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

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

Healthy Start Brooklyn targets the project area of three Central Brooklyn neighborhoods: Bedford Stuyvesant, Brownsville, and East Flatbush (seven contiguous zip codes). The project area has one of the largest populations of African Americans in the country, as well as considerable Caribbean (predominantly Jamaican) and Latino (mainly Puerto Rican) populations. This demographic picture, however, does not aptly capture undocumented groups from Africa (e.g., Nigerian, Senegalese), certain Caribbean countries (e.g., Bajian from St. Vincent, Haitian, Trinidadian), and Latin America (Mexican), and more recently, a small Chinese population has settled in the area.

Historically, East Flatbush and parts of Brownsville have seen great shifts in its populations in the post World War II era, in which Jews and other groups migrated out of the neighborhood, ushering in an extensive Caribbean population. In Bedford Stuyvesant, African American populations settled at the turn of the 20th Century and throughout the 1900s, and more recently in the 1980s and 1990s, African populations have settled. These demographic changes have spurred fundamental social, cultural, and political changes.

The project area exemplifies a host of challenges prevalent in underserved urban neighborhoods: poorly maintained housing stock, high unemployment, and poor access to adequate housing, suitable and consistent health care, jobs, and social services. From an environmental and health perspective, the project area is part of Brooklyn’s “asthma alley,” with remarkably high rates of asthma-related hospital admissions among residents. Moreover, the area also part of the “lead corridor” — residents who have higher incidences of elevated blood lead levels.

As a low-income, high-risk neighborhood, Central Brooklyn experiences dramatic health disparities from the rest of New York City such as low education, high rates of teen pregnancy, substance abuse, homelessness, AIDS, STDs, violence, child abuse, unintended pregnancy and infant mortality. Demographic information for our targeted communities, including race/ethnicity, births and infant deaths is summarized in the following table:
### Brooklyn Healthy Start

*Census Data 2000 for Zip Codes: 11207, 11212, 11213, 11216, 11221, 11225, 11233*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Black</th>
<th>White</th>
<th>Puerto Rican</th>
<th>Other Hispanic</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>371,209</td>
<td>15,092</td>
<td></td>
<td>90,705</td>
<td>18,013</td>
<td>495,019</td>
</tr>
<tr>
<td># Women of Child-bearing Age</td>
<td>95,503</td>
<td>3,222</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Live Births</td>
<td>5,479</td>
<td>324</td>
<td>615</td>
<td>1,038</td>
<td>95</td>
<td>7,551</td>
</tr>
<tr>
<td># Births 17 and under</td>
<td>305</td>
<td>6</td>
<td>53</td>
<td>51</td>
<td>0</td>
<td>415</td>
</tr>
<tr>
<td># Births 18-19 year olds</td>
<td>524</td>
<td>7</td>
<td>80</td>
<td>95</td>
<td>1</td>
<td>707</td>
</tr>
<tr>
<td># Births with Prenatal Care in 1st Trimester</td>
<td>3,051</td>
<td>151</td>
<td>377</td>
<td>621</td>
<td>38</td>
<td>4,238</td>
</tr>
<tr>
<td># Births with No Prenatal Care</td>
<td>128</td>
<td>3</td>
<td>18</td>
<td>13</td>
<td>1</td>
<td>163</td>
</tr>
<tr>
<td># Births with Late Prenatal Care</td>
<td>1,840</td>
<td>105</td>
<td>186</td>
<td>332</td>
<td>44</td>
<td>2,507</td>
</tr>
<tr>
<td># Infant Deaths</td>
<td>56</td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>68</td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1,000 live births)</td>
<td>10.2</td>
<td>3.1</td>
<td>9.8</td>
<td>3.9</td>
<td>10.5</td>
<td>9.0</td>
</tr>
<tr>
<td># Neonatal Deaths (to 28 days)</td>
<td>40</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>46</td>
</tr>
<tr>
<td># Postneonatal Deaths (29-365 days)</td>
<td>16</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td># Low Birth Weight (1501-2500 g)</td>
<td>481</td>
<td>21</td>
<td>48</td>
<td>53</td>
<td>7</td>
<td>610</td>
</tr>
<tr>
<td>% Low Birth Weight</td>
<td>8.8</td>
<td>6.5</td>
<td>7.8</td>
<td>5.1</td>
<td>7.4</td>
<td>8.1</td>
</tr>
<tr>
<td># Very Low Birth Weight (&lt;1501 g)</td>
<td>147</td>
<td>2</td>
<td>11</td>
<td>14</td>
<td>4</td>
<td>178</td>
</tr>
<tr>
<td>% Very Low Birth Weight</td>
<td>2.7</td>
<td>0.6</td>
<td>1.8</td>
<td>1.3</td>
<td>4.2</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Disparities in perinatal and interconceptional health are particularly striking in the Central Brooklyn. Compared with women in the city as a whole, mothers in these neighborhoods are less likely to receive prenatal care, and their infants are 1.4 times more likely to be born with low birth weight and have twice the risk of death in the first year of life. Performance on Healthy People 2010 national targets is similarly poor: in Central Brooklyn in 2001, over one-third (36%) of pregnant women received late or no prenatal care (National goal is less than 10%); 12% of newborns weighed under 5.5 pounds (National goal is less than 5%); and 11.4 infants per 1,000 live births died before their first birthday. (National goal is less than 4.5).

Blacks represent the majority of the HSB participant population; 94% of participants are black, 3% Hispanic, 3% white, and 3% other. The majority (81%) of HSB participants were between 18 and 35 years of age; 5% of the participant population was under age 18, and 9% was over the age of 35. English (80%), Spanish (10%), and French-Creole (10%) were the primary spoken languages of our participants.
II. Project Implementation

Healthy Start Brooklyn (HSB) was built on the principle that an integrated and coordinated service delivery system is vital to respond to the unmet perinatal health needs in the project area (PA) and to address the disparities in infant mortality. HSB is a collaborative, community-based program devoted not only to reducing ethnic and racial disparities in infant mortality rates, but improving perinatal health and comprehensive systems of care in the Brooklyn neighborhoods of Bedford-Stuyvesant, East Flatbush, and Brownsville.

Overall project activities were designed to promote comprehensive systems of care by 1) increasing awareness of and access to services for pregnant and post-partum women and infants, 2) addressing system barriers and promoting a continuum of care, and 3) participating with the community in efforts that bring innovative strategies, collaborative approaches and a commitment to reducing infant mortality and improving maternal and child health outcomes.

The project was built upon existing state, city and community-based initiatives and collaborated with community providers to enhance the perinatal service system. This ensured that comprehensive and integrated systems of care were provided to New York City’s most underserved communities. In response to identified needs in the PA, HSB provided three community-driven core strategies of outreach and client recruitment, case management, and health education and training. These strategies strengthened PA capacities to provide families with health and social services and culturally sensitive support before, during, and between pregnancies and through the infants’ second year of life. Specific program components for interconceptional health and depression screening and referral enhanced the core program strategies to improve perinatal health.

The New York City Department of Health and Mental Hygiene (DOHMH) is the oldest municipal health department in the country. Public health nurses have been improving health outcomes through home visiting for over a century. The Bureau of Maternal, Infant and Reproductive Health (BMIRH) was established in 1967 to focus DOHMH efforts on infant and maternal health. BMIRH’s programming has maintained a tradition of community outreach: for over 22 years, BMIRH has promoted community-based programs in Central Brooklyn to improve perinatal and interconceptional health. During the past 14 years, Healthy Start has supported service coordination to reduce the infant mortality rate through a collaborative effort of research and medical institutions, community agencies, and DOHMH.

The New York City Department of Health and Mental Hygiene through its Bureau of Maternal, Infant, and Reproductive Health, served as lead agency overseeing HSB, in partnership with Brooklyn Perinatal Network (BPN), Caribbean Women’s Health Association (CWHA), Kings County Hospital Center (KCHC), and Brookdale University Hospital and Medical Center (BUHMC).
Brooklyn Perinatal Network: Brooklyn Perinatal Network was established in 1988 from a community task force to address high infant mortality. BPN’s purpose is to prevent and reduce infant/maternal illness and death by fostering a strong collaboration and strategic coordination among service providers in Central Brooklyn’s at-risk communities. By enabling at-risk residents to access vital information, coordinate care, supportive health and social supportive services and assisting families to secure public health benefits and resources needed to maintain health, a significant reduction in infant death and improved maternal and child health status has taken place in Central Brooklyn. As a network of over 40 organizations, BPN and member agencies provide medical care, education and supportive health and social services to at-risk residents seeking comprehensive care. In addition to managing the HSB consortium, BPN was engaged in outreach and client recruitment efforts from the beginning.

Caribbean Women’s Health Association: Caribbean Women’s Health Association is a community-based, multi-service organization established in 1982 providing comprehensive, culturally-sensitive health care, immigration and social support services to its diverse constituents. CWHA has grown from a volunteer group to a professional multi-service organization operating four community service centers in Brooklyn and Queens, providing services to over 50,000 individuals annually. CWHA has targeted high risk, low income women in the Brownsville area of Brooklyn who have received little or no prenatal care, and has sought to coordinate services through case management. CWHA provided preconceptional case management, as well as moderate risk prenatal case management and referral services to pregnant and parenting families, as well as outreach and client education.

Kings County Hospital Center: As a public hospital, Kings County Hospital Center has long been one of the largest and busiest providers of medical care to the Central Brooklyn community. Kings County Hospital Center is the anchor facility for the Central Brooklyn Family Health Network. The network is comprised of Dr. Susan Smith McKinney Nursing Home & Rehabilitation Center, East New York Diagnostic & Treatment Center, Flatbush Avenue Health Center, Bedford-Stuyvesant Alcoholic & Treatment Center and six satellite Family Health clinics. KCHC provides a Pediatric and Maternal HIV Center, as well as the Women's Health Services Labor, Delivery and Recovery program that has provided mental health services and developed postpartum depression prevention and intervention strategies for HSB.

Brookdale University Hospital and Medical Center: Brookdale is a major provider of health services for Central and Southeastern Brooklyn and maintains six family-care centers, providing a community network for the continuum of primary care services. In addition Brookdale formed Neighborhood Health Providers, a comprehensive Medicaid Managed Care program while also maintaining an ambulatory network of primary care satellites. Brookdale provided interconceptional care and perinatal depression screening for HSB.
Under the directorship of BPN, a consortium of community providers and consumers was convened to serve as an advisory body in the development and implementation of HSB local health systems action plan to address priority needs of the PA. (BPN is located in Brownsville where the IMR was the highest at the grant’s outset). Through community-centered strategies and broad-based consortium activities, the project expanded the accessibility of needed services, mobilized community resources to collaborate and integrate services which addressed infant mortality, improved quality, comprehensiveness, and accessibility to culturally sensitive services, and strengthened community collaborations.

**Healthy Start Core Services: Outreach and Client Recruitment**

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets.

Outreach and recruitment served as the entry point for case management, screening for perinatal depression, health education and interconceptional care. Outreach workers were the primary publicists who marketed HSB to prospective program participants. Outreach workers shared the languages, traditions, values, and cultures of the communities they served in order to establish trust and build rapport with the women and adolescents they met to successfully encourage them to enroll in the program. When outreach workers were able to successfully refer women to other agencies and organizations within our target community to address their urgent and short-term needs, they helped to build trust and confidence in HSB.

To increase awareness and name recognition, outreach workers made presentations and disseminated information to faith and community-based leaders; business, labor and professional associations; elected officials and community boards; medical, mental health and social service providers; educators and PTA meetings; and others identified by the consortium and project staff.

**Health facilities**: Outreach workers worked to assure referrals from community services providers. The outreach workers developed relationships with front-line staff members who helped to identify prospective program participants. These facilities include: Bedford-Stuyvesant Family Health Center, Brookdale University Hospital and Medical Center, Brownsville Multi-Service Family Health Center, Interfaith Medical Center, Kings County Hospital Center, University Hospital of Brooklyn (SUNY Downstate) and Woodhull Hospital.

**Social Service Providers**: In addition, outreach workers established links with service providers outside of the health sector. These included after school and youth centers, day care centers, domestic violence services, educational facilities, faith-based settings food programs, homeless shelters, libraries, multi-service centers, parks and recreational facilities, public assistance centers, schools, and substance abuse counseling and prevention services.
Community outreach: Finally, outreach workers promoted the program directly in community settings where women and young children congregated, such as: grocery stores and neighborhood bodegas, hair and nail salons, health-related facilities and laundromats.

This multifaceted outreach strategy maximized the likelihood that eligible women were referred to, and had the opportunity to enroll in HSB. The value of HSB was appreciated by many in Bedford-Stuyvesant/ Brownsville area. Program participants referred their family members, friends and neighbors to the program. It was by word of mouth that many program participants located HSB services.

Program promotion was also conducted by all program staff in network meetings, presentations, community health fairs and other fora. Lastly HSB partners promoted its services with the development and wide-scale dissemination of a program flyer.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.

