HEALTHY START IMPACT REPORT 2001-2005

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

Downstate New York Healthy Start (DNYHS) was created in 1997 under Phase II of the Healthy Start Initiative. Since 1999, the project has been organized as a partnership of three community-based organizations and a school of public health. Columbia University Mailman School of Public Health (CUMSPH) serves as the grantee and subcontracts with the following agencies that serve as local lead agencies to provide Healthy Start services: Economic Opportunity Commission of Nassau County Inc (EOC).; Queens Comprehensive Perinatal Council, Inc. (QCPC); and Suffolk County Perinatal Coalition, Inc (SCPC).

The DNYHS service area crosses three geopolitical boundaries in metropolitan New York City and Long Island. The project ranges over 50 miles from the semi-rural Suffolk County hamlets of Bellport (zip code 11713), Coram (zip code 11727), Medford *(*zip code 11763), and Patchogue (zip code 11772), to the suburban Nassau County town of Hempstead (zip code 11550), to the urban Queens communities of South Jamaica (zip code 11433), Rockaway Beach (zip code 11692*)*, and Arverne (zip code 11693).

Although highly diverse in nature, the communities share several common characteristics. Each of the target communities are in proximity to areas of great wealth. However, their residents, predominantly African-American, Latino, and immigrant, find themselves on the social and economic periphery with health and supportive services often unavailable or inaccessible. From 2001 to the present, each project area experienced large growth in its immigrant population, most arriving from impoverished communities in Central America and the Caribbean. DNYHS' target areas are, therefore, a mixture of well-established and newly rooted communities.

The initial needs assessment conducted in 2001 indicated that the racial and ethnic disparity in perinatal health was significant. One of the clearest expressions of the target population's disadvantage is the alarmingly high ratio of black infant deaths to white infant deaths. In the period from 1996 through 1998, black infants were 4 times as likely to die within their first year as were white infants in the DNYHS project area. This ratio was double the national black-white disparity in infant mortality during that time period. The black infant mortality rate for the combined areas was 14.1 infant deaths for every 1,000 live births, compared with a rate of 3.4 for whites. In two of the areas – Nassau and Queens –high infant mortality rates spanned the entire population within the zip codes, at rates of 11.6 and 12.3 per 1,000 live births, respectively. In the Suffolk County zip codes, although the total number of births to white women was approximately three times the number of births to black and Latina women combined, the infant mortality rates for babies born to women of color ranged from six to eight times the rate for white infants.

Racial/ethnic disparities were also found among the most common correlates of infant mortality: teen births, late or no prenatal care, low birthweight, and preterm births. For the period 1996 to 1998 across the entire DNYHS project, 16% of all births to black women were to teens 18 years of age and younger, compared with a teen birth rate of 5% among white women.

Among black women during this period, 9% delivered with either no or late prenatal care, compared with 3% for whites. Blacks were twice as likely to have low birthweight babies as were white women (14% and 7%, respectively), and black women were also more likely to deliver babies prematurely (26%) than were white women (17%).

The factors underlying such racial disparities are complex, and the DNYHS local lead agencies adapted the required Healthy Start core services and core system models to best fit the needs of the communities served. Throughout the core services and system interventions, the aim of DNYHS has been to bridge the identified gaps by providing community residents with information, skills, and support needed to access systems of care; furnishing providers with the strategies and training they need to serve their communities sensitively; facilitating collaborations to improve the delivery of services in the DNYHS communities; and more broadly, to facilitate access for all community stakeholders including consumers, to the policy-making process.

II. PROJECT IMPLEMENTATION

A. CORE SERVICES

1. Outreach and Client Recruitment

a. Approach

The Downstate New York Healthy Start subcontracting local lead agencies are established community-based organizations firmly entrenched in the communities they serve and have, since DNYHS' inception in 1997, provided all of DNYHS' core services. Funded in the 1997-2001 Healthy Start cycle to provide outreach services only, the subcontracting agencies were well prepared to continue outreach and recruitment activities into this next project period.

The project's Outreach and Client Recruitment model was designed to achieve program-wide objectives while addressing the local needs of each target area. The project partners customized their outreach and recruitment strategies and tailored their intervention efforts to identify those clients most in need, integrating strategies previously developed with improved mechanisms to keep up with the changing community landscape.

The DNYHS target communities are characterized by economic and social isolation, and for some targeted populations, there exists a mistrust of organizations and institutions. To insure effective, community-savvy outreach, the DNYHS local lead agencies adopted a peer lay worker model. Peer workers were found to be knowledgeable, non-intrusive, and culturally appropriate to the clientele served and the subcontracting agencies report the model to be the most effective mode of outreach and case retention.

Indeed, lay staff proved instrumental to overall project success. Service site management personnel worked closely with outreach team members to modify outreach strategies taking into consideration such logistical issues as location and time of day to maximize client recruitment and enrollment. Peer staff identified local "hot spots" not readily apparent to non-residents, and

facilitated the program's identification of the culture, language, social and economic issues of the target communities. Communication between professional supervisors and paraprofessional staff served a key role in program development regarding the efficacy of outreach strategies, emerging client needs, and suggestions regarding how best to address client barriers in receiving health and social services.

b. Outreach Intervention Components and Changes over Time

1) Overview

DNYHS outreach is grassroots, providing the first "street-level" link with the community and the opportunity to educate consumers about available services and identify women who can benefit from DNYHS services. We conceptualize outreach and case management as ends of a continuum of service engagement. In order to initiate the engagement process into Healthy Start services as soon as possible, outreach is provided by the same staff that provides case management. Throughout this report the general term "case managers" will be used to refer to outreach/case management staff, some of who are also called case coordinators or maternal and child health advocates by their respective agencies.

DNYHS outreach has the following steps:

1. Identification of potential clients;
2. An intake process which introduces the various services offered and determines eligibility;
3. Orienting the woman to Healthy Start and the case management process;
4. Obtaining the woman's consent to participate in the program and formally enroll her, if eligible.

DNYHS outreach target populations' are pregnant women and women with children aged two and under. In 2002, upon the introduction of interconceptional care services as a mandatory program component, targeted outreach expanded to include women who deliver at local hospitals with a history of late and/or no prenatal care.

Overall, the project's outreach/case management staff devotes an average 30% effort to outreach activities, with 70% of their efforts devoted to case management activities. Percent effort is related to case management caseloads and fluctuations have occurred over time as agencies expanded or decreased efforts as needed. Outreach, however, is a mainstay of program services as openings continually occur due to case closures. Outreach also provides a vehicle for community-level participant recruitment for agency health education and consortium activities.

2) Program Participant Outreach

Within each service area, outreach is achieved both through direct community canvassing by staff and through referral networks with health and social service providers. The following are the site specific outreach components for program participant recruitment:

Economic Opportunity Commission Staffing and Program.

EOC employs one full time Case Coordinator and one full time Maternal Child Health Advocate; each spending 6 hours weekly on recruitment/outreach in the 11550 target zip code in Nassau County, which is in Hempstead, NY. Case management staff is supervised by a full time Program Director.

EOC's consortium sponsors a dynamic element of their outreach program. Consumer Empowerment workshops based on the Family Empowerment Program designed by Cornell University are offered to all in the community. The Family Empowerment Program trains staff to work with clients to set goals, which are based on the clients' own personal strengths. The workshops serve as a very effective vehicle to identify women in need of case management services. Case managers are also responsible for outreach activities and conduct street outreach, community canvassing activities, and participate in community health fairs.

EOC Healthy Start has capitalized on the name recognition of the larger organizational structure to hold creative outreach events with local businesses in the community. The National Association of Cleaner's sponsors a Coat Drive with EOC Healthy Start for Hempstead residents. Over the past four years, more than 500 coats have been donated by the community, cleaned by local cleaners, and distributed to residents and DNYHS clients during the winter holidays.

EOC established reciprocal referral linkages with a number of area service providers to direct women to Healthy Start services including county clinics and local hospitals. External referral linkages include Five Towns HIV Center for specialized services for women who are pregnant and HIV positive, and domestic violence agencies in its area. In addition to those referral linkages, EOC Healthy Start benefits from the State-funded HIV outreach and education program housed in another division of EOC.

Queens Comprehensive Perinatal Council Staffing and Program.

The QCPC team is configured of 4 FTE Case Coordinators who divide their time between outreach and case management activities. Deployed evenly between South Jamaica and Rockaway Beach/Arverne located in Queens, New York City, they each spend approximately 2-3 hours per week on outreach activities. The QCPC Director of Maternal Child Health Programs provides supervision.

Case coordinators have designed and prepared DNYHS flyers, business cards and maternal and child health literature to distribute to local businesses, churches, schools, laundromats, banks, the community health center and WIC offices to promote the importance and availability of Healthy Start services and their doula training experience. They conduct street outreach and community canvassing activities, and participate in community health fairs. Outreach included visits to the local housing projects in order to network with community residents and provide culturally appropriate material about infant mortality and the availability of services at QCPC. Through the relationships established via networking with public housing development associations, the tenants themselves have helped identify pregnant women and served as recruiters for DNYHS services. Working with the tenants associations, the case

coordinators organized such events as Mothers' Luncheons and Baby Showers on-site at the housing developments.

QCPC coordinated outreach services with a number of providers and programs serving the target area, which provided the opportunity to reach women of childbearing age and refer them to Healthy Start services. They include: Ida B. Wells, an alternative high school for pregnant and parenting teens; the Life Alternative High school to organize teen pregnancy prevention workshops; the New York City Department of Health's Family Health fairs and Immunization Awareness days; and co-sponsoring the Queens Borough government's Women's Legislative Forum and Housing Conference.

QCPC established reciprocal referrals with other agencies through formal and informal agreements to ensure optimal linking of mothers and children with available health and social services, including the State Health Department Community Health Worker programs at the Caribbean Women's Health Association and Safe Space; Visiting Nurse Service of New York; the Family Rehabilitation Program at Family Consultation Services, Inc.; and two agencies that refer perinatal clients identified with substance abuse issues - the Aspire Program at Queens Hospital Center and the Jamaica Family Center.

Suffolk County Perinatal Coalition Staffing and Program.

SCPC has on staff two full time and one part time case manager to perform outreach and case management activities in the target areas of Bellport, Coram, Medford and Patchogue. Each worker spends approximately 10 hours a week conducting outreach in the target zip codes. SCPC's Assistant Director provides supervision of all service staff employed by the project.

SCPC's staff conducts street outreach weekly to recruit and enroll women. A successful activity has been the development of an outreach flyer providing service information that is posted at various neighborhood venues, including: laundromats, hair salons, libraries, local community based organizations, Department of Social Services, Families and Nutrition (FAN), Women, Infant and Children (WIC), local health centers, Boys and Girls Club of Bellport, K-Mart, churches, supermarkets, the local health department, check cashing facilities, libraries, food pantries, and the Salvation Army.

Additionally, case managers have liaised with health and social service providers to be granted weekly on site access, and also participate annually at special events. Outreach tables have been arranged at the following locations: the South Brookhaven Health Center, the soup kitchen at the Congregational Church**,** the annual Coram Community Health Day and the annual Bellport Community National Night Out, as well as health fairs in the target communities.

Targeted outreach venues have included homeless shelters for teen parents. SCPC has collaborated with Planned Parenthood staff and arranged outreach events using Planned Parenthood's Smart Wheels van. The van is stationed at shelters during these events providing for ease of access and recognition. Another targeted outreach venue was Stony Brook Hospital's Neonatal Discharge Unit, which contacted SCPC case managers directly, prior to the hospitalized woman's discharge. This element of the referral relationship has ended due to new HIPPA confidentiality laws. SCPC regularly places advertisements in local newspapers with a

large circulation in Suffolk County, and circulates a newsletter to agencies and individuals who would refer potential enrollees for Healthy Start services.

SCPC also has established a number of reciprocal referral relationships with case management and human service organizations in the county that work with at risk women who would benefit from Healthy Start services. These organizations include: Family Service League which provides mental health services; Child Protective Services, which provides preventive services related to parenting support; Project Outreach and Crossings, which provides substance abuse counseling related to alcoholic and narcotics; and Suffolk Public Health Nursing, which provides short term intensive medical management services to pregnant and postpartum women.

3) Community Participant Outreach.

Workshops and health education programs are open to all community residents and are a part of each local lead agency's recruitment service program. Each DNYHS local lead agency delivered a tailored program of outreach to community-level participants. DNYHS clients themselves attract community participants, by providing word-of mouth testimonials of their experience to families, friends and neighbors.

The most successful outreach approaches identified by the local agencies include:

- Distribution of enrollment incentives including baby supplies, t-shirts, and free vouchers at local hair salons.
- Maintaining a planned and consistent outreach schedule to develop ongoing visibility and rapport within the communities.
- Hiring bilingual and/or community residents to conduct outreach.
- Sponsoring special events including Mothers' Day luncheons, baby showers, teen pregnancy prevention workshops, family health fairs, immunization awareness days, a women's legislative forum, and housing conferences.
- Networking regularly and systematically with other local health and social service agencies to develop effective and ongoing referral networks.
- Conducting staff forums to discuss barriers and successes in daily practice.

c. Resources and Events and their Impact on Implementation of Outreach Services

The success of the DNYHS outreach program derives from each local lead agency's ability to identify key characteristics of the local environment and adapt outreach strategies to them. Two of our service areas- Nassau and Suffolk- have experienced significant growth in the Spanish-only speaking population during the project period. In Nassau 37% of the client population speaks Spanish only, and in Suffolk the Spanish speaking client base is 21%.

The majority of the women and families served are very recent immigrants, many undocumented, from Latin American countries that arrive and settle in Long Island for seasonal and migrant work. Health and service needs have been great among the population due to the lack of knowledge of the resources available, an inability to negotiate those resources coupled with modest incomes, restricted eligibility for government assistance, and unfamiliarity with the health care system. Barriers are particularly great among undocumented immigrants, who fear that coming to the attention of any type of institution would jeopardize their status. Many clients disclosed to case managers their feelings of fear and anxiety about entering public systems of care.

Outreach to this population has posed a special challenge due to shortages of bilingual workers. EOC and SCPC have applied due diligence to overcome this service barrier. While SCPC has been able to successfully hire two bilingual case managers to address the language needs of its clientele, EOC has had less success. To meet the need, EOC hired a bilingual administrative assistant who provides translation services for their Spanish-only speaking clients and helps Spanish-speaking women through the enrollment process. EOC also instituted a dedicated Spanish language hotline that explains DNYHS services to callers, and has placed a television in the reception area that plays Spanish-language perinatal health education videotapes for Spanish consumers waiting for case management staff members to assist them.

2. Case Management

a. Approach

Access, in its broadest terms, is one of the central issues facing DNYHS communities. In Nassau and Suffolk counties community residents lack affordable, comprehensive transportation networks. Throughout the DNYHS area, people experience difficulty in obtaining high-quality, comprehensive medical care as affordable social services are in severe under-supply. There is a shortage of health and human service providers who are competent in the language, culture, and the exigencies of the daily lives of many community members. Given the many service needs of low-income residents of these communities, people often have difficulty navigating the complex public and private health and social services delivery systems. Pressing social needs like unstable housing, domestic violence, and undocumented immigration status not only interfere with the ability to seek health care in a timely manner but also contribute directly to the poor health of families.

