questions required open ended responses, others used a Likert type scale. In one innovative item, respondents were asked to indicate which services they needed help with and whether they actually received help for those services. Results of the survey were used to restructure program interventions each year as we listen to and programmatically responded to our consumers' voice.

A client profile study was completed annually. The study examined the demographic, social and health characteristics of women served and of their service needs, based on client-level data obtained from the CHART client database. The purpose of these studies was to make sure the program enrolled a high percentage of the high-risk women as outlined in the outreach plan.

Patterns of needs were examined and characteristics of clients receiving a particular menu of outreach, case management, health education and job readiness services were identified. Comparisons were made of differences in service needs among various target population sub-groups; adolescent versus adult women; foreign-born vs. U.S.-born; prenatal vs. postpartum women; self-referrals vs. inter-agency referrals. The studies yielded important information for program administrator regarding the needs of her clientele.

A cross-sectional design was to be employed. The study population was to consist of all cases active during each calendar period. In order to minimize the methodological and analytic difficulties presented by varying client enrollment periods and by changes over time in client needs and risk status, which could bias results unless carefully controlled, the study was to consist of two components. The first was to be a descriptive assessment based on the entire clientele enrolled during the budget period, examining client

characteristics at enrollment and the overall prevalence of particular categories of service needs as noted throughout the budget period. This analysis was to be designed to give service personnel basic programmatic information needed for program planning and monitoring. The second component was to examine group differences in service needs based on needs presented within one month of intake. By limiting the period of observation to a discrete interval that was common to all cases, methodological problems stemming from differing lengths of exposure to the intervention and changes in status could be avoided. However, findings from this analysis was to be limited to group differences as presented at intake and cannot be interpreted as representing the full array of needs as they may evolve over time. If an eleven-month eligibility period proved insufficient to achieve an adequate sample size for detecting sub-group differences in smaller programs, the eligibility period will be extended.

Measures included age, race/ethnicity, birthplace, source of referral to the program, parity, number of children living with mother, and pregnancy/parenting status at intake. Service needs were to be examined with a focus on income support, health care coverage, housing, food and infant supplies, childcare, and need for education and employment services. Average number of needs presented also was to be examined. Data analysis was to consist of descriptive statistics employing appropriate bivariate statistical tests.

3. Logic Model Planning

CHHS subjected its program model to the rigorous scrutiny of a logic model tool developed by the New York University Center for Health and Public Service Research. A logic model is a way to lay out how and why a program believes its program model will work.

Our logic model defined the relationships between program operational resources, the activities a program plans to implement and the changes or results the program hopes to achieve. The logic model method employed helped to bring discipline and clarity to program planning. It helped us clarify goals, create a shared understanding of mission; define methods by linking activities to goals; identify gaps in logic and in knowledge and finally this evaluation method helped to make program assumptions explicit. The method helped to bring focus and clarity to program management. It kept energy and resources focused on achieving stated results and allowed managers to track progress. The method allowed managers to make mid-course corrections. Finally, the method helped to make our program evaluation relevant and targeted by identifying the assumptions that needed to be tested. It also allowed program participants and evaluators to tell the program "story" to policy makers and funders. At the beginning of each program year, the CHHS program completed the logic model grid and discussed the results during team meetings, supervisory sessions, site visits and annual review sessions.

The CHHS logic model components were:

*Resources/Inputs: Resources dedicated to or consumed by the program. What the program needs to carry out the activities planned.

*Program Activities: The processes, tools, events, technology, and actions that are an intentional part of the program implementation.

*Outputs: The direct products of program activities or what you hope the activities will produce (e.g. participation rates in case management, health education, etc.).

*Outcomes: Benefits or changes for participants during or after the program activities. What does the CHHS program expect to happen as a result of the outputs (e.g. infant mortality reduction)?

*Impact: The fundamental intended change occurring in organizations, communities or systems as a result of program activities. (e.g. perinatal health systems change in Harlem)

For each of the components above, the CHHS program wrote a few assumptions that explained our thinking. The logic model was revisited annually to see if our core assumptions about the CHHS program are on course. If our hypothesis, theories and assumptions were off course, changes in program design were made immediately. The logic model was used to evaluate each core service area including the consortium, health systems plan, case management, outreach and health education components.

C. Findings and Discussion

1. Evaluation Implementation

Evaluation activities during year-one of the project were low following unsuccessful attempts to engage the NYC Department of Health and Mental Hygiene in conducting evaluation of the project and the absence of an on-site evaluator. In the absence of evaluation resources, program managers for each core service area developed performance objectives and instruments to capture service utilization information. They also developed an outreach and marketing plan and a perinatal system-change plan.

