I. OVERVIEW OF RACIAL AND ETHNIC DISPARITY FOCUSED ON BY PROJECT

Syracuse Healthy Start (SHS) employs a population-based preventive approach that provides a universal intervention to childbearing women in a geographically determined community. This report will describe the impact of the second round of Healthy Start funding in Syracuse, “Eliminating Disparities in Perinatal Health.” From 1997-2001, Syracuse Healthy Start Project had received an initial $5 million/four year award from the Health Resources and Services Administration to decrease infant mortality and adolescent pregnancy in a 30 census-tract area in the City of Syracuse (Central Syracuse). The second phase of the Syracuse Healthy Start project (2001-2005) used the first four years of experience as a foundation for project planning over the next four years.

During 1985-1987, infant mortality in Syracuse averaged 15 infant deaths per 1,000 live births, making it the fourth highest of 56 small United States cities surveyed by the Children’s Defense Fund. The infant mortality rate (IMR) for African Americans in Syracuse reached 30.8 per 1,000 live births during 1985-1987, the highest of any of 47 US cities reporting comparable data. Many intervention programs began or expanded in response to this crisis and rates improved during the early 1990s. Infant mortality rates slowly declined, but the citywide average rate of 11.4 for 1991-1993 was still 63% greater than the Healthy People 2000 goal of seven. In 1996, African American infant mortality remained at a standstill; the African American rate for Syracuse fluctuated around 21 from 1993 to 1996. During 1994-1996, Onondaga County experienced greater disparity in infant mortality rates between African American and Caucasian infants than other upstate New York Counties and the nation as a whole. In response, the Onondaga County Health Department created an infant mortality working group to address these issues.

For the funding period of 2001-2005, the decision was made to increase the project area from the original census tracts in the Central Syracuse to the entire City of Syracuse. This expanded project area averages approximately 2,300 deliveries per year, more than double the approximately 1100 deliveries per year of the original census tracts served from 1997-2001. The project’s predominate focus is on the disparities between the African American and the white infant mortality rate and related issues of poor birth outcomes due to low birth weight and prematurity. Of the average 2,300 infants born each year to Syracuse residents 1260 (55%) are white, 870 (38%) are African American, and 170 (7%) are of other races. About 160 (7%) of these infants are Hispanic (of any race). Infant mortality in Syracuse (12.1 infants deaths per 1,000 live births 1999-2001) is 92% higher than the statewide average (6.3) and is more than twice the Health People 2010 target of 4.5. There is almost a three-fold disparity between African American rates (20.3) and white infant mortality rates (7.1) in Syracuse. Hispanic Syracusans also have elevated infant mortality (24.9 infant deaths per 1,000 live births) but small numbers require cautious interpretation.
II. Project Implementation

A. Core Services

1. Outreach

How you decided on the approach & rationale
Syracuse Healthy Start (SHS) outreach is an integrated, population-based strategy that seeks to enroll all pregnant women in the city of Syracuse to ensure that they receive appropriate and timely services. Outreach strategies were an outgrowth of successful interventions of the first four years of the project with modifications to increase efficacy as the project matured. In years one through four (1997-2001), many of the now existing components of the Outreach Model were identified and developed.

Components and resources, including changes
Outreach is provided through a variety of venues. Prenatal clients are identified, enrolled and retained through diverse strategies including: the SHS Registry, Community Health Worker Outreach, Neighborhood Outreach, health fairs, informational events, media campaigns and extensive coordination with health care and human services organizations. In addition to concerted efforts to enroll women during the prenatal period, efforts are made to enroll women in the postpartum period through outreach to the birth hospitals and the Women, Infants and Children (WIC) program. Outreach components include:

Syracuse Healthy Start Registry (ongoing): The SHS Registry is a computerized database which captures demographic information on all women who have consented for SHS services. All participants and their children are entered into the Registry in order that their receipt of preventive services can be monitored. The Registry information assists with identifying women with multiple risk factors. The data entered into the Registry is used to create reports on entry into prenatal care, WIC enrollment, risks factors during pregnancy including smoking and substance use, and birth outcomes. Over the four years of the project, the Registry database was upgraded to accommodate the needs of the project. Staffing for the registry includes Registry Coordinator, Assistant Registry Coordinator, Data Tech and .5FTE Community Health Worker.

The chart below illustrates how a referral to the Registry translates into services for consumers:
Outreach by Community Health Workers (ongoing): Community Health Workers (CHW) serve in both the outreach and case management portions of the SHS activities. They link with WIC, Early Head Start, neighborhood groups, faith communities, food stamps, JOBS plus, Correctional Health and many neighborhood locations to enroll pregnant women. In addition, the CHW program conducts summer street outreach campaigns in which the workers canvass Syracuse neighborhoods to provide outreach information about SHS and healthy birth outcomes. The CHW Program is part of the Salvation Army and is funded via Title V funds through NYSDOH. In 2001, there were seven CHWs; currently there are five, one of whom is directly funded by SHS, and provides data entry for .5 FTE and home visiting and outreach for .5FTE.

Outreach by Neighborhood Outreach Workers (NOWs) (ongoing, initiated 3/05): This new program, initiated by the Executive Council of the SHS Consortium, is staffed by individuals who are indigenous to the communities served by SHS. The NOWs’ primary purpose is to promote Syracuse Healthy Start and facilitate enrollment in the project to individuals who may not hear of the program any other way. They provide basic referral information for prenatal and other community-based services and complete SHS Intake information for individuals interested in enrolling. The NOWs conduct street outreach in partnership with AIDS Community Resources Outreach van program, staff health fairs, and provide outreach at WIC and other venues. In March 2005, four NOWs were hired through Family Ties Network at 10 hours per week. Supervision was provided by the Case Management Coordinator at OCHD.

Hospital Based Outreach by Public Health, Family Planning and SHS Public Health Fellow (ongoing): OCHD Public Health Team and Early Intervention CARES nurse coordinators check with each of the three birth hospitals to identify infants with a need for public health or early intervention services. From project inception until mid 2005, Family Planning Services of OCHD provided in-hospital outreach to newly delivered mothers to provide education regarding reproductive and infant care. They linked new mothers with Family Planning Services, the SHS Registry and provided other referrals as indicated. In April 2005, the Public Health Fellow began to visit newly delivered mothers at Crouse Hospital. Her role is to provide education, information about SHS and facilitate referrals to the project. Women who are not interested in enrollment but who want information about SHS education or outreach events are added to the community participant mailing list. During the 2001-2005 funding cycle, staffing included: two PHNs from Public Health Teams, one LPN from Family Planning, and the Public Health Fellow.

Program linkages with local obstetrical, pediatric, family medicine providers (ongoing): The Registry Coordinator provides outreach to all local prenatal care and pediatric clinics, a number of private obstetricians, case management agencies, and community-based organizations, especially agencies working with immigrant and “at-risk” populations. Materials and referral information are shared on a frequent basis.

Program linkages with pregnancy testing sites (ongoing): SHS is linked with both Family Planning Services and Planned Parenthood in a number of activities. Both agencies refer pregnant clients to SHS.
Self-referral via hotline (435-2000) (ongoing): The “2000” number is widely advertised on television, in print media, health fairs, brochures and posters. Women seeking information or services are encouraged to call this number. Callers’ questions are answered and referrals completed for SHS, Pregnancy CARE and other OCHD services. Approximately 600 calls come into the hotline per month.

Community referrals: SHS also receives referrals from hairstylists, neighborhood groups, childcare providers, and faith-based communities. An example was Look Good, Feel Good: Hair Stylists for a Healthy Start. In the first round of SHS activity, we trained 15 local hairstylists in various topics related to the prevention of infant mortality in Syracuse. During 01-02, the stylists had an additional four training sessions. In 2001-02, with collaboration of two of our local Medicaid Managed Care organizations (Total Care and United Health Care) participating women who completed 11 prenatal visits received a gift certificates for beauty supplies and other services. After 2002-2003, subsequent to many staffing changes at SHS, the program lost momentum. Despite efforts by the Health Model Coordinator, it was not possible to revitalize the program.

Special focus on incarcerated women: SHS continues to work closely with the justice system to improve services to pregnant inmates. (See IV. Accomplishments) Public Health Nursing and CHW services are offered to all pregnant women incarcerated at the county jail (Justice Center) or penitentiary (Jamesville Correctional Center). A PHN and CHW provide the visits at the correctional facilities and for home follow-up after release. Medical care is provided via a contracted physician.

Community Wide Events: Three all-day community outreach events were held between August 2003 and August 2004. The events were co-sponsored by SHS and HOPE Worldwide, a faith-based charity. These events were developed with the intent to embed health care information into a family-friendly environment while promoting SHS services to the community. Individuals from OCHD, subcontractors and HOPE Worldwide, staffed these events. In addition to program staff representatives from community-based organizations, credit unions, managed care organizations, Onondaga County Department of Social Services and Health Department staffed program tables and disseminated information to consumers and their families. In addition to SHS sponsored events, Project staff regularly attended health fairs organized by other agencies. An abbreviated listing includes: New York State Fair, PowerJam, Juneteenth, Latin Festival, City Wide Crusade, and Dunbar Association Health Fair.

Resources or events that either facilitated or detracted from successful initiation and implementation

The original Microsoft Registry Database was modified in late 2002 and a new system went into effect on 1/1/03. The original database did not allow for input of new information on women experiencing a second pregnancy nor did it allow for multiple referral sources. The revised database has corrected these problems which has allowed for easier reporting of program data. In 2004, OCHD Information Technology began working with SHS to develop new, linked databases which will allow for sharing of more complete information.
Follow up on women after they have been released from the justice system has proven to be a challenge. Many women do not return to the addresses listed upon entry into the jails or their phone numbers are disconnected. Until 2004, cases would be opened by the PHN assigned to the correctional facilities and clients were transferred another PHN for home visiting and follow-up in the community. Since 2004, the PHN and Community Health Worker who provide case management at the correctional facilities continue to follow the women after release. This has resulted in increased success retaining clients post release (15% in 2004, 38.3% in the first half of 2005). Both case managers believe that this joint follow-up has contributed to meeting the needs of the women effectively and has contributed to their success post-release.

Implementation of the NOW program has proven to be both challenging and rewarding. The original vision of the program was proposed in September 2004 to the Principal Investigator by the Co-chairs of the Executive Council. At that time, the intent was to hire five workers at 10 hours a week, with a plan to increase staffing to 10 workers should funding be secured for an additional four years (2005-2009). Family Ties Network was identified as the appropriate subcontractor to hire the workers, with the Case Management Coordinator/SHS Associate Director initially providing supervision and training. Recruiting efforts were directed at community-based organizations charged with serving the SHS target populations, partner agencies and Executive Council members. Four qualified candidates who reflected the SHS target population were hired beginning March 2005. Training was held over six weeks and was provided by both SHS staff and community partners, including Lead Poisoning, Children’s Protective Services, Syracuse City Police Department and Family Ties Network staff. Emphasis was on the development of outreach skills and knowledge of community services. Outreach services were initially provided in structured areas in partnership with free food giveaways, and partnering with AIDS Community Resources’ (ACR) Van outreach program, Safety First. This partnership has facilitated development of the NOW program. ACR outreach staff have helped to mentor the NOW staff and have provided invaluable help in development of the program. This is a partnership SHS and ACR plan to continue.

Retention of NOW staff has proven to be a problem. Workers have been able to use their experience as outreach workers to qualify for higher-paying positions with more hours and benefits. Despite this challenge, SHS believes that the NOW program will prove fruitful. NOWS averaged over 250 outreach contacts per month and provided referral resources and early entry into SHS services to others. Given that this aspect of the outreach component was implemented for the last two months of the funding cycle, SHS does not yet have enough data to establish the full impact of the NOW program on SHS enrollment.

2. Case Management

How you decided on the approach & rationale
In order to determine the best approach to case management, SHS conducted community-wide needs assessments and risk assessments with SHS registrants. In addition, SHS continues to seek input from SHS Consortium. Results of these assessments indicated that case management and care coordination were understaffed and inadequately integrated into the health delivery system. In 1997-2001, SHS successfully provided case management through the Risk Reduction and the Adolescent Health Models. Therefore, in this round of funding, services were expanded in order
to be able to meet the needs of the increased project area. Subcontracting some case management services from differing agencies allowed SHS to meet the multiple needs of clients. By sharing resources between and among programs, Case Managers were able to access the same trainings and provide integrated services through shared protocols. In return for partial funding of case management services, many programs offered “universal enrollment” in SHS to all SHS eligible participants and provide case management services to all participants using SHS protocols. In this fashion, SHS was able to reach many more women and families through case management services.

Components and resources, including changes
SHS provided an integrated population-based system of five case management programs with shared protocols, goals and benchmarks for measuring success. Oversight of the Case Management program was provided through OCHD by the Syracuse Healthy Start Associate Director/Case Management Coordinator.

These programs are:

- **The Salvation Army Pregnancy Case Management and Community Services**
  
  - Community Health Worker Program (CHWP): is a Title V funded program administered through a partnership between OCHD and The Salvation Army. CHWP is sited at the OCHD and works in partnership with the Public Health Teams. The Community Health Workers have at least a high school diploma and extensive training in Case Management and outreach services. Originally, seven CHWs were funded. Due to a decrease in state funding, in 2004-2005, the program functioned with five CHWs.
  
  - Teen-age Services Act (TASA): is a NYS Medicaid-waiver case management program offering case management services to pregnant, parenting and at-risk adolescents. Staffing ranged between 15 – 20 case managers dependant on staff turnover and funding.

- **OCHD Public Health Teams and Family Life Teams**
  
  - Public Health Teams (PHT) are comprised of Public Health Nurses (PHN) who provide home visiting, services at the county’s correctional facilities, and outreach to hospitals. There were a total of 28 nurses on staff in 2001; due to decrease in other funding, there were 17 nurses on staff in 2004-2005.
  
  - Family Life Teams (FLT) were developed by OCHD in partnership with the Syracuse City School District (SCSD) and the Salvation Army in August 1998 to ensure that pregnant and parenting students receive screening, referral and case management services. This program utilized the services of Public Health Nurses and TASA case managers at each of the Syracuse area high schools and middle schools. Four of the PHNs and four of the TASA workers were assigned to the Family Life Teams.

- **Comprehensive Medicaid Case Management** (CMCM) is a Medicaid-waiver case management program of the Syracuse Community Health Center (SCHC) which employs paraprofessional staff who provide case management and home visitation. One case manager was funded by SHS.

- **Catholic Charities Alliance Program**: Serves families with complex needs who are often involved with child welfare services. One case manager was funded by SHS.
All of the case management programs provided the core components of case management, including: intake and assessment, care planning, case monitoring, referral and follow-up. Protocols were integrated across all providers and were incorporated into subcontractors’ Scopes of Services. All efforts were supported by evidenced-based “best practice” models that corresponded with NYS guidelines for Medicaid-reimbursed case management and with the National Association of Social Workers recommendations for case management.

Assessments included screening for: smoking, intendedness of pregnancy, problems with a previous pregnancy, STDs, douching, language, transportation, housing, family planning, employment, substance use, smoking, and depression. Across the board protocols and a standardized Client Assessment Form (CAF) were established to ensure that all clients received the above assessment, that appropriate referrals were made and that those referrals were completed. As needed, the case manager provided intervention and advocacy in cases where the client was unable to advocate for herself.

The case management system was designed to be able to offer both social case management and nursing case management at the same time for participants with multiple needs. In these cases, there was regular consultation and case conferencing in order to ensure that service needs are met and not duplicated. This flexibility proved invaluable in providing comprehensive case management services to adolescents and to individuals who are incarcerated or recently released from the justice system.

Case Management supervisory staff meet monthly with SHS Case Management Coordinator. In addition, monthly inservices are developed on an annual basis for all outreach and case management staff. Supervision of field staff is provided by each program’s supervisors.

From 2002-2004, SHS provided funding through The Salvation Army for a Fatherhood Initiative. The program provided case management services to young men, generally partners of women/teens receiving SHS case management. Referrals were also sought from community groups, including the Onondaga County Probation Department. The focus of the program was on increasing the male partner’s awareness of and involvement in the health care needs of the woman and infant. Personal goal planning included objectives related to job skills, sexual responsibility and parenting. One of the benchmarks of this program was for the father to read to his baby for two one-half hour periods a week. Key linkages included OCHD’s literacy initiative. A partnership was also established with AIDS Community Resources to provide an eight-week fatherhood parenting class for SHS participants. This program was discontinued in July 2004 due to limited success in engaging participants and in retaining program staff. SHS continued to provide support for fatherhood initiatives through the education model.

Methods for data collection have been modified through the four years of the grant. Originally, data was gathered through the Social Risk Assessment (SRA). This was a one-time collection of information completed shortly after case management intake. The SRA was found to be inadequate to the project’s needs and with the input of project and subcontractor staff was revised in 2003. The current form, the Client Assessment Form (CAF), was implemented in January 2004. The CAF is completed at initial assessment, around the time of delivery and at 90
days post partum. The CAF captures information about the client’s health and social needs; since it is completed at specific intervals, the project is able to track changes in a participant’s situation or behavior (e.g., smoking, substance use, housing stability, etc.).

**Resources or events that either facilitated or detracted from successful initiation and implementation**

SHS benefited from the variety of resources and services available through its case management program. We were able to tap into the resources of the County Health Department, which allowed us to provide public health nurse home visiting services through the entire PHT rather than just through the nurses who are funded through SHS. In addition, SHS participants benefited by the additional PHT members, a Public Health Social Worker and a Nutritionist.

Partnerships with Onondaga County Department of Social Services ACCESS program and the subcontractors have helped to set the standards for service provision and for staff training. All outreach/case management staff attended monthly in-services on a variety of topics. In addition, SHS subsidized Family Development Training (FDC), a 110-hour home visiting curriculum designed by Cornell University and offered through Catholic Charities Alliance program to all case management subcontracting agencies. Participants received seven college credits for participation. FDC training is an “interagency strengths-based training for frontline family workers.” FDC training also helped to standardize the level of expertise and training of case management staff. In addition, one of our subcontractors, The Salvation Army, is accredited by the Council on Accreditation and therefore provides services in accordance with the standards of that organization.

OCHD, The Salvation Army and the SCSD continue to be excited about the on-going success of the Family Life Team programs at the city high schools and middle schools. This collaboration allows teens the opportunity to receive on-site information and services at their schools. All teens at these schools have access to both a Public Health Nurse and a TASA social case manager. SHS is convinced that the FLT partnership was a strong contributor to the low repeat pregnancy rate among our teen population.

Changes in funding to subcontractors since the first four years of the project had mixed results. SHS was able to use funding of some staff positions at the Salvation Army to engender additional referrals to the SHS Registry. The Salvation Army obtained consents and CAFs on all of the women served by their programs who were eligible for SHS services. All of those participants received SHS services although SHS did not fund all of the case management positions at The Salvation Army. This was not the case with Syracuse Community Health Center, which submitted data only for the case management position funded by SHS. SHS continued to work closely with SCHC on other projects and SCHC provided representation to a number of SHS sponsored committees and allowed SHS to use their meeting space. SHS and SCHC continue to discuss ways in which we can enhance our partnerships to increase data collection for the SHS registry.
3. Health Education

How you decided on the approach & rationale
The Health Education component built on the success of the in-service education services offered in the first funding cycle (1997-2001). SHS had experience in engaging the provider community and the consumer community through a combination of direct education to consumers and in-service to health and human services providers. It was decided to continue to build expertise by researching evidence-based, “best practice” models. That information is then brought to the community. SHS is confident that health education messages are based upon the most up-to-date and reliable research.

Components and resources, including changes
Health Education included in-service training for providers and extensive consumer education. Our goal was to decrease the risks associated with prematurity, low birth weight and infant mortality by reaching consumers and providers with consistent messages and information to provide appropriate referrals, support and intervention. In addition to core health education topics of Healthy Start, continuing education was provided on issues related to cultural competency, communication, parenting, “Write it Easy to Read” and other topics as needs were identified. Our belief is that these efforts will promote both individual change and ultimately systems-wide change in the way health care services are offered in the Syracuse community.

The lead agencies for in-service activities were Family Ties Network and State University of New York (SUNY) Upstate Medical University/ Center for Maternal and Child Health (CMATCH). Family Ties coordinated pediatric in-service activities and had one full time equivalent (FTE) health educator position. CMATCH coordinated obstetrical in-service activities and had one FTE health educator position. Physicians from CMATCH and St. Joseph’s Hospital Health Center Pediatrics reviewed all medical in-service materials. SHS was fortunate to have the expertise of both of its medical consultants who provided us with in-kind services.

Provider education was provided through different media: group education, one-on-one education to providers and written materials. Methods included:
- Grand Rounds, both to Pediatricians and OB/GYN providers
- SHS newsletter
- In-service “Tour” to providers’ offices, clinics and partner agencies on the chosen topic.

In 2003 a major in-service topic was post-partum depression. During that time, presentations were provided at Grand Rounds, a Newsletter was prepared, and six in-services were presented by CMATCH staff to partner agencies and medical providers. This approach led to clear dissemination of information across disciplines leading to delivery of health care messages to all consumers, SHS participants and non-participants alike and facilitated system-wide changes (e.g., implementation of screening for depression, smoking cessation program). Each major topic for provider education followed the same model (see Section IV, Accomplishments, for details).
The **Miracle Continuity Elective** was co-sponsored by SHS and SUNY Upstate Medical University. This course elective paired first-year medical students with a family receiving prenatal care at the Upstate Medical Hospital University care sites. Students visited the families during home visits or medical appointments. The visits were conducted during early pregnancy, 2-4 weeks postpartum, labor and delivery, and during the hospital stay and at 12 months. Students attended monthly seminars designed to provide feedback and attain academic goals. This intense medical case management model allowed students and families to benefit from an opportunity to explore the intricacies of family life during the reproductive period. For many of these young medical students this will be their only occasion to interact with disenfranchised individuals and thus may offer them an enhanced ability to relate to the needs and challenges of the families most affected by inequities and poor health outcomes.