DNYHS' case management approach is strengths-based and family-centered in recognition of the importance of supporting and strengthening the full family unit in order to assure the well being of each member. DNYHS provides supportive case management focusing on developing a family's own strengths and resources and securing access for families to needed health and social services. The DNYHS model of case management combines traditional linkages of clients to a range of service providers along with a home visiting component oriented to health education. DNYHS case management has two major goals:

- *Providing assistance to clients to increase their access to health and social services needed to support positive birth outcomes and healthy children.*

This is the management element of case management, and is built around assessment and reassessment of service needs, developing a thoughtful service plan, arranging and tracking referrals, and providing direct assistance to our clients to make it easier for them to access the services they need.

- *Providing health information throughout pregnancy and the first two years of childhood*.
  In the DNYHS model, health education is provided according to an established schedule that indicates specific topics that are relevant to the pregnancy stage of the mother, and the age of the infant or child after birth.

b. Case Management Intervention Components and Changes over Time

1) Program Development History

Among our greatest advancements in the first budget year of the grant, was the development of a new case management program for a geographically expansive project, while accommodating existing differences among the local lead agencies with respect to staffing patterns and service delivery models. The process was extensive as in Phase II, the prior grant period, DNYHS had been funded to provide outreach services only.

In 2001/2002, the first year of the project period, we devoted a great deal of effort to case management program planning and development, standardizing case management operation protocols, curriculum development, and staff training needs. In the fall of 2001, MSPH retained a social work consultant with prior knowledge of the Healthy Start initiative to assist the project in this development. DNYHS also benefited from the prior work of the Executive Director of QCPC, which had initiated a case management model with a specific prenatal and postpartum home visiting and health education teaching focus for its clients.

A working committee was convened consisting of the two executive directors and one program director of the three local lead agencies and the DNYHS Project Director. Working with the case management social work consultant, the committee met in September 2001, November 2001, and January 2002 to discuss how the new project-wide service would affect local operations and programs. These meeting provided the context that shaped the development of project-wide case management protocols.

By the end of 2001/2002, DNYHS was prepared to implement a project wide case management protocol which included standardized tools for assessment, service plan development, referral tracking, home visiting guidelines, program quality assurance, data collection, and minimum case management staff training needs. Based on the work of the consultant and project staff, the case management protocols were presented in July 2002 at a project-wide session held in Jamaica, NY. The day long training provided an in-depth introduction to and training in DNYHS project-wide case protocols and data collection forms, and demonstrated how both components work together to assure quality service delivery. Attendees practiced skills needed to work with a participant or family over time according to a service plan based on a combination of program and individual goals. Attendees practiced

writing service plans derived from risk assessments. Staff learned to develop client specific service plans, and practiced building rapport through home visiting, scheduled office encounters, and one-on-one health education to improve the quality of life for clients, infants, and their families. To facilitate the continued development of skills and quality service delivery follow-up technical assistance visits took place in November and December 2002, supplemented by staff participation in trainings provided by the New York City Department of Health and Mental Hygiene.

As a result of the new case management component, DNYHS revised caseload targets from a projected annual unduplicated count of outreach cases to one calculated on average case managed caseload as determined by agency staffing capacity. With primary focus on quality of service provision, DNYHS settled on an average monthly caseload of 25 cases per FTE.

Additionally, revisions were made to program forms and the data collection system in order to track the new activities performed in case management. Forms developed included: Recruitment, Enrollment, Prenatal Care Monitoring, Pregnancy Outcome/Infant Update, Child Healthy Status, Services Tracking, and Status Update. Grantee local evaluation staff worked with the case management social work consultant and program staff to modify data collection instruments and quality assurance training needs. The project database was updated to include the new forms and data elements.

2) Case Management Intensity Levels

DNYHS has identified four levels of intensity of case management services. The level of intensity of case management needed is determined based on whether the woman is pregnant and/or has an infant and has particular at-risk characteristics. Women often move from one service level to another, in both directions, as needs change. Case management staff is assigned cases with different service intensity needs commensurate with worker training and experience.

Level I. Information and Referral

This lowest level of service intensity is aimed at women of childbearing age residing in the catchment areas who are neither pregnant nor parenting an infant and have short term service referral needs. For example, a woman may need assistance enrolling in public benefit programs or may have a housing crisis for which she needs immediate help. This level of service also is provided to women who are pregnant and parenting an infant who choose not to enroll in longer term DNYHS case management services. These women are given assistance in getting needed services and followed up to assure receipt of services. Based on current experience, they are enrolled for a period of up to 90 days. This service level includes women who are given referrals to other case management programs if they are in need of specialized case management services not provided by DNYHS, e.g., women with HIV/AIDS or chemically dependent women.

Level II. Low Intensity Case Management

Women who are pregnant and/or parenting an infant who reside in one of the targeted zip codes who do not have any of the characteristics listed below under Medium and High Intensity

Case Management are offered Level II services. This level is intended for women who do not present with any special service needs or risk factors but can benefit from the ongoing involvement and support of a case manager, particularly to make sure she is able to keep her prenatal appointments and well baby visits and to provide basic perinatal and infant health education.

Level III. Medium Intensity Case Management

Medium intensity case management is intended for women who are pregnant and/or parenting an infant who reside in one of the targeted zip codes who present with at least one of the following characteristics and none of the risks listed below under high intensity services: No medical home for her or her infant; no health insurance coverage; language barrier; single parent; transportation barriers; limited formal education; unemployment.

Level IV. High Intensity Service Level

Women identified for high intensity level case management services are women from the catchment area who are pregnant and/or parenting an infant who have any one of the following characteristics: Lack of prenatal care; current smoker; chemically dependent; history of infant death; history of STD, HIV/AIDS; history of domestic violence; unstable housing or is homeless; inadequate social support; history of miscarriage; two pregnancies within an 18 month period; chronic health conditions; a multiple birth. Based on current experience, these women tend to have multiple needs, which require substantial worker involvement to resolve.

3) Case Management Components

The DNYHS case management model has three components:

- Identifying, contacting, recruiting, and enrolling women and infants in need of services.
- Assisting eligible families in locating and obtaining needed services.
- Educating women to take charge of their health and the health of their families.

To achieve these goals, DNYHS' case management consists of the following activities:

1. Intake
2. Assessment and Service Planning
3. Service Referral and Coordination
4. Support Services including Client Advocacy
5. Ongoing Monitoring and Tracking.
6. Individual and Group Health Education

Intake. The intake process serves to identify those clients that need short term information and referral services from those with more complex needs that require the ongoing assistance of case management.

Assessment and Service Planning. After intake, clients are assessed for service needs and an individualized service plan is developed with the full participation of the client. In this stage,

staff works with the client to determine her social, medical and financial needs; identify the personal and external resources that are available to address those needs; and develop a plan to help obtain identified service needs.

Service Coordination. The case manager makes specific referrals based on the service plan developed and re-assesses the client at prescribed intervals and as need arises to make sure that the appropriate services were received and to determine what additional services might be needed.

Support Services and Client Advocacy. The case manager helps the client address such problems or issues as domestic violence, HIV/AIDS, unstable housing, etc. and assists the client in identifying benefits to which she is entitled, assists with the necessary forms and paperwork, and generally guides a client through the bureaucracy of service providers. Case managers also accompany clients on health care and social services visits as needed.

Ongoing Client Contact and Monitoring. Service plans are monitored to assure that clients are receiving needed services. A prescribed schedule of telephone contacts and home visits enables the case managers to monitor the service plan. The home visit provides the case management staff with the opportunity to observe the family's immediate environment and to discuss with the client whether her needs are getting met and if new needs have arisen.

Individual and Group Health Education. Home visits also serve as a vehicle for providing support and one-to-one health education. Health education is also provided in group sessions held at agency and community settings.

4) Description of Case Management Service Coordination Activities

Following the client's request for services, the case managers contact the potential medical or social service provider. Referral completion is confirmed by contacting the client or by the process described below under referral tracking. Medical release forms are used by each agency to enable the case worker to obtain prenatal, postpartum and child health visit updates. Throughout enrollment, case managers engage clients through home visits and other formal and informal contacts and at home visits clients receive the health curriculum information appropriate to the stage of parent and infant. Clients also participate in the agency's group health education sessions. Case managers monitor prenatal and postpartum medical care utilization to make sure women are receiving adequate care.

DNYHS case managers also monitor the health service needs of infants as part of the overall service package. At the time of enrollment, parenting clients are educated about the benefits of immunization for their child. The DNYHS case management agencies track immunization of infants during home visits, based on project protocols. During home visits the case managers continue to provide information to their clients on the importance of keeping their child immunization appointments and immunization reminder cards are mailed to all case-managed clients based on the standard vaccination schedule. A thorough record of all immunizations are kept in client's case records and referral completion is tracked through client and pediatric provider contact

5) Staff Training

Each agency had an in-house training program for outreach/case management staff provided on a monthly or bimonthly basis.

EOC: offered staff training through an extensive excellent in-house training program, which utilizes the Family Credentialing Model developed by Cornell University.

QCPC: Both QCPC's Executive Director, who has an RN and MPH degrees, and the Director of Maternal and Child Health Programs, with an MA in Community Health Education, provided staff development workshops via monthly in-service training. Additional training for QCPC staff was provided by a variety of other agencies and included the Department of Youth & Community Development's family development training and credentialing program; Medicaid's Prenatal Care Assistance Program (PCAP) pre-screening and family Medicaid pre-screening; immigrant eligibility for public benefits and housing issues; and identification and reporting of child abuse and maltreatment. A consultant also educated staff on labor and postpartum support and provided doula training.

SCPC: All staff received an initial eight hours training on perinatal health topics and subsequent in-house training on a bi-monthly basis. Additional staff development was received through the Suffolk County Department of Health, Long Island Association of AIDS Care, Suffolk County Coalition of Substance Abuse, Victims Information Bureau, Cicatelli Assoc., Cornell Cooperative Extension, State University of New York School of Medicine at Stony Brook, Planned Parenthood, Crossings Recovery Center, Economic Opportunity Center of Suffolk County, La Leche, Postpartum Resource Center of New York, and the March of Dimes.

Case management staff at each local lead agency also received training by grantee staff on the Strengthening Family Connections health education modules, developed by Wayne State University for the Detroit Healthy Start project. Training covered use of the various modules and included interactive role play. MSPH staff also presented supplemental information on behavior change through health education and facilitated discussions about the importance of health education for case management.

6) Case Management Quality Assurance and Technical Assistance

The staff configurations at all DNYHS lead agencies consists of multi-disciplinary teams that include peer workers, paraprofessionals, licensed social workers, social work interns, health professionals, and health educators. Each agency utilized consultants with social work credentials to perform case conferencing with their respective staff. This model was initiated by Queens Comprehensive Perinatal Council, and later adopted project-wide, as a means to provide in-service training and supervision for case managers. Each consultant is a certified master's level social worker.

Case management staff meets once weekly or monthly with the case management consultants for the purposes of:

- Assessing potential new clients and determining if they should be case managed or designated for information and referral status.
- Reviewing current cases and providing updates.
- Identifying service plan changes for follow-up with the client.
- Reviewing health education teaching foci for clients.
- Assessing clients for case closure.
- Emphasizing the importance of professional conduct, healthy boundaries and effective case management techniques.

Case management consultation has proved to be instrumental for providing a forum in which staff members can overcome personal barriers to reaching clients. We have discovered that the DNYHS peer-lay model of case management involves many staff members from similar backgrounds as the clients they serve; thus, case managers may have similar social, environmental and psychological barriers towards healthy behaviors and service provision. Case management consultation brings those barriers to the table in discussions with staff, to address them, separate myths from reality about those barriers and beliefs, and works to set boundaries between the case management staff and the client/community population that is being served.

At the project level, the quality of case management services was facilitated by the development of the DNYHS Case Management Manual. The manual provides an overview of the DNYHS case management process, as well as instructions on all forms and their proper usage and guidance to staff in delivering health education according to the appropriate perinatal stage. (The DNYHS Case Management Manual has been electronically reproduced and distributed to other Healthy Start projects.)

Monthly project-wide conference calls for case management supervisors and quarterly meetings for case managers were first instituted in the fall of 2003 and facilitated by grantee staff. The quarterly meetings, attended by case management staff from all 3 local lead agencies, provide an opportunity for technical assistance and in-service training, networking, sharing best practices, and obtaining advice from peers and the project's Program Manager on how to best resolve challenges encountered in providing case management.

Each year, grantee project staff provided technical assistance through annual reviews and quality assurance assessments of case management activities at each site. Project-wide, case management minimum standards are utilized to assure basic service quality and consistency across all case management sites. These standards cover such issues as minimum frequency of client contact, minimum frequency of home visits, reassessment schedule, case activity and case inactivity, case closure procedures, assessment of case documentation notes, assessment of case management and health education service quality, quality assurance measures in place at the sites, and client retention protocols. Information is gathered through a variety of sources including face-to-face interviews with staff, review of case files, and the DNYHS database.

c. Resources and Events and their Impact on Implementation of Case Management

Each local lead agency has experienced barriers to enrollment, retention, and receipt of services within their respective case management programs. As described earlier, the communities served by EOC and SCPC are characterized by a large number of newly arrived Spanish-speaking immigrants, many undocumented and in need of services who do not use

DNYHS services out of fear of being reported to Immigration and Naturalization Services. The local lead agencies have either hired Spanish-speaking staff or made accommodations within their office for the purpose of creating an inclusive environment and improving outreach to this critical population.

A major barrier for retaining clients in the program is the unstable living arrangements of clients due to the shortage of affordable housing in the target communities. Many families frequently move in and out of the service areas, therefore making them ineligible for continuation of Healthy Start services until residency is reestablished. As a result, the project established a policy that such families would remain eligible for services.

The cost and lack of reliable public transportation also prevents many clients from keeping their referral appointments. For example in Suffolk County, a semi-rural area with limited public bus service serving as the only means of public transportation, a typical one-way taxi fare for a cross-town ride is $10-$15. To help deal with cost barriers, the local lead agencies dispense public transportation fare cards and taxi vouchers for travel to doctors' appointments. Additionally, some DNYHS clients have TANF work or education requirements that prevent them from keeping their medical or social service appointments.

Each service area reports that a shortage of services and long waiting times had an impact on the ability of women to receive the services they were referred to by the case managers. In Nassau, the Hempstead Health Center, a referral linkage for primary care and PCAP services was closed and relocated to an area inaccessible to clients with transportation barriers. In Queens, QCPC contends with a shortage of referral resources for women who need smoking cessation programs. SCPC's clients have experienced prenatal care appointments delays of up to seven days in the Suffolk County Health Clinics. Each local lead agency has reported the unavailability of low cost or free smoking cessation programs, and a lack of follow up capacity for postpartum depression referrals as barriers significantly impacting case management services.

3. Health Education and Training

a. Approaches

Downstate New York Healthy Start's health education and training program served three populations: individual clients enrolled in the core service case management program, other community residents, and providers (including case management staff). Each local lead agency has designed a health education program that culturally befits their respective communities. EOC and SCPC deliver health education presentations in both English and Spanish, and distribute dual language health materials. QCPC provides health education in an African-centric teaching modality.

To ensure receipt of appropriate health education services, DNYHS case managers delivered health education according to a prescribed case management home visiting and contact schedule. Although health education was also provided to clients informally at agency office visits or during telephone calls, health education was primarily delivered via home visits. During pregnancy home visits occur at least once per trimester. For the typical postpartum woman,

health education was received at the first postpartum visit, and also through out the nine postpartum home visits made as part of the typical schedule.