During year-two, progress was made in establishing evaluation capacity and in commencing some evaluation activities. A full-time, project-dedicated evaluation manager was hired in August of 2002, and a full-time management information system manager was hired in September. The MIS manager attended a five-day computer training course in FoxPro programming which would increase our ability to customize CHART to meet emerging evaluation needs and fix problems when they occurred. The MIS manager, with the assistance of a computer consultant service, rewired the site to improve computer workstation connectivity with the server and the local area network. CHART was reinstalled and updated. Data entry took place throughout the period. The Program Monitoring Tool instrument was revised to eliminate those elements that were appropriate only The Healthy Start/NYC project and to make the instrument more consistent with the local NMPP project.

In year-three, the CHART computer database application was reprogrammed by the computer consultant to provide client-level data for the new HRSA national performance measures, which were unveiled by HRSA at a meeting held in February. We also used the occasion to upgrade the application by trouble shooting data entry and system problems, streamlining data forms to be less labor intensive, adding some new fields, such as depression screening. and creating additional data monitoring reports. Case

managers and the data entry clerk received two half-day training sessions in interfacing with the system. Data quality assurance activities continued through the period to improve validity of system data. The MIS manager monitored data entry activities and produced reports on missing and inaccurate data. We investigated other data collection systems that might be an improvement over the current CHART system, which presented many problems. In the end we decided to stay with CHART, because of the high cost to replace it, and work on addressing its problems.

In year-four, we experienced difficulties in generating data for our annual HRSA continuation application due to computer programming deficiencies. Instead, required data was obtained through manual review of and extraction of data from client paper files while we attempted correction of the computer program that produces the data. Contract dispute with the computer consultant led to failure in correcting the program and the hiring of another consultant who was able to provide some improvement in data analysis and reporting. When additional project funds for evaluation became available, we investigated the feasibility of converting CHART to a web-based system to facilitate the modification of CHART and gain capacity for on-line and multi-site use. We decided against this option and instead upgraded our computer equipment.

The client satisfaction survey yielded a low response rate from clients. Initially, questionnaires were administered to clients by mail at prescribed intervals of six-months after admission and at each six-month interval thereafter. Response was poor even when workers administered the surveys with anonymity protected. A better response rate was obtained by conducting the survey at client social events where incentives were offered for completing the questionnaire. Even so, the sampling stood at only ten percent of clients served and every effort to improve that rate has been unsuccessful.

2. Summary of Findings

Hypothesis I: At the start of the project period, CHHS hypothesized, firstly, that high-risk women who participate in our case management and other core services will have lower infant mortality rates, fewer low birth weight births, and fewer pre-term deliveries than Central Harlem resident women who do not participate. By the end of the project, we found that the high-risk women who participated in CHHS case management and other core services had lower rates of adverse birth outcome indicators than Central Harlem residents.

- CHHS had no infant deaths among participants live births compared to an infant mortality rate of 7.3 per 1,000 live births for Central Harlem residents.
- Our participant infant low birth rate was 3.1 percent of live births compared to 11.1 percent for area residents.
- Our participant infant pre-term rate was 9.9 percent compared to 12.0 percent for area residents.

Hypothesis II: CHHS hypothesized, secondly, that to reduce infant mortality our local perinatal health care system must be transformed: the general public in Harlem must come to an understanding that infant mortality is the number one social problem in

Harlem and everyone in the community, clergy, tenant leaders and teachers must concretely know what they must do to transform this problem. We believe that we have proved this hypothesis to be true in that the infant mortality rate of Central Harlem decreased by 60 percent from 12.2 in the base period of 1996-1998 to 7.3 in 2003, the latest available rate. The proof of the hypothesis is qualitative, rather than quantitative, and consists of evidence presented in details in the Local Health Systems Action Plan and the Health Education sections of this report and summarized below.

- Each year during Phase III, the CHHS conducted a massive public relations and social marketing campaign that made infant mortality reduction in Harlem and throughout NYC the number one public health and political issue. This campaign resulted in the New York City Council and Mayor under two separate administrations allocating $27m over four years to fight infant mortality.
- CHHS held four citywide infant mortality conferences that mobilized MCH activists from the across NYC to address the problem.
- The advocacy team met with decisions makers from the Mayor's office and City Council leadership to inform them about their budget and policy development role in reducing infant mortality in Central Harlem.
- Over the last four years, CHHS played an instrument role in creating the Citywide Coalition to End Infant Mortality that has led an advocacy campaign that secured twenty-seven million dollars from the Mayor's office and New York City Council.
- During Phase III, the CHHS program achieved the goal by collaborating with our elected officials and senior staff from Harlem Hospital and the birthing center opened on September 7, 2003
- CHHS provided health education messages to community residents, consortium members, health care providers and the general population using a variety of strategies, each tailored to the educational level and interests of participants.