**Consumer health education** was provided through providers, non-professional sources (e.g. hairdressers for health), media messages through the home visiting program, in small groups and through the Consortium events. All messages were designed to be linguistically targeted to consumers’ needs, with written materials at appropriate literacy levels. SHS relied heavily on its home visiting staff to deliver one-on-one health education messages to program participants. In addition, since 2001, the CHW program utilized a specific curriculum for home visiting designed by the Florida State University, “Partners for a Healthy Baby.” This curriculum is divided into modules tailored for stages of pregnancy or newborn development.

SHS has worked to **coordinate services** and health related messages through both medical providers and home visitors. *Make Yours a Fresh Start Family*, a smoking cessation program endorsed by the American Cancer Society is one such effort. This model of smoking cessation utilizes the transtheoretical model of behavioral change. All patient materials are “easy-to-read” at about the fourth grade reading level and feature glossy photographs of diverse groups of individuals. Documentation of delivery of the messages used a form that was included in both obstetrical clinical risk assessment and case management recording of participant visits. In addition, WIC staff provided additional reinforcement to the model.

A major initiative in Health Education was the SHS **Speaker Series on Health Disparities**. This series began in 2003 with a presentation by Dr. Michael Lu on “Why Are so Many of Our Babies Dying?” Nationally renowned experts in the area of health disparities were enlisted by the Project to share their research with diverse audiences, including consumers, community members, providers and policy makers. This initiative is more fully addressed in the section detailing program accomplishments.

SHS offered health education during an already existing community program at a faith-based center. During the **Doctors in Communities** presentations, a medical provider presented on a topic relevant to the participants and answered questions afterward. This allowed medical providers and community members alike to assume ownership for the community’s health and well being.

In addition to provider and consumer education, with the assistance of the OCHD Bureau of Health Promotions, SHS developed a number of **media campaigns**, including a bus ad
campaign, television and radio ads (including ads in Spanish). Project staff also appeared on local network shows on topics related to healthy childbearing.

**Resources or events that either facilitated or detracted from successful initiation and implementation**

The SHS Speaker Series on Disparities was incredibly successful. The combination of nationally known speakers and a strategic design drew individuals with disparate representations, including the new Chancellor of Syracuse University, individuals representing city and county government, physicians and other health and human service providers. In order to enhance the appeal of the evening events to consumers, topics were chosen carefully, and transportation, a nutritional meal and free childcare were provided.

However, this approach is expensive and requires supplemental funding. SHS will continue to seek these funds but has not always been able to acquire enough funding to keep to the same format. It will be determined over the course of the next four years which components of the series need to be duplicated “as is” to ensure success.

A number of staffing changes at both CMATCH and Family Ties took place mid-cycle. The CMATCH In-service Coordinator left in mid 2002. This position was changed to two part-time positions in late 2002; Behavioral Specialist and In-service Coordinator. The Health Education Coordinator left in February 2003 and was replaced in June 2003.

SHS has relied heavily on the ‘trickle-down’ approach of patient education based on the premise that education to providers will lead toward increased direct education to consumers. In the light of competing priorities in medical providers’ offices, it has been difficult to measure the effectiveness of this approach. Emphasis for the next four years will shift to more direct consumer education events along with continuation of provider in-service education efforts.

**4. Interconceptional Care**

**How you decided on the approach & rationale**

Interconceptional care was deliberately designed as an integrated part of all SHS services – outreach to newly delivered women and women with infants, case management, and health education efforts, which included developing an awareness in the provider community of the interconceptional needs of women. This approach allowed us to deliver interconceptional care through already established, successful venues.

**Components and resources, including changes**

The focus of the Interconceptional component was on providing information and encouragement to keep post-partum appointments, referrals to family planning services (both through established medical homes and new referrals to family planning programs) and on highlighting the benefit of spacing pregnancies. Direct case management services to women and their infants with enhanced services to infants are also part of the program. SHS’ intent was to integrate interconceptional care into the entire project through the following approaches:
**Education and services to clients**

- Outreach to newly delivered women at a major birth hospital.
- Post partum education through case management visits.
- Services provided at schools through Family Life Teams to pregnant and parenting teens. Information is provided on family planning, parenting, immunizations and completion of goals related to graduation from school.
- Information dissemination regarding the NYS DOH Family Planning Extension (two year automatic eligibility for post-partum women who were covered under PCAP) and Family Planning Benefit Programs coupled with referrals to participating providers.
- Screening and referral at WIC sites: all women with infants are routinely asked about their needs for family planning services.
- High Risk Women’s Project: Since fall 2004, all women at elevated risk for subsequent poor pregnancy outcome who did not receive a referral through usual channels were identified through a screening of birth certificate information and contacted and offered services post partum. SHS plans to assess the efficacy of this program during 2005-2006 (see appendix A-1 for criteria).
- Case Management sub contractors provided continued case management and home visiting to women with children up to age two. In those visits, developmental screening, parenting education, and identification of needs and referrals for additional services are completed.
- Consumer education offered at educational sessions, Speaker Series, Consortium events and health fairs. Transportation and childcare were available for all consumer events.

**In-service Education to Providers**

The SHS Obstetrical Advisor convened a committee of representatives from prenatal care providers and major birth hospitals to consider issues related to interconceptional care. One goal of the committee is to help providers shift their perception of the post partum visit being an end point of care to the visit being part of a continuum of women’s health care. This committee convened in July 2004 and will continue its work during the upcoming funding cycle.

**Resources or events that either facilitated or detracted from successful initiation and implementation**

The inception of the Nurse Manager meeting in 2004 proved to be an invaluable resource for information sharing regarding interconceptional issues. Through this venue, SHS staff discovered that the procedures in place for sharing of information between the birth hospital and the prenatal care providers were spotty at best. Prenatal care providers did not always receive notification that a patient had delivered, or if there were any delivery-related concerns. Therefore the provider’s offices were not able to track effectively if a participant had a need of a post partum appointment. This open dialogue has led to exploration of where those breakdowns exist and to suggestions for change that have led to more effective communication procedures.

A structured change in procedures between WIC and Family Planning Service helped connect women with interconceptional services. All WIC participants were routinely asked about their...
plans for family planning and were referred to services as necessary. In addition, Public Health Teams, Family Planning and WIC augmented their screening to ensure that all participants were offered services and provided follow up on those referrals.

In addition, two New York State DOH programs, Family Planning Extension Program and Family Planning Benefit Program offered women without traditional health insurance the opportunity to continue to receive insurance coverage for their reproductive health care. Facilitated Enrollment sites for Medicaid benefits, the ability of Family Planning and Planned Parenthood to enroll individuals for benefits on site and the promotion of these programs by the case management, outreach and health education models helped to engage many women into routine women’s reproductive health care services.

5. Depression Screening & Referral

How you decided on the approach & rationale
Depression screening services were new to this second round of funding. In order to decide upon an approach, a comprehensive literature review regarding emotional and psychological needs of women during pregnancy was performed. Depression screening was incorporated as a best practice model for case management and prenatal and post-partum care. Significant effort was made to make depression screening and referral a standard of care for all providers. In order to facilitate this change, SHS amended existing forms for documentation, provided staff and provider training and increased efforts to increase community understanding of the issues of perinatal mood disorders through community-wide seminars.

Components and resources, including changes
In 2001, after extensive research, the Center for Epidemiologic Studies Depression Scale (CES-D) was chosen as a screening tool, and the Social Risk Assessment was modified to include three screening questions. A positive response to these questions or concerns by the case manager triggered the full CES-D. Participants who received case management services via the Public Health Teams had access to the Public Health Social Worker for further assessment. In addition, the Aubry Perinatal Assessment Tool was amended to include a number of behavioral concerns, including screening for perinatal depression.

Specific interventions to help train and educate staff on the perinatal depression and screening tools were arranged. Technical assistance in training staff was obtained from Mindi Fullilove, MD, psychiatrist on the faculty of Columbia University and Regina Canuso, MS, APRN, BC, the Mental Health Coordinator from Head Start/Early Head Start.

The SHS Mental Health Committee was convened by CMATCH in 2001. This committee included representatives from all SHS models, consumers and partner agencies. In addition, mental health practitioners were encouraged to attend. Since January 2004, the committee has been co-chaired by staff from CMATCH and Ms. Canuso of Head Start. The committee worked to identify potential partners, referral resources, and barriers to services and developed “best practices” recommendations. A recent example of implementation of best practice is the shift from use of the CES-D to Edinburgh Perinatal Depression Screening tool. The Edinburgh has been widely recommended over the CES-D as it addresses suicidality. The committee worked to
develop provider directories with some assistance from the Onondaga County Mental Health Association.

Since 2004, all participants were screened for depression using the Client Assessment Form. In addition all major prenatal clinics and Pregnancy CARE providers incorporated depression screening in their care to patients. If a participant had a positive screen, either her medical provider or case manager initiated a referral for further assessment and counseling services.

**Resources or events that either facilitated or detracted from successful initiation and implementation**

SHS found the implementation of depression screening services to be a mixed success. We engaged all case management subcontractors by including in the Scope of Services a requirement that depression screening be completed on all participants. We have not had the same successes with medical providers. Anecdotally, we have been told that physicians believe that when a screen is positive but a referral is not possible or successful, they risk medical malpractice. A valid concern on the part of providers is that Syracuse suffers from a limited capacity for mental health services. Typically, unless it is a mental health emergency requiring emergency room care, there is a wait for mental health services for 3 – 6 months. In April 2004, Four Winds Hospital, an in-patient mental health facility was closed. These beds have not been replaced, leading many local residents (especially children and adolescents) to seek care outside the community.

Despite the difficulty in finding resources, SHS has had support of members of the mental health community. Ms Canuso’s involvement with the mental health committee is one such example. In addition, we have had mental health therapists volunteer to provide seminars to case managers – most recently, two local therapists provided a free in-service to case managers throughout the community on “Calming Techniques for Mothers and Infants.”

**B. Core Systems**

1. **LHSAP**

**How you decided on the approach & rationale**

As a Local Health Department within New York State, the OCHD has a structurally coordinated relationship with the NYS Department of Health (NYSDOH). Based on a careful assessment of community needs, a Municipal Public Health Services Plan is submitted bi-annually to the NYSDOH to receive state aid funds. Many of the services described in that plan are collaborative programs with the Syracuse Healthy Start project.

In 2001, we reviewed the maternal and child health aspects of the Municipal Public Health Services Plan and found it lacking with types of system-wide enhancements that SHS sought. Accordingly, we developed more well defined goals, with the following three priorities: 1) Addressing gaps in the coordination of obstetrical, pediatric and case management services, especially for women of color. 2) Providing information to both providers and consumers that will promote healthy behaviors that would decrease the present disparities. 3) Working toward
reducing fragmentation with regard to linkages between medical providers and other preventive services.

Since its development, SHS has regarded the LSHAP to be a “living document” that is revised on a regular basis in an effort to be responsive to local data, emerging needs and changing priorities. Identified priority areas are related to the larger goal areas developed in the Association of Perinatal Networks’ framework for strategic planning, “Charting the Course for Perinatal Health in New York State.” Our goals are a match with their stated goals to eliminate barriers and disparities, assure quality care, and improve the health infrastructure and system.

Components and resources, including changes

Objective 1: Increasing linkages among agencies to promote a system of seamless care
SHS has sought to bring together groups of providers to focus on breastfeeding, smoking cessation, perinatal substance abuse, STD/HIV, adolescent issues, lead in pregnancy, depression, racial and ethnic disparities and many other issues. The goal of these groups is to decrease fragmentation of services and begin to work together. Other elements of this goal have included:

- Targeted outreach to difficult to serve women and families
- Improved coordination with pediatric and prenatal care providers
- Integration of case management services
- Uses of evidence-based, best practice models
- Increased coordination of screening for drug alcohol abuse, domestic violence, depression

Objective 2: Promotion of evidenced-based prenatal care and case management services
SHS has researched and promoted both evidenced-based best practices and has provided screening tools that help prompt providers to ask and document the delivery of these practices.

Objective 3: Ensuring perinatal services to the most vulnerable

- Linguistically competent care: all OCHD services have access to ATT language translation line, SHS and Family Ties Network has purchased educational materials in other languages
- Addressing the needs of incarcerated women: This initiative, begun in 2001, has grown throughout the four-year period.
- Targeted outreach to zip codes with the highest number of poor birth outcomes. Efforts included street outreach, health fairs and education materials distributed at local clinics, markets and agencies.

SHS continues to work closely with all of the local birth hospitals, substance abuse providers and law enforcement (particularly probation and correctional facilities) to ensure that the goals and targets of the LHSAP are addressed and new areas of concern identified in a timely fashion.

Resources or events that either facilitated or detracted from successful initiation and implementation

Challenges to successful implementation included many of the root issues related to infant mortality and health disparities. The needs assessment in the 2005-2009 grant submission points out that the poverty rate in Syracuse is 27%. In of many of our neighborhoods between 45 and
70% of households are living in poverty. Only 76% of our residents are high school graduates. Syracuse Healthy Start is only one initiative of many seeking to change the health care status of our residents. Data from Michael Lu, presented at the initial Speakers Series, suggests that stressors such as racism and poverty contribute over the course of an individual’s life span to sub-optimal health and birth outcomes. This information has helped to form decisions and lead the way toward implementing changes; however, it is clear that the needs of the population are many and success can only be achieved through on-going partnerships with multiple entities, including local and state governments.

SHS successfully enlisted the partnerships of organizations and entities that are interested and concerned with the well being of Syracuse residents. Their willingness to partner greatly facilitated the broad reaching tasks of this project.

2. Consortium

How you decided on the approach & rationale
In this second four-year contract, OCHD continued with the approach to community Consortium-building that had been developed in the earlier contract period. OCHD contracted with Family Ties Network, Inc., the Title V-designated Comprehensive Prenatal/Perinatal Services Network that serves Syracuse and Onondaga County. Family Ties Network had successfully established the Consortium, building on the agency’s previous experience convening health and human service workers and consumers for networking and collaborative projects to meet the needs of pregnant women, infants and children.

Components and resources, including changes
Resources devoted (staffing and Consortium programming funds): Syracuse Healthy Start values the Consortium, as shown by the allocation of funds for a full-time Consortium Coordinator position throughout the contract period. The contract with Family Ties Network included the participation of Family Ties Network’s Executive Director (ED) in consortium-building and collaboration efforts. The project contributed 15% of the ED’s salary in the first year of the contract, decreasing to 10% in the final three years in response to budget constraints. The project also contracted for secretarial and program support of an Administrative Assistant, at 50% time in the first two years, decreasing to 30% time, also due to budget constraints. (Please note: the ED and Administrative Assistant also contributed efforts to support the Healthy Start Health Education component of Family Ties Network’s contract.) The Consortium component received funds throughout the contract for Consortium meetings, childcare and transportation for consumers, Consortium training, program supplies, and appropriate travel.

The key components of the Consortium intervention are the dedicated Consortium Coordinator who works in concert with the other SHS staff, the Executive Director of the Perinatal Network, and the Chair of the Consortium. All of these individuals work in concert to engage the community in the program. The key organizational components are the wider Consortium, the leadership group of the Consortium, which is called the SHS Executive Council, and the Committees of the Consortium. Please see below for more details on the structure and function of the Consortium.
Resources or events that either facilitated or detracted from successful initiation and implementation of each intervention.

The Consortium has experienced growth and revitalization of purpose since the hiring of a new Consortium Coordinator, in December 2003. The Coordinator has a strong collaborative and interpersonal skills and a real spirit for the work of Healthy Start. She has been able to establish positive relationships with the Executive Council and has recruited additional individuals who are willing to work toward the goal of the project.

Prior to the hiring of the current Coordinator, the Consortium experienced some challenges during the 2001-2005 contract due to staff turnover in that position. The Coordinator who had joined the program in the summer of 2000 left in 2001 for another position within the Syracuse community. The position was vacant for a short time. The new Coordinator was hired in November of 2001 and left for another position at the end of December 2002. The next Coordinator began in March 2003, but was not happy in the position and left in August. There were challenges for continuity of committee work, due to the time needed for new coordinators to become familiar with the Consortium which have since resolved with continuity in the position.

Highlight how the Consortium was established and identify any barriers that emerged in its establishment and how they were addressed.

The SHS Consortium was established before the 2001-2005 contract (during the 1997-2001 contract). To establish the Consortium, the Consortium Coordinator invited health and human service providers who were engaged in Family Ties Network’s Onondaga Sub-Council (a group working to improve maternal-child health), and additional providers appropriate to the SHS service area, to attend the kick-off meetings and be involved in the ongoing work. Recruitment of consumers focused on inviting individuals served by the Healthy Start case managers and by other providers and programs (e.g. OB offices, Early Head Start, faith-based organizations, community groups, etc.) to participate in Consortium activities. A series of meetings were held to tell the community about the problem of infant mortality and to engage consumers and providers in discussions about how to address the problem in our community. A group of interested providers and consumers was recruited to become the first members of the SHS Consortium Executive Council, the leadership group of the Consortium. A consultant was engaged to assist the Executive Council to develop its own by-laws and operating procedures.

It was a challenge to find a time for the large Consortium meetings that would be appealing to all constituents. The approach used was an early evening, weekday meeting (5:00 to 7:00), with dinner and childcare provided. Transportation assistance was also provided as needed to consumers. It was also a challenge to find a venue in a neighborhood location that was large enough, accessible, had good acoustic qualities, and had adequate room for childcare. These challenges remain. During the 2001-2005 contract we have worked with several church congregations that have graciously provided excellent meeting space.
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 (consumer, provider, government, or other). Also, please describe the size of the consortium, listing the percent of active participants.

Structure of the Syracuse Healthy Start Consortium

**Definition:** The Syracuse Healthy Start Consortium is a coalition of health and human service providers, consumers, community members, businesses, community- and faith-based organizations that informs, strengthens, and promotes the work of the Syracuse Healthy Start Program. The working structure of the Consortium remained consistent throughout the 2000-2005 contract.

**Composition:** During 2004, there were approximately 200 individuals active in the Consortium (Being active is defined as attending two or more events per year). This included 93 health and human service providers, 28 consumers, 20 community members, 28 representatives of Community-Based Organizations, 16 individuals from churches and other organizations, and 14 from State and Syracuse City government. The racial and ethnic breakdown was: 66% white, 26% African American, 3% Latino/a and 5% other. The breakdown by gender is 84% female, 16% male.

**Leadership:** The Leadership group of the Consortium, the SHS Executive Council, has 15 members: 5 consumers, 5 health and human service providers, and 5 community members. Executive Council members are recruited and elected from the larger Consortium. They can serve up to two consecutive two-year terms. The Executive Council meets ten or more times per year. They serve as an advisory board to the project by:
- working to provide community input into the design of services
- providing advice on program efforts such as outreach, health education, publicity, etc.
- reviewing the service reports and the SHS evaluation
- providing community insight into barriers to prenatal care, ideas for systems improvement
- working toward identifying sources of funding support and program sustainability (grant-seeking, development of partnerships with the business community)
- representing the SHS Program in collaboration with the National Healthy Start Association and its advocacy efforts

**Activities:** The members of the Consortium attend Consortium meetings, scheduled four times per year, so that they stay informed about SHS services, communicate with other members of the Consortium on issues of mutual concern, and become involved in SHS Committees and other collaborative opportunities that are of interest to them as individuals or appropriate for their organization. The providers and agency representatives agree to actively refer consumers who need SHS services to the SHS program, to consumer education opportunities, and to the SHS Consortium. All Consortium members receive the quarterly SHS Consortium Newsletter, as well as invitations to all SHS-sponsored events.
Committee Structure:
SHS Standing Committees and ad hoc committees focus on specific health systems issues:
- Mental Health Committee
- Health Education Committee
- Outreach Committee
- Social Marketing Committee
- Fatherhood Committee
- Perinatal Substance Abuse Committee
- Nominating Committee
- Steering Committee (Ad hoc)

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

Family Ties Network and the Consortium were charged to develop a community resource guide/directory that could be used by staff and consumers. Staff researched the human services resource guides that were already published in the community, and found that the directory published by Exceptional Family Resources, an agency serving families of children with special health care needs, is perfect for our needs. This guide is inexpensive, easy to read and use, and is completely updated every two years. We purchase copies each time the guide is updated, and provide them to case managers, members of the Consortium, faith-based groups, and any interested consumers and collaborators.

The Consortium has been successful in reaching out to businesses and faith-based organizations in our community for donations of cash and materials to assist with outreach/education events, including two summer Carnival/Health Fairs and one Education Baby Shower. The Project also received a grant from Fidelis, a health insurer, which is dedicated to a Consortium planning meeting in the new grant period. The goal of the meeting is to develop a plan to advance community participation in strengthening our system of care for families. In spring 2005, the Executive Council developed and submitted a mini-grant proposal to the NYS Department of Minority Health for an asset-based community development project, but unfortunately the project was not funded. The Executive Council will be developing other funding proposals in the coming year.