The Brooklyn Perinatal Network conducted outreach and client recruitment primarily in Bedford-Stuyvesant, while CWHA conducted outreach, client recruitment and case management for moderate-risk women in Brownsville. BPN had three outreach workers: two conducted outreach full-time and one served as outreach supervisor and conducted outreach half-time. BPN was experienced in coalition building to develop an effective consortium and community organizing to conduct effective outreach to engage hard to reach women and families. CWHA had three full-time staff responsible for both outreach and case management activities supervised by the CWHA HSB Coordinator. CWHA had a strong community health worker model of outreach and case management upon which HSB could build and strengthen with additional case management/outreach staff.

All outreach efforts were sensitive to potential concerns women may have in accessing services, and worked to allay fears. For women interested in services, field-based outreach workers arranged a time and place, for referral to the program where a public health nurse (PHN), case manager, social worker and nutritionist conducted the risk assessment to fully enroll the client for services. When women in need of services were not ready to access case management services, the outreach workers continued to work with them to address barriers and connect them to services. A team approach helped to assure a creative, problem-solving approach to supporting women in accessing services.

Upon agreement from the prospective client, the PHN met the client and conducted a screening and risk assessment. The program utilized a screening tool – the antepartum risk assessment – which is based on risk levels for psycho-social and poor pregnancy outcomes. This screening tool was adapted for use by all partners and was revised as needed to assure that it meets the needs of the population being served.
Based on the findings of the risk assessment, when case management services were deemed necessary and the client agreed, she was then formally recruited into the program. For clients who were not pregnant, a risk assessment regarding their overall health was conducted, and preconceptional or interconceptional counseling, education and referral services were then offered.

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

The successful initiation of HSB core services was held back by the slow contracting process between DOHMH and its sub contractors resulting in a delay in funding nine months or more before being received. This occurred annually except the final year on the HSB grant.

Implementation of core services is challenging based on the realities of Bedford-Stuyvesant and Brownsville which are demanding neighborhoods with many needs. The barriers to successful outreach and client retention largely relate to the many intertwined effects of poverty and racial/ethnic minority status. Prospective clients were wary of obtaining services because they are poor, distrustful of service providers, often lack a high school education or adequate housing, have multiple social and medical problems, and may be an undocumented immigrant.

Many HSB program participants had a very difficult time finding safe and affordable housing. Many local private shelters exclude women after delivery of their babies. This problem leads many postpartum women and some pregnant women and families to seek shelter at the New York City Emergency Assistance Unit located outside of Brooklyn. OCR was impacted greatly by client mobility. Some women participating in the program request a desire to remain in case management but cannot due to geographical constraints. In other instances outreach workers cannot find program participants and lose contact due to confidentiality constraints. When program participants do not initiate contact with HSB after a move, we lost a participant who needed Healthy Start services. This barrier was shared with the Regional Healthy Start Consortium and HRSA’s Region II consultant.

The New York City shelter system is vast and can be insensitive to the needs of the woman and her family. However, pregnant women are triaged quickly with the new Emergency Assistance Unit (EAU) process. Affordable housing has diminished and the waiting list for public housing was closed. Permanent housing options for clients are scarce and housing remains the number one issue that clients need to be addressed.

As a requirement of the TANF program many participants enter the Work Experience Program, and if the participant needs childcare she was expected to find a provider. Participants unable to find childcare were sanctioned or threatened with case closure. This presents a need for clients receiving BHS services to have a strong support network which was not often the case. The lack of safe and affordable childcare detracts from successful intervention.
Undocumented women who were pregnant and need prenatal care were no longer requesting services as observed in previous phases of the Healthy Start program. Changes in the immigration law and the emphasis on increased security since September 11, 2002 may be dissuading women from accessing services. The tri-application for WIC, Medicaid and Public Assistance, has contributed to a fear that a client’s personal information would be shared with the Immigration and Naturalization Service and the family would then be deported.

**Healthy Start Core Services: Case Management**

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets.

During the antepartum risk assessment, risk factors for poor pregnancy outcomes were determined based on scientific literature and American College of Obstetrics and Gynecology guidelines including: chronic medical illnesses and risk factors, including diabetes mellitus, hypertension, cardiac disease, and HIV/AIDS; pregnancy complications such as a history of early spontaneous abortion, fetal death or infant death, prior low birth weight or pre-term infant; and psychosocial risk factors, including smoking, drug or alcohol use, late prenatal care, unaddressed poor socioeconomic status, inadequate social support, homelessness, and history of domestic violence.

Based on this assessment, women with: one to four moderate risk factors were identified as moderate-risk; more than four moderate risk factors or two high risk factors were identified as high risk; three or more high risk factors or any one very high risk factor were identified as very high-risk; and women who did not qualify as moderate- to very high-risk for poor pregnancy outcomes were not offered case management but were offered health education services and referrals to prenatal care and other social services as appropriate. All women classified as moderate- high- and very high-risk were offered comprehensive case management and, if not already started, they were connected to prenatal care services.

Case management (CM) reflected a service delivery philosophy which affirmed a client’s rights to: a culturally competent provider, a quality life, privacy, confidentiality, self-determination, nondiscrimination, compassionate non-judgmental care, and dignity and respect. All HSB clients signed an agreement accepting case management.

Case management remained the vehicle by which this myriad of issues was addressed in a coordinated and integrated manner. The multi-step process of all case management employed by HSB included: intake; assessment; initial service plan development and implementation; reassessment; service plan update implementation; monitoring; termination and case disposition activities; client advocacy, interagency coordination and systems development activities; supervisory review; and internal case conferencing.
The case management model was the centerpiece of the program. Since the program’s inception, the CM model has been increasingly successful in helping pregnant women to deliver healthy babies and care for them through the infant’s first two years of life. CM increased the accessibility and acceptability of early prenatal health care for women. In addition, CM also addressed related issues: substance and alcohol use; HIV/AIDS; domestic violence; housing and child-care; concerns related to parenting skills, public assistance and immigration; language and cultural barriers; and education and job training needs.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.

Comprehensive case management was provided by BMIRH and CWHA. BPN provided additional case findings through its outreach and referral activities. There were differences in the case management model provided in Bedford-Stuyvesant and Brownsville, based on the role that each partner could play. The case management of high- and moderate-risk women in Bedford-Stuyvesant was nurse directed and coordinated at BMIRH. The case management of moderate-risk women in Brownsville was coordinated through lay community health workers at CWHA. This difference in approach was based on organizational capacities and strengths in each neighborhood.

Following a needs assessment, BMIRH public health nurses, public health advisors (PHA), social worker and/or nutritionist developed a care plan with the client. Home visits and coordination of care was provided by the public health nurse and a public health advisor (PHA), who worked together to address the clients’ health and social needs, and provide education, follow-up and referrals as needed. BMIRH case managers were managed by the Supervising Public Health Nurse (SPHN). Staff members were required to prepare weekly schedules of planned home visits, and weekly activity log submissions that recorded completed work which were reviewed and approved by both the supervising public health nurse and project director. Due to the program’s emphasis on finding housing and addressing clients’ immediate needs including food, clothing and baby supplies, the social worker met with clients in the office. Weekly team and staff meetings were conducted to support supervisory efforts and to keep staff informed and involved in working toward project goals. Individual supervision was provided to each employee monthly to review cases and provide feedback. Client satisfaction surveys and supervisory telephone calls to clients also provided guidance on case management activities and program development.

CWHA had five full-time staff: three case managers, supervised by its program coordinator and a nutritionist which was hired mid-contract. Each case manager had a minimum of 13 long-term cases and screened 35 individuals on average monthly. Trained case management professionals, who assess and assist families, and a nutritionist and social worker who provided an assessment of all prenatal clients, made up the community health worker service teams. This case management approach did not include clinical assessments, mirrored BMIRH’s screening process but CWHA staff worked closely with women to develop and
follow-up on individualized service plans, assuring that health and social needs were met and coordinated. CWHA were able to liaise with the SPHN when needed and she accompanied their staff on home visits.

Home visits provided an important adjunct to case management services whenever possible. However, incorrect addresses, partners who objected to such visits, family fear of exposure of undocumented immigrants in the home, welfare-to-work mandates and worker safety concerns, sometimes interfered with home visiting. In addition, clients living in someone else’s home or in the shelters were often concerned that home visits would be disruptive. In light of these barriers, HSB encouraged home visiting, especially during the initial assessment and when the baby was born, but it was not required. CMs also accompanied clients on health or social service visits. For instance, CMs accompanied clients to appointments and public benefit agencies as needed, and made special efforts to accompany a young mother to her first prenatal care visit. In addition, since many clients were likely to obtain their health care at clinics regularly visited by HSB case managers, contact with clients often took place in conjunction with clinic visits.

Orientation, and ongoing staff training and development, was provided by BMIRH’s Community Educational Services (CES). Orientation and training covered all key aspects of maternal and child health: pregnancy, nutrition, alcohol, tobacco and illegal substance abuse, smoking cessation, lead law update, HIV and STD, child health, and domestic violence. Skills-based training focused on outreach processes, including communication skills, relationship building, networking, documentation and cultural competency.

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

Case managers participated in a two-week core skills building training, facilitated by CES which focused on working with families using a strength-based model. Staff learned how to help families recognize their strengths and develop their own service plan designed to meet their personal goals and objectives. Staff also attended trainings facilitated by DOHMH covering topics like domestic violence and pregnancy, substance abuse and pregnancy and postpartum depression.

In 2002, Thomas Frieden was named Commissioner of Health in New York City. Under his leadership the department’s strategic direction included;

- Targeting service to communities with the greatest health need reinforcing DOHMH’s commitment to working in Bedford-Stuyvesant and Brownsville;
- Reducing delivery of direct case management (home visiting) services by DOHMH and build capacity for service delivery by community providers;
- Integrating outreach and case management services;
- Supporting program models that are evidence-based (proven to improve maternal and infant health and social outcomes) and are sustainable.
As a result of these policy changes, changes were made in the HSB program as well as the new services delivery model for the June 2005 HS cycle.

**Healthy Start Core Services Health Education and Training**

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

The overall goal of the health education and training core service was to increase the practice of health behaviors that promote maternal, infant and reproductive health among Healthy Start program participants and community residents at large. Toward this end, health education services employed a variety of strategies and structured learning opportunities, taking into account the culture and norms of the community, and the needs and priorities identified.

Program and community participant education, training and leadership development was the centerpiece of the HSB health education core service. The overall goals were to:

- Provide culturally sensitive information and resources to eliminate disparities in perinatal health;
- Increase provider and community knowledge of strategies to eliminate perinatal health disparities; and
- Strengthen and coordinate community-based services and empower communities to work together to reduce the infant mortality rate and improve the health status of women and infants.

*B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.*

Initially, HSB planned to engage one full-time and one part-time health educator to fulfill this essential core service. The health educator, supervised by the project director, had two staffing changes. In addition, due to changes in salary of other program staff, the part-time health educator position was eliminated. As a result, The health educator's role was to a) develop methods for assessing participant and community health education needs; b) interact with case management and direct service staff to expand knowledge base and develop teaching methods for effective learning; c) ensure culturally competent health education messages and materials; d) coordinate with other health education providers to utilize the rich resources available within Brooklyn and greater New York; and f) work with the Healthy Start Brooklyn team in planning and implementation of participant education activities.
One-to-one Education
Case management and other direct service staff members provided information, education and counseling to clients on a one-to-one basis as part of the case management process. Priority topics included expectations of a normal, healthy pregnancy, promotion of healthy behaviors such as nutrition, exercise, smoking cessation, avoidance of substance abuse, and prevention of HIV/STD. The expectant mother also learned ways to assess dangers in her pregnancy such preterm labor, perinatal depression, gestational diabetes, and signs of infection. She was also guided to consider the maternal role; topics such as breastfeeding, SIDS, family planning, job training or education were emphasized. Other topics were covered as needs emerged.

The case managers were assisted with best practice models and theoretical frameworks known to influence learning and behavior change.

Group Instruction
Individual education was augmented by group instruction. Education in group settings was provided or coordinated by the HSB Health Educator. Workshops on parenting skills and on maternal and child health risk factors were offered to program participants. Group activities incorporated a multimedia approach including participant-centered learning activities, presentations/discussions and videos in HSB program offices or other community-based locations, and offering both single and multiple session workshops. The topics covered a range of maternal, child health topics, as well as related social service issues such as housing, WIC, family planning, immigration, GED, job training and education.

The program participant sessions used innovative strategies such as peer education, support groups, and male involvement. The program targeted individuals, such as men, teenagers and extended family members that often were not reached through traditional parenting and education programs, and were tailored to the needs and sensitivities of the community.

Community Participant Education
Community participant education activities involved three related approaches to health education. These included education and training workshops; community special events and project area health campaigns; and public education materials. The underlying goals of these approaches were to increase awareness among community residents and providers of the disparities in perinatal health, measures to promote access to services, important actions and personal preventive health behaviors to improve health.

Education and Training for HSB Team and Health Care Providers
Orientation and ongoing staff training and development were provided by CES. Orientation and training covered key aspects of maternal and child health: pregnancy, nutrition, alcohol, tobacco, smoking cessation, lead law updates, illegal substance abuse, HIV and STD, child health, domestic violence and others. Training also included outreach processes, including
communication skills, relationship building, networking, documentation and cultural competency. In addition, each agency identified staff training and educational needs and assisted in conducting such training or identified workshops and conferences offered by other community agencies.