3. Findings – Program Monitoring

Table 1: HRSA National Performance Measures: 2004

PM Number	Performance Measure	Baseline	Objective	Indicator	Numerator	Denominator
PM-07	The degree to which MCHB supported programs ensure family participation in program and policy activities.	10	18	13	N/A	N/A
PM-10	The degree to which MCHB supported programs incorporated cultural competence elements into their policies, guidelines, contracts, and training.	41	69	46	N/A	N/A
PM-14	Degree to which morbidity/mortality review processes are used.	6	6	6	N/A	N/A
PM-17	The percent of all children from birth to age 18 participating in MCHB supported programs that have a medical home.	64	90	96	122	127
PM-20	The percent of women participating in MCHB supported program that have an ongoing source of primary and preventive services for women.	65	78	88	148	169
PM-21	The number of women participating in MCHB supported programs requiring a referral, which receive a completed referral.	40	55	53	74	138
PM-22	The degree to which MCHB supported programs facilitates health providers' screening of women participants for risk factors.	8	32	24	N/A	N/A
PM-35	The percent of States and Communities having comprehensive systems for women's health services.	29	42	36	N/A	N/A
PM-36	The percent of pregnant program participants of MCHB supported programs that have a prenatal care visit in the first trimester of pregnancy.	60	68	61	41	67

This table shows national performance measure data cumulative up to CY 2004, the latest period for which such data is available,

Numerators and denominators are not indicated (N/A) for performance measures utilizing rating scales. Numbers for performance measures utilizing rating scales are raw scores.

Performance Measure #36, Baseline data: In 2002, 59.6% of women who gave birth received prenatal care during the first trimester of pregnancy, according to target area vital statistics data. The denominator includes pregnant women who entered the program after the first trimester when the program was not able to impact on prenatal visit during the first trimester.

Table 2: Consortium Performance Measures

PM Number	I. Performance Measure	Objective	Indicator	Numerator	Denominator
PP-01	The percent of case managed clients that participate in consortium activities.	20	22	33	153
PP-02	The percent of planned service providers that participate in consortium activities.	100	120	30	25
PP-03	The percent of planned community health education meetings held.	100	100	2	2
PP-04	The percent of planned general consortium meetings held.	100	50	1	2
PP-05	Percent increase in attendance at consortium meetings.	10	70	717	1020

Note: Objectives are for the project period June 2001 to May 2005. Indicator, Numerator and Denominator are for the calendar year period January to May 2005.

PP-1: The number of case managed clients served in the calendar year period January to May 2005 was 153 (denominator). During the period, the number of case managed clients that participated in consortium activities was 33 (numerator) which is 22 percent of the target (indicator).

PP-2: The number of service providers targeted for consortium attendance in the calendar year period January to June 2005 was 25 (denominator). During the period, the number of service providers who attended consortium activities was 30 (numerator) which is 120 percent of the target (indicator).

PP-3: The number of planned community health education meetings in the calendar year period January to May 2005 was 2 (denominator). During the period, the number of community health education meetings held was 2 (numerator) which is 100 percent of the target (indicator).

PP-4: The number of planned general consortium meetings targeted in the calendar year period January to June 2005 was 2 (denominator). During the period, the number of

general consortium meetings held was 1 (numerator) which is 50 percent of the target (indicator).

PP-05: The number in attendance at consortium meetings in calendar year 2003 was 1020 (denominator). During calendar year 2004, the number in attendance at consortium meetings was 1737, an increase of 717 (numerator) which is a 70 percent increase in attendance (indicator).

Table 3: Consortium Meetings Held

Committee Name	2002	2003	2004	2005	Total
General Consortium	4	4	1	1	10
Health Education	4	4	2	1	11
Case Management	5	2	0	1	8
Outreach	2	3	2	0	7
Consumer Involvement	12	25	6	6	49
Male Involvement Consortium	12	21	12	0	45
Perinatal System	4	0	0	0	4
Totals Committee Meetings	39	59	23	9	123
Special Events		2	17	1	20
Total Meetings	43	61	40	10	154

Table 4: Consortium Meeting Attendance

Committee Name	2002	2003	2004	2005	Total
General Consortium	91	108	500	28	727
Health Education	55	23	25	45	148
Case Management	43	37	0	112	192
Outreach	12	18	14	28	72
Consumer Involvement	80	243	46	0	369
Male Involvement Consortium	210	523	95	176	1004
Perinatal System	43	68	0	86	197
Totals Committee Meetings	534	1020	680	475	2709
Special Events			1057	99	1156
Total Meetings	534	1020	1737	574	3865
Consumer Attendance		146	47	33	226

Table 5: Outreach Performance Measures

PM Number	II. Performance Measure	Objective	Indicator	Numerator	Denominator
PP-06	The completion of the year-five edition of the Outreach and Marketing Plan.	Yes	Yes	N/A	N/A
PP-07	Percent of planned memorandum of understanding executed with organizations that serve our clients.	100	55	11	20
PP-08	Percent of targeted outreach contacts made in the community to reduce infant mortality.	100	16	329	2000
PP-09	The percent of the targeted number of eligible women who are served in the case management program.	100	92	185	200

PP-6: The Outreach and Marketing Plan was completed for each calendar year up to 2005.