Staff utilized to implement this core intervention differed in accommodation of the needs of each individual agency. EOC's staffing pattern includes a community health nurse who worked in conjunction with the Maternal Child Health Coordinator and the Case Coordinator to provide program participant health education. The community health nurse also provided staff education and assists the consortium coordinator in providing provider and consortia trainings. QCPC's full time Director of Maternal and Child Health Programs, who has a degree in community health education, provided health education curriculum development for case management staff and provider training. SCPC employed a health education coordinator to facilitate program participant heath education and also assist the full time consortium coordinator with consortium and provider trainings.

b. Health Education Intervention Components and Changes over Time

The development of a comprehensive health education and training program presented a new challenge to the DNYHS perinatal partners during the first year of the project period. While the successes achieved in outreach could be utilized to inform the project of what health and resource information was needed among the target population, our peer lay model of case management provision required that we devote attention to developing within our staff the knowledge and skills necessary to facilitate change in health behaviors. As with other Healthy Start core services, the implementation of health education and training took an individual agency focus supplemented by project wide development opportunities.

1) Case Management Health Education Training

Each agency adopted perinatal health education training protocols for case management personnel. The agencies had individualized programs that included a mix of in-service on site development as well as external development resources. Topics for case manager development included:

- Smoking cessation
- STD prevention
- Substance use and pregnancy
- Mood disorders and their treatment
- Public health programs and income support programs
- Crisis intervention
- Working with the difficult clients and building on client assets
- Reproductive Health
- Breast feeding
- Domestic violence
- Cultural diversity
- Immigrant eligibility for public benefits
- Medicaid managed care
- Housing issues

- Parenting education

2) Program Participant Health Education

All women enrolled in DNYHS case management received individual health education and were invited to participate in group health education sessions.

Individual health education included use of established curricula and materials. Upon enrollment, clients are given written health education materials and receive copies of the "Baby & Me" and "Best Start" books that provide clients with information on perinatal and newborn health and wellness. DNYHS agencies use the Strengthening Family Connections modules, developed by faculty at Wayne State University for the Detroit Healthy Start project. The tool provides an interactive approach for case managers to help educate clients about a variety of topics including prenatal and postpartum care, reproductive health, infant care and feeding, infant growth and development, and parenting. All materials employ appropriate literacy levels for clients, and include scripts and prompt to encourage discussion between clients and caseworkers. These modules were utilized during home and office visits with clients per the case management home visiting and contact schedule.

Group health education sessions were generally offered on a monthly basis and at special perinatal health education events. The following describes specific health education events and activities conducted at each local lead agency:

- EOC conducted group health education through its Personal Empowerment Workshops covering such topics as contraception, parenting skills, nutrition, postpartum depression awareness and HIV/AIDS.

- A special group health education program at QCPC (Kukhulisa Kahale) was offered monthly for case management participants. Topics included: "Preparation on Becoming a Parent," "Parenting Overview," "Healthy Child Development," "Helping Your Child Learn," perinatal substance abuse, HIV/STDs, breastfeeding, domestic violence, and smoking cessation. QCPC also offered health education at baby showers, Mother's Day events presented by a midwife consultant, and at Immunization Awareness Days.

- Through a separately funded program by a grant from New York State, SCPC utilized volunteer community "Mentoring Moms" to provide education on smoking cessation, preterm labor, infant development and substance abuse. For the majority of this project period, SCPC provided specialized smoking cessation services through a grant from the New York State Department of Health. Services included one-on-one counseling as well as a six-week smoking cessation program for women provided by a certified social worker. The grant came to a conclusion in 2004. SCPC also held quarterly baby shower events that were health education focused.

While the three local lead agencies were the primary providers of health education; they also referred clients to specialized health education services using well-developed linkages to community health education networks including: Planned Parenthood; HIV services; area

community colleges; and EOC's State-funded HIV outreach and education program. The agencies also used community health education resources to invite guest speakers to address program participants at group health education sessions.

3) Provider Health Education Training

The local lead agencies were also involved in activities focusing on educating providers to better serve the perinatal population. Agency staff worked to educate service providers about perinatal health issues and build cultural competency. In addition to trainings provided in the health education program, provider development is incorporated into the Local Health System Action Plans of each agency. Examples of provider trainings are given in the table below.

4) Community Participant Health Education

Additionally, each agency provided health education to community residents. Community health education forums included:

- Booths at health fairs;
- Literature tables at community health centers and churches;
- Posters and other media materials hung or distributed at a variety of community settings;
- Presentation at community health centers, local health departments, local departments of services, child care centers, and colleges.
- Designing and distribution of community newsletters; and
- Local television stations.

Specific agency activities included EOC's Personal Empowerment Workshops, which were open to all community members; QCPC's annual Legislative Breakfasts, used as forums for perinatal health education and awareness; and QCPC and SCPC's doula programs in which community women were recruited to provide labor and delivery support and education to pregnant peers; and SCPC's smoking awareness and cessation workshops.

The following table provides examples of the health education and training topics that were provided to the various audiences over the 4-year project period.

Health Education Topics Covered in Trainings, 2001-2005

Pregnant/Parenting Case Management Clients:	*Consortium Consumers & Community Participants:*	*Case Management Staff:*	*Providers:*
• Preparation on Becoming a Parent • Parenting Overview • Healthy Child Development • Helping Your Child Learn • Smoking Cessation • Domestic Violence • Perinatal Substance Abuse • HIV/AIDS/STDs prevention • Breast Feeding • Breast Awareness • Family Planning • Prevention of Infant Mortality • Nutrition Workshops • Parenting Workshops • SIDS Prevention	• Postpartum Depression • Smoking Cessation • HIV/AIDS • Breastfeeding • Pre-term Labor • Premature Birth • Placental Complication • Reproductive Health • Breast Care • AIDS Prevention & Detection	• Asthma Awareness • HIV/AIDS Awareness • Childbirth Education/ Doula Training • Domestic Violence • Family Planning Options • Postpartum Depression • Domestic Violence • Serving Families	• Postpartum Depression Awareness • Smoking Cessation and Maternal Child Health • Folic Acid Update

c. Resources and Events and their Impact on Implementation of Health Education

Of particular importance to note was the unavailability of appropriate perinatal smoking cessation services across all service areas. Available services are primarily fee-for-service, which make them unaffordable to the DNYHS target population. State Medicaid does not cover smoking cessation counseling services and reimbursable pharmacotherapy is not accepted as standard treatment for pregnant women.

4. Interconceptional Care

a. Approaches

The DNYHS approach to interconceptional care is to: 1) engage in case management women who have recently delivered with inadequate or no prenatal care or who are in need of services; and 2) provide a basic package of interconceptional services to all women enrolled in case management. This strategy, incorporating interconceptional care into the case management spectrum of services, allows for monitoring of needs of women and their infants to assure linkage to necessary services, and the opportunity to provide critical health promotion education.

b. Interconceptional Care Intervention Components and Changes over Time

Interconceptional care was added as a mandated core service in the second year of the project. During program year 2002/2003 all project partners progressed very quickly as they developed plans to recruit, track and monitor high-risk postpartum women and their families. Targeted outreach strategies were developed and formal linkages with hospitals, clinics and other sources of recruitment were formed. The case management teams of each agency provided the

interconceptional care services. The following describes DNYHS interconceptional care core service package:

1. Making sure the woman has received her postpartum visit.
2. Linking women with a medical home, including assistance obtaining health insurance.
3. Linking infants with a medical home, including assistance obtaining health insurance and coordinating care.
4. Referrals to family planning/contraception services.
5. Parenting education provided by case management staff.

1) Interconceptional Care Outreach

Each local lead agency developed formal and informal referral relationships with local hospitals to identify high-risk women in need of services. Specific referral networks were developed by the local lead agencies to facilitate identification and recruitment of women in need of interconceptional services:

Nassau

- Nassau University Medical Center and Long Island Jewish North Shore Hospital
- EOC's in-house Head Start program
- Winthrop Hospital
- Nassau County Department of Health Perinatal Unit
- Nassau University Medical Center

Queens

- Rockaway Beach/Arverne - St. John's Episcopal Hospital
- South Jamaica – Queens Hospital Center

Suffolk

- Stony Brook Medical Center, the major tertiary medical center

Interconceptional Care Referral Networks

Each local lead agency has also developed a wide and diverse network of referral sites for women and infants to both primary and specialty services. Case managers monitor service completion and provide supportive services including advocacy and accompaniment to appointments, as needed. Medical facilities to which participants are referred include:

Nassau

- Planned Parenthood (family planning services, some primary care)
- Hempstead Health Center (primary care)
- Nassau County Department of Health (primary care)
- Winthrop Hospital (primary care)
- Nassau University Medical Center (primary care)
- EOC Head Start (early intervention for infants/toddlers)

- Women's Contemporary Care Unit at Winthrop Hospital (primary care, specialized care)
- Mercy Hospital (specialized care)
- Early Intervention Services in Hempstead (early intervention screening/medical evaluation)
- Northshore LIJ Pediatric Unit (specialized pediatric care)

Queens

- Jamaica Hospital (primary care, specialty care, early intervention for infants/toddlers)
- Queens Hospital Center (primary care, specialty care, early intervention for infants/toddlers)
- LIJ-Schneider Children's Hospital (primary care, genetic counseling, early intervention for infants/toddlers)

Suffolk

- Planned Parenthood (family planning services, some primary care)
- SUNY Stony Brook Medical Center (primary care)
- Suffolk County Department of Health (HIV/AIDS services, early intervention assessments)
- Early Head Start (early intervention for infants/toddlers)
- The New School (early intervention assessments)

c. Resources or Events and their Impact on Implementation of Interconceptional Care

The same service shortages and barriers to utilization that exist for case management were present for interconceptional care services. In particular, inadequate public transportation systems make it very difficult for our low-income women and families to keep referral appointments for the services they need.

5. Depression Screening and Referral

a. Approach

Depression Screening and Referral was added as a core service mandated activity after the submission of DNYHS' original application for funding. In the first quarter of program year 2002/2003 the project devoted substantial effort towards planning and preparedness, and this new core service intervention was implemented by DNYHS' local lead agencies prior to the closure of the second year. Preparedness activities included the consideration of the stigma associated with accessing mental health services within the Latino and African American communities, and our client's response to depression screening. For this reason each local lead agency sought out a depression tool that was culturally appropriate to the population served.

Each local lead agency also assessed the referral capacity of their communities to determine the availability of accessible mental health providers for DNYHS' target population. Each agency found within their communities a shortage of affordable mental health services for low-income women.

b. Depression Screening & Referral Intervention Components and Changes over Time

1) Implementation of Depression Screening and Referral Services

Depression screening and referral services were incorporated into case management activities. EOC and SCPC selected the Edinburgh Screening tool to screen both pregnant and interconceptional clients. This tool, available in English and Spanish, is linguistically appropriate to the Nassau and Suffolk communities served. QCPC identified a depression screening scale that is culturally sensitive for pregnant and postpartum women of color. QCPC uses the Postpartum Depression Screening Scale (PDSS) developed by Cheryl Tatano Beck, D. N. Sc. and R. Gable, Ed. P.

The target population for screening is all women enrolled in case management services. The protocol for depression screening standard across each site is at the first home visit, each postpartum home visit, and if the pregnant/postpartum woman exhibits signs of depression or expresses depressive symptoms or feelings. If the tool's score demonstrates the likelihood of depression being present, the client is referred to a mental health provider with whom the agency is linked. Of special concern to DNYHS local lead agencies are the women who report prior episodes of depression, as well as those with a history of substance abuse, domestic violence, and other risk factors given the shortage of mental health treatment services within communities. Dependent upon urgency of need, the woman will be referred to an MSW within the agency for further assessment and advice for referral to care.

If a client screens positive for depression and agrees to seek mental health services, the case managers contact the appropriate providers to arrange the referral. The case manager then follows up with the client to see if she was able to receive the service. If the case manager is unable to contact the client, the case manager contacts the mental health provider directly. If there is an issue that can be resolved with the help of the case managers such as lack of transportation or apprehension of receiving services, they will provide assistance or accompaniment as needed.

2) Staff Development

Case management staff at each local lead agency was trained to provide depression screenings at home visits. Each agency's MSW consultant, who is conferred with regarding the results of all screenings, provided additional support.

DNYHS worked closely with the Postpartum Resource Center of New York, recognized for its work on perinatal mental health issues. The Postpartum Resource Center was the primary resource for staff training and program consultation. A clinical psychologist from the Association for Black Psychologists also was retained to provide training on perinatal mental health to case management staff at QCPC. Additionally, all case managers attended a perinatal depression technical assistance program offered by HRSA's Division of Perinatal Systems and Women's Health in June of 2004. Case management team members received during the 2-day session eight hours of continuing education.

3) Client and Community Education

Community education to reduce the stigma attached to mental health needs and increase awareness of the signs and symptoms of perinatal depression has been a component of each agencies depression screening and referral program. The broader issues of accessibility and provider awareness and competence have become focal points of each agencies consortia and Local Health System Action Plans.

Case management staff provided DNYHS pregnant and postpartum case managed clients with education on perinatal depression through the health education component at home visits, and also through group health education efforts. We have found that one-on-one education in the home lends itself to a greater degree of comfort with this sensitive topic. Within the community setting, perinatal depression educational workshops have been delivered in both English and Spanish. In 2003, SCPC received a small grant that allowed for the design of a poster and public education campaign on perinatal mental health targeting women of color. This very successful campaign led to an increase in case management clients screened for depression and also increased the number of women seeking enrollment into Health Start case management.

4) Referral Networks

Each of the local lead agencies developed formal linkages to refer clients for mental health services, specifically depression counseling. EOC developed a formal referral linkage with North Shore Family Guidance Center. QCPC has formal referral mechanisms in place with the Neighborhood Help Center and two mobile crisis intervention programs. SCPC has a formal referral link with a local mental health provider, which employs the CSW that serves as their case management consultant.

5) Provider Education

Provider education is a component of each agency's depression screening and referral program and the local lead agencies have devoted substantial effort to educating area health care providers about the mental health issues affecting pregnant and parenting women. The local lead agencies have found that most providers are not aware of the unique mental health needs of this population further contributing to the shortage of perinatal mental health care. The perinatal partners have joined in collaborative projects, hosted special events, conducted focus groups, and facilitated workshops aimed toward provider awareness and education. Notable activities have included QCPC's Annual Legislative Education breakfast in December 2003 that focused on educating policymakers and city, state and federal legislative representatives on perinatal depression, the activities of the SCPC local consortium's Perinatal Mood Disorder Taskforce that have resulted in reduced wait times for mental health appointments, and EOC's work with the Nassau County Health Department Perinatal Network's advocacy subcommittee to promote awareness of mental health issues among OB/GYN's when doing discharge planning.

c. Resources or Events and their Impact on Implementation of Depression Services

Many of the concerns that came to light during the initial planning phase of depression screening and referral implementation continue to be of concern to project partners. They include: appropriateness of staff to properly administer the screening tools; the need for provider education and training regarding perinatal mental health screening; and the severe shortage of accessible and affordable mental health care resources for follow-up assessments and treatment.

Each agency has through its case management and consortia activities devoted efforts towards addressing the gaps identified through providing perinatal depression education, promoting awareness, assisting in coordination of services, and facilitating dialogue between mental health and prenatal providers. However, the severe shortage of mental health services for perinatal low-income women remains a significant barrier to the full and effective implementation of this core service component. These shortages raise serious challenges regarding the appropriateness of screening women if limited services are available.