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

Health Education and Training began in earnest and met its goals during the first half of the grant period. During the last two years the lack of continuity in CES project staff provided detrimental to expanding health education and building a momentum based on earlier successes. That said, all project staff at DOHMH and partnering agencies received ongoing professional development throughout the grant beyond the initial project scope. For example, the perinatal depression team provided ongoing sessions on how to deal with clients with mental illness, and DOHMH provided cross-cultural communication and training, and web cast trainings on a myriad of maternal-child health issues.

Healthy Start Core Services Interconceptional Care

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets.

Client outreach and recruitment for the interconceptional care component was conducted by all HSB partners including Brookdale University Hospital and Medical Center, and Kings County Hospital Center. High-risk pregnant and postpartum women who resided in the PA were identified while in the hospital, admitted for delivery or as a result of a pregnancy-related complication. For those clients already discharged, the PHN/PHA collected contact information and followed-up to arrange a visit in the clients’ home. The initial interview, in the hospital or in the home of the client, determined if the client had emergent health and psychosocial service needs, or required immediate referrals, and if she was enrolled with another case management agency.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.

For the interconceptional program component, the case manager was responsible for conducting assessments, developing a plan of care with the client, and providing education, counseling and referrals for needed services. The case manager facilitated case management through a schedule of home visits, based on the level of risk evident in the mother and infant. The PHA, a lay health worker well experienced in and knowledgeable about the community, played a vital role in advocacy and in linking the client to health, social and supportive services. This ensured that the infant had a medical home, was not just receiving
episodic care, and that client could obtain preventive health care. Although the mother and infant were at the center of care coordination, the assessments also included a profile of family needs and its support systems. The case manager tried to link other children in the family with health services and to involve the spouse or domestic partner in the case management process. Since families often face multiple problems that often take priority over their health, staff responded to these needs by providing information about services, advocating on client’s behalf or by accompanying them to resources. Another aspect of case management was empowering clients through the development of knowledge and skills that enabled clients to negotiate service systems independently. Clients who received pregnancy testing services at BMIRH and tested negative received family planning information from HSB staff.

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

The interconceptual care component was substantially changed from project inception to implementation. The initial budget encompassed two full-time staff housed at Kings County Hospital Center that would be charged with providing interconceptual care. It became evident that once HSB began hiring staff that the salary-line items were insufficient to hire city employees. Given this budgetary shortfall, the decision was made to eliminate the two positions at Kings County Hospital Center.

At Brookdale, midwives referred clients to CWHA. Because the contract between DOHMH and Brookdale was so delayed their ability to maintain or hire staff was severely limited. On good faith, Brookdale engaged a doctor to serve on a voluntary basis to provide perinatal depression screening and interconceptional care, but given the contracting delay the volunteer ceased providing these services.

Interconceptional care was provided on a one-to-one basis to clients, especially those seeking pregnancy tests and those enrolled in case management. During the second half of the grant, HSB hired a social worker that successfully worked with her clients in spacing future births. Early in the project, at least six clients had repeat pregnancies. For those clients enrolled in HSB who were serviced by the social worker, not one client had a repeat pregnancy while enrolled in case management.

Because of staff turnover in the area of evaluation, a quantitative assessment of other successes as a result of case management and interconceptional care is harder to measure.
Healthy Start Core Services Depression Screening and Referral

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets.

Data from previous Healthy Start programs demonstrate that approximately 45% of pregnant and postpartum women experience some level of depressive symptoms. In clinical presentations, the majority of postpartum depression cases were mild in severity with more than one half of diagnosable cases meeting the criteria for minor rather than major depression. Depressive states during pregnancy or following delivery were not more frequent than at any other stages; however, there is an increased risk of depression commencing shortly after childbirth. For pregnant women who require treatment for depression and do not receive it, we know that it can lead to low birth weight, pregnancy complications, or preterm labor. In addition, for those who experience depression during their pregnancy are at high risk to develop postpartum depression. Women who are socially disadvantaged have unplanned pregnancies, have poor social support systems and those who have anxieties about the health of their babies were more likely to suffer postpartum depression. In light of this, the prevalence of postpartum depression may be higher for women in the PA. Persistent depression for postpartum women beyond the expected “baby-blues 6-8 week period” can interfere with appropriate bonding with the infant, result in poor parenting behaviors, put the child at risk generally, and for the mother, can lead to an early repeated pregnancy.

The goal of the project was to provide education, screening, evaluation and treatment of women who were at risk of perinatal anxiety and depression. The following were the plan objectives: 1) screen and recognize depression systems during the prenatal assessment, and initiate therapy; 2) address the mental and emotional needs of the women and support them through a normal healthy delivery; 3) observe the client during the postnatal period for signs of postpartum depression or psychosis and treat if necessary; 4) increase community involvement and awareness of the various types of emotional disorders women can experience during pregnancy and the postpartum period; and 5) provide in-service training to providers, staff from collaborating agencies and community organization regarding prenatal and postpartum depression.

The Edinburgh Postnatal Depression Scale (EPDS) – made available by the Association of Perinatal Networks of New York and the Postpartum Resource Center of New York, Inc. – was chosen as the screening tool for the depression treatment program. The EPDS focuses on the emotional and psychiatric aspects of depression. It is widely used both clinically and in research with pregnant and postpartum women, and is the only tool designed to screen women during the immediate and early postpartum period. It is also easy to understand (since it’s self administered), inexpensive, adequately sensitive and specific for a disorder.
B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.

These services were provided by Kings County Hospital Center through a depression treatment team (DTT). This program component was fully staffed with a psychologist, a psychiatric nurse practitioner, and a case manager throughout the grant period.

The Women’s Health Services at Kings County Hospital Center saw five to ten new clients daily for prenatal services which in turn were referred to DTT for depression screening. As a result, DTT screened 25-50 clients per week, out of which 20 were referred for further evaluation and treatment. In addition, because the DTT was successful in developing and building relationships within KCHC, we were able to facilitate depression screening and referrals of clients from other Kings County Hospital departments.

The referral process included the following:

- The WHS screening nurse performed initial intake on all new clients; the nurse gave a consultation form to the client, and referred her to the DTT for screening. Over time, this was expanded to screen clients who came in for re-visits.
- Based on the providers’ clinical assessment, all returning clients who did not go through the screening process were referred by their providers.
- The DTT was responsible for giving the EPDS to the clients. If the client’s score on the EPDS was 9 or above, the client was scheduled for further evaluation/treatment with the psychologist or the psychiatric nurse practitioner.
- All HSB partners – CWHA, BPN and BMIRH – used the EPDS to screen and refer clients to the depression treatment program.

Once the client came in for further evaluation the psychologist conducted a total psychological assessment on the client. At the end of the assessment, the psychologist made a recommendation for treatment, and referrals to appropriate services. If the client was in need of medication, the client was referred to the psychiatric nurse practitioner for medication and medication management. If the client’s need was therapy without medication, the client was referred to the psychologist. If the client was in need of case management services, then the client’s chart was forwarded to the social worker who worked with the case manager to link the client to the appropriate services.

Once the participant was screened and the participant agrees to go into therapy case management, a full intake was done (up to two sessions for evaluation and diagnosis), cases were then presented at treatment team meetings to assess appropriate treatment plan, type of therapy and therapist to be determined. Intensive individual therapy was for 90 days in total. After 90 days, cases were evaluated for discharge to less intensive treatment, group therapy or a referral to another agency for long-term treatment. Patients were referred to weekly group therapy for maintenance as long as necessary. When cases were presented at treatment team meetings, necessity of medication evaluation was also determined. Patients were
evaluated and seen on a monthly basis by the nurse practitioner for medication management.

Group therapy sessions – “Me and My Baby” support groups (12 weekly sessions) were tremendously successful. Group sessions offered new mothers ways to interact and bond with their babies, while giving them the opportunity to share their experiences, ideas, feelings, and concerns with one another. The group which met every Friday for an hour was facilitated by a psychologist intern who was supervised by a licensed psychologist. Refreshments were served and carfare was reimbursed.

DTT clinical staff also developed and conducted training sessions for HSB project staff on mental health issues, and the use of the Edinburgh Postnatal Depression Scale to ensure the most effective coordination of services. Because most staff members working in women health care settings have limited knowledge of mental illnesses, staff training focused on basic understanding of mental illness, and within that, postpartum depression, its sequel and treatment. The following diagnostic categories of mental illness were discussed: psychotic disorders; schizophrenia; mood disorders; major depressive disorders; bipolar disorders; and anxiety disorders. Postpartum depression was then introduced as a specific mental illness. The three aspects of postpartum depression were introduced and defined: postpartum blues; postpartum depression; and postpartum psychosis. In addition the following were discussed: socio-cultural factors and their impact on our patient population and on the incidence of postpartum depression; the effects of untreated postpartum depression on the mother and her infant; and prevention and treatment options.

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

Initially, this core service component began late and was rushed in the beginning without much thought or planning due to late receipt of funds. That said, the impact of the depression screening and referral component is incalculable.

First, the depression treatment program resulted in an increased collaboration between the Obstetrics & Gynecology Department and the Department of Behavioral Health at Kings County Hospital which in turn has set a standard for all other Health and Hospitals Corporation hospitals in New York City. Second, due to the uniqueness the program, numerous connections were established with various departments within DOHMH, HHC and MHRA who were also attempting to integrate depression screening in various manners into primary care. Third, various local hospitals and women’s health clinics have established connections with the depression treatment program. Fourth, perinatal depression has increasingly become of focus at consortium meetings and other women’s health forums.

Throughout the program from March 2002 – April 2005, the depression treatment program screened 2,019 women, conducted 1,062 individual sessions, 199 group sessions, and had 117 clients in ongoing treatment. The program presented at the following forums: BPN policymakers’ breakfast, Brooklyn Perinatal Consortium meetings, Brooklyn Perinatal Regional Forum, CWHA Advisory Council meeting, DOHMH staff meetings, KCHC social
work staff meeting, MIRHP Case Managers Training, National Women's Health Day, New Dimensions, New York City Citywide Regional Perinatal Forum, Northern Manhattan Perinatal Forum, SUNY Early Intervention program and Title IV grantee meeting.

We have found that 45% of both the pregnant and postpartum women we have seen have a significant level of depressive symptoms, which is much higher than is typically reported. There was very little follow up with treatment which appears to be due to several variables: stigma of mental illness intertwined with cultural issues, perception that they would receive poor quality of care, and fear of child welfare becoming involved if they admit to depressive feelings. The poor follow up with treatment is the largest barrier at this time.

Core Systems-building Efforts: Local Health System Action Plan

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets.

The local health systems action plan (LHSAP) was built upon a statewide framework for perinatal health, city-wide health promotion, community health assessment, and HSB needs assessments. The HSB LHSAP dovetailed with local action plan with city- and state-action plans.

“Charting a Course for Perinatal Health in New York State – A Framework for Strategic Planning” was the template used by perinatal health stakeholders and all levels of the perinatal system. It was developed by the Association of Perinatal Networks of New York which brought together NYSDOH, DOHMH, Healthy Start initiatives and perinatal networks to create the framework. It has three primary goals that mirror those of HRSA/HS: 1) eliminate barriers and health disparities; 2) assure quality care; and 3) improve the health infrastructure and system.

Take Care New York, New York City’s health policy agenda, recently developed by DOHMH, concentrates on ten core issues that have the biggest impact on New Yorkers’ health: 1) Have a Regular Doctor or Other Health Care Provider; 2) Be Tobacco Free; 3) Keep Your Heart Healthy; 4) Know Your HIV Status; 5) Get Help for Depression; 6) Live Free of Dependence on Alcohol and Drugs; 7) Get Checked for Cancer; 8) Get the Immunizations You Need; 9) Make Your Home Safe and Healthy; and 10) Have a Healthy Baby. These core issues have both direct and indirect impact on maternal and child health. Brooklyn District Public Health Office (BDPHO) coordinates efforts to fulfill Take Care goals for Central Brooklyn residents.

The DOHMH identifies needs as part of the citywide Community Health Assessment, required of all local health departments by NYSDOH and conducted every two years.
During the past two years, HSB developed a framework for the Local Health System Action Plan. The framework was developed for the Healthy Start Brooklyn grant (2001-2005), which encompassed an area composed of seven contiguous zip codes in Bedford-Stuyvesant and Brownsville.

The framework developed by the HSB partners and the consortium included: community health planning; planned activities; media campaign; women’s health/preconception health; community education; provider education; infant mortality review; SIDS reduction; low birth weight infant follow-up; implementation; evaluation and impact; and partnership development. We recognize that the current framework still needs to be refined appreciably with the broad input of a number of stakeholders. Most important is BPN and CWHA who provided the leadership to begin the creation of the existing framework.

The Healthy Start consortium was the policy and advocacy arm of the Healthy Start program in Brooklyn. Insights, challenges, and barriers were identified through outreach efforts, case management, educational programs, and, most importantly, consortium member knowledge and experience. These were discussed at consortium meetings and in consortium subcommittees. The consortium coordinator placed an emphasis on identifying key topics for action and developing plans for further research, data collection, needs assessment, policy analysis, policy development and advocacy. These priority issues and the strategies for addressing them became the specific goals of the LHSAP.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.

