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# **Improving Services for Pregnant Women and Children 0-1 in Central New York State**

**Environmental Scan and Recommendations**

**Prepared for the Community Health Foundation of Western  
and Central New York**

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**Table of Contents**

Introduction .....	1
Methodology.....	3
Statistical review .....	3
Initial service availability assessment .....	3
Clarification of service capacity and unmet needs.....	4
Development of final report .....	6
Service area profile.....	7
Demographics .....	7
Adult health behaviors and outcomes .....	10
Child well-being trends.....	12
Summary .....	14
Service capacity.....	16
Prenatal and perinatal service provision to low-income women: the PCAP and MOMS programs.....	16
Home visiting programs: county health department home visiting, Health Families New York, and Nurse Family Partnership .....	19
Other program models: CPPSNs, WIC, community health worker programs, and community-based organizations ..	21
Comprehensive Prenatal-Perinatal Services Networks (CPPSNs).....	25
WICs .....	25
Community Health Worker Programs (CHWPs).....	26
Other community-based organizations and agencies..	26
Strengths, gaps, and limitations to service provision .....	27
Strengths.....	27

Adequate service capacity throughout the region .....	27
Strong cooperation and collaboration between service providers .....	28
High quality and breadth of services available throughout the region .....	29
Service gaps .....	30
Absence of standardized at-birth risk assessment procedures .....	32
Absence of collectively understood and implemented accountability system.....	33
Limitations to service provision.....	33
Issues with communication strategies and information delivery systems .....	33
Difficulties accessing services .....	35
Punitive policies.....	36
Coordination issues related to service provision.....	37
Recommendations .....	39
Community Health Worker Program model .....	41
Centering Pregnancy model .....	42
Enhanced coordination through Comprehensive Prenatal-Perinatal Services Networks .....	43
Educational and informational materials.....	44
Strengthen WIC-DOH relationship.....	45
Developing a standard risk assessment .....	46
Conclusions .....	47
References .....	49
Appendix A: Key informant interview protocol.....	51
General introduction.....	51

Background/context .....	51
Accessing services .....	52
Who is not accessing services? .....	54
Service engagement and retention .....	55
Other contacts .....	56
Appendix B: Overview of key pre/perinatal services available in target service area.....	57
Prenatal care assistance programs.....	57
Home visitation programs.....	59
CPPSNs, WICs, Community Health Worker Programs .....	60
Community-based organizations (CBOs).....	61

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**List of Figures**

Figure 1: Grouping of counties by demographic similarity...5

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**List of Tables**

Table 1: Regional demographics .....	8
Table 2: Poverty indicators by county .....	9
Table 3: Teen pregnancy and abortion rates.....	10
Table 4: Adult health indicators .....	11
Table 5: Service utilization summary (2007) .....	12
Table 6: Infant mortality per 1,000 births and low birth weight rates per 1,000 births (percentage of county births) in 1997 and 2007 .....	13
Table 7: Child maltreatment reporting, substantiation rates, and foster care.....	14
Table 8: Summary of PCAP minimum requirements.....	17
Table 9: Type of prenatal care assistance program by county .....	19
Table 10: Type of home visiting program providing pre/perinatal services by county .....	20
Table 11: Other programs providing pre/perinatal services or support by county .....	22
Table 12: Prevention Agenda Objectives for 2013.....	40



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**List of acronyms and key terms**

<b>CBOs</b>	community-based organizations
<b>CHFWCNY</b>	Community Health Foundation of Western and Central New York
<b>CPPSNs</b>	Comprehensive Prenatal-Perinatal Service Networks
<b>FIMMRR</b>	Central New York Fetal-Infant Mortality/Morbidity Review Registry
<b>HF, HFNY</b>	Healthy Families, Healthy Families New York
<b>HSS</b>	health supportive services
<b>MOMS</b>	Medicaid Obstetrical and Maternal Services Program
<b>NFP</b>	Nurse Family Partnership
<b>NYSDOH</b>	New York State Department of Health
<b>PCAP</b>	Prenatal Care Assistance Program
<b>WIC</b>	Women, Infants, and Children program

**Use of “service provider” vs. “practitioner”**

We use the term “provider” throughout the report to refer to anyone who provides services or care in any non-medical or non-clinical capacity (e.g. staff who provide health information, education, or counseling, staff who provide services offered as part of the health supportive services package). We use the term “practitioner” throughout the report to refer *specifically* to medical/clinical professionals who are providing medical/clinical care (e.g. obstetricians, general practitioners, nurse midwives).

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**List of appendices**

**Appendix A** Key informant interview protocol

**Appendix B** Overview of key pre/perinatal services available in target service area

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# Introduction

The Community Health Foundation of Western and Central New York (CHFWCNY) is dedicated to improving the health and health care of residents in western and central New York. The Foundation's specific target service area includes 8 counties in central New York State – Cayuga, Cortland, Herkimer, Oneida, Onondaga, Oswego, Madison, and Tompkins. These counties have a combined population of approximately 1.1 million and these residents reside in diverse settings including moderate size cities (e.g. Syracuse), small towns, and rural communities. Among the health care issues of particular interest to the Foundation is the relatively high infant mortality rate within these counties, a trend which has led to a specific focus on the services available for pregnant women and infants under 1. In the past, the Foundation has made specific investments in addressing the needs of this population including the Nuts and Bolts Initiative (2005) and the Central New York Fetal-Infant Mortality/Morbidity Review Registry (FIMMRR) and is currently looking for additional strategies that will improve birth outcomes for children in poverty.

Although a number of early intervention initiatives and model early intervention programs exist in the service area, the quality and reach of these efforts is unclear. Before making further investments in this area, the Foundation is interested in better understanding the array of local actors providing assistance to pregnant women and their young children, the degree to which these agencies work together in insuring adequate coverage and quality of care for all those in the target population, and the specific ways in which additional resources might be used to improve the efficiency and effectiveness of these efforts.

To facilitate their planning process, the Foundation hired Chapin Hall to conduct an environmental scan of its service area for the purpose of outlining the health and well-being status of pregnant women and newborns in these communities and the array of health and support services available for this population. Specifically, Chapin Hall was asked to assess the behaviors, health care access, and service utilization rates of women in the target area; the degree to which provider behavior and attitudes influence health care access and utilization; and the role support

services and existing networks are playing or might play in improving service quality, capacity, and utilization. The purpose of this report is to review our procedures, summarize our core findings, and outline a list of recommendations for possible research and development projects suitable for Foundation investment.

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# Methodology

Our methodological approach segmented the scan into four tasks: a statistical review of the target service area, an initial service availability assessment, a clarification of service capacity and unmet needs, and the preparation of a final report. To date, we have completed all of these tasks. In this section, we briefly describe our methods in conducting this assessment.

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## Statistical review

In order to examine the current health status of residents living in the eight counties in the region and to better understand the regional and demographic picture of the study area, we completed a statistical review. Four main types of data were reviewed and documented. The first type of data included a scope of the target population including birth rates, fertility, number of pregnancies, and number and percentage of births to teens. These data were found on the U.S. Census Bureau website and the New York State Department of Health (NYSDOH) under vital statistics. The second type of data focused on health behaviors, health outcomes, and primary health care usage including levels of smoking, substance abuse, access to routine preventive care, and other adult health indicators. This information was found at the NYSDOH website within the Community Health Assessment Clearinghouse. The third type of data included in this statistical review was information about the current use of services, particularly prenatal care and Medicaid enrollment and utilization data. These data were accessed from both the NYSDOH vital statistics and Community Health Assessment Clearinghouse. Finally, we secured information pertinent to assessing infant well-being outcomes such as infant mortality rate, percentage of low birth weight babies, and child maltreatment rates from various administrative data sources maintained by the NYSDOH and the New York State Office of Children and Family Services.

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## Initial service availability assessment

After completing the statistical review, project staff obtained a list of key pre/perinatal contacts in the target service area from the Foundation and contacted these individuals for informational interviews.

These first-wave contacts included the executive directors of the three Comprehensive Prenatal-Perinatal Service Networks (CPPSNs) that serve the area, as well as administrators from other regional organizations that provide pre/perinatal services (e.g. Healthy Families New York, SUNY Upstate Medical University). In addition, staff from Chapin Hall reached out to the Ounce of Prevention Fund, a Chicago-based partner agency in child and family policy, for additional source recommendations based on that organization's ongoing work with early intervention advocacy in New York State.

Staff developed an interview protocol [see Appendix A] based on the objectives discussed in the initial work plan and used it to guide informational interviews with each of the contacts suggested by the Foundation and partners at the Ounce. At least one Chapin Hall staff member participated in each informational phone interview. At the end of each interview, staff asked informants for referrals to other contacts whose experiences and impressions might be relevant to the project, and then followed-up with those referrals and requested an interview. In many cases, these second-wave informants were frontline service providers,<sup>1</sup> often within county health departments, community-based organizations, or related agencies in the region. The interview-and-referral process was repeated for second-wave informants until we reached saturation with the type of information collected. In total, staff spoke with 26 service providers during these phone interviews.