PP-07: The number of planned memorandum of understanding executed in the project period of 2001 to 2005 was 20 (denominator). During the project period, the number of memorandum of understanding executed was 11 (numerator) which is 55 percent of the target (indicator).

PP-08: The number of planned outreach contacts made in the community in the project period of 2001 to 2005 was 2000 (denominator). During the project period, the number of outreach contacts made in the community was 329 (numerator) which is 16 percent of the target (indicator). Recruitment contacts were scaled back because of full enrollment.

PP-09: The number of women who were targeted to be served in the case management program during each year of the project period of 2001 to 2005 was 200 (denominator). During the project period, the average number of women who were served in the case management program each calendar year was 185 (numerator) which is 92.3 percent of the target (indicator). The program was not operational in the first five months of the period, June to November 2001.

Table 6: Outreach Contact Type

	2002	2003	2004	2005-5 mos	Total
Street	9	27	3	8	47
Housing Project	6	19	1	0	26
Event		10	6	0	16

	2002	2003	2004	2005-5 mos	Total
Agency	39	76	22	8	145
Commercial	8	51	0	17	76
Other		11	5	3	19
Total	62	194	37	36	329

Table 7: Outreach Contact Method

	2002	2003	2004	2005-5 mos	Total
One-On-One	43	240	188	122	593
Printed Flyer	20	11523	2633	811	14987
Phone Call	2	45	11	29	87
Letter		0	0	0	0
Presentation	7	34	4	4	49
Other		6	0	91	97
Total	72	11848	2596	1057	15573

Table 8: Outreach Referral Source

	2002	2003	2004	2005-5 mos	Total
Outreach worker	42	83	31	16	172
Other NMPP	82	36	15	4	137
Other Agency	40	4	23	4	71
Self-Referral	69	18	30	5	122
Total	233	141	99	29	502

Table 9: Health Education Performance Measures

PM Number	**III.** Performance Measure	Objective	Indicator	Numerator	Denomination
PP-10	Percent of the targeted number of community members and service providers who attend community health education presentations.	100	124	154	124
PP-11	Percent of case managed clients who receive a home or office-based individual health education session.	90	36	55	153

PM Number	III. Performance Measure	Objective	Indicator	Numerator	Denomination
PP-12	Percent of enrolled clients who attend health education group workshops.	50	27	42	153

PP-10: The targeted number of community members and service providers who attend community health education presentations during the calendar year period of January to May 2005 was 124 or 42% of the annual target of 300 (denominator). During the same calendar year period, the number who attended community health education presentations was 154 (numerator) which is 124 percent of the targeted number (indicator). Ninety four community residents attended the Valentine Day's workshop event.

PP-11: The number of case managed clients served during the calendar year period of January to May 2005 was 153 (denominator). During the same calendar year period, the number case managed clients who received a home or office-based individual health education session was 55 (numerator) which is 36 percent of those served (indicator).

PP-12: The number of case managed clients served during the calendar year period of January to May 2005 was 153 (denominator). During the same calendar year period, the number of case managed clients who attended a health education group workshop was 42 (numerator) which is 27 percent of those served (indicator).

Table 10: Health Education Individual Session Appointment Outcome

	2002	2003	2004	2005	Total
Show	69	97	90	58	314
No Show	100	130	83	32	345
Total	169	227	173	90	659

Table 11: Health Education Group Sessions

	2002	2003	2004	2005	Total
Clients	26	15	14	8	63
Staff	10	4	2	0	16
Community	1	12	10	5	28
Total	37	31	26	13	107

Table 12: Health Education Group Attendance

	2002	2003	2004	2005	Total
Clients	87	53	47	42	229
Staff	95	58	42	10	205
Community/Provider	315	193	698	154	1356
Total	497	304	787	202	1790

Table 13: Health Education Clients (Duplicative) Served

	2002	2003	2004	2005	Total
Individual Sessions	30	143	87	55	315
Group Sessions	43	29	42	42	156
Total Clients Served	73	172	129	97	471

Table 14: Health Education Topics Delivered

	2002	2003	2004	2005	Total	Percent
Alcohol/ Substance Abuse	16	8			24	4.17
Asthma	8	17	6		31	5.39
Breast Feeding			16	14	30	5.22
Child Birth				5	5	0.87
Domestic Violence				2	2	0.35
H.E. Assessment				12	12	2.09
Home Safety			20		20	3.48
HIV/STD	5	6			11	1.91
Immunization	9	8			17	2.96
Infant Care & Feeding			13	6	19	3.30
Infant Growth & Develop.			13	2	15	2.61
Lead Poisoning	4	2			6	1.04
Nutrition	23	10		20	53	9.22
Parenting	7	9		1	17	2.96
Prenatal & Postnatal Care			19	13	32	5.57
Reproductive Health	38	8	18	1	65	11.30
Smoking Cessation		7		6	13	2.26
Stress Management	35	13		6	54	9.39
Other	24	48		3	75	13.04
Total Sessions	169	136	180	90	575	100.00