DOHMH brought together community groups and public health-related institutions to identify specific public health priorities and develop plans to address them. Community health profiles were developed enabling the health department to enhance its ability to assess and address a community’s particular public health needs. The BDPHO director played a leadership role in developing the Community Health Assessment for Central Brooklyn.

The framework was reviewed and revised by the HSB consortium, Comprehensive Prenatal-Perinatal Services Network (CPPSN) and Regional Perinatal Forum (RPF) members; in particular, specificity was sought regarding particular topics of focus and action steps. A four-year action plan was developed by December 2005. Implementation followed.

A fundamental responsibility of the community consortium coordinator was to ensure the development of the LHSAP. Consortium members that encompassed all categories of stakeholders were the leading force engaged in the development of the LHSAP. HSB team members that were also involved include the BDPHO director, administrators, staff and consumers and the evaluation team.
The LHSAP was built upon a statewide framework for perinatal health, city-wide health promotion, community health assessment, and HSB needs assessments. HSB dovetailed its local action plan with city- and state-action plans.

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

The greatest challenge in developing a LHSAP stemmed from the need to develop an integrated model that addresses mandated requirements from two primary sources of funding serving Central Brooklyn – HRSA and NYSDOH.

The overall objective of the Healthy Start consortium, reducing infant mortality and improving maternal and child health broadly in the community, was shared by two other collaborations in Central Brooklyn: the State-funded Comprehensive Prenatal-Perinatal Services Network, led by Caribbean Women’s Health Association, and the Brooklyn Regional Perinatal Forum, co-led by CWHA and SUNY Downstate, a Regional Perinatal Center. Most Healthy Start consortium organizational members were also part of these other collaborations. Indeed, over the past several years, the leadership of these three collaborations, acknowledged the need to avoid duplication of effort, to use participants’ time judiciously, and to coordinate efforts to maximize results, have planned on integrating these collaborations into a single umbrella entity. The umbrella entity was the Regional Perinatal Forum, initiated in 2003. Both the CPPSN and HSB consortium brought unique characteristics to the umbrella entity.

The process of integrating this work began with in-depth conversations with the co-chairs of the RPF, CPPSN and DOHMH. The BDPHO promoted this integration, and worked to ensure that the development and implementation of LHSAP was led by community participants selected by the consortium membership, that membership was broadly inclusive of community-based organizations, government agencies, and medical providers, and that the partnership strived for substantial and consistent consumer participation.

The sustainability of financially vulnerable service providers and CBO’s also served as a challenge. Loss of funding for safety net programs and services was a recurring risk with declining public and private funding sources. Significant energies were usually diverted to address these reductions, including collaboration and technical assistance in expanding resource development which was discussed as a component of the LHSAP. Another challenge was both geographical spread and population density. It was important to consider geography and how population related to the neighborhoods when stakeholders agreed to be responsible for implementation of a plan component. Every effort was made to include all stakeholders in the development of the plan to optimize ownership and stewardship for its implementation. Lastly, it is critically important that our area’s doctors and other decision-makers are fully involved and invested in developing local health system action plans.
In our proposed model for future years, DOHMH and BDPHO will provide a facilitative role in ensuring the development of the LHSAP and making certain it ties into, as well as informs, county, city and state action plans. Understanding these priorities and accessing health departments’ expertise and leadership is more fully understood as a result of our experiences with our current Healthy Start grant.

Core Systems-building Efforts: Consortium

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets.

The role of the HS consortium was to: 1) Recommend policy for HS, and contribute to the development of HS and other related applications for provision of services to the PA’s perinatal and infant population. 2) Contribute to, review and recommend approval of the local health action plan. 3) Advise on organizational approaches for coordination and integration of services across the PA. 4) Provide advice regarding program direction and strategies for implementation. 5) Ensure conflict of interest policies govern all activities of the consortium. 6) Receive reports of program management activities such as data collection, monitoring and evaluation, and public education. 7) Assure referral systems and linkage arrangements for the continuity of care across service providers. 8) Share responsibility for the identification and maximization of resources for project purposes. 9) Promote community ownership to planning, to sustain project services beyond the funded period. 10) Continually recruit organizations/groups with the requisite interest, skills, and resources in infant mortality and perinatal health. 11) Sponsor, conduct, and monitor educational training and awareness activities for service providers to ensure HS has sensitivity and understanding of the special needs that impact the perinatal health of the PA. 12) Ensure the ongoing participation of clients and consumers representative of the target population in the consortium and in HS project activities. 13) Encourage and ensure a commitment from service providers to enhance the development of cultural competence in service delivery.

The existing Bedford Healthy Start Consortium, which has served the Brooklyn Perinatal Network-based Healthy Start project for several years, has engaged in advocacy, needs identification, services coordination, education and consumer development to improve the status of maternal and child health. The Consortium advised the Healthy Start/New York City project on approaches and solutions to addressing barriers to care and challenges to accessing services for project area residents at high risk for poor health status and birth outcomes. Participants of this consortium included health and social service providers, clients/consumers of the project services, area residents, health advocates, community-based organizations and community leaders.

Ten years of continued commitment in supporting the Healthy Start mission, from a range of organizations, has enabled the program to take full advantage of its members’ expertise and work to ensure maximum integration and enhancement of service delivery.
**B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.**

BPN chaired the local-level Healthy Start Consortia. The consortium maintained a committee structure of six standing committees and/or workgroups as needed. The consortium's goals were to: increase the proportion of consumers/providers participating in the work of the Healthy Start/Brooklyn consortium on program and policy direction for the HSB Project; increase the capacity (knowledge and skills) to participate in the consortium of at least 65% of the local consortium members; and achieve a common understanding of the local Healthy Start initiative, community empowerment and collaboration among all consortium members.

The Brooklyn Healthy Start Consortium worked closely and collaborated as appropriate with the Healthy Start New York City Consortium and the Brooklyn Task Force of Infant and Maternal Mortality and Family Health. The Brooklyn consortium design included two co-chairs, a provider and a consumer co-chair with an additional consumer "in-training". The consumer "in-training" was one who possessed leadership potential and received additional support and mentoring to take on the task of co-chair.

The consortium met on a quarterly basis. At minimum, committees or workgroups met once per quarter and reported on activities at the general consortium membership meetings.

The following committees/workgroups were established:

**Management and Governance:** The Management and Governance committee served as the HS consortium executive committee and as the anchor for the Brooklyn Healthy Start's collaborative structure, while providing oversight for the project. The membership included the project partners, chairs of the sub-committees, and representation from public and private MCH groups.

**Evaluation:** This committee ensured that the initiative was meeting its overall program goals and objectives and having an improved impact on systems building, collaboration and service coordination. This committee developed an evaluation tool for outreach and case management and developed a method to report on the consortium processes such as increased linkages and improved service coordination. This committee also ensured that bi-directional referrals/linkages among consortium members occurred. Bi-annually, the committee reviewed the overall project.

**Consumer Involvement:** This committee was heavily focused on education/trainings to consumers. Consumers were the primary participants of this committee. In Year 2, the committee selected one priority issue related to improved health and well-being outcomes and conducted a workshop series. Another activity included visiting newly elected officials at the state, federal and city level to discuss policy issues.
Inter-conceptual/Pre-conceptual: This committee focused on reviewing education materials available and assessed its cultural appropriateness and sensitivity, with a particular focus on adolescents. This committee reviewed current materials available and selected appropriate materials for use. As a committee they conducted a health education workshop at two alternative high schools.

Perinatal Depression: This committee provided a special focus on the mental health needs of women during pre- and post-natal periods of birth and childbearing process, which is vital to the acquisition of birth outcomes. This committee conducted quarterly evaluation review of this component of the project. They continued to identify, refer and provide education and support, and monitored the outcomes.

Resource Development: This committee worked to identify potential sources of funding to preserve key initiatives and supplement Health Start funds. In Year 2, this committee identified two businesses for consortium participation.

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

Some major challenges for the effectiveness of the consortium were:
- Inconsistent participation/involvement of consortium members
- Limited resources were available to provide financial and other incentives for consumers’ involvement.
- High mobility of consumers/clients, usually due to housing instability.
- The management of the Consortium needs a wider inclusion of stakeholders, policy makers, and constituency in following up on proposed activities.

D. For consortium, please address the following additional elements:

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

The success of Healthy Start was founded on its collaborative, community-driven model which established a consortium in 1991 to assure overall coordination and to maximize community participation. In 1992, the HS/New York City by-laws defined the relationships, roles and responsibilities of the Project's major stakeholders, and described the mission of the HS/New York City Consortium and other governing bodies responsible for meeting the Project objectives.

Beginning in 1998, dramatic changes in health care delivery, welfare and immigration policy changed the barriers to access early and continuous prenatal care, postpartum care, and infant immunizations. In response to these changes in health care and the economic and social climate, the Healthy Start/New York City Consortium expanded into the Citywide Healthy Start Consortium in 2002. The expanded consortium took on additional
responsibilities in the areas of policy education and advocacy to address barriers confronting participants’ access to services, including services enabling them to receive public benefits to which they were entitled.

Historically, the Perinatal Networks were NYSDOH-sponsored programs with a maternal-child health mandate. From their early days, they supported the development and coordination of local perinatal services by working closely with the NYSDOH, DOHMH, and New York State Office of Children and Family Services (OCFS). Thus, they were uniquely positioned to play a leadership role in creating and enhancing perinatal system linkages. The infusion of Healthy Start funds helped the Brooklyn Perinatal Network expand these efforts. In particular, the consortia formed at local levels became crucial mechanisms for promoting collaboration among various segments of the perinatal system, and for providing a forum for policy development, service coordination and consumer participation in HS/New York City's development and administration.

2) Briefly describe the working structure of the Consortium which was in place for the majority of the implementation, its composition by race, gender and types of representation (consumer, provider, government, or other). Also, please describe the size of the consortium, listing the percent of active participants.

The working structure of the consortium included several standing or ad hoc committees including consumer participation; governance; interconceptional care; perinatal depression; and resource development and sustainability.

Goals for the racial and ethnic breakdown of the consortium were: 83% black (African-American, Afro-Caribbean and new immigrants from West Africa), 10% Latino, 5% white, and 2% Asian. The racial and ethnic breakdown was: 95% black (African-American and Caribbean) and 5% other. A matrix guided recruitment efforts to work towards a racially and culturally representative community Consortium comprised of both providers and consumers. To achieve the goals outlined in the Matrix required focused recruitment of new members by existing members.

Types of representation on the consortium included program and community participants; community-based organizations; private agencies and organizations; providers contracting with HSB; hospitals and health care providers; faith-based organizations; businesses; and representatives from state and local government.

The consortium has 142 members: 85% of the consortium participants attended at least 50% of meetings. These included general quarterly meetings and sub-committee meetings. Of the 142 members, 4% (no more than 12) program and community participants; 26% community-based organizations; 8% private agencies and other organizations; 8% providers contracting with HSB; 38% hospitals and health care providers; 1% faith-based organizations; 4% businesses, including health plans; and 11% representatives from state and local government.
Based on this experience, the ideal makeup of a future HSB Consortium is as follows:

<table>
<thead>
<tr>
<th>Member Percentages</th>
<th>Categories</th>
<th>Example of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>Program participants</td>
<td>Primarily consumers engaged in case management services at BSFHC and SCO/FD</td>
</tr>
<tr>
<td>10%</td>
<td>Community participants</td>
<td>Past clients, parent advocates, block association members <em>(Leaders that were not necessarily affiliated with a CBO)</em></td>
</tr>
<tr>
<td>15%</td>
<td>Community-based organizations</td>
<td>Abundant Life, Brooklyn Perinatal Network, CAMBA, Caribbean Women’s Health Association, Bedford Stuyvesant Crown Heights HIV Care Network, Miracle Makers, Early Head Start, Head Start, Planned Parenthood of New York City</td>
</tr>
<tr>
<td>5%</td>
<td>Private agencies &amp; organizations</td>
<td>Training programs, HMO’s, professional associations</td>
</tr>
<tr>
<td>8%</td>
<td>Providers contracting with HSB</td>
<td>BPN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CWHA <em>(Voluntary/ executive leadership; front-line staff)</em></td>
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<tr>
<td>17%</td>
<td>Hospitals &amp; health care providers</td>
<td>Brookdale University Hospital and Medical Center, Brownsville Multi-Service Family Health Center, Interfaith Medical Center, Kings County Hospital Center Lyndon Banes Johnson Health Complex, Maimonides Medical Center and SUNY Downstate, Woodhull, Wyckoff Heights Medical Center</td>
</tr>
<tr>
<td>10%</td>
<td>Faith-based Organizations</td>
<td>Bridge Street AME, Christ the Rock Church, Concord-Baptist Church, Lenox-Road Baptist Church, Mt. Lebanon-Baptist Church</td>
</tr>
<tr>
<td>5%</td>
<td>Businesses</td>
<td>Recruit members from Brooklyn Chamber of Commerce business; community-relations staff from local banks and small businesses</td>
</tr>
<tr>
<td>15%</td>
<td>State &amp; local government</td>
<td>Representatives from: Administration for Children Services (ACS) Brooklyn District Public Health Office (BDPHO) City Council’s Office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Boards 3, 8 and 9 including members from their health committees</td>
</tr>
</tbody>
</table>
3) **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/collaboratives serving the same population.

