

CityMatCH

Abstract Compendium: Examples from the Field

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Oral Presentations

Work it out: Engaging public health partners in the 21st century

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CATEGORY

Adolescent health / pregnancy prevention

FOCUS

Program Policy Focus

ISSUE

The purpose of the Whites Creek Fitness Club (FC) is to impact the overall preconception health of 30 young women, 13 to 20 years of age, at risk for poor birth outcomes based on current health status. The specific aims of FC are to improve nutrition and physical activity efficacy among teens living in the disparate 37189 zip code area of Nashville through a 12-week, community-based health education program.

SETTING

Urban, community center connected to high school with 64% participation in Free/Reduced Lunch; only 18% of adult residents have education beyond an Associate's Degree education.

Intended Audience

- Young women, 13 to 20 years old, living or attending school in the 37189 zip code and surrounding areas.
- All program activities take place after school at the community center zoned to serve students in the 37189 ZIP Code area.

PROJECT

The Whites Creek Fitness Club (FC) represents a multi-sector collaboration to increase the overall preconception health of 30 young women, 13 to 20 years of age, at risk for poor birth outcomes based on current health status. Collaborative organizations include the local health department, public high school, community center, local extension program. All program staff fees, facilities fees, and materials were leveraged and provided in-kind.

The primary program activities include: 120 minutes of weekly nutrition/healthy eating education with a Registered Dietitian and 120 minutes of weekly supervised group and individual physical activity sessions

with a Certified Personal Trainer. Pre/post test assessments were administered for changes in nutrition knowledge and pre/post microfit analyses were administered for changes in physical fitness. Participants completed journals and small group discussions regarding structural inequalities in their neighborhoods (e.g. food deserts, racism, violence, etc). USDA approved Empowering Youth curriculum was utilized to deliver nutrition education.

ACCOMPLISHMENTS/RESULTS

- Significant changes in pre and post microfit analyses for students who completed program (e.g. increase flexibility, aerobic fitness level and some change BMI).
- Increase nutrition and healthy eating knowledge-based on pre/post test assessment.
- Increase in weekly physical activity in target population (a mean of 120 minutes or more per week).

BARRIERS

- Lack of student transportation to the community center for education activities. Barrier overcome by teachers voluntarily transporting students after school.
- High rate of program attrition over half of students who started the program completed the full 12 weeks. Many students had conflicting work schedules or a family crisis that prohibited their program completion.

LESSONS LEARNED

- Provide incentive items when possible to encourage youth participation and to decrease rate of program attrition.
- Utilize a strong psycho-social model for small group discussions on structural inequalities.
- Leveraging existing resources is possible to create new programs.

Key Partners included:

Metro Public Health Department

Metro Public School District

Metro Parks and Recreation

UT Extension Program

Breastfeeding and maternal infant interactions in non-feeding settings of low income women in a nurse home visiting program

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CATEGORY

Child growth, development, preventive care

FOCUS

Data Focus

BACKGROUND

Given the financial and social stressors associated with poverty and with young maternal age, young mothers living in poverty face challenges beyond those experienced by all parents. These stressors may negatively impact the interactions between a new mother and her infant, which can affect that child's social and emotional development. Much research has been devoted to the physical health benefits of breastfeeding and increasing breastfeeding rates of those most vulnerable. Breastfeeding is known to release calming hormones in the mother and child, necessitates human touch, and is associated with a decreased risk of postpartum depression. These factors have the potential to positively impact interactions between a mother and infant.

OBJECTIVES

The purpose of this study was to explore whether or not a relationship exists between infant feeding choices and the quality of maternal infant interactions in non-feeding settings. This study was conducted within a nurse home visiting program aimed at enhancing maternal infant interactions in mothers that are considered at risk for not choosing to breastfeed and for having lower quality interactions with their infants.

METHODS

This study was a retrospective analysis of data from a Nurse-Family Partnership program. Age, education, depression, race, birth weight, and whether or not the nurse addressed breastfeeding prenatally were evaluated to predict breastfeeding initiation. The same variables plus feeding choice were measured against the total maternal score on the Nursing Child Assessment Satellite Tool (NCAST) Teaching Scale, a standardized measure of caregiver-child interactions. The maternal scores and subscale scores were compared by duration of breastfeeding. Finally, participants' scores were compared to national samples

from the NCAST database.

RESULTS

Mothers whose nurses addressed breastfeeding prenatally had a 3.56 times higher incidence of breastfeeding. Higher education ($p=.039$) and surprisingly, lower age ($p=.029$), were also associated with breastfeeding. Breastfeeding duration was the only significant factor ($p=.019$) determining total NCAST score. The mean NCAST score for the never breastfed group was significantly lower ($p=.036$) than the breastfed for ≤ 8 weeks group, and significantly lower ($p=.025$) than the breastfed for > 8 weeks group. The two breastfeeding groups, ≤ 8 weeks and > 8 weeks, were not significantly different from each other. The sensitivity to cues subscale ($p=.046$) and total score ($p=.041$) could be predicted by the number of weeks breastfeeding. Participant NCAST scores were significantly higher, 42.95 for those that breastfed > 8 weeks compared to 37.34 for similar population of mothers from the NCAST database.

LIMITATIONS

Limitations include that the data is retrospective and the complexity of variables related to breastfeeding decisions and maternal infant interactions. The results apply only to like populations of young, low income, first time mothers.

CONCLUSIONS/IMPLICATIONS

Breastfeeding was associated with improved maternal-infant interactions outside of the feeding setting. Program participants had both higher breastfeeding rates and higher maternal NCAST scores than comparable populations. Encouraging breastfeeding in vulnerable mothers may have a subsequent influence on interactions with their child and interventions aimed at encouraging sensitive care-giving in vulnerable mothers may improve breastfeeding rates.

Being born at the right place: Definitions and data collection on neonatal levels of care

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CATEGORY

Prematurity / Preterm birth / Birthweight
Infant mortality and morbidity

FOCUS

Program Policy Focus

BACKGROUND

Perinatal regionalized systems, to include obstetrical transport and appropriate referral to neonatal intensive care, have been an important mechanism for improving outcomes for preterm and medically complex infants. However, regionalized systems have deteriorated and regulatory language defining levels of neonatal care vary significantly. Maternal Child Health Bureau National Performance Measure #17, which measures the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates, has been below the goal of 90% for many states. Recent increases in infant mortality may, in part, be an unintended consequence of deficiencies in regional organization of perinatal care.

Setting:

Regional, state, and national organizations evaluating neonatal levels of care to improve birth outcomes.

METHODS

We studied how states assess National Performance Measure #17 using three data sources. First, we collected data from states on definitions of levels of newborn care including language from the American Academy of Pediatrics' 2004 policy statement. Second, using birth certificate data (2003 revision), we compared the percentage of very low birth weight infants born in facilities with a neonatal intensive care unit (NICU) by states. Third, state-specific reports of the National MCHB Performance Measure #17 from 2002-2006 were assessed to see if they met performance goals.

RESULTS

Review of the state data revealed that no consensus exists for definitions of neonatal levels of care. States varied in infant gestational age and birth weight criteria, healthcare provider criteria, transport responsibilities, and, enforcement of standards used. The 2003 revised birth certificate provided new data on NICU admission as well as use of effective therapies, such as antenatal steroids and surfactant. Only 10 states reported reaching the national goal of 90% of VLBW infants delivered in appropriate facilities with all states ranging from 33% to 92%.

LESSONS LEARNED

Improving perinatal regionalized systems of care requires better data and involvement from multiple stakeholders.

CONCLUSIONS/IMPLICATIONS

Health departments have an opportunity to participate in defining newborn levels of hospital care and lead in the development of methods to monitor the quality of maternal, perinatal, and newborn care through policy, data collection, and analysis.

Validation of fertility treatment use questions on the 2004 Pregnancy Risk Assessment Monitoring System survey

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CATEGORY

Prematurity / Preterm birth / Birthweight
Other: data quality

FOCUS

Data Focus

BACKGROUND

Women who conceive with the assistance of fertility treatments are at increased risk of multiple gestation pregnancies and accompanying adverse pregnancy outcomes in addition to low birth weight (LBW, 1500-2499 g) births among singletons. The Pregnancy Risk Assessment Monitoring System (PRAMS) could help state health departments assess outcomes associated with fertility treatments, but a previous study suggested that PRAMS questions about fertility treatments lacked specificity and substantially overestimated ART use (estimates were 2.6-fold higher than expected) The questions were revised in 2004.

OBJECTIVES

To assess the validity of the revised PRAMS questions regarding various fertility treatments

METHODS

Weighted estimates of the prevalence of births conceived using assisted reproductive technology (ART) by age, plurality, and infant birth weight in three PRAMS states (FL, MD, UT) in 2004 were compared with corresponding estimates from the National ART Surveillance System (NASS), the current gold standard for ART use.

RESULTS

The estimated number of ART births ascertained from PRAMS was 3,700 (95% confidence interval=2,300–5,200), compared to 2,939 ART births reported to NASS. PRAMS and NASS estimates of maternal age, plurality, and infant birth weight did not differ. For example, while PRAMS overestimated

the number of singleton births and LBW singleton births by 33% and 8%, respectively, neither of these differences reached statistical significance.

LIMITATIONS

Standard errors of the estimates from PRAMS were large, resulting in wide confidence intervals, because births resulting from ART comprised only a small percentage of the PRAMS sample. Additionally, there are no US population-based reporting systems for the use of non-ART fertility treatments; thus, the validity of the PRAMS questions specific to such treatments could not be assessed.

CONCLUSIONS/IMPLICATIONS

Validity of the PRAMS questions for estimating ART births has greatly improved since the question revision; however a slight overestimation remains. Comparisons of outcomes associated with various fertility treatments should be cautiously interpreted. As states shoulder much of the cost related to adverse outcomes related to ART, data from PRAMS can be used to describe maternal behaviors and infant care practices associated with ART use.

Creating community involvement to conduct a perinatal periods of risk (PPOR) assessment

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CATEGORY

Infant mortality and morbidity

FOCUS

Program Policy Focus

ISSUE

In Arapahoe County, Colorado, the infant mortality rate for African Americans is 3.4 times higher than for whites, which is greater than the national disparity. The community identified a need to examine the risk factors for this disparity and focused their assessment in the City of Aurora, Colorado.

SETTING

Aurora, Colorado is the third largest city in Colorado, and is situated adjacent to the City of Denver in Arapahoe County. In Aurora, fourteen percent of the population is African American compared to four percent in the state of Colorado.

PROJECT

Aurora Healthy Baby Initiative is a community collaborative formed to examine the perinatal periods of risk (PPOR) in the African American community in Aurora to provide data to guide an action plan to improve African American birth outcomes. Community collaboratives to examine health disparities have been supported by both the National Institute of Medicine and Healthy People 2010.

The collaborative was created by Tri-County Health Department, the local public health department; the Healthy Start Project, Colorado Department of Public Health and Environment; the Colorado chapter of the March of Dimes; and the City of Aurora.

ACCOMPLISHMENTS/RESULTS

In the Fall of 2006, 13 key informant interviews were conducted with local medical professionals, current community-based organizations, and political leaders in the City of Aurora. Information from the key informant interviews indicated a need to gather expertise and different community perspectives on this

disparity in a more formal setting. The community collaborative was initiated in June 2007 and has evolved to include over 30 individuals and 20 different agencies / organizations. In 2008, the collaborative received technical assistance from a Centers for Disease Control and Prevention recipient of a National Centers for Excellence award in eliminating disparities and funding from the state health department to initiate a strategic planning process and to complete the PPOR analysis and evaluation. The collaborative was also selected to participate in the Partnership to Eliminate Disparities in Infant Mortality Action Learning Collaborative sponsored by CityMatCH, AMCHP and NHSA. In December 2008, a local African American consultant was engaged to assist in the strategic planning process to facilitate the creation of a logic model for evaluation and the creation of a 2-3 year strategic plan.

BARRIERS

The lack of a champion from the African American community as well as inconsistent collaborative leadership has resulted in difficulty engaging collaborative members. In addition, a lack of adequate funding resulted in an inability to accomplish goals and necessary action steps in a timely manner.

LESSONS LEARNED

- A champion or facilitator from the African American community was essential to engage and retain the members of the community as well as to establish relationships with key stakeholder.
- Consistent leadership without competing priorities was necessary to establish meeting agendas, handle logistics, and communication for the collaborative.
- The involvement of a city political leader was instrumental in gaining access to community support and key stakeholders.
- Additional funding for a paid coordinator was needed earlier in the process to be able to continue progress toward goals and action steps.

Promoting Infant Safe Sleep through a Pack ‘n Play® Program

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CATEGORY

Infant mortality and morbidity

FOCUS

Program Policy Focus

ISSUE

The City of Milwaukee’s infant mortality rate is one of the highest in the nation. Each year, there are a significant number of deaths due to unsafe sleeping. The Cribs for Kids program was identified as a possible program to decrease deaths due to unsafe sleep.

SETTING

This program targets all of the birthing hospitals in the city, the Bureau of Child Welfare, the City of Milwaukee Health Department (MHD), the Milwaukee Fire Department, and other community agencies as part of the program.

PROJECT

Phase I: included two of the birthing hospitals who have approximately 55% of the births in Milwaukee. One of the hospitals identified the Cribs for Kids program and the use of Pack ‘n Plays® to provide safe sleep. This institution created guidelines and teaching strategies to use when identifying a family who needs a safe place for their infant to sleep. Funding was secured from a foundation at the hospital and through a local grant. A safe sleep “champion” organized the delivery of the program at the hospital. One year later, another large hospital identified funds to use for Pack ‘n Plays® and modeled their program after the first one.

Phase II: involved the MHD, who identified at-risk infants through their home visiting programs and the Milwaukee Fire Department, who identified at-risk infants when making an Emergency Medical Service call.

Phase III: included a large clinic in Milwaukee that serves an at-risk population, several HMOs and the Bureau of Child Welfare.

- In many communities, the Cribs for Kids program issues Pack ‘n Plays® through one centralized community location. Milwaukee has several functional programs but no community base, and no

centralized location or consistent program method. To address this issue, a meeting was called for all of the various Pack ‘n Play® programs to determine if Milwaukee should attempt to create a centralized community Cribs for Kids program. It was decided that expanding the Milwaukee program to a community base would take too much funding for now, and the current system is working as is.

ACCOMPLISHMENTS/RESULTS

- As of February, 2009, more than 2000 Pack ‘n Plays® have been delivered.
- An evaluation plan has been designed for agencies with Pack ‘n Play® programs.
- A decision was made to track the number of all Pack ‘n Plays® given out, so that there is data to share with future funding sources.
- The group learned key lessons from each other, and plans were made for implementation of safe sleep using other sources such as churches.

BARRIERS

- Funding is needed to create a community base, and none has yet been identified.
- Institutions often establish their own systems without involving the community, making the creation of one centralized program difficult.

LESSON LEARNED

This initiative demonstrates that even under less-than-ideal circumstances, such as a lack of funding, community agencies can come together to address a problem and contribute to the solution through their individual resources. Coordination and communication are key.

Reactions to race among adult women (Age 18 and Older) in Franklin County, Ohio

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CATEGORY

Racial and ethnic health disparities

FOCUS

Data Focus

BACKGROUND

Recent studies have suggested that the experience of racism contributes to a range of poor health outcomes. This includes adverse birth outcomes and may help to explain the continued disparities between Black and White women even after adjusting for education and income. Dr. Camara Jones developed several questions for the Behavioral Risk Factor Surveillance System (BRFSS) to try to measure racism. Only a few states have used the module and very little analysis has been performed or published since its inclusion in the 2002 BRFSS. We are also unaware of county level analysis.

OBJECTIVES

Our objective is to examine the experience of racism by women in Franklin County, Ohio. This includes how often women think about race, how they perceive being treated when seeking health care, and physical and emotional symptoms as a result of race based treatment.

METHODS

Data are from the 2005 Franklin County Health Risk Assessment, a telephone survey of adults (age 18+) that took place between January 2005 and March 2006. Data were analyzed for 1417 women. Descriptive analyses were performed looking at self-reported race and the following four questions:

- How often do you think about race?
- Within the past 12 months when seeking health care, do you feel your experiences were worse than other races, the same as other races, better than other races, or worse than some races but better than others?
- Within the past 12 months on average, how often have you experienced any physical symptoms, for example a headache, an upset stomach, tensing of your muscles, or a pounding heart, as a result of how you were treated based on your race?
- Within the past 12 months on average, how often have you felt emotionally upset, for example angry, sad, or frustrated, as a result of how you were treated based on your race?

RESULTS

In Franklin County for all women age 18 and older (all differences are statistically significant):

- Non-Hispanic black women think about race more often.
- More non-Hispanic black women report being treated worse than other races in the healthcare setting.
- More non-Hispanic black women report having emotional symptoms as a result of racism in the preceding 12 months.
- More non-Hispanic black women report having physical symptoms as a result of racism in the preceding 12 months.

LIMITATIONS

- Telephone survey, therefore, individuals without a telephone are not included.
- Results are limited to Franklin County.
- Unable to examine women of child bearing age due to sample size.

CONCLUSIONS/IMPLICATIONS

Non-Hispanic black women in Franklin County, Ohio are far more likely than non-Hispanic white women to report be treated worse than other race in the health care setting and to report having emotional and/or physical symptoms as a result of how they were treated based on their race. Non-Hispanic black women are also more like to spend time thinking about race.

Implementing perinatal depression screening in a Medicaid-based program

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CATEGORY

Preconception health and health care
Mental health

FOCUS

Program Policy Focus

ISSUE

Depression is one of the most common complications during and after pregnancy. It disproportionately affects minority women. Untreated depression during pregnancy is associated with preterm delivery, neonatal growth retardation, maternal complications, and is an important predictor of postpartum depression.

The Comprehensive Perinatal Services Program (CPSP) is an enhanced program for Medi-Cal (Medicaid) eligible pregnant women. Los Angeles County CPSP provides support and oversight to approximately 450 state-certified CPSP providers. Besides obstetrical care, CPSP includes a comprehensive assessment of health education, nutrition, and psychosocial variables affecting pregnancy that is completed each trimester and postpartum. The current CPSP assessment tool does not specifically address depression. According to the 2005 Los Angeles Mommy and Baby (LAMB) Survey, the prevalence of depression during pregnancy was 12-37%.

Our project aims to increase education and screening for perinatal depression among Los Angeles CPSP providers.

SETTING

The intervention sites are Los Angeles CPSP providers in two pilot areas, one of which has the highest incidence of depression based on the LAMB Survey. CPSP clinics in other areas that request training will also be included.

PROJECT

A baseline survey of at least 20% of CPSP providers will be conducted to assess the extent and frequency of depression screening. A pilot group of providers and staff will receive depression education and screening training at their clinic sites. Routine screening for all prenatal patients at least once each trimester and postpartum will be promoted in accordance with the American College of Obstetricians and Gynecologists guidelines. Follow-up questionnaires at three months and six months will be sent to participants to assess incorporation of training recommendations. In addition, patients who received depression screening will be asked to provide feedback. These results will be used to provide feedback to providers and refine provider trainings.

ACCOMPLISHMENTS/RESULTS

- Providers' knowledge of perinatal depression screening, treatment, and resources will increase.
- Depression screening in the pilot areas will increase by at least 50% compared to baseline.
- Perinatal depression trainings will be offered to all County CPSP providers at their clinic sites. Follow-up information will be provided through posting of a Perinatal Depression Toolkit on the LA County CPSP website.

BARRIERS

- Clinician reimbursement – screening and referral time reimbursable through CPSP.
- Lack of mental health providers for diagnosis and treatment – identify local referral resources.
- Stigma associated with depression – patient education needed.

LESSONS LEARNED

- Providers are more likely to screen for depression during pregnancy when given appropriate tools and training.
- Depression screening can be incorporated into the CPSP psychosocial component, thereby reducing complications associated with perinatal depression.

Utilizing a life course framework in community maternal and child health planning

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CATEGORY

Infant mortality and morbidity
Other: Community MCH planning

FOCUS

Program Policy Focus

ISSUE

The value of moving before and beyond pregnancy in identifying and intervening to address risk factors that impact on poor birth outcomes and health disparities has been recognized by researchers and practitioners alike. Operationalizing this approach offers a challenge for planning and delivering maternal and child health (MCH) services at the community level.

SETTING

As one of 30 state-designated, community MCH organizations, the Northeast Florida Healthy Start Coalition, Inc. is responsible for developing a five-year service delivery plan and annual action plan to guide funding and programmatic decisions related to Florida's Healthy Start initiative. The service delivery plan also serves as the local health systems action plan (LHSAP) for its federal Healthy Start program, the Magnolia Project. In past planning efforts, the Coalition utilized assessment tools, such as the Perinatal Periods of Risk (PPOR), that moved beyond the prenatal period. As a result, increased attention and resources have been directed to preconception health and broader social determinants in its program strategies. For its 2009-2014 service delivery plan, the Coalition recognized the need to utilize a broader, life-course perspective.

PROJECT

A life-course framework was developed for conducting the five-year needs assessment and planning process. This framework offered an alternative approach to examining birth outcomes and health disparities that considered health and development over the mothers'/families' life course, not just during pregnancy. It also broadened the focus of the planning process to include health and social equity.

A community Planning Committee examined data on MCH health status, available health and social services, and social determinants (economic, educational and environmental) for four phases of the

reproductive life course (infancy, childhood and adolescence, preconception and pregnancy and childbirth). Recognizing that the Healthy Start program only provides individual case management and risk reduction services, plan strategies were developed on two levels:

- What actions can be implemented by the Healthy Start program?
- What partnerships are needed between Healthy Start and other organizations to address broader social determinants and health equity?

ACCOMPLISHMENTS/RESULTS

The community Planning Committee successfully undertook an eight-month planning process utilizing a life-course perspective. Comprehensive data sets were compiled for each of the four phases of reproductive life. After reviewing the data for each phase, the committee articulated findings, recommended interventions specific to the Healthy Start program, and identified key community partnerships necessary to impact broader health, social and environmental determinants.

BARRIERS

Time and defining a comprehensive data set that was not overwhelming to the committee.

LESSONS LEARNED

- Access to broad health, social and environmental data sources is invaluable to the life-course planning model.
- As service providers, we have a lot to learn regarding the impact life circumstances on birth outcomes.
- Community partnerships, a variety of perspectives, are crucial to the successful development of a life-course based service delivery plan.
- The life-course perspective can be successfully operationalized in a community planning process.

Enhanced surveillance, analysis of, and rapid response to simultaneous outbreaks of syphilis among heterosexuals and men-who-have-sex-with-men(MSM)/bisexual in Cuyahoga County, Ohio

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CATEGORY

Infectious disease and MCH

FOCUS

Program Policy Focus

ISSUE

A nationwide increase in syphilis incidence heightens the risk of congenital syphilis. The index of suspicion among perinatal care organizations, medical care centers and clinics to recognize syphilis symptoms and screen for syphilis may be very low. Conversely, surveillance information, including congenital cases occurring or prevented, do not diffuse to caregivers. Our objective was to circumvent this disconnect, obtain syphilis surveillance data from state officials and disseminate outbreak information to clinicians and the public.

SETTING

City of Cleveland and Cuyahoga County (pop. 1.37 million); A consortium of city, county and state public health officials and public health agency medical directors having affiliation to local medical centers.