B. CORE SYSTEMS BUILIDING EFFORTS

1. Local Health System Action Plan

a. Approaches and Rationale

Local Health System Action Plans (LHSAPs) served as the focal point for local consortium activities. All plans were used to educate the broader communities about the health needs of perinatal women. The LHSAP also helped to define discussions with legislators and policymakers on local, state and federal levels of government. LHSAPs were used to develop strategic collaborations with organizations and agencies in order to strengthen service delivery to pregnant and parenting women. The goals of the plans focused on policy change to improve the accessibility and quality of perinatal services, educating providers to better meet maternal and child health services needs, and developing collaborative approaches for increasing community awareness of MCH issues and how individuals can promote their health.

DNYHS deliberated how the success of a perinatal health system in meeting the needs of its local community is dependent upon a number of elements, among which are political, economic, social, cultural, organizational, and behavioral factors. Since it was not feasible to address every potential facet of a perinatal system, DNYHS, through the Project Governance Board, initiated a series of discussions with the local lead agencies and the Local Consortia to identify issues that were important to the communities being served.

Each local lead agency was given the freedom to develop an individualized plan based on its own needs assessment processes, in which members of the local consortia, including consumers, providers, and other key community stakeholders were all involved in discussing their communities' needs. Examples of community stakeholders included:

- County health advisory boards
- Head Start

- Local area hospitals
- Local health departments
- Planned Parenthood
- Faith-based institutions
- Community-based organizations
- Advocacy organizations
- Research organizations

The way in which needs were assessed and priorities identified differed among the local consortia. In Nassau, the plan was developed in response to a major crisis in the funding and staffing of county health clinics, which created a severe obstacle to primary care accessibility. In Queens, a series of focus group discussions were held with providers and consumers to determine needs and plan priorities. In Suffolk, the local consortium began with the Healthy People 2010 goals and held focus groups to identify participants' knowledge of and experience with perinatal mood disorders. The other goals of Suffolk's LHSAP were determined through consortium group discussions and consumer needs identified by case management staff.

b. LHSAP Intervention Components and Changes over Time

DNYHS Local Health System Action Plans encapsulated strategies for assessing community needs and perinatal system strengths and weaknesses, and developing a coordinated community-wide response in addressing those issues. At each agency, Healthy Start staff had the primary responsibility for organizing and coordinating LHSAP activities. While the entire consortium in each community was involved in implementing the LHSAP, each consortium also had sub-committees that focused on particular aspects of the plan. Both EOC and QCPC have separate subcommittees for consumers to provide them with a supportive environment in which to solicit their input. SCPC created several special committees focusing on particular content areas of their LHSAP including a Perinatal Mood Disorder Task Force, a Breastfeeding Committee, and a Substance Abuse Committee.

Nassau developed a local health system action plan in response to the massive downsizing of health care services in Nassau County that disproportionately affected lower-income residents in the area. The plan consisted of EOC's Healthy Start program bringing together health care providers and consumers on the consortium to create a "survival guide" that helps residents navigate the health care system in light of the downsizing. The booklet, which is currently being finalized, will also serve as a resource guide that lists referral agencies for health and social services in Hempstead and surrounding areas. After the booklet is finalized, it will be distributed to local area residents, DNYHS program participants and health and social services providers, and will be updated on a semi-annual basis, if needed.

Queens developed two separate local health system action plans for each of their service areas. The primary aim of the plans was to build community awareness about infant mortality and maternal and child health issues. The plan for South Jamaica consists of working with local media outlets to develop public service area announcements about infant mortality rates in Southeast Queens; the plan for Rockaway Beach/Arverne consists of working with area churches to create "health resource centers" to distribute brochures and flyers on a variety of health

education topics. For each plan, a group of providers and consumers worked together to develop talking points for the public service announcements (in the case of South Jamaica), and health education topics relevant to risk factors in maternal and child health and the prevention of infant mortality and low birthweight. The public service announcement messages are being finalized by the consortium, and are anticipated to be recorded and distributed to the selected media outlets by the end of 2005. The health resource centers currently are being assembled in the selected area churches, and will be ready for use by fall 2005.

The **Suffolk** consortium developed two plans for its entire service area. The first focuses on creating breastfeeding-friendly workplaces in Suffolk County. Consortium providers and consumers collaborated with the Suffolk County Chamber of Commerce to educate business owners on the benefits of breastfeeding and create strategies to create a breastfeeding-friendly environment for employees and customers. A Breastfeeding Committee was established including representatives from the local chapter of American Academy of Pediatrics, WIC, La Leche League, and staff from the regional perinatal medical center. The committee members reached out to local health care providers to encourage them to become certified lactation consultants. In collaboration with La Leche League, the Committee hopes to develop a phone counseling system for Healthy Start participants and to make this available to all county residents. In addition, the Committee hopes to devise a public information campaign to encourage utilization of lactation consultants.

The second Suffolk action plan focuses on creating awareness of perinatal depression. SCPC staff and a consortium subcommittee, in conjunction with long-time partner the Postpartum Resource Center, developed several educational workshops for providers on the signs and symptoms of perinatal depression, and encouraging screening, referral and/or treatment. SCPC also developed a poster campaign encouraging women in their target areas to learn to recognize symptoms of perinatal depression and call them – or other health and social service agencies – to find screening and treatment services.

c. Resources and Events and their Impact on Implementation of LHSAP Activities

The challenges to developing and implementing the LHSAP are similar to those that the local consortia face in trying to obtain broad participation. Specifically, some of the most formidable challenges have been:

- Convening all stakeholders together to develop and implement the LHSAP.
- Consistent and sufficient staffing to support implementation of LHSAP activities.
- Obtaining stakeholder buy-in, particularly the faith-based communities and consumers.
- Sufficient funding for LHSAP activities.

Each consortium has faced particular challenges in achieving the goals of its LHSAP. In Hempstead, the health services cutbacks were related to the county's fiscal situation. Furthermore, the Hempstead Consortium experienced of staff turnover with their paid Consortium Coordinator position. Some health providers were reluctant to participate in LHSAP activities because they felt that this implied that they were not already serving the community's

needs. The Queens consortium needed to address the concern expressed by clergy in promoting information related to sexual health. Local consortium members met with several churches to provide further clarity about the purpose of the LHSAP and the consortium as a whole. In Suffolk, one of their LHSAP areas of need – addressing perinatal substance abuse – could not be implemented due to insufficient staff and monetary resources.

2. Consortium

a. Approaches and Rationale

As a partnership of three geographically-dispersed community-based organizations, DNYHS developed a consortium organizational structure designed to maximize community participation on both the local and project-wide levels. The project has two types of consortia -- a project-wide Project Governance Board and four local consortia in the target communities. The local consortia are charged with addressing issues specific to each local community, including development and implementation of the Local Health System Action Plan. Charged with recommending policy, contributing expertise, reviewing agency goals and operations, facilitating systematic change at the local level, and sharing responsibility for community ownership and participation of the project, the consortia incorporate broad and diverse participation organized in meaningful and focused ways.

b. Consortium Intervention Components and Resources

The exact makeup and function of the four local consortia have been shaped by the nature and needs of the project, consumers and the surrounding communities. They all have common goals and all include as members health care providers, representatives of other human services organizations, local businesspeople, clergy, and local policymakers. All the local consortia meet regularly (at least every two months) and have established procedures. Each local consortium has expanded its programs to include a forum in which consumers can meet among themselves, formulate their concerns, and practice their skills before bringing them to the more public table with other Consortia members. The Nassau and Suffolk consortia activities were coordinated by a Consortium Coordinator who was a paid staff member at each of their respective Healthy Start sites, while Queens consortia activities were convened by the Director of Maternal Child Health Programs and facilitated by a paid consultant.

Nassau

The Nassau Consortium Committee met monthly and hosted bi-weekly educational workshops for program and community participants. Consortium members who are health care providers from local hospitals and clinics facilitated many of these workshops. These activities aimed to bring awareness of maternal and child health issues to the entire Hempstead community. The local consortium in Hempstead met monthly to discuss and vote on issues of concern to the consumer body.

Queens

Because of the geographic separation between the communities, separate local consortia served the Rockaway Beach/Arverne and South Jamaica communities in Queens. Each consortium is co-led by a local consumer and a service provider. The Queens consortia conducted quarterly joint meetings that included both the Arverne/Rockaway Beach and South Jamaica consumers. Each meeting included training on the Local Health System Action Plan topics (SIDS, breastfeeding, and mental health/stress management) as well as additional topics recommended by the consumers. QCPC utilized a consortium consultant who facilitated consumer empowerment trainings to reinforce leadership themes. Consumers utilized the trainings to work collaboratively with providers in the development and implementation of the Local Health System Action Plan and other consumer empowerment activities. Quarterly joint consumer/provider meetings were convened to provide a forum for dialogue regarding the LHSAP.

Suffolk

The Suffolk Consortium held 10 General Consortium Meetings and 10 Consumer Consortium Meetings each year. The Suffolk Consortium has subcommittees to focus on particular issues: the Breastfeeding Committee and the Perinatal Mood Disorder Task Force. The consortium also sponsored several Perinatal Health Care Forum meetings each year.

Project-Wide

The project-wide Consortium, known as the Project Governance Board (PGB), was formally constituted in March 2000, after MSPH became the project grantee. The PGB's operations are regulated by a set of by-laws, which allow the Board authority to provide governance, oversight and guidance for the project. The by-laws specify the roles and responsibilities of all project parties and PGB voting procedures, and define he process for oversight of partner performance and include a conflict of interest clause. Each partner agency is represented on the PGB by an executive, a consumer member, and a service provider. The PGB includes representatives of the New York State Department of Health Bureau of Women's Health and each local department of health (for New York City, Nassau and Suffolk Counties, respectively). Board structure includes three at-large members, who are individuals or representatives of organizations with an interest in maternal and child health.

The Project Governance Board met quarterly. Meetings included updates and consultation on recent legislative, policy, and organizational developments affecting the DNYHS communities. In addition, representatives from the partner agencies shared accomplishments, challenges and best practices with their counterparts.

DNYHS created a Leadership Development Institute to sponsor project-wide technical assistance events for staff, consumers, and community members in implementing the consortium and local health systems action plan components. Institute activities included periodic consumer luncheons that focused on empowerment activities and project-wide forums designed to train local lead agencies and their consortia leadership on the development, implementation and evaluation of their respective Local Health System Action Plan.

c. Resources and Events and their Impact on Implementation of Consortium Activities

Major impediments to consumer participation were transportation and child care. Child care is a major factor affecting retention. During this project phase, quarterly coordinators' meetings were convened to provide a space for program and consortia coordinators to discuss these challenges. Discussions continued during the quarterly Coordinators' Meetings to examine possible child care services – such as holding concurrent activities for infant and children – during consortium meetings and activities in order to maximize community participants' attendance. All local consortia encouraged program participants to bring their children to the meetings with them if they have no other arrangements. In addition, each program and community participant was provided a small reimbursement for any paid child care services that they may utilize in order to attend consortium meetings and activities.

As noted above, consortium activities centered on the development and implementation of Suffolk County's substance abuse system action plan was interrupted by the lack of funds available to them. SCPC staff and consortium leadership were forced to abandon this particular system action plan and postpone it until they can find additional support from another public or private funding agency.

d. Establishment of the Consortia

During the first two years of the project (1997-1999), a Project Steering Committee functioned as the governing body for the project under the aegis of the original grantee and was comprised of the Executive Directors of each of the Local Lead agencies and the Project Director with the grantee organization. However, the project found that membership was too limited and the committee did not adequately represent the broad MCH provider community and consumers. To address these limitations, the local lead agencies and CUMSPH – upon becoming the grantee organization in 1999 – developed a new governance body, the Project Governance Board (PGB), which was officially established in March 2000. Rather than duplicate efforts by creating another consortium on a project-wide level, the PGB included representatives from the local consortia, including consumer representatives and local provider representatives from each target service area.

All consortium bodies in the DNYHS project were established in 1998, during the previous funding cycle. The Nassau County consortium, formerly called the Family Empowerment Consortium of Nassau County, developed working by-laws, governance and administrative organization. As an operating arm of the Family Empowerment Consortium, a Consumer Advisory Committee, composed of over one hundred consumers, met monthly to discuss and vote on issues of concern. A major barrier for this project phase has been waning provider and consumer participation due to changing consortium staff. Through the staff changes, the Nassau County consortium still continues to reach out to community health and social services providers and consumers through monthly meetings facilitated by EOC program staff.

The Queens consortia were organized into two distinct groups, one that served the communities of Rockaway Beach and Arverne and the other served the community South Jamaica. Each consortium is led by a local consumer and service provider, with management

support provided by a consortia consultant and the QCPC Director of Maternal Child Health Programs, who travels between the two consortia for the purpose of networking, management and oversight of each individual consortium's activities and projects.

Despite geographic distances between the service areas for SCPC, the Suffolk County consortium includes consumer and provider participation from the four target areas within the County. The consortium serves as a forum for service provider agencies, consumers, politicians and business leaders to share information and work together. In 2000, the consumers formed a Consumer Committee, which meets on its own to develop strategies to address their needs and select spokeswomen to represent their concerns at general consortium meetings.

e. Consortium Working Structure

DNYHS consortium structure was built upon the strong local consortia already established in each target community during the first two years of the project in 1998-99. As noted above, there is a project-wide Project Governance Board that serves in an advisory capacity and four local consortia that focus on community-specific activities.

The PGB's operations are regulated by a set of by-laws, which allow the Board authority to provide governance, oversight and guidance for the project. The by-laws specify the roles and responsibilities of all project parties and PGB voting procedures, and define the process for oversight of partner performance and include a conflict of interest clause. While, the gender of the PGB was primarily female, it represented the majority of the ethnically diverse populations served by the project. The PGB race/ethnic make-up was 14 African-Americans, 4 White and 3 Latina women (there was one unfilled member-at-large seat at the end of the project phase).

The makeup and function of the four local consortia were shaped by the nature and needs of the project, consumers, and the surrounding communities. Members include health and social services providers, local businesspeople, clergy, elected officials, and representatives from the local health departments and other public agencies. All the local consortia meet regularly (at least every two months) and have established procedures. All of the consortia have expanded their programs to include a specific forum in which consumers can meet among themselves, formulate their concerns, and practice their skills before bringing them to the more public table with other consortium members.

The following table identifies the composition and active participation of each DNYHS consortium body:

	PGB	Nassau	Queens	Suffolk
Total # members	17	31	41	80
% Active Participation	59%	44%	63%	70%
Member Type:				
State/local government	23%	44%	5%	24%
Program participant	-	22%	2%	9%
Community participant	23%	3%	27%	11%
Community-based organizations	-	6%	29%	38%
Private agencies, organizations	18%	29%	-	1%
Providers contracting with Healthy Start	18%	-	-	-
Other providers	18%	-	37%	12%

f. Activities to Assess Ongoing Needs, Identify Resources, & Establish Priorities

Case management and supervision staff often detected patterns in service delivery needs for their clients. The staff worked with agency leadership to determine the agency's best response to those needs through consumer workshops, health education presentations, and local health systems action planning activities.

Quarterly project-wide consortium coordinators' meetings were held. During these meetings, consortium coordinators provided updates on their local activities, and discussed strategies and best practices for implementation. Consortium coordinators also reported their activities 3-4 times per project year through quarterly progress reports where they detailed consortia activities, accomplishments and challenges.