Table 15: Case Management Performance Measures

PM Number	**IV.** Performance Measure	Objective (%)	Indicator (%)	Numerator	Denominator
PP-13	The percent of female participants who are informed of the program's ability to link their partners with community resources.	70	41	82	201
PP-14	The percent of WIC eligible women who do not receive WIC at enrollment and who 30 days after enrollment receive WIC.	95	47	15	32
PP-15	The percent of women participants who are referred for medical services receiving those medical services.	90	57	47	83
PP-16	The percent of infants and toddlers who receive timely immunization per schedule.	90	4	3	69
PP-17	The percent of infants born with low birth weight.	10	6	1	18
PP-18	The percent of women participants who are screened for depression.	50	81	129	159

Note: This table shows case management performance measure data for CY 2004, the latest period for which such data is available. Source of data is the CHART database.

PP-13: Eighty-two of 201 participants (41 percent) were informed of the programs ability to link their partners with community resources.

PP-14: Fifteen of 32 participants (47 percent), who did not have WIC at enrollment, received WIC within 30 days after enrollment.

PP-15: Forty-seven of 83 participants (47 percent) who were referred for medical services received those medical services. In many cases follow-up of medical referrals were conducted but not recorded in CHART and were counted as unknown.

PP-16: Three of 69 infants (4 percent) received immunization per schedule. Immunization data were not always available. Many received immunizations that were not per schedule. During the period 58 percent of infants received well-baby visits within four weeks after birth and can be assumed to have received scheduled immunizations.

PP-17: One of 18 Healthy Start births (6 percent) was below 2500 grams in weight.

PP-18: One hundred twenty-nine of 159 participants surveyed (81 percent) were screened for depression by program staff.

Table 16 Case Management Cases

	2001	2002	2003	2004	2005	Total
Start of Period	0	14	98	109	123	0
New Cases	14	124	138	92	30	398
Closed Cases	0	40	127	78	66	311
End of Period	14	98	109	123	87	87
Clients Served	14	138	236	201	153	398

Table 17: Case Management CHART Forms Completed

	2002	2003	2004	2005	Total
Intake	149	126	145	29	300
Assessment	136	127	142	27	296
Service Plan	38	99	76	27	202
Referral & Appointment	181	382	404	60	846
Encounter	1586	1695	1914	356	3965
Closure	45	36	73	36	145
Total Forms	2135	2453	2804	535	5792

Table 18: Case Management Client Visits

	2002	2003	2004	2005	Total
Home Visit	198	338	406	86	830
Field Visit	85	145	163	12	320
Office Visit	239	409	573	73	1055
Total Client Visits	522	892	1142	171	2205

Table 19: Case Management Referral Outcome

	2002	2003	2004	2005	Total
New Referrals Received	263	172	132	16	320
Completed – Intake	141	93	88	15	196
Completed – Referred	69	20	7	0	27
Completed – Refused	83	22	10	1	33
Completed – Lost	30	59	17	0	76

4. Findings – Client Profile

Table 19: Age

	Number	Percent
19 years and less	65	16.3
20 - 34 years	303	76.1
35 years and more	30	7.6
Total	398	100.0

Table 20: Race

	Number	Percent
Black	312	80.4
White	14	3.6
Asian	2	0.5
Native American	3	0.8
Native Hawaiian	0	0.0
Other	57	14.7
Total	388	100.0

Table 21: Ethnicity

	Number	Percent
African American	249	65.7
Puerto Rican	39	10.3
African	25	6.6
Dominican	25	6.6
West Indian/Caribbean	11	2.9
Mexican	6	1.6
Asian Indian	1	0.3
Central American	4	1.1
Haitian	4	1.1
Other	15	4.0
Total	379	100.0

Table 22: Hispanic Ethnicity

	Number	Percent
Hispanic	102	26.0
Non-Hispanic	291	74.0
Total	393	100.0

Table 23: Primary Language Spoken

	Number	Percent
English	346	86.9
Spanish	32	8.0
French	17	4.3
Other	3	0.8
Total	398	100.0

Table 24: Current Marital Status

	Number	Percent
Single	316	81.2
Married	57	14.7
Divorced	2	0.5
Separated	14	3.6
Total	389	100.0

Table 25: Residence Location

	Number	Percent
Central Harlem 10026, 27,30,37,39	272	68.3
East Harlem 10029 10037 10035	53	13.3
Washington Heights 10031 10032 10033	61	15.3
Other Manhattan	7	1.8
Other NYC	5	1.3
Total	398	100.0

Table 26: Education Completed in USA

	Number	Percent
No formal education in USA	20	4.9
Elementary School	6	1.5
Secondary School/Jr. High	159	39.9
High School/GED	178	44.8
College Level	25	6.4
Graduate Level	10	2.5
Total	398	100.0