PROJECT

Cleveland Department of Public Health twice obtained syphilis surveillance data, in July 2008 and January 2009, from the Ohio Department of Health in Columbus. Data were analyzed and shared with a consortium of local and state public health agencies and representatives from school districts, Ryan White funding and child and maternal health (CMH) offices. The outbreak of early syphilis (primary, secondary, and early latent) began in July 2007 and has accelerated through November 2008. Two populations were identified: heterosexuals males and females (88% African American) and men who have sex with men and male and bisexual males (across all races/ethnicities). Since the latter group is more often identified in outbreaks, an outbreak among heterosexuals alarmed public health officials. Two-thirds of heterosexuals

infected with syphilis were under age 35, among whom Chlamydia and gonorrhea rates are highest; the number of female cases equaled males. Two females were pregnant when found positive for syphilis and treated. No congenital cases have been reported to date. Medical directors of the three local and county public health offices informed the public and clinical community through a press briefing and an alert letter for general circulation. PowerPoint slide presentations for medical and prevention education were disseminated.

BARRIERS

Syphilis surveillance data reported by state offices does not provide orientation or behavior of cases at the county or city level. Had local health officials relied solely on these reports, the outbreak among heterosexuals may have gone undetected entirely, or at least delayed for months. Swift action by Disease Intervention Specialists to warn local health officials of the overall increase was key to initial recognition. Obtaining surveillance data for analysis was critical to uncover the outbreak among heterosexuals and begin prevention activities. Because of previous surveillance cooperation with state STD prevention units, CDPH was able to obtain local syphilis data.

LESSONS LEARNED

All cases of congenital syphilis are preventable. MCH offices and prevention programs should monitor trends in STDs that impact CMH and develop stronger ties to epidemiology and surveillance offices at local and state levels. MCH programs should encourage LHDs (local health departments) to develop and maintain analytical capacity to routinely analyze vital statistics and STD surveillance data and provide current findings that impact CMH activities. If analytical resources are few to review surveillance data in-depth, LHDs can partner with local universities to leverage resources.

INFORMATION FOR REPLICATION

- Share FTE of a data analyst for surveillance capacity.
- Analysis: use of SAS software or similar. Can be done in Excel using pivot tables and queries.
- Basic epidemiology knowledge (e.g. incidence rate) and use of census data for denominators are needed.
- Joint consortium of local and state public health officials is suggested.
- Open communication of surveillance results between public health officials and disease intervention specialists (who perform patient/partner notification of HIV, syphilis and other STDs) with CMH offices, emergency rooms, hospitals, clinics and subspecialty providers.

Re-designing the Black Infant Health Program in California: Positive leadership for maximum impact**PRIMARY CONTACT:**

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CATEGORY

Infant mortality and morbidity
 Racial and ethnic health disparities

FOCUS

Program Policy Focus

ISSUE

The California Department of Public Health, Maternal, Child and Adolescent Health (CDPH/MCAH) Division places a high priority on addressing the persistent poor pregnancy outcomes that disproportionately impact African-Americans. Infant mortality rates have declined in California, yet African-American infants are more than twice as likely to die as white infants and African-American women have more than triple the risk of pregnancy-related death compared to other racial/ethnic groups. California's Black Infant Health (BIH) Program was established in 1989 to reduce high infant mortality rates among African-Americans in the state. Under CDPH/MCAH's leadership, BIH is undergoing a strategic re-development to maximize its impact.

SETTING

BIH provides community-based, culturally-sensitive health promotion and support services to pregnant and parenting African-American women at risk of adverse birth outcomes in 17 local health jurisdictions where over 90% of all California African-American births occur. Between 1997-2007, BIH served 28,330 women and 19,791 infants. Compared to the population of African-American women in California, most BIH clients are at high risk, medically and psychosocially. Data suggest that BIH may be improving birth outcomes by decreasing the number of very low birth weight infants and shifting them into the mid-low birth weight category, yet it has not had an impact on the Black-White disparity in pregnancy outcomes.

PROJECT

Because of the lack of progress in reducing infant and maternal health disparities CDPH/MCAH engaged the University of California San Francisco, Center on Social Disparities in Health to conduct an assessment of BIH with the goal of re-designing the program for maximum effectiveness. The assessment

revealed that the current model was based on outdated research and that BIH was implemented differently across the 17 sites. The revised BIH program intervention features a standardized, evidence-based model that builds upon current program strengths, latest research/science, and best practices. CDPH/MCAH is leading the program revision in partnership with UCSF and local MCAH/BIH staff.

ACCOMPLISHMENTS/RESULTS

With leadership from CDPH/MCAH, the workgroup has developed a revised model that:

- Engages African-Americans to learn about poor birth outcomes in their community by focusing on the life course perspective and the social determinants of health, an approach that resonates with this population
- Provides services to pregnant and parenting African American women.

BARRIERS

Conducting major program revision is a lengthy process and keeping the partners fully engaged has been a challenge especially since participation in the revision process is additional to their current work. Change is difficult—sites are committed to their current program model, and the proposed revisions have created apprehension for some providers. Common concerns revolve around staffing, funding and whether the clients will be appropriately served.

LESSONS LEARNED

CDPH/MCAH's leadership has created a clear sense of direction and purpose within the BIH community. MCAH has worked diligently to fully engage BIH staff and stakeholders as partners in the revision process by listening to their concerns, initiating open discussions about race and health and fostering an environment where participants feel they are creating a program that will help to reduce the Black-White gap in pregnancy outcomes.

Reasons for perceived discrimination among new mothers: 2005 Los Angeles Mommy and Baby (LAMB) survey

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CATEGORY

Racial and ethnic health disparities

FOCUS

Data Focus

BACKGROUND

Perceived discrimination has been linked to the health of new mothers. However studies addressing the reasons for their perceived discrimination are lacking.

OBJECTIVES

To investigate racial disparities in the reasons women report feeling discrimination.

METHODS

We used data from the 2005 LAMB Survey. LAMB is a biennial, population-based survey modeled after the Pregnancy Risk Assessment Monitoring System. Perceived discrimination was measured using Krieger's seven-item discrimination scale. We performed multivariate logistic regressions to evaluate the racial disparities in the reasons new mothers felt they suffered discrimination while controlling for maternal characteristics. Variables included in the multivariate models included mother's race, years in the US, mother's education, mother's age and marital status.

RESULTS

The data presented are from the 2005 LAMB survey (N=5,211) and responses are weighted to represent all Los Angeles County births in 2005. Overall 42% of African American and 41% of Asian American women reported some form of discrimination. In the multivariate logistic regression, when looking at specific forms of discrimination, we found that all women reported similar rates of discrimination due to being pregnant. White women reported more discrimination due to gender than other women (aOR 1.75, p<0.05). Asian women were slightly more likely to report discrimination due to age (aOR 1.53, p<0.05) compared to white women. Asian and Latino mothers had about two and a half times the odds of reporting discrimination because of their immigration status when compared to white women (aOR 2.50

and 2.42, respectively) $p < 0.05$. Not surprisingly, the greatest differences were seen in the odds of reporting discrimination due to color or race. African American women had nearly five times the odds (aOR 5.06), Asian women nearly four times the odds (aOR 3.92) and Latino mothers more than two and a half times the odds (aOR 2.65) of reporting discrimination due to color when compared to white women, $p < 0.0001$.

LAMB data are self-reported by new mothers and may be subject to potential sources of error. Women may not recall events prior to their pregnancies and may be hesitant to report on behaviors perceived to be unhealthy.

CONCLUSIONS AND LIMITATIONS

Our findings revealed both African American and Asian American mothers had reported high discrimination rates, mostly due to their color.

Health care providers need be aware of the role of discrimination in poor health among new mothers and help women to use culturally appropriately coping strategies. Further research is needed to identify specific factors associated with perceived discrimination for each race/ethnicity, especially for African American and Asian American mothers. LAMB is a population-based study providing an analytical approach to explore perceived discrimination. Other urban counties can adopt our methodology in combination with other approaches in their efforts to improve maternal health.

Maximizing urban MCH potential to prevent infant and child deaths through effective child death review teams, improved data collection and action

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CATEGORY

Infant mortality and morbidity
Other: Child and adolescent mortality

FOCUS

Program Policy Focus

ISSUE

Child Death Review (CDR) is a multidisciplinary team process that brings together community agencies to systematically discuss the factors that play a role in a child's death; in order to understand how and why children die in order to take action to prevent other deaths. When effective, CDR leads to improvements in child health and safety. At least 37 states have local child death review teams, including in all of their major cities. Urban teams have unique challenges in conducting effective reviews. The National Center for Child Death Review promotes supports and enhances child death review methodology and activities at local, state and national levels. The Center has worked with a number of urban regions to improve the effectiveness of their reviews. This presentation will describe these efforts and offer concrete suggestions for enhancing urban CDR effectiveness. It will also present data from the National CDR Case Reporting System to illustrate the potential for using CDR findings for improvements in infant and child health.

SETTING

CDR teams are a comprised of professionals from the child health, safety and protection fields. This workshop will describe the challenges faced by a number of urban CDR teams throughout the U.S. and engage participants in describing their own challenges as CDR team members. The findings of these teams across the country have wide-ranging implications for MCH systems and the potential to influence health and human service agency policies and practices.

PROJECT

The CDR process is carried out in a wide variety of formats and stages of evolution throughout the country. In terms of data collection, 29 states are using the national CDR Case Reporting system. CDR data has been utilized to demonstrate risk factors in most areas of child deaths. This workshop will describe efforts related to reviews, data collection and outcomes of deaths related to infant sleeping environments, perinatal drug intoxication, fires, child abuse and neglect, poisoning, youth suicide and homicide, and drowning.

BARRIERS

There are a number of barriers to successful urban CDR, including large numbers of deaths, large community agencies, restrictions on data sharing and difficulties in converting reviews into effective recommendations and action for prevention and systems improvements. This workshop will work with participants to address these barriers and identify solutions; and share successes from other communities throughout the U.S.

Coordinating health services: WIC and other public health programs

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CATEGORY

Child growth, development, preventive care
 Other: Partnership/Collaboration/Public Health Systems Nutrition

FOCUS

Program Policy Focus

CONTENT

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) was established to maintain and promote the health of low-income women, infants, & children up to age five. The program promotes the health of this population by providing nutritious foods to supplement diets of participants who are at nutritional risk. Additionally, the program provides referrals to other health services such as prenatal care, home visitation, dental, immunization, and mental health services.

Referrals to these services sometimes require WIC recipients to navigate a complex system where services referred to may not be centrally located. This may result in reduced rates of follow-up to referred services, which in turn may compromise the health of the women, infants and children participating in the program.

A few state and local health departments have coordinated health services using WIC clinics as the central point of access. State and local models of collaboration between WIC and other public health programs improve access to services and promote the efficient and effective use of state and local resources for eligible populations.

The Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO) have identified models of WIC-public health collaboration that use strategies focused on policy, administrative and clinical coordination, and community-based initiatives. The purpose of sharing these examples is to both highlight models and promote peer-to-peer communication and exchange around lessons learned from multi-sector collaboration.

PROJECT

Missoula County (MT)

- Missoula County WIC program serves as the primary conduit for family services in the local health department.
- Confidentiality issues have precluded other WIC and MCH programs from venturing into this partnership, but a memorandum of understanding (MOU) was developed to satisfy both USDA and HHS in assuring confidentiality .
- Enhances WIC clients' access and enrollment in Maternal and Child Health case management services.
- Information is shared between the two programs: MCH staff can use the data in the WIC chart accordingly.
- WIC is doing the marketing-outreach work for the MCH program staff, and they cover the cost of a full time receptionist who helps explain the paperwork and scheduling for the MCH nurses, social workers and dietitians.

Rhode Island

- Work closely with community partners to make a smooth transition for vendors, local agencies, clients, and farmers for the WIC food package. A workgroup of diverse partners meet monthly to work through issues, such as finding foods that meet the requirements and assessing client understanding of the new package.
- All WIC sites are located within Federally Qualified Health Centers, Community Health Centers, or hospitals: MOUs for collocation were developed.
- Co-train hospital staff to identify and enroll women/kids eligible for WIC.
- Collaborate with local chefs and farmers to teach WIC clients at farmers markets how to cook fresh food and try new things.
- Use Kidsnet (RI immunization registry) and share immunization, lead screening, early intervention, hemoglobin levels, height, weight, and other risk factors with hospitals and other programs.

First comes data, then comes action: Chattanooga's experience after Perinatal Periods of Risk analysis

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CATEGORY

Preconception health and health care
Infant mortality and morbidity

FOCUS

Program Policy Focus

ISSUE

The goal for the Chattanooga-Hamilton County Health Department's Infant Mortality Prevention program is to fully implement all six stages of the PPOR approach, mobilizing data with community-based action.

SETTING

The PPOR approach was initiated by the March of Dimes River Valley Division and the Infant Mortality Prevention program in Chattanooga/Hamilton County, Tennessee.

PROJECT

In order to fully utilize the data analysis conducted with PPOR, the March of Dimes and the Infant Mortality Prevention Program in Chattanooga hosted two summits (targeting the medical community, the other social service providers and grassroots community groups) to share results of the PPOR data analysis and to mobilize the community into action. At the summit for social service providers and community groups, focus groups were conducted to identify gaps in services, barriers, and ways to improve collaboration to help reduce Hamilton County's infant mortality rate. To continue the momentum created by the summits, a PPOR Action Workgroup was created with members from the medical community, social service providers, researchers, higher education, and community representatives to provide recommendations for targeting prevention efforts and creating policy and systems change.

ACCOMPLISHMENTS/RESULTS

The PPOR Action Workgroup used the PPOR analysis combined with focus group results to create short-term and intermediate objectives and actions aimed at reducing the infant mortality rate. An 18-month

timeline was created for two reasons: it is the remaining term of Tennessee's Governor (who initiated Chattanooga's Infant Mortality Prevention Program) and it provides recommendations until the local Fetal Infant Mortality Review Team (starting July 2009) will be able to take the lead role for action. Based on importance and changeability, the PPOR Action Workgroup created three major objectives to:

- Create Preconception Health campaigns targeting young women and medical providers.
- Improve public transportation access for women accessing health care services.
- Improve care coordination services among social service providers.

Evaluation Plan:

Results of the three objectives for action will be monitored by a process evaluation of marketing/campaign activities to change normative attitudes towards preconception health, transportation policies to increase equitable access to healthcare resources, and care coordination activities and policies to increase access to wrap around services.

BARRIERS

- Financial capital to implement changes.
- Resistance towards change in health care delivery systems.
- Full engagement from policy makers.

LESSONS LEARNED

Early on, the Infant Mortality Prevention program engaged stakeholders and community members to initiate the PPOR approach. Those stakeholders and community members were vital in recruiting for the PPOR Action committee to make the recommended changes. The PPOR data analysis provided the disparity gaps of infant mortality and risk factors, but the analysis is limited by information provided in vital records and existing data. Qualitative data collection at the summit and with target women provided insight into gaps and barriers in addressing infant mortality. Lastly, the feasibility of an 18-month action period with short-term and intermediate objectives helped engage workgroup members.

INFORMATION FOR REPLICATION

Health Department staff time (local and State) was used to conduct the PPOR analysis and focus groups with target women; sponsors paid for both summits; and a graduate student intern coordinated the summit focus groups and analysis.

Key partners included the Governor's Office for Children's Care Coordination, March of Dimes, Chattanooga Medical Society, Eastside Taskforce, Girls INC, Erlanger Health Systems, Southside/Dodson Avenue Community Health Centers, Re Start Chattanooga, La Paz de Dios, UT College of Medicine, Chattanooga State Community College, Ochs Center for Metropolitan Studies, BlueCross BlueShield Volunteer State Health Plan, and the Chattanooga-Hamilton County Health Department.

Women together for health: Challenges and successes

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CATEGORY

Chronic disease and MCH (Asthma, Diabetes, Obesity)

Racial and ethnic health disparities

FOCUS

Program Policy Focus

ISSUE

The Women Together for Health (WTFH) program, delivered through the Maricopa County Department of Public Health, aims to prevent chronic disease and promote healthy weight. Recent local data reveal a growing obesity trend among children and adults. By targeting women of childbearing age, the program intends to influence the person responsible for making many of the family's choices regarding nutrition and leisure time: the mother.

SETTING

WTFH is taught throughout Maricopa County, including public school literacy programs, Head Start classrooms, churches, and community centers. The target audiences are low income women, those that identify as ethnic minorities, and those with fewer years of formal education, because of the health disparities that exist within these populations. Classes are taught in English or Spanish.

PROJECT

WTFH addresses physical activity promotion, nutrition education, stress management, and tobacco exposure reduction. This interactive course includes exercise sessions, food sampling, and other hands-on activities. The program is co-taught by Health Educators from the Office of Health Promotion and Education, and Registered Dietitians in the Office of Nutrition Services. Data measurement consists of pre/post surveys and pedometers with step-logs.

ACCOMPLISHMENTS/RESULTS

In 2008, WTFH had 706 participants and 370 program completers. The program staff was successful in reaching their target audience: 76% identified as ethnic minorities, 42% did not graduate high school,

88% did not graduate from college, and 64% had received financial assistance from the Department of Economic Security, Arizona Health Cost Containment System, or Women, Infants, and Children. About 25% of participants reported no physical activity at pre-test, while only 5.7% reported so at post-test. Over 65% increased their daily step count by 2,000 steps by the program's end. About 20% of participants switched to low- or non-fat milk from whole, 35% increased fruit and vegetable consumption by one serving in each category, 51% increased fruit and vegetable consumption in either category, the percentage reporting choosing whole grains moved from 60% at pre-test to 79% at post-test, and 46% reported an increase in reading nutrition labels. One-hundred percent of program participants made at least one dietary improvement. Nearly 70% maintained these healthy lifestyle behaviors three months post-program.

BARRIERS

The two major barriers encountered were low rates of step-log compliance and high program attrition rates. Few women faithfully returned completed step-logs, a major instrument of measurement for determining program effectiveness. Additionally, lack of consistent attendance was frequently experienced in community education settings, and was also a barrier to participants' adopting the healthy behaviors promoted in class.

LESSONS LEARNED

Halfway through the year, program staff restructured the use of incentives to address the lack of step-log compliance. Participants continued receiving an attendance incentive, but additional incentives were provided only upon receipt of a step-log. This caused a 23% increase in step-log collection compared to 2007, a marked success. In terms of attrition, the objective of 50% completion was exceeded; however the existing rate of 53% should not be passively accepted. Program staff should strive to recruit committed women, and aim to retain participants' interest throughout the program's length.

INFORMATION FOR REPLICATION

This program is funded through the federal Maternal and Child Health block grant, via the Arizona Department of Health Services. Women Together for Health employs 6.5 Full Time Employees, with a budget of \$587,000 per year; however, over \$100,000 of this money goes directly to Child Passenger Safety programming partnerships.

Reducing maternal morbidity and mortality in Los Angeles County: A focus on maternal hemorrhage

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CATEGORY

Preconception health and health care
Other: Maternal Mortality

FOCUS

Program Policy Focus

ISSUE

Obstetric hemorrhage is a rare but life-threatening event. Management requires early recognition and decisive action. Seventy-five percent of all maternal deaths in Los Angeles County (LAC), California, from 1994-1996 were potentially preventable. Data for 1999-2003 demonstrated that pregnancy-related deaths were three times more likely among African Americans than other racial/ethnic groups. Two main contributing factors to deaths were providers' failure to recognize and manage risks, and women delaying or not requesting prenatal or emergency care. This project aims to reduce hemorrhage-related morbidity and mortality through the prevention, recognition, and response to obstetric hemorrhage, the most common cause of pregnancy-related death in LAC.

SETTING

The project addresses contributing factors to maternal deaths at the provider, facility, and patient levels at the 10 highest volume delivery hospitals in LAC. These hospitals annually deliver 33% of the 150,000 births in LAC and 40% of the 11,400 births to African Americans. Participants include obstetrical providers, women of reproductive age, and hospitals.

PROJECT

We are one of four pilot projects that the California Maternal Care Quality Collaborative selected and supports for the Local Assistance for Maternal Health project. A grant from the California Department of Health, Maternal, Child, and Adolescent Health Program funds this initiative to support projects to reduce maternal morbidity and mortality in California. The project team includes the LAC Department of Public Health and key stakeholders from provider, hospital, and patient organizations.

The three-year project will follow best practice recommendations to:

- Develop presentations and other materials to educate providers to recognize and manage obstetrical hemorrhage.
- Update hospital hemorrhage protocols, conduct simulation drills, identify at-risk hospitalized patients, and improve the accuracy of case reporting.
- Develop bilingual brochures to educate women of reproductive age on their risk of hemorrhage and the importance of seeking care.

Educational sessions will be evaluated using pre/post training surveys. Monitoring tools will be developed to track quality improvement.

ACCOMPLISHMENTS/RESULTS

When implemented countywide, the project is expected to reduce maternal morbidity and mortality, and avert approximately 220 life-threatening morbidities and 2200 serious morbidities.

BARRIERS

- Increasing rates of primary and repeat Cesarean Section deliveries. Reducing rates of this predisposing factor for obstetric hemorrhage is beyond the scope of this project.
- Inability to require recommended changes to providers and hospitals, we can only recommend. We will attempt to have key stakeholder participation by having them as partners through the development and project implementation.
- Challenges addressing the appropriate personnel to recommend and streamline hemorrhage codes. Work with partners who have relationships with appropriate personnel.

LESSONS LEARNED

- Incorporating the participation of key stakeholders through our collaborative advisory group has facilitated the development and buy-in of project recommendations.
- Change is a multi-level approach that has to be introduced and reinforced at all levels.

HIV prenatal testing and discussions among race/ethnicity in the 2005 Los Angeles LAMB study

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CATEGORY

Infectious disease and MCH
Racial and ethnic health disparities

FOCUS

Data Focus

BACKGROUND

Despite high prenatal HIV testing in Southern California, there are discrepancies in testing within races. African Americans and Latinas are populations that are at higher risk for HIV.

OBJECTIVES

We examined the prevalence of discussing and testing for HIV in relation to race and ethnicity among postpartum women in Los Angeles County to assess possible gaps in prenatal HIV discussions and testing.

METHODS

We used data from the 2005 Los Angeles Mommy & Baby Project (LAMB). The LAMB Project surveys from a population-based representative sample of postpartum women in Los Angeles County biennially. The survey was provided both in English and Spanish, and topics include discussing HIV with a healthcare provider, and receiving an HIV test during the respondent's previous pregnancy. Chi-squared tests and Fisher's Exact tests were used to discover significant differences between the mothers' race/ethnicity and HIV testing.

RESULTS

2005 LAMB data analyzed a total of 5211 respondents, of which 1316 were White, 1414 were Latina and 1085 were African American. Among the respondents, discussing and testing for HIV varied across racial groups ($p < 0.0001$). African Americans reported having tested more than Latinas, and both groups more than Whites ($p < 0.0001$). 84.56% of responding African Americans reported having an HIV test, while 79.99% of Latinas and 60.20% of Whites and reported HIV testing. African Americans and Latinas reported discussing an HIV test with a healthcare provider greater than their White counterparts

($p < 0.0001$). 80.50% of African Americans discussed HIV testing during their prenatal care, whereas 72.97% of Latinas and 60.60% of Whites reported discussing HIV testing.

LIMITATIONS

A self-administered mail survey may suffer from biases and self-censorship, particularly surrounding the sensitive topics and stigmatized issues such as HIV. Also, African American women and Latinas had lower response rates than their White counterparts. This was accommodated through oversampling and weight adjustment for these responses.