Each local consortium had as part of its structure a consumer subcommittee, which met on a monthly basis to discuss issues of importance to program and community participants. These subcommittees, which met on a monthly basis, allowed consumers to discuss local health issues among themselves, formulate their input in a setting of their peers, and select individual consumers to present their perspectives to the larger consortium. The Consumer Committees were able to share the perspectives they formulated with providers and other consortium members during consortium meetings. The Queens consortia held quarterly "mini-forums", where consumers and provider members of each consortium met to discuss topics in relation to maternal and child health.

g. Community Strengths

The DNYHS local consortia members, especially consumer members, served as an important source of outreach to potential Healthy Start participants (both for case management services and consortium participation), and provided general health information regarding community needs on behalf of the local lead agencies. This approach recognized the existing local consortia as the most appropriate agents for addressing community needs at the local level. In addition, the local lead agencies have had considerable experience and history in each of their respective communities as agents of collaborations – they have brought consumers and providers

in both the public and private sectors to the table in order to identify and address barriers to optimal maternal and infant health. Meetings with local legislators were helpful in establishing a relationship with the local consortia. As a result, a representative from the staff of Suffolk County legislature is part of the Suffolk County consortium, and EOC hosts empowerment workshops and consortium meetings with the assistance and participation by Nassau County government officials.

h. Weaknesses and Barriers Experienced by the Consortia

One major challenge for the local consortia was the recruitment and retention of diverse participants, particularly such critical stakeholders as consumers, faith leaders, and day care/school representatives. In some cases, obtaining the consumers' correct addresses and phone numbers was a challenge. Direct contact between DNYHS agency staff and prospective consortium members was important in establishing rapport and communicating the vital nature of their participation within the consortia. All local lead agencies have reported how one-on-one discussions with potential consortium members has helped them understand how collaboration among health and social services providers, faith-based organizations and the education system can help pregnant and parenting women by building a services network and a mechanism to observe health trends in their local communities.

The large geographic area covered by the project was a barrier to participation in project-wide PGB meetings and consortium technical assistance events. In order to address these participation barriers, DNYHS program staff encouraged local consortia leadership to attend project-wide meetings and forums and report back to their larger local consortia the topics discussed and strategies learned.

i. Activities and Strategies to Increase Resident and Consumer Participation

Case management staff helps identify clients who are interested in participating in the consortium. Consumer members recruit other community residents through word of mouth. In order to stimulate consumer recruitment and participation in local consortia, a project-wide consortium recruitment brochure was created targeting consumers. These brochures detail Healthy Start consortium activities and the skills and benefits consumers gain from participation which include reimbursement for child care and transportation, opportunities for travel to Healthy Start meetings in Albany, New York, and Washington, leadership development and networking with other Healthy Start consumers. Discussion on strengthening the role of consumers, particularly through consumer recruitment and retention, was an agenda mainstay of the quarterly DNYHS Coordinators' Meetings.

A primary vehicle for supporting consumer participation was the creation of separate Consumer Committees for each local consortium. These committees, which met on a monthly basis, allowed consumers to discuss local health issues among themselves, formulate their input in a setting of their peers, and select individual consumers to present their perspectives to the larger Consortium. The Consumer Committees then shared their perspectives with providers and other Consortium members in full Consortium meetings. Consumer input and perspectives have come to be valued by provider and governmental members of the Local Consortia, who have few

channels for obtaining these perspectives. Consumers from the Local Consortia were represented on the Project Governance Board and were involved in development of their community Local Health Systems Action Plan. They attended project meetings with the State Health Department to discuss community perinatal health needs.

Several project-wide activities were conducted as part of the project's Leadership Development Institute to recruit and facilitate consumer membership. These included empowerment luncheons and skills-training activities. The local lead agencies also encouraged consumer participation in the consortia by providing baby supplies, transportation fare cards, and childcare stipends as well as opportunities to attend Healthy Start and other educational conferences.

Each local agency has engaged in extensive programs to increase the capacity of consumers to participate in planning and advocacy efforts. QCPC provided community organization training to consumers, which helped prepare the consumers for playing an active role in QCPC's Legislative Breakfast, and educating local elected officials regarding community needs. The Queens local consortia trained consumers in public speaking and meeting planning and facilitation. In Nassau, consumers received empowerment training through the weekly Personal Empowerment Program sponsored by the local consortium's Consumer Committee and monthly family empowerment workshops.

To further stimulate recruitment and retention, each DNYHS local consortium developed a consumer advocacy project that uses arts and creative expression to help empower consumers to advocate for maternal and child health issues. Program and community participants were responsible for developing the theme for each project, and received training on using the finished products as advocacy tools to educate local policymakers and others about the Healthy Start program.

Nassau consumers resolved to create a book of poetry and photography containing words and images through the eyes of program and community participants in relation to their pregnancy and parenting experiences, particularly related to the Healthy Start program. Once the book is completed, consortium members will distribute the book to county, state and federal legislative representatives, and to key stakeholders throughout the target community.

Queens consumers collectively decided to develop an educational video as their advocacy project. The video will address the impact of infant mortality in South Jamaica and Arverne/Rockaway Beach, with an emphasis on Sudden Infant Death Syndrome (SIDS) Breastfeeding and Stress Management. Once completed, the video will be used to educate regional health providers through in-service trainings focusing on cultural sensitivity and competency.

The Suffolk consumer advocacy project involved the designing and sewing of a quilt. During the creation of the quilt, consumers receive training on advocating to elected officials, self esteem building, and self-empowerment exercises. The quilt will be displayed to elected officials from the targeted communities to illustrate what Healthy Start has meant to each of the participating consumers.

j. Consumer Input in the Decision-Making Process

Consumers from each local consortium were represented on the Project Governance Board and within the leadership structures of the local consortia themselves. In this capacity, consumer leaders were able to provide input in major consortium activities directly to DNYHS staff and consortia leadership.

Each local consortium assessed community needs by convening monthly consortium meetings, with specific emphasis being placed on the needs of Healthy Start program and community participants. The DNYHS consortia held regular meetings for consumers only and conducted focus groups at the beginning of each program year to determine the year's focus for the consortia. All local consortia facilitated consumer participation through a Consumer Committee. The Consumer Committees shared their perspectives with providers and other consortium members during general consortium meetings.

QCPC's Consortium sponsored four consumer-provider meetings per year, devoted to both identifying gaps and seeking solutions with the active participation of members of the Consumer Committee. These meetings included "mini-forums," with invited speakers who framed a topic for input from all present. In Nassau County, consumers participated actively in the Consortium's monthly meetings, where particular attention is paid to soliciting their input. In SCPC's dispersed geographical area, consumers participated in four meetings with local providers as well as in area-wide SCPC Consortia meetings and conferences. Consumer representatives also attended state-wide Healthy Start meetings with the State Health Department as representatives of the local agencies to discuss community perinatal health needs and provide a consumer perspective in the discussions of perinatal health issues.

k. Utilizing the Suggestions Made by the Consumers

Consumers participated in strategic planning for the local consortia and helped identify community concerns and barriers to health care access. Consumers helped in communication/media efforts through the development of health messages on preventing infant mortality and maternal child health promotion. Consumers participated with providers in training sessions on working with media – specifically, how to develop press releases, PSAs on infant mortality and promoting healthy pregnancy outcomes. Consumers also assisted with the development and distribution of consortium recruitment materials, such as flyers and brochures, and have directly recruited many members of the consumer subcommittees.

Many suggestions made by the consumers were used to direct consortium activities, specifically in relation to leadership development training and local consortia activities. The content for the leadership development training activities for consumers were collected directly through participation and attendance at consumer recruitment luncheons. Also, consumers regularly made suggestions to consortia staff and case managers to direct the focus of health education workshops and consumer development activities through their local consortia.

MSPH project staff attended each local consortia meeting at the start of the project years in 2002, 2003 and 2004 to discuss development and implementation of consumer leadership

development activities. During these meetings, consumers from the local consortia discussed their preferred topics of leadership development and community concerns to be addressed during the project year activities through consumer empowerment workshops, health education seminars and leadership development activities conducted through project-wide consumer workshops.

At the behest of consortia coordinators, who frequently discussed recruitment and retention strategies with their participating consumers, DNYHS consortia coordinators and MSPH project staff worked with consumer representatives to develop consortia outreach materials, such as flyers and brochures, geared specifically toward both potential consumer and provider members.

3. COLLABORATION AND COORDINATION WITH STATE TITLE V AND OTHER AGENCIES

a. Approaches and Rationale

As a partnership, DNYHS was extensively involved in a number of collaborative activities centered upon maternal and child health issues, including partnerships with State and local health departments. These collaborations enabled DNYHS partners to take an active role in working on priority areas identified in the State's Title V program needs assessment.

At the project-wide level, a representative from the New York State Department of Health served as a member of the Project Governance Board (PGB). Regular meetings of the NYSDOH Bureau of Women's Health and the New York Healthy Start projects facilitated collaboration across the state. The meetings provided the opportunity to discuss ways of developing linkages with Medicaid managed care organizations, improving consumer leadership development and participation, and establishing training collaborations for case management staff. DNYHS, particularly through the local consortia, enhanced these essential activities by sponsoring the participation of consumers at the meetings.

SCPC is a state-funded Comprehensive Prenatal-Perinatal Services Network (CPPSN) and QCPC served in this capacity in the first three years of the project period. QCPC and SCPC are members of the Association of Perinatal Networks of New York, a 14-member statewide organization comprised of all the State perinatal networks. The Association is an important mechanism for community-based advocacy around state perinatal health issues, particularly in high-risk communities. The State DOH participated in bi-monthly meetings of the Association, providing another avenue for collaboration. In 2002, the Nassau County Department of Health (NCDOH) was designated as its county's perinatal network. The NCDOH is a member of the local Healthy Start consortium and the Nassau Healthy Start Program Director sits on several Nassau County Perinatal Network committees including advocacy, needs assessment, and education.

b. Collaboration & Coordination Intervention Components and Resources

DNYHS partners worked in collaboration with a number of State perinatal health programs that provide health services. All DNYHS agencies had cross-referral relationships with local providers participating in the Prenatal Care Assistance Program (PCAP), the State Medicaid expansion program for pregnant women. For example, QCPC worked with four local PCAP providers to refer women in need of prenatal care to these facilities, which, in turn, referred women needing case management to QCPC. Many PCAP providers participated in the Healthy Start local consortia. Healthy Start case managers provide an essential role in helping women keep their prenatal care appointments with PCAP providers.

New York State mandated in 2002 that perinatal service providers across the state engage in Regional Perinatal Forums, which are regional collaborations of hospital and community-based providers. These forums are convened to help improve pregnancy outcomes, increase access to care, improve the quality of care, and address other state and region-wide public health issues related to maternal and infant health. Each Forum is co-chaired by the regional perinatal medical center and the Comprehensive Prenatal-Perinatal Services Network in the region. The forums include representation from all hospitals providing various levels of perinatal services, hospital associations, managed care organizations, consumers, substance abuse providers, HIV services providers, and other organizations that provide perinatal-related services. In New York City, the Regional Perinatal Forums were organized by city borough, while in Long Island, the Regional Perinatal Forum was organized as a bi-county forum encompassing both Nassau and Suffolk Counties. A representative from QCPC co-chaired the Regional Perinatal Forum for Queens County, and SCPC Healthy Start Consortium Coordinator was a co-chair of the Long Island Forum. EOC also participated in the Long Island Regional Forum

DNYHS local lead agencies coordinated activities with local Medicaid administrative agencies. QCPC has an ongoing collaborative relationship with the New York City Human Resources Administration (the local Medicaid authority) and continues to serve as a member of the HRA Community Advisory Board. QCPC participated in reciprocal training and has a formal agreement with HRA to determine presumptive eligibility for Medicaid and PCAP, eliminating a major barrier to receiving timely prenatal care. QCPC maintained its participation in a program for education and outreach for Medicaid managed care, as well as establishing referral linkages with local Medicaid managed care plans. QCPC conducted outreach and education, and facilitated enrollment activities as a subcontractor of the designated Medicaid managed care enrollment broker. Through a referral arrangement with a local Title XXI Child Health Plus enrollment agency and an agreement with a managed care organization, QCPC provided community education about Child Health Plus and enrollment information.

In Suffolk County, SCPC provided facilitated enrollment to Medicaid and PCAP for the County Department of Health, with which SCPC has a strong relationship. SCPC also provided facilitated enrollment into Child Health Plus. EOC made referrals to the NCDOH for enrollment in Child Health Plus, Family Health Plus, and other Medicaid programs. Each agency also has close ties to local WIC programs. For example, QCPC conducted cross referrals with three area WIC programs and provided perinatal educational workshops to both WIC clients and staff.

On both a project-wide and community level, DNYHS pursued close collaboration with the local departments of health in New York City, Nassau County, and Suffolk County. Representatives from each of the local health departments serve on the local lead agency Board of Directors and/or the local consortia. A representative from each local health department also served on the DNYHS Project Governance Board (PGB).

EOC worked closely with the NCDOH Community Health Worker Program to coordinate provision of case management services, in addition to strengthening ties with the County perinatal network for services planning activities. In addition, EOC and the DOH established interagency referral mechanisms. The Nassau County Healthy Start program also collaborated closely with the NCDOH through consortium activities, and in development of the Parenting Education course offered by EOC to Healthy Start participants and residents of the target area in Hempstead, Nassau County.

QCPC had a grant from the New York City Department of Health and Mental Hygiene to develop grassroots strategies for reducing infant mortality**.** Through this initiative, QCPC explored the efficacy of such strategies as outreach, case management, male mentoring, and health education in conjunction with several faith-based and community-based organizations. These community-based organizations provided referrals to QCPC and QCPC referred male partners of clients to the Jamaica Fathers Project. QCPC also had an ongoing partnership with the NYCDOH district health center in Jamaica for perinatal and child health services.

Through a memorandum of agreement, Suffolk County DOH (SCDOH) referred high-risk women to SCPC for case management services. SCPC also worked with the SCDOH to strengthen the availability of interconceptional services and to improve the identification and treatment of perinatal mood disorders. SCPC maintained strong relationships with county-run health centers, which provide smoking cessation programs, prenatal care, primary care, childbirth classes, substance abuse services, social work, and dental services.

Each of the local lead agencies fostered existing or new collaborations with a variety of stakeholders in their local communities. Examples of these relationships are listed below:

Nassau

- Links for outreach and interagency referrals with Winthrop Hospital, Mercy Hospital, Nassau University Medical Center, and Hempstead Health Center.
- Outreach and recruitment for teen clients with Uniondale High School.
- Section 8 education/awareness/referrals with US Department of Housing and Urban Development.
- Interagency referral linkages with Planned Parenthood.
- Financial awareness and budgeting services for Healthy Start clients with Primerica.

Queens

- Strong partnership relationship with the major regional hospital providers, ambulatory health care programs, and WIC.
- Enhanced regional perinatal services coordination with the Citywide Coalition to End Infant Mortality.

- Participated as active member of the NYC Human Resources Administration (HRA) Community Advisory Board in South Jamaica.
- Partnered with the Arverne HRA office.

Suffolk
- Partnered with prenatal/perinatal health care providers around training and educational services.
- Identified stakeholders to be involved in LHSAP breastfeeding activities including the Babylon Breast Cancer Coalition, American Cancer Society, American Lung Association and Cornell Cooperative Extension.
- Hosted joint videoconference on breastfeeding with SUNY Albany School of Public Health and the New York State Department of Health Bureau of Women's Health.
- Participated on the March of Dimes' Premature Birth Committee.
- Hosted a Perinatal Mood Disorder symposium with Stony Brook University Hospital.

c. Resources and Events and their Impact on Implementation of Collaboration Activities

As noted above, all DNYHS local lead agencies participated in the Regional Perinatal Forum in their area. Representatives from QCPC and SCPC were selected as co-chairs of the Queens and Long Island forums, respectively, while EOC was a major contributing force to strengthening service linkages within the Long Island forum. All three agencies continue to participate in various committees on each forum and develop services provision strategies with the health and social services providers also participating in the forums.