The "Consortium Training" portion of the budget allocated $5,000 in most of the years. The Executive Council had the role of determining what types of training they wanted. The trainings included several strategic planning and team-building day-long Executive Council retreats. Some of the key SHS staff were invited to several of these as well. In addition, the EC used some of this funding to send EC members, consumers and community members to conferences that offered appropriate educational information, such as the National Healthy Start Association Meetings, the NYS Perinatal Association Conferences, and other national and local conferences.

As described above, the Executive Council provided ongoing input to guide the use of the Consortium Meeting and Consortium Training funds. There was an additional process in 2001 and 2002 for the Executive Council to direct the use of carry-over funds. The OCHD received
permission from National Healthy Start to develop a proposal for use of the funds. The Executive Council asked for proposals from the Consortium on how these funds should be used. The Executive Council received a number of proposals from sub-contractors and staff and other agencies in the Consortium, and also had ideas of its own. A committee reviewed all the proposals and made decisions on what items and projects to put in the proposal to HRSA for use of the funds.

Another example of the Executive Council’s input into decisions is that the childcare reimbursement policy and rate were developed by a committee that included consumers. The reimbursement rate was increased by the Committee as one of the uses of the carry over funds.

SHS worked with other consortia in the Community. We all share the goal of minimizing duplication of services. For this reason, instead of starting a new sub-committee under Healthy Start, we instead collaborated with these existing groups:

- Syracuse Area Domestic Violence Committee (coordinated by Vera House)
- Breastfeeding Connection of CNY
- Coalition of Concerned Community Partners (a coalition funded by a NYS DOH Office of Minority Health (OMH) grant to work on decreasing disparities in diabetes, obesity, and kidney disease in Syracuse)
- American Lung Association Asthma Moms Project, 2001-2003 (also was funded by a NYSDOH OMH grant)
- Syracuse Community Service Project (Adolescent Pregnancy Prevention and Services Program)
- Tobacco-Free Onondaga County Coalition
- March of Dimes Program Committee
- CNY Regional Perinatal Forum
- HIV Care Network (Ryan White HIV Care Network in CNY)
- Syracuse/Onondaga County Lead Task Force
- Safe KIDS Coalition
- FLAGS (Family Literacy Alliance of Greater Syracuse)
- United Way’s Success-by-6 (Health Committee and Hunger Committee)

**Describe the community’s major strengths which have enhanced consortium development.**

One major strength of the community is the strong health care institutions and health care leaders who have shown dedication to the project and specifically the Consortium. These include two local physicians and other providers. These providers have a consumer-friendly approach to care, and work to engage consumers in the project by encouraging participation in Consortium events. Another major strength of the Syracuse Community is the large number of human service agencies that provide high-quality services to pregnant women, infants, and children. Several of these agencies are key sub-contractors to the Syracuse Healthy Start Project. Many staff members of these agencies serve on the Consortium and many of its committees, and participate in collaborations with other components of the Project to meet community needs.
Describe any weaknesses and/or barriers which had to be addressed in order for the consortium to be moved forward.

During the tenure of one Consortium Coordinator, misunderstandings, personality conflicts, and differing expectations led to tension, breakdown in communication, and the development of opposing factions among the members of the Executive Council. This situation was difficult for all. During this time, the original Project Director left, and a new Project Director was hired. After several attempts to mediate, clarify the differences, and repair the relationships, a respected facilitator assisted, leading to better communication and a rededication to focus on the goals of the project. The Consortium Coordinator moved to another job, also contributing to a new tenor among the Executive Council. The new Project Director worked with Family Ties Network and the leadership of the Executive Council to rebuild and refocus the efforts of the Council.

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

Many of our most involved consumers were identified through case managers and other providers. Through the case management relationship it has been possible to identify and provide support to consumers who are interested in increasing their participation. This strategy was utilized throughout the funding period. We also reached out to consumers and community members at health fairs and community events such as the annual Juneteenth Celebration. Another strategy was to send invitations to events to churches and community groups. Several Executive Council members were recruited from community members who attended Speaker Series events in 2003 and 2004. Our strategy was to continue to add recruitment methods to the ones previously used.

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

The Consortium's primary method of obtaining consumer input into decision-making was through the involvement of consumers on the Executive Council and its committees. As described in the section about Consortium resources, consumers were active on the Committee that determined how the project proposed to spend carry-over funds. Consumers from Syracuse Healthy Start also collaborated with consumers from the Rochester and Buffalo Healthy Start programs to plan and carry out the "Consumer Voices" conference, held in Rochester in 2001. In addition, Family Ties Network and Syracuse Healthy Start conducted two consumer surveys, asking about access to care and satisfaction with care issues. In 2004, the Executive Council proposed to OCHD that the Project hire community-based outreach workers, to improve penetration of the target communities, and to provide employment and training opportunities to community members.

How did you utilize the suggestions made by the consumers?

On a routine basis, the suggestions of consumers were incorporated into programming and into planning. One specific example was the decision to hire outreach workers near the end of the 2001-2005 program period, as a pilot effort. The pilot was successful and let to the incorporation of the Neighborhood Outreach Workers into the program structure for the new funding period.
3. Collaboration and Coordination with State Title V and other agencies

How you decided on the approach & rationale
Syracuse Healthy Start has a long history of successful partnerships with other community members. Since 1991, OCHD had instituted a number of intervention programs in response to the crisis of high infant mortality in the City of Syracuse. Partners included a perinatal network, Family Ties Network, Inc., the Access Center of the Department of Social Services, Comprehensive Medicaid Case Management, Community Health Worker Programs and the Salvation Army Teen Support and Advocacy programs were established. All of these programs were partners in the first phase of funding. SHS determined to use these established partnerships as a foundation to link with a broad network across the city. SHS relied on these partnerships to bring a wider awareness of the issues of health disparities in birth outcomes across the project area and beyond.

Components and resources, including changes
As a local health department with an organizational relationship to the NYS Department of Health (NYSDOH), OCHD enjoys a history of collaboration and cooperation with Title V and Title V funded programs. Many Title V programs are collaborative programs, allowing for crosscutting interests to be addressed comprehensively. SHS staff attends NYSDOH and Healthy Start collaboration meetings bi-annually. These meetings are generally held in Albany and are attended by Healthy Start projects from across the state. The meetings are used to foster communication, explore areas for collaboration and provide updates on programmatic developments. In 2004, these meetings included participation in the National Healthy Start Association Regional Conference in Newark, New Jersey. The Director of the Perinatal Health Unit of the Bureau of Women’s Health in Albany worked with SHS and other regional projects to plan the event. Close relationships are maintained with DOH Title V staff, including the Syracuse Field Office and with staff sited in Albany.

A core component of our collaboration with Title V is our relationship with Family Ties Network, a major subcontractor. Family Ties is a DOH-funded Comprehensive Prenatal-Perinatal Services Network (CPPSN). The plans and actions of the CPPSNs and the Healthy Start Projects work synergistically in areas such as community outreach and education, coordination of services, advocacy and sharing of best practices.

SHS also partners with the majority of Title V funded and Title V related programs in Onondaga County. These include:

- Pregnancy Care Assistance Program (Onondaga County Health Department Pregnancy CARE)
- Children with Special Health Care Needs and Early Intervention
- Family Planning Service of the Onondaga County Health Department
- Child Health Plus and Family Health Plus
- The Association of Prenatal Networks of New York
- Community Health Worker Program
- Adolescent Pregnancy Prevention Services Program
- TASA Case Management
- Onondaga County Lead Poisoning Prevention Program and Dental Program
• Onondaga County Migrant Health Program

In 01-02, SHS funded the New York State Association of County Health Officials, (NYSACHO) to co-sponsor a meeting of NYS Title V staff, the 14 NYS Perinatal Networks, the five Healthy Start sites and the County Health Officials of NYS. This conference, titled “Eliminating Disparities in Maternal and Child Health: New York State Agenda for the Next Decade” was held in Syracuse on November 14, 2001. This daylong event drew over 100 participants from agencies all over NYS. This event was chaired by the SHS Consortium chair; three SHS consumers actively participated in discussion.

In addition to major ties with Title V, SHS has ongoing collaborative relationship with over 100 agencies, service providers, hospitals, schools, universities, faith communities and community and minority organizations. Of special note was SHS’s partnership with HOPE Worldwide, a faith-based charity founded in 1991 by the International Churches of Christ. (See Project Accomplishments).

SHS staff also served on a number of committees working on issues related to improving birth outcomes. A partial listing of committees includes:

- **SHS Perinatal Substance Abuse Committee.** This committee was instrumental in developing substance abuse screening based on Ira Chasnoff’s model, and helped to organize Ira Chasnoff’s technical assistance visit to Syracuse in 2004.
- **Breastfeeding Promotion:** SHS serves on the Breastfeeding Connection and on the UNICEF 10-step Baby Friendly Hospital Initiative, which is seeking to bring Baby Friendly designation to our local birth hospitals.
- **Tobacco Free Onondaga County Coalition:** works to encourage a smoke-free environment in Onondaga County
- **SID Outreach Coalition:** SHS serves on this coalition. Over the past four years accomplishments include: providing in-service education to Onondaga County foster parent/adoptive parent training program, training of child care providers, providing SIDS risk reduction messages to medical providers (joint activity with Social Marketing Committee, addressed in section IV). In partnership with the Center for Sudden Infant Death Syndrome a “kit” of SIDS reduction materials was developed and distributed to pediatricians and family practitioners on a regional basis.
- **Domestic Violence Coalition Medical issues Committee:** SHS participates in the White Ribbon Campaign, and the distribution and design of a Domestic Violence poster. The poster is on prominent display in many public and private areas, including restrooms in prenatal provider’s offices.

Other major categories of linkages included:
- Onondaga County Departments of Social Services, Mental Health and Probation
- Medicaid Managed Care Organizations
- HIV-related services
- Onondaga County Child Fatality Review Team
- Syracuse City School District
- Health Care Providers
Syracuse Healthy Start Project Number: 743452

- Substance abuse treatment providers
- Department of Corrections
- Weed and Seed
- Community-based organizations

**Resources or events that either facilitated or detracted from successful initiation and implementation**
Healthy Start was able to maintain and facilitate ongoing partnerships via its structured approach to collaboration. SHS staff served on a number of committees and participated in local events such as health fairs and community-wide events sponsored by OCHD and other organizations. Decisions about participation were made with consideration to the population served and the best use of time available to do the work of the project. All Healthy Start sponsored events were planned carefully and we deliberately sought to bring together individuals from disparate backgrounds (medical, social services, insurance, law enforcement, housing, government and financial) to work together toward community change.

The Speaker Series on Health Disparities further served to raise awareness in the wider community regarding the issues and brings a level of energy to planning the next steps.

Events sponsored by SHS such as the Baby Shower and Health Fairs, served to promote SHS in the community, but also promoted SHS services within the community of providers. In some instances, another entity’s participation in a Healthy Start sponsored event promoted good will and established additional partnership that helped lead to systems change. For example, we partnered with Weed and Seed on the February 2004 Baby Shower. Weed and Seed is a federally funded organization through the Department of Justice that works with local communities to design strategies for deterring crime and promoting economic growth. Coordination of services facilitated sharing of resources and opportunities to collaborate with additional agencies which impact quality of life and were outside of the health arena.

**4. Sustainability**

**How you decided on the approach & rationale**
SHS continuously sought to find ways to make the achievements of Healthy Start sustainable. We seek to make focused change in the community so that efforts to increase knowledge, change behaviors and improve access to and utilization of care will be sustained.

**Components and resources, including changes**
As a Project, we hope to find sustainability through the following:
1. System-wide enhancements Provider training
2. Medicaid Managed Care Reimbursements
3. In-Kind contributions
4. Diversification of funding streams

**Systems-wide enhancements** included: use of a selected intervention such as using the same smoking cessation intervention across disciplines (i.e. Make Yours a Fresh Start Family), dissemination of “best practices” regarding chemical dependency screening, drug testing and
referral for services, and health services for pregnant inmates. This helped bring about changes in standards of care.

**Training:** In each year of the project, SHS provided training and information on a variety of topics to both health care and human service providers. Topics included: including fathers in sonogram (*POP Sonogram*), Post-partum Depression, Smoking Cessation, and Preterm Birth.

**Medicaid Managed Care** reimbursements: OCHD negotiated reimbursement agreements with three local Medicaid Managed Care organizations for public health home visiting of pregnant women and families of newborns. The funding secured by this mechanism does not cover entirely the cost of these visits, but does defray them somewhat. The Salvation Army TASA program is a fee-for-service Medicaid Waiver program. Case management services provided by this program are reimbursed through Medicaid.

**In-kind contributions:** SHS has the resources of Onondaga County Health Department available to its participants. This includes lead screening, the immunization program, dental services, health promotion and more. In addition, we received support from the OCHD Director of Surveillance and Statistics, and the Commissioner of Health (Principal Investigator).

**Diversification of funding:** Throughout this funding period we continued to apply for grants both through the bureaus of OCHD and for grants that will specifically support SHS activities. SHS specific grants include:

- Area Health Education Center (AHEC) provided fiscal support for the Speaker Series on Health Care Disparities in both 2004 and 2005. In addition, a mini-grant was obtained from National Institutes of Environmental Health for the Series.
- March of Dimes provided support for the Speaker Series. In addition, SHS provided technical assistance to Partners in OB/GYN in writing a March of Dimes grant to develop and deliver a CenteringPregnancy program.
- Fidelis Care NY agreed to underwrite the cost of a Next Steps Community Planning Meeting.
- Additional support for the Speaker Series was received from Family Ties Network, Syracuse Community Health Center, Excellus Blue Cross/Blue Shield, Upstate Medical University and Syracuse University, the OCHD Bureau of Health Promotion and Disease Prevention and the Immunization Action Plan.
- The CDC funded a study whose purpose was to evaluate SHS efforts to decrease preterm delivery through bacterial vaginosis screening and treatment, smoking cessation and case management, through 12/03.

**OCHD Grants** have included funds from:

- NYSDOH for Facilitated Enrollment for Child Health Plus and Family Health Plus
- NYSDOH for ACT for Youth funding
- NYSDOH for the OCHD Community Health Worker Program
- NYSDOH a grant to provide Migrant Health services
- NYSDOH to Family Ties Network, Inc; a continuation of the comprehensive Prenatal/Perinatal Services Network grant
- NYSDOH to enhance our Child Fatality Review activities. This grant ended in 2003.
• NYSDOH to OCHD to increase the access of disadvantaged women, including racial and ethnic minorities to HIV prevention, HIV counseling and testing and STD screening.

Resources or events that either facilitated or detracted from successful initiation and implementation
Over time, SHS has applied for other grant funding. This includes an application to the Agency for Health Care Research and Quality for conference funding for the Speaker Series and through The NYS Office of Minority Health to support the community-based strategic planning efforts of the Consortium. Neither of these grant applications were funded. Family Ties has also applied through NYS DOH for support of smoking cessation efforts through the Perinatal Networks. This grant decision is pending.

SHS is impacted in much the same way by environmental events as other organizations seeking to promote prevention of any negative condition. It has been widely speculated that contributions for Tsunami relief contributed to a shortfall in contributions to the United Way of Central New York and to other local fundraising efforts. In this year’s funding requests for the United Way, requests were 2.5 times greater than the funds available. Potential loss of funding to SHS subcontractor’s other programs may eventually indirectly affect the strength of our partnerships (i.e. as other resources dry up, agencies may need to reallocate priorities leaving less flexibility to support SHS programming).

Ultimately, the test of sustainability of the project’s achievements goes well beyond financial support of the project. Sustainability is related to permanent changes in the quality of care and awareness and potential changes in behavior in the Syracuse community. Collaboration across systems has lead to changes which will affect sustainability of many program efforts: examples include the Back to Sleep campaign, which has raised awareness and increased educational services provided by pediatricians on the topic of SIDS; increased screening for depression, substance abuse and domestic violence by prenatal providers; and improved health services for pregnant inmates have begun to change the standard of care in the Syracuse community. SHS believes that these changes will go far to change the quality of care offered to all residents of the community.

III. MANAGEMENT AND GOVERNANCE

Structure of project management:
The project management rests with the Onondaga County Health Department, lead agency for the Project. An administrative chart for the Syracuse Healthy Start Project is attached (Appendix A-2). The project leadership is composed predominately of OCHD staff, with responsibility for specific models shared by sub-contractors.

The Project Director: Responsible for overall management, writing and negotiating of contracts, review of budgets, and writing additional grants to ensure sustainability of project funds. Participates with other management staff in linkage with and reporting to Consortium, meeting with sub-contractors, review of statistical data and integration of scientific information, systems
analysis for quality assurance, planning for in-service education needs and community health education, and overall coordination of effort between agencies.

**Associate Director/Case Management Coordinator:** Assisted with overall management of subcontracts, writing additional grants, reporting to Consortium, linkage with other agencies, systems analysis for quality assurances, overseeing linkages to HIV/AIDS prevention activities, efforts related to domestic violence, Perinatal Substance Abuse, Mental Health, Fatherhood and others. Managing case management sub contracts, including development of assessment forms, and benchmarks and convening case management supervisors group.

**Consortium Coordinator:** Responsible for recruitment of consumers, meeting with consumer outreach groups, overseeing the work of the Consortium, representing the Consortium at various meetings, setting up meetings of the Executive Council. The Consortium Coordinator is employed by Family Ties Network, Inc. under a sub-contract.

**Outreach Coordinator/Registry Coordinator:** Responsible for implementation and coordination of the Healthy Start Registry, outreach to medical providers, preparation of data and reports to subcontractors and granting agency.

**Health Model Coordinator:** Overall responsibility for managing health education to providers and consumers; convenes Health Model committee, oversees development of consistent health messages. The Health Model Coordinator is employed by Family Ties Network, Inc. under a sub-contract.

**Evaluator:** Leadership of evaluation team, preparation of annual evaluation and other deliverables such as data reports and client satisfaction surveys.

**Chairperson SHS Consortium Executive Council:** Provides leadership to the Executive Council of the Consortium, and serves in an advisory capacity to project leadership.

Each subcontracting agency has a primary contact person who is responsible to ensure that the contract deliverables are met. Sub contracting agencies include: Family Ties Network: The Salvation Army; Syracuse Community Health Center; Catholic Charities, SUNY Health Science Center, Center for Maternal and Child Health (CMATCH) and Syracuse Model Neighborhood Facility.

**Resources**
The SHS project staff relied heavily on the programmatic and fiscal guidance of Lloyd F. Novick, MD, MPH, Commissioner of Health for Onondaga County and Principal Investigator of SHS. Dr. Novick's expertise was invaluable in that he has both extensive public health experience, on local state and national level as well as authorship of numerous articles, books and papers. Dr. Novick is a strong proponent and recognized authority on the population-based strategies implemented by the project. Effective July 2005, Dr. Novick resigned from OCHD to accept a position in academia. Cynthia Morrow, MD, MPH has been appointed as Commissioner of Health and will serve as Principal Investigator for the next funding cycle.
Other OCHD staff who have been utilized over the course of the project include: Director of Public Health Nursing; Director of Surveillance and Statistics and other staff as able on an in-kind basis for various aspects of the project.

**Changes**
There have been a number of staffing changes over the life of the project. During these periods, significant support was received from OCHD administration and subcontractor administrators to ensure that project deliverables were met and that services were not compromised. Transitions of major project positions are enumerated as follows:

*Project Director:* Sandy Lane, PhD, MPH was with the project from inception until 2002. In September 2002, Brenda Paul, MPH, MSW was hired as Project Director. Ms. Paul resigned in January 2005. From January 2005 through mid May 2005, Luisa Manfredi-Batki, MPH, JD served as Interim Director. Since Ms. Manfredi-Batki’s departure, Jean Reilly MSW, the Project’s Associate Director has served as Interim Director.

*Associate Director/Case Management Coordinator:* This position was originally filled by Maizie Shaw who remained with SHS until late 2002. Anne Knittel was hired in December 2002 and remained with the project until July 2003. Jean Reilly, MSW/LMSW was hired in November 2003 and remains with the project.

*Consortium Coordinator:* Marissa Mims replaced Arethea Brown in November 2001. Ms. Mims resigned in December 2002 and was replaced by Ana Schulman in early 2003. Ms. Schulman unexpectedly resigned in July 2003 and was replaced in December 2003 by Pam Boea, who remains with the project.

*Outreach Coordinator:* Barbara Bourgeois left the project in mid-2001 and was replaced by Florence Schweitzer in August 2001. Ms. Schweitzer left in 2002, and was replaced by Anne Young Packham who served from October 2002 until March 2003. Stacey Barone accepted the position in April 2003 and remains with the project.

*Health Education Coordinator:* Karen Dygert became coordinator of the Health Education Model in 2001. She left the Project in February 2003. She was replaced by Anne Andrianos in mid 2003.


**Distribution of funds**
The Project Director met with the OCHD Fiscal Officer and the project’s assigned Accountant on a monthly basis, for the overall fiscal management of the project. As expected, as a component of the grant, all major fiscal decisions were discussed with the Consortium Executive
Council. Additionally, the Project Director met with OCHD Senior Administrative staff on a monthly basis to keep them apprised of the project and any budgetary issues.

**Additional resources**
With our community partners we applied for a variety of grants, to complement and supplement the funds from Healthy Start. (listed in Part II, Sustainability).

**Cultural competency of contractors and project staff**
SHS is very conscious of cultural competency of staff and ensuring that grant employees reflected the community that we serve. At all levels, and particularly those that directly involve the community, staff is diverse and exceptional care is taken underscore the importance of diverse voices within the Consortium and Executive Council.