CONCLUSIONS

Our findings demonstrate striking differences in prenatal HIV discussions and testing within racial groups in Los Angeles County. This data indicates that recent attempts to increase testing and discussions among heavily impacted African Americans and Latinas may be effective, and that continued effective culturally sensitive targeted campaigns to increase prenatal HIV testing among African Americans and Latinas in this region is necessary. Such initiatives would create earlier diagnosis and treatment for the mother and baby, as well as improved long term outcomes.

A bird's eye view of state adolescent health policy (and how you can get involved)

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CATEGORY

Adolescent health / pregnancy prevention

FOCUS

Program Policy Focus

CONTENT

The presentation will include an overview of state legislatures across the country: What do they look like? How do they function? What does red or blue have to do with it? Who are legislators? How do they like to receive and process information? With the nitty-gritty taken care of, we'll talk about the adolescent health issues state legislatures around the nation are debating. Hundreds of bills in the hopper around adolescent wellness, sexual education, teen pregnancy prevention, suicide, graduated driver licensing, dating violence, and much more. We'll explain how CityMatCH's member representatives can get involved in the legislative process and describe the role every state employees can play in helping elected officials make good decisions for adolescent health. No presentation would be complete in 2009 without a state budget update (maybe more appropriately, a "downdate?").

Infant safe sleep: Assessing knowledge and practice in physician clinics

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CATEGORY

Infant mortality and morbidity

Racial and ethnic health disparities

FOCUS

Program Policy Focus

BACKGROUND

Despite the Back to Sleep successes, almost one-third of the infant deaths in Michigan continue to involve unsafe sleep practices and SIDS. The key to reducing these deaths is parent education. Altering behaviors related to infant sleep practice requires changes in knowledge, practice and beliefs. Safe sleep messages and patient education have been contradictory. Sustainable, replicable, evidence-based models were needed to assure accurate, consistent education. This study focused on obstetrical/gynecological and pediatric clinics – the natural networks for pregnancy, delivery and infant care – and the need for, and impact of, enhancing the role physician clinics play in reinforcing safe sleep.

Michigan communities with high disparity in infant mortality: Kent, Genesee, and Ingham Counties. In three health plans serving commercial and Medicaid members; each plan identified the two largest ob/gyn and two largest pediatric clinics.

METHODS

This was the second phase of a systems approach to infant safe sleep. The first phase was institutionalizing education in hospitals by assessing provider knowledge/practice, adopting policies, standardizing education, and auditing compliance. This project built on that strategy by determining the roles physician practices play in supporting families to implement safe sleep measures, and exploring the feasibility of establishing policies and curricula.

OBJECTIVES

- Create baseline data about family education practices.
- Identify patterns of patient education regarding safe sleep.

- Identify parent reported behaviors.
- Develop evidence to guide next steps for promoting safe sleep among practices in target communities.

Physicians and staff from 12 practices were surveyed (275 total) to assess knowledge/practices about safe sleep education. Staff was also surveyed about readiness for change, barriers to, and what would facilitate change in, patient education. Patients at each site were also surveyed (652 total) to obtain information about education they received from the practice regarding infant care, health and safety, and their perceptions/practices regarding infant safe sleep.

ACCOMPLISHMENTS/RESULTS

- Parent education about safe sleep increases the likelihood of practicing safe sleep. Conversely, education on ‘SIDS’ did not significantly predict safe sleep practice.
- Women’s/parents’ knowledge of back sleep (83.3%) and crib usage (94.4%) was good but needed improvement on other safe sleep measures, e.g., bedsharing, soft bedding.
- There were important gaps in knowledge and inconsistent practice among pediatric providers.
- There were significant differences between ob/gyn and pediatric practices: only 1/3 of ob/gyn practices reported providing safe sleep education compared to over 3/4 of pediatric practices.

BARRIERS

- Inadequate staff knowledge about all facets of safe sleep practices.
- Lack of perception of the need to change patient education practices.
- Lack of access to materials and methods to address diverse languages, cultures, education levels, and engaging extended family.
- Lack of time/office space to educate patients.

LESSONS LEARNED

- Physician practices may not be reaching their full potential in providing safe sleep education.
- Practical, knowledge, and attitudinal barriers need to be addressed to enhance providers’ roles in providing safe sleep education.
- Providers could consider safe sleep education as quality assurance/quality improvement initiatives.
- Health departments can partner with health plans and clinics to support data collection on safe sleep and other infant health issues.

Developing a national Perinatal Depression Information Network

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CATEGORY

Mental health

FOCUS

Program Policy Focus

ISSUE

Depression during and after pregnancy, also known as perinatal depression, is the number one complication of childbearing. It affects as many as one in seven pregnant women and new mothers. Research indicates that, if left untreated, perinatal depression affects the physical and mental health of both the woman and her baby. With limited funding, programs across the country are looking for innovative ways to tackle this issue.

SETTING

To address this concern the Pennsylvania Perinatal Partnership, administered through the Family Planning Council in Philadelphia, launched a 15-month project to create a national web-based Perinatal Depression Information Network (PDIN) in July 2008. A nationwide network of this type does not currently exist and such infrastructure is necessary to respond to this public health challenge.

PROJECT

The PDIN creates a means for conversation, idea sharing and resource development among professionals and state officials throughout the United States. The aim of the network is to link individuals involved in model perinatal depression programs with those searching for program ideas. Several PDIN concepts include: Perinatal depression screening tools and successful evaluation measures; periodic national conference calls, webinars and listserv emails addressing such topics as third-party payments, legislative initiatives (both state & federal), best practices; new findings for medication, and screening tools; policy briefs synthesizing key initiatives for systems change in maternal and child health, mental health, and primary care evidence-based research studies and findings

ACCOMPLISHMENTS/RESULTS

Qualitative data was collected through in-depth phone interviews with all 50 states and the District of Columbia. This has resulted in the discovery of many new, exciting, and innovative projects occurring across the country. Many of these activities include innovative approaches that address and break down common barriers. With state budgets tightening and maternal and child health programs slated for deep funding cuts across the country, many states have affirmed that this project could not have come at a better time. Now, more than ever, information sharing will be a necessity for many states to seek out existing resources and innovative ideas to continue perinatal depression efforts in their communities. Once completed and available for all to view on the PDIN website, one can only imagine the difference this will make in helping programs across the country tackle the issue of perinatal depression.

BARRIERS

Collecting data from across the country has proved to be a very challenging and time consuming undertaking. Ensuring that the information is accurate and remains up-to-date is a constant demand that will continue after the 15-month development period ends. In order for PDIN to be effective, it must continue to expand and flourish. A plan is being devised to guarantee its future at a nationally recognized organization.

LESSONS LEARNED

PDIN will fill a major gap in sharing information and knowledge about this often neglected type of depression. States will have the tools to more efficiently and effectively help women and their families get support, help and treatment for perinatal depression.

INFORMATION FOR REPLICATION

The project was funded by the Thomas Scattergood Behavioral Health Foundation, a private foundation, and the Pennsylvania Department of Public Welfare. The total budget for this project was \$100,000.

Assessing knowledge of Sudden Infant Death Syndrome among African American women in two Mississippi communities

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CATEGORY

Infant mortality and morbidity
Racial and ethnic health disparities

FOCUS

Data Focus

BACKGROUND

Although infants of all demographic and socioeconomic backgrounds are at risk for SIDS, the African American population bears a disproportionate burden of SIDS, a phenomenon noted throughout the world and shared by Mississippi infants. Sudden Infant Death Syndrome is the third leading cause of Mississippi infant mortality with nonwhite infants dying of SIDS at two to three times the rate of white infants.

OBJECTIVES

The purpose of this study was to assess the level of SIDS related knowledge among African American women to improve methods for SIDS education and outreach.

METHODS

An African American faculty was contracted to conduct six focus groups among African American women in urban and rural communities in Mississippi.

RESULTS

Some themes were common among participants from both the urban (n=29) and rural (n=28) communities. Participants in both areas had at least heard the term SIDS. Because there was inconsistency among participants as to the source of information, it is not surprising that overall knowledge related to SIDS was incomplete, and in some cases inaccurate. One group had suggested SIDS was a scary topic to discuss with pregnant mothers. The term “crib death” seemed to be a cause of confusion suggesting that putting the baby in a crib was dangerous. Timing of the delivery of information was presented as a mechanism for improving maternal interest and retention of SIDS risk reduction information. Another concern was not the message, but the deliverer of the message. Groups emphasized a lack of trust in

communities and suggested the most effective community educator would be a person with whom mothers could relate. The location where the message might be received was emphasized as a strong indicator of whether or not information would reach those who need it. Finally, the educational materials themselves need modifications. The “tone” of language utilized in educational materials was disturbing. Participants recommended materials be changed to reflect positive outcomes rather than negative outcomes. The cultural influences and perceptions that discussion of death and dying poses a threat or “bad luck” seems to be a practical explanation for ineffective educational tools and strategies. Transitioning to phrases such as saving babies and lives rather than using terms such as death and dying presents as a logical evolution for educational materials to follow.

LIMITATIONS

At the close of each session, the researcher gave a short synopsis to clarify misunderstandings and answer participants’ questions about SIDS and crib death. However, there were only 57 participants in the entire study so, again, only a small group of women received accurate information.

CONCLUSION/IMPLICATIONS

SIDS information is not fully understood and is not consistently distributed resulting in a lack of knowledge among African American women extending the risk for high rates of SIDS events in Mississippi.

Because Mississippi has traditionally led the nation in SIDS deaths and overall infant mortality, it is important that actions be taken to reduce infant deaths and reduce disparities in birth outcomes.

Healthy Start taking “a life course perspective” from theory to practice

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CATEGORY

Infant mortality and morbidity

FOCUS

Program Policy Focus

CONTENT

To improve birth outcomes and the health and well-being of women and children in Omaha, Nebraska, the Omaha Healthy Start (OHS) HealthNET case management program will utilize a life course model by fully integrating the health care delivery system of its grantee organization Charles Drew Health Center, Inc. (CDHC). CDHC is a federally-funded community health center. CDHC provides offering health care for the entire family. OHS seeks to use the model as a point of reference among statewide MCH providers interest in advancing discussions from the efficacy of the life course model, to actual implementation.

OHS, located in the East/Northeast sector of Douglas County in Omaha, Nebraska, continues to report disproportionately high health disparities and poor MCH health outcomes among its residents – especially among African-Americans and other minorities. Data support the need to better integrate programs and services that focus on critical periods and early life events.

OHS, a federally-funded infant mortality reduction initiative, has operated in the Greater Metropolitan Omaha area since 1997. Its mission is to engage public health and MCH health systems and service providers in reducing the infant mortality rate and improve birth outcomes, especially in the African-American community.

Annual program performance goals include:

- Reduction in low and very low birth weight births.
- Reduction in IMR.
- Improved percentage of entrance into prenatal care.
- Effective collaboration with community-based health and social service programs.
- Inclusion of pre-conceptional health training for program participants.
- Improved adequacy of prenatal care among OHS program participants.
- Improved health education and training for program and community participants.

- Effective engagement of the entire community in identifying strategies to assure optimal health for the MCH population.

OHS provides in-home and office visitation, nursing assessments, health education and training, support group meetings, leadership development training, male involvement services, and transportation services to support the active participation in its HealthNET case management program.

Annually, OHS interfaces with 250+ pregnant and postpartum, women, and 300+ infants and toddlers 0 to 2 years of age. In addition, OHS works one-on-one with 150 men through its male involvement initiative. Efforts are made to integrate the on-site health care services provided by CDHC on behalf of all OHS program participants.

OHS is working to develop an interdisciplinary review panel that gives oversight for the implementation of its life course model. The proposed abstract presentation will exam the overall success of implementing the model; the processes used to identify OHS program participants for inclusion in this initiative; integrating existing TQM policies and procedures in the overall review process; development of tools needed to track participant compliance, service delivery, interdisciplinary team meetings and recommendations; and identification of barriers and challenges in successfully implementing this initiative.

It is imperative that the OHS team identify “champions” for the development and implementation of this initiative. OHS is poised to work with the State of Nebraska Office of Women’s Health to develop an effective process for disseminating findings associated with this initiative.

New policy support and best practice for extensive implementation of Nurse-Family Partnership

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CATEGORY

Child growth, development, preventive care

Adolescent health / pregnancy prevention

FOCUS

Program Policy Focus

ISSUE

Securing significant federal funding for prevention services has been perpetually difficult, despite research indicating how deep and intertwined are the roots of chronic disease and serious developmental challenges in children. Nurse-Family Partnership has been successful in convincing policymakers of its value as a preventive intervention and its cost-effectiveness, and now has the potential for federal funding and major investments in state and city-based program implementation.

SETTING

MCH leaders in cities anywhere in the U.S., but particularly where poverty is concentrated.

PROJECT

With city partners, we are designing the fiscal and administrative infrastructure to support Nurse-Family Partnership at sufficient scale to impact maternal and child health in urban environments over the long term.

ACCOMPLISHMENTS/RESULTS

A recent study by Dr. Ted Miller at the Pacific Institute for Research and Evaluation (PIRE) concluded that based on research conducted on Nurse-Family Partnership (NFP) in Memphis, Tennessee (low-income, urban African-American women and families), whenever Medicaid provides NFP services to an eligible first-born child, the expected Federal cost savings over a ten-year time horizon exceed the Federal government's costs to provide the services. The reason for this savings is that the program reduced

birthrates and raised employment in participating families, resulting in reduced Medicaid (TennCare) and Food Stamp usage and costs. TennCare services were fully capitated so the savings resulted from differences in eligibility, not differences in health care utilization.

In part because of this evidence, federal funding for Nurse-Family Partnership may become more available if the Nurse Home Visitation Program proposed in President Obama's budget is approved by Congress. Hundreds of cities across the nation already operate Nurse-Family Partnership, and some have found ways to substantially expand services to reach more women while preserving program quality. New York City, for example, is now serving over 2,000 women.

BARRIERS

Once appropriate financing is in place, the most important task becomes maintaining program quality and impact. This requires efforts to recruit and retain qualified nurses, support their learning process as they develop mastery of this distinctive nursing practice, make sure client referral streams are productive, and use program management data to monitor and improve program performance. With advance planning and a strong consulting relationship with Nurse-Family Partnership, all of these challenges can be met successfully.

LESSONS LEARNED

Financing and implementing an evidence-based program at scale requires unique investments in program planning, implementation, quality assurance, and advocacy for sustainability. Typical concerns such as staffing, client engagement and retention, and political sustainability have been met successfully in many urban contexts. We are eager to share these lessons learned and partner with urban MCH leaders to extend the impact Nurse-Family Partnership can have with vulnerable children and young families.

INFORMATION FOR REPLICATION

- Implementation cost for Nurse-Family Partnership is heavily dependent on local nursing salaries. On average, the program costs about \$4,500 per family per year.
- Local programs use a combination of city, county, state, and federal funding, including Medicaid, augmented in some cases by private foundation grants or gifts.
- Key partners often include city or county health departments, hospitals, WIC clinics, schools, family planning clinics, state health or human service agencies and low income families.

The Eco-Cultural Family Interview: Building upon a community-based home visiting program's demonstration of improved birth outcomes by enhancing family care planning

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CATEGORY

Prematurity / Preterm birth / Birthweight
Child growth, development, preventive care

FOCUS

Program Policy Focus

ISSUE

Traditional methods of home visitation and case management are built around questionnaires and yes/no responses of clients. A more effective method identifying the social, economic, and mental health needs of clients is needed, in order to better meet their needs.

SETTING

The Eco-Cultural Family Interview is administered to randomly-selected participants in Milwaukee's Empowering Families of Milwaukee (EFM) program every six months. EFM is an intensive and comprehensive home visitation program. This program was implemented to address startling racial disparities in infant mortality. Pregnant women and their children who reside in a high-risk area of the city are visited by a team of nurses, social workers, and community health workers.

PROJECT

The Ecocultural Family Interview (developed by Dr. Tom Weisner at UCLA in 1994) is an informal, guided conversation with parents about how they run their daily routine – how they organize their daily activities and why. The EFI is based on a family's resources and constraints – their "ecology," and their beliefs and values – the family's "culture." Rather than requiring that a family answer a scripted questionnaire, with finite answers, the EFI allows the family to talk about their lives in their own words.

The EFI Project aims to determine how use of the EFI as a family assessment can better identify the needs of families, and how this information can be used to modify care plans and improve social service

delivery.

ACCOMPLISHMENTS/RESULTS

- Using known social determinants of health, a culturally-appropriate EFI tool has been adapted to fit the EFM population.
- All EFM staff have been trained in the EFI history and protocol, proper equipment use, and effective interviewing techniques.
- Full implementation is underway and preliminary data may demonstrate:
 - Improved psychosocial markers and an increased attainment of identified care plan goals throughout duration of project.
 - Increased utilization of services and resources.

Evaluation Plan:

The EFI project will be able to analyze the qualitative data obtained through the longitudinal interviews and identify strengths and barriers that affect family functioning. In addition, the following quantitative outcome indicators will also be analyzed:

- The number of services or resources provided to the family based on their interview content, and the number of these resources that are used by the family.
- Care plan goal attainment.
- Participants' psychosocial and developmental markers.

A final report will outline best practices for providing care to high-risk families to improve birth outcomes and healthy child development.

BARRIERS

Overall project completion and analysis may be affected by staff turnover and program attrition over the three-year span of the project.

LESSONS LEARNED

Historically, home visiting assessments are scripted question and answer formats. Introducing a guided conversation, with open-ended questions and no finite answers has been an innovative paradigm shift in the way that many home visitors have practiced. Incorporating training, mentoring, and consultation into the implementation of the project will be a key to successful outcomes.

Franklin County Maternal Depression Initiative

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CATEGORY

Mental health

FOCUS

Program Policy Focus

ISSUE

The purpose of the Maternal Depression Initiative is to explore the mental health needs of pregnant and parenting women in Franklin County, Ohio and enhance the system of care.

SETTING

Columbus Public Health's Caring For Two project conducts routine screenings for postpartum depression (PPD.) Screenings are conducted by visiting nurses prior to delivery and within four to six weeks after delivery to help identify antepartum and PPD. Analysis of the Edinburgh Postnatal Depression Scale screens indicated that 36% of mothers are at moderate to high risk for PPD. Intended audience includes pregnant and parenting women in Franklin County.

PROJECT

The Maternal Depression Task Force (MDTF) is a collaborative effort among individuals from the health and social service fields that organized to address the lack of awareness and education regarding depression resources during and after pregnancy. The methodology was a three-pronged approach including:

- Needs assessment – identify how mental health system works and determine how women at-risk for depression are identified.
- Resource assessment – assess availability of mental health services and identify gaps in services.
- Strategic action identification – identify strategies to effectively educate on the severity of maternal depression and develop mental health system improvement plan.

Maternal depression is a critical issue and adversely impacts birth outcomes, infant development, and mother well-being. Our ultimate goal is increased screening and access to mental health services for mothers.

ACCOMPLISHMENTS/RESULTS

The MDTF developed three subcommittees to address the priorities identified: Resource List; Outreach & Education, and Wait Time Studies. The Resource group developed two service provider directories – one for consumers and one for healthcare professionals. The Outreach group developed a PowerPoint education tool for healthcare professionals and organized two trainings to occur in April and June, 2009. The objectives of the trainings are to: discuss symptoms and occurrence of Perinatal Mood Disorders (PMD); identify screening tools used to identify Maternal Depression; list treatment options for PMD; and, identify resources for PMD. The Wait Time group conducted a baseline wait time study in 2008 and will conduct subsequent studies in 2009.

BARRIERS

While we detect possible depression through a proactive screening process, the next steps of referral and treatment are a serious challenge. Mental health referral sources for maternal depression are few and mothers referred experience delays in getting necessary services. Additional barriers identified included: lack of resource awareness; overburdened resources and long wait times; fear of stigma; continuity of care; lack of cultural competency and bilingual services; low appointment show rates; lack of compliance with treatment plan; limited screenings; and lack of transportation.

LESSONS LEARNED

- Our local data are compelling and underscore the lack of community resources available for screening and treating depression for high risk mothers.
- Data highlight a critical community need for a mental/behavioral health partnership that can respond quickly and effectively to maternal depression.
- Untreated depression complicates our efforts to help moms achieve good birth outcomes.
- There's an important role for health department leadership in group facilitation, coordination of intervention, and outcome evaluation.

INFORMATION FOR REPLICATION

- Approximate annual budget is contracted for \$5,500.00.
- Resources: Utilize National Healthy Start funding to cover program planning, development and resources; additional resources include in-kind contribution from task force members, including personnel time to participate in planning meetings and providing space.
- Key partners and stakeholders include the following task force members: Catholic Social Services; Columbus Neighborhood Health Centers; Columbus Public Health; Council on Healthy Mothers & Babies; Dublin Counseling Center; Mount Carmel Health System; Nationwide Children's Hospital; Northwest Counseling Services; Ohio Department of Health; OhioHealth; Ohio State University; OSU Medical Center; and POEM, Inc.

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Chronic disease and MCH (Asthma, Diabetes, Obesity)

Racial and ethnic health disparities

FOCUS

Program Policy Focus

ISSUE

Twenty-three percent of children in Los Angeles (LA) County suffer from obesity and rates of other chronic disease such as diabetes are increasing (County of LA Department of Health Services Public Health, LA Health, 2003). In the general population, 80% of preventable death and disability is associated with chronic disease (LA County Department of Health Services, The Burden of Chronic Disease, 2000). The LA Chronic Disease Management Consortium (CDMC) convenes multiple hospitals together to reduce the high incidence of chronic disease in LA County and to help individuals with chronic disease better manage their disease thereby improving the health of patients and communities.

SETTING

The CDMC is a collaboration of six partnering organizations in LA County including, California Hospital Medical Center, Children's Hospital Los Angeles, Good Samaritan Hospital, Harbor-UCLA Medical Center, Huntington Memorial Hospital and National Health Foundation (NHF). Programs developed by the consortium serve patients of partnering hospitals and their surrounding communities targeting low-income, underserved and uninsured populations. Programs are offered at hospital sites and local community based organizations.

PROJECT

Through a unique collaborative model, the CDMC has successfully developed and implemented multiple chronic disease prevention and management programs (both interventions and education) focusing on diseases that have high rates in hospital communities. To date, CDMC projects include PCAP (Pasadena Community Asthma Project), HELP (Healthy Eating Lifestyle Program), Type 2 Diabetes Program and the planning phase of Heart HELP (cardiovascular disease program). Each program is developed to fit the needs and cultural backgrounds of the target populations; builds upon the experience and successes of the

preceding program; and is implemented by a multidisciplinary team (including physicians, nurses, and promotoras etc.). NHF, an independent non-profit organization, is responsible for facilitation of the collaborative and for data collection and evaluation of programs.

ACCOMPLISHMENTS/RESULTS

Each CDMC program includes robust evaluation from planning through implementation utilizing web-based data collection systems developed by NHF to assess program impact. Data is used by the collaborative to ensure programs are effectively reaching intended goals and outcomes.

Program Outcomes:

- PCAP: Huntington Hospital showed a 30% decrease in pediatric inpatient admissions related to asthma after program implementation.
- HELP: Participants experienced BMI-z score reductions of 0.16 ($p > 0.001$). At follow-up 30% more of children received “good” scores related to knowledge about nutrition and 37% more improved their fitness score (assessed amount of screen time, time spent playing or exercising, frequency of physical activity/wk, type of exercise and number of steps walked).
- Type 2 Diabetes: In Prevention workshops, more than 27% of participants lost weight (4 or more pounds) and 36% reported increasing their knowledge about healthy eating. In the Intervention workshops 65% of participants reported increased confidence in managing their diabetes.