4. Sustainability

a. Approaches and Rationale

In 2001/2002, the first year of funding, the economic fallout and political environment that resulted from the tragic events of September 11, 2001 was of particular concern to DNYHS. City and county budgets were being reduced, resulting in severe cutbacks in critical health and social services; while simultaneously the City and its surrounding Counties were experiencing an increase in need. While there has been some economic recovery, state and local government fiscal situations remain one in which expansion of services is limited.

This environment has shaped DNYHS sustainability efforts and the partnership has devoted its attention to strengthening the organizational infrastructure of the local lead agencies and local consortia to have the capacity to competitively seek additional sources of funding and community support. Both on the project wide and individual agency level sustainability planning has been directed to strategic planning, administrative and board capacity building, and identifying and applying for grants/contracts to sustain and enhance DNYHS services.

b. Sustainability Components and Resources

Each local lead agency allocated funding in budget year 2004/2005 for retaining a sustainability consultant to provide assistance in developing an overall strategic plan for

agency/consortia development and/or board development. Two of the agencies were able to retain non-profit development consultants prior to the close of the final grant year. Elements of the agencies strategic plans include:

- Assessment of agency strength and determination of service priorities.
- Board member development in areas of financial management, fundraising and board growth.
- Consortium technical assistance in conducting community assessments and writing grant proposals.

Each agency receives funding from a variety of sources as part of the agency's overall programmatic activities. Healthy Start participants utilize all services offered by these other programs. They include:

EOC

- Early Head Start
- Head Start
- HIV/AIDS counseling and off-site testing facility
- Displaced Homemaker Program (job training)

Queens

- New York City Council funding through the New York City Department of Health and Mental Hygiene (Bureau of Maternal/Infant & Reproductive Health) which helps support QCPC's operational expenses and community perinatal health education activities.

Suffolk

- Funded by the New York State Department of Health as a Comprehensive Prenatal-Perinatal Services Network (CPPSN). This funding gives Healthy Start program participants access to several additional supportive and enabling services, including: the agency's Doula program and the peer support Mentoring Mom's Program.
- Funding from New York State Department of Health Bureau of Tobacco Cessation for smoking cessation activities. (2001-2004)
- An appropriation from the Suffolk County Legislature for emergency transportation. (2002)
- Received a small grant from the Long Island Funds for Women and Girls to support additional Doula trainings. (2002)
- Funding by Catholic Health Services for new and gently-used infant clothing and goods for the "Baby's Dresser".
- Funded by the United Way for Poster Campaign to educate women about Postpartum Depression. (2001/2002)
- Funded by the March of Dimes to provide Health Fairs for perinatal women and community providers. (2002)
- Funding by NYSDOH AIDS Institute to support Prenatal Care Partnership (2002)
- Funding by the Tobacco Action Coalition to provide incentives to support smoking cessation.

- An appropriation from the Suffolk County Legislature to support operating expenses. (2005)
- Financial support from Commerce Bank's Affinity Program. Commerce Bank will make a donation to SCPC based on a percentage of the average balance of members' Affinity Banking Program accounts. All checking, savings, money market, CDs and retirement accounts are included in the program. (2005)
- In response to an article that appeared in Newsday about SCPC, a local Girl Scout organized a diaper drive for the agency bringing in over $1000 worth of diapers given to her by her community. (2005)
- A donation from the South Shore Chapter of the Lionesses Club of over $1000 in new baby items. (2005)

Additional applications submitted to sustain Healthy Start programs that were not granted funding, include:

- Paul Newman Charitable Foundation (SCPC- 2002)
- Roslyn Foundation (SCPC- 2004)
- Aetna Foundation (SCPC- 2004)
- American Legacy Foundation (EOC, QCPC, SCPC- 2004)
- Ms. Foundation (SCPC- 2003)

c. Resources and Events and Their Impact on Implementation of Sustainability Activities

A critical barrier affecting sustainability is the fiscal situation faced by local governments. Each consortium included representation from legislative offices of County executives and State and federal legislative representative. QCPC and SCPC hosted annual legislative breakfast for policymakers to inform them of the latest maternal and child health trends in their communities, and highlight the successes of their Healthy Start programs. QCPC has a longstanding relationship with New York City Council members in their target communities, and continues to work with other Healthy Start programs in New York City to secure funding from the New York City Council for infant mortality prevention. EOC hosted consortium meeting at which Nassau County legislators attend, and worked with the County Legislator's office to build awareness around infant mortality in Hempstead and surrounding communities. SCPC and its consortium received a Proclamation from the Suffolk County legislature for their exemplary work in combating infant mortality and low birthweight.

At the project-wide level, a comprehensive program of administrative and fiscal review initiated by MSPH in 2000 continued to be conducted. Each agency's accounting system was reviewed with regard to their internal fiduciary capacity to utilize DNYHS funds. The reviews performed by an independent auditor have been utilized by agency directors as a learning vehicle and has proved instrumental to overall agency functioning.

d. Other Sustainability Issues

Prior to the current project period, the local lead agencies explored potential contractual relationships with managed care organization (MCO) to provide outreach and health education

services to the MCOs. Because of overall reimbursement limitations, managed care organizations were not interested. While New York State provides some Medicaid coverage for perinatal case management, these funds are extremely limited and not available to DNYHS agencies.

The perinatal partners have actively sought grants/contracts from a variety of sources both for the purpose of maximizing Healthy Start funds as well as overall agency service provision. Success has been met in varying degrees. Often, success has been specific to the financial resources and political backdrop of the target communities. In Nassau County the current fiscal environment has led to increased competition for scarce resources. In Suffolk, a county also experiencing fiscal shortfalls, a reduction in the number of county grants and awards has resulted. In New York City, public funds for infant mortality prevention have been targeted to communities not currently served by Healthy Start.

Despite each local lead agency's attempts to seek grant funding from other sources, as described above, the DNYHS agencies have had limited success in securing other sources of funding.

III. PROJECT MANAGEMENT AND GOVERNANCE

A. Project Management Structure

Columbia University Mailman School of Public Health has served as the project grantee since 1999. The grantee subcontracts with the three local lead agencies (EOC, QCPC, and SCPC) to implement the program on the local level. The grantee provides fiscal and programmatic oversight for the project. Fiscal and grants management support was received from the Center for Applied Health, also located at CUMSPH, for the majority of the project. Throughout the four year project period, the CUMSPH project team has coordinated all project-wide activities related to governance, program implementation, performance monitoring, evaluation, and technical assistance, and maintained primary responsibility for subcontract monitoring, fiscal management and Healthy Start reporting requirements.

The project is governed by the by-laws of the Project Governance Board (PGB), which were instituted in 2000. The PGB met quarterly and, as discussed above, was comprised of representatives from the grantee, the three local lead agencies, the local consortia, state health department, and other stakeholders. The PGB served in an advisory capacity and provided a forum for partners to share accomplishments, challenges and effective service strategies.

Project management was facilitated by DNYHS directors meetings which were held quarterly. These meeting were attended by the Principal Investigator/Project Director, and the directors of the local lead agencies. They were a forum for programmatic and administrative review, discussion, and decision making. These meetings provided the opportunity for the local lead agencies to share strategies for addressing performance issues and project challenges.

CUMSPH has also coordinated, at the request of the local lead agencies, a project management structure for supervisors and front line staff. The CUMSPH Program Coordinator and Program Manager hold monthly conference calls and quarterly meetings with local lead agency staff members in charge of implementing program activities. The quarterly Coordinators' meetings provided a time to confer about the progress of case management implementation and local consortium activities, and discuss project-wide technical assistance and training opportunities. Quarterly case management meetings, convened by the Program Manager, and attended by all case managers, provided an opportunity for front line staff persons to network, share best practices, receive technical assistance on case management process and discuss challenges in the field.

B. Resources Essential for Fiscal and Program Management

As an academic institution, Columbia University has brought a number of educational resources to the project as well as a strong record of commitment to community-based public health services. The Department of Sociomedical Sciences of Mailman School of Public Health focuses on social and behavioral factors affecting health and health care. The Department operates a master's of public health program in Health Promotion, which focuses on training health professionals to design, implement, and evaluate community-based programs. Students in the Department are a valuable project resource, serving as DNYHS program assistants.

During the project period, three monitoring protocols were developed to assure program quality and accountability. They include: 1) a Quarterly Progress Report that included information on staffing, implementation of core services, community health education, consortium activities, collaborative activities, local health system action plan implementation, and sustainability activities; 2) a Performance Data Report that included service delivery and utilization information based on the project data system; and 3) a Care Review Protocol that was used by the DNYHS Program Manager to conduct in-depth reviews of program participant case records at each agency for the purpose of assessing the quality of core services in accordance with established protocols.

As founding partners of DNYHS in 1997, the local lead agencies bring considerable resources to the project. In addition to their long term experience with the Healthy Start program, each agency is an established and well regarded community institution known for providing culturally competent and supportive services to families in their communities. Economic Opportunity Commission of Nassau County is a local community development organization with over 25 years experience in community-based efforts, a successful Head Start project, and a longstanding relationship with the local Empowerment Zone. The status of Suffolk County Perinatal Coalition as a State-funded Comprehensive Prenatal-Perinatal Services Network has been an important factor enhancing the project's linkage with the New York State Department of Health's Bureau of Women's Health. Queens Comprehensive Perinatal Coalition is a well known entity among both residents and service providers in its communities.

An invaluable fiscal resource to the local lead agencies has been the provision by Columbia University of payment advances in the first quarter of each project year. As community based organization with restricted cash flow, the agencies were dependent upon the

advances for the maintenance of program activities and personnel staffing. Without timely advances, program delivery would most assuredly be disrupted.

C. Changes in Management and Governance

The 2001-2005 project periods saw no major changes to project management and governance. The DNYHS perinatal partnership has been in existence since 1997, and through ongoing efforts to sustaining communication and program improvement, functions well as a community-academic partnership.

D. Process for Distribution of Funds

Although CUMSPH as project grantee maintains primary responsibility for fiscal management of DNYHS, funding allocations are decided jointly by consensus between the perinatal partners.

Overall funding distribution is decided at project level through a convening of the Principle Investigator/Project Director and the directors of the three subcontract agencies to negotiate the funding split between the university and the community agencies. Once the overall split has been determined the community agency directors meet to decide how to divide the balance of funding. Program components such as case management caseloads and responsibility for consortia and staff technical assistance are considered.

During each program year MSPH monitored spending to insure the appropriate programmatic distribution of funds. The subcontracting partners submitted monthly expense reports as well as all back up documentation to the DNYHS Program Manager for review. Any issues noted were brought to the attention of the Principal Investigator/Project Director who provided feedback to the agencies regarding project performance.

E. Non-HS Resources for Quality Assurance, Program Monitoring, Service Utilization and Technical Assistance

The following non-HS resources have been instrumental to the project for staff development and technical assistance:

- Economic Opportunity Commission's in-house training program, based on the Family Credentialing Model developed by Cornell University.
- York College scholarships for QCPC staff to receive the family development training and credentialing program provided by their Department of Youth & Community Development**.**
- Funding by NYSDOH for SCPC's Doula program, and also the Long Island Fund for Women and Girls which has supported additional Doula training opportunities at SCPC.

F. Cultural Competency of Contractors and Project Staff

Each local lead agency provided culturally competent care throughout the project period as part of an overall operational plan. Each agency:

- Employed staff that was representative and culturally appropriate to the target communities and often recruits from the communities served.
- Sought culturally appropriate health education literature for the field and for distribution to the community.
- Hosted special education events, Kwanzaa, Baby Showers, etc. which were culturally relevant to the target audience.
- Maintained a staff training schedule that included attending workshops focused on cultural diversity and sensitivity.
- Created an office setting that was culturally representative of the community, including displays of artwork, books and magazines.
- Provided incentives to consumers such as books and t-shirts that included a cultural component.
- Employed staff that linguistically matched the targeted population.

IV. PROJECT ACCOMPLISHMENTS

A. Objectives and Accomplishments

The following describes the project's successes in achieving its goals and objectives for the project period. A summary of project period objectives and accomplishments and the specific strategies and activities implemented has been included in Appendix A - Final Report/Implementation Plan.

1. Outreach and Client Recruitment Accomplishments

Outreach and recruitment activities were facilitated by each agency's knowledge of its community and its members, resulting in targeted approaches to street and community canvassing activities occurring in each year. Significant effort by the local lead agencies to broaden relationships within the community led to access to areas previously not granted, as exemplified by QCPC's outreach activities at public hosing developments within the Rockaway Beach/Arverne communities. Persistent efforts with building management to bring awareness of program objectives and the needs of the community resulted in the procurement of building keys for entry on agreed upon designated outreach days. Similar efforts with emergency shelter staff allowed SCPC to provide concerted outreach to women living in shelters that were residents of the targeted areas and therefore eligible for services. EOC's efforts established new linkages with key health care providers that served as a source of referrals to Healthy Start services.

At the close of the 2005 project year, there were 222 women, infants and toddlers enrolled in DNYHS case management services, surpassing our target number of 215. DNYHS achieved its outreach and recruitment objective in every program year.

Objective 1*: By 5/31/05, enroll 25 cases per case management FTE into DNYHS case management services.*

Project Period Objective	215
Project Performance as of 5/31/05	222

2. Case Management Accomplishments

Successful case management practice was supported through cooperative partnerships established with a number of health and service providers. The broadened relationships expedited arrangement of appointments, follow up with clients for missed appointments, and improved service plans through shared information.

Case management activity was enhanced by consultant LMSWs retained by each agency for case conferencing; clinical social workers, psychologists, and other experts retained project-wide to share case management best practice strategies with lay staff; and the supportive program services of labor support Doulas, the peer Mentoring Moms program, baby showers, mothers day luncheons, and provision of needed infant and toddler goods. Each supported the engagement of women into case management care for the receipt of the core service package of activities.

DNYHS met the majority of its case management goals for the project period and several objectives were met or surpassed in successive years. Major objectives met by the end of the project period include: referral completion activity; linking women to primary care providers; the percent of women receiving a postpartum medical visit; the percentage of case managed clients completing a referral for substance abuse treatment; and the percentage of case managed participants completing a referral for family planning services. Several other objectives were within several percentage points of meeting the target goals including the proportion of children under age 2 receiving age-appropriate immunizations and the proportion of children receiving well child visits.

Of particular note in the final year of the project period is the relatively high number of newly enrolled women who entered case management services already linked to a primary health care provider. In the half-year 2005 only 6 enrolled not having a healthcare provider, and all women were successfully linked to a medical home following their enrollment into services.

Objective 6, linking children with a medical home, and Objective 9, referral completion for HIV/STD services demonstrated marked decreases in CY2005 compared with earlier years. Reductions in these referral activities may be a reflection of incomplete reporting by case management staff as the performance numbers for this objective were uncharacteristically low. We believe this to be indicative of poor data quality, a technical assistance issue for the project addressed through ongoing team development trainings.

