Project Abstract

Based on review of vital statistics data, conservative estimates are that more than 50% of pregnancies in New York City occur without appropriate planning. The results are poor outcomes (low birth weight, pre-term birth, infant death) among women with these unplanned pregnancies, since women who have unplanned pregnancies are more likely to be uninsured, receive inadequate prenatal care, and engage in high-risk activities.

The objectives of Health Bridge are to (1) Reduce barriers to prenatal care, and (2) Increase awareness among women of reproductive age of the importance of maintaining good prenatal care during pregnancy, and maintaining good nutrition before, during, and after pregnancy.

Health Bridge will be housed in the Office of Family Health (OFH). See description of the Office of Family Health – attachment 1. The Project will
(1) Review the OFH 1998 Prenatal Care Appointment Survey results, and work with staff of the Health Information Services (HIS) Unit to conduct the 2001 survey. See attached survey and summary – attachments 2 and 3. Based on information from these surveys, Health Bridge will work with providers; educating them about the barriers pregnant women face when trying to access prenatal care, and helping them to design strategies to reduce these barriers. (2) Collaborate with the Maternal, Infant and Reproductive Health Program's (MIRHP) Community Educational Services (CES) Unit, and the Department of Health's Infant Mortality Initiative, to educate women of child bearing age about the importance of planning their pregnancies. (3) Use existing partnerships with perinatal networks, New York City Department of Health (NYCDOH) Sexually transmitted Disease (STD) clinics, and hospitals to reach target women.

Project Description

Health Bridge will operate out of the New York City Department of Health's Office of Family Health, which houses the Maternal, Infant & Reproductive Health Program (MIRHP). MIRHP has 5 Field Sites, which are located in the New York City Health Districts with the poorest infant health indicators – Central Harlem (Manhattan), Mott Haven (Bronx), Jamaica East (Queens), Bedford Stuyvesant and Fort Greene (Brooklyn). In 1998, the areas served by these field sites accounted for –

- 23% of live births
- 35% of live births to teenagers
- 28% of low birth weight (<2500g) live births
- 28% of premature (<37 weeks gestation) live births
- 32% of very premature (<34 weeks gestation) live births
- 27% of live births with late or no prenatal care
- 30% of Medicaid covered live births
- 30% of infant deaths
- These areas combined had an infant mortality rate of 9 per 1000 live births, compared to the citywide rate of 6.8 per 1000 live births.

Health Bridge will focus on improving access to prenatal care by educating providers of prenatal care about barriers that pregnant women face when trying to access prenatal care, and educating women of child bearing age in target areas on the importance of prenatal care. In addition the Health Bridge staff will provide educational awareness for women of reproductive age in these areas regarding the importance of being healthy prior

to pregnancy. Pregnancy planning education will focus on the importance of the following in fostering a healthy pregnancy:

1) Maintaining adequate nutrition before, and during pregnancy.
2) Having a social support system before, during, and after pregnancy.
3) Having sufficient economic resources to meet the needs of the growing family.
4) Having health insurance coverage (Medicaid, PCAP, etc) to cover prenatal care, labor and delivery, postpartum and pediatric care.
5) The importance of good prenatal care, and what constitutes good prenatal care.
6) The importance of establishing a good relationship with a health care provider.
7) Seeing a health care provider to assess high-risk behaviors and health problem, and initiating measures to eliminate or reduce them.
8) The importance of spacing births, and maintaining good health between pregnancies.

Through this funding request, Health Bridge will start a pilot in communities of highest needs. Later on, lessons learned from these approaches can be replicated in other communities in New York City. The progress indicator that Health Bridge will focus on will be the rate of planned pregnancies, and the number of women who are healthy before becoming pregnant. The objective is to decrease unplanned pregnancies thereby increasing the proportion of pregnant women who are healthy (take their prenatal vitamins and iron, take folic acid, receive prenatal care, have a private provider, don't drink, smoke or use illicit drugs), and decreasing the percent of pre-term births.

Health Bridge will work with the MIRHP Field Sites' case management and outreach staff, and other education services for pregnant women to distribute educational materials to women of child bearing age. To the extent possible educational materials will also be

distributed through provider sites. The aim of this activity will be to encourage women of childbearing age to get counseling on pregnancy planning, and the importance of being healthy prior to pregnancy. In addition, Health Bridge will work with the CES Unit to educate staff of MIRHP field sites and community clinics regarding barriers to accessing prenatal care, and steps to a healthy preconception period. This educational process will also encompass informing staff at provider sites regarding the availability of appropriate educational materials, and the importance of making educational materials culturally appropriate.