Table 27: Employment Status

	Number	Percent
Unemployed	267	69.5
Employed Full-time	13	3.4
Employed Part-time	19	4.9
Student	35	9.1
Self-Employed	1	0.3
Homemaker	35	9.1
Disabled	14	3.6
Total	384	100.0

Table 28: Health Insurance Coverage

	Number	Percent
No insurance coverage	23	6.2
Medicaid	300	80.4
PCAP	50	13.4
Total	373	100.0

Table 29: Public Program Status

	Number	Percent
Food Stamps	167	41.6
WIC	236	58.9
Family Assistance:	114	28.4
Safety Net Services	6	1.5

Table 30: Living Arrangement

	Number	Percent
Alone	39	10.0
With Relative	144	36.8
With Own Children	96	24.6
With Partner	52	13.3
With Non-relative	19	4.9
With Husband	34	8.7
Other	7	1.5
Total	391	100.0

Table 31: Housing Arrangement

	Number	Percent
Apartment	254	66.1
House	4	1.0
Shelter	121	31.5
Homeless	5	1.3
Total	384	100.0

Table 32: Pregnancy/Parenting Status at Enrollment

	Number	Percent
Pregnant	187	47.0
Parenting	204	51.3
Both	7	1.8
Total	398	100.0

Table 33: Risk Factors and Reasons for Enrollment

	Number	Percent
Unemployed	320	15.2
Social services needed	294	13.9
Inadequate income or no income	292	13.9
Pregnant participant	180	8.5
School dropout <12 grade	157	7.4
Unstable housing	141	6.7
Homeless	128	6.1
Teen pregnancy/mother	95	4.5
History of or current depression	65	3.1
Marital or family problems	63	3.0
Domestic violence	60	2.8
Late/No Prenatal Care	53	2.5
Medical Care Needed	42	2.0
History of Child Abuse/Neglect	35	1.7
History of Abortions	33	1.6
History of psychiatric care	26	1.3
Nutritional Needs	23	1.1
Drug problem/history	18	0.8
Pregnancy/Mother age >35	16	0.8
Premature Infant	16	0.8
Low Birth wt Infant	9	0.4
Alcohol problem/history	4	0.2

	Number	Percent
Abortion Unsuccessfully	4	0.2
Maternal HIV	2	0.1
Other	33	1.6
Total of all risk factors mentioned	2108	100.0

5. Findings – Client Satisfaction

Table 34: Survey Question: How did you hear about the program?

Answer	2002	2003	2004
Another program	7.4%	6.3%	12.8%
Hospital or clinic	14.8%	31.3%	28.2%
Family or Friend	25.0%	12.5%	2.6%
Saw a flyer	25.0%	18.8%	17.9%
Another client of the program	14.3%	12.5%	25.6%
Other ways	11.1%	18.8%	12.8%
Total number of answers	27	16	39

Table 35: Survey Question – What kinds of help did you need when you came to the program and did you get them?

Answers	2002	2003	2004
Medical services			
Need and got help	77.8%	75.0%	88.9%
Need but did not get help	22.2%	25.0%	11.1%
Percent of all responses	32.1%	20%	43.6%
Health care for infant			
Need and got help	50.0%	80.0%	83.3%
Need but did not get help	50.0%	20.0%	16.7%
Percent of all responses	35.7%	25.0%	29.3%
Health insurance			
Need and got help	10.0%	75.0%	90.9%
Need but did not get help	50.0%	25.0%	9.1%
Percent of all responses	35.7%	20.0%	26.8%
Housing assistance			
Need and got help	27.8%	40.0%	38.1%
Need but did not get help	72.2%	60.0%	61.9%
Percent of all responses	64.3%	50.0%	51.2%
Financial assistance			
Need and got help	53.9%	100.0%	77.0%
Need but did not get help	46.2%	0.0%	23.1%
Percent of all responses	46.4%	25.0%	31.7%
Educational/vocational services			

Answers	2002	2003	2004
Need and got help	40.0%	66.7%	54.5%
Need but did not get help	60.0%	33.3%	45.5%
Total response	53.6%	30.0%	53.7%
Other services			
Need and got help	25.0%	100.0%	83.3%
Need but did not get help	75.0%	0.0%	16.7%
Percent of all responses	85.7%	15.0%	14.6%

Table 36: Survey Question – How did/do you get along with your case worker?

Answers	2002	2003	2004
Very well	53.6%	58.8%	80.5%
Well	28.6%	35.3%	17.1%
OK	10.7%	5.9%	2.4%
Poorly	7.1%	0.0%	0.0%

Table 37: Survey Question – Would you recommend this program to a friend?

Answers	2002	2003	2004
Yes	100.0%	93.6%	97.5%
No	0.0%	6.3%	2.5%

Table 38: Survey Question – Overall, how satisfied are you with the services you received?