In 2004, the SHS Evaluator, Kim Jaffee, completed a Multi-Cultural Competency Assessment for Organizations Study. The tool used was adapted from HRSA “Cultural Competence Works.” Recommendations from the study included offering cultural competency training to all staff, including subcontractors, and implementing recruitment and retention policies that promote a diverse workforce.

SHS also looks for opportunities both internally and within the provider community to enhance cultural competency and diversity. The 2003-2004 Speaker Series on Elimination of Health Disparities (described elsewhere) sought to bring an enhanced understanding of health disparities and health outcomes for both the community at large and for SHS and partner organizations. Information from the Institute of Medicines’ report, *Unequal Treatment*, shaped many of the topics addressed in the series.

SHS intends to continue to address issues of cultural competency and plans to implement training for health care providers who serve the SHS population in the next grant period.

**IV. PROJECT ACCOMPLISHMENTS**

Significant improvements have been seen in a number of areas including: increased receipt of early and adequate prenatal care, reduced smoking during pregnancy, increased WIC utilization, and reduced repeat pregnancies among women under age 18. The following is a narrative description of the project’s major accomplishments in the core services of Outreach, Case Management, Health Education, and Depression. Each section details the activity, lessons learned and any barriers we dealt with during implementation. Attached to this report, in Attachment I is a Status Report/Implementation Plan, which lists major accomplishments by Objective, Strategy and Progress.

**Outreach**
Penetration rate in high poverty communities
The table on the next page reports Syracuse Healthy Start penetration rates, and race, ethnicity and poverty data from the 2000 Census, by zip code. Syracuse Healthy Start enrolls the highest proportion of eligible women from zip codes with the greatest proportions of racial and ethnic minorities. The highest penetration rates are for zip codes where at least 50% of the population
is black, or where more than 9% of the population is Hispanic. Enrollment of eligible women into SHS is also higher in zip codes with high poverty rates.

<table>
<thead>
<tr>
<th>Zip code</th>
<th>% Black*</th>
<th>% Hispanic* (of any race)</th>
<th>% Below Poverty Level**</th>
<th>SHS Penetration Rate ***</th>
</tr>
</thead>
<tbody>
<tr>
<td>13202</td>
<td>58.0</td>
<td>9.4</td>
<td>52.4</td>
<td>37.4%</td>
</tr>
<tr>
<td>13203</td>
<td>14.0</td>
<td>4.0</td>
<td>24.3</td>
<td>24.4%</td>
</tr>
<tr>
<td>13204</td>
<td>22.2</td>
<td>13.5</td>
<td>34.6</td>
<td>35.0%</td>
</tr>
<tr>
<td>13205</td>
<td>50.4</td>
<td>3.2</td>
<td>25.9</td>
<td>40.9%</td>
</tr>
<tr>
<td>13206</td>
<td>6.6</td>
<td>2.4</td>
<td>16.0</td>
<td>17.9%</td>
</tr>
<tr>
<td>13207</td>
<td>33.3</td>
<td>4.2</td>
<td>18.3</td>
<td>28.2%</td>
</tr>
<tr>
<td>13208</td>
<td>6.9</td>
<td>3.1</td>
<td>20.0</td>
<td>26.8%</td>
</tr>
<tr>
<td>13210 ~</td>
<td>22.1</td>
<td>4.4</td>
<td>40.7</td>
<td>24.0%</td>
</tr>
<tr>
<td>13224</td>
<td>36.7</td>
<td>3.2</td>
<td>13.5</td>
<td>12.8%</td>
</tr>
</tbody>
</table>

*Source: U.S. Census Bureau, Census 2000 Summary File1.
**Source: U.S. Census Bureau, Census 2000 Summary File3.
***Penetration rates are based on the linked SPDS-SHS Registry file (77% match rate), and are underestimates of the true rates. These rates reflect the proportion of women residing in the target zip codes, who delivered live infants in 2004, and are in the SHS Registry.
~ This zip code is made up of predominately Syracuse University Students and one public housing complex

Community Events
In recent years SHS successfully **collaborated with faith-based organizations** to reach and engage community residents. The partnership between SHS and HOPE Worldwide yielded great success. HOPE Worldwide is a faith-based charity founded in 1991 by the International Churches of Christ. Its non-sectarian programs serve disadvantaged children and the elderly by providing education and medical services throughout the United States and in developing countries. Over 80 HOPE Worldwide volunteers assisted SHS in coordinating and executing three community-wide health fairs aimed at engaging and educating consumers. The events were held in a west-side neighborhood identified via census data to have high rates of poverty, gang violence, drug activity, teen pregnancy and infant mortality. Residents are predominately African-American and Hispanic. A week before each event, HOPE volunteers and SHS staff canvassed surrounding neighborhoods offering invitations to the upcoming festivities and leaving residents with health related materials written in both English and Spanish. Over 1000 residents were reached in a four-hour period. Over 225 community members (adults) participated in these events.

It was noted that the first event brought out predominately families who were not SHS eligible (e.g., not pregnant, older children). Since the initial event in 2004 we shifted to a baby shower theme to attract more pregnant women and families with infants. We also modified the way we marketed the events. In addition to the door-to-door campaign, we notified local doctor’s offices (specifically OB/GYN, family practitioners, and pediatricians), WIC, and left flyers at places where families with young children may visit (e.g., laundromats, grocery stores, restaurants, and libraries).
### Media Outreach

Widespread media campaigns were launched in 2001 and in 2003. OCHD has had a long-standing relationship with the local ABC affiliate, WIXT. The rating for the evening news is the highest in the city of Syracuse. Airtime was purchased to highlight a plethora of important health related issues. During July-September 2003 SHS was highlighted during the prenatal health campaign. In July, “The Prenatal Care Video” was played on the station as a public service announcement. This two-minute video stressed the importance of receiving prenatal care for the health of the mother-to-be and the baby. This video ran throughout the day for the purposes of capturing the at-home mom, the teenage girl and the working woman.

In August 2003 a mock home visit was aired during the evening news broadcast. Cameras followed the Director of Women’s Health on a visit with a female program participant. During the interview, the Director asked general health questions of the program participant and her infant daughter. The participant also shared that being involved in the SHS program benefited her new family. After the segment viewers were encouraged to call the station if they wanted to enroll in the program. SHS staff were available to answer the incoming calls. Other SHS staff appeared in specialty segments on healthy childbearing, including a segment on preparation of nutritious meals during pregnancy.

In September 2003, the SHS Project Director was interviewed during the morning show, “Daybreak” and the PBS affiliate show entitled “Hour CNY.” The following issues were discussed during the interview:

- State of infant mortality in the city of Syracuse
- Purpose of the National Healthy Start Program
- Services provided by Syracuse Healthy Start
- How to register for Healthy Start services
- How to get involved in Healthy Start as an interested community member
- Healthy Start’s upcoming event

As a result of the media campaign, the community at large was educated about the issues of infant mortality and poor birth outcomes, and were welcomed to participate in the Healthy Start Consortium.

### SIDS Risk Reduction Project

In 2001 the SID Outreach Coalition was formed to address the growing number of SIDS deaths. Representatives from New York State Center for Sudden Infant Death Syndrome, Onondaga County Child Care Council, SHS, and Success By 6 were part of the initial work group. Early in 2001 the group reviewed health messages on SIDS risk reduction, and disseminated recommended health messages throughout the health and human services organizations in order to promote accuracy of education. The group then embarked on a campaign to encourage health care providers to discuss SIDS risk reduction with their patients. A survey entitled, “The CNY Physician Survey”, was distributed to obstetricians, family practitioners, and pediatricians throughout the region. Of the approximately 100 providers (21.3% obstetricians, 26.6% family practitioners, and 52.1% pediatricians) who returned the survey, 21% incorrectly stated the safest
sleeping position for infants, 25% did not routinely talk about SIDS and 38% did not provide written information about SIDS.

In response to these findings, the work group reached out to the SHS Social Marketing Committee to help create resources for area physicians. The Social Marketing Committee conducted four focus groups. The focus group participants aided in the development of a SIDS resource packet that has been sent to physicians’ office since 2004. The resource packet includes information describing SIDS, SIDS prevention measures and a consumer-friendly pamphlet that encourages patients ask their doctors questions about SIDS. In addition, members of the SID Outreach Coalition conduct on-site provider education. To date 10 provider’s offices have received in-service information, and have ordered new supplies of the SIDS informational packets. The Coalition plans to do a follow up survey of providers in 2005-2006.

**Dental Collaborative**

Access to dental care for Medicaid recipients has been a long-standing problem in the Syracuse community. Few providers have been willing to accept patients on Medicaid and waiting lists can be long at local dental clinics especially for preventive care. In light of research that shows a correlation between preterm labor and periodontal disease, SHS has consistently encouraged program participants to seek dental care.

Through the efforts of the Inservice Coordinator at CMATCH, agreements between the prenatal programs and the dental clinic at University Health Care Center (UHCC) were developed that provide for referral and services between both programs. Referral processes have been formulated which include improved communication and feedback between the service areas. Prenatal patients at UHCC now have access to both preventive and acute dental care services.

**Case Management**

**Prenatal Services to Incarcerated Women**

Pregnant women in jail are an especially high-risk population because many incarcerated women have lifestyles replete with high-risk behaviors such as substance use, risky sexual behaviors, and/or unstable living environments. Until 2001, pregnant inmates at the county jail or penitentiary were transported to an outside clinic for prenatal care. This meant they were required to attend their appointments in an orange jumpsuit wearing shackles and potentially wait for hours before being seen. As a result, many pregnant inmates refused needed services. Since 2001, OCHD has provided obstetrical services on-site at both facilities. In addition, all incarcerated pregnant women received case management services, including visits during their incarceration and home visiting after release. While this portion of our project has small numbers, SHS is pleased with results to date. Anecdotally, case manager involved with the program has shared positive stories of women who have remained clean and sober and have delivered full-term, healthy, drug free babies.

In the first year of the program, the OCHD Director of Women’s Health Services provided care to 77 percent of women incarcerated more than seven days. PHT nurses contacted 71.7% of the women and provided services to 47%. Incarcerated women who received PHT services delivered babies at an average gestational age of 38.3 weeks and 3066 grams.
Family Life Teams (FLT) are fully described in Section II, Case Management. This partnership between the Syracuse City School District, Public Health Teams and The Salvation Army TASA program dates back to 1998. PHNs and TASA case managers are stationed in all city high schools and middle schools. Statistics from the (draft) 2005 Family Life Team Report (See Appendix A-3) document the success of this collaboration. Since the school year 2000-2001 the participation rate increased from 65% of all pregnant and parenting students to 82% (2004-2005). Of these students, 42% received both nursing and social case management services. During the 2004-2005 school year, there were 106 babies born; 96 (91%) weighed over 2500 grams at birth. Low birthweight in this population has been declining consistently since implementation of this program.

In addition to case management services, FLT actively partner with WIC and Family Planning Service to provide interconceptional care targeted to adolescents. The objectives are to promote students to enter and receive early prenatal care, enroll in WIC, and to receive other needed preventative health and psychosocial services.

Supplementary activities
Throughout the last four years SHS conducted activities to support the core case management services. “Ladies Afternoon Out”, Literacy Book Campaign and the Intervention Evaluation are examples of activities that were specifically provided for SHS program participants.

• In May 2004, SHS program participants were invited to a “Ladies Afternoon Out.” This was an afternoon of pampering for a program participant and a friend. This objective of this activity was twofold: To educate women on the importance of relaxation, self care and how stress affects a person’s body; To introduce other women to the SHS program. The women received free cookbooks, information on folic acid, breast self-exam, 15-minute massages; stress reduction and relaxation techniques offered by Doulas of Central NY, makeovers with Mary Kay products, and attended a demonstration of quick fresh fruit recipes. In addition, representatives from major health service providers (Syracuse Community Health Center, Lead Poisoning Program, Perinatal Center) distributed incentive items and answered questions.

• In 2003 SHS distributed new children’s books to program participants and encouraged parents to obtain library cards. The books that were chosen for the give-away, Good Night Moon, Guess How Much I Love You and Let’s Count Baby, were selected with the input of the fathers who were involved in the Fatherhood case management program. The Literacy Book Campaign gave away 1,200 new books to SHS families.

• SHS has had some increased success by engaging emerging populations through Catholic Charities extensive service base, including their refugee resettlement program. The Case Manager from Catholic Charities Alliance program has developed a group education program for new Somalian mothers. She has engaged participants from her case management caseload and devised a seven-week program on prenatal and parenting education. This is provided at participant’s homes with guest speakers on specific topics.
and with a stipend paid to one of the women to act as a translator. This project has been small but successful and has contributed to cross-cultural learning.

Health Education

Family Planning Postpartum Program
Crouse Hospital is the regional high-risk maternity center. Approximately 3,800 babies deliver there a year, an average of eleven babies a day. In the first years of the grant, collaboration with Syracuse Model Neighborhood Faculty’s Family Planning (SMNF) and Crouse Hospital linked new mothers with family planning services. SMNF staff visited newly delivered women in Crouse Hospital and provided education regarding reproductive and infant health care and linked them with postpartum family planning services and Healthy Start Services. Linguistically appropriate educational materials were provided and follow-up appointments were scheduled, either in the home or by telephone. In 2002, staff provided more than 600 women with postpartum counseling services, of these 73% was to teens. This program ended in mid 2005 due to other staffing needs, according to the Director of Family Planning Service.

During the nurse managers’ meetings, staff from Crouse Hospital and SHS sub-contractors expressed concern that a considerable number of newly delivered women were not receiving referrals for services. After consultation and planning with hospital staff, OCHD administration and Director of Public Health Nursing, the SHS Public Health Fellow began providing health education in the hospital to women identified by Crouse staff. During the one-on-one hospital visits SHS reviewed important upcoming medical appointments, safe sleeping environment for new baby, family planning, breastfeeding, and related SHS services. In the first two months of this project (April and May 2005), 34 women were visited by SHS staff.

Miracle Continuity Elective
The Miracle Continuity Elective was co-sponsored by SHS and SUNY Upstate Medical University. First year medical students were paired with a family receiving prenatal care at the University care sites. Students and families met at prenatal visits, home visits and during postpartum stays.

Throughout the project cycle 80 medical students visited with 40 families who delivered 40 healthy babies. In April 2005 at the annual New York State Perinatal Association (NYSPA) Conference SHS Obstetrical Advisor delivered a presentation on the Miracle Elective to 50 conference attendees.

In-service Provider Education
The goal of the in-service education component is to reach providers with consistent health messages, introduce community resources, and interventions for identified risks associated with low-birth weight and infant mortality. CMATCH has compiled a database of approximately 300 Syracuse-area medical and human service providers so that these individuals can be contacted efficiently with any new information and upcoming in-services. SHS staff conducts annual provider “Tours” which include on-site educational in-services, presentations at Gynecology and Pediatric Grand Rounds and a newsletter sent to all providers on the CMATCH database. CMATCH Health Educational Tours were:
2000: Smoking During Pregnancy
2001: Perinatal Substance Abuse and Breastfeeding
2002: Family Violence
2003: Perinatal Depression
2004: POP Sonogram (Prenatal Opportunities for Parenting) and Pre-term Labor
2005: SIDS

In 2004 and 2005, SHS Obstetrical Consultant, and the OCHD Commissioner and SHS Principal Investigator, individually presented lectures at Grand Rounds on the importance of medical providers conducting preconceptional and interconceptional care and counseling to area hospital medical residence and other hospital staff.

In late 2004, the Mental Health Committee reached out to individual mental health providers to attend the committee meeting and help provide insight into access issues in the Syracuse community. As a result of this outreach, two practitioners with training in Eye Movement Desensitization and Reprocessing (EMDR) volunteered to provide a case management in-service on “Soothing Techniques for: Workers, Parents and Kids.” The facilitators taught the participants simple alternative soothing techniques parents could use with themselves and their children. Thirty-five human service providers attended the session. Participants commented that it was refreshing to learn alternative calming techniques that they could in turn teach their clients/patients. Follow-up evaluations completed 90 days after the event indicated that those who responded found the event useful and had been able to incorporate the techniques into their work with clients.

Doctors in Communities
In 2003, SHS conducted two interactive health education sessions called “Doctors in Communities.” Health care providers volunteered their time and conducted sessions on women’s health, pediatric care, and general wellness issues. These sessions were built upon existing community activities that occur at churches, in order to focus on neighborhoods with the highest incidence of Infant Mortality.

These informal intimate gatherings were a way to accomplish community level education. The 25 community residents who attended the sessions were able to ask questions of a medical doctor that may have gone unasked during a regimented medical visit. The strategic purpose of these sessions was to allow medical providers and community members alike to assume ownership for the community’s health and well being, especially as it related to decreasing infant mortality rates and reducing racial/ethnic disparities in health status. SHS continues to collaborate with community faith-based leaders when planning outreach events.

Elimination of Health Status Disparities Speaker Series
In an effort to respond to the theme of funding: Elimination of Health Status Disparities, SHS conceived and implemented a Speaker Series with nationally and internationally known experts in areas of maternal and child health (MCH) and/or disparities. The goals of the Series were to:
- Increase awareness of SHS
• Mobilize community members at all levels to own the persistent gaps in MCH outcomes among racial/ethnic subgroups, especially among African Americans, as compared to white infants
• Provide state-of-the-art education to community members at the grassroots and professional levels
• Develop long-term strategic planning for SHS, including sustainability efforts.

The Series was designed to have four levels of audience participation.
• Community Level. SHS partnered with local churches in areas to host the Speaker for a consortium/community evening event. Childcare, transportation and dinner were provided. The invited speaker was asked to design an interactive presentation whereby community members could participate in a safe and comfortable environment. A total of 227 community members attended these evening events.
• Professional level. Doctors, nurse, social workers, the clergy, other allied health professionals, among others, were invited to a breakfast gathering. Continuing education credits were offered to social workers, doctors, and nurses. A total of 600 professionals and paraprofessionals participated in the breakfast gathering.
• Key policy makers, civic leaders and SHS staff were invited to a luncheon to discuss strategic approaches to working toward eliminating disparities. A total of 108 representatives were present at the luncheons.
• Onondaga County Health Department staff. Contact hours or continuing education credits were offered for nurses. The Series presented an opportunity for sustainable staff development. A total of 150 SHS and county employees attended these sessions.

The Speaker sessions are summarized briefly as follows:
• September 2003: **Dr. Michael Lu** from UCLA discussed “Why Are so Many of our Babies Dying?” Dr. Lu discussed our moral responsibility as a nation and as a locality to bring equity to all segments of our society. An article and editorial ran in the local newspaper as a result of Dr. Lu’s presentations highlighting Syracuse Infant Mortality Rate (Appendix B-1).
• November 2003: **Dr. Vijaya Hogan** of UNC-Chapel Hill discussed was “Bacterial Vaginosis Screening” She discussed the implication of bacterial vaginosis (BV) in health status disparities between African American and Caucasian women.
• February 2004: **Dr. Karla Damus** of Albert Einstein College of Medicine and the March of Dimes discussed the National Prematurity Campaign and heralded a local call to action. The exchange of ideas during the luncheon discussion shaped many of our approaches to interconceptional care during the latter part of the funding cycle. Dr. Damus presented a March of Dimes module which offered nursing staff Continued Education Units/Credits.
• May 2004: **Dr. Thomas LaVeist** of Johns Hopkins University discussed racial disparities and the role of trust in healthcare.

• June 2004: **Dr. Brian Smedley**, of Institute of Medicine (IOM) presented some insight on the Unequal Treatment report findings. One hundred and sixteen professionals attended the luncheon gathering. (Due to Dr. Smedley’s schedule he was unable to conduct evening and breakfast sessions.)

• September 2004: **Dr. Camara Jones** of the Centers for Disease Control and Prevention discussed the impacts of racism in health care and the lost of potential to the nation and the world.

In addition to the Speaker series, SHS applied for and received a HRSA-sponsored Technical Assistance visit from **Dr. Ira Chasnoff** of the Children’s Research Triangle and University of Illinois-College of Medicine. In May 2004, Dr. Chasnoff conducted six separate sessions to different levels of participants. A total of 287 consumers, physicians, and human service providers attended the sessions which included:

• Policy Discussion with Civic Leaders, County Government (21 participants)
• Physicians’ Luncheon, including pediatricians, obstetricians and family practitioners (17 participants)
• Perinatal Substance Abuse Committee which also included invited guests from child welfare, substance abuse services (20 participants)
• Evening Consumer Event: Dr Chasnoff’s presentation focused on infants affected by substance use and how parents could advocate for those children within the school system. 52 consumers attended.
• Two in-service sessions for case managers and social service staff entitled: “Special Treatment Needs of Substance Using Women and Why Traditional Male Focused Treatment Modalities are Less Effective with Women” and “Strategies Related to How to Address the Needs of Children Affected by Prenatal Drug Exposure.” A total of 179 attended the two sessions.

**Baby Friendly Hospital Initiative (BFHI)**
Since its inception in 1999 SHS has been a supporter of the BFHI. BFHI is a global program sponsored by the World Health Organization and the United Nations Children’s Fund (UNICEF) to encourage and recognize hospitals and birthing centers that offer an optimal level of care for lactation. The BFHI assists hospitals in giving breastfeeding mothers the information, confidence, and skills needed to successfully initiate and continue breastfeeding their babies and gives special recognition to hospitals that have done so.