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### **Clarification of service capacity and unmet needs**

After completing the initial service availability assessment, staff qualitatively examined key themes emerging from the informational interviews and aligned these findings with an analysis of the basic demographic characteristics of the counties to produce groupings of the counties by demographic similarity. The county groupings are as follows (see Figure 1):

**Group 1:** Urban counties with heterogeneous demographics [Onondaga and Oneida counties]

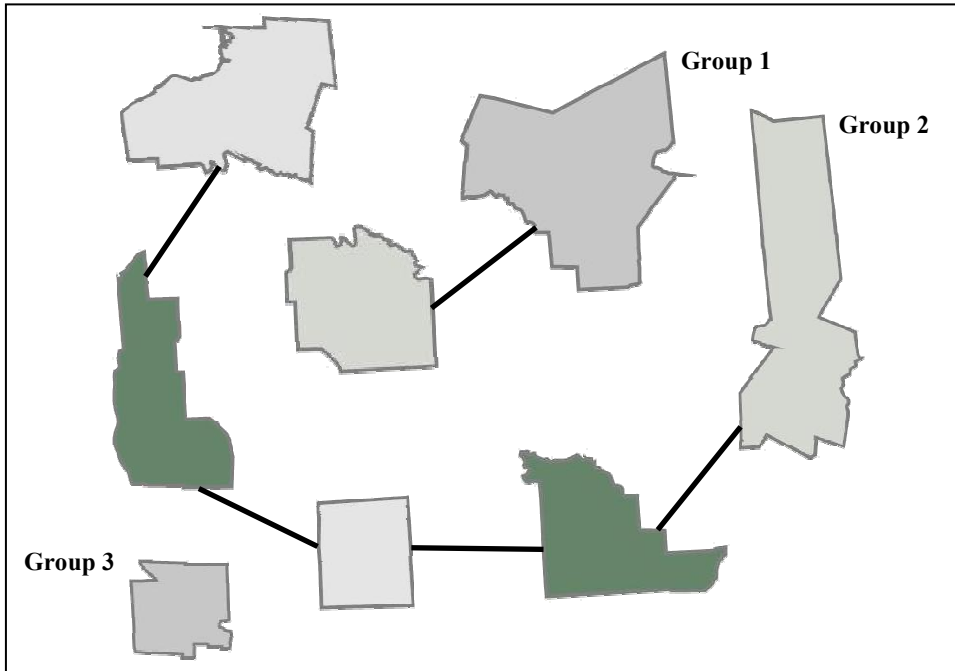
**Group 2:** Rural counties with homogeneous demographics [Oswego, Cayuga, Cortland, Madison, and Herkimer counties]

**Group 3:** Mixed urban/rural counties with mixed demographics [Tompkins County]

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<sup>1</sup> See “List of acronyms and key terms” for a discussion of the distinction between “service provider” and “practitioner” throughout the text of this report.

**Figure 1: Grouping of counties by demographic similarity**



When determining which agencies to target for site visits, staff applied four criteria to guide the site visit selections:

1. type of prenatal care assistance programs (PCAP or MOMS program) available in the county (i.e. agencies were targeted in a way that ensured all types of assistance programs were represented in site visits)
2. demographic characteristics of the county as defined above (i.e. agencies were targeted in a way that ensured all groups were represented in site visits)
3. the uniqueness and replicability of the service environment (i.e. an agency was targeted if it had successfully implemented a program that could be modeled elsewhere)
4. the representativeness of the service environment to other areas (i.e. an agency was targeted if it could serve as an example of similar agencies in the general service area)

Using these criteria, staff followed-up with seven service provision agencies and two CPPSNs to request an in-person interview in order to further clarify and confirm the conclusions of the initial interviews, to observe service operations, and to conduct in-depth conversations and focus groups with those having direct client contact. All agencies responded positively to the request, and these visits occurred from August 18, 2009 to August 21, 2009. In total, staff spoke with 23 direct service providers during the site visits.

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## **Development of final report**

Following completion of the site visits, Chapin Hall staff aggregated the results of the initial service availability assessment and the site visit interviews in order to clarify service availability, access, and quality issues. In particular, we focused on exploring those areas in which respondents disagreed on issues of service availability or barriers to participant access, as well as instances in which our observations of the service delivery process differed from those that had been provided during the interviews. Based on these reviews, staff developed a list of recommendations for discussion with Foundation staff (presented later in this report).



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# Service area profile

The Community Health Foundation of Western and Central New York serves an eight county area including Cayuga, Cortland, Herkimer, Madison, Oneida, Onondaga, Oswego, and Tompkins Counties. These counties form a contiguous region in the heart of upstate New York including the eastern Finger Lakes region, parts of the northernmost regions of the Appalachian Mountains, as well as the southeast coast of Lake Erie. The following section provides an overview of the area's current demographic profile, health behavior and outcome data, and child well-being trends.

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## Demographics

As summarized in Table 1, the counties range in geographic size from Cortland, a compact county of 500 square miles, to Herkimer, a county which covers 1,400 square miles and spans 83 miles from north to south (US Census Bureau 2000). Cortland also has the smallest population, at about 48,000 people, while Onondaga and Oneida boast much larger populations of over 400,000 and 200,000 respectively (US Census Bureau 2008). Within the region, urban areas of over 50,000 people include Syracuse in Onondaga County and Utica in Oneida County. Small towns, ranging in population from 35,000 down to almost 11,000 include Rome (Oneida County); Ithaca (Tompkins County); Auburn (Cayuga County); Cortland (Cortland County); Oswego and Fulton (Oswego County); and Oneida (Madison County). Looking across all the counties, the proportion of females of childbearing ages (15-44) is fairly consistent, ranging from 19-21% of the population in 6 of the counties, with slightly higher proportion of women in this age group in both Cortland County, at 23%, and Tompkins County, at 28% (New York State Department of Health 2007). The relatively higher proportion of young women in Tompkins County is to a large extent a function of Cornell University and Ithaca College being located in this county. As such, the increased proportion of females with the potential to give birth in this county may not represent a significant or unique service delivery challenge for the area.

**Table 1: Regional demographics**

<b>County</b>	<b>Population Estimate (2007)</b>	<b>Census Population (2000)</b>	<b>Area, in Square Miles (2000)</b>	<b>Female Population Among Child Bearing Ages, % of Pop (2007)</b>
Cayuga	80,066	81,963	693.18	19.1%
Cortland	48,369	48,599	499.65	23.8%
Herkimer	62,558	64,427	1411.25	19.6%
Madison	69,829	69,441	655.86	21.7%
Oneida	232,304	235,469	1212.7	19.1%
Onondaga	454,010	458,336	780.29	21.0%
Oswego	121,454	122,377	953.3	21.8%
Tompkins	101,055	96,501	476.05	28.1%

The counties in the target service area have similar racial and socio-economic characteristics. Although whites constitute close to (or more than) 90% of the population in all of these counties (New York State Department of Health 2003-2007), the area is not void of diversity. Onondaga and Oneida counties each have substantial refugee populations. Of the 3,632 refugees resettled in New York State in 2008, 36% reside in Onondaga and Oneida counties. Many of these refugees are from Burma, Bhutan, Somalia, or the Ukraine (New York State Office of Temporary and Disability Assistance 2008). A few counties in the region also have small population of immigrants from Mexico and Guatemala who work as migrant farm laborers. Although it is difficult to know how many migrant workers reside in each county because of seasonal variation and lack of documentation status, Tompkins and Oneida counties seem to have the highest numbers based on Community Health Profile Data (New York State Department of Health 2003-2007).

In each of the counties, between 1 and 2 of every 10 residents live in households below the poverty line. As summarized in Table 2, Tompkins County has the highest percentage of individuals at or below the poverty line (18%) while Madison County has the lowest (11%). As found in national statistics, children are overrepresented in the poverty population, with 1 out of 5 children in Cortland, Oneida, and Oswego counties living in poverty. The only county in which the proportion of poor children is notably lower than 20% is Tompkins County, suggesting that a higher proportion of children in this county as opposed to other parts of the service area live in middle or higher income households. With the exception of Madison County, the median income for the counties within the project's target area is below both the New York State and United States median incomes. Madison County's median income is roughly equivalent to the U.S. median income of \$50,740. The county with the lowest median income, Herkimer County, is \$12,000

below the U.S. median and is roughly \$38,000 (US Census Bureau 2007). Poverty indicators including percent unemployment and median household income are shown in Table 2.

**Table 2: Poverty indicators by county**

<b>County</b>	<b>Percent unemployed (2004-06)</b>	<b>Percent of population at or below the poverty line (2005)</b>	<b>Percent of children (&lt;18) at or below the poverty line (2005)</b>	<b>Median household income (2007)</b>
Cayuga	4.9	12.7	17.9	\$45,100.
Cortland	5.6	15.3	20.0	\$40,770
Herkimer	5.3	12.7	18.1	\$38,732
Madison	5.1	11.3	13.8	\$50,924
Oneida	4.8	15.2	20.9	\$44,082.
Onondaga	4.6	13.4	18.0	\$48,807
Oswego	6.3	15.9	22.0	\$44,854
Tompkins	3.6	18.7	15.6	\$44,379

Fertility and birth rates have remained relatively steady over the past 10 years, although some slight variation has been observed in some of the counties. As noted in Table 3, the proportion of total pregnancies among teens (ages 10-19) ranges from 11-14% across the counties. Madison has the lowest and Oswego has the highest. Those proportions have slightly decreased since 1997, with the exception of Oswego County where the proportion of teen pregnancies saw a slight (approximately 1%) increase. In 2007, live births to teens ranged from under 5% in Tompkins County to over 13% in Oswego County. As expected based on these numbers, Tompkins, along with Onondaga, have the highest induced abortion ratios and Oswego has the lowest (New York State Department of Health 1997; New York State Department of Health 2007). Again, the trends in Tompkins County should be considered in light of the large proportion of young women who reside in the county while attending Cornell University and Ithaca College.