BARRIERS

- Retention rates of class participants throughout the duration of the four to six week programs and soliciting participants to attend follow-up visits.
- Recruitment of participants for prevention focused classes.
- Securing funding for sustaining programs after initial grant is completed.

LESSONS LEARNED

- Implementing programs at local community-based organizations increases participation and retention rates.
- Program implementation by paraprofessionals or promotoras vs professionals can yield more successful outcomes.
- The collaborative model increases impact of programs, helps garner resources and creates more effective programs.

INFORMATION FOR REPLICATION

As a result of its proven success, a replication package, funded by the UniHealth Foundation, was developed for the adoption and implementation of CDMC's HELP pediatric obesity program at other hospital sites and clinical settings. This unique, community-based and proven-effective program reaches children and families in need of obesity interventions and education. The replication package is a step-by-step guide designed for successful adoption of the program and includes materials needed for training, implementation and evaluation. The program was developed to utilize current hospital staff, therefore the cost of replication is relatively inexpensive at approximately \$4,000 (not including staff time). Organizations involved in developing the replication package include California Hospital, Good Samaritan Hospital, Huntington Hospital and National Health Foundation.

Currently, National Health Foundation (NHF) is marketing the replication package locally in Los Angeles County and nationally. Several hospitals have expressed interest in utilizing the replication package and NHF remains in discussion with these organizations.

Building partnerships to promote preconception health

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CATEGORY

Preconception health and health care

Family planning

FOCUS

Program Policy Focus

ISSUE

Preconception health promotion has been adopted by the California Department of Public Health's Maternal Child and Adolescent Health Division (CPPH/MCAH) as an evidence-based strategy for improving pregnancy outcomes. However, to reach women of childbearing age effectively, preconception health promotion efforts must involve multiple programs across and within agencies. Building successful partnerships depends on innovative leaders who reframe the delivery of women's health services—through an open-minded consideration of a woman's reproductive health and her plans for pregnancy across the lifespan—rather than create new programs that may pose a burden in these financially challenging times.

SETTING

The Preconception Health and Healthcare Initiative (PHHI) facilitates the integration of preconception health promotion into existing programs serving the seven million women of childbearing age in California. To reach this ethnically and geographically diverse population, CDPH/MCAH collaborates with its partners in the local health jurisdictions (LHJs) and with community based agencies and clinics that provide family planning services.

PROJECT

CDPH/MCAH has employed a number of successful strategies to further the goal of preconception health promotion in California including:

- Needs assessment with local MCAH programs.
- Building alliances between Divisions within the Department of Public Health, as well as outside organizations, through the Preconception Health Council of California (PHCC).

- Collaboration with the California Family Health Council (CFHC) which oversees the Title X Family Planning Clinics in the state.
- Development of a comprehensive preconception health website.

ACCOMPLISHMENTS/RESULTS

CDPH/MCAH launched everywomancalifornia.org, a website that serves as a hub for preconception health promotion activities in the state. Through its work with the CFHC, CDPH/MCAH is developing a reproductive life planning tool that will become an integral part of the family planning services provided by the Title X clinics by 2015. Collaboration with partners in the LHJs has resulted in a shift in thinking about how we can improve maternal and child health, as evidenced by the fact that preconception health was rated a priority by staff in charge of local MCAH programs. These collaborative efforts have been bolstered by the growing national preconception health movement, which has been reinforced by the CDC and other public health leaders across the country.

BARRIERS

Asking people to change their way of thinking, especially if it has been the standard for decades, is difficult. People worry that new ideas mean more work. State agencies are often rooted in set way of conducting business and may be resistant to change, especially in tough budget times. Transitioning folks to web-based information resources has also presented a challenge since some staff fear technology.

LESSONS LEARNED

We have learned to be open communicators, patient listeners and passionate leaders with a clear vision. We have seen the power of a public/private partnership with broad representation and we have learned to find creative ways around barriers to collaboration that sometimes arise within state government. Ultimately our success lies in emphasizing that we are encouraging a new approach, not a new program, that will better serve mothers and babies in the state.

INFORMATION FOR REPLICATION

This program is funded with our Title V monies. We can give more information about the budget and the stakeholders who have shaped the Initiative (members of the PHCC primarily) during our presentation.

Giving voice to African American women in shaping health disparity inquiry

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CATEGORY

Infant mortality and morbidity
Racial and ethnic health disparities

FOCUS

Data Focus

BACKGROUND

In Wisconsin, infants born to African-American women are three to four times more likely to die before their first birthday than infants born to white women. Around 2002, African American infant mortality declined dramatically and achieved rates comparable with Whites in the City of Madison and Dane County. Public Health-Madison & Dane County (PHMDC) is a partner in a larger collaborative research project to better understand this phenomenon.

OBJECTIVES

Our goal is to give voice to African-American women and community members in order to generate hypotheses that will shape research involving African American infant mortality. We hope to illuminate the experiences and perceptions of African-American women, and to identify community-level factors or variations in healthcare practices that might account for the apparent improvement.

METHODS

As a preliminary effort, PHMDC conducted two focus groups made up of African American women. The first group included eight women who had some historical perspective of childbearing in Madison and Dane County prior to the year 2000. All participants in the second group experienced their pregnancies and gave birth after 2002. Participants were asked about their life course as well as experiences with healthcare, family, community, and their perceptions of race and racism. Additionally, 22 individual interviews were conducted with providers, community members and African-American women to fill in gaps and pursue themes suggested by the focus groups. All activities were filmed.

RESULTS

Themes around race, poverty, healthcare, fathers, and community emerged, and the construct of resilience has been especially noticeable in the younger participants. Footage from the focus groups and interviews has been used to develop a mini-documentary that will be shown at local events to encourage awareness and dialogue among community members, stakeholders and providers. This will shed light on the lived experience of African Americans in our community and generate suggestions to explore. This process will assure community engagement and awareness of the larger ongoing research project.

LIMITATIONS

Many lessons were learned in this process about the importance of choosing an appropriate setting, format, and moderator when conducting sensitive interviews. Our findings may be limited by some characteristics of the participants or through the context of our inquiry. Sampling through social networking, the ideological dispositions inherent in issues of race and infant mortality, and assumptions about what is known and what must be revealed could all contribute to bias and gaps in data. This would be strengthened through more random recruitment of participants, a more longitudinal approach, or if replicated in a similar-sized population with different birth outcomes.

CONCLUSIONS AND IMPLICATIONS

Our participants report deep satisfaction in their relationships with providers, and the construct of resilience is a consistent theme throughout the interviews. Identifying factors that foster resilience could help us to develop programs that promote resilience as a means of health promotion. It is important to also identify healthcare providers' actions and attitudes that cause African American women to feel valued and respected. Promoting these factors might lead to a reduction in many health disparities and improved population health overall.

Health care providers and preconception counseling: An evaluation of a folic acid education program in North Carolina

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CATEGORY

Preconception health and health care
Birth defects

FOCUS

Program Policy Focus

ISSUE

North Carolina has had historically high rates of neural tube defects (NTDs), up to 70% of which can be prevented if women of childbearing age take adequate amounts of folic acid prior to pregnancy. Only one-third of women ages 18-45 report that their provider has discussed folic acid with them.

SETTING

In North Carolina, health care providers in private practices and public health centers participate in trainings offered by the North Carolina Folic Acid Campaign.

PROJECT

In the Office Champion program, health educators called regional coordinators train health care providers to talk to their female patients about taking multivitamins with folic acid during their childbearing years. The program provides an in-office training and the appointment of a folic acid "office champion" (usually a nurse) who volunteers to promote the folic acid message in the provider's office. In addition to basic folic acid facts, the training addresses how and when to talk with women about folic acid. Office Champions then remind clinicians to talk to patients about folic acid and coordinate the distribution of educational materials for patients. Regional coordinators maintain contact with Office Champions to share new research and folic acid materials, providing a personal connection between the Campaign and local health providers.

ACCOMPLISHMENTS/RESULTS

More than 500 practices have been trained by this program since 2003.

An internal evaluation took place in 2007-08 and included key informant interviews and a pre-post design survey of private practices. A total of 280 providers (physicians, mid-levels, and nursing staff) completed a pre-intervention survey; 104 providers completed a second survey 3-6 months after the intervention (training).

The program was effective in increasing provider knowledge about folic acid and unintended pregnancy. The program also increased the proportion of providers who reported counseling women about folic acid from 51% to 67% at annual exams and from 48% to 60% at routine visits. The survey identified the most commonly discussed preconception health topics: folic acid, tobacco, alcohol, and nutrition/exercise.

BARRIERS

- Securing an appointment to provide training for a private practice can be challenging.
- The success of the program in a specific practice often relies on the commitment of the Office Champion.

LESSONS LEARNED

- In-office trainings can influence provider knowledge and counseling behaviors.
- This program can reach many more women than a traditional public health campaign; each provider who receives the training has the potential to reach hundreds of women.
- Rural practices are more receptive to this type of program than urban practices due to more flexible scheduling and less attention from pharmaceutical representatives.
- Trainings need to be kept short: 15-20 minutes. Many practices expect to receive a snack or lunch.
- An important role of health educators is to facilitate dialogue during the training about who is responsible for providing preconception health education for patients and how that can best be accomplished.
- Multiple visits rather than a single training by a regional coordinator can improve an office's ability to promote preconception messages such as folic acid appropriately to female patients.

INFORMATION FOR REPLICATION

This program is one component of a comprehensive folic acid campaign in North Carolina. Funding comes from a Vitagrant settlement and ongoing state support. Many partners collaborate, including the state health department (contract administration), a statewide MCH health non-profit (materials production), and March of Dimes (program administration).

Reinventing MCH: Taking a leadership role in your local health department

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CATEGORY

Other: Innovation in Leadership

FOCUS

Program Policy Focus

ISSUE

Reinventing Maternal and Child Health is a task that each of us needs to be actively involved in at the local level. This requires the ability and confidence to inspire and create innovation in practice. As we refine and define the ways in which we want to refocus the directions of our work in MCH, we need to hear from one another about what has worked, what has not, and how do leaders “stay the course” when it looks like the course will be bumpy and treacherous.

SETTING

The Family Maternal and Child Health Programs are part of Contra Costa Health Services. Contra Costa is a large urban/rural mix county in Northern California, just northeast of San Francisco. Our county has about 13,000 births a year with a population of approximately one million. It is a diverse county with a mix of people from different ethnic, social and economic backgrounds.

PROJECT MODEL

The focus of this presentation is the implementation of a 15-year initiative designed to reframe our work in MCH and make a paradigm shift in our approach to improving birth outcomes and reducing disparities in health among our population of families, women, youth and children. The aim of this project was to refocus the directions of our MCH related programs in light of growing social and economic disparities in order to develop an MCH agenda that reflected and embraced an understanding of social justice and health equity, with the Life Course Perspective as the guiding framework.

ACCOMPLISHMENTS/RESULTS

In 2005, we launched the Life-Course Initiative. To date, we have conducted multiple staff trainings, secured buy-in from key leadership, engaged our community partners, and developed and implemented a financial security project designed to integrate the key concepts of the Life-Course Perspective into our day-to-day practice. Getting to this point has taken considerable work, planning and focus. It has also required the use of leadership techniques, theories, and skills aimed at creating a community that was open to and willing to change.

BARRIERS

Making change at a local health department takes time. People have been operating under a particular way of thinking for several decades, and suggesting that they change or consider new directions can be complicated and challenging. The primary barriers had to do with staff worrying that making this paradigm shift would require more time for them to do their work and that “we are just a health department, so how can we really make a difference with this new perspective?” Open and candid discussions focusing on staff and community partners’ concerns were enormously helpful in shaping the Initiative and the collaborations that have resulted.

LESSONS LEARNED

Participants talk candidly about their struggles in introducing innovation and the lessons they have learned from doing so, their “survival tips.” Introducing innovation and change requires a range of leadership skills, the ability to be flexible while maintaining your vision, and the capacity to trust that the direction you are seeking to move in will benefit your staff, your programs, and the community of families, women, children and youth you serve.

Child Health Liaison Program: A modified approach in El Paso County, Colorado

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CATEGORY

Child growth, development, preventive care

FOCUS

Program Policy Focus

ISSUE

In the United States, 58% of mothers with children younger than six years of age are in the labor force. Of these children, 85% are cared for in non-parental care arrangements. Given the significant percentage of children served in these settings, healthy and safe child care environments are critical to the well-being of this population. In Colorado, early childhood education staff has minimal health and safety training and the state's child care licensing requirements are not equivalent to the National Health and Safety Performance Standards.

SETTING

This community-based pilot project took place in El Paso County, Colorado. Twelve sites targeted were licensed child care centers/preschool programs that serve children four years of age and younger. In total, the intervention sites served 1,275 children and employing 230 staff. Thirteen Child Health Liaison (CHL) candidates were chosen from the 12 programs, and included an owner, director, assistant director, assistant coordinator, health liaison, and classroom staff.

PROJECT

CHL is a 10-month program designed to improve the quality, health and safety in early care and education (ECE) settings. Our program was modeled after a CHL program first developed by Boulder County Department of Public Health. CHL assignees served as health champions and advocates within their facility, working in partnership with other staff members and families. CHL assignees attended monthly standardized trainings, and received on-site mentoring for the implementation of targeted health and safety practices and center based policy changes.

Project planning solicited community stakeholders, including a crucial partnership with El Paso County's Early Childhood Council, which was looking for ways to integrate health into comprehensive early care

and education programs in our county.

ACCOMPLISHMENTS/RESULTS

Data were collected regarding changes in:

- Health and safety knowledge.
- Learning environments.
- Provider practices in targeted intervention areas, using pre- and post-training tests, on-site observations and surveys.

Pre- and post-test scores showed modest increases in mean scores for 7 of 10 modules. Changes in learning environments were assessed using the ECERS-R (Early Childhood Environmental Rating Scale-Revised) and ITERS-R (Infant and Toddler Environment Rating Scale-Revised), specifically using the ‘Personal Care Routine’ subscale. Center-based programs improved on post-test environment rating scales, but only ECERS-R scores showed statistically significant increases.

Several targeted interventions were noted:

- An increase in compliance with immunization documentation from 83.4% to 88.2%.
- 73% of CHLs stated they improved nutritional value of their center’s menu.
- 73% of the CHLs reported having more educational materials on health or safety accessible in the center
- An improvement in hand washing practices.
- Integration of health and safety resources for families.

BARRIERS

- High turnover in classroom staff made implementation of the program challenging.
- Participants reported resistance to practice changes amongst classroom staff.
- Financial constraints were a significant barrier to improvements in the centers.

LESSONS LEARNED

- Local early childhood councils and ECE providers are essential partners for integration of health initiatives into early childhood systems.
- Stipends and incentives help avoid high attrition, but are difficult to sustain.
- Mentoring is an essential component for a successful CHL program.

RESOURCES

- MCH block grant funds.
- Private sources: Pikes Peak Community Foundation.

KEY PARTNERS/STAKEHOLDERS

Alliance for Kids-El Paso County's Early Childhood Council.

Innovative solutions for HIV, STD, and teen pregnancy prevention: Program integration

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CATEGORY

Adolescent health / pregnancy prevention

FOCUS

Program Policy Focus

ISSUE

Many states implement efforts to address HIV, STD, or pregnancy prevention among school-aged youth; however, agency structures, funding requirements, and limited time can inhibit collaboration and coordination between various programs. In this time of economic uncertainty there is greater need to increase collaborative efforts, pool and leverage resources, increase communication between a variety of stakeholders, and use new technology to effectively implement innovative solutions to prevent HIV, STD, and pregnancy among adolescents.

SETTING

The National Stakeholders Meeting (NSM), designed by the National Stakeholders Collaborative (NSC), a partnership between the Association of Maternal and Child Health Programs, the National Alliance of State and Territorial AIDS Directors, the National Coalition of STD Directors, and the Society of State Directors of Health, Physical Education and Recreation, is a capacity-building process that brings together state health agencies, state education agencies , and other stakeholders to strengthen communication and collaboration and to improve HIV, STD, and teen pregnancy prevention among adolescents.

PROJECT MODEL

Since 2003, with support from the Centers for Disease Control and Prevention - Division of Adolescent and School Health (CDC/DASH), 33 teams have participated in NSMs, three day capacity building meetings supported by nine to 12 months of technical assistance.

The process is designed to help stakeholders:

- Increase communication and collaboration.
- Articulate a shared vision.
- Identify current programmatic and policy gaps.
- Develop innovative collaborative ideas.
- Create state specific action plans.
- Build capacity around important issues such as: youth development, funding for collaborative projects, policy and advocacy, disparities, best practices, and engaging hard to reach youth.

ACCOMPLISHMENTS/RESULTS

The process has not only led to the development of trusting relationships between state health and education agencies, and other stakeholders, but has also led to data sharing, collaborative action planning, reconciliation of differing philosophies, improvement of communications, increased parent and community support for youth access, and development of innovative programs for addressing reproductive and sexual health among adolescents. For example, websites and technology campaigns have developed out of the collaborative efforts in states such as Missouri, where they launched an outreach campaign using social networking sites, and California where they provide youth with access to online reproductive health information through community partners.

Evaluation Plan:

Retrospective pre-post surveys are conducted by an outside evaluator with all participants after the events, and after the technical assistance follow-up period (9-12 months). In 2010, qualitative interview will be conducted with participants.

BARRIERS

Barriers to collaboration include time, resources, competing priorities, lack of communication, inability to meet face-to-face, and silo funding structures.

LESSONS LEARNED

NSMs can help strengthen communication and collaboration between state departments of education and health, and other stakeholders. Specifically, integrated data sets facilitate the development of well-informed plans required by all MCH programs, new channels of communication create new opportunities, programmatic synergy results from a track record of collaboration and networking, and new/strengthened partnerships provide increased access to staff, expertise and resources otherwise unavailable.

Community coalition building through PAR models for children and youth with special health care needs

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CATEGORY

Other: Community based systems of care and support for families with children with special health care needs

FOCUS

Program Policy Focus

CONTENT

Children and youth with special health care needs constitute 16-20% of the U.S. population under the age of 25. Champions for Inclusive Communities (ChampionsInC.org), funded through the U.S. MCHB, serves as a research and development support center for state level MCH/CYSHCN programs. State and local communities across the country are working with us in building systems of care and support for CYSHCN. Our data document the process of coalition building and the effectiveness of community coalitions in this systems building effort as well as the resource they provide to families. Coalitions as private/public partners (including parents and youth) have demonstrated the effectiveness of coalition building for this population. It cross-cuts public and private services/parent-provider partnerships/pediatric medical homes, educational settings and inclusion in the life of the community in which these children and their families live.

In this presentation, case studies of communities of excellence will be highlighted and used as models for systems building efforts. We are in the process of selecting at least one site to co-present this work with more specifics on how they work together and problem solve the issues they face. The communities to be highlighted represent a range of ethnicity, size, resources and geography. The individual efforts are funded in a variety of ways and represent the full spectrum of ethnicity, size, collaboration and effectiveness.

If accepted, depending upon the amount of time our session will be provided, we have selected coalitions from several different locales to present with us. The focus of the overall symposium will demonstrate

how coalition-building forms strong ties and builds better safety nets for children and families with special health care needs. In addition to the relationships that are fostered, concrete outcomes can be demonstrated as a function of coalition activities. Many of the coalitions we are following use a PAR approach in problem-solving. In general they have better family-provider partnerships, are able to be more flexible and resilient in changing circumstances and have at least rudimentary continuous quality improvement processes to guide their work.

INFORMATION FOR REPLICATION

We are in the process of doing a cost study as part of our work with several communities. We will be able to present preliminary data on costs and budgets by the time of the conference

Providing Tdap vaccines to postpartum women to reduce pertussis in newborns

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CATEGORY

Infant mortality and morbidity

Infectious disease and MCH

FOCUS

Program Policy Focus

ISSUE

Pertussis cases in Salt Lake County have increased by over 300% since 2006. Pertussis is highly contagious in unvaccinated infants. Recent studies have shown that about half of babies with pertussis get the illness from their parents. An additional 25% to 35% get the illness from another household member. Pertussis can be very serious in infants and young children by causing pneumonia, seizures, and even death.

SETTING

Health officials are now urging new mothers to protect their newborns by getting vaccinated themselves against pertussis. CDC says that new parents, especially mothers, should receive the Tdap vaccine before taking their babies home from the hospital. Despite the availability of Tdap in hospitals, many new mothers leave the hospital without receiving the vaccine because they did not understand the purpose of the vaccine.

PROJECT

The Salt Lake Valley Health Department has instituted a project to ensure that all mothers of newborns receive information about the Tdap vaccine. This education is provided at all WIC clinics, and at the two Health Department Clinic sites where prenatal services are housed. Public Health Nurses teach about the importance of Tdap when doing home visits where there is a young child. In addition, all adults presenting for Immunization services at a Health Department Clinic are asked about their Tdap status and educated about the importance of receiving the vaccine, even if they are not the ones presenting for immunization services.

ACCOMPLISHMENTS/RESULTS

Many women are unable to pay for a Tdap vaccine after leaving the hospital because of not having insurance or Medicaid. As a result, we have provided outreach to area hospitals about the importance of providing education and offering Tdap vaccination prior to leaving the hospital. In addition, we have worked with both medical providers for OB and for pediatrics to provide education to women during antepartum about the importance of Tdap and requesting that pediatricians and other pediatric healthcare providers discuss Tdap with parents when the infant is brought in for newborn care.

We are working to receive doses of Tdap for unfunded women receiving prenatal services at one of our Health Department Clinics. The goal is for 100% of postpartum women in Salt Lake County to receive education about the importance of receiving Tdap to protect their newborn against pertussis. The project has just started in 2009 and we have already seen increases in the number of postpartum women receiving education about the importance of Tdap.

BARRIERS

We have not had a budget for this project. We are relying on partnerships with the medical and public health community to get this important message to postpartum women. We provide education on Tdap to adults receiving services from any of the programs in our Division. We have utilized local media to help spread the message, email tags, fax pages and web links to spread our message.

Honey Child Prenatal Education Program: A faith-based model designed to reduce disparities in birth outcomes among African American women

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CATEGORY

Faith and health
Racial and ethnic health disparities

FOCUS

Program Policy Focus

ISSUE

According to information from the March of Dimes Perinatal Data Center, the rate of preterm births in the United States is highest among African-American infants (17.8%), followed by Native Americans (13.4%), Hispanics (11.8%), Caucasians (11.3%) and Asians (10.4%). Prematurity/low birth weight is the leading cause of death for African-American infants.

SETTING

To address this disparity, the March of Dimes Texas Chapter launched the Honey Child Prenatal Education Program in 2006. Honey Child is a faith-based prenatal education program that couples group education and mentoring to mediate risk factors associated with preterm births in African American women. In 2008, the March of Dimes Texas Chapter piloted Honey Child in five churches in Texas.

PROJECT

The church provides a trusted site conveniently located within the neighborhood to focus on health promotion. Group facilitators and mentors are drawn from local churches. The program is intended for use by lay facilitators and mentors who have received specialized training from the March of Dimes Texas Chapter's staff and volunteers.

The intervention takes place in a church setting and targets African American pregnant women with a specific focus on women ages 18-36. The Honey Child prenatal curriculum includes six two-hour sessions. Topics include nutrition, stress reduction, prenatal care, self-esteem, preterm labor, and labor and delivery. The mentor's role is critical in not only providing social support but also providing gentle accountability for positive health behaviors outside of the sessions. The program uses incentives as a way

to promote health behaviors through positive reinforcement for participants and a stipend for program coordinator and host church.