The SHS Inservice Educator provided facilitation of the BFHI group. This helped to prevent any potential difficulties related to turf issues since the Inservice Educator was not affiliated with a birth hospital. Initially, the group concentrated on public outreach and media campaigns. A significant accomplishment took place in August 2004, during World Breastfeeding Week; representatives from all three local birth hospitals and a variety of local health and human service organizations met to discuss the National Breastfeeding Campaign. As a result of this meeting, letters were sent to all the local media outlets informing them of the campaign and strongly
encouraged each to play or display Public Service Announcements that were produced by the U.S. Department of Health and Human Services and the Ad Council.

Undoubtedly the most significant achievement of the BFHI was the development of uniform breastfeeding policies at all three local birth hospitals. Prior to this each hospital had individual policies which varied, creating confusion for the physicians who practiced at more than one hospital. By coming together to create a uniform policy, the three birth hospitals met Step 1 of the 10-Steps that Baby Friendly USA requires for Baby Friendly Designation. In 2004, St. Joseph’s Hospital and Health Care Center achieved another step in the process by creating their own discharge diaper bag. This bag is not affiliated with a formula manufacturer and is filled by hospital staff with appropriate supplies for each new mother as needed.

SHS also conducted staff training in support of BFHI policies. Most recently, in March 2005, the Health Education Coordinator facilitated training to case managers on how to support women in choosing and maintaining breastfeeding.

**Paternal and Child Health/Fatherhood Initiatives**

During 2002-2004 SHS directed consumer health education toward fathers. This education emphasized key messages such as breastfeeding promotion, SIDS risk reduction, shaken baby syndrome, and domestic violence. The overall goal was to increase the male partner’s awareness of and involvement in the health care needs of women and infants. As a part of this health education, each summer SHS co-sponsored an annual *MaleCall* Conference, and began the *POP Sonogram* initiative.

The *MaleCall* Conference is designed to empower and educate males in the community on paternal and child wellness issues. This conference featured speakers on gun and gang violence and other serious topics and health related issues. In March 2005 the event drew over 60 males between the ages of 16 and 26. Presentations were made on violence, sexually transmitted diseases, poverty and abuse.

The *POP Ultrasound* is a Prenatal Opportunity for Parenting Initiative, which promotes a father’s active participation in his child’s life from the onset of pregnancy. The initiative uses the prenatal ultrasound as a tool to encourage optimal prenatal parenting. CMATCH conducted annual on-site education for providers and stressed the importance of using appropriate language and the use of fetal models to illustrate the development of the fetus. SHS developed a pamphlet for distribution to the father which discussed the following:

- Pregnancy and Fatherhood
- Preparing for Birth
- Labor and Delivery
- Prenatal Parenting

**Depression**

In 2001 Onondaga County Health Department and SHS Executive Council applied for HRSA funding entitled “Improving Women’s Health through Screening and Intervention for Depression During and Around the Time of Pregnancy.” This grant was awarded with no financial allocation; however, SHS used the model proposed by the grant to offer as many of the
interventions as possible. Through the use of the CAF, depression screening questions were asked of 100% of program participants. The PHSW provided additional evaluation and counseling to those who had a positive response to the screening questions (approximately 15% see Form 9). This data corresponds to national estimates that between 10 and 20 percent of women experience depression during pregnancy and the postpartum period.

Other
With funding from the CDC, SHS conducted a chart review to examine the use of two interventions recommended during in-services. Bacterial Vaginosis (BV) screenings and the use of the smoking cessation program Make Yours a Fresh Start Family were chosen because both BV and smoking are leading causes of prematurity. Approximately 3,300 charts of hospital records, prenatal medical records and laboratory records were reviewed. The BV portion of the review consisted of 23 unique character identifiers (such as race/ethnic origin, previous spontaneous abortions, highest grade completed, payment source, smoking while pregnant, drug and alcohol history, occupation, WIC enrollment, pre-pregnancy weight, height, delivery type, complications in labor, abnormal conditions of newborn, etc). The data extrapolated for the smoking cessation portion of the chart review were: stages of readiness to quit, number of cigarettes smoked per day, years of smoking and counseling provided.

V. IMPACT

A. Systems of care – collaborative interaction among organizations and services involved in promoting maternal and infant health and social support services

1. Approaches used to enhance collaboration
SHS believes that change in social systems can only be implemented by engaging the entire community and developing a community-wide ownership and commitment for change. SHS has worked cooperatively with multiple organizations involved in maternal and infant health and social support services throughout the funding period. All community-wide SHS sponsored events are inclusive in that all community members are encouraged to attend regardless of affiliation. SHS worked in collaboration with multiple groups to bring positive health care messages to the community, improve access to health care and decrease fragmentation of services.

Project efforts are supported through co-sponsorship of events and shared in-services. In order to generate interest and attendance, invitations are sent to both traditional and non-traditional providers. All SHS committees are open to participants from within SHS, partner agencies and consumers.

Key examples of this approach are the Speaker Series on Health Care Disparities and the technical assistance visit in 2004 of Dr. Ira Chasnoff. As previously described, efforts are made to engage all levels of the community in the event. The mailing list was developed strategically by considering all constituencies we wished to engage. This included grassroots organizations (e.g., service organizations, faith-based initiatives, social change organizations such as the Alcohol Advertising Reform Initiative), local elected officials, representatives from higher education, law enforcement, and the judicial system. The Speaker Series was a broadly based
plan to bring information on health disparities to the entire Syracuse community. Information brought by the Speakers was challenging, especially when participants were asked to look at levels of racism and its effects. This effort continues to prompt dialogue among participants. At a recent training session, one attendee stated that she had learned of SHS through the Series and attending had changed her perceptions to the point that she is changing her career path to look for ways to ameliorate health disparities.

Dr. Chasnoff’s technical assistance visit was developed as a collaborative effort with the members of the Perinatal Substance Abuse Committee. This committee includes representatives from the Health Department, SHS sub-contractors, physicians, perinatal social workers and nurses, substance abuse program administrators. Decisions regarding the design of the visit were made collaboratively, invitations were widely sent with sessions were designed to fit each constituency’s interests. The first session was with local government and civic leaders. Attending were: representatives of the County Executive’s office, Health Commissioner and other OCHD administrators, Special Children’s Services/Early Intervention, Department of Mental Health, CEO of SCHC, president of Syracuse Behavioral Health (substance abuse), Child Protective/Child Welfare services, Probation, Chair of the County Legislature Health Committee, and the Director of the Perinatal Network in Broome County. Other sessions included a Physicians’ Luncheon (attendees included pediatricians, obstetricians and family practitioners), Perinatal Substance Abuse Committee, an evening event with consumers, and two training sessions for case managers.

Dr. Chasnoff’s visit helped the perinatal substance committee refocus on established goals and objectives. Many of the committee members were the same individuals who attended training at Children’s Research Triangle in 2000. Some of the recommendations from that training had since been implemented in the Syracuse community, such as use of the “4P’s Plus” in both the case management and the prenatal programs. The Substance Abuse Committee continued to grapple with implementing needed services throughout the funding cycle and continued to campaign for an inpatient rehabilitation facility for pregnant women and their children. A Best Practices recommendation for screening and testing was disseminated in 2003. (See Appendix A-4).

SHS has participated in a number of community-wide coalitions and their related campaigns, such as the Domestic Violence Coalition’s family violence campaign and design of poster and Success by 6’s various campaigns.

SHS also participated on a number of community-wide coalitions and their related campaigns, such as the Domestic Violence Coalition’s family violence campaign and design of poster and Success by 6’s various campaigns.

SHS consistently included maternal and infant health and social support service providers in all SHS-sponsored events. These events have included baby showers, health fairs and “Ladies
Afternoon Out” events. This has allowed these services to promote their programs to SHS clients and helped engage participants in a wide range of services to promote positive health practices.

2. Identify Structured changes (procedures or policies) established for purpose of system integration

As described elsewhere in this report, SHS worked to promote community-wide systems change through a variety of methods. We engaged both health and human service providers in efforts to provide the same screening and interventions across disciplines. The Aubry Prenatal Summary (Aubry Tool) was designed by the SHS Obstetrical Advisor, Dr. Richard Aubry, to help increase providers’ consistency in provision of care across the community. The Aubry Tool was revised twice during the funding period in order to improve screening services. In 2001-2002 the form was amended as follows: 1) the self-administered page is now literacy-level appropriate; 2) two questions address domestic violence and 3) five questions (4 Ps+) address substance abuse. In 2002-2003, a Behavioral Insert was added to include assessment and screening for smoking cessation, alcohol and drug use, family violence, and depression. The “Aubry Tool” is used by many of the major prenatal providers in Syracuse, including the Perinatal Center, Women’s Health Services, Syracuse Community Health Center, all PCARE contracted providers. These same screening areas are incorporated into Case Management assessment, providing integration across provider disciplines.

As described in Section II, Health Education Model, SHS seeks to ensure widespread dissemination of best practice recommendations via the SHS Newsletter, presentations to providers, grand rounds and community wide events. An up-to-date database of over 300 community health and human service providers was developed and maintained by CMATCH.

There were instances in which Healthy Start programming led to changes in the delivery of services. Dr. Karla Damus’s presentation for the Speaker Series included information about new approaches for group prenatal care, including CenteringPregnancy. As a result of her suggestion, the Associate Project Director and the Health Education Coordinator attended training on CenteringPregnancy and shared this information with number of providers in the Syracuse. In short time, one of the major obstetrical providers, Partners in OB/GYN, expressed interest in developing a Centering program. This group practice is a major contractor with the OCHD Pregnancy CARE program, providing care to almost 40% of Pregnancy CARE enrollees. SHS staff assisted writing grant proposals from the March of Dimes and the Allyn Foundation to provide start-up funding. Once the grants were approved, Partners and Family Ties Network sponsored a local CenteringPregnancy training in March 2005. Additional prenatal care providers (Upstate Women’s Health, Syracuse Community Health Center) attended and are considering offering the model. Partners in OB/GYN began providing Centering care in the summer of 2005.

Case Management providers had access to the same training programs, including the FDC and monthly inservice education. All case management providers followed the same guidelines, used the same Client Assessment Form (CAF) and delivered comparable services. In 2004 the SRA was redesigned to improve data collection and analysis. There are a number of positive outcomes from this change. The CAF is completed at specific intervals, therefore allowing for
measurement of change. Both HRSA reporting requirements of other funders of the case management programs were incorporated into the form, thus, case management agencies and individual case managers viewed the form as a benefit since it decreased paperwork. Lastly, and of great importance, the name of the form was changed at the request of the case managers. They believed that calling the form a “risk” assessment did not allow for focus on participant’s strengths. This request was a powerful indicator that case managers had incorporated the strengths-based approach of SHS’s case management model into their day-to-day work with participants.

In addition to the above, a set of minimum expectations for the case management programs was developed in 2002. These “Benchmarks” for case management were based on extensive review of the literature, local data and with the consensus of all case management supervisors. These benchmarks were written into the Scope of Services for each case management sub-contract, and progress toward attainment was reviewed through quarterly chart audits.

SHS has achieved considerable progress toward consistency across systems. An example is the smoking cessation intervention, Make Yours a Fresh Start Family. As a result of SHS efforts, a pregnant woman will receive screening questions and intervention from the office nurse at her obstetrical provider’s office, from her obstetrician, from her WIC nutritionist, from her case manager during a home visit and potentially her hairdresser. She may also see a SHS television ad about the risks of smoking during pregnancy. As part of our interest in ensuring the efficacy of our interventions, SHS quality improvement project for 2005 was an assessment of the results of our smoking cessation effort. Matching the birth certificate information from the Statewide Perinatal Data System (SPDS) with the SHS registry provided a means to compare between SHS participants and non-SHS participants. Results indicated that SHS participants are ten percentage points more likely to decrease their smoking by at least 50% than non-participants (73% participants vs. 63% non-participants).

Under the direction of the OCHD Commissioner, the Directors of WIC, Family Planning and the Public Health Teams developed internal policies and procedures to ensure that no woman would “fall through the cracks” between services. It has been our experience that even women who are “difficult to reach” are likely to keep WIC appointments. OCHD determined to use that to advantage. Over the course of the 2004 project year, procedures were established to ensure that WIC participants were routinely given information about family planning and, as needed, a scheduled appointment for family planning services. In addition, follow-up procedures were established that included use of Community Health Workers to ensure follow-up to individuals who missed family planning appointments. Reciprocal procedures to ensure follow-up were established between Family Planning, WIC, and Public Health Teams. Family Life Teams in the high schools and middle schools were also utilized in order to ensure that there were no gaps. Adolescents at risk for pregnancy were provided with contact information for the nurse who serves their schools. This allowed teens access to a trained professional who could respond to questions in a timely and confidential manner. SHS has found that this partnership has contributed to our decrease in SHS’ repeat teen pregnancy rate.
3. Key relationships that have developed as a result of Healthy Start efforts covering the following areas

a. Among health service agencies; health and social service and w/community-based organizations

SHS has been instrumental in providing a forum whereby individuals representing various entities could sit together and work toward common goals. SHS believes that stronger relationships between and among agencies were forged as a result. (See also Section III, Collaboration). Examples include:

- **SIDS Coalition**: SHS shared recruiting for bereavement groups for communities of color, African American’s in particular.
- **Domestic Violence Coalition**: In partnership with SHS staff, developed a database of practitioners and pilot tested a survey to measure physician beliefs and perceptions about Domestic Violence.
- **Perinatal Substance Abuse**: Promotion of best practices to all prenatal providers and birth hospitals for screening and testing for substance use.
- **Nurse Manager’s meeting**: participants include representatives from post-partum units of birth hospitals, SHS staff, managers of major prenatal clinics, Director of Public Health Nursing, medical providers. Efforts centered on improving interconceptional care.
- **Baby Friendly Hospital Initiative**: All birth hospitals are represented and the group has been led by SHS. This group has made strong collaborative inroads toward obtaining “Baby-Friendly” status.
- **Outreach to Crouse Hospital’s** post-partum unit has lead to improved relationships with Crouse, and invitation for SHS staff to participate in a Childbirth Education teaching day
- **Child Fatality Review Team**: The Onondaga County Medical Examiner’s Office has coordinated a Child Fatality Review Team since 1996. Members of the Team include representatives from SHS, the Department of Social Services, NYS Regional Office of Child and Family Services, Onondaga County Health Department, Onondaga County Department of Mental Health, Office of the District Attorney, County and City law enforcement officers, health care providers and community-based organizations devoted to child abuse prevention, domestic violence and infant death.
- **AIDS Community Resources** has been a strong collaborator with the Neighborhood Outreach Project. This has been an extraordinary opportunity for both programs and has allowed us to explore the intersect between HIV prevention and promoting healthy childbearing.
- **Spanish Action League and SALUD**: Representatives from these organizations who serve the Spanish-speaking population are members of the SHS Consortium and Executive Council.

3b. Relationships that focus on involvement of Consumers/Community Leaders with above organizations

Most SHS committees offered opportunity for consumer and community input. The Executive Council encouraged representation from the Consortium on many SHS committees. This afforded open communication between consumers and many of our partners and linked agencies. In particular, consumer involvement has been integral to development of the projects of the SIDS Outreach Coalition (See Accomplishments, Section IV). A SHS consumer volunteered to use
her newborn as a model for safe sleeping environment photos for the SIDS posters and
Newsletters.

HOPE Worldwide has partnered with SHS on three major events. HOPE has shared its staff, especially its campus ministry director, in event planning with SHS and its partners. HOPE volunteers helped us canvass the community the week before the events to invite individuals, and helped run the events by cooking, leading educational games, and offering educational sessions on topics such as responsible parenting. Many of the HOPE volunteers have also been participants in SHS services. HOPE’s Campus Ministry Director is a member of the Executive Council of the Consortium.

Membership in the SHS Consortium and service on the Executive Council has also helped to promote relationships. The Consortium and Executive Council have a diversity of membership from medical providers, social service providers, faith-based organizations, community leaders and consumers. Working toward common goals has increased working relationships and trust between these diverse constituencies.

As previously mentioned, the Speaker Series on Health Disparities was attended by non-health and human services organizations and individuals. Participants included Central New York Health Systems Agency, the Lung Association, FOCUS Greater Syracuse, American Cancer Society, the Kidney Foundation, InterReligious Council, Alcohol Advertising Reform Initiative, a Criminal Court judge, Dean of the College of Human Services and Health Professions the Syracuse University Chancellor and the Syracuse City Chief of Police.

The February 2004 Baby Shower and the Crouse Outreach Project were supported by donations from area churches. Early in the year, church groups who had previously donated hand knitted or crocheted baby items were approached regarding support of the project. Donations were received from 10 church groups, many of whom send items throughout the year. This has made it possible for all women who have been visited to receive a gift of a hand knit or crocheted blanket (to which a SIDS prevention message is attached) and a hat. This initiative has drawn significant community participation and provides opportunity for woman-to-woman support. To date, SHS has received enough donations to provide blankets for a year. (See Appendix B-2 for news article)

4. Impact project has had on Comprehensiveness of services

a. Eligibility/Intake requirements for health or social services

SHS chose to expand its catchment areas from the Center Syracuse area to the entire city of Syracuse. This changed our pool of potential recipients of services and almost doubled the number of annual births in the project area (from 1200 births per year to 2300 births per year). Since SHS is population-based, there are no eligibility requirements beyond residence in Syracuse and being either pregnant or parenting a child under age two. Entry into the program requires no more than the clients’ signature indicating consent to accept services and have demographic data entered into the Registry.
SHS partners with other providers to ensure that intake requirements for services are simplified whenever possible. Family Planning and Pregnancy CARE are able to complete presumptive Medicaid eligibility applications for all pregnant women, which helps to ensure ease of entry into prenatal care services. Presumptive eligibility for Medicaid has been a NYS-sponsored endeavor for over 10 years. Onondaga County Department of Social Services, under the direction of NYS provides a single application that serves to facilitate eligibility assessment for Food Stamps, Medicaid, Temporary Assistance and Day Care.

Through the case management program, trends, barriers and problems regarding service provisions and eligibility are tracked and monitored. Case managers work closely with medical providers to improve appointment kept rates and to keep participants in prenatal services.

b. (Impact on) Barriers to access and service utilization and community awareness of services

In the spring of 2003, the Public Health Team embarked on a project with the Bureau of Surveillance and Statistics to identify and attempt to locate women in the city of Syracuse who were at risk for future high-risk pregnancies with the possibility of poor birth outcomes. The sources of the risk information were the Statewide Perinatal Data System (SPDS) and the SHS registry. Criteria for identification were evidence-based factors for risk of low birth weight and other sub-optimal birth outcomes. These included established medical and behavioral risks and social and economic determinates of health. Of 336 women identified as high-risk, 109 were reached and interviewed. When comparing sociodemographic characteristics, risk factors and birth outcomes, these 109 women were statistically representative of the 336 who had been identified. Of those identified, 63% were known to SHS and 37% were not known to SHS. Of interest, women with short interpartum spacing or high parity and women with more than two risk factors were less likely to be known to SHS.

Important findings of the survey included:

- 62% of the women interviewed obtained prenatal care in the first trimester
- 29% of the women we interviewed had some disruption of health insurance in the past two years
- 20% reported they changed their health care provider at least once during the last two years
- 25% had previously been referred to public health services, but had refused
- 43% of the Healthy Start and 83% of the non-SHS clients thought they did not think they needed services

Barriers to enrollment were varied and included: consumers’ perceptions of need for care/services; difficulty of casefinding in populations with multiple risk factors (many move frequently and are not socially connected). The study pointed out that consumers at highest risk (e.g. substance abusers, those with mental health issues, short interpartum spacing and late prenatal care seekers) appear to be less likely to enroll in SHS services. These individuals may have a lower degree of connection to the community or support services; thus it may be difficult to identify until they come to the attention of a service provider. Even if identified, these individuals may move before they can be located through outreach services. In addition, the use of cell phones rather than landlines may be contributing to the inability to find these prospective
consumers, since disposable phones are often not in service for an appreciable length of time, adding to the difficulty of successful outreach.

The results of the High Risk Women’s project has stimulated changes in the SHS program such as:

• Initiation of the Neighborhood Outreach Worker Program
• Improved procedures and protocols between Family Planning, Public Health and WIC
• Weekly screening of birth certificate information to identify high-risk women who were not otherwise referred to the project.

These findings were shared at the APHA Annual Meeting in November 2004 by Don Cibula, PhD, OCHD Director Surveillance and Statistics. (See Appendix A-5 & A-6 for interview tool and PowerPoint slides).

c. Care coordination, including descriptions of mechanism implemented to assure continuity of care, quality improvement, follow up system for client referrals

Services to Incarcerated Women: In 2001, the Onondaga County Health Department created a comprehensive program to provide obstetrical care and risk reduction information to pregnant inmates in the Justice Center and the Onondaga County Penitentiary at Jamesville. Bringing care to the inmates improved compliance, and solved the problems of transportation and security needs. The program consists of routine prenatal care, diagnostic obstetric services, Public Health Team visits, HIV testing and counseling and care monitoring. A CAF was completed on all inmates; Syracuse residents were entered into the SHS database. When the women were released they are already part of the SHS system and they continued to be connected with case management services.

Standards of Care for service to incarcerated pregnant women were finalized in 2002. They are as follows:

• Referred to SHS if held for more than 48 hours
• Receive initial prenatal history and physical exam by a physician obstetric provider if held for seven days or more.
• Receive an obstetric ultrasound or have an ultrasound verified through receipt of medical records from another provider if held for seven days or more.
• Receive regular prenatal visits from an OB provider on a schedule recommended by the American College of Obstetrics and Gynecologists and more frequent assessments if urgent conditions arise.