Health Bridge will work closely with the OFH Infant Mortality Reduction Initiative that is now forming in Brooklyn. In addition Health Bridge will assist in the training of staff at NYCDOH STD clinic to provide counseling and referrals for women who visit the clinic for STD testing.

Awareness of the efforts of Health Bridge will be fostered through the use of electronic and print media that reach the target community. Community outreach efforts will also serve the purpose of giving feedback to the community regarding the progress of Health Bridge.

Project Objectives and Activities/Methods

Activities to be conducted prior to project start-up:

1. Literature search on
    a) Factors that determine the utilization of prenatal care services.
    b) Effective strategies utilized by community-based efforts to reduce barriers to prenatal care.
2. Review of the results of the OFH 1998 Prenatal Care Appointment Survey.
3. Participation in the analysis of 1999 vital statistics data regarding prenatal care, and latest available vital records data regarding pregnancy outcomes for areas covered by the MIRHP field Sites.
4. Review of Field Sites records regarding the percent of clients who are actively planning their pregnancies to assess the need for education regarding the importance of pregnancy planning.

Activities to be conducted during grant period:

1. Participation in the 2001 Prenatal Care Appointment Survey, in conjunction with OFH research staff, to determine current barriers to the receipt of prenatal care.
2. Reach out to prenatal care and women's health providers in target areas, particularly those that were included in the 2001 Prenatal Care Appointment Survey.
3. Prepare or obtain educational materials, and distribute these materials to providers in the target areas.

4. Collaborate with perinatal networks, Healthy Start funded projects, and women's health services organizations to facilitate community forums and other formats for presenting information to the community.
5. Work with CES Unit, the Infant Mortality Initiative, and community-based organizations to promote the importance of preparing for a healthy pregnancy. Efforts will be made to refer women seen at the community forums to community-based providers and MIRHP Field Sites where appropriate. In addition the NYCDOH Women's Healthline will be used as the telephone line to provide referrals.
6. Work with NYCDOH STD clinics to educate staff on providing referral and counseling regarding pre-pregnancy planning to clients.

Evaluation Plan

Evaluation staff at the Office of Family Health will use the following strategies to assess the impact of Health Bridge in the target areas:

1. Testing of participants before and after educational awareness presentations conducted by Health Bridge to assess knowledge gain.
2. Survey of women who receive comprehensive case management at MIRHP sites through the efforts (referral, follow-up, etc) of Health Bridge regarding pregnancy outcomes. This will then be compared to average pregnancy outcome in the client's area of residence.
3. Work with OFH research staff to survey providers to assess service changes made to reduce barriers to receiving prenatal care at their facilities. This survey will be conducted near the end of the project period.
4. Data on the number of attendees at community forums wherein the Public Health Educator makes presentations will be collected.
5. Monitoring of calls to the Women's Healthline to determine how many calls come in from people who attended a Health Bridge presentation, saw printed information from Health Bridge, heard a Health Bridge presentation on the radio, or saw information about Health Bridge on television.

Project Impact

The expected impact of Health Bridge is a reduction in poor pregnancy outcomes as a result of educating providers, pregnant women, and other women of reproductive age on the importance of being healthy before becoming pregnant, and staying healthy during pregnancy. Infant mortality and morbidity are very painful issues for families, and can negatively impact their wellbeing and that of the community at large. Unfortunately infant morbidity and mortality are experienced at an increased rate for families that are already dealing with other socioeconomic factors such as poverty, substance abuse, inadequate housing, and high unemployment.

By educating pregnant women and women of reproductive age regarding the importance of planned pregnancies, and positive health behaviors before, during, and after pregnancy, and by working with community-based organizations and health care providers to improve access to prenatal care more participants will begin to plan their pregnancy. The expected result is improved pregnancy outcomes among these women.

Educating providers about the barriers they present to women seeking prenatal care, and assisting them in the development of strategies for reducing these barriers, will enable providers to improve access to their services for pregnant women in the areas they serve.