ACCOMPLISHMENTS/RESULTS

Phase I: Development of manuals for Honey Child coordinators, facilitators, mentors and participants completed in 2007-08. Self administered data collection instruments (enrollment survey, knowledge and stress survey pretest and post test, satisfaction survey and post intervention survey) gained IRB approval.

Phase II: Implementation of Honey Child in five churches in Texas.

Preliminary results of Honey Child 2008 –

- 83 percent of participants showed a statistically significant increase in knowledge from baseline to follow-up, with 53 percent showing a 20% or greater increase in knowledge.
- Approximately 91% were full term, nine percent were born before 37 weeks, and 1.9% born less than 32 weeks of gestation. The mean age was 38.4 weeks.
- There was a statistically significant inverse correlation between perceived maternal stress and social support. As social support increased, maternal stress decreased.
- On a scale of one to 10 (1 being worst and 10 being best), the participants gave the Honey Child Prenatal education experience an average score of 9.5.

BARRIERS

Faith-based organizations gaining access to participants in public health organizations caused recruitment goals to not be reached.

LESSONS LEARNED

Successful implementation requires African-American faith-based leadership, involvement, input and ownership. The gains in knowledge are important as the participants share this knowledge with their social networks thereby increasing and expanding the role of Honey Child.

Midnight spa parties: An innovative way to provide preconception health information to college-aged African American women

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CATEGORY

Preconception health and health care
Racial and ethnic health disparities

FOCUS

Program Policy Focus

ISSUE

African American women with a college education have similar birth outcomes of white women without a high school diploma. Traditionally young women attending college have not been included in campaigns to impact infant mortality. This project is aimed at targeting this forgotten population using an age-appropriate, fun venue to deliver key preconception health/wellness information

SETTING

These events take place on college campuses with a large number of African American women. In Nashville, Historically Black Colleges and Universities have been utilized. The participants are primarily students on the campus, but the event also draws young women from the surrounding community.

PROJECT

These model events are a part of a larger project in partnership with the Federal Office of Minority Health to train college students as peer educators, and to have them plan, and execute events in their community around preconception health. The events are designed for participants to receive education on issues such as:

- Protecting the Girls: Breast Health,
- Oh! No He Didn't Hit Me!: Domestic Violence on campus,
- What's in Your Genes?: Knowing Your Sickle Cell Status,
- The Freshman 15: Nutrition for College Students,

Screenings are also available for:

- STD/HIV,
- Pregnancy,
- Fitness,
- Blood pressure and diabetes,

Other topics/ Services provided:

- Keeping the Do Done: Taking care of natural hair,
- Managing Debt: Financial Planning,
- Chair and hand massages,
- Yoga,
- And much more

Participants complete a health assessment upon entry to the event, visiting educational tables for small group sessions that rotate every 20 minutes, or screening tables. Participants can go in whatever order interests them. Spa services are available first come/first serve. Each education session, screening or other service earns the participant a stamp. Stamps are redeemable with an event evaluation upon exiting for t-shirts, bags, and other give aways. Each participant receives a one-on-one review of their health assessment and a statement of their potential birth outcomes based if they were to become pregnant now on their individual score

ACCOMPLISHMENTS/RESULTS

The Health Assessment information is used to determine the kind of educational information needed at future events. The exit survey has shown this to be a very effective way of getting health information out to a hard to reach generation. Currently, a pre and post-test to assess knowledge acquisition is being tested.

Evaluation Plan: These events have resulted in over 200 young women receiving a preconception health assessment, as well as important health/wellness information. These assessments have clearly shown how much this information is needed. Samples of some of the results follow:

- 74% of all attendees have scored in the moderate risk category.
- 10.9% report having been physically abused.
- 12.9% report having had an STD in the past.
- 34% report having had a pregnancy scare.

INFORMATION FOR REPLICATION

Budget: \$2,000 per event

Resources: Student event monies on Campuses, and “creative financing”

Key Partners: Public Health, Academic Institutions, High Profile student groups on campus

Poster Presentations

Improving perinatal-infant oral health

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CATEGORY

Child growth, development, preventive care

Other: Perinatal health care

FOCUS

Program Policy Focus

ISSUE

Oral health is a key component of overall health and wellbeing for women across the lifespan, and a mother's oral health status is also important because of its relationship to the health of her child. Dental treatment is safe during pregnancy; however many women do not access care throughout the perinatal period. There is a need for greater educational efforts to increase awareness among women of the importance and safety of dental treatment during pregnancy, as well as among providers who treat or refer women during the perinatal period.

SETTING

This Project is a five-year national initiative that targets American Academy of Pediatric Dentistry (AAPD) membership, prenatal and dental providers, maternal and child health professionals, policymakers, pregnant women and parents, and the general public, seeking to improve awareness of several key audiences simultaneously and to improve access to oral health care for pregnant women and infants.

PROJECT

Intervention components include:

- Educating prenatal and oral health providers on the safety and importance of oral health care during pregnancy, and encouraging referrals to care through promotion and dissemination of the New York State Oral Health Care During Pregnancy and Early Childhood Practice Guidelines.
- Capacity-building to effectively address perinatal oral health within AAPD leadership and membership, and facilitating educational opportunities for AAPD membership and other dental professionals in treating pregnant women and young children.
- Promoting the preventable and infectious nature of dental caries to MCH professionals and the public to increase their knowledge and actions in preventing dental disease, and to encourage women to access care

before, during, and after pregnancy.

- Educating policymakers on the importance of adequate public and private insurance coverage for oral health care for women in the perinatal period.
- Educating families, health care and child care providers, and others who come in contact with young children about dental caries- including how to prevent the disease and manage it after onset.

ACCOMPLISHMENTS/RESULTS

Several key documents were developed collaboratively and disseminated to over 4,000 stakeholders nationally. These include the abridged New York State practice guidelines for prenatal and oral health providers, as well as a policy brief and consumer document. Many other resources targeting pregnant women, parents, and the public have been developed and disseminated. New partnerships have been developed with diverse MCH organizations to reach these populations. A website has been created, and numerous clinical educational opportunities have been provided to pediatric and general dentists to encourage treatment and referral of pregnant women and infants. Anticipated results include an increased awareness of the importance and safety of oral health care during pregnancy among prenatal providers and oral health providers, leading to increased coordination of care and greater access to treatment. Anticipated results also include increased awareness of the importance of oral health and the safety of dental treatment during pregnancy among pregnant women, as well as among maternal and child health organizations, policymakers, and the general public.

FIMR/HIV pilot project- initial findings

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CATEGORY

Infant mortality and morbidity
Infectious disease and MCH

FOCUS

Program Policy Focus

ISSUE

Perinatal HIV transmission is a sentinel health event. Many HIV-exposed infants become infected due to missed prevention opportunities. The FIMR/HIV Pilot Project (FHPP) is a methodology to adapt the Fetal and Infant Mortality Review (FIMR) process to identify and address missed perinatal HIV prevention opportunities and improve the health and well being of HIV-positive pregnant women in three pilot communities.

SETTING

The pilot projects were located in communities with high rates of HIV infection among women of child bearing age. Each project site consisted of a partnership among HIV/MCH programs (including a robust existing FIMR program), health care providers, and community leadership.

PROJECT

Over a two-year period, each of the pilot sites identified and reviewed between 25-35 cases of perinatal HIV exposure that met the criteria established for the project. Project staff abstracted information from the mothers' and infants' medical records and conducted maternal interviews to identify gaps in care and missed perinatal HIV prevention opportunities. Cases were reviewed and evaluated by an independent case review team (CRT) that made recommendations for systems improvements. A community action team (CAT) was convened to implement those recommendations.

This program was developed through a collaboration of the Centers for Disease Control and Prevention, CityMatCH, the American College of Obstetricians and Gynecologists, and the National Fetal and Infant Mortality Review program along with the invaluable insight and contributions of the pilot sites.

ACCOMPLISHMENTS/RESULTS

All three pilot sites completed the required number of case reviews and held regular CRT meetings. CATs made recommendations that resulted in positive changes in all three project communities.

BARRIERS

- A lengthy IRB process,
- Access to HIV/AIDS data,
- Budget and time constraints.

LESSONS LEARNED

- Using the FIMR methodology increases and strengthens the partnership between MCH and HIV, resulting in improvements to systems of care for women.
- Having representation from both the MCH and HIV fields and a diverse membership in the makeup of the CRT and CAT is essential.
- Implementing a two-tiered system—a CRT to identify potential improvements and a CAT to carry out improvements—is critical.
- Conducting maternal interviews produces a wealth of qualitative information not available in the medical records and provides a unique and powerful opportunity for the mother to share her experiences.

PUBLIC HEALTH IMPLICATIONS

CDC is continuing to support the FIMR/HIV methodology. Participating partners are providing fiscal support to new project sites and are developing a FIMR/HIV Learning Community & Resource Center.

Utilizing new technology to facilitate home visiting, data collection, and quality assurance

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CATEGORY

Preconception health and health care
Infant mortality and morbidity

FOCUS

Data Focus

BACKGROUND

Healthy Start, Inc. utilizes a multidimensional approach for service implementation to women, men and children with the goals of reducing infant mortality, poor birth outcomes and elimination of health disparities. Relying on the multidisciplinary teams consisting of outreach workers, nurses, social workers and various specialists, program staff develops sound strategies with the assistance of best model practices, data abstraction and evaluation to address areas of concern in an identified project area. By using portable computers, Healthy Start, Inc. can capture the data accurately, save on printing costs, and evaluate the data accurately.

OBJECTIVES

To provide audience members with an outline on how to simplify data collection processes through the use of new technology available to home visiting programs, and to provide a description of the Healthy Start, Inc. model of utilizing data collection and abstraction on health and social issues disparately effecting women of color in targeted communities resulting in specific outreach and case management strategies to promote positive outcomes for women and their families.

METHODS

Audience will receive specific examples of the Participant Information Management System used by Healthy Start including an interactive demonstration, as well as program strategies and outcomes resulting from data analysis, both quantitative and qualitative. Audience will also receive examples of products/ resources used to coordinate care for consumers including male-based programming, depression screening tools, database equipment and evaluation reports.

RESULTS

By using portable computers, Healthy Start, Inc. can capture and download the data accurately and quickly, save on costly printing costs and in turn save paper, and evaluate data accurately.

LESSONS LEARNED

Audience will receive best practice model concepts including program design, specific case management tools and examples, evaluative assessment items and take home packets outlining the poster session.

Does condom use at last sex inform about condom use at sexual debut? Analysis of the National Survey of Family Growth, Cycle 6

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CATEGORY

Adolescent health / pregnancy prevention

FOCUS

Data Focus

OBJECTIVES

The first aim of this study is to investigate the observed association of condom use at last sex and condom use at sexual debut in young adult females. The second aim of this study is to assess differences in condom use behavior by race. The third aim of this study is to assess the effect age at sexual debut and number of sexual partners has on condom use at last sex.

METHODS

Secondary analysis was performed on the National Survey of Family Growth (NSFG). The analytic sample was limited to women reporting ever having vaginal sex with a man, having vaginal sex with a man in the previous 12 months, and women under 25 years. Respondents with missing or invalid data on the dependent variable were excluded from analysis. The final analytic sample size following descriptive analysis was 917. STATA 9.0 was employed for the analysis of these data. Frequency and chi-squared analyses were conducted on the appropriate collapsed variables. Person correlation was also performed to assess and control for continuous variables that may be highly related. Cross tabulations and logistic regression analyses were used to evaluate the stated associations.

RESULTS

The mean age was 20.8 years (range, 15-24). Women self-identified as White (59%), Black (16%), Hispanic (20%), and Other (4%). The mean years of education were 12.4 years (range 9-19). Fifty-seven percent of women were never married, 22% were currently married and 18% reported cohabitating. The average age for initiating sex was 16.5 years while the mean number of years having sex was 4.4 (range 0-12). On average women reported having one sexual partner in the last 12 months (range 0-1), but averaged approximately 3.5 sexual partners since sex initiation (range 1-50). Nearly half of the respondents reported condom use at sexual debut and nearly half reported ever testing for HIV. Interestingly, only 35% percent reported using condoms at most recent sex in the last 12 months. Results

of the logistic regression show the odds of using a condom use at 1st sex are 2.68 times higher if women reported condom use at last sex than if they did not after controlling for other variables.

CONCLUSIONS/IMPLICATIONS

The findings in this study support the hypothesis that there is an association between condom use at last sex and condom use at sexual debut. The results of this study also illustrate significant differences in condom use at last sex between Black women and White women, thus supporting the second hypothesis that condom use at last sex differs by race. Comprehensive sexual education that addresses not only abstinence

but also safer sex options should be employed prior to sexual debut in adolescents. Over time, regular practice of condom use may form a habit of consistent condom use. Efforts to prevent the further spread of HIV in minority populations should continue, as Black women reported higher condom use than White women. Additional research should also analyze trends of condom use behaviors over time by assessing previous cycles of the NSFG.

Preconceptual body mass index (BMI) and its impact on birth outcomes

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CATEGORY

Preconception health and health care

Prematurity / Preterm birth / Birthweight

FOCUS

Data Focus

BACKGROUND

Intra-conceptual health is an important part of having healthy or positive birth outcomes. The health of the mother before pregnancy is an important component of having a healthy baby. Studies have shown that women that are healthier before getting pregnant are more likely to have positive birth outcomes compared to women that have negative health problems. Getting women to be at a healthy weight for their height is especially important, component of health.

OBJECTIVES

To examine the impact of pre-pregnancy Body Mass Index (BMI), on birth outcomes such as low birth weight and prematurity.

METHODS

Vital Statistical Records for Orange County, Florida from 2006 to 2008 were used for the analysis. In total, 56,627 births and their respective outcomes were included in the study. The birth outcome variables under consideration included prematurity (gestation less than 37 weeks) and low birth weight (birth weight > 2499 grams).

Using the Centers for Disease Control and Prevention's recommendation for BMI categorizations, women were grouped into 4 categories, underweight (BMI <18.4), Normal weight (BMI 18.5-24.9), Overweight (BMI 25.0-29.9) and Obese (BMI 30.0+). Estimated birth weight 90 days before pregnancy was used to calculate the pre-pregnancy BMI. Women with missing information for any of the relevant variables were excluded from the study.

Mean differences in low birth weight and prematurity was measured using ANOVA. Analysis of the dataset was performed using SPSS 13.0.

RESULTS

Among the underweight women 14.2% had low birth weight babies, as compared to 10.1% for Normal weight women, 9.6% for overweight women, and 11.6% for obese women. There was no significant difference in low birth weight outcomes between the normal and overweight women.

Underweight and obese women had a statistically significant greater percentage of premature infants (15.5% and 16.8%) respectively as compared to normal weight women 12.8% and overweight women 13.4%.

LIMITATIONS

One of the main limitations to this study is recall bias introduced through self-reported pre-pregnancy weight.

CONCLUSIONS/IMPLICATIONS

Women, who were either obese or underweight, had statistically significant higher percentages of premature and low birth weight infants as compared to women who were normal or overweight prior to their pregnancy. Most public health messages are geared towards encouraging women to lose weight, but there should a concerted effort to encourage underweight women to achieve a healthy weight as well.

The role of faith in family planning for southern African-American women

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CATEGORY

Faith and health

FOCUS

Data Focus

BACKGROUND

African-American women in the Southeast United States face inexplicably higher rates of unwanted pregnancies and negative birth outcomes. Although statistical data indicate that religion does not correlate with whether or not adult women use contraception, our preliminary qualitative research indicates that religious/spiritual/cultural findings may mediate some activities which underlie choices women make – consciously and subconsciously- about their sexuality, partners, and family formation.

OBJECTIVES

We conducted a survey of low-income, African-American women regarding how faith affects their reproductive health decision making. We hypothesized that they would

- Demonstrate a high level of religiosity and spirituality.
- Demonstrate a positive correlation between religiosity, spirituality and use of highly effective contraceptive methods.

METHODS

We collected data for three weeks from women attending Women, Infant and Children (WIC) programs clinics at two urban, metro-Atlanta health clinics. The survey included questions on contraceptive usage, family planning, religious attendance, religiosity/spirituality scales, and demographics. 441 women, ages 19-49, participated in the study, including 378 women who self-reported as African-American or Black Caribbean (79.89% Christian affiliation, 5.29% Muslim affiliation, and 7.14% other or no affiliation).

RESULTS

Low-income, African-American women showed a very high level of spirituality (mean value = 59.5 out of 14-75 scale) and moderate religiosity (mean = 11.8 out of 4-24 scale), which appeared to be tied to their beliefs about contraceptives. A one-point increase on the religion scale indicated an 8.7% decreased

likelihood in using highly effective contraceptives ($p=.015$); spirituality was not a significant predictor. Additionally, 24.34% of respondents indicated that at least one method of contraception was against their religious beliefs, although only 1.32% reported that their beliefs actually prevented them from using a contraceptive method suggested by a provider. The majority of respondents, 58.20%, believed that their religious institution would be supportive of their family planning choices, although 24.60% indicated that they would leave or switch their faith institution if their family planning choices were not supported (as opposed to not discussing choices publicly), indicating the importance of religious institutional support.

LIMITATIONS

The study is limited by a relatively small sample size, comprised primarily of Christian women.

CONCLUSIONS AND IMPLICATIONS

Religion and faith play a mixed, but important role in the reproductive health decision making of low-income, African-American women and should be considered when developing interventions. Religion can have a two-pronged impact on reproductive health issues such as unintended pregnancy and contraception. On an individual level, religious views and spirituality may influence a person or couple's decision-making about contraceptives, choices about when and how to have a family, and a myriad of other health decisions faced on a daily basis. At the community level, faith institutions have the potential to be very influential in areas of education, counseling, and establishing community norms – whether from the pulpit, in spoken values shared through adult education classes, or unspoken values shared among a religious community. Given the great importance of religion and spirituality to this population of low-income, African-American women, incorporating faith values and institutions should be considered in effective outreach programs.

The effect of chronic illness on barriers to and use of prenatal care among low-income pregnant women

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CATEGORY

Preconception health and health care
 Chronic disease and MCH (Asthma, Diabetes, Obesity)

FOCUS

Data Focus

BACKGROUND

Women who delay entry into prenatal care or receive no PNC are at risk for having undetected complications of pregnancy that can result in severe maternal morbidity and sometimes death. Little is known about whether women with chronic illness are more or less likely to enter prenatal care early; in fact, women who have chronic illness may be more likely than others to delay entry into prenatal care (PNC) because of increased barriers or more likely to enter early because of prior knowledge of illness. Given the importance of ameliorating adverse health conditions prior to or early in pregnancy, it is essential to understand whether women with chronic illness are appropriately accessing the care delivery system.

OBJECTIVES

Evaluate the relationship between chronic illness and barriers to prenatal care among low-income women; Suggest strategies for improving access to and use of prenatal care among low-income women.

METHODS

One hundred-thirty African-American low-income postpartum women in two Chicago communities were asked about their PNC experience (timing of prenatal care entry,) and health status (chronic conditions) before and during pregnancy in a structured survey, which asked about their PNC experience and health and insurance status before and during pregnancy. Data were analyzed using SPSS statistical software.

RESULTS

The survey asked about 11 chronic conditions; 61 women (46.9%) reported having been diagnosed with one or more of these conditions prior to pregnancy. The most common were lung problems/asthma (20.8%), migraines (16.9%), and obesity/overweight (10.8%).

Women were asked about barriers to PNC. The most common were transportation (25.4%) and clinic hours (22.3%). Women with chronic conditions had a mean of 1.87 barriers, whereas women without chronic conditions averaged 1.57 barriers. Women with chronic illness were 1.2 times more likely to have a barrier than women without chronic illness (95% CI, 0.6-2.6). Women diagnosed with chronic conditions before pregnancy were 1.5 times more likely to begin PNC after the first trimester [defined here as after 12 weeks (95% CI, 0.3-1.4)] and 2.1 times more likely to delay PNC until after half way through pregnancy (95% CI, 0.2-1.4).

LIMITATIONS

Data on presence or absence of chronic conditions were based on self-report. Women may have had pre-pregnancy chronic conditions but did not report them or may have had undiagnosed conditions. Participants are not a random sample of all low-income pregnant women in the target communities. Finally, due to small sample size, estimates were unstable.

CONCLUSIONS/LIMITATIONS

Low-income women with chronic illness appear more likely to have barriers and delay PNC entry. In order to actualize PNC benefits, efforts to connect women to care as early in pregnancy as possible are essential. Health outreach prior to pregnancy might be the most important strategy.

Innovative strategy to reaching women at-risk for poor pregnancy outcomes

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CATEGORY

Infant mortality and morbidity
Racial and ethnic health disparities

FOCUS

Program Policy Focus

ISSUE

The St. Petersburg Healthy Start Federal Project (Project) strives to eliminate disparities in infant mortality and other perinatal outcomes. Most recent data (2007) reveals that the Black infant mortality rate (15.9) is almost three times the White infant mortality rate (5.5). A three-year case study review of Black women in Pinellas County experiencing an infant loss revealed that many of them had risk factors such as repeated STDs, chronic health problems, previous poor birth outcomes, and emotional health issues.

SETTING

The Project serves an estimated subpopulation of 12,000 African American women of child-bearing age, 2,000 African American infants up to age 2 years, and their families residing in a four contiguous zip code area in South St. Petersburg located in Pinellas County, Florida.

PROJECT

As a federally-funded Healthy Start Program, the St. Petersburg Healthy Start Federal Project provides all required core services including: outreach and client recruitment, case management, health education, interconceptional care and depression screening and referral. In response to data collected through annual case study reviews, a new approach was implemented to reach women at-risk for poor pregnancy outcomes. The case study reviews elucidated that over 80% of Pinellas County Black women with an infant loss had received services at the Pinellas County Health Department. As a result, the Project created the position of Clinic Resource Specialist (CRS). The CRS addresses the needs of at-risk women presenting to the health department. The CRS, a social worker, identifies risk factors assesses client needs, delivers education and provides community referrals.

ACCOMPLISHMENTS/RESULTS

Between April 2008 and March 2009, the CRS served 260 unique clients. A detailed analysis of a sample of 129 clients revealed that:

- Top three reasons for referral to the CRS were: Family Planning needs (73), positive pregnancy test (52), and repeated STDs (25).
- There were 22 clients with a “positive” depression screening score, indicating a need for referral for mental health services.
- Clients received women’s health education on topics such as baby spacing (77), nutrition (55), and STDs (24).
- Top five referrals provided included: Case Management (34), Education (27), Medical Care (25), Family Planning (22), and WIC (21).

BARRIERS

Barriers to implementing CRS delivered services included increasing awareness and buy-in of Health Department staff, potential loss of clients due to perceived wait time, and limited staffing of CRS position.

LESSONS LEARNED

Services delivered by the CRS present an opportunity to prevent poor birth outcomes by reducing risk factors prior to pregnancy in Health Department clients. Results support the need to incorporate the Life Course Perspective in service delivery.

Circumstances of perceived discrimination among new mothers: 2005 Los Angeles Mommy and Baby (LAMB) survey

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CATEGORY

Racial and ethnic health disparities

FOCUS

Data Focus

BACKGROUND

Perceived discrimination has been found to be related to health problems. However, studies addressing the life-course exposure of discrimination to mothers in Los Angeles County are lacking.

OBJECTIVES

To investigate racial disparities in the circumstances women report feeling discrimination.