As detailed above, the Consortium was engaged in the completion of the Development of a Local Health Systems Action Plan which addressed ongoing needs. BPN and CWHA led the development of the LHSAP with CDOH and NYSDOH. This plan proposed to coordinate planning efforts of other maternal and child health forums. The coordination of planning efforts included the Brooklyn Healthy Start Initiative Consortium, the NYSDOH Comprehensive Perinatal-Prenatal Services Network (CPPSN), Regional Perinatal Forum (RPF), Brooklyn Task Force, Infant Mortality Reduction Initiative (NYC Council Initiative), Northern Brooklyn Coalition, Administration of Children Services’ Neighborhood-based Services Network. In reviewing the outcomes of the consortia and taskforces, common issues included: service coordination and linkage, advocacy for public policy, access to care, collaboration with Title V agencies, outreach and clinic engagement, public promotion, resource development and consumer and community education. The Advocacy and Public Policy subcommittee served three of the forums mentioned above, and the two forums; Healthy Start and the Comprehensive Perinatal Prenatal Services Network held joint meetings twice a year, to reduce redundancies.

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

The community recognizes the tremendous need for and the importance of a well-functioning consortium to address maternal child health. This is the single largest strength which has enhanced consortium development. By agreeing to plan and focus in a collaborative way, the consortium development process began to develop a systems-of-care approach for maternal, child and family health. The strength of this approach is its comprehensive nature that supports the community’s safety net of health and human service providers to preserve and expand service capacity to meet the needs of families.
bearing and parenting infants and young children.

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

It was critical to have every consortium member participate in the conversation. Creative participative approaches were essential to ensure the exchange of ideas, and develop effective channels of communication. Meeting agendas were developed in advance and mailed in a timely manner in an effort to actively engage all attendees to participate in the meetings. Participants across all categories will be encouraged to attend breakout sessions that are not related to their subgroup or professional occupation to allow for cross-fertilization of ideas.

In addition to providing various meeting formats, HSB involves members in one or more, standing or ad hoc committees of interest including consumer participation; governance; interconceptional care; perinatal depression; and resource development and sustainability.

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

All providers were encouraged to recruit consumers for involvement in the consortium (general meetings and/or committee participation). Addressing additional gaps in representation was the responsibility of all consortium members. Areas not represented that were targeted include: teen parenting programs, housing, immunization, substance abuse, community businesses, entitlements and health insurance providers, and elected officials. DOHMH was the primary recruiter for governmental agencies participating in the consortium. Financial and personal development incentives were utilized to attract residents who were potential clients, as well as clients for participation in the Healthy Start consortium.

The most effective strategies used for engaging consumers and residents in the HS consortium activities was providing an incentive, such as childcare, refreshments at meetings and events, and/or providing information and referrals for essential services, such as employment, small business/cottage industry, education, housing, citizenship. Hosting of activities and workshops, by the consumer and other sub-committees has been successful in addressing topics of interest to consumers. From these workshops, we were able to identify consumers who were interested and had the time to participate in quarterly consortium meetings, advocacy activities, training/development sessions and other consortium-sponsored activities, such as outreach and community informational events. Sometimes car fare/taxi/travel was reimbursed for events. Public transportation metro-cards and incentive gifts, and refreshments were always provided and advertised on the outreach flyers. Consortium participants and project partners were asked to identify and recruit clients and other consumers to participate in activities. The consortium coordinator followed up one-on-one with consumers to support and encourage their involvement with other consortium activities. Clients in the case management process were also solicited for participation in...
HSB actively encouraged consumers to attend outside meetings, including the New York State meetings of Healthy Start projects. This proved to be a tremendous challenge to program participants (by definition program participants were mothers with one or more young children, often single heads of households) to obtain childcare to attend and engage in discussions at decision making tables. In the future, HSB will develop relationships with day care agencies that can offer care on a one-time basis to consumers able to attend HSB meetings.

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

Consumers were invited to participate in consortium committees including consumer involvement which made recommendations to HSB for activities to address participants’ needs. During this grant cycle, consumers requested social activities and skills-based programs on parenting, resume writing, and how to develop home-based day-care businesses.

8) How did you utilize the suggestions made by the consumers?

HSB put consumers’ suggestions into action. For example, the consumers suggested that the consumer workgroup change its name to Parent Support and Skills Development Group. Consumers served on the governance committee/executive committee, committees that developed communications or marketing materials, among others. New consumers joining the consortium were mentored by consumers with experience serving on consortiums to welcome them and encourage their participation.

Training and support were provided to consumers to serve as the voice of Central Brooklyn participants at the local, state and national level. Leadership training with workshops on a range of topics including how to run meetings, build consensus, develop negotiating skills and use critical thinking, and public speaking were offered.

Core Systems-building Efforts: Collaboration and Coordination with State Title V and Other Agencies

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets.

At the community level, DOHMH facilitated and supported the Healthy Start consortium in collaboration with the New York State-funded Comprehensive Pregnancy and Perinatal Service Network and the Regional Perinatal Forum; and refined and implemented the local health systems action plan. These efforts were coordinated with New York State Title V sustainability program and with other agencies, including the New York State Office for
Children and Families Services.

NYSDOH’s Title V MCH grant supports the Regional Perinatal Forums which actively promotes a city wide review of MCH. BMIRH coordinates and supports New York City’s five Regional Perinatal Forums and facilitates the Citywide Perinatal Forum. HSB learned from and contributed to the discussion aimed at improving perinatal outcomes and decreasing disparities in access to care. The BMIRH regularly communicated with the Bureau of Women’s Health and Title V to assure coordination and support of New York City’s comprehensive maternal and child health services.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.

HSB has worked to strengthen the existing collaboration between DOHMH and NYSDOH by working directly with NYSDOH, with recipients of Title V funding that service the HSB PA, and with HSB’s partners.

NYSDOH has expressed its commitment to maintaining a strong collaborative relationship with the HSB initiative. HSB and partner staff participated in several meetings held by the NYSDOH with all NYS Healthy Start grantees to ensure coordination with other state MCH activities, and provided an opportunity to share experiences and best practices.

HSB has ongoing communication with the NYSDOH Title V representative in New York City, regarding program implementation. We have had preliminary discussions with this State representative regarding the role of DOHMH and NYSDOH in the development of a citywide perinatal health plan. As a participant on the Citywide Healthy Start Consortium, the NYSDOH Title V representative has advised us as to the ongoing role of the Citywide Consortium in coordinating with NYSDOH efforts. Currently, DOHMH in partnership with NYSDOH, identified a program person, Sandra True, R.N. to facilitate the coordination of the operation for the Borough-wide Regional Perinatal Forums.

DOHMH has a long-standing and cooperative relationship with Medical and Health Research Association (MHRA), the previous Healthy Start grantee, and a key recipient of Title V and Title X funds. MHRA, through MIC-Women’s Health Services, is the largest provider of prenatal care in New York City, a PCAP provider, and a long-standing participant in DOHMH Women’s Healthline’s Direct Appointment System. A revised linkage agreement with MIC was established this year. BMIRH case management staff initiated regular site visits to MIC sites to enhance referrals to both programs, and improve referrals of high risk women in prenatal care to HSB case management services. MHIRP met with the Community Healthcare Network, another Title V recipient, to develop and formalize a similar relationship.
C. Identify any resources or events that either facilitated or detracted from successful initiation and implementation of each intervention.

Coordination of services for HSB clients has remained a challenge throughout. Our reality is shared by all agencies serving our communities. In May 2005 Commissioners from the city’s child welfare, homelessness, probation and welfare departments convened in Bedford Stuyvesant to launch a new project designed to ease delivery of services. *One City/One Community* is geared toward families who live in Bedford-Stuyvesant, are served by three or more city agencies, and whose cases are considered difficult to resolve. Rather than have each family apply for help at several different agencies, the project will assemble the relevant case workers and address the family’s problems en masse. The city hopes the three-year pilot project will serve approximately 200 individuals or families per year and eventually spread to other neighborhoods.

**Core Systems-building Efforts: Sustainability**

A. Describe how you decided on your approach to each service, and each Core Systems-building efforts and the rationale for your particular approach based upon your particular community’s needs, service system and its challenges and assets.

Overall, HSB was a partnership of agencies with years of experience addressing perinatal health in the Project Area served by the initiative. The Resource Development Committee of the HSB Consortium explored and applied for public and private funding opportunities. HSB partners also developed plans to specifically address sustainability. All partners were successful in securing additional resources in support of their services, and continued to seek funds for their services.

B. Identify the components of your intervention and the resources (including personnel) needed to implement the intervention. Note any changes over the project period and the rationale for the changes.

The Resource Development Committee worked to identify potential sources of funding to preserve key initiatives and supplement Healthy Start funds. In Year 2, this committee identified two businesses for consortium participation.

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

Under Denise Hilton’s leadership the Comprehensive Prenatal-Perinatal Services Network supported by the NYSDOH held a series of successful semi-annual joint meetings with over 50 attendees. In June 2004, Dr. Jung from Kings County Hospital Center provided a historical perspective on health disparities in New York City. Given the interconnectedness with CPSSN, HSB initiated an ongoing dialogue with our areas doctors and hospitals which
will help sustain the progress achieved during the past four years.

D. For sustainability, please address the following additional elements:

1) Describe your efforts with managed care organizations and third party billing.

DOHMH participates in NY CONNECT, a program that allows us to bill Medicaid for case management services provided in specific zip codes. DOHMH began billing for Medicaid services. This program provides a source for third party reimbursements back to the program. Internal meetings were ongoing to ensure that dollars raised by the program would come directly back to program services HSB program needs. Currently, funds raised by the programs are being redeployed back to the HSB program service.

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

DOHMH secured support – through the NYSDOH – for the Community Action Plan for Prenatal Care Initiative to reduce mother-to-infant HIV transmission through the recruitment of high-risk pregnant women into prenatal care. Through this funding, BMIRH staff conducted outreach, provided HIV counseling and testing, linked women to prenatal care or other health services, and case management. DOHMH also received funding through the NYS Early Identification and Intervention Services project to provide HIV counseling and testing to women seeking pregnancy testing at our field sites.

BPN collaborated with the ACS System of Care project (which received federal funding for five years) and with the Successful Start Healthy Families America Home Visiting Program (funded by OCFS) to effect coordination as a sustainability measure. Both programs targeted the MCH population of fragile families and served part of the HS target area in the Bedford health district.

Additionally, BPN – sought through its CHIP process – the development of partnerships and collaborations that would result in resources that could be harnessed to preserve and enhance the community’s MCH service capacity. Agenda for Children Tomorrow (ACT), a public-private partnership project, supported this planning effort. ACT secured resources for ACS to establish and maintain Neighborhood Based Services Networks and community collaboratives.

3) Describe whether or not you were able to overcome any barriers or to decrease their negative impact.

BMIRH was able to overcome the barriers it faced and any potential negative impact that would have resulted through sound management and in-kind support from DOHMH. Any policy direction changes that were not anticipated at the grant’s onset that decreased in-kind staff support to HSB were compensated by seeking volunteers completing professional training through an internship program.
III. Project Management and Governance

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

The management and governance steering committee maintained primary responsibility for project management and governance. The committee met quarterly. The BMIRH and its five subcontractors were all fully engaged and active committee participants. The committee was co-chaired by Lorna Fairweather (BMIRH) and Denise West (BPN). Committee membership encompassed:

BMIRH
Lorna Fairweather, MPH, Project Director
Adah-Capri Adkins, Secretary
Sandra True, RNC, MPH, Director of Community Initiatives *(2nd half grant)*
Debbie Kaplan, RPA, MPH, Assistant Commissioner *(1st half grant)*
Marie Etienne, RN, Supervising Public Nurse III *(Sep 2002 -)*
Leslie Leila Brandon, MSW, MPH *(June 2002 -)*

Brookdale Hospital
Roger Kim, MD

Brooklyn Perinatal Network
Ngozi Moses, Executive Director
Denise West, Deputy Executive Director
Ronald Vializ, Outreach Supervisor
Lawrence Ubakanma, Senior Outreach Worker
Jennifer James, Consortium Coordinator
Joy Bobb, Project Manager *(1st half)*
Yolanda Vascones, Project Manager *(2nd half)*

Caribbean Women’s Health Association
Adrienne Mercer, Program Coordinator
Martha Reid, Senior Case Manager
Antoine Sears, Nutritionist

Kings County Hospital Center—Perinatal Depression Program
Gregory Calliste, Deputy Executive Director
Hilary Combs, Psy.D., Clinical Director
Sylvia Garbutt, RN, MSN, Nurse Practitioner
Andrea Remy, Coordinating Manager

NYSDOH
Martha Baez, Deputy Director of Women’s Health
Implementation decisions were determined by the management and governance committee which was well attended by all agencies. BMIRH was responsible for quality assurance, data management and evaluation; administrative functions including the budgetary activities, and the monitoring of Healthy Start expenditures and reports. BMIRH’s assistant commissioner was responsible for ensuring the HSB program was integrated into overall direction and policies of the health department.