Objective 2*: By 5/31/05, case managed clients will have a referral completion rate of 85%.*

Project Period Objective	85%
Project Performance as of 5/31/05	85%

Objective 3*: By 5/31/05, 100% of case managed woman who had no medical home at enrollment will be linked to a regular primary health care provider.*

Project Period Objective	100%
Project Performance as of 5/31/05	100%

Objective 4*: By 5/31/05, 85% of case managed women will have initiated prenatal care during the first trimester of pregnancy.*

Performance Period Objective	85%
Project Performance as of 5/31/05	81%

Objective 5*: By 5/31/05, 85% of case managed women who deliver after enrollment will have received a postpartum medical visit.*

Project Period Objective	85%
Project Performance as of 5/31/05	89%

Objective 6*: By 5/31/05, 82% of children under 2 years old who had no medical home at enrollment will be linked to a regular primary health care provider.*

Project Period Objective	82%
Project Performance as of 5/31/05	72%

Objective 7*: By 5/31/05, 88% of case managed children under 2 years old will have received their full schedule of age-appropriate immunizations.*

Project Period Objective	88%
Project Performance as of 5/31/05	86%

Objective 8*: By 5/31/05, increase to 85% the proportion of children under two years old who have received appropriate well child visits during the time of their enrollment in DNYHS.*

Project Period Objective	85%
Project Performance as of 5/31/05	84%

Objective 9*: By 5/31/05, increase to 97% the proportion of case-managed participants who have completed a referral for HIV/STD services.*

Project Period Objective	97%
Project Performance as of 5/31/05	80%

Objective 11*: By 5/31/05 increase to 80% the proportion of at-risk case managed clients who have completed a referral for substance abuse treatment.*

Project Period Objective	80%
Project Performance as of 5/31/05	82%

Objective 12*: By 5/31/05, increase to 91% the number of case managed participants who have completed a referral for family planning services.*

Project Period Objective	91%
Project Performance as of 5/31/05	88%

3. Health Education and Training Accomplishments

The health education objectives for referral completion to area smoking cessation health education and parenting education were not met in the five-month CY2005 project period. Performance numbers for these objectives are uncharacteristically low and are not representative of customary service delivery in this area. This may be explained by the five-month reporting time period which would impact service completion numbers or, as noted earlier, may indicate incomplete reporting, an issue being addressed by grantee technical assistance sessions.

Each agency has directed considerable efforts to improving staff performance in identifying smoking cessation needs. Each targeted area, however, is impacted by the dearth of smoking cessation treatment services. Staff consistently provided referrals to all women that smoked or lived in households with smokers; however, clients have reported a lack of service providers available to them, along with extended wait times as impacting their ability to access care. As described earlier there are few free or low-cost smoking cessation programs in the communities and Medicaid reimbursement is not available for supportive counseling smoking cessation services.

The parenting education objective is also a measure of the completion rate to outside agencies. Limited transportation networks, childcare options, and language barriers have each impacted client success in accessing care.

As a rudimentary component of the DNYHS case management program all case managed clients have received health education covering a number of topics. The impact of smoking and second hand smoke, as well as parenting information are elements of the curriculum used by case managers in home visits and information in these areas were further provided within monthly or quarterly health education sessions, and in supplemental group education sessions offered in English and Spanish with childcare and transportation vouchers often provided as needed.

Objective 10*: By 5/31/05 increase to 100% the proportion of at-risk case managed clients who have completed a referral for smoking cessation health education.*

Project Period Objective	100%
Project Performance as of 5/31/05	67%

Objective 13: *By 5/31/05, increase to 98% the proportion of case managed participants who have completed a referral for parenting education.*

Project Period Objective	98%
Project Performance as of 5/31/05	86%

4. Interconceptional Care Accomplishments

DNYHS achieved a 100% referral completion rate in linking interconceptional case managed participants with needed services. As with case management activities, the interconceptional care program was facilitated by the cooperative partnerships established with providers, the extensive staff development opportunities provided, and the dynamic supportive program activities developed such as the Mentoring Moms program. All case managed clients received the interconceptional care services outlined in the objective below.

Objective 14: *By 5/31/05, increase to 90% the proportion of case managed participants who have children under 2 that have received the following interconceptional care services: 1) completed referral to parenting education, 2) completed referral to family planning services, and 3) linkage to a regular primary care medical provider*

Project Period Objective	100%
Project Performance as of 5/31/05	100%

5. Depression Screening and Referral Accomplishments

A major strength of the DNYHS program were the community awareness campaigns delivered by each agency to bring attention to the mental health needs of women during the perinatal period and tackle the stigma associated with seeking care. The project partnered early with the Postpartum Resource Center, respected in the New York Metropolitan area for their work in this area and under the guidance of the Center and its Executive Director, DNYHS' protocols were developed and strengthened. QCPC partnered with PRC and provided community focus groups and SCPC acquired funding to conduct a successful poster campaign targeting women of color. In CY2005, the posters were recreated in Spanish. Coupled with these efforts were each agencies diligence in investigating the cultural appropriateness of available screening tools and selecting a best fit for their communities.

Through these efforts the local lead agencies have successfully increased the percentage of women screened for postpartum depression in their communities. In CY2004 the percentage of women screened was 78%, in CY2005 that number had increased to 94%.

Objective 15: *By 5/31/05 maintain at 96% the proportion of case managed participants who have been screened for postpartum depression.*

Project Period Objective	96%
Project Performance as of 5/31/05	94%

6. Consortium Accomplishments

Active consumer participation in consortia activities has been achieved in each program year and DNYHS' consumers have provided significant contributions to every component of service delivery. However, the project-period goal of 50% consumer membership was not achieved primarily because one agency developed new guidelines in 2004 for consumer membership, restricting active members to those who attended meetings on an ongoing basis. Thus, the percentage of consumer members decreased compared with earlier project years when the level was as high as 66%. Project-wide, maintaining a large percentage of consumers in consortia activities has proven difficult as women and families contend with the daily issues that impact their lives, as well as transportation and childcare issues that impact their ability to remain consistent. Each agency has addressed transportation and childcare to the limits that they could through stipends to cover associated costs. To strengthen membership each agency has also hosted special recruitment and retention events as stated in the project's implementation plan.

Objective 16: *By the end of the project period, assure that at least 50% of consortia membership is composed of DNYHS consumers.*

Project Period Objective	50%
Project Performance as of 5/31/05	23%

B. Mentoring and Technical Assistance

DNYHS sought technical assistance from Wayne State University in order to provide the health education core service for our case managed clients. Upon conclusion of the discussions, DNYHS purchased the "Strengthening Family Connections" visual health education modules. Strengthening Family Connections modules are used at home and office visits with clients per the case management home visiting and contact schedule. The tool provides an interactive approach for case managers to help educate clients about a variety of topics including smoking cessation, HIV/STDs, preterm labor, back to sleep/safe sleep, substance abuse, infant care and feeding, infant growth and development, and parenting. The materials employ appropriate literacy levels for clients, and include scripts and prompts to encourage discussion between clients and caseworkers. Case managers and clients have received the health education modules well, stating that the materials were easy to see and understand, and helped give visual reinforcement to the health education focus for that session.

DNYHS also took advantage of training opportunities for health program administrators. In 2002, HRSA funding allowed Sharon Rumley, Executive Director of QCPC to attend the Johnson & Johnson/UCLA Health Care Executive Program, offered at the UCLA Anderson School of Business, which is a management training program for the leadership of community-based health programs. The primary objectives for the program are to provide participants with modern management practices, enhance their capacity to collaborate with other health and social services providers, develop their capability to find additional sources of program funding, and provide tools to help them deliver effective services in community-based organizations.

Through the assistance of HRSA's Division of Perinatal Services and Women's Health, DNYHS held a project-wide technical assistance session in June 2004 to help project staff in implementing the core service component on postpartum depression and perinatal mood disorders. The technical assistance sessions were led by Drs. Michael O'Hara and Lisa Segre from the University of Iowa. Approximately 25 participants attended the sessions, including DNYHS staff, and representatives from Planned Parenthood of Nassau County, Winthrop Hospital, Nassau University Hospital, Caribbean Women's Health Association, Healthy Families and the Southeast Queens Clergy. Topics covered included screening and referral; psychological and medical treatment; cultural diversity; case management of depression; and family and community support.

DNYHS also provided technical assistance in the areas of case management service delivery development and consortium leadership development activities. After presenting at the 2003 Healthy Start Annual Grantee meeting, several Healthy Start projects from across the country asked to receive our case management protocol manual. CUMSPH distributed nearly 50 copies of the DNYHS Case Management Manual to Healthy Start projects across the country during the summer of 2004, with many recipients stating that they were pleased with the simplicity of the protocols and that they planned to implement similar protocols within their programs. Also in the summer of 2004, MSPH compiled a number of procedures and protocols used for consortium leadership development and consumer empowerment activities and created a compact disc of information called the "Leadership Development Toolkit." Approximately 60 compact discs have been sent to Healthy Start projects across the country requesting it, and the feedback has been positive, especially in the areas of developing consumer participation and retention activities. The project is in the process of finalizing a grant seekers handbook, which will be made available to all Healthy Start projects in the fall of 2005.

V. PROJECT IMPACT

A. Systems of Care

1. Impact on Collaboration and Comprehensiveness of Services

The DNYHS local lead agencies and their consortia continued in this phase to serve as primary conduits in their communities for improved communication and collaborations among stakeholders involved in promoting perinatal and infant health, and support services. Over the four years of the project, each local lead agency engaged in significant collaborative efforts with health and social service providers, including their local departments of health and local state providers, and through improved linkages created more coordinated, comprehensive service networks for women, infants and families in the targeted communities.

a. Local Consortia

The four local consortia in Nassau, Queens, and Suffolk Counties, have served as common meeting grounds for consumers, community based organizations, physicians, legislators, health and social service agencies, and other stakeholders to network, share

information, and build relationships. Consortia meetings and membership have acted as community vehicles for strengthened working relationships within and among local organizations; enhanced linkages between providers; and media for consumer voice to be heard. Below is a listing of major collaborative consortia and agency activities and their outcomes. Due to the nature of the service systems, many collaborative activities cross service provision areas and could be listed under multiple headings.

EOC- Nassau

Health Care Providers

- Obtained key consortium membership of Nassau University Medical Center, Winthrop Hospital, and local pediatricians.
- Developed an approach for encouraging community OB/GYNs to include perinatal depression in discharge planning, in collaboration with the Nassau County Department of Health.
- Facilitated a unique partnership between Winthrop University Hospital, Northshore Family Guidance Center and EOC Head Start to provide health education and educational development information to consumers attending EOC's Personal Empowerment Workshops.

Community Organizations

- Worked with Partnership for Healthy Moms and Babies Advocacy Board, a community-based system-wide referral processing service formed to help pregnant and parenting women in Nassau County navigate health and social services in the county.
- Worked closely with Uniondale High School to identify and link pregnant teens to Healthy Start services.

Local Department of Health

- Facilitated collaborative efforts between Hempstead Community Health Center, the Department of Social Services, and the Nassau County Department of Health, to link uninsured parenting and pregnant women to medical providers.
- Worked closely with the NCDOH Community Health Worker Program to coordinate the provision of case management services, in addition to strengthening ties with the County perinatal network for services planning activities.

Medicaid

- Established cross-referral relationships with local providers participating in the Prenatal Care Assistance Program (PCAP), the state Medicaid expansion program.

QCPC- Queens

Health Care Providers

- Following the successes achieved through the Perinatal Partnership (described below), QCPC worked with local substance abuse providers to assist them in developing a more coordinated system of care.

- Maintained strong relationship with the major regional hospital providers, ambulatory healthcare programs, and WIC.
- Partnered with Visiting Nurse Services (VNS) Early Steps Family Center to ensure comprehensive case management service interventions are achieved on the Rockaway peninsula.
- Spearheaded a standardized universal referral form that is used by all referring agencies under the rubric of the Regional Perinatal Partnership (RPP). The RPP was created by QCPC in 1999 to address service delivery issues at the provider level in South Jamaica and Rockaway Beach.
- As the Queens Regional Perinatal Coordinating Body under the City Wide Coalition to End Infant Mortality, worked to provide enhanced regional perinatal service coordination among agencies in the county.
- Provided training to local providers in cultural competency in perinatal health care. To further cement this collaboration, providers worked with QCPC consumers to develop a training video focusing on perinatal issues important to the women in Queens in order for providers to be aware of the important social and environmental factors that affect women's health during and after pregnancy.

Local Health Department

- QCPC received a grant from the New York City Department of Health and Mental Hygiene to develop grassroots strategies for reducing infant mortality.
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Community Based Organizations

- Through the NYCDOH grant, QCPC worked in conjunction with several faith based organizations, as well as the Jamaica Father's Project and Caribbean Women's Health Association. These community-based organizations provide referrals to QCPC and QCPC refers male partners of clients to the Jamaica Father's Project.

Medicaid

- Established cross-referral relationships with local providers participating in the Prenatal Care Assistance Program (PCAP), the state Medicaid expansion program.
- Through a referral arrangement with the local Title XXI Child Health Plus enrollment agency and an agreement with a managed care organization, provided community education about Child Health Plus and enrollment.
- Served as a member of New York City Human Resources Administration (HRA) Community Advisory Board.
- Participated in reciprocal training with HRA and has formal agreement with HRA to determine presumptive eligibility for Medicaid and PCAP, eliminating a major barrier to receiving timely prenatal care.

SCPC- Suffolk

Health Care Providers

- Collaborated with substance abuse providers to develop protocols for serving the perinatal population.

- Hosted a breastfeeding video conference as part of Women's Health Grand Rounds sponsored by the University of Albany School of Public Health and the New York State Department of Health's Bureau of Women's Health that attracted providers through the east end of Long Island, an area lacking services.
- Maintained strong relationships with county-run health centers, which provide smoking cessation programs, prenatal care, primary care, childbirth classes, substance abuse services, social work, and dental services.
- Prior to new HIPAA regulations, partnered with Stony Brook University Hospital's Neonatal Unit to identify and refer to SCPC hi-risk women delivering without appropriate pre and/or post natal care.
- Successfully piloted a medical information release form that provides for information sharing among the perinatal system providers.
- Developed a large-scale media awareness program resulting in the delivery of extensive training, health education and other resources on perinatal mood disorders to health providers throughout Suffolk County.
- Worked with the Association of Perinatal Networks in New York to develop a consistent message of perinatal mood disorder awareness for providers to use with their patients should questions of post-partum depression arise during a medical visit.

Community Organizations

- Provided a Faith Based Breakfast for clergy recruitment into the consortium.
- Presented to Suffolk Community College's Nursing Program, resulting in an increased appreciation of community driven systems change among student nurses and their desire to become involved with the consortium.

Local Department of Health

- Through a memorandum of agreement, the Suffolk County Department of Health (SCDOH) referred high-risk women to SCPC for case management services.
- Worked with the SCDOH to strengthen the availability of interconceptional services and to improve the identification and treatment of perinatal mood disorders.

Medicaid

- Established cross-referral relationships with local providers participating in the Prenatal Care Assistance Program (PCAP), the state Medicaid expansion program.

b. Local Health System Action Plan

Collaborative pathways towards improved coordination of care were additionally provided by the activities necessary to execute community Local Health System Action Plans as key stakeholders came together around the common goal of improved access within their communities.

- In Nassau County the advancement of LHSAP activities helped reduce territorialism existing between providers, a secondary effect of the uncertainty caused by layoffs and downsizing due to the continued budget crisis. Various health and human service providers, along with

the Nassau County Department of Health worked together to overcome differences and jointly produced with consumers the health care system "Survival Guide".