METHODS

We used data from the 2005 LAMB Survey. LAMB is a biennial, population-based survey modeled after the Pregnancy Risk Assessment Monitoring System. Perceived discrimination was measured using Krieger's seven-item discrimination scale. We performed multivariate logistic regressions to evaluate the racial disparities in various circumstances where new mothers reported discrimination while controlling for maternal characteristics. Variables included in the multivariate models included mother's race, years in the U.S., mother's education, mothers age and marital status.

RESULTS

The data presented are from the 2005 LAMB survey (N=5,211) and responses are weighted to represent all Los Angeles County births in 2005. Overall 42% of African American and 41% of Asian American women reported some form of discrimination. In the multivariate logistic regression, when looking at specific situations of discrimination, we found that at home and at school Asian women were significantly more likely to report discrimination (aOR 1.82 and 2.5, respectively) $p < 0.05$, when compared to white women. When looking at getting housing African American women reported more discrimination than white women (aOR 1.95) $p < 0.05$. We also found that both Asian and African American women were slightly more likely to report discrimination when getting a job (aOR 1.47 and 1.43, respectively) $p < 0.05$. Latino, Asian and African American women were all significantly more likely to report discrimination

from the police or courts compared to white women. Latino and Asian women had approximately two times the odds (aOR 2.09 and 1.79, $p < 0.05$) while African American women had three times the odds of reporting discrimination from police or courts (aOR 3.03, $p < 0.05$).

LIMITATIONS

LAMB data are self-reported by new mothers and may be subject to potential sources of error. Women may not recall events prior to their pregnancies and may be hesitant to report on behaviors perceived to be unhealthy.

CONCLUSIONS/IMPLICATIONS

Our findings revealed both African American and Asian American mothers had high reported discriminated rates and that the circumstances in which women report discrimination vary by race/ethnicity. Culturally-sensitive strategies and policies are needed to ensure housing and workplace fairness as well as equal access and treatment by police and court officials. Health care providers should become aware of the role of discrimination in poor birth outcomes. Further research is needed to identify specific factors associated with perceived discrimination for each race/ethnicity, especially for African American and Asian mothers. LAMB has allowed us to move beyond the case-based approach to a population-based one, taking us from a descriptive to an analytical approach. Other urban counties can adopt our methodology in combination with other approaches in their efforts to improve birth outcomes.

Giving fathers ACCESS: Acknowledgement, cooperation, camaraderie, encouragement, skills and support

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CATEGORY

Men in MCH

FOCUS

Program Policy Focus

CONTENT

It is imperative that MCH providers transform our reception of male involvement with the goal of supporting the meaningful inclusion and participation by men in all aspects of the health care delivery system to improve birth outcomes and the health and well-being of women and families.

Fathers for a Lifetime (FFL) a program of Omaha Healthy Start (OHS) – an infant mortality initiative serving men that reside in Greater Metropolitan Omaha, Nebraska. FFL operates with the fundamental belief that great strides toward improved MCH outcomes are linked to greater awareness about the impact of responsible fatherhood. Recognizing the impact an involved father has in the life of his child, FFL offers custodial and non-custodial, expectant and incarcerated fathers, young men planning to become fathers, and fathers of all ages an opportunity to share information, find support and network in a relaxed learning environment.

On August 2002, the first FFL ten-week educational session was held. The focus of each session is to link father involvement with improved birth outcomes, improved MCH statistics, elimination of disparities in the MCH population, and increased knowledge about preconception health, and perinatal, pediatric and adolescent health.

In 2003, the National Fatherhood Initiative (NFI) recognized FFL as an example of a best practice model for establishing a local fatherhood initiative. In 2004, FFL opened a Resource Office. The Resource Office provides one-on-one case management and care coordination to assist and support men in identify appropriate resources for employment, housing, health care, continued education, resolution of child support issues, family mediation and child visitation.

To date, over 750 men have graduated from the FFL ten-week educational sessions.

An additional 250 men have been assisted through the FFL Resource Office. Resource office staff field approximately 150 calls and 50 plus office visits monthly.

FFL remains committed to engaging key stakeholders, representing all aspects of the community, in supporting the efforts of fathers to get connected and stay connected to their children. FFL has successfully partnered with health care providers, public health professionals, law enforcement, child support enforcement, child abuse and neglect advocates, parenting trainers, district court judges, family mediators, mental health therapists to provide education, information and resources for men.

The proposed abstract presentation will include specific qualitative and quantifiable results based upon pre and post test results, health care assessments, weekly session evaluations and process and impact evaluation results. It will also identify numerous barriers to successfully integrating male involvement in other local and state MCH areas. Educating MCH personnel on the role of fathers in MCH, creation and maintenance of father-friendly work environments; meaningful engagement and recruitment of fathers in all aspects of perinatal health care and education; conflicting institutional messages regarding the role of fathers in MCH; limited resources for low-income uninsured fathers; and myths related to masculinity are among the barriers/challenges that face male involvement initiatives around the country in their efforts to support men in gaining ACCESS to MCH programs and services.

Using qualitative methods to assess client satisfaction: Results of a telephone survey

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CATEGORY

Racial and ethnic health disparities

FOCUS

Data Focus

BACKGROUND

Assessing client satisfaction with community programs is a vital component in program evaluation. Client satisfaction provides evidence of success as well as gaps from the client perspective. The St. Petersburg Healthy Start Federal Project in Pinellas County, Florida has struggled to obtain client satisfaction data. Mailed surveys resulted in an 11% (18/164) response rate. When focus groups were planned, 19 clients agreed to participate, however, only one individual attended. Perceived burden of paperwork, literacy limitations, transportation issues, and scheduling conflicts can all negatively impact response rates.

OBJECTIVES

The current study sought to use a telephone survey to collect client feedback on their Project experiences. It was hypothesized that conducting a brief telephone survey would increase response rates because the barriers of paperwork, transportation, literacy, and time would be addressed.

METHODS

Via a database, all clients who had received a face-to-face service from Project staff between January 2007 and December 2008 were compiled into a list of 442 clients. Attempts were made to contact all 442 clients, resulting in 103 completed surveys. The survey contained seven questions and took approximately ten minutes to complete. Feedback was gathered on topics such as the Project's helpfulness and suggestions for improvement. Responses were entered into a spreadsheet, and independently content analyzed by two staff.

RESULTS

Results were organized by themes that emerged from the content analysis and the number of respondents represented by each theme. Results indicate a general level of satisfaction. Examples of positive themes included (client statements in quotes):

"It provided me with stuff I needed like strollers and a baby bed."

- Basic needs: the Project assisted clients in obtaining baby supplies, Medicaid, housing, and food.

"It helped me with learning developmental stages and interacting with the baby."

- Instruction: Clients found helpful the information on topics such as parenting and pregnancy. Clients also appreciated having someone knowledgeable to answer questions.

"They could come out and see you more than once a week."

- Increase home visits: some clients felt that home visits were too infrequent.

"Need more information given out for coordinated childcare."

- Childcare: Clients would prefer more assistance in obtaining childcare services.

LIMITATIONS

Responses could only be generated from clients with a working telephone number. Thus, responses cannot be viewed as generalizable to all clients. Also, because the questions were open-ended, it is not possible to gauge client agreement among the themes. For example, although ten clients said that more home visits are needed, we cannot conclude that only ten clients agree with this statement.

CONCLUSIONS/IMPLICATIONS

Interview results illuminated clients' perspectives on their experiences with the Project, and also shed light on the types of needs the Project is addressing from the client point of view. Qualitative methods are especially useful in garnering information from marginalized groups, help to overcome any literacy barriers, and allow program administrators to gather clients' feedback in their own words. This helps administrators to avoid a possible disconnect between intended program activities and client reactions.

Blueprint for nutrition and physical activity: Cornerstones of a healthy lifestyle

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CATEGORY

Chronic disease and MCH (Asthma, Diabetes, Obesity)

Other: Determinants of health - nutrition and physical activity

FOCUS

Program Policy Focus

ISSUE

Positive eating and physical activity are cornerstones to healthy lifestyles. The Association of State and Territorial Public Health Nutrition Directors created the Blueprint for Nutrition & Physical Activity: Cornerstones of a Healthy Lifestyle to assist public health professionals in incorporating these essentials into community programs. The Blueprint outlines practical, consumer-focused, state and local strategies for improving eating and physical activity that if used will lead to healthier lives for children, adults and families. The Blueprint offers strategies and actions to address priority nutrition and physical activity issues in the context of a community's resources and needs.

The Blueprint was designed to address both nutrition and physical activity together. The expert advisory group that developed the Blueprint ensured that the content reflects current knowledge and best practices in these areas.

SETTING

Public health agencies can use the Blueprint as a resource to better integrate healthy eating and physical activity interventions into community activities and programs.

PROJECT

Blueprint for Nutrition & Physical Activity: Cornerstones of a Healthy Lifestyle outlines practical, consumer-focused, state and local strategies for improving eating and physical activity that, if used, will lead to healthier lives for children, adults and families.

The Goals of the Blueprint for Nutrition and Physical Activity:

- To promote healthy eating and physical activity.
- To improve the quality of life through health promotion and disease prevention.

- To eliminate inequalities in healthy eating and physical activity due to race, ethnicity, culture, gender, age, disabilities and socioeconomic status.

The Cornerstones

There are five overarching critical elements to help people in communities be physically active and eat well. They are: access, collaboration, science and research, workforce and communications. These elements are the cornerstones around which the Blueprint is organized. Each cornerstone has at least three strategies with accompanying action steps recommended by experts and leaders in the field of nutrition and physical activity. Each community can adapt these strategies to fit more closely with their needs.

ACCOMPLISHMENTS/RESULTS

The Blueprint has been used in a number of states to create programs and resources intended to improve the eating and activity patterns of communities. Examples include: better integration of nutrition services into Kansas MCH programs; the development of a community needs assessment in Utah; a South Carolina healthy eating and active living issue coalition; in Alabama a comprehensive state wellness plan; and others

BARRIERS

Many public health professionals who would benefit from using the Blueprint are not aware that it exists. Outreach to public health professionals is needed to ensure the use of this tool.

LESSONS LEARNED

The Blueprint is an easy to use tool that is well received by public health professionals once they are aware of the resource. The Blueprint helps public health professionals incorporate evidenced based nutrition and physical interventions into programs and activities to support healthy communities.

Changes in New Orleans birth outcomes following Hurricane Katrina**PRIMARY CONTACT:****Lyn Kieltyka, PhD**

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CATEGORY

Prematurity / Preterm birth / Birthweight

Infant mortality and morbidity

FOCUS

Data Focus

BACKGROUND

Programs targeting pregnant women based on geographically defined high-risk areas, such as Healthy Start New Orleans (HSNO), face unique challenges following massive population disruption, such as that which occurred in New Orleans following Hurricane Katrina in August, 2005. While expanded geographic coverage areas offered HSNO the opportunity to continue to serve pre-existing clients, little is known about displacement impact in terms of population-based birth outcomes in the originally targeted geographic areas in the year following the disaster.

OBJECTIVES

This study describes differences in New Orleans area birth outcomes, including low birth weight (LBW), preterm birth (PTB), and infant mortality (IM), in 2004 compared to 2006, stratified by HSNO catchment area.

METHODS

Louisiana Vital Records birth and death certificate data from 2004 and 2006 were used to define NOHS pre-hurricane geographic catchment areas (NOHS-CA) using residential zip codes in Orleans Parish. Percentages and rates with 95% confidence intervals (95%CI) were used to describe differences in birth outcomes between the two time periods for NOHS-CA and non-catchment areas (non-NOHS-CA) separately. SAS v 9.1 was used for computations, with confidence intervals calculated using SABER (CDC).

RESULTS

From 2004 to 2006, the number of live births to Orleans Parish residents fell from 6,838 to 2,626. NOHS-CA accounted for 4,923 (72.0%) and 1,727 (65.8%) of these births in 2004 and 2006, respectively. From 2004 to 2006 in NOHS-CA, LBW fell from 13.8% (95%CI=12.8%,14.8%) to 12.1% (95%CI=10.6%,13.7%), PTB fell from 16.6% (95%CI=15.6%,17.7%) to 14.3% (95%CI=12.7%,16.0%),

and IM fell from 10.8 per 1,000 live births (95%CI=8.1,14.1) to 8.7 per 1,000 (95%CI=4.9,14.3). In non-NOHS-CA from 2004 to 2006, LBW remained stable at 13.1% (95%CI=11.6%,14.7%) and 13.2% (95%CI=11.1%,15.6%), PTB fell from 15.9% (95%CI=14.3%,17.6%) to 14.7% (95%CI=12.4%,17.2%), and IM rose from 7.3 per 1,000 (95%CI=4.0,12.2) to 10.0 per 1,000 (95%CI=4.6,18.9). It is clear that New Orleans has experienced changes since Hurricane Katrina, especially in the number of reported births to residents. However, these results fail to show statistically significant differences for the birth outcomes of LBW, PTB, or IM, indicated by overlapping confidence intervals for each area between the two time periods 2004 and 2006.

LIMITATIONS

Lack of statistically significant findings may be due to small numbers, evidenced by wide confidence intervals for many measures. Despite lack of statistical significance, meaningful differences likely exist. Additional years of post-hurricane data would help clarify the interpretation of possible changes in birth outcomes.

CONCLUSIONS/IMPLICATIONS

Over three years after Hurricane Katrina, there is no statistical evidence that birth outcomes have changed significantly in New Orleans, either in previously defined high-risk geographical areas or former lower risk areas. However, the differences reported between the two time periods are likely meaningful, despite lack of statistical significance. Programs with targeted geographic reach such as HSNO who use vital records data for program planning after a major disaster may find it difficult to balance apparent changes in birth outcomes with a lack of statistically significant findings. Proper interpretation of data, including consideration of sample size issues, is key to effectively guiding future program direction.

TN Adolescent Pregnancy & Prevention Partnership's National Day to Prevent Teen Pregnancy: Nashville's Day to Prevent Teen Pregnancy

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CATEGORY

Adolescent health / pregnancy prevention

FOCUS

Data Focus

BACKGROUND

A data collection tool was created on Survey Monkey to be used as a companion tool to gather local data on those who participated in the National Day's online quiz. The online quiz is to increase sexual health knowledge among teens and to increase awareness in the community. In addition to the quiz, each participant and their parents will be provided information on Alignment Nashville Adolescent Sexual Responsibility's resource guide and other resources around responsible sexual health among adolescents.

Specific Measurable Objectives:

- Delay the initiation of sex or intentions of having sex if not ready.
- Delay attitude toward childbearing.
- Increase parent/child communication.
- Change belief that most peers are having sex.
- Encourage participants to identify a medical home to have those annual Early Periodic Screening Diagnosis and Testing (EPSDT) exams completed and other medical services that may be needed.

METHODS

The Nashville Day to Prevent Teen Pregnancy's Survey Monkey tool will be available for each participant that completes the National Day's online survey. The online survey will be available at 13 locations with the anticipated participation of 20 participants at each site. In the past, the National Campaign to Prevent Teen and Unplanned Pregnancy has provided the number of online participants by state only. Nashville's Day Survey Monkey tool will capture local data that will provide how each participant scored and if the survey would change their behavior on sexual responsibility.

RESULTS

100% of the participants that complete the online survey will change their behavior on sexual responsibility, identify a medical home, delay child bearing and/or the initiation of sex, and develop communication skills to have discussions around adolescent sexual responsibility with their parents.

LIMITATIONS

A potential barrier for replication of the local data tool would be that organizations may not have the accessibility to have a Survey Monkey account. To alleviate this potential barrier, a paper copy can be provided for replication.

CONCLUSIONS/IMPLICATIONS

As a result of participating in the National Day's online survey, those teens will be encouraged to avoid or reduce risky sexual behavior (by either delaying sex or using contraception effectively) will help prevent teen pregnancy and sexually transmitted diseases (STDs) including HIV/AIDS.

INFORMATION FOR REPLICATION

Budget:
\$1729.80

Resource used:
City/county/local government funds
Alignment Nashville (private funds-HealthWays)

Key partners/collaborators:
Metro Public Health Department MCH Division
Alignment Nashville's Adolescent Sexual Responsibility Committee

Hartford Pediatric Outreach Project: Coordinating services for hard-to-reach children at risk for developmental delays

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CATEGORY

Child growth, development, preventive care
Racial and ethnic health disparities

FOCUS

Program Policy Focus

ISSUE

Navigating systems of care is difficult and time consuming, especially for families with limited education and financial resources. The goal of the Pediatric Outreach Project was to strengthen a comprehensive system of early identification and referral for children at risk of development or behavioral problems by enhancing the capacity of hard-to-reach families to access services.

SETTING

The Project targeted low-income, under-insured and uninsured families living in the North-End neighborhoods of Hartford. Hartford, CT is a medium-size city of 124,699 people, with all of the ills of large urban centers; 95.5% of its school population are African American or Hispanic.

PROJECT

Care coordinators met with families in their homes for the intake assessment, provided information, made referrals, and followed up to ensure connection with services needed. Families were connected with the statewide Ages & Stages (ASQ) Child Development Monitoring Program. Care coordinators were trained to conduct the ASQ screenings with the families; if the questionnaire revealed a potential problem, they facilitated assessment and referral services.

ACCOMPLISHMENTS/RESULTS

51 hard-to-reach families and 99 children participated with 120 referred for services. 22 referrals were for household needs, 20 for day care, 20 for employment or education, 19 for housing; 12 for lead testing and, 8 families were referred to CDI for the ASQ program.

ASQ questionnaire was administered for 32 children; age of child ranged from four to 36 months. Development delays identified in 25% of children in areas of communication, fine motor, problem-solving, and personal/social development. 38% of children enrolled in ASQ Developmental Monitoring

Program.

Families received two or more referrals for services, 80% received follow up intervention. For cases with follow up, 91% were connected to services, seven percent didn't receive the service requested, two percent were pending at end of the project. Also, 98% of families were connected to at least one service.

BARRIERS

It took several months and five drafts to establish protocols across the participating organizations which delayed the initiation of services, and therefore, it didn't meet the target of 200 children. However, once families were identified and recruited, it worked at full capacity and a total of 99 children (51 families) received services from March through October, 2008.

LESSONS LEARNED

There are many difficulties with linking hard-to-reach families and children to needed services in urban communities. Based on what was learned during the short period that the project was implemented, the issue is not so much a lack of services, but more one of comprehensive coordination among services. By providing families with accurate information on programs and very concrete support that addresses specific needs, they can be empowered and motivated to access services on their own. Moreover, many families, including those with limited education, were available and receptive to learning about their child's development, and in fact, took pleasure in completing the Ages and Stages Questionnaire. All of this has far-reaching implications (with high benefit to cost) for positively impacting outcomes for a sizable population of children that typically do not receive needed services.

INFORMATION FOR REPLICATION

Funding was provided by the CT Children's Trust Fund -state agency for this pilot project.

The funding covered salaries and fringes of two (2) FTE care coordinators and program supplies.

Additional funding for overhead and indirect cost was provided in-kind by the City of Hartford.

The CT Child Development Infoline, the CT Children's Trust Fund, the City of Hartford Health and Human Services Department, and the University of Hartford were the key organizations in the developing and implementation of this project.

BorderMACH: A binational approach to building maternal and child health capacity in the US-Mexico border region

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CATEGORY

Chronic disease and MCH (Asthma, Diabetes, Obesity)

FOCUS

Program Policy Focus

ISSUE

Vital statistics and other health surveillance data from the binational US-Mexico border region show disparities in prenatal care, adolescent birth, sexually transmitted infections such as congenital syphilis, diabetes, and other outcomes. The population is generally low-income, underserved and of Mexican-origin. The United States-Mexico Border Health Commission has identified specific MCH (Maternal and Child Health) goals for the region, but community level data are scant and MCH personnel have limited experience using data for public health action. Further, binational collaboration in MCH is minimal.

SETTING

Most of the region's 14 million US and Mexican residents live in 14 pairs of highly urbanized and interdependent sister city communities in 10 border states. Residents cross the border in both directions for health services and other reasons, yet US and Mexican health institutions do not share MCH data and do not collaborate on MCH programs. In addition, MCH partnerships between U.S. or Mexican border communities in different states are rare, as are MCH border resources.

PROJECT

Through training, technical assistance, and other activities, the BorderMACH (Maternal And Child Health) Initiative aims to develop key competencies among US and Mexican health professionals to work collaboratively throughout the region and to use local data for MCH decision-making. BorderMACH was initiated by CDC in 2007, and has developed in collaboration with Mexico's Secretariat of Health (SS) and other national, state and local partners. CDC provides modest financial support and both CDC and SS provide significant in-kind resources.

ACCOMPLISHMENTS/RESULTS

Accomplishments include regional consensus among MCH authorities for increased collaboration, data sharing and data skills training. In 2008, a binational advisory committee outlined the content and structure of the training. Development teams then designed curriculum around targeted competencies for the first of three planned workshops. States and local health entities selected core teams of health professionals from three pairs of sister city communities to participate in the first round of training and have agreed to support the teams through the two-year training period; selection criteria included team expertise in data, program and policy issues. Pre-workshop assessments have been held for each pair of participating teams in order to provide comparison data for post-workshop assessments and to help shape workshop content. The first workshop is scheduled for June, 2009.

BARRIERS

Potential barriers may include insufficient financial and/or human resources to complete development of future workshops, competing local and state health department priorities that could jeopardize institutional support of training teams, and political developments that could threaten binational collaboration.

LESSONS LEARNED

A binational approach to MCH capacity building is possible if sufficient interest and commitment exist among partners. Progress to date has depended on support from national, state and local level government entities.

A prematurity education program for home health care providers**PRIMARY CONTACT:**

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CATEGORY

Preconception health and health care
 Prematurity / Preterm birth / Birthweight

FOCUS

Data Focus

BACKGROUND

Prematurity is a growing problem in the United States with one in eight babies being born before 37 weeks of gestation. Prematurity is the leading cause of neonatal mortality, and is the number one cause of infant mortality in non-Hispanic black infants. Many home health care programs in the Dayton, Ohio region visit women with risk factors for premature birth. In order to assess what education the home health care providers were providing clients about prematurity a survey of home health care providers was conducted in 2005. Results indicated that only 28.6% of home health care providers had the standard practice of discussing preterm delivery with a woman with a prior preterm delivery. In addition, only 52% of respondents felt they had the expertise to counsel women regarding preterm delivery and 46% felt that this lack of expertise was the largest barrier to counseling. When asked what information would be most useful in educating women about preterm delivery, 53% reported that educational materials would be helpful and 33% reported continuing education would be helpful.

OBJECTIVES

The objective of this project is to increase the education of home health care providers working with women at risk for premature birth. The education emphasizes modifiable risk factors and strategies to avoid premature birth. The overall aim of the project is to decrease prematurity in the Dayton, Ohio region.

METHODS

A PowerPoint presentation from the March of Dimes was presented to home health care workers on the epidemiology and biology of preterm birth. Pre and post intervention surveys were given to assess if the intervention increased awareness of modifiable risk factors associated with prematurity and increased comfort level of discussing preterm delivery with clients. Prevalence of survey answers were calculated and used to compare differences in means of answers in pre and post surveys.

RESULTS

Results from the pre-and post-surveys indicated that knowledge of modifiable risks associated with prematurity increased from 73.8% to 97.4%. The percent of home health care providers that reported being well prepared to assess clients for risk of premature birth increased from 40.8% to 76.3%. In addition, the percent of home health care providers reporting that they felt comfortable discussing the risks of premature birth increased from 45.2% to 84.2%

LIMITATIONS

This is the initial intervention with only one group of health care providers (n = 42). The n will be increased with additional interventions to other health care providers. Long term retention of the educational intervention is not known yet.