**Table 3: Teen pregnancy and abortion rates**

<b>County</b>	<b>Teen Pregnancies, percent of total pregnancies (1997)</b>	<b>Teen Pregnancies, percent of total pregnancies (2007)</b>	<b>Total Induced Abortions, per 1,000 live births (2007)</b>	<b>Live Births to Teen Mothers, percent of total live births (2007)</b>
Cayuga	13.1%	12.4%	236.8	85 (10.7%)
Cortland	15.2%	11.4%	282.2	50 (9.5%)
Herkimer	14.9%	11.9%	166.0	62 (8.7%)
Madison	11.5%	11.2%	121.8	70 (9.0%)
Oneida	14.5%	14.3%	376.8	279 (10.7%)
Onondaga	13.6%	12.4%	297.1	539 (9.7%)
Oswego	13.9%	14.6%	172.2	182 (13.2%)
Tompkins	13.5%	9.8%	373.9	45 (4.8%)

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### **Adult health behaviors and outcomes**

A look at health behaviors and outcomes within these eight counties reveals that smoking and lung cancer are major health concerns for the area. As summarized in Table 4, Cayuga, Cortland, Madison, Oneida, Onondaga, and Oswego Counties all have significantly higher rates of lung cancer incidence than New York State. Over 1 in 5 adults throughout the counties report current smoking behavior, with the highest rates reported in Herkimer, Madison, Oneida, Onondaga, and Oswego Counties. Rates of obesity and overweight also are high, with over half of the women in all of the target counties being overweight or obese (New York State Department of Health 2003-2007). Service providers confirmed that smoking is a very common behavior in the region. Many providers noted during interviews that although the rates of smoking have decreased for the population as a whole, smoking rates among women of childbearing age have either not decreased or have decreased by a lesser degree.

**Table 4: Adult health indicators**

<b>County</b>	<b>Lung Cancer Rates, Age Adjusted Incidence, per 1,000 (2001-2005)</b>	<b>Percent Female Adults who are Current Smokers (2005-2007)</b>	<b>Percent Adults Overweight/Obese BMI=25+ (2005-2007)</b>
Cayuga	84.7*	24.3	59.2
Cortland	76.3*	20.4	51.6
Herkimer	75.6	25.7	62.9
Madison	79.1*	29.3	62.0
Oneida	80.5*	27.9	61.7
Onondaga	83.4*	25.8	59.5
Oswego	96.3*	27.9	61.7
Tompkins	59	20.4	51.6

\* Rate significantly higher than New York state-wide rate

In spite of these worrisome indicators, women appear to both access and use routine preventive health care. According to 2003 data, over 80% of women in all the counties reported having received a Pap smear within the past 3 years. This is comparable to 2002 New York State data indicating 84% of women statewide for the same indicator. Between 85% and 89% of adults throughout all the counties reported having health insurance in 2003. Also in 2003, 84% to 90% of all adults across the counties reported having a physical exam in the past 2 years. Although this would indicate that over 8 in 10 women have access to regular care, a lesser proportion of women report using any form of birth control. Within all counties, less than 70%, and in some counties less than 60%, of women between the ages of 18 to 44, are using some form of birth control (New York State Department of Health 2003-2007).

As summarized in Table 5, prenatal service utilization data reveal that in 2007, from 70%-80% of women in each county received prenatal care during the first trimester. The percentage of women receiving late (during the 3<sup>rd</sup> trimester) or no prenatal care ranged from approximately 3% to 5% within each county. The likelihood of receiving prenatal care and the timing of this care, however, varies by race. While in every county between 74% and 83% of White women receive prenatal care, as few as 50% of Black women receive early prenatal care in Herkimer, Madison, Oneida, and Oswego counties. Fewer than 50% of Hispanic women receive early prenatal care in Cayuga and Cortland counties. These racial and sometimes cultural variations in service use were confirmed during interviews when service providers stated that many of the refugee populations from Africa are less likely to access timely prenatal care. Additionally, service providers in areas with migrant farm worker populations confirmed that some women delay care due to concerns about immigration status and service eligibility.

Nearly half the births in every county in 2007 were covered by private insurance, with the exceptions of Onondaga and Tompkins counties in which about 60% of births were covered by private insurance. Most of the remaining births throughout the counties were either covered by Medicaid or another government sponsored health plan. The remaining births, from 0.6% to 2.6%, were classified as self-pay, meaning the mother did not have insurance (New York State Department of Health 2007).

**Table 5: Service utilization summary (2007)**

<b>County</b>	<b>Percent of live births receiving early prenatal care</b>	<b>Percent of live births receiving late or no prenatal care</b>
Cayuga	77.4%	3.1%
Cortland	76.1%	2.7%
Herkimer	76.2%	3.4%
Madison	79.5%	4.9%
Oneida	70.6%	4.7%
Onondaga	75.9%	3.9%
Oswego	74.1%	4.2%
Tompkins	72.5%	3.2%

## **Child well-being trends**

In addition to the current demographics, vital statistics, and health outcomes data, we also examined child well-being trends, including birth outcomes and child abuse data.

Infant mortality rates have demonstrated variability over the past decade in several of the counties. As noted in Table 6, substantial improvements on this indicator have occurred in Cayuga and Tompkins counties. Infant mortality rates in four of the counties (Cortland, Herkimer, Oneida, and Onondaga), however, have remained above the New York State infant mortality rate (5.5 in 2007). Cortland County has the highest IMR of the 8 counties at 7.6. The percentage of low birth weight babies, those who are born at less than 2500 grams (5.5 pounds), has increased statewide and in all target counties over the past ten years, as summarized in Table 6. In 1997 none of the 8 counties in the region had a percentage of low birth weight babies that exceed the state percentage of 7.8%. However, by 2007 both Cortland and Oneida counties had percentages higher than the state average of 8.1%. Overall, the low birth weight percentages had modest increases in Cayuga, Herkimer, Onondaga, Oswego, and Tompkins counties during this period but increased sharply in Cortland County where the rate of infant mortality almost doubled (increasing from 3.6 to 7.6). (New York State Department of Health 1997; New York State Department of Health 2007). During interviews one provider stated: “I have been working in this community since the early 1980s and although the infant mortality rate has gone down, the low birth weight numbers have remained roughly the same during all that time.”

**Table 6: Infant mortality per 1,000 births and low birth weight rates per 1,000 births (percentage of county births) in 1997 and 2007**

<b>County</b>	<b>Infant Morality, &lt;1year (1997)</b>	<b>Infant Mortality, &lt;1year (2007)</b>	<b>Low Birth Weight Rate (1997)</b>	<b>Low Birth Weight Rate (2007)</b>
Cayuga	6.4	3.8	57 (6.1%)	50 (6.3%)
Cortland	3.6	7.6	26 (4.6%)	47 (8.9%)
Herkimer	8.6	5.6	35 (5.0%)	41 (5.8%)
Madison	4.8	5.1	46.0 (5.6%)	54.0 (6.9%)
Oneida	5.9	6.1	190 (7.0%)	229 (8.8%)
Onondaga	6.7	6.5	436 (7.3%)	438 (7.9%)
Oswego	4.8	5.1	89 (6.2%)	90 (6.5%)
Tompkins	8.2	3.2	48.0 (5.6%)	56.0 (5.9%)
New York State	6.7	5.5	20,145 (7.8%)	20,560 (8.1%)

Infants are particularly vulnerable to child abuse and neglect. Nationwide, the rate of victimization among infants under the age of one is approximately 22 per 1,000 infants. In contrast, the rate of victimization for children ages 4 to 7 is approximately 11 per 1,000 children, and for adolescents, the rate drops to around 5 per 1,000 (USDHHS 2009). As such, efforts to more fully engage new parents in supportive services during pregnancy or at birth are considered an important strategy in reducing rates of maltreatment. According to state maltreatment reports, child maltreatment is a significant risk to child well-being within the target area. As summarized in Table 7, reported rates of maltreatment per 1,000 children under 18 in all target counties are considerably above the statewide average. The relatively small number of children in these communities contributes to instability in these estimates, a fact that suggests caution in making too many assumptions about a single year's data. Rather than perceiving these rates as high, it is possible that in more populous counties many children in risk situations go unnoticed while in smaller communities residents and local professionals are more likely to take action by seeking assistance for the family. Although more likely to be reported to local child welfare officials, the rate of substantiated child maltreatment cases is comparable to the statewide average in Cayuga, Herkimer, Onondaga, and Tompkins Counties. In contrast, substantiated child maltreatment rates are almost twice the statewide average in Oswego, Oneida, and Madison Counties and more than twice the statewide average in Cortland. The reason for these high rates of confirmed cases is not self-evident. In the absence of more detailed data, it is difficult to discern if this high rate of substantiated cases is a reflection of significant differences in maltreatment exposure in these countries or a function of variation in agency practice. On balance, an increased likelihood for local child welfare officials to substantiate reported cases is found only in Oneida and to a lesser extent in Cortland counties. In all other instances, local child welfare officials appear to substantiate, on average, fewer cases than elsewhere in the state. One provider noted during interviews that

there have been two deaths in recent years resulting from child abuse within that county that may have influenced child welfare practices.