In addition, as noted in the case management section, procedures were modified to promote continuity of care; since early 2005, the same nurse and Community Health Worker have followed participants from incarceration through release into the community. In 2004, 15.1% (13/86) of incarcerated clients accepted services after release; in the first part of 2005, 38.3% (18/47) have accepted services (See Appendix A-7).

Family Life Teams: FLT were developed as a response to the closing of the OCHD/SCSD program for teen mothers, Y-MED. Y-MED, a middle and high school program for pregnant
and parenting teens was closed in 1998 due to decreasing enrollment. FLT were an innovative, collaborative way to provide services to teen mothers on-site in their home schools. (See Section IV Accomplishments)

Other successes in care coordination have been described in previous sections of this report. They include the WIC/PHT/Family Planning collaboration; Family Development Credentialing Curriculum; and the Bacterial Vaginitis grant from the CDC and collaboration between the Dental Clinic and Women’s Health clinics at Upstate Medical University (See section IV).

Under the leadership of Dr. Novick, OCHD has developed a strong quality improvement process. Since 1998, an Annual Quality Improvement Summit has been held. Participation is Department-wide, with collaboration between bureaus and programs on studies. SHS’ study topic for 2005 was “Do Syracuse Healthy Start Participants Reduce their Prenatal Cigarette Consumption More than Non-Participants?” Don Cibula, Director of Surveillance and Statistics, completed this study (See Appendix A-8). Previous topics related to populations served by SHS have included:

- Enhanced interdepartmental referral of adolescents (Family Planning Services, 2004)
- The effect of data sharing with the CNY Immunization Registry on the numbers of children tested for lead (Health Promotion 2004)
- Effectiveness of lead and nutrition education provided to parents/guardians of children with elevated blood levels (Health Promotion 2004)
- Impact of program changes on waiting time to initial pelvic exam (Public Health Teams/PCARE 2004)
- Development of unique partnerships to augment capacity to do outreach and recruitment (Healthy Start, 2003)
- Decreasing non-serviced client rate (Public Health Teams, 2003 & 2004)
- Care and pregnancy outcomes of women who have been incarcerated while pregnant (Justice Center and Jamesville Penitentiary, 2002)
- Establish procedures for developing public health education brochures for reading level, message comprehension and overall appeal (Public Health Education 2001)
- Retention rate of children over one year of age who participated in the WIC Program from birth to one year (WIC 2001)

**d. Efficiency of agency records systems and sharing of data across providers**

SHS uses the same data collection system across all subcontractors. The CAF allows us to collect all data required by HRSA. The CAF has also been used to help sub contractors cut down on their paperwork as they use the form to collect information needed for their other funders.

SHS collaborates with the Department of Social Services ACCESS program. ACCESS was developed in the late 1980’s as a response to the infant mortality crisis in Onondaga County. The program was used to help avoid duplication of services and to ensure that clients needed case management would not be placed on a waiting list at one program while openings existed elsewhere.
As noted previously, many providers are using the Aubry Tool to document the delivery of prenatal care services. This ensures that all clients are screened to both medical and social needs, including substance abuse, domestic violence, depression and smoking. Providers through CNY and in practices in six states, including Kentucky, California, Pennsylvania, Tennessee and Texas, have adopted the Aubry Tool, improving consistency of screening well beyond this project.

A barrier to the sharing of patient information between birth hospitals and prenatal/postpartum providers was identified in late 2004. While prenatal care summaries were shared routinely with the hospital by the prenatal provider, there was no clear mechanism in place to share birth history back to the prenatal clinic. Through the auspices of the Nurse Manager meeting, a meeting was set up with the hospital Medical Records offices, and immediate steps taken to begin to solve the concern.

OCHD has worked to minimize duplication of databases. Funding was secured in 2003 to develop a master database that will be shared with the Public Health Teams and the SHS project. This will provide accurate and up-to-date information on client status.

5. Impact on enhancing client participation in evaluation of service provision in following areas

a. Provider responsibility in maintaining client participation in system & sensitivity to culture, linguistic and gender (especially male) needs

Through the subcontract to SUNY Upstate CMATCH program, SHS has made a significant and extensive effort to educate providers (see section IV). A recent effort is the POP Sonogram – an effort to help practitioners involve fathers in the pregnancy through participation in the sonogram. In addition to educational outreach to medical providers, sonographers were in-serviced regarding the value of father participation and how to engage men during the sonogram itself. This outreach included a SHS Newsletter and Grand Rounds. During the Grand Rounds session, Michael Francis, from AIDS Community Resources Communities of Color initiative and Chair of SHS Fatherhood Committee shared his personal experiences as a father.

The Speaker Series on Health Care Disparities was a year-long effort to help increase practitioners’ understanding of the health disparities in the context of culture and to help providers throughout the community understand the impact of these disparities on the consumers of SHS and other medical and health care services.

Outreach was provided to medical offices and to human services organizations regarding the SHS project, and the multiple approaches to helping women and families achieve positive birth outcomes. Included in these presentations was information on services provided by SHS that can help to decrease provider’s “lost to service” or non-adherence rate. SHS has found that many providers who received outreach appear to be more tuned in to the needs of the consumers and will request follow up from case management or will take phone calls from case management staff – this has lead to improved communication and collaboration. In the first five months of 2005, 82 providers and their staff at six office groups requested and received in-services.
Participation of two physicians in the Consortium Executive Council has helped to form our approach to physician outreach. Dr. Richard Aubry is our obstetrical advisor and also serves on the Council. Dr. Luis Castro is a Family Practitioner who provides medical care at St. Joseph’s Hospital’s West Side Clinic. This clinic serves a significant number of Spanish-speaking participants. Dr. Castro’s participation in Executive Council helped to highlight the needs of the population in that part of the City and changing needs of the populations, especially with emerging immigrant and refugee groups. At Dr. Castro’s request, SHS arranged to have a Spanish-speaking CHW out-stationed at the West Side clinic during prenatal clinic hours. Dr. Castro also delivered in-services to Executive Council, the Regional Perinatal Forum and Family Planning Services, sharing information on delivery of culturally competent services.

**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 and mechanisms**

We had consumer participation on a number of SHS committees, including Fatherhood, Outreach, Health Education, and of course, the Consortium. Concerns and ideas raised in these groups helped to shape decisions regarding projects, interventions and tools. For instance, the Aubry Tool self-administered section was revised to be more "easy to read."

Consumers and community members were invited to participate in the Evaluation Advisory Group. The Evaluation Subcommittee of the Consortium met with the Evaluation Team and provided input in the identification of objectives and feedback on the evaluation report. The Executive Council also provided input on the evaluation report. In addition, the Evaluation Team met with the Consortium Executive Council every six months to assess the enrollment of the SHS participants, compared with women giving birth in the City of Syracuse, thereby including the Consortium in the data collection and reporting process.

The hiring of the Neighborhood Outreach Workers was initiated with consumer and community member input. After consultation with the Executive Council membership, the co-chairs developed a proposal for OCHD to consider hiring neighborhood-based individuals to actively provide outreach to the community. One of the women hired was a former client and member of the Executive Council.

A powerful change was effected with the input of consumers from the SIDS focus group and consumer input. One powerful message came from a consumer who shared that her doctor didn’t want to tell her about SIDS because he didn’t want to “scare her.” A flyer developed by Family Ties and the SIDS Outreach Coalition titled “Knowledge is Power” tells her story.

“Eat To Live,” is a 6-week nutrition program developed by an Executive Council Community Representative. This project was tailored toward improving the nutritional status of low-income women who are pregnant and/parenting and features both shopping, cooking and stress reduction techniques. Women who successfully completed the sessions received gift cards from local supermarkets. Participant evaluations will be used to shape future programming.
In 2004, the SHS Evaluator undertook a Client Satisfaction Survey. The Survey’s aim was to assess levels of client satisfaction with the nature and quality of services received by SHS participants. Respondents were asked about comfort with services, how they were treated by providers, and any perceived differences in treatment by race. The dataset was 1055 participants who were served in 2003. From May – June 2004 a random sample of 556 women was chosen; 92 (14.7%) were interviewed by a telephone survey. Respondents were 58.7% African American, 32.6% white and 5.4% Hispanic. Significantly, over 80% of the 556 could not be located by telephone – either the phone was disconnected or there was no response. The study was limited due to methodology and delays in implementation, which impacted the response rate. However, information gleaned from the study was valuable. Responses worth noting include:

- 96.7% indicated it was easy to make, cancel or reschedule prenatal appointments; and that it was convenient to get to appointments
- 64% had access to their own or a family member’s car for transportation
- On a scale of 1 – 10, 86% ranked their satisfaction with prenatal care at least “8.” No one ranked their satisfaction at less than “5”
- 100% indicated that their providers gave them information on how to take care of themselves during and after their pregnancy
- 85% felt their providers listened carefully to what they had to say
- 98% described office staff as courteous and respectful
- 30% of the consumers completing the survey identified themselves as enrolled in SHS; yet over 66% had received a home visit from a SHS case manager.

Two questions were asked about racial differences in treatment:

- Do you think that people living in Syracuse are treated differently by health care providers depending on what race they are? Yes: 35.9%; No 43.5%; Don’t Know 20.7%
- During prenatal care, were you treated worse than, the same as or better than people of other races? Worse than 2.2%; better than 0%; Same as 97.8%

Some of the findings of the patient satisfaction survey contrast markedly with the findings of the High Risk Women’s Study described earlier in this document. The high-risk women were asked to agree or disagree with the statement “My doctors and their staff are very critical about me and my lifestyle”; 59% disagreed, 41% agreed. Although the populations surveyed are not identical (i.e., the high-risk women’s study was limited to women with specific, identified risks vs. the entire SHS population), the comparison of data can give us clues about creative ways to reach these women. As noted previously, SHS has developed additional methods to try to reach these women.

B. Impact to the Community

Residents – Knowledge of resource/service availability, location, and how to access these resources

SHS Media Campaigns, described in earlier sections of this report, were developed with consideration of the target population’s viewing, reading and listening habits. Radio stations (including broadcasts in Spanish) and television shows that appealed to individuals of
childbearing age were chosen. Print media included a number of free weeklies aimed at young families and city residents.

SHS employed the hotline connected with the Pregnancy CARE program to help individuals access services. The Pregnancy CARE number has a long-standing history in the community and was chosen to be easy to remember (435-2000). This number is publicized for both programs and is displayed on all brochures and flyers for SHS services. At health fairs and through home visiting, individuals were given sturdy canvas bags with the SHS logo and phone number on it. These bags were also used by home visitors and educators on their routes – the phone number and name of SHS is prominently displayed.

Outreach to the community included posting of posters with tear-off phone numbers in local markets, community-based organizations, laundromats and other retail stores. Flyers advertising community-wide events were included in grocery bags in neighborhood markets.

**Consumer participation in establishing or changing standards 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**

Consumers were involved in other ways through attendance at Consortium events, participation in Executive Council meetings and Evaluation Team meetings. The initiation of the NOW program was at the suggestion of the Executive Council. In addition, the Executive Council was instrumental in the relocation of the Project’s administrative staff to the same site as the Public Health Teams in April 2005.

Consumer input was also sought through focus groups. A standout example was the focus group on SIDS education. As a result, there were changes initiated at the provider level regarding dissemination of materials and education messages regarding SIDS prevention.

**Community experience in working with divergent opinions, resolving conflicts, team building**

During the four years of the project, retention of the Consortium Coordinator was a concern. In 2002, relationships between the Consortium Coordinator were contentious and non-productive at times. In an effort to be proactive and begin to redefine roles and responsibilities, SHS decided to hire an outside consultant to help problem-solve. On behalf of SHS, Family Ties Network engaged an experienced and respected facilitator in our community to work with the leaders of the SHS Executive Council and with the Consortium Coordinator to explore conflicts. With facilitation, the Executive Council and Coordinator had improved understanding and willingness to work together. The group resolved to focus on the future, and rededicated itself to the work of Healthy Start. This effort was underway when the Consortium Coordinator left SHS at the end of December 2002. The transition was supported by the leadership of the new Project Director who began work in September of 2002.

SHS has continued to support the improved relationships through Executive Council Retreat, held 11/20/03, leadership events and team building opportunities. SHS administrative staff also instituted opportunities to share ideas and avoid misunderstandings. The co-chairs of the Executive Council requested more involvement in the Project by the Principal Investigator. This
has included participation in Executive Council monthly meetings and a separate meeting between senior project staff, the Principal Investigator and the Co-chairs of the Executive Council. In this way, SHS has worked to ensure that all voices on the Consortium are heard.

Other opportunities for leadership training included attending National Healthy Start Association, Title V collaboration meetings, and leadership and advocacy training sessions. For example, on August 22, 2003, Executive Director and seven SHS consumers attended the first half of an advocacy education workshop hosted by Rochester HS. The second half, held on September 13, 2003, was attended by two of these consumers.

**Creation of Jobs**

The NOW and CHW programs are examples of hiring from the community. Both programs seek to hire individuals who represent the target population. One of the Neighborhood Outreach Workers is a previous client who participated in numerous SHS events, including our media campaign, moved into a position on the Executive Council and subsequently was hired by the project.

As available, SHS has provided internships to consumers. In 2002-2003, one of the Consortium members ran a six-week, 16 session young parents group based on the Florida State Home Visitor’s training modules. Internships for Consortium members completing educational requirements were provided during the four-year period.

**C. Impact on the State. Over the past four years HS has supported activities to strengthen and develop relationships with the State Title V program. In some states, coordinated activities across sites. Describe activities and impact that this approach has had on your relationship to State Title V, State Children with special Health Care Needs program, State Medicaid and SCHIP, EI and other.**

OCHD is the grantee agency for the Early Intervention and Children with Special Health Care Needs programs. These programs shared space with SHS, attended SHS events and shared in-services. Participants in these programs were invited to SHS consumer events. Child Health Plus (SCHIP) and Family Health Plus Facilitated Enrollment programs also reside within the Health Department. Relationships between programs are collaborative, each program is aware of the range of services available and works to ensure that children and families receive all needed services, sharing of information and shared participation in staff development sessions.

As noted in Part II Collaboration, SHS attended biannual Title V meeting with the other Healthy Start Projects across the state. In 2004, the State Title V representative was a planning participant and delivered a presentation for the Regional National Healthy Start Association conference. These shared events allowed for sharing of ideas across projects, and provided a forum for shared identification of issues and concerns affecting Healthy Start participants across the state.

NYS DOH Title V staff who are employed at the Syracuse Field Office attended many project events and collaborated on the Perinatal Network and Perinatal Forum events. Through the
Syracuse Healthy Start Project Number: 743452

Perinatal Forum, SHS and State Title V staff collaborated on the Perinatal Economics Committee in an effort to identify and ameliorate economic barriers to care.

During the 2001-2005 funding period, Syracuse Healthy Start funding and program activities provided much synergistic benefit to Family Ties Network, which is the State-funded Prenatal/Perinatal Network that serves the local 4-county area. At the most basic level, the contract to provide Consortium Coordination and Health Education services to the SHS Project assisted this relatively new agency (incorporated in 1997) to continue development of administrative and programming capacity. In addition, the provider and consumer contacts, information and education gained from SHS work helped the agency in all its efforts to improve maternal child health and health care.

Through the maternal child health consortia that Family Ties coordinates, many of the provider education presentations, newsletters, and other materials developed by SHS were shared with health and human service providers throughout Cayuga, Oswego, and Madison counties in Central New York. This expands the reach and multiplies the impact of SHS programming. Specific topics of materials disseminated included perinatal substance abuse screening and referral, smoking cessation education, SIDS risk reduction, and safe sleep promotion.

D. Local Government

SHS has had partial success in engaging local government. The Onondaga County Legislature bears responsibility for approval of OCHD budget items. Through this process and other frequent interactions between the Health Department and the Legislature, SHS and the issue of Infant Mortality has been highlighted. Individual legislators have expressed interest and concerns regarding birth outcomes in Syracuse and Onondaga County. Sandy Baker, Chair of the Onondaga County Legislature Health Committee, is also a participant on the OCHD Health Advisory Board. SHS reports to the Health Advisory Board annually about major accomplishments and concerns. Ms. Baker is also a frequent participant at SHS and OCHD sponsored events. In addition, SHS had some success in engaging the law enforcement and judicial branch of government. One of the Criminal Court judges, who has an interest in disparities, has been a participant in the Speaker Series as has the police chief and one of the Syracuse Police Department’s information officers.

SHS has had less success in engaging City Hall. Despite many invitations, the Mayor’s office has not been a participant in SHS events. However, the President of the Common Council has attended a number of events, in particular the Speaker Series Policy Luncheons. Throughout the next four years of funding, SHS plans to continue to pursue input and participation from city and county government.

E. Lessons Learned

In 2001, the Syracuse Healthy Start Project expanded our project area from what we termed as Central Syracuse, to the entire City of Syracuse, effectively doubling the target population. Central Syracuse had an average of 1100 births per year; the City of Syracuse averages 2300 births per year. Despite this adjustment in population and a decrease in funding, we did not adjust our expectations in regard to the percentage of individuals served. Per program data from
1999, 620 individuals received a social risk screening interview that year. In 2004, 1325 individuals had at least one Client Assessment Form completed, representing more than a twofold increase in participation in number of participants served, but does not reflect an increase in the overall penetration rate of the project. In retrospect, it may have been advisable to adjust the projects’ objectives with regard to penetration rate to reflect the increase in the target population.

VI. Local Evaluation

Reports from each project year follow on the next pages.
HEALTHY START LOCAL EVALUATION REPORT
2001

PROJECT NAME: Syracuse Healthy Start

TITLE OF REPORT: Eliminating Disparities in Perinatal Health: Performance Indicators 2001

AUTHORS: Kim D. Jaffee, PhD and Chu Chu Wu, MS

Section I: Introduction

Local Evaluation Component

A. How was the local evaluation designed? Were project staff involved in conducting the local evaluation or was the evaluation contracted out? If contracted out, identify the name of the contractor.

For 2001, the Syracuse Healthy Start local evaluation built upon data collection systems developed during the first four years of federal Healthy Start funding, and monitored progress toward the specific indicators required by the federal Healthy Start Program and the local project. In keeping with the goal of eliminating disparities, specific indicators were aggregated by race and ethnicity.

The evaluation was subcontracted to the College of Human Services and Health Professions, School of Social Work at Syracuse University, with Kim D. Jaffee, PhD, as the Evaluator. The Evaluator and her team worked closely with the Syracuse Healthy Start project team and the federal Healthy Start team in the design of the approach and evaluation plan, and to ensure compliance with reporting requirements.

B. Present a brief history of the local evaluation and describe all components. Was each of these components the subject of an evaluation study? Were some components of the evaluation added, dropped or modified? Please explain.

The comprehensive evaluation plan that was developed in the first four years of federal Healthy Start funding was carried forth into the 2001 evaluation. This plan involved the identification of objectives, data collection and reporting, and monitoring and feedback. These objectives were based on performance indicators and described in measurable terms what will be achieved, when it will be achieved, and the target population. The evaluation employed an existing data collection and reporting system to monitor progress toward goals, and used existing community-based and other local information systems to capture new data elements, whenever possible. If new databases needed to be developed, they were so done with the intention that they would be sustainable and relevant in the community. The evaluators produced the annual evaluation report and worked with the project team to review the information and create action plans based upon it. The evaluation team disseminated the
information to the Executive Council of the Consortium, the Evaluation Subcommittee of the Consortium, and the Syracuse Healthy Start subcontractors, and received input from these key stakeholders.

The evaluation plan also included a Multicultural Competency Assessment for Organizations, which was identified as a tool for administering to staff at SHS agencies to assess the degree to which the agency provides culturally competent services for people of differing backgrounds. This survey was not administered until the third year of the four-year project (please see local evaluation report for calendar year 2003).

Another component of the evaluation was a Family/Healthy Start Client Satisfaction Survey. The survey was developed and piloted with SHS participants, with the intent that it would be used in future evaluations to collect information on the participants’ satisfaction with the SHS services and program.

C. Discuss the type of study (e.g., formative, process, outcome) and the involvement of the community and consortia in conducting the evaluation.

This study was a formative evaluation that worked through a process of continuous feedback and provided information to the local project and sponsors. The evaluation established baseline data by race and ethnicity, i.e., black, white, Hispanic, and other, for each of the performance measures.

The community and Consortium were involved in the key parts of the evaluation process. The Evaluation Subcommittee of the Consortium met with the Evaluation Team and provided input in the identification of objectives and feedback on the evaluation report. The Executive Council also provided input on the evaluation report. In addition, the Evaluation Team met with the Consortium Executive Council every six months to assess the enrollment of the SHS participants, compared with women giving birth in the City of Syracuse, thereby including the Consortium in the data collection and reporting process.

Key Questions/Hypotheses

Discuss key questions and hypotheses the local evaluation addressed.

This was the first year of a four-year project and the evaluation established baseline data for the following objectives: early prenatal care; adequacy of prenatal care; late/no prenatal care; low birthweight; very low birthweight; preterm delivery; small for gestational age; large for gestational age; repeat adolescent pregnancy; first trimester prenatal care for adolescents; in hospital infant deaths and NICU admissions; smoking during pregnancy; breastfeeding; unintended births; immunization; Healthy Start penetration in the target area; WIC enrollment; case management; providers and consumers receiving educational information; community agencies using service tracking; and Consortium participation and capacity.
Section II: Process

A. Discuss the procedures for conducting the local evaluation. Discuss the methodology(ies) in the local evaluation. Describe the sampling design if any, and any comparison or control groups used.

This evaluation used the Central New York Regional Perinatal Data System (RPDS), linked with the Syracuse Healthy Start Registry through a unique ID, to establish baseline data and to monitor progress towards goals. Performance measures were reported for SHS participants who resided in the project area and for all women residing in the project area, regardless of their enrollment status.