CONCLUSIONS/IMPLICATIONS

The intervention increased knowledge of modifiable risk factors of prematurity to home health care providers. In addition, home health care providers felt more prepared to assess clients for risk of premature birth and more comfortable discussing preterm birth risk factors with clients.

Implications: This intervention has the potential to increase knowledge of preterm risk factors to women at high risk for preterm delivery, which could possibly lead to decreased preterm birth in the Dayton, Ohio region.

Birth Equity Initiative: Eliminating the disparity in infant mortality in Boston**PRIMARY CONTACT:**

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CATEGORY

Infant mortality and morbidity
 Racial and ethnic health disparities

FOCUS

Data Focus

BACKGROUND

Trends in mortality and birth weight among black and white infants continue to indicate a racial disparity. Massachusetts data report 4.2 deaths per 1,000 live births for white infants and 11.1 deaths per 1,000 live births for black infants in 2006. 2006 Boston data report an infant mortality rate of 3.6 per 1,000 live births for white infants and 13.2 for black infants, a disparity persistent for decades. In response to this critical issue, the Brigham and Women's Hospital Center for Community Health and Health Equity created the Birth Equity Initiative: Eliminating the Disparity in Infant Mortality in Boston.

OBJECTIVES

To identify the root causes of the excess infant deaths among African Americans and to identify models of practice to reduce the racial disparity.

METHODS

Data from the National Center for Health Statistics, the Massachusetts Department of Public Health, and the Boston Public Health Commission were analyzed to identify the racial disparity. A structured review of the literature was conducted to evaluate the research defining the root causes of the excess infant deaths among African American women. A review of reports from state agencies, national institutes, and philanthropic organizations as well as interviews with researchers and health policy experts were conducted to identify models of described best or promising practices to reduce the infant mortality gap between black and white infants, targeting the etiology of the disparity. Those that addressed maternal psychosocial stress, social determinants of health, and measures to improve healthcare quality for this population were selected.

RESULTS

Differences in low birth weight and premature birth account for the disparate outcomes. Research to explain the disparity implicates stress-mediated premature birth, chronic psychosocial stress over the reproductive life course, the influence of social factors, particularly bias, and differences in the quality of care received. Of 27 programs identified, 19 (70%) addressed maternal psychosocial stress, 11 (41%) addressed social determinants of health, and 7 (25.9%) addressed healthcare quality improvement measures. Three programs emerged as comprehensive models.

LIMITATIONS

No single source or collection of sources exists to chronicle of all programs across the nation that seek to address the racial disparity in infant death for African Americans. Thus, a limitation of this study is the inability to confirm that this exhaustive review evaluated all models available.

CONCLUSIONS/IMPLICATIONS

Infant mortality is a significant indicator of a community's health and social welfare, and remains a focus of the local health community. Social determinants of health are a significant initiator of disparities thus indicating the need for a clinical and community collaboration to address the disparity. A comprehensive, health system-based and community-based intervention is necessary to support maternal health, reduce psychosocial stress, and enhance community assets. The Brigham and Women's Hospital Birth Equity

Eliminating the Disparity in Infant Mortality in Boston seeks to address these factors associated with the disparity in infant death and close the gap on these disparate birth outcomes.

SPARC (Sickness Prevention Achieved through Regional Collaboration)

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CATEGORY

Chronic disease and MCH (Asthma, Diabetes, Obesity)
 Racial and ethnic health disparities

FOCUS

Program Policy Focus

ISSUE

The principal goal of the SPARC (Sickness Prevention Achieved through Regional Collaboration) is to increase access to preventive health screenings and vaccinations among seniors living in targeted communities in Fulton County. To make it more accessible, SPARC uses locations where seniors frequent or otherwise perceive as convenient. Research indicates that nationally, less than 27% of seniors age 50 and older are up to date with basic preventive services. While working to increase the number of seniors receiving regular and timely preventive health screenings and vaccinations, SPARC also contributes toward efforts to reduce some of the health disparities evident among Fulton County seniors. For example, the death rate among black female age 60-74 due to cardiovascular disease is over three times that of white female in the same age group.

SETTING

SPARC events are held at senior centers, churches, fire departments, and senior housing located in Fulton County. Seniors who do not access preventive health screenings and vaccinations through a primary health care provider may be more inclined to obtain such services in a setting viewed as convenient, and affordable.

PROJECT

SPARC is an ongoing initiative administered through a partnership between the Fulton County Human Services Department and the Atlanta Regional Commission. SPARC uses a community-based model that is designed to increase the number of seniors who obtain preventive health screenings and vaccinations. Activities may include:

- Tailor local prevention outreach to each community-educating client to practice healthy behaviors

- Create new points of contact for preventative services
- Bundle delivery of preventive services together
- Create central locus of coordination at both the county and regional level

The health issues targeted by SPARC are respiratory-related sickness associated with Influenza and Pneumonia, high cholesterol, high blood pressure, diabetes, and breast and cervical cancer.

ACCOMPLISHMENTS/RESULTS

The SPARC initiative has had many accomplishments since its conception in 2006. The number of people screened has doubled from 353 in 2006 to 997 in 2008. Overall, the SPARC's program has provided approximately 2,451 preventive screenings to individuals who would not have had access to preventive care. SPARCS has expanded its intended audience to not only include senior citizens, but people of all ages. The screenings offered to participants has expanded to include: depression, glaucoma, dental, HIV, and bone mass.

BARRIERS

The barriers encountered during the SPARC event entailed transporting clients to mammography appointments and lack of public awareness. Efforts to overcome these barriers included:

- A SPARC provider is volunteering to transport some of clients to their mammography appointment
- Increasing public awareness through radio announcements, going door-to-door with fliers, advertising in local news papers and church bulletins

LESSONS LEARNED

It was learned that the community-based model has increased preventive health care among seniors and individuals of all ages. In addition, it was learned that people want to be healthy and will invest time in preventive care when it is easily accessible and money is not a barrier.

The health and insurance status of pregnant low-income women with chronic illness

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CATEGORY

Preconception health and health care
Chronic disease and MCH (Asthma, Diabetes, Obesity)

FOCUS

Data Focus

BACKGROUND

Early, high-quality prenatal care potentially optimizes healthy outcomes for women, infants, and families. However, low-income women are generally more likely to enter prenatal care later and thus, to have higher rates of adverse birth outcomes. Improving timeliness of prenatal care among low-income women is likely to require broad social and health policies that focus on factors affecting women before pregnancy including pre-pregnancy insurance coverage. As preconception and interconception health care gain attention as strategies for improving pregnancy outcomes, it is important to understand the role of insurance coverage for low-income women prior to pregnancy, particularly among women with chronic illness.

OBJECTIVES

Describe the potential relationship between pre-pregnancy health and insurance status of low-income women; identify the key characteristics of a population of chronically ill, low-income pregnant women based on survey findings; evaluate the potential role of preconception and interconception care in improving pregnancy outcomes among similar populations

METHODS

A structured survey asked 130 postpartum African American low-income women in two high-risk Chicago communities about health (chronic illness) and insurance status before and during pregnancy. Survey results were analyzed using SPSS statistical program.

RESULTS

The mean age of respondents was 25.4 years, almost 60% had a high school education or less, and the average number of previous live births was 1.9. During pregnancy, 42.3% received TANF, 80.8% used WIC and food stamps, and 59.2% reported total household income under \$1000/month.

Medicaid coverage prior to pregnancy was reported by 76% of the participants, private insurance by 11.5%, and 11.5% were uninsured. Ninety-three percent of the women reported Medicaid payment for delivery.

Participants reported 11 chronic illnesses, including lung problems/asthma (20.8%), migraines (16.9%), and obesity/overweight (10.8%). Among women with pre-pregnancy chronic illness, 85.2% had pre-pregnancy Medicaid, 11.5% had private insurance, and 3.3% were uninsured. Among women without chronic illness, 70.8% had pre-pregnancy Medicaid, 9.2% had private insurance, and 20% were uninsured. The relatively high prevalence of pre-pregnancy Medicaid coverage among all participants is likely due to Illinois' generous Medicaid policies, including its Illinois Healthy Women program, and/or the high prevalence of TANF assistance among this group.

LIMITATIONS

Analyses were based on self-reported data. As a result, data on absence or presence of chronic conditions and time of diagnosis may be subject to recall bias. However, women were interviewed soon after their pregnancies ended, so the effect of this bias is likely minimal.

CONCLUSIONS/IMPLICATIONS

The pervasiveness of chronic illness prior to pregnancy among this population underscores the significance of pre-pregnancy health insurance for low-income women. In order for women with chronic illness to enter pregnancy healthy and obtain needed preconception/interconception care, pre-pregnancy insurance is critical.

The co-location of psychiatric services within a community-based MCH agency

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CATEGORY

Mental health

FOCUS

Program Policy Focus

ISSUE

The issue was how to connect our participants with quality mental health care that was sensitive to their needs. Our program participants faced several barriers in trying to access mental health services such as transportation, child care, lack of or insufficient health insurance, a shortage of psychiatrists which extends the waiting time for an appointment to at least six weeks, and mistrust of the medical system.

SETTING

Office space for the psychiatric services was co-located within our program's offices. Our intended audience was either pregnant or postpartum women who were enrolled in our program and scored high enough on the depression screen to warrant evaluation by a psychiatrist.

PROJECT

We partnered with Women's Behavioral HealthCARE at the Western Psychiatric Institute and Clinic to provide psychiatric services for our participants suffering with depression. The pilot was named Healthy Start CARES. The services were provided one afternoon per week for five months. Child care, transportation, and the services were free. During the office visits the participant could have any of her Healthy Start staff present with her. Letters were sent to the participants' PCP's to inform them of the participant's treatment status. Home visiting continued during the participants' treatment.

ACCOMPLISHMENTS/RESULTS

Sixteen of twenty-nine participants who were referred to the pilot project came for services. The average wait for an appointment with the psychiatrist was two weeks. Ten participants had lowered their scores on the depression screen. Those participants who wanted to include medication in their treatment received prescriptions that were affordable and easy to obtain. The Healthy Start staff maintained their home visits with the participants, monitoring their progress and implementing the strategies that were devised when they came to the CARES project. The scores on the client satisfaction surveys showed a high rate of

satisfaction with the treatment and care the participants received.

BARRIERS

Even with the provision of child care and transportation, almost half of the participants did not come to the office. We believe that some of the reasons are mental health issues that prevent them from being able to make the effort to prepare for the trip; a young age might prevent them from seeing the value in the services; and for some, their mental health is just not high enough on their priority list yet.

LESSONS LEARNED

There were days when the doctor and nurse did not have anyone to see because we could not get the participants to the office. It has been a team effort to provide these services; more people have become involved than we had planned. There are people who are so sick that they cannot get themselves to a provider. The people who need services the most, are the least likely to obtain them.

Step Up To Health: Health education and physical activity for "tweens" at risk for diabetes and future poor birth outcomes

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CATEGORY

Adolescent health / pregnancy prevention
Racial and ethnic health disparities

FOCUS

Program Policy Focus

ISSUE

African American youth are at increasing risks for chronic diseases based on staggering obesity data. Younger and younger school-aged children are being diagnosed with Type II Diabetes, Hypertension and other chronic conditions that can be linked to weight issues during puberty.

SETTING

This innovative program takes place in 15 community centers dispersed around the county in high risk urban areas. The target participants are youth between eight and fourteen years-of-age who have a family history of diabetes, or who live in an area with a known disparity in obesity, diabetes or in life expectancy.

PROJECT

This program brings together local government, academic institutions, and private not-for-profit organizations to address the health and wellness of the community's youth.

Each community center recruits from its client's 15-20 youth who are interested in taking part in the Step Up program. Once recruitment is completed a Step Coach who usually is a student at a local college with experience in Step dancing, is assigned to the team. Teams practice three to four times a week for at least 45 minutes. This provides a source of vigorous aerobic activity. Prior to each practice the students have a health information "rap" session organized and executed by student health ambassadors. Subjects that are covered range from nutrition, tobacco, staying healthy, risky behavior, bullying, etc. Each participant receives a complete health and fitness assessment, health knowledge and habit assessment and is required to have a complete medical physical prior to joining. Students must also maintain good academic standing

to participate. Teams perfect five to eight minute routines around a health message. Throughout the year, teams have the opportunity to compete against the other local teams as well as teams from neighboring communities and states. This friendly competition keeps the students interested and dedicated to their team.

Health ambassador students collect baseline surveys on each youth as well as baseline health assessments. This information is recollected at the end of the academic year and aggregate data is compared. Changes in knowledge and fitness level are documented for the participants.

Because of the changing ages of the participants, Body Mass Index will not be used as the primary measure for success. Instead, the complete fitness assessment will be done, which gives each student an overall fitness score. Improvements in these scores will be used to determine success. In addition, the baseline health knowledge survey and the follow up will be used to determine the effectiveness of the health education sessions. Preliminary data is indicating a significant increase in knowledge as a result of participating in the program.

ACCOMPLISHMENTS/RESULTS

Preliminary data shows a significant increase in exercise tolerance for the youth as well as increased attempts to make healthy decisions around nutrition and to avoid risky behaviors such as cigarette smoking.

INFORMATION FOR REPLICATION

- Resources are from a \$250,000, state diabetes prevention grant
- Key partners include government public health and parks/recreation, academic institutions and not for profits

Abstracts for Publication Only

Integrated home visitation: A comprehensive approach

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CATEGORY

Infant mortality and morbidity

Child growth, development, preventive care

FOCUS

Program Policy Focus

ISSUE

The principal goal of the City of Milwaukee Health Department's (MHD) Integrated Home Visitation system is to improve birth outcomes and promote healthy families through comprehensive, family-centered health services to at-risk pregnant women and parents of young children in Milwaukee.

SETTING

The majority of visits take place in the homes of City of Milwaukee residents who live in high-risk neighborhoods. These neighborhoods are plagued by poverty, as well as an infant mortality rate which is one of the worst in the nation.

PROJECT

The Integrated Home Visitation system comprises four home-visiting models, working together to seamlessly address various at-risk populations with targeted interventions. The programs operate through a central referral center at the MHD, which accepts and assigns referrals from all over the city. Three programs attempt to engage women prenatally, and the fourth focuses on families after the birth of an at-risk baby. Each component of the home-visitation system offers inclusive strength-based education, support, and resources to families.

The four models are distinguished by the following:

- Nurse-Family Partnership: offers long-term nursing services to first-time parents.
- Empowering Families of Milwaukee: offers long-term wraparound services to at-risk families by a multi-disciplinary team, consisting of a nurse, a social worker, and a community health worker.
- Parents Nurturing and Providing for their Children: offers intensive, city-wide nursing services mainly to pregnant women.
- Core Team Nursing: offers short-term home visits city-wide to at-risk newborns and their families.

ACCOMPLISHMENTS/RESULTS

Initial outcomes for the Nurse-Family Partnership and Empowering Families of Milwaukee programs have indicated that the percentage of preterm or low birth-weight babies of clients are half the rate of that of the zip codes in which they provide service.

Evaluation Plan:

In 2009, all four programs are synthesizing their evaluation plans to assure that the same indicators are measured. Data sets include process indicators such as the number of visits conducted, as well as outcomes indicators such as: rate of low-birth weight babies, percent of clients who quit smoking, percent of clients who sustained breast-feeding, and percentage of children reaching age-appropriate developmental milestones.

BARRIERS

The major barrier is that clients are harder to reach: young, at-risk pregnant women do not always access health care services early in their pregnancy; more women are working outside the home; and distrust of anyone who might want to visit them at home makes it difficult to establish an initial relationship with the client.

LESSONS LEARNED

There is no “one size fits all” approach to home visiting. Rather than attempt to create one monolithic program that can meet the needs of all, the MHD encouraged the organic development of separate but connected home visiting programs. Staff can be trained in their specific program model, allowing for greater depth of skills and knowledge. And each referral received by the health department is sure to be a good match for one of the programs allowing clients to receive comprehensive care that is tailored to their unique circumstances.

Measuring the impact of a nutrition and physical activity collaborative: Two years of experience from the Get Healthy San Mateo County Evaluation Committee

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CATEGORY

Child growth, development, preventive care
Chronic disease and MCH (Asthma, Diabetes, Obesity)

FOCUS

Data Focus

BACKGROUND

Since April 2006, the Get Healthy San Mateo County (GHSMC) Task Force has implemented many of the 29 objectives and 111 action steps related to childhood nutrition, physical activity, policy and the built environment developed during a one-year planning effort.

METHODS

The Evaluation Committee has released two annual reports that provide:

- Analyses of trends around 27 ongoing indicators of nutrition and physical activity among children/adolescents.
- Information from Task Force member surveys.
- Accomplishments, challenges and recommendations from GHSMC's eight committees.

Indicators include:

- Pediatric Nutrition Surveillance Survey (PedNSS) data on child weight.
- California Healthy Kids Survey (CHKS) data on exercise and diet.
- California Physical Fitness Test (CPFT) data on children meeting fitness standards.

Task Force members were surveyed about their level of satisfaction with the Task Force and its committees, their ability to influence both, and the county's ability to address nutrition and physical activity concerns.

RESULTS

PedNSS data revealed a positive trend in the first two years of data analyzed, with the percent of children aged two to four years who were “overweight” decreasing from 19.4% in 2006 to 17.9% in 2007.

Between 05-06 and 06-07, CHKS data likewise revealed positive trends, with improvement in light exercise (increasing from a mean of 3.44 to 3.53 times per week) and in fruit consumption (increasing from a mean of 1.85 to 2.09 times per day).

In the CPFT, improvement in the percentage of children passing 6 out of 6 fitness standards was evident in both genders and all racial/ethnic groups between 05-06 and 06-07. Examples include overall improvement (from 35.1% to 38.1%), and improvement in the Hispanic (from 23.4% to 26.1%) and Chinese (from 51.2% to 53.9%) populations.

Three years of data were analyzed for Task Force member surveys (05-06, 06-07 and 07-08). Each year 30 or more people completed the surveys, approximately one-half of active GHSMC members. One question asked members if they “have increased confidence in County's ability to address this health issue.” The percentages for “strongly agree” plus “agree” changed from 86% to 78% to 84% over the three years.

Accomplishments (e.g., creation of the clearinghouse www.gethealthysmc.org), challenges (e.g., under-representation by youth and under-served communities) and recommendations (e.g. highlight local work during Task Force meetings) were identified by all eight committees.

LIMITATIONS

The data collected only begin to describe the complex factors influencing child health, nutrition and physical activity indicators, and health outcomes. Existing data sources describe certain populations, namely, low-income children (PedNSS), and children in participating public schools (CPFT and CHKS). Task Force member surveys capture information from about one-half of regular Task Force members.

CONCLUSIONS/IMPLICATIONS

These data suggest improvement in nutrition and physical activity indicators for San Mateo County children – ongoing assessment is needed to see if these trends continue. New data sources are being identified and analyzed to provide a broader picture of environmental impacts on health (e.g., availability of healthy food options in neighborhoods). The work of engaging diverse stakeholders and providing them with clear benefits from participation in the GHSMC Task Force is ongoing.

AMCHP's Adolescent Health Maternal & Child Health Leadership Development Initiative: Lessons learned and future direction

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CATEGORY

Adolescent health / pregnancy prevention

Other: MCH leadership development/leadership competencies

FOCUS

Program Policy Focus

PROJECT

Guided by the belief that leadership is key to improving maternal and child health (MCH) outcomes, that leadership is needed throughout the organization, and that leadership can be improved and developed by learning and experience, in 2008 AMCHP, working in collaboration with Edwards Educational Services <http://realityedservices.com/> launched a pilot leadership development initiative for State Adolescent Health Coordinators. The initiative is a one-year pilot project working with MCH programs in five states.

A key component of the initiative is the application of the 12 MCH Leadership Competencies through organized training, collaborative meetings and virtual support. Over the course of the year-long pilot, AMCHP hopes the Adolescent Health Leadership Development participants will achieve the following outcomes:

- Gain a greater understanding of the 12 MCH Leadership Competencies and how they can be applied in multiple arenas;
- Be able to apply the 12 MCH Leadership Competencies in a day-to-day professional environment;
- Develop a learning collaborative who will learn and grow together in the application of these competencies;
- Learn leadership skills that will enhance career growth and opportunities, and become embedded in professional practice, creating sustainability over time; and
- Have a repertoire of skills that can be shared with others to distribute leadership throughout the organization.

Predicated on the belief that leadership development programs should use real organizational issues to provide challenges, feedback, and support, the adolescent health leadership development initiative sought

to integrate learning and application by creating a 12 module curriculum that provide an overview of an MCH leadership skills and the requirement of a professional activity, based on real-world program needs, to demonstrate competency of the skill. On-going support through an interactive wiki, video conferencing, and emails and phone calls provides participants guidance in their leadership development journey.

ACCOMPLISHMENTS/RESULTS/BARRIERS

In June of 2009, the pilot group will come back together to evaluate the experience, discuss challenges, celebrate successes, communicate ideas to improve the initiative and discuss thoughts on bringing the concept of leadership development for State Adolescent Health Coordinators to other states. AMCHP is proposing this session to share the lessons learned along with tools and resources from this and to provide a forum to discuss strategies for the future of MCH leadership development efforts.

Results from a pre-hurricane maternal child health preparedness focus group

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CATEGORY

Other: Preparedness

FOCUS

Program Policy Focus

OBJECTIVE

Preparedness efforts have rarely included pregnant and lactating women with young children. This vulnerable population is not targeted with preparedness information specific to their situation. This research sought to provide inputs as about health behavior and intent (prospective) with this vulnerable population. Lessons from Hurricane Katrina in New Orleans in 2005 and the many hurricanes that have hit the Florida Keys have clearly demonstrated that women and families need specific instructions when a disaster hits their homes. What do pregnant, lactating and parenting women (with children under age 3) living in the Florida Keys know about emergency preparedness?

METHODS

Ten English speaking pregnant women or women with a child under the age of three in the home were recruited from a local new mother support group. Data was collected with the use of a transcriptionist and back up audio, and then reviewed by the principal investigator. Participants received a \$25 gift card to a local grocery retailer for participation, lasting approximately an hour and half.

RESULTS

The results of the (n=7) women participating in the focus group suggest that pregnant, lactating and parenting women in the Florida Keys may be unprepared for an emergency such as a hurricane and do not have adequate plans for childbirth delivery, feeding and caring of their infants when impending hurricane mandates evacuation or shelter in place. Family “rules” for evacuation often do not match those practiced in the region by emergency planners, and unlikely sources for information emerged as common themes.

CONCLUSIONS

Pregnant, lactating women and young families parenting infants represent a vulnerable population often overlooked by disaster planners. This project assessed the level of readiness and identified trustworthy communication sources in a disaster by conducting a focus group of the local target population in the Florida Keys.

Ironically, the focus group was held on the eve of an evacuation order for the Florida Keys because of impending Hurricane Ike.

The need for standardized evidence-based protocols in place to assist this vulnerable population was reinforced by the results of the Florida Key focus group perceptions. The need for clear instructions for women who must give birth during any type of crisis with minimal or no assistance can be introduced during prenatal visits and childbirth education classes. Information should include instructions for gathering supplies for a basic birth kit and basic delivery instructions.

Priorities should also include preventing unnecessary post-disaster mortality in both mother and baby. Emergency relief staff must be trained in proper health protection of infants specific to breastfeeding, safe feeding, and relactation.