With respect to foster care placement, the proportion of children less than age 2 admitted to foster care in the eight-county region is generally comparable to the proportion of such cases found statewide. In New York State, babies under age 2 constitute 20% of the children taken into foster care each year (Kids Well-being Indicators Clearinghouse 2006). The relatively small number of children taken into care in the most rural counties make it difficult to assess trends. However, in the three more urban counties, the numbers are comparable and stable.

**Table 7: Child maltreatment reporting, substantiation rates, and foster care**

County	CAN reports per 1,000 children < 18, 2007	Substantiated Cases per 1000 children < 18, 2007	% of reported cases that are substantiated, 2007	Children, 0 < 2 years, admitted to foster care, 2000		Children 0 < 2 years, admitted to foster care, 2006	
				N	(%) *	N	(%) *
Cayuga	70	17	26%	18	23%	8	29%
Cortland	102	39	39%	4	5%	16	21%
Herkimer	70	20	28%	7	13%	6	12%
Madison	85	29	34%	16	16%	8	16%
Oneida	75	33	44%	42	17%	54	18%
Onondaga	60	18	30%	107	28%	55	24%
Oswego	95	27	28%	13	9%	8	7%
Tompkins	73	19	26%	12	18%	13	20%
Statewide	47	16	35%	3,360	20%	2,834	20%

\* Because of the small number of cases reported at the county level, these percentages are not stable indicators

## Summary

This statistical review identified several issues to consider in improving health care access and well-being outcomes for pregnant women and their newborns. These issues include the following:

- Although the overall rate of access to early prenatal care appears high, Black and Hispanic women are significantly less likely to access these services. Understanding the factors contributing to this discrepancy will be important if reforms are to result in higher usage. Our interviews suggest that the problem may be more of an access rather than an availability concern. In other words, adequate services seem to exist in the counties but minority women are either unaware of these resources or feel unwelcomed by those agencies offering this assistance.



- Concentration of new refugee populations in various areas within the target community may require local providers to adopt specific outreach efforts. Issues of language and culture will be important to address if these new residents are to have full access to available services.
- The small but persistent number of immigrants working as migrant laborers in the target service area may suggest the need for more directed outreach and specialized services. These populations may be particularly suspicious of government programs and their mobility may make it difficult for pregnant women to engage in ongoing, center-based care.
- Although the rate of births to teen mothers in the target area is comparable to similar trends at the state and national level, young maternal age presents a significant risk factor for a number of undesirable outcomes, such as poor maternal choices, low birth weight and child maltreatment. As such, this group may represent a target population in need of specific attention.
- Smoking and obesity trends in the service area may underscore a need for specific public health education and awareness opportunities. Both of these behaviors pose significant risk to the health of pregnant women and can have impacts on birth outcomes and the subsequent health of the infant. As such, any comprehensive plan to improve perinatal health should include efforts to reduce these behaviors among pregnant women and women of child-bearing age.

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# Service capacity

Our analysis of the range and capacity of services for pregnant women and newborns in the target service area involved in-depth interviews with key stakeholders who provide or coordinate direct services. Over the course of these interviews, we identified a number of programs and agencies that offer low-income women pre/perinatal services in one or more of the target counties. Appendix B provides a comprehensive overview of the services identified during our research. In this section, we describe some of the most prominent models that deliver pre/perinatal services to women in this region, as well as our impressions of their capacity to provide this care.

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## **Prenatal and perinatal service provision to low-income women: the PCAP and MOMS programs**

The most important way that low-income women receive pre/perinatal services in New York State is through one of two prenatal care assistance programs administered through the NYSDOH: the Prenatal Care Assistance Program (PCAP) and the Medicaid Obstetrical and Maternal Services Program (MOMS). Originally established in the late 1980s, the PCAP program provides enhanced Medicaid reimbursement for the provision of prenatal care to women at or below 200% of the federal poverty level. For a facility to provide care as a PCAP, it must operate under Article 28 of the Public Health Law and be certified to “provide prenatal, obstetric or maternity and newborn services” (State of New York 2000). As outlined in Table 7, all PCAP facilities are required to meet minimum requirements for services and care as defined in Title X, Section 85.40 of New York’s Codes, Rules, and Regulations.

**Table 8: Summary of PCAP minimum requirements**

<b>Subdivision of 85.40</b>	<b>Minimum requirements</b>
(c) Outreach	Facilitate entry into maternal services, provide linkages to community-based resources, and publicize the availability of services
(d) Risk assessment	Provide risk assessment of maternal and fetal risk throughout pregnancy
(e) Care plan/coordination	Ensure coordination of care across providers, access to resources and information, provide and encourage referrals, provide the opportunity for prenatal or postpartum home visitation services
(f) Nutrition services	Provide nutrition education and counseling, assistance with WIC enrollment (where applicable)
(g) Health education	Provide health education information and resources about pregnancy, labor, delivery, infant care, and family planning; resources must accommodate culture and language factors, as well as the individual ability of mothers to comprehend materials
(h) Psychosocial assessment	Provide psychosocial screening and referrals
(i) Prenatal diagnostic and treatment	Provide prenatal diagnostic and treatment services, arrange for delivery of prenatal care
(j) HIV services	Provide confidential HIV testing, education, and counseling, provide HIV management services or referrals
(k) Records/reports	Maintain comprehensive prenatal record for women
(l) Internal quality assurance	Develop policies to ensure quality of care, conduct audits of client records
(m) Postpartum services	Coordinate provision of pediatric care, provide and encourage referrals, assess family planning needs, advise mother on Medicaid eligibility for infants

The minimum requirements that define the PCAP program ensure that it is one of the most comprehensive sources of pre/perinatal services available to low-income women in New York State. In our initial service availability assessment, many providers noted both the “one stop shop” convenience of the PCAP program for clients as well as the high level of care that pregnant women receive at PCAP clinics. As one provider noted, “what’s really great about PCAP is that they get *exceptional care* from these clinics – better than you’d imagine.”

From their inception in the late 1980s, PCAP clinics were often housed within individual county health departments and local hospitals. Although the PCAP model proves attractive in areas that are both population-dense and served by public transit systems, many rural counties struggled to provide pre/perinatal services under the PCAP model. The minimum requirements required by Section 85.40 are

expensive for small health care facilities and clinics to provide due to the high cost of employing support staff (including nutritionists and social workers) and providing fully maintained facilities. More rural counties also found it difficult to attract and retain the low-income women that PCAP is intended to serve due to outreach and transportation factors.

In light of these concerns, the NYSDOH implemented an alternative program, the Medicaid Obstetrical and Maternal Services (MOMS) program, to meet the diverse care provision needs of its counties. Launched in the 1990s, this program provides enhanced reimbursement to private practitioners who provide prenatal services to qualified low-income women in their offices. Supplemental services – such as outreach, risk assessment, nutrition services (including lactation consultation), referrals, and care coordination – are provided by a designated partner agency enrolled with the NYSDOH as a Health Supportive Services Program (HSSP). Although the standards for the MOMS program were not codified (PCAP’s minimum requirements were written into the state’s Title X), in order to be reimbursed by the state for services rendered, medical service providers and HSSPs must meet established eligibility/practice requirements and standards. Oftentimes health supportive services are provided by individual county health departments, as well as by partner agencies such as regional CPPSNs, the Women, Infants and Children program (WIC), Head Start/Early Head Start, Healthy Families New York, or by community-based organizations such as Planned Parenthood, Catholic Charities, or community action agencies.

While the MOMS program successfully addresses the gaps that result from using a PCAP model in counties that lack sufficient access to or capacity for care, it is not without flaws. Many of our informants pointed to the separation of health supportive services from medical services as a primary weakness of the MOMS model. Although pregnant women gain the ability to choose their provider, they sacrifice the convenience of having all aspects of their prenatal care coordinated and rendered at one location. Many service providers emphasized the difficulties that pregnant women – especially those in rural areas or those with other young children – face in getting to their appointments. The MOMS program increases the amount of time that these women must spend accessing care because they obtain medical services and health supportive services in separate locations at different appointments.

Despite their relative strengths and weaknesses, the PCAP and MOMS programs are often the most prominent and accessible points of entry into prenatal care for women in the target service area. Providers interviewed in our initial service availability assessment often remarked that because the PCAP and MOMS programs have long-standing histories in the region, women recognize them as the primary conduits to care. In addition, the fact that many county health departments acted as PCAP providers at some point in the recent past has tagged county health departments as the ‘first stop’ for many low-income women who suspect or know they are pregnant, regardless of what type of prenatal care assistance program their counties currently support. One provider noted that they are now servicing “third-generation PCAP moms,” reflecting the longevity and prominence of the program in her area, while another provider explained that “the word has been out long enough that many women will know to go to the county health

department as their first point of contact.” Table 8 delineates which type of prenatal care assistance program is currently available in each county within the target service area.