Budget Justification

The funds being requested will be used to pay the salary of a Public Health Educator who will dedicate 100% of her/his time to Health Bridge. These are among the duties of the Public Health Educator:

1. Work with HIS research staff to conduct the 2001 Prenatal Care Appointment Survey.
2. Conduct literature searches related to the goal of Health Bridge.
3. Develop and distribute educational materials to providers and clients.
4. Become familiar with vital record and field site data, and work with HIS research staff to get needed data.
5. Work within established partnerships between OFH and other DOH units, governmental agencies, community-based organizations, and prenatal providers in the target areas.
6. Evaluate the project.

The Public Health Educator will be paid an annual salary of $38,106 commensurate with current Department of Health salary ranges, and his/her maternal and child health experience. In addition to the annual salary an amount of $9,908 (26% of the annual salary) has to be added to cover fringe benefits. The total being requested is $48,014.

In addition to providing office equipment and supplies for the project to include telephone service, furniture, office space, computer and peripherals, software, copier and copy paper, postage, books and scientific journals, and continuing education for the Public Health Educator OFH will fund the following:

1. Printing of educational material to be distributed by the Public Health Educator as part of community outreach efforts. 20,000 color flyers will be printed on letter-sized cardstock paper and folded at a unit cost of 8.7 cents each.
2. Travel of the Public Health Educator to provider sites, and community-based organizations within the target areas. At least 240 trips are anticipated for the project period at a cost of $1.50 per trip. In addition the Department of Health will cover out of town travel for the Public Health Educator for professional development.
3. A laminator to be used in the preparation of educational materials for providers.
4. Presentation equipment to be used by the Public Health Educator to do educational presentations. The presentation equipment will be a projector and accompanying notebook computer for PowerPoint slide presentations.
5. Supervision, computer support, data analysis support, as well as support from the MIRHP CES and Field Site Units.

Future Funding

The Office of Family Health has requested funds to establish a Women's Health Program within the Office of Family Health. The Program is expected to be either partially or fully funded by the ended of the 2002 fiscal year. Therefore, it is expected that in year 2 Health Bridge will be incorporated into the Women's Health Program.

In addition, the Office of Family Health is working closely with the Centers for Disease Control and Prevention (CDC) and the New York State Department of Health's Bureau of Child and Adolescent Health, and Division of Family and Local Health. Both agencies offer grants for community-based efforts such as Health Bridge. Once Health Bridge has been established in the target areas, the Office of Family Health will apply for funds, as they become available to continue Health Bridge in the target areas, and to expand Health Bridge to other New York City communities.

Attachment 1

Description of the Office of Family Health

New York City Department of Health's Office of Family Health houses:

1. The Health Information Services (HIS) Unit which conducts research and evaluation in the areas of maternal and child health, preventive health, and access to care. Specific studies include infant mortality surveillance, pregnancy outcome studies, breast-feeding and access to care surveys.
2. The Maternal, Infant and Reproductive Health Program (MIRHP) which has -
    - ❖ The Community Educational Services (CES) Unit, which conducts educational awareness at the community level.
    - ❖ Field Sites located in Mott Haven in the Bronx, Bedford and Fort Greene in Brooklyn, Central Harlem in Manhattan, and Jamaica East in Queens. The sites provide free pregnancy testing and comprehensive case management and referrals.
3. The Women's Health Program, which is currently in its developmental stages.
4. Community Clinical Services, a contract monitoring unit for the NYCDOH Communicare Clinics.

Attachment 3

Summary of the 1998 Prenatal Care Appointment Survey

Since 1992 the prenatal care appointment survey has been conducted on a biennial basis to monitor changes in access to prenatal care.

The 1998 Prenatal Care Appointment Survey involved a brief telephone survey of 131 prenatal care providers in New York City; the survey was conducted in Spanish at 57 of these sites. The telephone interviewer posed as a 26 year-old single undocumented women

- in her ninth week of pregnancy
- with a positive pregnancy test as conducted free through a MIRHP Field Site
- working as a domestic
- without health insurance
- and living with a friend.

The survey results indicate that at more than half (50.4%) of the sites surveyed there were barriers to receiving a prenatal care appointment. Some of the barriers included requiring the caller to:

- Come in and register first before the appointment can be made.
- Speak with provider staff about insurance coverage first before the appointment can be made.
- Come in to have her pregnancy test repeated at the provider site before an appointment can be made.

Other issues highlighted by the survey include the fact that hospitals were less likely to give prenatal care appointments and more likely to have long waiting periods in the

case of those that do give appointments. There’s still insufficient knowledge on the part of the clerk that answers the telephone regarding services that undocumented immigrants qualify for.