The leadership team which BMIRH provided was tremendous. Brief biographies of key BMIRH staff follows:

**Deborah Kaplan**, R-PA, MPH, is the Assistant Commissioner of the Bureau of Maternal, Infant and Reproductive Health, New York City Department of Health and Mental Hygiene. Ms. Kaplan provided overall leadership and oversight of the DOHMH role with the Healthy Start Grant, and supervision of Sandra True, Director of Community Initiatives. She interacted with DOHMH Assistant Commissioner/BDPHO, Deputy Commissioner/Division of Health Promotion and Disease Prevention, and Commissioner. Ms. Kaplan led the city’s efforts in applying for HRSA funding in 2001 and provided primary oversight until November 2002 on our grant. Ms. Kaplan has over 25 years experience in clinical care, health education, program development and program leadership in the public sector in New York City.

**Sandra True**, BSN, MPH, RN, as the Director of Community Initiatives for the Bureau of Maternal, Infant and Reproductive Health, New York City Department of Health and Mental Hygiene managed the implementation of the NYC Regional Perinatal Forum Initiative, supervised the BHS program in Bedford-Stuyvesant/Brownsville; developed new forms and data system that tracked HRSA indicators; oversaw the implementation of Nurse-Family Partnership in Queens and Harlem and now in process in Brooklyn, and developed and implemented a Newborn Home Visit Program in Central/East Harlem and Bedford-Stuyvesant/ Bushwick. She joined BMIRH in November of 2002. Ms. True has over 35 years experience in nursing with 25 years experience in administrative, clinical, and community health care delivery internationally and nationally.

**Lorna Fairweather** is the Project Director of HSB and is situated at the BMIRH Bedford-Stuyvesant field site. Since September 2001, her responsibilities have included the day-to-day administration and oversight of the Brooklyn Healthy Start Project, general project development and the coordination and monitoring of program activities. She collaborates with community providers and provides oversight of the Consortium and co-chair the Governance Committee. She also coordinates with the supervising public health nurse that is responsible for the case management services delivered by the team at site of the lead agency. In addition, she meets with the four partners to ensure the performance of contractual obligations of the partners in the project and the implementation of service activities of all project staff. She reports to the Director,
Community Initiatives. For the 13 years prior to joining the health department, Ms. Fairweather worked at the Caribbean Women’s Health Association where she served as Director of Social Services when she left. Ms. Lorna Fairweather was born in Jamaica, West Indies and migrated to New York City in 1974.

**Hilary Combs** served as the Perinatal Depression Coordinator with oversight of the depression screening, referral and treatment process; creation of educational programs for community providers and consumers; and formation of a women’s mental health network in Brooklyn. Beginning in 2001, Ms. Combs has held the position of Clinical Director, for the Perinatal Depression Treatment Program, Healthy Start Brooklyn, at Kings County Hospital Center. She has designed and implemented assessment and treatment of pregnant and postpartum women; collected data and designed outcome measures; conducted trainings for doctors, nurses, case managers and volunteers; provided group, individual, and couples treatment with pregnant and postpartum women suffering from depression or other emotional disorders; and supervision and teaching of, staff, psychiatric fellows, psychology interns and externs.

**Yvonne Sinclair** served as Director, Community Educational Services in the Bureau of Maternal, Infant and Reproductive Health at the New York City Department of Health and Mental Hygiene since 2003 where she supervises eight staff in the design and implementation of training and education for providers in maternal, infant and reproductive health, and in parenting education for consumers. She brought 25 years of experience in developing and implementing health education programs and in program management.

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

Within BMIRH’s office of grants management – Wilmer Ortiz and Marlene Lewis – were essential for fiscal management. Monthly meetings were held to review expenditures and re-direct funds for programmatic use. Program management officer, Edward Morgan was responsible for accounts payable. Both Debbie Kaplan and Lorna Fairweather provided program management continuity throughout the four-year grant period which proved essential.

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

Effectiveness was limited by our ability to hire and manage staff, purchase needed goods, contract appropriately and manage contractors.

From the project’s onset, monthly or bimonthly meetings were held. Meetings were held more often when programmatic changes were implemented, especially when BMIRH updated its data collection system and new forms were introduced in January 2004. Management teams,
comprised of the project director and supervising public health nurse or director of community initiatives met with staff at each agency to ensure understanding and compliance with these changes.

In early 2002, Thomas Frieden was named Commissioner of Health in New York City. Under his leadership the department’s strategic direction focused on data collection and analysis; strengthening health promotion; monitoring contracts more effectively; and strengthening central and divisional administrative support. Transforming data into information was seen as critical to set priorities, and monitor efforts and programs. Public health management encompassed sound management of people and data. Under the leadership of a new commissioner, the city began efforts to get out of direct service delivery resulting in a massive redeployment of nurses and public health advisors. As a result of this large scale policy change, HSB was able to engage a highly qualified supervisory public health nurse (Level III) which resulted in need for budget modification. Personnel resources were shifted into the supervisory public health nurse and out of Kings County Hospital Center for interconceptional care because there were not enough funds.

On July 1, 2002, the New York City Department of Health merged with the Department of Mental Health, Mental Retardation and Alcoholism Services enabling the City to address complex health problems with an integrated public health and mental health response.

In 2004, Take Care New York set an agenda of the City’s ten priority health interventions and a framework for action. These ten priorities encompass: 1) have a regular doctor or other health care provider; 2) be tobacco free; 3) keep your heart healthy; 4) know your HIV status; 5) get help for depression; 6) live free of dependence on alcohol and drugs; 7) get checked for cancer; 8) get the immunizations you need; 9) make your home safe and healthy; and 10) have a healthy baby. These core issues have both directly and indirectly impacted maternal and child health. DPHO coordinated efforts to fulfill Take Care goals for Central Brooklyn residents.

The project director reviewed the project’s scope and relative progress at the outset in order to adjust the staffing to meet the community’s needs. In September 2001 there were three nurses and four public health advisors at BMIRH available to complement HSB staff. Based on the budget, HSB decided to eliminate one nurse and one public advisor at Kings County Hospital Center, and incorporated the mandates dictated by these positions by the overall program.

Contracting was a tremendous barrier to program implementation. There were significant delays in contracting, staff hiring and significant staff turnover which had the greatest negative impact on evaluation.

Sandra True was brought on board as the director of community initiatives to oversee these changes in management.
D. Describe what process had to be developed to assure the appropriate distribution of funds and what happened with the process over time.

We looked at what was happening programmatically and matched funds appropriately by expanding the SCOPE; deliverable-based system as required by DOH; partners’ contracts included invoice and billing into their contracts. HSB met monthly with the grants management fiscal team. The program management officer, put a system into place that enabled the fiscal expenditures to be reviewed daily by director of community initiatives and program director.

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

The evaluation team was staffed and functioning in July 2002. The Healthy Start project evaluator, Dr. Leslie Kaufman, was hired in July 2002, to design and direct the Healthy Start program evaluation. In addition to Dr. Kaufman, Ms. Linnea Evans, a CDC Public Health Prevention Specialist, who was a research fellow at the DOHMH, conducted research on the project. This encompassed site visits, participating in meetings, and conducting field observations. Ms. Cynthia Alston, an MIS specialist/data analyst at the DOHMH, also worked on the evaluation. Gwendolyn Richardson, PhD, who is a researcher in the Bureau, was added to the HSB team to assist in the development of new forms and data system. (Dr. Kaufman was a HS resource, while all other participants were “non-HS” resources.)

Unfortunately, both Dr. Kaufman and Ms. Evans were on leave during the second half of 2003 resulting in a tremendous deficit in quality assurance and program monitoring. HSB was never able to effectively replace the evaluation team. Likewise the psychologist for the Perinatal Depression Program went on leave in late 2003 returning in March 2004.

In September 2004, HSB established relationships with Columbia University School of Social Work; New York University School of Social Work, and NYC Administration of Children’s Services (ACS). Social work interns were placed at HSB under the supervision by the social worker, and provided support to the case managers. ACS helped the social work team broaden its scope and impact, which was an important factor in service utilization.

After the reorganization of the bureau, HSB lost the DOHMH in-kind services of three public health advisors and two clerical staff.

During the grant period, Adam Karpati, MD, MPH was named Assistant Commissioner at DOHMH and director of the Brooklyn District Public Health Office (BDPHO), a newly established, community-based arm of the health department serving low-income, high-risk neighborhoods in North and Central Brooklyn. BDPHO targets resources and programs on a variety of topics, including lead poisoning prevention, physical activity and nutrition, and early
child development. A key priority for the BDPHO is partnering with local community-based organizations to plan and implement programs. Dr. Karpati is a physician and medical epidemiologist, and was the lead author on two recent health department publications: Health Disparities in New York City which documents socioeconomic and racial/ethnic health inequities across multiple health outcomes, and the series Community Health Profiles which compiles a broad array of health and sociodemographic data for 42 NYC neighborhoods. Dr. Karpati began to oversee DOHMH’s contribution to the broader, community-oriented aspects of the project, including ensuring the inclusiveness and success of the community consortium, and the development and implementation of a community action plan.

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

All project staff and contractors receive cultural competency training. In addition, HSB staff and contractors reflect the clients served by speaking French, Spanish, Creole and Ibo.

IV. Project Accomplishments

A. Describe each major strategy implemented, with its goals and objectives and accomplishments for this project period. Within the narrative describe in quantitative and qualitative terms the degree of success in achieving the goals and objectives. Describe any barriers that had to be dealt with during implementation and how they were addressed. Summarize all lessons learned. Strategies and goals and objectives that were commonly used across services can be cross-referenced. You may wish to use the Suggested Format, in Attachment A for this part of your report.

See the table on the following page.

B. For those projects that received mentoring or technical assistance from another site, please discuss any activities/lessons learned from those projects that you utilized in your project. If you provided technical assistance, describe your activities, feedback received on them, and any other lessons learned.

Not applicable.
### Project Implementation Components

<table>
<thead>
<tr>
<th>Goals &amp; Objectives: By 6/1/05 ...</th>
<th>Project Performance Indicators</th>
<th>Overall Project Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthy Start Overall Accomplishments:</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Infant Mortality Rate</strong></td>
<td>Decrease by at least 20% (9.7/1,000 live births) the infant mortality rate for the PA.</td>
<td>Infant mortality rate of infants born in the PA.</td>
</tr>
</tbody>
</table>