B. Identify and describe the data sources.

The Central New York Regional Perinatal Data System (RPDS) is a population-based birth registry that captures information on all live births in the Central New York Region. It consists of the New York State Electronic Birth Certificate (EBC) and additional questions, e.g., such as intentions of pregnancy, and breastfeeding, that are intended to be used for quality improvement purposes. The RPDS contains data on: maternal demographics; obstetrical history; prenatal care; labor and delivery information; and birth outcomes. The SUNY Upstate Medical University, Center for Maternal and Child Health, which manages the RPDS, provided the de-identified data files to the evaluation team.

The Syracuse Healthy Start Registry is a monitoring system for pregnant and postpartum women and their infants. The Registry is used to enroll participants into Healthy Start, and captures information on: characteristics of program participants; risk factors, referrals and service interventions based on identified need.

C. What measures were used? Describe any instruments used.

The evaluation used the following measures for 1) program participants and 2) pregnant women residing in the project area who delivered a live infant in 2001, by race and ethnicity (black, white, Hispanic, other):

- Percent who initiated prenatal care in the first trimester
- Percent of recently delivered women receiving adequate prenatal care
- Percent with late or no prenatal care
- Percent of low birthweight, very low birthweight, preterm, SGA and LGA infants
- Percent of teens (<18) giving birth after having been pregnant before
- Percent of teens (<18) who initiated care in the first trimester
- Percent who smoked during pregnancy
- Percent, who at time of discharge, reported their intent to breastfeed
- Percent whose births were unintended at conception;

and, for program participants only:

- Percent of in-hospital deaths among infants born to program participants (by race/ethnicity black, white, Hispanic, other)
- Percent of NICU admissions among infant born to program participants (by race/ethnicity black, white, Hispanic, other)
• Percent enrolled in WIC (by race/ethnicity black, white, Hispanic, other)
• Proportion receiving case management
• Incidence of risk behaviors, such as smoking, substance use, family violence and inadequate diet among pregnant and parenting women after receiving the Social Risk Assessment (by race/ethnicity black, white, Hispanic, Asian, Native American, other)
• Percent of infants participating in the project who are appropriately immunized for their age.

The evaluation used these additional measures:
• Percent of eligible women in the project area who were enrolled in the project
• Percent of agencies providing services in the project area and participating in the Healthy Start electronic tracking system
• Number of providers and consumers in the project area receiving in-service education and information
• Number of providers in the project area receiving in-service educational information in cultural competence
• Proportion of Consortium and Executive Council members who were consumers
• Proportion of Consortium and Executive Council members who were racial/ethnic minorities
• Proportion of Consortium Executive Council members attending at least 50% of meetings for which they were eligible voting members
• Proportion of Consortium members attending two or more meetings annually.

Section III. FINDINGS/DISCUSSION
Present the findings of your local evaluation including a discussion of any methodological limitations of the evaluation (e.g., completeness and quality of data, and response rates to survey instruments).

The evaluation established baseline data by race and ethnicity for the measures reported in section II, part C, and identified disparities by race for program participants and for women residing in the SHS project area. The evaluation findings can be summarized as follows:
• For all of the measures except for smoking during pregnancy and WIC enrollment, there were white-black disparities and white-Hispanic disparities, with blacks and Hispanics having the less favorable values.
• 83% of 2 year olds residing in Onondaga County were age appropriately immunized.
• The SHS penetration rate was 52% overall, 38.5% for whites, 71% for African Americans, 85% for Hispanics, and 87% for teens less than 18.
• Out of 57 possible referring agencies, 53 (93%) referred clients to SHS and used the electronic tracking system.
• 858 providers and 1140 consumers received in-service education and information (these counts are not unduplicated); and an estimated 50,000 consumers received media-based information.
• Consumers made up 32% of the Consortium and 50% of the Executive Council.
• Racial/ethnic minorities comprised 49% of the Consortium and 79% of the Executive Council.
• 100% of the Consortium members attended at least two meetings.
• 80% of the Executive Council members attended at least 50% of their meetings.

The study may be limited by the following:
• Findings based on the linked RPDS-SHS Registry data files may be limited by the degree to which these databases were matched.
• Hispanic origin was not a field on the Electronic Birth Certificate (part of the RPDS) and was derived from responses to the ethnic origin question, where respondents could only select one ethnicity from many categories including American, mixed and other. Thus, the Hispanic category may be an underestimate of the Hispanic population served by SHS and residing in the target area, and may not be comparable to future evaluations when the Electronic Birth Certificate has a separate field for Hispanic origin.
• The Central New York Regional Immunization Information System did not include the complete participation of providers and individuals. Therefore, only aggregate Onondaga County data could be provided.

Section IV: Recommendation

A. Present all recommendations that stemmed from the local evaluation. Please be sure to include policy, program, practice as well as other recommendations.

The Evaluation Team recommended that, in concert with Syracuse Healthy Start’s overall effort to address cultural competency, there was a need to assess the degree to which agencies delivering Healthy Start services provide multicultural competent services for people of different backgrounds.

B. Discuss directions for further evaluation studied that emerged from the local evaluation.

During the project period, a Multicultural Competency Assessment for Organizations was administered to all agencies delivering Healthy Start services in Syracuse.

Section V: Impact based upon the recommendations/results of the local evaluation

A. Describe changes in the perinatal system or any impact on the community in general that resulted from the local evaluation results.

Given the focus on disparities and the importance of cultural competence, the SHS project developed a Speaker Series that brought in nationally and internationally known experts in areas of maternal and child health and/or inequities and disparities. The goal of the Series was to increase awareness of SHS, educate community members about the persistent gaps in MCH outcomes by race/ethnic subgroups, provide state-of-the-art education to community members at grass roots and professional levels, and to develop long-term strategic planning for SHS including sustainability efforts.
B. *Describe changes in project implementation, management or administration that resulted from the local evaluation results.*

In year two of the four-year project, the Syracuse Healthy Start Registry was significantly modified to allow for the capture of longitudinal data. The Registry now captures subsequent births to participants where previously the new record overwrote the old record. This change allows the Registry to better capture data in the interconceptional period and facilitates the follow-up of families until the child is two years of age.

The Client Assessment Form, which captures demographic, service and referral information for all SHS participants, was revised to capture the new objectives relevant to the SHS project.

Section VI: Publications. None.
HEALTHY START LOCAL EVALUATION REPORT
2002

PROJECT NAME: Syracuse Healthy Start

TITLE OF REPORT: Eliminating Disparities in Perinatal Health: Performance Indicators 2002

AUTHORS: Kim D. Jaffee, PhD and Chu Chu Wu, MS

Section I: Introduction

Local Evaluation Component

D. How was the local evaluation designed? Were project staff involved in conducting the local evaluation or was the evaluation contracted out? If contracted out, identify the name of the contractor.

For 2002, the Syracuse Healthy Start local evaluation built upon data collection systems developed during the first five years of federal Healthy Start funding, and monitored progress toward the specific indicators required by the federal Healthy Start Program and the local project. In keeping with the goal of eliminating disparities, specific indicators were aggregated by race and ethnicity.

The evaluation was subcontracted to the College of Human Services and Health Professions, School of Social Work at Syracuse University, with Kim D. Jaffee, PhD, as the Evaluator. The Evaluator and her team worked closely with the Syracuse Healthy Start project team and the federal Healthy Start team in the design of the approach and evaluation plan, and to ensure compliance with reporting requirements.

E. Present a brief history of the local evaluation and describe all components. Was each of these components the subject of an evaluation study? Were some components of the evaluation added, dropped or modified? Please explain.

The comprehensive evaluation plan that was developed in the first five years of federal Healthy Start funding was carried forth into the 2002 evaluation. This plan involved the identification of objectives, data collection and reporting, and monitoring and feedback. These objectives were based on performance indicators and described in measurable terms what will be achieved, when it will be achieved, and the target population. The evaluation employed an existing data collection and reporting system to monitor progress toward goals, and used existing community-based and other local information systems to capture new data elements, whenever possible. If new databases needed to be developed, they were so done with the intention that they would be sustainable and relevant in the community. The evaluators produced the annual evaluation report and worked with the project team to review the information and create action plans based upon it. The evaluation team disseminated the
information to the Executive Council of the Consortium, the Evaluation Subcommittee of the
Consortium, and the Syracuse Healthy Start subcontractors, and received input from these
key stakeholders.

The evaluation plan also included a Multicultural Competency Assessment for
Organizations, which was identified as a tool for administering to staff at SHS agencies to
assess the degree to which the agency provides culturally competent services for people of
differing backgrounds. This survey was not administered until the third year of the four-year
project (please see local evaluation report for calendar year 2003).

Another component of the evaluation was a Family/Healthy Start Client Satisfaction
survey. The survey was developed and piloted with SHS participants, with the intent that it
would be used in future evaluations to collect information on the participants’ satisfaction
with the SHS services and program.

F. Discuss the type of study (e.g., formative, process, outcome) and the involvement of the
community and consortia in conducting the evaluation.

This study was an outcome evaluation that measured progress towards goals over time,
including whether the program met its goals. The evaluation compared 2002 data with 2001
baseline data, by race and ethnicity. The study did not calculate whether of the changes over
time were statistically significant.

The community and Consortium were involved in providing feedback and direction to the
evaluation through the establishment of an Evaluation Advisory Committee of the
Consortium, with representation from the subcontractors. The Advisory Committee and the
Executive Council provided input on the evaluation report.

Key Questions/Hypotheses

Discuss key questions and hypotheses the local evaluation addressed.

This was the second year of a four-year project and the evaluation compared 2002 data with
baseline data for the following objectives: early prenatal care; adequacy of prenatal care; late/no
prenatal care; low birthweight; very low birthweight; preterm delivery; small for gestational age;
large for gestational age; repeat adolescent pregnancy; first trimester prenatal care for
adolescents; in hospital infant deaths and NICU admissions; smoking during pregnancy;
breastfeeding; unintended births; immunization; Healthy Start penetration in the target area; WIC
enrollment; case management; providers and consumers receiving educational information; and
Consortium participation and capacity.

Section II: Process

D. Discuss the procedures for conducting the local evaluation. Discuss the methodology(ies) in
the local evaluation. Describe the sampling design if any, and any comparison or control
groups used.

This evaluation used the Central New York Regional Perinatal Data System (RPDS),
linked with the Syracuse Healthy Start Registry through a unique ID, to establish baseline
data and to monitor progress towards goals. Performance measures were reported for SHS participants who resided in the project area and for all women residing in the project area, regardless of their enrollment status. For both SHS participants and women residing in the project area, the evaluation employed historical comparison groups by comparing performance measures for women delivering in 2002 with those who delivered in 2001.

E. Identify and describe the data sources.

The Central New York Regional Perinatal Data System (RPDS) is a population-based birth registry that captures information on all live births in the Central New York Region. It consists of the New York State Electronic Birth Certificate (EBC) and additional questions, e.g., such as intentions of pregnancy, and breastfeeding, that are intended to be used for quality improvement purposes. The RPDS contains data on: maternal demographics; obstetrical history; prenatal care; labor and delivery information; and birth outcomes. The SUNY Upstate Medical University, Center for Maternal and Child Health, which manages the RPDS, provided the de-identified data files to the evaluation team.

The Syracuse Healthy Start Registry is a monitoring system for pregnant and postpartum women and their infants. The Registry is used to enroll participants into Healthy Start, and captures information on: characteristics of program participants; risk factors, referrals and service interventions based on identified need.

F. What measures were used? Describe any instruments used.

The evaluation used the following measures for 1) program participants and 2) pregnant women residing in the project area who delivered a live infant, by race and ethnicity (black, white, Hispanic, other):

- Percent who initiated prenatal care in the first trimester
- Percent of recently delivered women receiving adequate prenatal care
- Percent with late or no prenatal care
- Percent of low birthweight, very low birthweight, preterm, SGA and LGA infants
- Percent of teens (<18) giving birth after having been pregnant before
- Percent of teens (<18) who initiated care in the first trimester
- Percent who smoked during pregnancy
- Percent, who at time of discharge, reported their intent to breastfeed
- Percent whose births were unintended at conception;

and, for program participants only:

- Percent of in-hospital deaths among infants born to program participants (by race/ethnicity black, white, Hispanic, other)
- Percent of NICU admissions among infant born to program participants (by race/ethnicity black, white, Hispanic, other)
- Percent enrolled in WIC (by race/ethnicity black, white, Hispanic, other)
- Proportion receiving case management
- Incidence of risk behaviors, such as smoking, substance use, family violence and inadequate diet among pregnant and parenting women after receiving the Social Risk Assessment (by race/ethnicity black, white, Hispanic, Asian, Native American, other)
• Percent of infants participating in the project who are appropriately immunized for their age.

The evaluation used these additional measures:
• Percent of eligible women in the project area who were enrolled in the project
• Number of providers and consumers in the project area receiving in-service education and information
• Number of providers in the project area receiving in-service educational information in cultural competence
• Proportion of Consortium and Executive Council members who were consumers
• Proportion of Consortium and Executive Council members who were racial/ethnic minorities
• Proportion of Consortium Executive Council members attending at least 50% of meetings for which they were eligible voting members
• Proportion of Consortium members attending two or more meetings annually.

Section III. FINDINGS/DISCUSSION

Present the findings of your local evaluation including a discussion of any methodological limitations of the evaluation (e.g., completeness and quality of data, and response rates to survey instruments).

The evaluation findings can be summarized as follows:
• For all of the measures except for smoking during pregnancy and WIC enrollment, the white-black disparities and white-Hispanic disparities persisted, with blacks and Hispanics having the less favorable values.
• For SHS participants, the following measures showed an improvement from year one: repeat adolescent pregnancy, early prenatal care, late/no prenatal care, adequate prenatal care, teens <18 receiving early prenatal care, smoking, and WIC enrollment. Low birthweight, very low birthweight, preterm delivery, and SGA worsened for black women, while breastfeeding and unintended pregnancy worsened for all racial/ethnic groups.
• 79% of 2 year olds residing in Onondaga County were age appropriately immunized.
• The SHS penetration rate was 41% overall, 31% for whites, 55% for African Americans; and 57% for Hispanics.
• 1451 providers, 921 SHS participants and 3507 consumers received in-service education and information, and an estimated 1,270,000 consumers received media-based information (these counts are not unduplicated).
• Consumers made up 31% of the Consortium and 38% of the Executive Council.
• Racial/ethnic minorities comprised 36% of the Consortium and 79% of the Executive Council.
• 76% of the Consortium members attended at least 2 meetings.
• 77% of the Executive Council members attended at least 50% of their meetings.

The study may be limited by the following:
• Findings based on the linked RPDS-SHS Registry data files may be limited by the degree to which these databases were matched. Lower penetration rates for 2002 are, in part, the result of 306 pregnancies that were not entered into the Registry due to the development of the new Registry data system.
• Hispanic origin was not a field on the Electronic Birth Certificate (part of the RPDS) and was
derived from responses to the ethnic origin question, where respondents could only select one
ethnicity from many categories including American, mixed and other. Thus, the Hispanic
category may be an underestimate of the Hispanic population served by SHS and residing in
the target area, and may not be comparable to future evaluations when the Electronic Birth
Certificate has a separate field for Hispanic origin.

• Immunization information could not be measured for SHS participants because the Central
New York Regional Information Immunization System did not include the complete
participation of providers and individuals. Therefore, only aggregate Onondaga County data
could be provided.

Section IV: Recommendation

C. Present all recommendations that stemmed from the local evaluation. Please be sure to
include policy, program, practice as well as other recommendations.

The Evaluation Team recommended that, in concert with Syracuse Healthy Start’s overall
effort to address cultural competency, there was a need to assess the degree to which
agencies delivering Healthy Start services provide multicultural competent services for
people of different backgrounds.

D. Discuss directions for further evaluation studied that emerged from the local evaluation.

During the project period, a Multicultural Competency Assessment for Organizations was
administered to all agencies delivering Healthy Start services in Syracuse.

Section V: Impact based upon the recommendations/results of the local evaluation

C. Describe changes in the perinatal system or any impact on the community in general that
resulted from the local evaluation results.

Given the focus on disparities and the importance of cultural competence, the SHS
project developed a Speaker Series that brought in nationally and internationally known
experts in areas of maternal and child health and/or inequities and disparities. The goal of
the Series was to increase awareness of SHS, educate community members about the
persistent gaps in MCH outcomes by race/ethnic subgroups, provide state-of-the-art
education to community members at grass roots and professional levels, and to develop long-
term strategic planning for SHS including sustainability efforts.

D. Describe changes in project implementation, management or administration that resulted
from the local evaluation results.

In year two of the four-year project, the Syracuse Healthy Start Registry was significantly
modified to allow for the capture of longitudinal data. The Registry now captures subsequent
births to participants where previously the new record overwrote the old record. This change
allows the Registry to better capture data in the interconceptional period and facilitates the follow-up of families until the child is two years of age.

The Client Assessment Form, which captures demographic, service and referral information for all SHS participants, was revised to capture the new objectives relevant to the SHS project.

Section VI: Publications. None
HEALTHY START LOCAL EVALUATION REPORT
2003

PROJECT NAME: Syracuse Healthy Start

TITLE OF REPORT: Eliminating Disparities in Perinatal Health: Performance Indicators 2003

AUTHORS: Kim D. Jaffee, PhD and Mark Thomas, MA

Section I: Introduction

Local Evaluation Component

G. How was the local evaluation designed? Were project staff involved in conducting the local evaluation or was the evaluation contracted out? If contracted out, identify the name of the contractor.

For 2003, the Syracuse Healthy Start local evaluation built upon data collection systems developed during the first six years of federal Healthy Start funding, and monitored progress toward the specific indicators required by the federal Healthy Start Program and the local project. In keeping with the goal of eliminating disparities, specific indicators were aggregated by race and ethnicity.

The evaluation was subcontracted to the College of Human Services and Health Professions, School of Social Work at Syracuse University, with Kim D. Jaffee, PhD, as the Evaluator. The Evaluator and her team worked closely with the Syracuse Healthy Start project team and the federal Healthy Start team in the design of the approach and evaluation plan, and to ensure compliance with reporting requirements.

H. Present a brief history of the local evaluation and describe all components. Was each of these components the subject of an evaluation study? Were some components of the evaluation added, dropped or modified? Please explain.

The comprehensive evaluation plan that was developed in the first six years of federal Healthy Start funding was carried forth into the 2003 evaluation. This plan involved the identification of objectives, data collection and reporting, and monitoring and feedback. These objectives were based on performance indicators and described in measurable terms what will be achieved, when it will be achieved, and the target population. The evaluation employed an existing data collection and reporting system to monitor progress toward goals, and used existing community-based and other local information systems to capture new data elements, whenever possible. If new databases needed to be developed, they were so done with the intention that they would be sustainable and relevant in the community. The evaluators produced the annual evaluation report and worked with the project team to review the information and create action plans based upon it. The evaluation team disseminated the
information to the Executive Council of the Consortium, the Evaluation Subcommittee of the Consortium, and the Syracuse Healthy Start subcontractors, and received input from these key stakeholders.

The evaluation plan also included a Multicultural Competency Assessment for Organizations, which was identified as a tool for administering to staff at SHS agencies to assess the degree to which the agency provides culturally competent services for people of differing backgrounds. The survey was developed to assess the perceptions and experiences of multicultural competence from the perspective of directors, supervisors, and direct service providers in each of the SHS provider organizations.

I. Discuss the type of study (e.g., formative, process, outcome) and the involvement of the community and consortia in conducting the evaluation.

This study was an outcome evaluation that measured progress towards goals over time, including whether the program met its goals. The evaluation compared 2003 data with 2002 and 2001 data, by race and ethnicity, but did not calculate whether of the changes over time were statistically significant. The evaluation was also a process evaluation in that it assessed the cultural competence of agencies providing services to SHS participants.

The community and Consortium were involved in providing feedback and direction to the evaluation through the establishment of an Evaluation Advisory Committee of the Consortium, with representation from the subcontractors. The Advisory Committee and the Executive Council provided input on the evaluation report.

Key Questions/Hypotheses

Discuss key questions and hypotheses the local evaluation addressed.

This was the third year of the four-year project and the evaluation compared 2003 data with 2002 and with baseline data for the following objectives: early prenatal care; adequacy of prenatal care; late/no prenatal care; low birthweight; very low birthweight; preterm delivery; small for gestational age; large for gestational age; repeat adolescent pregnancy; NICU admissions; smoking during pregnancy; breastfeeding; unintended births; immunization; Healthy Start penetration in the target area; WIC enrollment; case management; providers and consumers receiving educational information; and Consortium participation and capacity. In addition, baseline data were collected for the following new objectives: satisfaction with prenatal care, interconceptional care and spacing, and perinatal depression assessment and referral.

The Multicultural Competency Assessment for Organizations addressed the following key questions:

• Do the agencies that serve SHS participants provide their staff with diversity or multicultural competency training?
• Do agency staff, board members, volunteers, task forces, and committees reflect the cultural diversity of the clients that they serve?
• Do these agencies have institutional policies aimed at the recruitment and retention of culturally diverse staff?
• Can these agencies adequately respond to the needs of clients who do not speak English?
• Have these agencies established linkages with other organizations serving the same client population?

Section II: Process

G. Discuss the procedures for conducting the local evaluation. Discuss the methodology(ies) in the local evaluation. Describe the sampling design if any, and any comparison or control groups used.