**Table 9: Type of prenatal care assistance program by county<sup>2</sup>**

<b>County</b>	<b>Type of prenatal care assistance program (MOMS or PCAP)</b>
Cayuga	MOMS only
Cortland	PCAP and MOMS
Herkimer	PCAP only
Madison	MOMS only
Oneida	MOMS and PCAP
Onondaga	PCAP only
Oswego	MOMS and PCAP
Tompkins	MOMS only

The PCAP program is the dominant model of care in the three larger, more urban counties (Onondaga, Oneida, and Oswego), while MOMS is an important model for counties with a more rural setting. It is important to note, however, that the urban/rural rule for determining which prenatal program model will be the best fit for any particular county is *not* always appropriate; in many cases, the needs of the county change organically over time, as does the preferred prenatal service provision model. Having a MOMS program is also dependent upon private providers’ willingness to apply and enroll as MOMS providers. Not all counties have providers who are willing to engage in this process. As one provider noted when asked about why there was no MOMS program in her county, “I’m not entirely sure why we don’t have a MOMS program...PCAP just seemed to suit the needs of the community better.”

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### **Home visiting programs: county health department home visiting, Health Families New York, and Nurse Family Partnership**

In addition to the prenatal services provided under the PCAP and MOMS programs, pre/perinatal services focusing on general parent education and support as well as basic health care are also available through several different home visiting programs offered throughout the region. These include county health department-sponsored home visiting programs, Healthy Families New York (HFNY), and the Nurse Family Partnership (NFP), as well as Early Head Start programs that include a home visiting component.

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<sup>2</sup> This information was supplied to us by individual county health departments and informants at the New York State Department of Health. While it may not reflect the ‘official’ MOMS/PCAP designations, this is the current functional distribution of PCAP and MOMS programs in the region to the best of our knowledge.

Table 9 illustrates which home visiting programs are currently available in each county in the target service area.

**Table 10: Type of home visiting program providing pre/perinatal services by county**

<b>County</b>	<b>Type of home visiting program providing pre/perinatal services</b>	<b>Early Head Start program</b>
Cayuga	HFNY, county health department home visiting programs	---
Cortland	county health department home visiting programs	---
Herkimer	HFNY, county health department home visiting programs	Herkimer CDC
Madison	HFNY, county health department home visiting programs	Community Action Program For Madison County
Oneida	HFNY, county health department home visiting programs	ACCESS, Calvary, Griffiss Child Development Center, Home Base Gore Rd., Ilion, Matts, Ney Ave, Pre-natal out of Calvary, Pre-natal out of Gore Rd. Site
Onondaga	NFP, county health department home visiting programs	Atonement Day Care Center, Lydia's Lullaby, Merrick Early Head Start, Sumner
Oswego	county health department home visiting programs	---
Tompkins	county health department home visiting programs	---

As outlined in Section 85.40 and in the MOMS provider standards, both the PCAP and MOMS programs are required to provide clients with the opportunity for prenatal or postpartum home visiting services. To satisfy this requirement, individual counties have one or more of the abovementioned voluntary home visiting programs in place to provide supplemental services to pregnant women or women with infants. Of the three types home visiting programs found within the area, two (HFNY and NFP) are evidence-based, national-model prevention programs designed to promote positive parenting skills and parent-child interaction, with the ultimate goal of preventing child abuse and neglect. The NFP program model utilizes registered nurses to deliver home visitation services, as do many of the county health department home visiting programs. Consistent with the Healthy Families America model which endorses hiring home visitors with diverse backgrounds, the HFNY programs in the target service area employ trained paraprofessionals to deliver home visitation services.

The specific type of service and support provided to clients varies across the three home visiting models. The HFNY model provides weekly or bi-weekly hour-long visits to parents during and after pregnancy.

The visits continue at a diminishing rate until the child is five years old, or until he is enrolled in Early Head Start or Head Start (DuMont et al 2008). Similarly, the NFP model provides 70-90 minute-long home visits throughout pregnancy (exact frequency determined by stage of pregnancy and level of need/crisis) until the child's second birthday (Olds 2006). The county health department home visiting programs can vary in frequency and duration, but typically will provide 4-5 visits (reimbursable by Medicaid) split between prenatal and postpartum visits, with additional non-reimbursable visits if the client demonstrates sufficient need or risk. All counties have some county health department-sponsored home visiting component to serve women in the PCAP or MOMS programs.

It is essential to note that the capacity to provide pre/perinatal services through home visiting programs is not uniformly distributed throughout the target service area. In many cases, the type and quantity of services clients receive will vary depending on their county of residence and eligibility for the available home visiting programs. For example, in counties served by both a county health department home visiting program and HFNY or NFP, pregnant women will be screened for eligibility in the more intensive HFNY or NFP models when they enroll in prenatal services. Women who are first-time parents and have accessed early prenatal care will be referred to NFP where available. Other pregnant women may be eligible for HFNY if they demonstrate sufficient risk of child abuse and neglect. Both of these programs offer intensive home visitation services and address a number of issues including maternal health, infant and child development and parental capacity. Those women who do not qualify for either of these programs will be offered home visits through the county health department home visiting program. However, this service option will not provide the same level of intensive and ongoing support as would be available through either NFP or HFNY. High risk women living in counties without access to either of these more intensive models (residents in Cortland, Oneida, Oswego and Tompkins) also are limited to the level of support provided the county's home visiting program.

Our assessment of the home visiting capacity in the target service area also suggests that child abuse and neglect prevention programs such as HFNY and NFP can effectively shift demand for home visiting services from overburdened county health department home visiting programs to established programs that are better equipped to meet the needs of high-risk families. This opens up new resources for lower-risk families seeking home visiting supplemental support from county health departments. Many of the providers we spoke with pointed to past NFP sites that they felt were successful at improving parent-child interactions in high-risk families and articulated a desire (as well as pending NFP grant applications) to establish more NFP sites in the area.

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### **Other program models: CPPSNs, WIC, community health worker programs, and community-based organizations**

Pre/perinatal services are also provided through a variety of other programs in the target service area, including CPPSNs, local WIC agencies, Community Health Worker Programs (CHWPs), and other

community-based organizations. Although a comprehensive listing of all public and private resources available to pregnant women and new parents was beyond the scope of this effort, we have included below a brief overview of programs that provide additional pre/perinatal services to women outside of PCAP, MOMS, and home visiting programs in Table 11.

**Table 11: Other programs providing pre/perinatal services or support by county**

<b>County</b>	<b>CPPSN</b>	<b>WIC</b>	<b>Community Health Worker Program</b>	<b>Other (CBOs, etc.)</b>
Cayuga	Reach CNY	Cayuga County Health Department	---	<u>Cayuga Seneca Community Action Agency</u> : Healthy Families, TASA (pregnant and parenting teens program), and care seat distribution <u>Catholic Charities</u> : parenting support program <u>Auburn Memorial Hospital</u> : childbirth classes <u>Finger Lakes Migrant Services</u> : support services for migrant population
Cortland	Mothers and Babies Perinatal Network	Cortland County Community Action Program	---	<u>Cortland County Community Action Program</u> : parent support and education, nutrition services, WIC <u>STEPS</u> : Adolescent pregnancy prevention <u>Catholic Charities</u> : parenting support <u>Finger Lakes Migrant Services</u> : support services for migrant population <u>Family Resource Center</u> : parenting classes and support
Herkimer	Mohawk Valley Perinatal Network	Planned Parenthood Mohawk Hudson	---	<u>Herkimer CDC</u> : Early Head Start <u>Catholic Charities</u> : parenting classes and support groups
Madison	Reach CNY	Cortland County Community Action Program	---	<u>Community Action Program For Madison County</u> : Starting Together home visiting program <u>Oneida Health Care Center</u> : breastfeeding support and baby weight station, birthing and parenting classes <u>Liberty Resources</u> : TASA (teen pregnancy/parenting program)



<b>County</b>	<b>CPPSN</b>	<b>WIC</b>	<b>Community Health Worker Program</b>	<b>Other (CBOs, etc.)</b>
Oneida	Mohawk Valley Perinatal Network	Fulmont Community Action Agency, Inc. Planned Parenthood Mohawk Hudson Oneida County Health Department	Oneida County Health Department	<u>Mohawk Valley Community Action Agency, Inc.</u> : Early Head Start <u>Family Nurturing Program</u> : parenting classes <u>Refugee Resource Center</u> : services for refugee population <u>Healthy Families</u> : Father involvement program <u>Catholic Charities</u> : parent support groups <u>Mohawk Valley Perinatal Network</u> : community baby showers, facilitated enrollments
Onondaga	Reach CNY	Onondaga County Health Department	Onondaga County Health Department (administered through subcontractor of the Salvation Army)	<u>Syracuse Community Health Center</u> : (subcontractor of Syracuse Healthy Start parenting support and home visiting program) <u>Syracuse Model Neighborhood Facility</u> : (subcontractor of Syracuse Healthy Start parenting support and home visiting program) <u>United Way's Success by Six Program</u> : training and support for parents, child care providers, and practitioners <u>PeerPlace</u> : web-based information and referral network <u>Catholic Charities</u> : parenting classes & services for the refugee population <u>Peace, Inc.</u> : Early Head Start <u>La Leche</u> : breastfeeding support