### Healthy Start Core Services:

<table>
<thead>
<tr>
<th>Outreach and Client Recruitment: Individual</th>
<th>Number of women/adolescents in the PA who have one-on-one contact with an HS outreach worker.</th>
<th>Number of women/adolescents in the PA who have one-on-one contact with an HS outreach worker.</th>
<th>From June 2001 to May 2005, 17,024 families were reached through outreach and client recruitment. Of these 9,848 were assisted during the prenatal period and 7,176 were assisted during the interconceptual period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach and Client Recruitment: Group</td>
<td>300 outreach presentations will be held at service sites in the HS PA.</td>
<td>Number of outreach activities held at health and social service sites in the HS PA.</td>
<td>Together CWHA, BPN and DOHMH conducted an average of 6 outreach presentations monthly for a total of 288 presentations.</td>
</tr>
<tr>
<td>Project Implementation Components</td>
<td>Goals &amp; Objectives: By 6/1/05 …</td>
<td>Project Performance Indicators</td>
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<tr>
<td><strong>Case Management:</strong></td>
<td>At least 524 moderate- or high-risk pregnant women who are continuing their pregnancy enroll in CM.</td>
<td>Percentage of moderate- or high-risk pregnant women in the PA who are enrolled in CM.</td>
<td>Baseline: The average number of MIRHP moderate- or high-risk pregnant clients who were enrolled in CM at the Bedford field site in FY ’00 was 210. From June 2001 to May 2005, 3,014 families were reached through case management. Of these 1,249 were assisted during the prenatal period and 1,765 were assisted during the interconceptional period.</td>
</tr>
<tr>
<td><strong>CM: Home Visiting</strong></td>
<td>At least 4,460 home visits by will be made by HS staff.</td>
<td>Number of home visits made by HS staff.</td>
<td>Baseline: Number of home visits made to MIRHP Bedford site clients in FY ’00 was 504. From June 2001 to May 2005, 2,584 families were reached through home visiting. Of these 1,137 were assisted during the prenatal period and 1,447 were assisted during the interconceptional period.</td>
</tr>
<tr>
<td><strong>CM: Social Work</strong></td>
<td>4,000 HS clients will be served by the HS social worker for assessment, support groups and/or referral for mental health services.</td>
<td>Percentage of HS clients who are served by the social worker for assessment, support groups and/or referral for mental health services.</td>
<td>Baseline: The average number of MIRHP Bedford site clients in FY99-FY00 who received social work services was 132 (38% of clients). Out of 1,000 case management visits and interventions, 166 clients needed social interventions. HS had one social worker on staff to serve these 166 clients from February 2002 - March 2005. A 90% retention rate was achieved for completed referrals and/or interventions. Social work services were not available from June 2001 to January 2002.</td>
</tr>
<tr>
<td><strong>CM: Prenatal Care Utilization</strong></td>
<td>Increase to at least 80% the number of pregnant HS participants who initiate prenatal care in the 1st trimester of pregnancy.</td>
<td>Percentage of participating pregnant women who are enrolled in prenatal care in the 1st trimester of pregnancy.</td>
<td>Baseline: Average percentage (1996-1998) of live births in the PA where the mother began prenatal care in the first trimester of pregnancy was 47%. 41% of the MIRHP Bedford site CCM clients began PNC in their first trimester.</td>
</tr>
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<table>
<thead>
<tr>
<th>Project Implementation Components</th>
<th>Goals &amp; Objectives: By 6/1/05 …</th>
<th>Project Performance Indicators</th>
<th>Overall Project Accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM: Nutrition</td>
<td>Increase to 85% the number of prenatal and postpartum HS clients in CM who receive nutrition screening, counseling, and education.</td>
<td>Percentage of prenatal/postpartum HS participants in CM who receive nutrition screening, counseling, and education.</td>
<td>A total of 1,529 women received nutrition education and counseling services including referrals to WIC throughout the project period. CWHA hired the HSB nutritionist mid-contract. In addition, HSB screened 3,806 prenatal women for overweight/obesity, underweight, hypertension, gestational diabetes and periodontal infection. Of these 26% received further risk prevention counseling.</td>
</tr>
<tr>
<td>CM: Smoking, alcohol &amp; substance use Screening</td>
<td>Provide screening for 98% of HS participants regarding the use of smoking, alcohol and substance abuse.</td>
<td>Percentages of participating pregnant and parenting women who receive (1) screening.</td>
<td>A total of 3,806 prenatal women and 7,063 interconceptional women were screened for smoking, alcohol and illicit drug use from June 2001 to May 2005. Nearly every woman receiving ongoing case management and home visiting services was screened.</td>
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<tr>
<td>CM: Smoking, alcohol &amp; substance use Referrals</td>
<td>Provide counseling, education and referral services for 90% of HS participants who smoke cigarettes or are alcohol or substance abusers.</td>
<td>Percentages of participating pregnant and parenting women who receive counseling, education and referral services for smoking, alcohol and/or substance abuse.</td>
<td>Of those women screened for smoking, alcohol and substance use, 37% of prenatal women received further risk prevention or risk reduction counseling and 15% of interconceptional women received risk prevention/risk reduction counseling. Of the 3,806 prenatal participants who received HIV/AIDS screening, 32% received risk prevention and/or risk reduction counseling and/or were referred for further assessment and/or treatment.</td>
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<tr>
<td>CM: Partner Violence</td>
<td>Increase to 95% the number of HS participants who are screened for partner violence.</td>
<td>Percentage of HS participants who are screened for domestic violence.</td>
<td>A total of 3,806 prenatal women and 7,063 interconceptional women were screened for domestic violence from June 2001 to May 2005. Three percent of prenatal clients and two percent of interconceptional clients were referred for further services.</td>
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<td>Project Implementation Components</td>
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<td>CM: Low Birth Weight</td>
<td>95% of low birth weight infants of HS participants will be referred for early intervention service visit within 2 weeks after hospital discharge.</td>
<td>Percentage of low birth weight infants of HS participants that are referred to their first early intervention service visit within 2 weeks after hospital discharge.</td>
<td>From June 2001 to May 2005 HS participants had a total of 299 live births. Of these 11% were low birth weight and 1% were very low birth weight. Direct health care service records were not collected for program and community participants. The percentage of low birth weight infants who were referred for early intervention within 2 weeks after hospital discharge is not available.</td>
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<tr>
<td>CM: First Pediatric Appointment</td>
<td>95% of infants of HS participants will attend their first scheduled pediatric appointment within 4 weeks after hospital discharge.</td>
<td>Percentage of infants of HS participants who attend their first scheduled pediatric appointment within 4 weeks after discharge from the hospital.</td>
<td>Baseline: Average % (FY99-FY00) of infants of Bedford MIRHP CCM clients who attended their first pediatric appointment within 4 weeks after hospital discharge was 89%. Direct health care service records were not collected for program and community participants. A total of 352 infants (0 to 11 months) and 220 children (12 months to 23 months) were served throughout the program. The percentage of infants who had their first pediatric appointment within 4 weeks after hospital discharge is not available.</td>
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<tr>
<td>CM: Immunizations</td>
<td>85% of 2 year-olds of HS participants will have received the full schedule of age-appropriate immunizations.</td>
<td>Percentage of 2 year-old children of HS participants who have received the full schedule of age-appropriate immunizations.</td>
<td>Baseline: The average (1996-98) level of immunization for children under the age of 2 in the PA was 58.2%. The CM and social worker asked to see immunization schedules for the children of participants in the program. They report that age-appropriate immunizations were on schedule.</td>
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<tr>
<td>Health Education and Training: Provider</td>
<td>Provide HS-related training workshops to at least 350 PA health and social service providers.</td>
<td>Number of health and social service providers who attend at least one training session provided by HS staff.</td>
<td>Baseline: Number of health and social service providers who received training through MIRHP in FY00 was 945. This is citywide total – there is no baseline number for PA providers. The CES unit in the BMIRH is charged with providing training workshops to the health and social service providers who are directly serving HS clients.</td>
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<td><strong>Health Education and Training:</strong> Program &amp; Community Participants</td>
<td>Provide at least 575 HS participants with health education sessions on, at a minimum, smoking cessation, HIV/STDs, domestic violence, nutrition and stress reduction.</td>
<td>Number of participating clients who attend at least one health education session.</td>
<td>A total of 7,775 women and 3,813 pregnant women received one-on-one health education during outreach, case management or home visiting services.</td>
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<td><strong>Health Education and Training:</strong> Program &amp; Community Participants</td>
<td>Provide 325 HS parents with workshops, support groups or one-on-one parenting education sessions about infant/child care and development.</td>
<td>Number of participating HS parents who participate in parenting education activities.</td>
<td>A total of 654 HS participants participated in pregnancy/childbirth activities and parenting skill building/education workshops and support groups.</td>
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<td><strong>Health Education and Training:</strong> Program &amp; Community Participants</td>
<td>Increase to 75% the number of HS participants who receive preconceptional screening, counseling and education regarding health and social factors that can impact on having a healthy pregnancy and infant.</td>
<td>Percentage of preconceptional HS participants who receive preconceptional screening, counseling and education at the time of a negative pregnancy test or during outreach activities.</td>
<td>The Depression Treatment Program clinical staff also developed and conducted training sessions for HSB project staff on mental health issues, and the use of the Edinburgh Postnatal Depression Scale to ensure the most effective coordination of services. The Depression Treatment Program presented at the following forums: BPN policymakers’ breakfast, Brooklyn Perinatal Consortium meetings, Brooklyn Perinatal Regional Forum, CWHA Advisory Council meeting, DOHMH staff meetings, KCHC social work staff meeting, MIRHP Case Managers Training, National Women's Health Day, New Dimensions, New York City Citywide Regional Perinatal Forum, Northern Manhattan Perinatal Forum, SUNY Early Intervention program and Title IV grantee meeting.</td>
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<td><strong>Interconceptional Care</strong></td>
<td>Increase to 60% the number of HS participants who receive interconceptional CM services for 2 years after delivery.</td>
<td>Percentage of HS participants who receive interconceptional CM services for two years after delivery.</td>
<td>Baseline: Average number of MIRHP clients at the Bedford site FY’99-FY’00 who received interconceptional CM services (for 1 year) after delivery was 69. 31% of HS participants were pregnant while 63% were interconceptional (6% were under 2 years of age). The number of repeat pregnancies was very low. For those women in intensive case management and home services, interconceptional care and counseling helped clients delay the onset of another pregnancy.</td>
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<tr>
<td><strong>Depression Screening and Referral: Screening</strong></td>
<td>Provide screening for 98% of HS participants regarding prenatal &amp; postpartum depression.</td>
<td>Percentage of HS participants who receive depression screening.</td>
<td>Throughout the program from March 2002 – April 2005, The Depression Treatment Program has screened 2,019 women. At a small scale, The Depression Treatment Program has increased collaboration between the OB/GYN Dept. and the Dept of Behavioral Health at Kings County Hospital and has set a standard for other HHC hospitals. At a larger level, due to the uniqueness the program, connections have been established with various departments within DOH, HHC and MHRA who are also attempting to integrate depression screening in various manners into primary care. In addition, various local hospitals and women’s health clinic have established connections with the Depression Treatment Program. Increasingly, perinatal depression has become of focus at consortium meetings and other women’s health forums.</td>
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<tr>
<td><strong>Depression Screening and Referral: Treatment</strong></td>
<td>Provide treatment, counseling, education and referral services for 90% of HS participants who are diagnosed with prenatal &amp; postpartum</td>
<td>Percentage of HS participants who need services are treated, counseled and/or referred.</td>
<td>Throughout the program from March 2002 – April 2005, The Depression Treatment Program conducted 1,062 individual sessions, 199 group sessions, and had 117 clients in ongoing treatment. We have found that 45% of both the pregnant and postpartum women we have seen have a significant level of depressive symptoms which is much higher than is typically reported. There is very little follow up with treatment which appears to be due to several variables: stigma of mental</td>
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### Project Implementation Components

- **Goals & Objectives: By 6/1/05 …**

  - Depression.

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<td>Depression</td>
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<td>Illness intertwined with cultural issues, perception that they will receive poor quality of care, and fear of child welfare becoming involved if they admit to depressive feelings. The poor follow up with treatment is the largest barrier at this time.</td>
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**Depression Screening & Referral**

In year one, 3/02-12/02, the strategy was to try to outreach to various domains within Kings County Hospital Center as a way of educating providers and to increase screening and referrals as few referrals were coming from case management services. Initially, outreach and depression screening were conducted in the maternity unit, the antenatal observation unit, as well as in the prenatal clinics. It was discovered that the first two days after giving birth was not an optimal time to screen for depression as the women were preoccupied with their new baby and their fragile physical state. Although the women on the antenatal observation unit often appreciated the services, the census was inconsistent and often the clinician were spending a lot of time for very few patients.

In the second year, 1/03 – 12/03, it was decided that focusing on the outpatient prenatal and family planning clinics was the most efficacious way of conducting outreach and screening. At the same time, the depression treatment team was conducting workshops and trainings in the community to raise awareness of perinatal depression and the treatment that was being provided through Healthy Start. In the second year, as the program became more established in women's health, groups were started to involve more patients and expose them to a type of therapy. The drop-in pregnant women’s group was established, the mommy-baby group and the medication education group.

In the third year, 1/04 – 12/04, the Depression Treatment team started to explore new ways to impact the community. The Baby Boutique was initiated, a room in which donated clothes, toys and other baby items were
**Project Implementation Components**

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<td>collected for needy mothers, and holiday and spring gatherings were organized to give gifts and have mothers interact socially. In addition, improvement in screening methods and follow up with treatment was also being explored. This was not accomplished in the third year however, in our fourth year, 1/05 – present, 100% screening of all new prenatal patients and patients having their GCT test has been initiated. The OB/GYN department became a staunch advocate of mental health screening and incorporating it into routine care.</td>
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**Core Systems-building Efforts:**

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<th>Consortium: Overall</th>
<th>Effective, well functioning local HSI consortium comprised of local providers, CBOs, businesses, hospitals, government agencies and consumers.</th>
<th>Attendance and participation at meetings, involvement in subcommittees (work groups), representation of key groups on the consortium, etc.</th>
<th>Baseline: The current Bedford HS Consortium is led by the BPN through existing HS funds. This consortium does not include participant from Brownsville, and is missing some key participants from Bedford. Community buy-in was reflected by active participation particularly in the last year. HSB could have done a better job on policy issues.</th>
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<tr>
<td>Consortium: Consumer Involvement</td>
<td>Established, informed and trained group of at least 5 consumers who participate fully in the Healthy Start Consortium.</td>
<td>Number of consumers who complete a consumer training program and are active participants in the HS consortium, as measured by participation and involvement in general and committee meetings.</td>
<td>Clients were active in subcommittee that planned social, educational, skill-building events as was their attendance in said sessions. For example, over 30 consumers receiving services at CWHA and BPN attended Kwanza celebrations. However, consumer involvement on the consortium and advocacy meetings was a challenge. Stronger mentoring and partnering clients with other participants will counter the less consistent participation of consumers in the full-scale Healthy Start Consortium meetings.</td>
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V. Project Impact

Based on a review of all of your project’s HS grant submissions during the project period, and the services and strategies implemented, describe the impact of Healthy Start on your Project Area and community. Please organize your description using the outline below.

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

1. Describe the approaches utilized to enhance collaboration.

DOHMH and its partners worked to merge a number of task forces into one to enhance collaboration. Up until this coalescing of multiple consortia, the same individuals went to the each of these meetings with similar goals and objectives. This was a tremendous accomplishment. HSB actively collaborated with Title V partners and the NYSDOH.