This evaluation used the Central New York Regional Perinatal Data System (RPDS), linked with the Syracuse Healthy Start Registry through a unique ID, to establish baseline data and to monitor progress towards goals. Performance measures were reported for SHS participants who resided in the project area and for all women residing in the project area, regardless of their enrollment status. For both SHS participants and women residing in the project area, the evaluation employed historical comparison groups by comparing performance measures for women delivering in 2003 with those who delivered in 2001 and 2002.

H. Identify and describe the data sources.

The Central New York Regional Perinatal Data System (RPDS) is a population-based birth registry that captures information on all live births in the Central New York Region. It consists of the New York State Electronic Birth Certificate (EBC) and additional questions, e.g., such as intentions of pregnancy, and breastfeeding, that are intended to be used for quality improvement purposes. The RPDS contains data on: maternal demographics; obstetrical history; prenatal care; labor and delivery information; and birth outcomes. The SUNY Upstate Medical University, Center for Maternal and Child Health, which manages the RPDS, provided the de-identified data files to the evaluation team.

The Syracuse Healthy Start Registry is a monitoring system for pregnant and postpartum women and their infants. The Registry is used to enroll participants into Healthy Start, and captures information on: characteristics of program participants; risk factors, referrals and service interventions based on identified need.

I. What measures were used? Describe any instruments used.

The evaluation used the following measures for 1) program participants and 2) pregnant women residing in the project area who delivered a live infant, by race and ethnicity (black, white, Hispanic, other):
• Percent who initiated prenatal care in the first trimester
• Percent of recently delivered women receiving adequate prenatal care
• Percent with late or no prenatal care
• Percent of low birthweight, very low birthweight, preterm, SGA and LGA infants
• Percent of teens (<18) giving birth after having been pregnant before
• Percent who smoked during pregnancy
• Percent, who at time of discharge, reported their intent to breastfeed
• Percent whose births were unintended at conception
and, for program participants only:

- Percent satisfied with prenatal care (by race/ethnicity black, white, Hispanic, other)
- Percent of NICU admissions among infant born to program participants (by race/ethnicity black, white, Hispanic, other)
- Percent enrolled in WIC (by race/ethnicity black, white, Hispanic, other)
- Proportion receiving case management
- Proportion who had at least one previous live birth and who gave birth to a subsequent infant in less than 24 months (by race/ethnicity black, white, Hispanic, other)
- Proportion screened for depression
- Proportion screened positive for depression who received mental health or supportive intervention services
- Percent of infants participating in the project who are appropriately immunized for their age.

The evaluation used these additional measures:

- Percent of eligible women in the project area who were enrolled in the project
- Percent of SHS participants satisfied with prenatal care, compared with non-participants
- Number of providers and consumers in the project area receiving in-service education and information
- Number of providers in the project area receiving in-service educational information in cultural competence
- Proportion of Consortium and Executive Council members who were consumers
- Proportion of Consortium and Executive Council members who were racial/ethnic minorities
- Proportion of Consortium Executive Council members attending at least 50% of meetings for which they were eligible voting members
- Proportion of Consortium members attending two or more meetings annually.

The Multicultural Competency Assessment for Organizations was a 23 item survey adapted from HRSA, Cultural Competence Works. It included three informational questions, followed by 20 statements regarding the agency’s multicultural competency. The survey concluded with two open-ended questions to assess providers’ perceptions of how well they thought their organization was doing in the area of cultural competence and what it could do to enhance multicultural competence.

Section III. FINDINGS/DISCUSSION

*Present the findings of your local evaluation including a discussion of any methodological limitations of the evaluation (e.g., completeness and quality of data, and response rates to survey instruments).*

The evaluation findings can be summarized as follows:

- For all of the measures except for smoking during pregnancy, and WIC enrollment, the white-black disparities and white-Hispanic disparities persisted, with blacks and Hispanics having the less favorable values.
- For SHS participants, the following measures showed an improvement over time: repeat adolescent pregnancy, early prenatal care, late/no prenatal care, adequate prenatal care, smoking and WIC enrollment. Low birthweight, very low birthweight, preterm delivery, and
SGA worsened for black women, while unintended pregnancy worsened for all racial/ethnic groups.

- Prenatal care satisfaction rates were very high (>90%) for all racial/ethnic groups.
- 61% of children 24-35 months, residing in Onondaga County, were age appropriately immunized.
- The SHS penetration rate was 35% overall, 22% for whites, 46% for African Americans; and 46% for Hispanics.
- 960 providers, 1,143 SHS participants and 210 community participants received in-service education and information, and an estimated 50,000 consumers received media-based information (these counts are not unduplicated).
- Consumers made up 40% of the Consortium and 48% of the Executive Council.
- Racial/ethnic minorities comprised 56% of the Consortium and 76% of the Executive Council.
- 100% of the Consortium members attended at least 2 meetings.
- 50% of the Executive Council members attended at least 50% of their meetings.

The findings of the Multicultural Assessment for Organizations can be summarized as follows:

- 4 SHS funded agencies were surveyed for a total of 83 respondents.
- 80% of SHS staff and subcontractors received diversity training through their agencies.
- Less than half of the respondents believed that their agencies had an institutional commitment to recruiting and retaining staff that reflects the diversity of the population served.
- 86% of respondents believed that their agencies have linkages with other organizations serving the same population.
- 57% of respondents report that their agencies provide clients with information in their primary language, and only 35% believe that their agency can respond to the needs of clients whose primary language is different from the majority served.

The study may be limited by the following:

- Findings based on the linked RPDS-SHS Registry data files may be limited by the degree to which these databases were matched. Lower penetration rates for 2003 are, in part, due to linkage problems between the RPDS and the new SHS Registry database.
- Hispanic origin was not a field on the Electronic Birth Certificate (part of the RPDS) and was derived from responses to the ethnic origin question, where respondents could only select one ethnicity from many categories including American, mixed and other. Thus, the Hispanic category may be an underestimate of the Hispanic population served by SHS and residing in the target area, and may not be comparable to future evaluations when the Electronic Birth Certificate has a separate field for Hispanic origin.
- Immunization information could not be measured for SHS participants because the Central New York Regional Information Immunization System did not include the complete participation of providers and individuals. Therefore, only aggregate Onondaga County data could be provided.

Section IV: Recommendation
E. **Present all recommendations that stemmed from the local evaluation. Please be sure to include policy, program, practice as well as other recommendations.**

The Evaluation Team had the following recommendations:

- Employ a multicultural competency training component that is part of the orientation for all new employees, volunteers and board members of agencies that contract with SHS.
- Regularly monitor the cultural competence training efforts of subcontractors.
- Appoint a staff manager responsible for cultural diversity issues, including training.
- Conduct ongoing follow-up forums on cultural issues and problem solving around diversity.
- All subcontracting agencies should have a plan for recruitment, retention and promotion of staff representative of the population served.
- Use diverse staffing to facilitate outreach and communication.
- Conduct an agency assessment of languages that are represented among consumers.
- Recruit bilingual employees that speak the languages that consumers speak.
- Forge relationships with other organizations that have bilingual employees that can be “shared” across agencies when necessary.
- Recruit and hire translators.

F. **Discuss directions for further evaluation studied that emerged from the local evaluation.**

Another analysis that emerged from the evaluation was a study designed to examine physician-identified barriers to intimate partner violence screening and treatment. The intent of the study was threefold: 1) to identify these barriers, 2) to determine the appropriate role for advocates, healthcare administrators and providers, and community members in addressing those barriers, and 3) to develop a coordinated response in meeting patient and provider needs. Data were collected, analyzed and were being written up for publication and dissemination.

Section V: Impact based upon the recommendations/results of the local evaluation

E. **Describe changes in the perinatal system or any impact on the community in general that resulted from the local evaluation results.**

Given the focus on disparities and the importance of cultural competence, the SHS project developed a Speaker Series that brought in nationally and internationally known experts in areas of maternal and child health and/or inequities and disparities. The goal of the Series was to increase awareness of SHS, educate community members about the persistent gaps in MCH outcomes by race/ethnic subgroups, provide state-of-the-art education to community members at grass roots and professional levels, and to develop long-term strategic planning for SHS including sustainability efforts.

On a monthly basis, SHS staff began meeting with Nurse Managers of organizations serving SHS participants to address issues arising in the postpartum and interconceptional periods. These monthly meetings have facilitated communication between the outpatient areas and the birthing hospitals and have resulted in quicker identification and resolution of problems.
F. *Describe changes in project implementation, management or administration that resulted from the local evaluation results.*

The SHS Public Health Fellow began an outreach to recently delivered women at Crouse Hospital, the largest birthing hospital, to increase SHS awareness among consumers and health providers, and to increase program enrollment.

The Client Assessment Form, which captures demographic, service and referral information for all SHS participants, was revised to capture the new objectives relevant to the SHS project. This form provides increased information on changes in client circumstances, goal achievement and referral utilization.

Section VI: Publications. None.
HEALTHY START LOCAL EVALUATION REPORT
2004

PROJECT NAME: Syracuse Healthy Start

TITLE OF REPORT: Eliminating Disparities in Perinatal Health: Performance Indicators 2004

AUTHORS: Martha A. Wojtowycz, PhD and Pamela Parker, BA

Section I: Introduction

Local Evaluation Component

J. How was the local evaluation designed? Were project staff involved in conducting the local evaluation or was the evaluation contracted out? If contracted out, identify the name of the contractor.

For 2004, the Syracuse Healthy Start local evaluation built upon data collection systems developed during the first seven years of federal Healthy Start funding, and monitored progress toward the specific indicators required by the federal Healthy Start Program and the local project. In keeping with the goal of eliminating disparities, specific indicators were aggregated by race and ethnicity.

The evaluation was subcontracted to the Center for Maternal and Child Health (CMATCH), Department of Obstetrics and Gynecology, SUNY Upstate Medical University, with Martha A. Wojtowycz, PhD, as the Evaluator. The Evaluator and her team worked closely with the Syracuse Healthy Start project team and the federal Healthy Start team in the design of the approach and evaluation plan, and to ensure compliance with reporting requirements.

K. Present a brief history of the local evaluation and describe all components. Was each of these components the subject of an evaluation study? Were some components of the evaluation added, dropped or modified? Please explain.

The comprehensive evaluation plan that was developed in the first seven years of federal Healthy Start funding was carried forth into the 2004 evaluation. This plan involved the identification of objectives, data collection and reporting, and monitoring and feedback. These objectives were based on performance indicators and described in measurable terms what will be achieved, when it will be achieved, and the target population. The evaluation employed an existing data collection and reporting system to monitor progress toward goals, and used existing community-based and other local information systems to capture new data elements, whenever possible. If new databases needed to be developed, they were so done with the intention that they would be sustainable and relevant in the community. The evaluators produced the annual evaluation report and worked with the project team to review the information and create action plans based upon it. The evaluation team disseminated the
information to the Syracuse Healthy Start leadership, the Executive Council of the Consortium, the Evaluation Advisory of the Consortium, and the Syracuse Healthy Start subcontractors, and received input from these key stakeholders.

**L. Discuss the type of study (e.g., formative, process, outcome) and the involvement of the community and consortia in conducting the evaluation.**

This study was an outcome evaluation that measured progress towards goals over time, including whether the program met its year four goals. The evaluation compared 2004 data with 2002 and 2001, 2002 and 2003 data, by race and ethnicity, but did not calculate whether the changes over time were statistically significant.

The community and Consortium were involved in providing feedback and direction to the evaluation through the establishment of an Evaluation Advisory Committee of the Consortium, with representation from the subcontractors. The Advisory Committee and the Executive Council provided input on the evaluation report.

**Key Questions/Hypotheses**

Discuss key questions and hypotheses the local evaluation addressed.

- This was the fourth year of the four-year project and the evaluation compared 2004 data with 2001, 2002 and 2003 data and measured progress towards goals for the following objectives: early prenatal care; adequacy of prenatal care; late/no prenatal care; low birthweight; very low birthweight; preterm delivery; small for gestational age; large for gestational age; repeat adolescent pregnancy; NICU admissions; smoking during pregnancy; breastfeeding; interconceptional care and spacing; immunization; Healthy Start penetration in the target area; WIC enrollment; case management; providers and consumers receiving educational information; perinatal depression assessment and referral; and Consortium participation and capacity.

**Section II: Process**

**J. Discuss the procedures for conducting the local evaluation. Discuss the methodology(ies) in the local evaluation. Describe the sampling design if any, and any comparison or control groups used.**

This evaluation used the New York Statewide Perinatal Data System (SPDS), linked with the Syracuse Healthy Start Registry, to monitor progress towards goals. Performance measures were reported for SHS participants who resided in the project area and for all women residing in the project area, regardless of their enrollment status. For both SHS participants and women residing in the project area, the evaluation employed historical comparison groups by comparing performance measures for women delivering in 2004 with those who delivered in 2001, 2002, and 2003.

SHS participants are more socioeconomically disadvantaged when compared with City of Syracuse residents. They are more likely to be adolescents, African-American and less likely to have completed high school (among women ≥ 20). Thus, SHS participants were also
compared with Medicaid recipients residing in the project area, but not linked with the SHS Registry.

K. Identify and describe the data sources.

The New York Statewide Perinatal Data System (SPDS) is a population-based birth registry that captures information on all live births in the New York State exclusive of New York City. It consists of the New York State Electronic Birth Certificate (EBC) and additional voluntary questions, e.g., such as the content of prenatal care, intentions of pregnancy, and perinatal depression, that are expected to be used for quality improvement purposes. The SPDS contains data on: maternal demographics; obstetrical history; prenatal care; labor and delivery information; and birth outcomes. The SPDS was implemented statewide on January 1, 2004. Birth hospitals enter the data directly onto the New York State Department of Health (NYSDOH) server using a web-based application and county health departments can download the data for all births to their residents and for all births in their county. However, the NYSDOH has not yet worked out the legal issues surrounding the sharing of voluntary information, and for this reason, data on the additional voluntary questions are not currently in the county export.

The SPDS differs from the RPDS in several ways: 1) the Electronic Birth Certificate data elements are slightly different, reflecting changes in the national birth certificate that occurred at the same time; 2) some of the additional quality improvement questions are different, e.g., satisfaction with prenatal care was replaced by the content of prenatal care; 3) definitions have changed for some key variables; and 4) the unique ID is no longer available, therefore, linkages with other data sets had to be done by variables in common.

The Syracuse Healthy Start Registry is a monitoring system for pregnant and postpartum women and their infants. The Registry is used to enroll participants into Healthy Start, and captures information on: characteristics of program participants; risk factors, referrals and service interventions based on identified need.

Dr. Don Cibula, Onondaga County Department of Health, Director of Surveillance and Statistics, linked the two datasets using variables in common (match rate of 77%), and provided the Evaluation Team with the de-identified file.

L. What measures were used? Describe any instruments used.

The evaluation used the following measures for 1) program participants and 2) pregnant women residing in the project area who delivered a live infant, by race and ethnicity (black, white, other race, more than one race, Hispanic origin):

- Percent who initiated prenatal care in the first trimester
- Percent of recently delivered women receiving adequate prenatal care
- Percent with late or no prenatal care
- Percent of low birthweight, very low birthweight, preterm, SGA and LGA infants
- Percent of NICU admissions
- Percent of teens (<18) giving birth after having been pregnant before
- Proportion who had at least one previous live birth and who gave birth to a subsequent infant in less then 24 months
- Percent who smoked during pregnancy
• Percent breastfeeding
• Percent enrolled in WIC
and, for program participants only:
• Proportion receiving case management
• Proportion screened for depression
• Proportion screened positive for depression who received mental health or supportive intervention services
• Number of pregnant and/or postpartum women who report they have a usual source of care or a “medical home”
• Percent of infants participating in the project who are appropriately immunized for their age.

The evaluation used these additional measures:
• Percent of eligible women in the project area who were enrolled in the project
• Number of providers and consumers in the project area receiving in-service education and information
• Number of providers in the project area receiving in-service educational information in cultural competence
• Proportion of Consortium and Executive Council members who were consumers
• Proportion of Consortium and Executive Council members who were racial/ethnic minorities
• Proportion of Consortium Executive Council members attending at least 50% of meetings for which they were eligible voting members
• Proportion of Consortium members attending two or more meetings annually.

Section III. FINDINGS/DISCUSSION
Present the findings of your local evaluation including a discussion of any methodological limitations of the evaluation (e.g., completeness and quality of data, and response rates to survey instruments).

The evaluation findings can be summarized as follows:
• For all of the measures except for smoking during pregnancy, and WIC enrollment, the white-black disparities and white-Hispanic disparities persisted, with blacks and Hispanics having the less favorable values.
• For SHS participants, the following measures showed an improvement over time: adequate prenatal care, smoking and WIC enrollment. Low birthweight, very low birthweight, preterm delivery, and SGA improved for black women, while breastfeeding rates improved for all racial/ethnic groups. Repeat pregnancy rates worsened for black adolescents.
• 85% of 2 year olds, residing in Onondaga County, were age-appropriately immunized.
• The SHS penetration rate was 38% overall, 31% for whites, 54% for African Americans; and 80% for adolescents.
• 100 % of SHS participants (1,020 prenatal and 645 interconceptional) were screened for depression; 155 prenatal and 77 interconceptional participants screened positive and received counseling; 64 prenatal and 77 interconceptional participants were referred for further treatment.
• 960 providers, 1,325 SHS participants and 787 community participants received in-service education and information, and an estimated 100,000 consumers received media-based information (these counts are not unduplicated).
• Consumers made up 21% of the Consortium and 47% of the Executive Council.
• Racial/ethnic minorities comprised 40% of the Consortium and 76% of the Executive Council.
• 100% of the Consortium members attended at least 2 meetings.
• 76% of the Executive Council members attended at least 50% of their meetings.

The study may be limited by the following:
• In January 2004, the NYSDOH implemented the Statewide Perinatal Data System (SPDS) which contained new data elements and definitions. Early prenatal care, late/no prenatal care and NICU admissions are not comparable with prior years.
• SPDS allows for the selection of more than one race. Women who select more than one race are in a separate category “More than one race”. “White” refers to women who select white as the only race. “Black” refers to women who select black as the only race. “Other” refers to women who select one race and it is not black nor white. “Other” may not be comparable over time.
• Ethnicity is a separate field from race, and therefore, Hispanic origin is reported separately and is not comparable to prior years.
• Findings based on the linked RPDS-SHS Registry data files may be limited by the 77% match rate.
• Immunization information could not be measured for SHS participants because the Central New York Regional Information Immunization System did not include the complete participation of providers and individuals. Therefore, only aggregate Onondaga County data could be provided.

Section IV: Recommendation

G. Present all recommendations that stemmed from the local evaluation. Please be sure to include policy, program, practice as well as other recommendations.

The Evaluation Team had the following recommendations:
• Given the favorable response to the Public Health Fellow at Crouse Hospital, expand outreach to the two other birth hospitals in Syracuse to increase awareness and enrollment in SHS.
• Employ qualitative methods, such as focus groups and key informant interviews that include NOW workers, the Public Health Fellow, and consumers, to further evaluate reasons for low SHS enrollment rates and strategies for improving them.

H. Discuss directions for further evaluation studied that emerged from the local evaluation.

A qualitative component, that included staff, such as NOW workers and the Public Health Fellow, consumers, and other culturally diverse groups, would provide valuable insight on the quantitative findings of the evaluation.
Section V: Impact based upon the recommendations/results of the local evaluation

G. Describe changes in the perinatal system or any impact on the community in general that resulted from the local evaluation results.

Given the focus on disparities and the importance of cultural competence, the SHS project developed a Speaker Series that brought in nationally and internationally known experts in areas of maternal and child health and/or inequities and disparities. The goal of the Series was to increase awareness of SHS, educate community members about the persistent gaps in MCH outcomes by race/ethnic subgroups, provide state-of-the-art education to community members at grass roots and professional levels, and to develop long-term strategic planning for SHS including sustainability efforts.

On a monthly basis, SHS staff began meeting with Nurse Managers of organizations serving SHS participants to address issues arising in the postpartum and interconceptional periods. These monthly meetings have facilitated communication between the outpatient areas and the birthing hospitals and have resulted in quicker identification and resolution of problems.

H. Describe changes in project implementation, management or administration that resulted from the local evaluation results.

SHS hired Neighborhood Outreach Workers (NOW) in March 2005 and a NOW supervisor in August 2005, to recruit eligible women into SHS. These outreach workers reflect the diversity of the SHS population and their supervisor is fluent in Spanish.

The SHS Public Health Fellow began an outreach to recently delivered women at Crouse Hospital, the largest birthing hospital, to increase SHS awareness among consumers and health providers, and to increase program enrollment.

Based on the HRSA site visit and the local evaluation recommendations, the Onondaga County Health Department will be conducting a department-wide cultural sensitivity training in January 2006.

The Client Assessment Form, which captures demographic, service and referral information for all SHS participants, was revised to capture the new objectives relevant to the SHS project. This form provides increased information on changes in client circumstances, goal achievement and referral utilization.

Section VI: Publications. None.
VII. FIMR

Syracuse/Onondaga County does not have a FIMR. SHS participates in the Child Fatality Review Team run by the Medical Examiners office.

CMATCH is currently pursuing funding to support a demonstration project for a Central New York Fetal and Infant Mortality/Morbidity Registry and Review (FIMMRR). This model would include very detailed medical root cause analysis of each fetal, infant and very low birth weight morbidity, utilize a Registry mechanism for analysis and evaluation, embodies the potential for action plans that include the full spectrum of participants.

VIII. Products
A copy of all products developed by Syracuse Healthy Start is provided.