Answers	2002	2003	2004
Very satisfied	37.0%	50.0%	75.6%
Satisfied	40.7%	43.6%	19.5%
Somewhat satisfied	11.1%	0.0%	4.9%
Not satisfied	7.4%	0.0%	0.0%
Very unsatisfied	3.7%	6.3%	0.0%

6. Discussion

National performance indicator data is reported for calendar year 2004, since January to May 2005 data is not available for this report. Of the eight national performance measures, three objectives were met or exceeded and for all measures indicators met or exceeded baseline conditions. Local performance indicators were reported for the period January to May of 2005, a five-month period and the final project reporting period. Some indicator data that were reported from the CHART client-level database may have been affected by poor data quality and computer programming malfunctioning, particularly for indicators which fell short of objectives where under–counting was suspected. In these instances, efforts were made to estimate or validate the data through chart review and cross-comparison with other data sources.

Evaluation of the local consortium program relied on evaluating the extent to which planned activities were implemented. Of the 176 consortium committee meetings planned for the project period 123 or 70 percent were held. Towards the end of the period, the emphasis of consortium activities shifted from committee work to large committee sponsored events, especially in the areas of male involvement, consumer involvement and community health education. Twenty special events meetings supplemented committee meetings and accounted for some 30 percent of total meeting attendance of 3,865 participants. Qualitative evaluation of the consortium program is provided elsewhere in this report.

Planned targets for the outreach core service were not met in some areas such as outreach contacts made in the community. As the program matured in years of operation and as the program became better known in the community, outreach activities for client recruitment purposes became less important and so outreach emphasis shifted to other areas of need such as supporting case management services in the community. Additionally, the program suffered from a high turnover rate in the outreach worker position.

The health education core service also experienced some failure to meet planned objectives in delivering health education services to case managed clients. Poor social conditions prevented many clients from availing themselves of services. More than half of all service appointments were not kept, even when attractive incentives were offered and service hours and locations were made flexible. Emphasis shifted to community health education events resulting in community participants accounting for three-quarters of health education group attendance. The program also suffered from a high turnover rate in the health educator position.

Case management service utilization data (Tables 15 through 19) is reported for each project calendar year except for years 2001 and 2002. The program was made operational in the last month of 2001 and during 2002 a service data reporting mechanism was not instituted. Data and computer programming problems may account for some shortfalls in performance indicators. A large problem was missing and unknown data, for instance, regarding immunization data and follow-up disposition on service referrals. We also ran into problems related to the computer program that produced data reports from the CHART client-level database. When this occurred, efforts were made to estimate or validate the data through chart review and cross-comparison with other data sources. For the CY 2004 reporting period, data was obtained by manual extraction of data from client folders, a time consuming and labor intensive process.

Client profile data is reported in Tables 19 through 33. The source is the CHART client-level database, mainly from the client intake and assessment data tables, and includes all 389 clients enrolled in the case management program during the project period. Only frequency tables are presented at this time as further cross-sectional analysis of the data is planned. Future analysis of year-to-year changes in client demographics may shed light on recruitment practices. Annual client profiles have been compiled but are not reported in these tables.

Client satisfaction data (Tables 34 through 38) is from the results of the Client Satisfaction Survey Questionnaire which was administered to 82 case management clients (27 in CY 2002, 16 in CY 2003 and 39 in CY 2004) about 10 percent of eligible clients. Efforts to obtain a larger number of completed questionnaires were unsuccessful due to unresponsiveness of clients: they generally failed to return completed questionnaires either mailed or administered at the office and even when incentives were offered. Most of the completed questionnaires were obtained at large client social events at which gifts were offered in return for completed questionnaires.

D. Recommendations

1. Take a women's health approach to perinatal health practice by focusing on women's health over the life course and on social condition impacting on the life course of racially disadvantaged groups.

2. Provide guidance and motivation for women with chronic diseases or other risk factors for pregnancy such as diabetes, hypertension and obesity as a strategy for decreasing racial disparities in improving birth outcome.

3. Promote the benefits of routine depression screening of pregnant and post-partum women and the appropriate treatment of those in need of such services.

4. Increase public awareness of perinatal mood disorder aimed at reducing stigma and remove barriers to mental health services.

5. Promote local government policy reforms of children, housing, public assistance and other municipal services that respond to the needs of pregnant and parenting women living in impoverished areas.

6. Collaborate closely with the local Title V agency to implement a movement for women's health and address slot capacity problems and difficulties in screening and treating women for various perinatal mood disorders.

7. Develop a local system action plan that builds upon the successes of the Healthy Start model of effective collaboration among local perinatal service providers and promoting citizen participation in promoting healthy births in the community.

8. Sustain and augment the Healthy Start program by initiating a citywide advocacy campaign for city council appropriations to address racial disparities in infant mortality rates where they exist across the city.

9. Train and deploy case managers to do more individual health education intervention focusing on disease prevention and assign the health education worker to do more of the community health education.