<b>County</b>	<b>CPPSN</b>	<b>WIC</b>	<b>Community Health Worker Program</b>	<b>Other (CBOs, etc.)</b>
Oswego	Reach CNY	Oswego County Opportunities	---	<u>Oswego County Oportunities:</u> Migrant health clinic, family planning clinic, WIC, facilitated enrollment, teen pregnancy and parenting program, transportation to medical appointments, breastfeeding support <u>Cornell Cooperative Extension:</u> nutrition programs and parenting support <u>Adolescent Pregnancy Prevention Program:</u> Educational support and sex education <u>Oswego Hospital:</u> birth and parenting classes
Tompkins	Mothers and Babies Perinatal Network	Tompkins County Health Department	---	<u>Child Development Council:</u> child care resource and referral, teen pregnancy and parenting support, home visiting for families with a child through age 3 <u>Faith-based organizations:</u> support groups for mothers <u>Cornell Cooperative Extension:</u> nutrition support and parenting support groups and classes <u>Catholic Charities:</u> facilitated enrollment and transportation to medical appointments <u>La Leche:</u> breastfeeding support <u>Cayuga Hospital:</u> birth and infant care classes

## **Comprehensive Prenatal-Perinatal Services Networks (CPPSNs)**

Established by the NYSDOH in 1987, Comprehensive Prenatal-Perinatal Services Networks (CPPSNs) are community-based programs that work with local service providers to improve pre/perinatal services throughout the region. As mentioned earlier, three CPPSNs serve women in the target service area: Reach CNY (headquartered in Syracuse, serving Cayuga, Madison, Onondaga, and Oswego counties), Mohawk Valley Perinatal Network (headquartered in Utica, serving Herkimer and Oneida counties), and Mothers and Babies Perinatal Network (headquartered in Binghamton, serving Cortland and Tompkins counties).

The NYSDOH has outlined three program priorities for CPPSNs, including to:

- Assist with access to comprehensive prenatal care for pregnant women, particularly underserved, hard-to-reach pregnant women
- Ensure the availability of a comprehensive system of perinatal care that addresses the continuum of perinatal health services: this includes services for women before they become pregnant to maternal and child health services
- Identify and address community-specific problems that may lead to poor birth outcomes (New York State Department of Health 2003)

Although some CPPSNs play an active role in the community to offer targeted programming to at-risk groups, CPPSNs typically focus less on direct service provision and instead serve a strategic guiding function within the region as well as coordinating function. On the strategic side, CPPSNs seek to identify important gaps in service provision and work with service providers to address the needs of the region; on the coordinating side, CPPSNs address the needs of service providers by organizing and hosting training sessions and learning opportunities. In addition, CPPSNs facilitate regional pre/perinatal service committees to foster collaboration and dialogue among providers in the region.

## **WICs**

Local WIC agencies are also a primary provider of pre/perinatal services in the region. In many counties, the local WIC office is widely regarded as the first stop for low-income women who find out they are pregnant. Many county health departments have long-standing agreements with WIC offices in their catchment area to provide immediate referrals to the county health department (or other relevant PCAP or MOMS health supportive service programs) for women who visit WIC seeking prenatal care and assistance. WIC agencies are also frequent partners of MOMS health supportive services programs, as many county health departments and WICs will share the services of certified lactation consultants or peer counselors. Many MOMS health supportive services providers will also rely heavily on the expertise of

WIC staff to provide lactation support and advice, as well as nutrition consultation, education, and services.

### **Community Health Worker Programs (CHWPs)**

The NYSDOH also supports pre/perinatal service provision through community health worker programs (CHWPs), administered by county health departments in two counties within the target service area (Oneida and Onondaga). The CHWP supplements county health department-run home visiting programs by providing one-on-one outreach, education, and home visiting services by trained outreach workers to women in the area. Outreach workers can work with women both inside and outside the home to facilitate enrollment in a prenatal assistance program; they also provide extensive referrals to other services and agencies, based on need. In the words of one provider we interviewed, the CHWP “helps educate and empower families.” Although this program is oftentimes used to provide pre/perinatal services, it can assist parents with children up to age six.

### **Other community-based organizations and agencies**

Further, a great number of community-based organizations (CBOs) and community action agencies also offer pre/perinatal services to women in the target service area. As mentioned above, Table 11 identifies some of the key CBOs and agencies that provide supplemental services to pregnant women and mothers with infants. The services offered by these organizations include birthing classes, parenting education classes and support groups, counseling services, early childhood development programs, teen pregnancy prevention and parenting programs, nutrition programs and support, and they also include specific programs that provide resources for refugee and migrant worker populations. Often these organizations play a critical role as partner agencies with county health departments, CPPSNs, and local WIC agencies to supplement PCAP and MOMS programming.

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# Strengths, gaps, and limitations to service provision

Now that we have examined the eminent models of pre/perinatal service provision and our initial observations of the capacity of providers to offer this care, we shift our focus to a consideration of the strengths, gaps, and limitations to pre/perinatal service provision in the target service area. These are the conclusions that we have drawn after protracted discussion with service providers and other analysts, both in phone interviews during the initial service availability assessment and in site visits during the clarification of service capacity.

The strengths we describe below may be readily observed in every county in the target service area. These are the issues that seem to receive the most attention by local service providers and administrators, and they are the areas in which the most progress has been made in improving service quality and access. In contrast, it is important to note that the gaps and limitations that we describe below the themes below do not always apply to every county or locality within the target service area. Rather, these are the most salient concerns throughout the region that hold some areas back from exhibiting an “exemplary” capacity to provide care, rather than just an “adequate” capacity. Although these issues were selected specifically for their generalizability to the eight counties in the target service area, we must be mindful that not every gap or limitation discussed below accurately describes the service provision environment of every county in the area.

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## Strengths

### **Adequate service capacity throughout the region**

Our assessment of the capacity of pre/perinatal service provision within the target service area indicates that – with some key exceptions, discussed below – pre/perinatal services are functioning with adequate capacity in the region. Although many of the county health departments we spoke to stressed the

limitations of providing care in light of labor issues (difficulties attracting nurses to public nursing programs, difficulties recruiting and retaining obstetric practitioners, especially in rural counties) or reduced budgets, most PCAP and MOMS programs are operating with sufficient capacity to serve those who both need and want pre/perinatal services. We did not feel that any PCAP or MOMS program had made cuts to their services or intentionally overlooked PCAP or MOMS-eligible women in order to “save on the bottom line.” Indeed, we felt that many service provision agencies held exactly the opposite agenda: in lean economic times, many of the providers we spoke to were working harder to provide even more assistance to women despite greatly reduced budgets. Although the current economic downturn has impacted the “bottom lines” of many of these organizations, they continue to provide sensitive and respectful care to pregnant women and mothers within their communities. As many of the providers mentioned, they are simply “making the most of what [they] have.”

It is important to note, however, that adequate service capacity and uptake of services are not uniformly distributed across the counties within the target service area, nor are they uniformly distributed within the counties themselves. As we will discuss below, some counties have found it difficult to serve hard-to-reach populations, such as refugees and migrant workers, or populations that have negative opinions about receiving public assistance. This latter group may include people who are “newly poor” as a result of the recent economic downturn (including those who face stigma about accepting public assistance in general), people who negatively associate public assistance programs like PCAP and MOMS with child protective services (especially those women who have had negative encounters with child protective services in the past), and women who are sensitive to outsiders’ intrusion in their lives and have negative feelings about “eyes within the home.” These issues tend to be more common in some counties than others, and they tend to be linked to certain key socio-economic and demographic characteristics (e.g. high rates of child abuse and neglect, high refugee populations, or high rates of undocumented workers/immigrants); within counties, these issues also tend to be more common in some areas than in others (e.g. urban areas that serve as refugee sites or agricultural areas that require a high volume of seasonal labor). Although overall service capacity may be functioning adequately across the target service area, we must be mindful that service capacity may be lower in some areas than in others due to the uneven distribution of these service provision issues.

### **Strong cooperation and collaboration between service providers**

In addition to operating with ample service capacity, we noted that counties in the target service area thrive in fostering cooperation among service providers. County health departments, local agencies, and community organizations frequently collaborate to launch new programs, author and disseminate educational material to current and prospective clients, co-sponsor training opportunities, and share information on best practices, strategic initiatives, and performance monitoring. During our visits, a number of providers responded enthusiastically when inquired about past collaboration with other agencies and organizations; providers also reported that in most cases, their relationships with other service

providers in the region were both positive and strong. This effective cooperation and mutual respect is likely the result of providers' shared sense of history and community, as much as it is the result of strategic and emphatic focus on collaboration by CPPSNs in the region. Indeed, the coordinating function served by the CPPSNs is an essential component to this success, as CPPSNs frequently organize (and fund) training and learning opportunities that lead to collaboration among service providers, both within and among counties. It is our belief that the service provision agencies and organizations on the ground could not achieve their full potential without the support provided by regional CPPSNs.