INFORMATION FOR REPLICATION

We believe that every community and hospital should work with local maternal and child health groups to address childbirth and care of postpartum women and care of infants. Of concern is the need for prenatal care to continue to prevent preterm birth, provide skilled care during birth, especially if services are unreachable or unavailable, and proper care and feeding of newborns.

The need for clear instructions for women who must give birth during any type of crisis with minimal or no assistance can be introduced during prenatal visits and childbirth education classes. Information should include instructions for gathering supplies for a basic birth kit and basic delivery instructions.

Healthy Start Programs, WIC programs and emergency management agencies would be considered key stakeholders to ensure policy development and implementation.

Screening for alcohol, tobacco and other drug (ATOD) use among pregnant women in Comprehensive Perinatal Services Program (CPSP) Clinics: An innovative approach by the Coalition for Alcohol & Drug Free Pregnancies (CADFP) in Santa Clara County, California

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CATEGORY

Preconception health and health care
Birth defects

FOCUS

Program Policy Focus

ISSUE

Prenatal exposure to alcohol, tobacco and other drugs (ATOD) is the leading preventable cause of birth defects and developmental disabilities impacting babies throughout their lives. 50% of pregnancies are unplanned; 50% of women of childbearing age report alcohol use. Best practices require that all pregnant women are questioned at prenatal visits about ATOD use. However, few OB/GYN's screen women for alcohol and the majority need assistance with training and resources. In a recent survey conducted by CADFP among OB/GYN providers in Santa Clara County (SCC), 98% of providers reported asking their pregnant patients about tobacco use, but only 11% screened for alcohol use.

Sixty seven percent of OB/GYN providers needed assistance in identifying ATOD users--validating CADFP's mission to raise the capacity of perinatal service providers to prevent and treat perinatal substance use.

SETTING

In our county, CADFP provides perinatal health professional's with education, resources and capacity building tools to implement a universal Screening, Brief Intervention, and Referral to Treatment (SBIRT) program. Other than the Kaiser network, there are no other public or private OB/GYN offices in SCC set up to implement SBIRT.

PROJECT

Phase I:
Activity 1: Establish baseline prevalence of current ATOD use in pregnant women at a Pilot. Comprehensive Perinatal Services Program (CPSP) Clinic.

Activity 2: Conduct SBIRT training at the pilot clinic to develop standardized office protocols.

Phase II:

Implement phased training at 6 CPSP clinics to integrate SBIRT protocols as part of the routine assessment by April, 2009. CADFP aims to expand training in all 26 CPSP sites in SCC within two years.

ACCOMPLISHMENTS/RESULTS

Activity 1 of Phase I has been completed. A survey of 399 pregnant women was conducted at a CPSP Clinic in 2007. Results of our survey show that one in five respondents were currently using ATOD. However 45.4% of women were at-risk (any positive response for 5P'S screening tool assessing for parents, partner, past, present, peers along with smoking, adverse mental health, and family violence) for substance use. CADFP has used these survey results in developing training curriculum for SBIRT at the CPSP clinics.

Phase I: Activity 1 is currently being implemented. Two trainings within the month of April will be conducted by CADFP staff. The first training will provide the OB/GYN staff an overview of the SBIRT program. The second training will include step by step methodology to seamlessly integrate office protocols with SBIRT.

Phase II: Evaluation of Activity 2 of Phase I will be used to integrate SBIRT protocols at all 26 CPSP sites by April 2011. Each of the CPSP sites will be trained to implement SBIRT to augment existing office protocols.

BARRIERS

- Social stigma around addiction issues.
- Misconception among health care providers.
- Limited Treatment options.
- Existing economic climate affecting resources.
- Lack of compassion and empathy from health care providers regarding addiction.

LESSONS LEARNED

Each OB/GYN office has unique office procedures; being sensitive to existing office protocols and time constraints is critical for successful integration of SBIRT.

INFORMATION FOR REPLICATION

Key partners/stakeholders who collaborated on this program were as follows:

Santa Clara County Public Health Department, Santa Clara County Department of Alcohol and Drug Services, Santa Clara Valley Medical Center(county hospital), all of the local CPSP clinics, First 5 of Santa Clara County, local March of Dimes, Santa Clara County Medical Association, Planned Parenthood (local), South Bay Children's Medical Group, and the FASD Task Force of Santa Clara County and many community volunteers.

Hip Hop for Health Project: A public/private collaborative

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CATEGORY

Adolescent health / pregnancy prevention
Chronic disease and MCH (Asthma, Diabetes, Obesity)

FOCUS

Program Policy Focus

ISSUE

The purpose of the Hip Hop for Health Project is to provide healthy weight/lifestyle education, health screening, follow-up, and referral for middle and high school students in the largest school district in Wyandotte County, Kansas.

SETTING

The Hip Hop for Health Project is collaboration between Unified Government Public Health Department of Kansas City, Kansas/Wyandotte County (UGPHD), Associated Youth Services (AYS), and Unified School District (USD) 500. In USD 500, 73% of students come from households below the federal poverty level.

PROJECT

The project model consists of three main components: screening, follow-up, and referral.

- Screening: The Hip Hop for Health Fairs take place at 14 USD 500 middle and high schools. Students from physical education classes assemble in the gymnasium for introductory presentations. Students then visit interactive exhibit stations to learn about various health topics and community resources. The atmosphere is fast-paced, fun and educational. Selected popular hip hop music is played in the background. AYS and UGPHD collaborate to screen students for height, weight, body mass index (BMI), and blood pressure.
- Follow-up: UGPHD and AYS collaborate to contact youth and their parents through mail and phone calls. Written information is provided about BMI screening results and the possible health and social consequences that could result from being overweight or obese.
- Referral: Parents are encouraged to discuss the screening results with their family health care provider. Parents are provided with contact information for weight management clinics available at Kansas

University Medical Center and Children's Mercy Hospital. Adolescents are also offered a Healthy Lifestyles screening at the UGPHD or the opportunity to enroll in AYS's Hip and Fit program.

ACCOMPLISHMENTS/RESULTS

As of March 1, 2009, 1,460 adolescents have been screened in nine schools. Of the students who completed a BMI screen, 18% were overweight and 31% were in the obese range. Follow-up letters have been sent to 100% of adolescents that have been identified as overweight or obese. Six youth have received a Healthy Lifestyles assessment. Sixty-nine students have participated in the Hip and Fit pilot.

Evaluation Plan: Resource Development Institute is the project's formal evaluator. Students and vendors complete an evaluation of the fairs. Data shows that 99% of youth reported increased awareness and knowledge of nutrition and health; 86% of youth received at least one health screening.

BARRIERS

- Incorrect and/or insufficient contact information for adolescents made follow-up challenging.
- Student and/or parental reluctance to view elevated weight and BMI as problematic.
- Because of absenteeism or block/alternate day scheduling, some students missed the screening in each school.

LESSONS LEARNED

- It is important to gain more parental "buy-in" for the project. Plans including adding an orientation meeting with the youth and parents, as well as family fun nights each quarter at the local YMCA.
- Multi-year funding has been requested to expand the project to all four school districts in Wyandotte County. This would allow organizers to conduct longitudinal tracking of participants to gauge how well commitments to healthy eating and increased activity are sustained.
- Health departments have a key role to play in community collaborations. A complex, endemic public health concern such as adolescent obesity is best addressed by a variety of resources.

Prenatal care in transition: A collaborative direct care model

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CATEGORY

Preconception health and health care

FOCUS

Program Policy Focus

ISSUE

The principal goal of a collaborative direct care model is to help ensure early, comprehensive and quality access to prenatal care for the uninsured and underinsured pregnant women in Wyandotte County, Kansas.

SETTING

Wyandotte County is the smallest geographic county in Kansas, but one of the most densely populated. It struggles with higher rates of unemployment, uninsured, poverty, and teenage pregnancy than the state average.

The Wyandotte County Prenatal Care and Referral Program, administered through the Unified Government Public Health Department's (UGPHD) Prenatal Program in Kansas City, Kansas/Wyandotte County partners with two birthing hospitals (one of these is a medical center of a state university), private OB/GYNS, state laboratory, and a private imaging service.

PROJECT MODEL

In December, 2006, the UGPHD transitioned from a decades-old, on-site, comprehensive prenatal care service delivery model. Focusing on the public health needs of the community and the health care needs of non-insured pregnant women, the UGPHD launched a prenatal care and referral program, working with community physicians and hospital providers to care for these women during their pregnancies. The UGPHD coordinates each woman's prenatal care needs; conducts education classes critical to ensuring healthy pregnancies; provides histories, screenings, routine initial lab and pharmaceuticals; and links women to participating medical and radiology providers for their prenatal care visits.

ACCOMPLISHMENTS/RESULTS

In 2007, 266 women received prenatal care through the new program. All women were uninsured. The vast majority were white, Hispanic and lived at or below 133% of the federal poverty level.

Program Successes:

- Clients generally complied with program requirements and provider expectations.
- Pregnancy and prenatal education received commendations from participating providers.
- The referral/case management process differs slightly by provider and client needs and was noted as a strength of the program.

EVALUATION PLAN

Evaluation of the program began in November, 2007, with a published report in May, 2008. The evaluation involved conducting interviews and site visits with providers, hospitals, and UGPHD staff to determine how the program was functioning and to identify opportunities for improvement.

BARRIERS

- Lack of adequate public transportation for clients assigned to providers at a distance from their homes.
- Interpretation (verbal) and translation (written) provider costs to meet needs of limited English proficiency clientele.
- Lack of public health insurance to cover prenatal care costs for the pregnant non-citizen.

LESSONS LEARNED

- A more aggressive marketing campaign was needed to avert misinformation about the changing service delivery model.
- Collaborative effort across governmental agencies, hospitals, private physicians and clients can be organized around a public health need.
- There is an important role for health department leadership to play regarding active participation in collaborative facilitation, coordination of the intervention model, and outcome evaluation.

Community baby showers: Integrating interconceptional health education with an innovative life course approach

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CATEGORY

Family planning
Other: Interconceptional health care

FOCUS

Program Policy Focus

ISSUE

The purpose of the Community Health Themed Baby Showers (Shower) is to promote longer interconceptional periods and improve the overall health of women, children and families. Maternal and child health researchers emphasize the importance of educating women on interconceptional health care in order to reduce the number of poor birth outcomes.

SETTING

The showers are held monthly at various locations within the area served by the St. Petersburg Healthy Start Federal Project (Project). Shower participation is targeted towards the pregnancy and interconceptional phases of the estimated subpopulation of 12,000 African American women of childbearing age, 2,000 African American infants up to six months and their families. Attendees are provided an opportunity to establish relationships with others in the community who are in similar situations.

PROJECT

The Project works to reduce significant disparities in infant mortality and low birth weight experienced by women living in an intervention area comprising four ZIP Codes in South St. Petersburg, Florida (33705, 33711, 33712, and 33713). The showers promote self-advocacy and provide interactive health education activities in a festive atmosphere. Interconceptional health education covers topics such as contraception and reproductive, mental, and financial health.

The showers are designed to do the following:

- Provide interconceptional education and counseling to project area and community families.
- Identify pregnant women for case management services.
- Link families with maternal and child health resources.
- Recruit lay health advisor training participants.
- Recruit consortium members.
- Provide intervention services using professionals from the community such as: a community health educator, certified lactation consultant and early childhood development specialist.

ACCOMPLISHMENTS/RESULTS

Women's Health Questionnaires are used to capture biological, behavioral, psychological, social protective and risk factors that may contribute to the birth outcomes across the span of each woman's life.

Results of participant survey pre/post intervention indicate participants were enthusiastic about the learning environment; had increased awareness of community resources; believed that the showers were educational and useful; were more receptive to case management; and were more likely to become actively involved in the community-based consortium.

Our success is measured at the end of the event when the families team up to play our interconceptional health-themed JEOPARDY trivia game. This game allows us to gauge how much of the information was retained. This presentation can be facilitated in 20-25 minutes and requires PowerPoint technology.

BARRIERS

- Lack of continuous reinforcement of interconceptional health education by physicians.
- Local health agencies and providers with insufficient cultural competency guidelines.
- Negative reputation of county health departments.

LESSONS LEARNED

- Most women who attend community showers lack financial and social resources to have traditional showers.
- Community awareness about the racial disparities in infant mortality and health disparities for women has to be increased.
- Educating the community about interconceptional care helps combat low birth weight and infant mortality.

Overcoming barriers to confidential care for inner-city adolescents

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CATEGORY

Adolescent health / pregnancy prevention

FOCUS

Program Policy Focus

ISSUE

Although state laws provide for confidential care for adolescents, many teenagers are not aware of this right, their parents do not understand it, and providers are uncertain about how to offer it. This program aims to ensure that Bronx teenagers have ready access to confidential care at the sites where they obtain primary and preventive care services.

SETTING

The program is in progress at 19 primary care sites (clinics, community health centers, and office practices) operated by a large Bronx medical center; about 40,000 adolescents (aged 13-21) use the sites annually. Young people and their families, site administrators, professional and support staff are all involved.

PROJECT

Policy development, systems changes, communication and education have been key components of this initiative, carried out under the auspices of a group of medical center physician and administrator volunteers.

Initial activities were designed to raise all stakeholders' awareness of New York State law protecting confidentiality for certain types of care to minors. Then came efforts to ensure that adolescents are comfortable with seeking confidential care, and to help parents accept this aspect of their children's care. Methods were also developed to facilitate confidentiality in provision of care by providers and support staff, such as accepting calls from teens to make their own appointments, routinely seeing youngsters alone for part of each visit, and arranging for selected insurance claims to bypass family notification.

Evaluation plans include follow-up chart reviews and post-visit surveys of teens and families.

ACCOMPLISHMENTS/RESULTS

The need for this initiative was demonstrated to medical center leadership and staff by:

- Focus groups of adolescents at several sites, supported by a CATCH grant from the American Academy of Pediatrics (AAP), showing that younger teens often didn't know their rights and older ones didn't always trust doctors to keep their secrets;
- An informal survey of reception staff and first level supervisors revealing gaps and variation in understanding of state laws; and
- Review of over 300 medical records finding no documentation of teenagers being seen alone.

Several thousand copies of a "Teens Health Care Bill of Rights" in a colorful, user-friendly version by the NY chapter of the AAP and the NY Civil Liberties Union have been distributed to youth at various sites. An official medical center policy, "Care of the Unaccompanied Minor" has been adopted and discussed at in-service, staff conferences and other meetings of site administrators, house officers, nurses, reception and billing staff. It has also been posted and distributed electronically. A preprinted medical record form for the adolescent preventive care visit has been prepared and adopted that includes a check-off box for when a patient is seen alone. This serves both as a reminder and for documentation.

BARRIERS

- Variations in size and heterogeneity of staffing patterns among different sites require multiple venues and formats for communication.
- Obtaining approval for new policies and procedures in a large medical center is a lengthy and complicated process.
- Achieving uniform compliance when introducing new systems and procedures at multiple sites in a non-hierarchical organization is a continuing challenge.

LESSONS LEARNED

Recognition of the problem and the need for change by a broad constituency of health professionals can help overcome existing barriers. Expect a multiyear effort, and prepare to do ongoing monitoring of results.

INFORMATION FOR REPLICATION

Except for the CATCH grant, there was no specific funding for this work. Administrators cooperated and physicians donated their time for meetings and paper work. Materials such as the Teen Bill of Rights were also donated. Dedicated leadership by members of the Division of Adolescent Medicine made it happen.

Coalition for Child Safety: Community keeping kids safe

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CATEGORY

Other: Violence Prevention

FOCUS

Program Policy Focus

ISSUE

Independence experienced three child deaths from child abuse in 2002 and continues to experience the effects of family violence.

SETTING

Independence, population 111,000 is served by the Coalition for Child Safety (CCS), a community initiative launched by the Independence Health Department in 2002. The Coalition has provided multi-faceted activities and projects via multiple modes to:

- Raise awareness of family violence (child/elder abuse, domestic violence, animal cruelty)
- Provide education for city employees and community members
- Offer support and resources for families/parents.

PROJECT

CCS is a model coalition comprised of community partner agencies who have committed to disallow ‘turf’ issues and to work together as closely as possible to support families and protect children. Our work is based on collaboration and communication, mobilization of resources, and leveraging of funding to provide the most benefit for families.

ACCOMPLISHMENTS/RESULTS

- Increased effective communication between agencies that serve families; in particular, a faxed notice from Children’s Division to Independence Police Department when a case is opened. If a police unit is dispatched to that family/address for any reason, responding officers know to evaluate circumstances in light of possible child welfare issues, and insist on seeing every child in the family. In 2009 we have collaborated to design a communication tool for Animal Services and the Children’s Division, acknowledging the link between animal abuse and family violence.

- Parents University; a workshop for parents and caregivers, where they choose class sessions from a variety of topics while their children are involved in fun, educational activities. A Showcase of community resources, programs, and services is provided to increase their access to family support opportunities. This event has grown in size and popularity since initiation in 2004.
- Community Mini-grants of \$500 provided by CCS to community groups for prevention activities in April (utilizing CTF funds). To date, eight grants of \$500 awarded.
- Family Resource Guides updated and printed yearly for services and resources in Independence area. These are distributed through partners and providers.
- Creation of an effective network; inter-agency communication is vastly improved, which strengthens our response to families in stressful circumstances, and mobilizes resources more effectively.
- City employee training on recognition and reporting of suspected child abuse/neglect, with laminated reference materials for use in the field.
- Multi-sector dialogue group leading to the creation of a training module for community groups explaining the link between animal cruelty, family violence, child/elder abuse.
- Resource library created which includes printed materials and a Child Abuse Prevention presentation kit.

LESSONS LEARNED

- Public health is seen as a neutral entity, thus is a natural choice for leading the coalition.
- Even tragedy wears out; motivation must be renewed and purpose redefined periodically to respond to emerging needs and to keep partners engaged.

Safe sleep advocates and breastfeeding advocates working together to teach safe sleep

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CATEGORY

Infant mortality and morbidity

FOCUS

Program Policy Focus

ISSUE

In Milwaukee, WI in 2007, 26 infants died in unsafe sleep environments and five by entrapment. In investigating this issue, the City of Milwaukee Health Department (MHD) discovered that patients in hospital birthing units were receiving conflicting information about safe sleep. Lactation consultants' advice is sometimes at odds with expert-recommended safe sleep practices. Literature indicates that parents do follow practitioners' advice, but they are often confused by fractured or conflicting messages.

SETTING

The Wisconsin Association for Perinatal Care (WAPC) has a group in each region of the state. An MHD public health nurse, who is also a representative from the WAPC Southeastern region, called an initial meeting to discuss the need to promote breastfeeding and teach safe sleep using a consistent message. Members of the Southeastern region of WAPC, and other community partners, were invited to the meeting.

PROJECT

The goal of this program was to bring the birthing units from local area hospitals together and make a commitment for safe sleep to be taught by all staff, as a strategy to reduce the incidence of SIDS deaths. During the first meeting, the group laid the foundation for addressing the issue. A presentation included differing viewpoints on bed-sharing as a way to improve success in breastfeeding and also as a risk for increased deaths due to SIDS. This first meeting led to a number of meetings over a one year period, during which participants discussed policies on breastfeeding and safe sleep, such as the Academy of Breastfeeding Medicine and the American Academy of Pediatrics policy on the reduction of SIDS.

RESULTS

- To provide safe sleeping for an infant, teaching on each birthing unit needed to foster room sharing, not bed sharing, even when mother was breastfeeding.
- The message needs to be the same whether it was delivered by a lactation consultant or a nurse.
- Each unit agreed to use the Continuing Education Program on SIDS Risk Reduction: Curriculum for Nurses” as a mandatory teaching module for the nurses. Each hospital agreed to implement the curriculum by June 2009.

In addition, a poem was created by a member of the group to be used in the bed of every newborn that outlines strategies to provide a safe sleep place for their new baby. The infant cards will be printed and given to the hospitals to use with each birth.

Full implementation of these suggestions will take place through WAPC and hopefully expand to the rest of the state.

BARRIERS

It is difficult to get multiple practitioners to teach materials the same way.

LESSONS

- On controversial issues, there is a need to present all sides of the issue, allow for brainstorming, and then move forward.
- Many minds often come up with the best solution.
- Health departments are often looked upon as neutral parties, and thus have the ability to call together a group of competitors and facilitate solutions to difficult problems.

Developmental screening in primary care pediatrics: Building bridges between the private and public health system in the Oregon Screening Tool and Referral Training (START) Initiative

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CATEGORY

Child growth, development, preventive care
Mental health

FOCUS

Program Policy Focus

ISSUE

Large communication barriers exist between primary care and the public health system (and other parts of the early childhood system) in creating coordinated care that works for families. This project was developed to improve developmental screening in pediatric practices; to improve practitioner understanding and utilization of standardized screening tools; teach proper documentation, billing of screening tools; and to build stronger linkages between the primary care system and public health, child care, and early intervention to strengthen early childhood prevention.

SETTING

Target populations include public and private pediatric practices throughout the state of Oregon.

PROJECT

The START project developed a curriculum to train primary care practices in implementing screening tools and effective referral. A panel of community partners from Early Intervention, Public Health, Child Care, and community based Mental Health attend each training to build relationships and share referral protocols. The curriculum is composed of four parts: Science of Developmental Screening, Specific Tools, Community Resource Panel, and Coding / Mapping the Workflow. Ages and Stages Questionnaire (ASQ), Parents' Evaluation of Developmental Status (PEDS), and the Modified Checklist for Autism in Toddlers (M-CHAT) are taught. This adult-learning friendly curriculum encourages uptake by practices while building relationships across the great divide of the public and private health systems.

ACCOMPLISHMENTS/RESULTS

In the first seven months, the program has trained over 254 participants which reaches roughly 81% of all children birth to five in a three county region of Oregon. A universal referral and release form has been developed for all Oregon counties –greatly improving the communication between the different stakeholders. The majority of providers have implemented at least one screening tool with over half implementing two screening tools in their practices. Post-training data is currently being analyzed from the first round of trainings.

BARRIERS

- Gaining access to primary care was a huge barrier – partnering with the local AAP chapter and bringing the training (and dinner) into the practice helped overcome this barrier.
- Overcoming the cultural barriers across disciplines was also significant – the community panels created a dialogue where participants began to share their frustrations and opportunities.
- Continued funding is a barrier until the State steps up to support this effort.

LESSONS LEARNED

Physicians and staff are receptive to screening for developmental disabilities and autism and this type of hands on training is well received. Lack of physician knowledge of community resources and the referral processes is significant and widespread. The lack of a universal referral and information release process has been an additional barrier for physicians and community providers working toward a coordinated care model. Public health home visitors are often seeing the same children and there is very little sharing of information/data across these disciplines. Strengthening developmental screening and linkages to community referral in primary care will increase our effectiveness in early identification of challenges. This approach also strengthens working relationships across disparate professional groups to increase access to appropriate services for families with children struggling with suspected social/emotional/developmental delays.

INFORMATION FOR REPLICATION

The approximate annual budget for START is \$100,000, which includes the staff needed to coordinate, physician stipends to deliver the training, materials, meals, and travel. This is a very modest amount to influence an important public health outcome such as this.

The seed monies for this initiative have come from a local managed care organization which manages Medicaid in our region. In states where this type of effort has been sustained, it has included a mix of Medicaid and private funds.

American Academy of Pediatrics-state chapter, Medicaid, Maternal Child Health - State and county, Early Intervention (special education), Child Care Resource and Referral, Mental Health providers who work with young children, Oregon State Early Childhood Matters Council and Commission on Children and Families.