10. Strengthen collaboration with local service providers, particularly women's health services providers, by enacting formal memorandum of agreements with them

E. Impact and Results

The project met its overall objective (Hypothesis I) of whether its interventions helped reduce the infant mortality in the target area by 50 percent by the end of the project period. The infant mortality rate at the start of the period in 1999 was 15.5 and 7.3 in 2003, the latest available rate, a reduction of 52.9 percent. (Source: Table 34. Summary of Vital Statistics 1999 and 2003. New York City Department of Health and Mental Hygiene)

The impact of the project on the local perinatal health care system and on the general public (Hypothesis II) in Central Harlem was substantial as discussed in qualitative terms in other areas of this report and summarized below.

1. Impact on Target Area Birth Outcome

Table 39: Central Harlem Birth Outcome Change

	Baseline 1999	Project Yr. 2003	Change (N)	Change (%)
Live births (average number)	1930	1909	21	1.1
Infant deaths (average number)	30	14	16	53.3
Infant mortality rate (per 1000 births)	15.5	7.3	8.20	52.9
Neonatal mortality rate (per 1000 births)	11.9	4.2	7.7	64.7
Post-neonatal mortality rate (per 1000)	4.1	3.2	0.90	22.0
Low birth weight rate (%)	9.7	8.7	-1.0	-10.0
Very low birth weight rate (%)	2.6	2.0	-0.6	-22.1
1st trimester entry into prenatal care (%)	46.6	63.8	17.2	37.0
No prenatal care (%)	3.9	1.0	-2.9	-74.4

2. Impact on System of Care

- Increased collaboration between target area institutional and community-based perinatal providers by developing memorandum of agreements between entities and through leadership in the Manhattan Regional Perinatal Forum.

- Increased awareness and capacity of local MCH providers of perinatal depression through profession training and information media campaign.

- Increased collaboration between providers of male services by organizing a male involvement consortium which provided job opportunities and career workshops.

- Increased involvement by local community residents/leaders in addressing perinatal issues through the establishment of a consumer involvement organization, various outreach to local churches and a beautician initiative.

- Increased the cultural competence of local MCH providers by raising their awareness of cultural issues of subpopulations and assisting them meeting the health care needs of West African immigrants.

- Improved the quality of the birthing experience for mothers who deliver at the local hospital by assisting in the establishment of a birthing center at the hospital with enhanced services including mid-wife services.

3. Impact on the Community

- Community residents became more knowledgeable about available community resources and were able to better access resources as a result of CHHS case management and health education and outreach services.

- Key CHHS consumers took an active role in advocating for funding of MCH services and policy changes at local public conferences, the local city council and the federal Congress.

- Job readiness and opportunities were created in community through annual job fairs, a computer training program and the agency hiring of residents.

4. Impact on State and Local Government

- The state and the project collaborated in creating and implementing a strategic action plan to improve maternal and child health in northern Manhattan through the work of the Manhattan Regional Perinatal Forum and other initiatives.

- The city and the project collaborated in reducing the high rate of infant mortality in the target area through the work of the Harlem Strategic Action Committee on Infant and Maternal Mortality and other initiatives.

- The local municipal hospital and the project collaborated in bringing more new mothers to the facility by improving the quality of its services through the establishment of a birthing center utilizing mid-wives.

F. Publications

Baby Death Rate Soars in Harlem. New York Post. March 18, 2001. Newspaper article

Battling Infant Mortality on Two Fronts in Harlem. Crain's New York Business. January 26, 2003. Newspaper article.

Central Harlem Healthy Start Program Explains Decline in Infant Mortality Rate. Caribbean Life. April 30, 2002. Page 58. Newspaper article

Child Got a Healthy Start. New York Daily News.. January 21, 2001. Newspaper article

Harlem Baby Deaths Up. New York Post. December 30, 2002. Newspaper article.

Healthy Families Healthy Babies City Council Initiative: A Five-Point Program to End Infant Mortality. Citywide Coalition to End Infant Mortality. April 2001. Paper.

Insufficient Fare for Public Health Services in New York City. The Caribbean Sun. Summer 2005, No. 5, Page 1. Journal article.

Reaching Out: Central Harlem Healthy Start Newsletter. Northern Manhattan Perinatal Partnership, Inc. Newsletter published quarterly in 2003 and 2004

Sustainability as Organizational Strategic Intent. The 2003 Healthy Start Grantee Meeting, Washington D.C., September 24, 2003. Conference presentation.

Sustaining Healthy Start Projects through Local Media and Legislative Efforts. Missouri Bootheel Healthy Start Regional Consortium: Business and Not-For-Profit Forum. Cape Girardeau, Missouri. March 21, 2003. Conference presentation.

Using CHART Forms and MIS to Capture HRSA and Local Performance Measures. The 2003 Healthy Start Grantee Meeting, Washington D.C., September 23, 2003. Conference presentation.