### **High quality and breadth of services available throughout the region**

Another key strength in service provision throughout the region lies in the quality and comprehensiveness of the services available to women. Although we did not conduct a comprehensive quality review, it seems evident that most clients are satisfied with the services they receive. Nearly all providers emphasized low rates in client dissatisfaction in standard quality assessments and surveys, as well as the protocol in place to ensure that service providers are held accountable to quality assurance standards. To gain a more robust understanding of quality, it would be necessary to examine the sampling and analytic veracity of quality assurance data collected by individual agencies and organizations (with particular regard to potential selection bias among respondents). At first glance, however, our qualitative analysis of this issue indicates that high rates of client satisfaction are likely in this region. In addition, it seems clear that the PCAP and MOMS programs in the area are meeting, if not surpassing, the minimum requirements of service provision as required by Section 85.40.

As to the breadth of the services offered to women, our interviews and site visits reveal that women throughout the region benefit from a comprehensive array of services throughout the region that include both pre/perinatal medical care, as well as a rich palette of health supportive services that include health education, information, counseling, and referrals. While it is less often the case that counties are able to support a "one stop shop" PCAP model that concentrates all pre/perinatal services in one location, we found that where practicable, services were typically grouped in a way that allows women to access many services by visiting one or two locations that were relatively close together. For example, in MOMS counties it is often the case that many of the health supportive services provided by the county health departments are available in the same building. Other services offered by partner agencies or organizations (such as WIC appointments, nutrition referrals, or parenting services) were usually located close to the county health department offices, accessible either by foot or by public transit. Of the spectrum of health supportive services available to women in the area, we found that providers were particularly concerned with providing breastfeeding support and counseling, and many counties in the region excelled in providing services that support women who breastfeed their infants.

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## Service gaps

Despite the key strengths discussed above, our review has identified three salient gaps in pre/perinatal service provision within the target service area. The first deals with capacity of providers to offer adequate postpartum care, while the others concern the absence of at-birth risk assessment procedures and a collective accountability system in the region.

### Gaps in postpartum service provision

One of the most important gaps that we found in our analysis concerned the lack of services available to women after they give birth. Under the PCAP and MOMS models, women are eligible to receive five Medicaid-reimbursable visits related to a pregnancy; these visits may be provided either at the provider or practitioner's office or at the woman's home by a public health nurse (in counties that operate as an Article 36 certified home health agency). Because so many of Section 85.40's minimum standards for PCAP and MOMS programs focus on prenatal services rather than postpartum services (see Table 8, above in "Service capacity") and because of the acknowledged importance of comprehensive prenatal care for pregnant women, PCAP and MOMS providers typically encourage women to attend four prenatal visits and one postpartum visit. In many cases, this means that women are assessed only once after they give birth, typically at a six-week postpartum follow-up visit. In cases where service providers have identified outstanding psycho-social issues during the pregnancy (e.g. extreme poverty or difficulty attaining self-sufficiency, high risk for maltreatment or neglect, teenage pregnancy), county health departments are often able to transfer women who have given birth from the prenatal care assistance program to a Medicaid-reimbursed maternal child health public health nursing program. This allows public health nurses to offer additional post-partum supportive services, including more intensive education and counseling. However, for the vast majority of PCAP and MOMS clients who do not exhibit clear or urgent signs of psycho-social or medical distress, postpartum support is not readily available.

When we spoke with service providers during the site visits, we asked about the type of assistance programs and support mechanisms that are available to parents with infants and young children in the region, asking that they elaborate specifically about any parenting education courses, parent support groups, or other programs that focus on strengthening parent-child relationship and encouraging better parenting. Although many providers emphasized the MCH home visiting services as a way for at-risk families to receive extra support or recent campaigns that increase public awareness of postpartum depression, few could point to organizations or agencies that provide supportive services to families with infants or very young children (breastfeeding/lactation support notwithstanding). In some communities, Catholic Charities provides parenting education courses and parent support groups; in others, the only parenting education courses available in the county are offered by either a nearby Healthy Families site (selective enrollment) or the county's department of social services (whose parenting programs are often geared to parents that have been reported to child protective services). When asked about the perceived imbalance between the availability of prenatal services versus postpartum services in the region, some



providers felt that the “emphasis [on prenatal over postpartum support] is right as it should be” while others believed that support for parents with infants and young children was a critical, yet lacking, component to improving the overall health and well-being of children and their families.

Two points may help clarify how this gap emerged and why a dearth in comprehensive postpartum programming exists in this region. First, neither the state of New York nor the federal government currently supports a public entitlement program that offers postpartum medical or supportive services to parents of infants and very young children. At their core, the prenatal care assistance models that exist in New York (PCAP and MOMS) are public entitlement programs with long histories of service provision. Although these programs accomplish much good, they are constructed with a short-term goal in mind: to provide critical prenatal care to women who cannot afford it and who would not otherwise receive it. While prenatal care assistance programs provide the infrastructure that local organizations use to provide additional *prenatal* programming, the absence of any comparable *postpartum* infrastructure makes it difficult for local organizations to provide these services. Whereas prenatal care assistance programs like PCAP and MOMS provide the platform that other agencies or organizations (e.g. WIC and other community-based organizations) can build from, postpartum programming must initiate its own infrastructure. Similarly, while the infrastructure provided by prenatal care assistance programs like PCAP and MOMS are readily identifiable within communities as a way to get “hooked into” the *prenatal* care system, families who need or want postpartum services do not know where to go to access *postpartum* care or what to expect in terms of content or structure.

In addition to the lack of postpartum entitlement programs, our health care system currently operates in a way that dichotomizes the provision of pregnancy services into two distinct segments: prenatal care and postpartum care. An obstetric practitioner typically renders medical services before birth, while a pediatrician typically renders medical services after birth. This fissure does not always result in a smooth transition into parenthood for new mothers and fathers, and indeed this arrangement can make it even more difficult for parents to identify services that carry over from the prenatal phase into the postpartum phase. Despite this, postpartum services (such as those mentioned above) have developed in many communities. However, it may not be easy for many parents to navigate this diverse network of services or clearly see that services are, indeed, available.

The lack of adequate postpartum support for women and families – both in terms of the services themselves and a network/infrastructure that supports them – represents a profound gap to effective service provision in this region, and it is one that should be considered at length before any investments in pre/perinatal services are made. Although for many women a one-time postpartum follow-up visit may be sufficient (especially for mothers who have had previous births), the imbalance between prenatal service availability and postpartum service availability may also reflect a strong normative standard in our society that undervalues the importance of this period in children’s and parents’ lives and underestimates parents’ need for comprehensive support services after birth. As one provider noted, “as a society we have the idea

that if you can conceive it and deliver it, you can take it home and make it work. We need to stop thinking that parents can fly alone until the school bus comes for kindergarten.”

### **Absence of standardized at-birth risk assessment procedures**

Related to the absence of postpartum services in the area, another key service gap concerns the lack of standardized at-risk birth assessment procedures in the target area. Although every parent and newborn can benefit from access to comprehensive pre/perinatal care and supportive services both before and after the birth of the infant, the ability of families to access appropriate support at the level they need varies greatly. One of the best ways to ensure that families receive an appropriate level of education, information, and referrals is to conduct an at-birth risk assessment that helps service providers identify families’ strengths and limitations, parenting expectations and style, and potential physical, emotional, and socio-economic risk factors for child maltreatment and neglect. This allows service providers to custom-tailor the education and referrals they provide to individual families, thereby ensuring that families receive information that is *appropriate* for their unique needs.

Some counties readily recognize the value that an at-birth risk assessment can bring to postpartum service provision and have integrated an at-birth assessment into the obstetric/pediatric system in the area. In many cases, an at-birth risk assessment requires the cooperation of local hospitals to conduct an assessment for every birth that occurs in the county. In Tompkins County, for example, all births that occur locally are assessed according to a three-tier scale:

- “routine risk” describes those who have a strong support network and will likely need minimal support
- “medium risk” describes those who may lack a strong support network and who will likely need supportive services shortly after the birth (e.g. first time breastfeeding, young mothers)
- “high risk” describes those who may have outstanding medical and/or psychosocial issues and who will need support very quickly after the birth (e.g. drug abuse, unstable housing)

Importantly, at-birth risk assessments can help guide county health department communications after birth – i.e. county health department can use the risk assessment outcome to determine how much follow-up a family will receive after birth – as well as help flag patients who may need extra support and services. In counties that have a Healthy Families program (Cayuga, Herkimer, Madison, and Oneida), the standardized Healthy Families risk assessment protocol is used to screen all new parents after the birth of the infant. Other counties (such as Tompkins) may have developed their own risk assessment tool to guide their postpartum follow-up care and referrals. The important point, though, is that at-birth risk assessments are not currently conducted in every county in the region, nor are the risk assessment tools currently in place compatible across county lines. This makes it difficult to exchange information and referrals for women who give birth in a different county than they live (often the case in rural counties that lack providers and hospitals). Perhaps more importantly, though, the lack of compatibility among different risk

assessment tools may make it difficult to track both the follow-up care of individual women that give birth and any important changes in at-birth risk for all women in a county over time.

While this will be further addressed in the “Recommendations” section, creating a systematic way to review a family’s relative needs at the time they become pregnant or shortly after they give birth in a non-stigmatizing manner is an important proposition for this region. Indeed, a standardized assessment tool that gauges the needs of *all* families that give birth in the region is considered preferable to an approach that singles out only some families as being likely to require additional support to care for their children or avoid child maltreatment.