- In Queens, carrying out the goals of the LHSAPs resulted in increased contact between providers and consumers in South Jamaica as they collectively designed public service announcements about infant mortality rates, and risk factors associated with infant mortality; and increased communication between QCPC and the faith based community in Rockaway Beach/Arverne, as the Maternal Child Health Coordinator recruited clergy to be resources for health and perinatal care education in their communities.

- In Suffolk, execution of the Breastfeeding-Friendly LHSAP brought business owners together with health and social service providers through a successful collaboration with the Suffolk County Chamber of Commerce. Additional partners included the American Academy of Pediatrics and WIC. SCPC's second LHSAP, which focuses on creating awareness of perinatal depression brought increased communication among the field of mental health care providers servicing the targeted communities as collectively they worked to reduce wait times for mental health care appointments.

c. Community Provider Forums

The local lead agencies regularly brought together consumers, providers, policymakers and city, state and federal legislative representatives in forums that served to educate, bring awareness to perinatal issues, and foster the communication necessary for understanding and structured change.

In the final program year of the period, EOC held is first annual Healthy Relationships Forum at the African-American Museum in Hempstead. QCPC sponsored mini forums in each program year around a pertinent perinatal health topic, facilitated by invited speakers and attended by consumers and providers. As a Comprehensive Prenatal-Perinatal Services Network (CPPSN), SCPC conducted education and coalition building activities bringing together CBOs, advocates, and community leaders. The 2004/05 program year marked SCPC's 15th Annual Conference. Over 100 providers routinely attend the annual conferences held on the eastern end of Long Island. Additionally, SCPC held a symposium for Perinatal Mood Disorders, and in the last two program years of the project period held videoconferences during World Breastfeeding Week, attended by nurse practitioners, lactation consultants and others in the field.

2. Impact on Enhancing Client Participation in Evaluation of Service Provision

A mainstay of the DNYHS project is the assurance of opportunities for meaningful participation by consumers in community and broader collaborations. The DNYHS Leadership Development Institute, created as a forum to educate, prepare and empower consumers to more fully participate at the local and regional level continued in this project phase to provide capacity building workshops, facilitating consumer ability to be leaders and advocates of change in their communities.

DNYHS consumers remained a guiding force behind all consortia activity during the project period. Consumers participated in strategic planning for all local consortia and helped identify community concerns and barriers to health care access. Consumer committees regularly met to discuss local health issues, formulate concerns, and shared their perspectives with providers and other consortium members during general consortium meetings.

In Nassau, consumer assessment of needs helped to shape the LHSAP survival guide. In Queen's, consumer complaints about treatment at local institutions led the consortium to develop a provider training. In Suffolk, the consortium (especially through its consumers, who voiced substantial dissatisfaction with fragmented services in a dispersed geographic area) were instrumental in identifying the need for an inter-agency release of information process and in bringing providers together to develop one. Suffolk consumers also identified transportation to services as an additional unmet need resulting in the coordination by the consortium of local agencies to gain Medicaid reimbursement for an expanded rage of transportation options.

As well as being active participants in all activities of the consortia and their respective LHSAPs, DNYHS consumers participated in legislative education conferences in Albany, NY and Washington, DC; attended project meetings with the State Health Department as representatives of the local agencies to discuss community perinatal needs; and presented at agency educational forums such as QCPC's Annual Legislative Breakfast.

Consumers also provided invaluable input to program components on a project-wide level at DNYHS. Consumers sit on the Project Governance Board as partners in program decision-making, and in year one of the project period (2001) attended focus groups and other meetings alongside staff, assisting in shaping the DNYHS' model of case management service delivery through feedback provided about the type of resources and training required for implementation.

B. Impact on the Community

Community residents' knowledge of perinatal health resources and services, and their availability have been significantly increased through the targeted programmatic activities of the local lead agencies. DNYHS local lead agencies provided consistent and direct outreach to residents in the target area for recruitment into program and consortium activities and delivered information about services. The activities of the case management program and information and referral programs provided individualized attention as referrals and follow-ups to both enrolled and non enrolled residents were performed.

On the community level each agency engaged in extensive health education activities, bringing the perinatal health needs of women and infants to the forefront of community attention. EOC held bi-weekly community health workshops via the Personal Empowerment series; QCPC held monthly health education events facilitated by their case coordination staff, and retained a consultant who facilitated consumer team building empowerment and advocacy trainings; and SCPC offered monthly health education sessions, multiple six-week smoking cessation programs, and quarterly health events.

Each local lead agency also hosted consortium meetings throughout the year to discuss pertinent maternal and child health issues, and introduced new providers to the audience in order to facilitate awareness of their programs. Both QCPC and SCPC held annual legislative breakfasts for consumers, area residents, providers, and representatives at all levels of legislative influence to provide updates on the work of the respective DNYHS agencies and to give perspective on the growing needs within perinatal health care.

Each local lead agency developed specific program initiatives to increase awareness of local health care services within their target communities. As reported above in the Consortium section, EOC developed a resource guide to help community residents navigate the changing medical care environment as part of their local health system action plan. Upon completion in late 2005, these booklets will be distributed to Healthy Start clients and residents across the village of Hempstead, as well as local providers and government agencies, and residents will be able to use this guide to access referrals and organizations that they would otherwise not have been unaware of.

QCPC developed a similar direct outreach plan by placing health education kiosks in four local churches in their Rockaway Beach/Arverne service area. This partnership was developed in order to reach high-risk women that lack knowledge about DNYHS and maternal child health issues overall. Residents who use this resource are immediately linked to QCPC and other area providers to access needed services.

SCPC developed awareness campaigns and provided a considerable amount of education and advocacy around perinatal mood disorder and breastfeeding to Suffolk County residents, and held annual conferences that focused on issues such as perinatal mood disorders, substance abuse and pregnancy, and the issue of pregnant and/or parenting women who are incarcerated. SCPC received an extensive amount of requests for technical assistance services because there is no other organization in Suffolk County that provides information and resources geared specifically towards maternal child health issues in the area.

All local lead agencies gave considerable attention to consumer empowerment training, initiating separate committees for training and support of consumers in taking an active role in consortium activities and agenda-setting. Each local consortium sent consumers to the offices of their legislative representatives in the New York state capital of Albany, and to congressional representatives in Washington to advocate for increased funding to enhance maternal child health services in their communities. Project-wide activities to enhance community participation include representation on the Project Governance Board (PGB), participation in Leadership Development Institute training sessions and consumer-only empowerment luncheons.

In the targeted communities of Nassau and Suffolk, the services that have been provided by the local lead agencies can not be found elsewhere. EOC and SCPC have served as the only agencies in their communities providing case management services to the perinatal population beyond one-year postpartum, and in Suffolk County SCPC served as the only case management program for at-risk pregnant and postpartum women. In all communities targeted, DNYHS agencies have been unique in their distribution of clothing, food, baby supplies and

transportation vouchers. For that reason, clients who have exhausted other resources have been historically directed to DNYHS agencies for assistance.

DNYHS agencies have tended to hire case managers and consortium coordinators who either work within or originate from communities very similar to their target communities. Additionally, DNYHS has found the leadership skills and training received through participation in program activities to be transferable career development tools, and many consumers have used skills honed through training sessions to initiate or better their own careers. The case management services of support, health education, and targeted referrals have also produced long term benefits and contributed to the ability of numerous Healthy Start clients to take proactive steps in their lives for the betterment of themselves, their infants and their families.

C. Impact on the State

As a partnership, DNYHS was extensively involved in collaborative activities with Title V and Title XXI programs and state and local health departments throughout the project period. At the project-wide level, a representative of the New York State Department of Health served as a member of the Project Governance Board (PGB) and received first person insight of local perinatal issues via consumers that sat on the Board. In each program year representatives from the grantee and local lead agencies attended the meetings or participated in the conference calls of the NYSDOH Bureau of Women's Health. Meetings provided the opportunity to discuss ways of developing linkages with Medicaid managed care organizations, improving consumer leadership development and participation, and establishing training collaborations for case management staff. DNYHS enhanced these important activities by sponsoring the participation of consumers at the meetings.

A unique factor of DNYHS was the relationship of the NYSDOH Bureau of Women's Health with the project through two of our local lead agencies. SCPC is a state-funded Comprehensive Prenatal-Perinatal Services Network (CPPSN); QCPC was a CPPSN in programs years 2001-2004. As existing and former CPPSNs the two agencies worked with the NYSDOH in developing perinatal and child health service infrastructures in their counties. In the 2004/2005 program year, SCPC provided technical assistance to NYSDOH in developing the state's postpartum depression awareness media campaign by lending materials and expertise gained through their own successful local campaign.

As a CPPSN, SCPC co-chairs the Long Island Regional Forum (LIRF), one of New York State's mandated Regional Perinatal Forums that brings together CPPSNs and regional perinatal medical centers for collaborative work. QCPC and EOC also actively participate in the Forums. The purpose of the Regional Perinatal Forums is to bring together hospitals and community-based providers to engage in activities to improve pregnancy outcomes, increase access to care, improve the quality of care, and address state and region-wide public health issues.

D. Local Government Role

Each local lead agency actively networked with its local legislature to bring the perinatal health needs of low income women and infants to local government attention. In consideration of

the nature of legislator's schedules and constituent's demands on time and resources, each agency's achievements are significant.

Nassau

- Held meetings with local legislators to discuss challenges with transportation and housing among Healthy Start consumers, resulting in the granting of additional transportation and Section 8 vouchers to consumers.
- Started a letter writing campaign to the county legislators regarding the health care cutbacks.
- A county legislator was recruited for consortium membership.

Queens

- Local, state, and federal legislators representing the target areas attended annual legislative breakfasts where QCPC discussed the Healthy Start program, infant mortality, maternal child health issues such as postpartum depression, and local collaborations to improve perinatal systems of care.
- As a member of the New York City Coalition to End Infant Mortality, successfully advocated for increased funding for City infant mortality prevention services.
-
- The local consortium participated in the National Healthy Start Association's Spring Education Conference to educate legislators on the importance of Healthy Start funding.

Suffolk

- The Consortium Coordinator attended the Suffolk County Legislature Health Committee meetings, which allowed local government officials to become familiar with Healthy Start activities. Consumers will attend future Health Committee meetings to voice their concerns to their elected officials.
- A representative of the Presiding Officer of the Suffolk County Legislature joined the consortium, enabling consortium members to share their concerns about women's health issues with a government official.

Each partner has maintained collaborative relationships with state and local departments of health. Representatives from each of the local Departments of Health (New York City, Nassau, and Suffolk) served on the Board of Directors and/or the local consortium of the local lead agencies, as well as, the project-wide Project Governance Board. (Please see *Systems of Care- Impact on Collaboration and Comprehensiveness of Services* for a listing of additional activities.)

E. Lessons Learned

The following summarizes many of the lessons we have learned since the project began in 1997:

1. Core Services

a. Outreach and Client Recruitment

- Indigenous or lay-staff significantly enhances community outreach and recruitment activities through familiarity and understanding of community norms and values.

- Maintaining a planned and consistent outreach schedule is pivotal for developing community trust, visibility and rapport.

b. Case Management

- A combined outreach worker/case manager approach to service delivery provides a single contact point of entry into case management services and promotes early engagement into services.

- The significant and pressing social needs of the targeted population often impacts what priority accessing medical care will have in their lives. Often social crises must be addressed first by case management staff.

- Staff development opportunities for lay-staff must be consistently provided. We have discovered that in the peer-lay model of case management many staff members come from similar backgrounds as the clients served; thus, case managers run the risk of having the similar social, environmental and psychological barriers towards healthy behaviors and service provision as clients served.

- Case Conferencing improves the quality of case management delivery and serves as a dynamic supervisory tool. Each local agency has utilized case management consultants to perform case reviews and consultations to staff. In addition to its intended purpose case management consultation has also provided a forum in which staff members work to overcome personal barriers to reaching clients and has improved overall staff performance. At conferencing barriers are brought to the table in discussions with staff to address them, separate myths from reality about barriers identified and work to set boundaries between staff and the client/community population that is served.

- Providing consistent interagency meetings at each staffing level facilitates improved communication, increased understanding and cooperative working relationships. Quarterly meetings between all program coordinators and consortium coordinators were implemented for the purpose of providing technical assistance in the areas of LHSAP and implementation of the case management model. Meetings resulted in an increased understanding about the differing program components and increased information sharing among local agencies. The success of those meeting led to the creation of quarterly meetings with case managers for training and technical assistance.

2. Core Systems-Building

a. Consortia and Local Health Systems Action Plan

- Recruiting consortium co-chairs who are respected in their field enhances provider buy-in to consortium activities.

- Providing consumers with leadership training is essential for helping them develop the skills needed to participate in the consortium and advocate for community needs.

- Separate consumer committees and the provision of leadership and advocacy training are sound options for facilitating a consumer voice.

- Consumer participation is facilitated by the provision of child care and transportation stipends.

- In negotiating with state and local officials to place maternal child health issues on the legislative agenda, it is important to make the link between early investments in MCH issues and later reductions in negative biopsychosocial outcomes.

b. Project Partnership & Management & Governance

- The commitment of all partners to a collaborative and community-driven approach is of primary importance.
- Partners can be united by making shared goals and values explicit.
- Establishing clear roles, responsibilities, and expectations is particularly important in the early phases of the partnership and is essential to engendering trust and enabling a collaboration to move forward.
- A mission statement and by-laws assist in formalizing the collaborative relationship and are essential steps in helping foment trust among diverse project partners.
- Respecting and understanding the differences in missions and roles among partners helps maintain the willingness to participate.
- While program mandates apply to all, implementation can vary in accommodation of local needs.
- Recognizing and drawing on the different assets of each partner is vital for minimizing competition and suspicion.
- Engaging all partners in the process of developing program capacity helps nurture the willingness to communicate and share. Mutual support of each partner's work creates an environment of cooperation, teamwork, and trust.

VI. LOCAL EVALUATION

Local evaluation activities have focused on providing information feedback regarding the implementation of project services and activities. A series of reports and presentations summarize these findings and are included in Appendix B.

VII. FETAL INFANT MORTALITY REVIEW (FIMR)

These activities were conducted by local health departments. FIMR was not a component of DNYHS.

VIII. PRODUCTS

DNYHS and its local lead agencies have created and distributed a number of products developed by staff and distributed project-wide and throughout the country to other Healthy Start agencies. The grantee office developed two toolkits for project activity guidance: the Case Management Manual for use in conjunction with our core services, and the Leadership Development Toolkit, a compilation of reports, presentations, and best practices for core systems activities. Each local lead agency developed outreach brochures to use as a recruitment tool for core systems and core services activities, as well as health education curricula. Below is a listing of products created by DNYHS, listed by agency – each product is enclosed with this impact report in Appendix C:

Columbia University Mailman School of Public Health

- Case Management Manual
- Leadership Development Toolkit

Economic Opportunity Commission of Nassau County

- Informational Brochure (English)
- Informational Brochure (Spanish)
- Parenting Skills Course Materials

Queens Comprehensive Perinatal Council

- Case Management Outreach/Recruitment Flyers
- "Kukhulisa Kahale" Parenting Curriculum Outline
- Consortium Outreach/Recruitment Flyers

Suffolk County Perinatal Coalition

- Informational Brochure
- SCPC/Postpartum Resource Center of New York/United Way Postpartum Depression Awareness Poster

IX. PROJECT DATA

Project data for each individual year of the project period are reported in Appendix D and the enclosed compact disc. Please note that in Forms 9 and 10, some data elements for CY2003 and CY2004 may differ from earlier submissions because of data entry updates that are incorporated into this final submission.