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

As a result of activities carried out by the HSB grant, Kings County Medical Center has developed new procedures and policies to integrate screening for perinatal depression into clinical care. The Kings County depression treatment team has built upon this success by increasing awareness and capacity of clinical and community providers in the screening and treatment of perinatal depression. The stigma attached to mental health issues was decreased, and efforts to encourage integration of screening, treatment and/or referral into providers’ practice began. There is an ongoing commitment by consortium members to continue to address perinatal depression in North Central Brooklyn.

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

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

Numerous relationships developed between and among agencies and organizations throughout the grant period.

- For example, graduate social work programs at the Columbia School of Social Work, New York University School of Social Work and ACS provided student interns to do field work placements for one year with the HSB social worker. Both nursing students and MPH graduate students also provided services to HSB.

- HSB worked with the Women’s Health Committee at DOHMH to host a domestic
violence forum entitled “Community Dialogue on Domestic Violence: A Brooklyn Perspective on Violence Against Women.” The overall turnout was spectacular; there were 138 attendees and representatives from community organizations and governmental agencies. We are pleased that the DOHMH made domestic violence one of the ten priority interventions in its Take Care New York health policy reminding both men and women that physical violence and abuse is against the law.

- Networked with existing group homes and shelters for placement of clients.

- BPN linked its HSB program with its programming for adolescents. The New York City Housing Authority held an HIV/AIDS awareness days for teens in Dec 2004.

- BPN forged relationships with immigration-related agencies to include immigration workshops and business-development skills as part of Healthy Start.

- CWHA worked with WIC (again part of Title V) within target area.

- Hospital involvement: Continued participation and collaboration with the area’s major hospitals such as Kings County Hospital Center, SUNY Downstate Medical Center, St. Mary’s Hospital/St. Vincent’s Catholic Medical Center, and Brookdale Hospital (particularly their Sickle Cell Prevention & Education project)

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

HSB engaged consumers, community and faith-based institutional leaders in its work. For example:

**Private partnership to combat SIDS** – This initiative focused on increasing consumer awareness about Back-to-Sleep and other infant safety issues. Following the completion of workshops on infant safety, participants received vouchers to receive a free crib through a local distributor. Over 150 women participated in the workshops and received cribs for their infants. This partnership was initiated by a local businessman in response to a news article about an infant death. The businessman and his colleagues paid for the cribs. HSB hopes to build upon the success of this model in the future.

**Meetings with State Beauty Culturist Association** – BPN and the Association met to discuss how to best utilize beauty salons and barber shops as community health information and resource centers to increase community and consumer awareness. The program was not finalized before end of project period.

**Coalition to SAVE Our Hospitals** – During the project period, two Central Brooklyn hospitals, Interfaith Medical Center and St. Mary’s Hospital, proposed to reduce their maternity services.
HSB was instrumental in educating and advocating on behalf of the community with policy makers and faith-based organizations on how these decisions will impact the community.

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

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

HSB served as the primary advocate for our clients in their ability to access health and social services. We were successful in intervening on behalf of clients through ongoing individualized advocacy led by the program’s social worker and case managers. Intensive documentation and case files proved a powerful tool in this regard. For example, letters on behalf of clients were invaluable in helping a new mother and her infant secure housing (often reversing negative decisions made by the relevant agency).

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

BMIRH ended the pregnancy testing service in February 2003 which resulted in fewer walk-in clients utilizing HSB services. This required more vigilant outreach efforts to create community awareness of services. Over time clients generated a greater awareness of services through word-of-mouth referrals.

For young women beginning their families locating an affordable, safe apartment was and remains extremely difficult. Homeless pregnant women that HSB served are moved from shelter to shelter every ten days, until they are placed in Tier II temporary housing. The challenge also poses a barrier to follow-up, women may be moved from one location to another throughout New York City, at a moment’s notice, and HSB was then unable to maintain their participation. This barrier impacted the continuity of case management was challenged due to transient stuff.

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

The social worker and case managers coordinated care. The continuity of care was greatly improved over the life of the project as BMIRH as each partner grew to fully understand each others strengths, and the best avenues to access care for their clients. Clients self-reported their completion of referrals to their social worker and/or case manager.

d. Efficiency of agency records systems and sharing of data across providers (within the confines of confidentiality rules) to reduce the
All data was recorded in accordance with HIPPA rules by DOHMH.

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

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

   The providers are representative of the cultural, linguistic and gender (both female and male outreach workers and volunteers were engaged) needs of the community serviced. Provider training, including cross-cultural communication, worked to further enhance provider sensitivity to their clients’ needs.

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

   HSB’s approach to attract consumer participation encompassed: 1) feedback from its prior Healthy Start experiences, 2) feedback from clients on effective approaches and methods of engagement, and 3) training recommendations. This approach worked to ensure that culturally appropriate and competent workers were utilized.

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

1. **Residents’ knowledge of resource/service availability, location and how to access these resources:**

   Because Healthy Start has been present in Brooklyn since 1991, its rich history provided a solid base on which to link and coordinate outreach services and referrals.

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

   By strengthening the leadership of all stakeholders – program and community participants – HSB will be better positioned to reduce disparities in access to and utilization of healthcare. Based on our experience during this grant cycle HSB will carry out the following activities during the next three years:

   - Identify four HSB consumers committed to provide leadership for the Consortium Consumer Involvement Committee. (CY 2005)
- Identify three policy/planning initiatives of interest and importance to the community consortium and, working through the consortium, initiate progress towards implementation. (CY 2006)

- Provide leadership and advocacy training to 10 CBO staff and consumers to strengthen consumer and community voice and involvement in HSB program implementation and sustainability, and in assuring a responsive local health system. (CY 2007)

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

Divergent opinions are common in our community. The consortium’s leadership needed to improve their ability to listen to and respect divergent opinions, and resolve conflicts. Team building activities continue to listen to and respect divergent opinions, and resolve conflicts. Team building activities continue to take place in 2005 and are planned for 2006 following DOHMH decision to partner with two CBOs with evidence-based case management models where home visiting is central to meeting the family’s needs. HSB will continue to forge its relationship with CWA and BPN given the decision to partner with other community-based partners. However, both organizations systemically involved in the Title V/NYSDOH funded initiatives. Hence, the strong need for an active, ongoing partnership. We will need to continue to resolve these conflicts and conduct team building activities.

HSB will need to develop and implement think-tanks for the community at large. Consortium committees will then be responsible for developing mechanisms to implement think tank ideas. During biannual consortium meetings team building activities will be scheduled and members will be engaged to buy into the process and plan. Engaging community leaders and their staff members into the process well versed in working with divergent opinions will be employed. In particular, Congressman Edolphus Townes, who co-wrote the Healthy Start legislation, will be invited to engage in these activities.

4. Creation of jobs within the community.

While HSB did not create jobs within our community, through case management services clients were encouraged to get a G.E.D., go to vocational schools and college.

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

The New York State Title V MCH grant supported the Regional Perinatal Forums which actively promoted a city wide review of MCH. BMIRH coordinated and supported New
York City’s five Regional Perinatal Forums (RPF) and facilitated the Citywide Perinatal Forum. HSB learned from and contributed to the discussion aimed at improving perinatal outcomes and decreasing disparities in access to care. BMIRH regularly communicated with the NYSDOH Bureau of Women’s Health and Title V to assure coordination and support of New York City’s comprehensive maternal and child health services. DOHMH and all HS partners participated in the biannual meetings hosted by the State.

The DOHMH facilitated and supported the Healthy Start consortium in collaboration with the New York State-funded Comprehensive Pregnancy and Perinatal Service Network (CPPSN) and the Regional Perinatal Forum, in order to refine and implement the local health systems action plan (LHSAP). These efforts were coordinated the with New York State Title V sustainability program and with other agencies, including the New York State Office for Children and Families Services (OCFS).

Intercollaboration was the biggest benefit to the state. Coordinated activities across the city and state have served to create a seamless process between Healthy Start and Title V. As a result of the intercollaboration, lessons learned in one project are exported to other cities and towns providing Healthy Start in New York State and in our region. HSB works closely with the State Title V representative. For example, at the Regional Healthy Start Meeting held in New Jersey in June 2004, HSB and the State’s Title V representative made a joint presentation.

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

New York City examined health inequalities across the city’s five boroughs and its many neighborhoods which resulted in an appropriate allocation of resources, development of sound public policies, an understanding of what was achievable and by highlighting ten major public health concerns in *Take Care New York* the local government drew attention to efforts to promote maternal and child health. Because the local government served as the lead agency of the project, we were able to connect HSB to other city agencies and programs to better address our clients’ needs.

The primary barrier for HSB was the city’s contracting process. This created tremendous programmatic and fiscal challenges which had to be overcome.

The Fund for Public Health in New York, Inc. (FPHNY) was established to address this barrier. FPHNY, a public-private partnership that leverages the capacity of the New York City Department of Health and Mental Hygiene, is dedicated to the advancement of the health and well-being of all New Yorkers. Both agencies are skilled at combining multidisciplinary approaches with traditional proven public health strategies to eliminate health disparities in neighborhoods and communities most at risk due to poor social and economic conditions. Beginning in June 2005, FPHNY will ensure efficient contracting and grants management on the newly proposed HSB model.
E. **Lessons Learned:** If not discussed in any sections above, please describe other lessons learned that you feel would be helpful to others.

In our reapplication for continued support, the following guides the reapplication plan based on lessons learned during this grant cycle:

- Target service to communities with the greatest health need.
- Reduce delivery of direct case management (home visiting) services by DOHMH. Build capacity for service delivery by community providers.
- Support program models that are evidence-based (proven to improve maternal and infant health and social outcomes) and are sustainable.
- Integrate outreach and case management services.

Our proposed model for Healthy Start Brooklyn draws on the experience and lessons learned from the current DOHMH Healthy Start grant, as well as other DOHMH programs aimed at low-income communities. Of the seven zip codes served by HSB, four no longer meet the HSB-IMR requirement of <10.58. The three that remain eligible are 11212, 11216 and 11233. These experiences have convinced us of the importance of integrating outreach and evidence-based comprehensive case management services.

One of our key insights over the past four years is the need for outreach and recruitment to be conducted by the same organization that will be providing other key services, particularly case management. Outreach and client recruitment is best accomplished by staff that works for the agency providing case management services to participants. This provides a seamless system for services.

Healthy Start Brooklyn will employ two approaches to the long-established service strategy of home visiting: The Nurse-Family Partnership and Healthy Families New York. Both programs use evidence-based models that have demonstrated improvement in maternal and infant outcomes in randomized controlled trials.
VI. Local Evaluation

Using the suggested format in Attachment C, submit a copy of the Healthy Start Local Evaluation Report for each local evaluation conducted. Instructions pertaining to this report are provided in Attachment B.

Not available. As detailed in III Project Management and Governance, local evaluation of HSB was not staffed during the second half of the grant. As a result, a local evaluation report is not available.
VII.  Fetal and Infant Mortality Review

For those programs that developed or participated in a FIMR, please identify the length of time you have had a FIMR process; whether it includes an emphasis on maternal and child mortality as well; the components of the process (including whether it has a home visitation component) and funding sources. Indicate whether you use a two-tiered approach [e.g., Community Review Team (CRT) and Community Action Team (CAT)] and what challenges and changes have occurred over time. Describe major accomplishments in implementing recommendations arising from the FIMR process and any other lessons learned.

Not applicable.
VIII. Products

* A copy of any materials that were produced under the Healthy Start grant funding must accompany this report. Examples of products include but are not limited to the following: brochures, booklets, posters, videotapes, audiotapes, diskettes, and CDs.

A HSB brochure and BPN-produced newsletters will be mailed under separate cover in mid-August.
IX. Project Data

Required forms are completed as directed.
X. List of Abbreviations

Administration for Children’s Services (ACS)
Brookdale University Hospital and Medical Center (BUHMC)
Brooklyn District Public Health Office (BDPHO)
Brooklyn Perinatal Network (BPN)
Bureau of Maternal, Infant and Reproductive Health (BMIRH)
Caribbean Women’s Health Association (CWHA)
Case Management (CM)
Community Educational Services (CES)
Comprehensive Prenatal-Perinatal Services Network (CPPSN)
Department of Homeless Services (DHS)
Depression Treatment Team (DTT)
Division of Healthy Start and Perinatal Services (DHSPS)
Edinburgh Postnatal Depression Scale (EPDS)
Health and Hospitals Corporation (HHC)
Healthy Start Brooklyn (HSB)
Human Resources Administration (HRA)
Infant Mortality Reduction Initiative (IMRI)
Kings County Hospital Center (KCHC)
Local health systems action plan (LHSAP)
Maternal Infant Clinics (MIC)
Medical and Health Research Association (MHRA)
New York City Board of Education (BOE)
New York City Department of Health and Mental Health (DOHMH)
New York City Housing Authority (NYCHA)
New York State Department of Health (NYSDOH)
New York State Office of Children and Family Services (OCFS)
Outreach and client recruitment (OCR)
Project Area (PA)
Public Health Advisor (PHA)
Public Health Nurse (PHN)
Regional Perinatal Forum (RPF)
Women’s Health Services, Kings County Hospital Center (WHS)