### **Absence of collectively understood and implemented accountability system**

Finally, the absence of a collectively understood and implemented accountability system in the region limits providers’ ability to establish and measure progress toward common service provision goals. Although service provision organizations and agencies work toward common objectives through their involvement in CPPSNs (as well as through their reporting of service use data to regional and state-level administrators and researchers), the region lacks a system that both encourages counties to come together to actively prioritize and set collective service provision goals. This can make it difficult to track the region’s collective progress toward improving pre/perinatal service provision. Although the Prevention Agenda (discussed in the Recommendations section of this report) sets targets for improving pre/perinatal service provision, no such system exists to help service providers set collective, regional goals (e.g. reducing the number of women who do not receive or receive late prenatal care, increasing the number of opportunities for best practices sharing across counties.)

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## **Limitations to service provision**

Another important facet of understanding the current capacity to provide service concerns the limitations to service provision within the area. We have identified several themes that help explain why pregnant women and mothers with infants may have difficulty accessing pre/perinatal services and why service providers may not be operating with optimal efficiency or capacity.

### **Issues with communication strategies and information delivery systems**

One of the most prominent differences in counties’ ability to deliver services to clients concerns their communication strategies and information delivery systems. Across the target service area, counties have a variety of different strategies for communicating with potential (or current) clients, and they deliver this information in different ways. Some counties provide a pre-assembled package of information to women upon enrollment in a PCAP or MOMS program, reflecting the need to offer comprehensive information

that is well developed (presents the information at an appropriate technical level), well assembled (information is given to clients in a easy-to-use format, such as in a binder), and is of high quality (information is up-to-date, easy to navigate, and includes only relevant information). Cayuga County is at the forefront of developing user-friendly information that make clients feel as though they are valued clients in the care provision process. As for delivering communications information, some counties have successfully linked an at-birth risk assessment to their communications efforts, and provide information to women based on their level of need. Tompkins County, for example, has developed a “Congratulations on the birth of your baby!” packet that all women receive after giving birth; however, women who exhibit levels of risk higher than “routine” receive additional supplemental materials. Despite these examples, many service providers have not had the time or resources to carefully craft a targeted communications strategy, nor develop innovative information delivery systems. As such, many of the providers relied on tri-fold brochures (often of low quality), flyers, and individual patient information sheets to convey services information to clients. Although this method is not ineffectual per se, underdeveloped communications strategies and information delivery systems can create several limitations to service provision, detailed below.

### **Information overload**

In many sites we visited, it was less the case that there was too little information, but more the case that there was too much information given to clients seeking or receiving services. Although it is important that service providers offer brochures about the services that local agencies and organizations provide, too much information can be daunting for prospective (or current) clients – in this case, clarity is key. We follow up with this limitation with a recommendation for enhanced educational and informational materials later in this report.

### **Administrative illiteracy**

Although much of the information being provided to women is practical and useful, many clients lack the facility to understand the high-level legal language and technical jargon often used in Medicaid enrollment letters and forms, and within program handouts and information sheets. This administrative illiteracy leads to profound barriers in service provision. Many providers noted the difficulties that stem from patient noncompliance, especially in the MOMS and PCAP enrollment process. For example, although a woman may be successfully enrolled with presumptive eligibility, she is still required to formalize the application process by submitting a complete battery of paperwork. Many women who do not follow through with this final step risk being denied services once their presumptive eligibility period ends. Although this does not seem like a difficult concept to understand, the enrollment materials that are used in the PCAP/MOMS enrollment process are not intuitive documents for people with low levels of general literacy (ability to read and comprehend) and low levels of administrative illiteracy (ability to comprehend how the system works).

Many county health departments have attempted to clarify the enrollment process by pairing clients with a facilitated enroller or patient navigator and by “cleaning up” the technical information contained within enrollment documentation into a more user-friendly format. However, these efforts do not seem consistent across all phases of the service provision process or informational literature (e.g. patients may receive help with enrollment but they may not receive help understanding what the educational materials actually say), nor do they seem sufficient to transform an otherwise baffling and difficult process into one that is transparent and easy to understand.

### **Difficulties accessing services**

As discussed above, although we believe that services are being rendered with adequate capacity, several important issues limit some women from accessing the services they need.

#### **Capacity to reach under-served populations, such as refugees and migrant workers**

One recurring theme that emerged throughout the phone interviews and site visits was the limitations that providers face in reaching under-served populations, such as refugees and migrant workers. Although this seems to be an important concern in Oneida and Onondaga counties in particular, it is perhaps less of an issue than we previously thought due to successful collaboration between county health departments and organizations serving refugees. Nevertheless, this is an important consideration to bear in mind when considering the barriers to effective service provision throughout the region.

#### **Transportation issues**

Simply stated, transportation remains one of the most salient barriers to service provision across the target service area. It is an issue that we discussed at length with every provider we spoke to during the initial service availability assessment and the clarification of service capacity site interviews. In rural counties, accessing any method of transportation presents a significant barrier to care, as women must struggle with either scheduling a Medicaid cab or using a rural transit system that can be infrequent and unreliable. As one provider noted, if a woman misses her first appointment with a Medicaid cab, “it’ll take an act of God to get that cab to come back and get [her] for the second time.” In urban counties, the cost, scheduling, and reliability of using public transportation profoundly impact whether women keep their pre/perinatal appointments. And, all women with other young children, no matter if they live in an urban or rural area, must address issues of ease-of-use and reliability. Many providers noted how difficult it is to get public transit tokens for clients’ other young children, as well as how difficult it is to arrange to take additional young children in the Medicaid cab to an appointment.

#### **Supply and demand issues within counties and recruitment issues in the region**

As the first several columns of Appendix B illustrate, some counties lack a sufficient number of obstetric practitioners to accommodate the demand of women who wish to receive care and give birth in their home county. In many communities throughout the target service area, the shortage of qualified practitioners has created an imbalance between the supply of pre/perinatal services – especially for those who qualify for

prenatal care assistance programs – and the demand for this care. Although county health departments are typically able to provide health supportive services quickly after a woman finds she is pregnant, the shortage of obstetric practitioners can lead to long wait-times for women who need to access medical services.

Importantly, these supply and demand issues are closely linked to general recruitment issues in the region. Many counties have faced difficulties attracting qualified staff across a number of disciplines – obstetric practitioners, family health practitioners, registered nurses, and qualified translators for refugee and migrant populations – to provide basic medical and supportive care. This issue especially plagues rural counties, which typically cannot offer an attractive high rate of pay to draw practitioners and providers to the community. The low pay of nurses in some areas also discourages nurses from accepting work in the public sector, which can sometimes diminish the capacity of county health departments.

### **Punitive policies**

A number of policies – both state-level and local-level – serve as important limitations to service provision in the area. The first and arguably most important is the impact of “paternity payback” policies on clients’ uptake of services. The entitlement structure of the prenatal care assistance programs in New York State names three parties as payers to prenatal service provision: the State of New York, the county, and the father of the child. This means that when an *unmarried* woman seeks prenatal services through a PCAP or MOMS program, the county has the legal right to attempt to recoup the costs of paying for this care from the father of the child. Not only is the county able to demand repayment from the father for Medicaid support provided prenatally, it can also request that the father pay for any and all health services rendered until the child reaches majority. All repayment by fathers occurs at Medicaid reimbursement rates, and the county is legally entitled to garnish fathers’ wages as a way to collect these payments. Many women will attempt to protect their partners by not listing the father’s name on the birth certificate. However, if the county has an idea of the father’s identify, it can mandate that the pregnant woman take a paternity test to verify the father’s identify. These policies are frequently referred to as “paternity payback,” and they can pose a significant barrier to care, as the threat of repayment of fathers can drive potential clients away from the prenatal care that they want and need because they fear the financial repercussions that the father may face.

In addition to “paternity payback,” punitive policies in the Medicaid presumptive eligibility process may create difficulties for some women to maintain their PCAP or MOMS coverage. If a woman is presumptively enrolled for services when she becomes pregnant and initially seeks care and then fails to follow up with her application (e.g. neglects to submit required paperwork), she can be “kicked out” of care until she becomes compliant. Given the limitations that some counties in their supply of practitioners, it may be very difficult for these women to receive the care they need once they become compliant due to the scheduling constraints of local practitioners.

Some private practitioners have also imposed policies that make it difficult for women to remain enrolled in prenatal care assistance programs. Some practices seek to penalize negligent women who miss appointments by attempting to charge a “no-show” fee which may present a financial barrier to the woman’s ability to resume care. Other practices have a “three strikes, you’re out” rule for women who miss a certain number of scheduled appointments (usually three). In counties where a limited number of providers accept Medicaid, this can have devastating effects. Once a woman is terminated by one provider or practice for failing to keep appointments, it may be difficult to locate an alternative provider or practice in her community, leaving her without services.

## **Coordination issues related to service provision**

### **Identifying clients’ first point of contact**

When considering the function and efficacy of both individual services and networks of services in an area, it is important to understand how women initially access these resources. We discussed this idea at length with providers during phone and site interviews, and one of the first questions we asked providers in each of the counties was how women “first become engaged with services” – in other words, what the first point of contact for pre/perinatal services network was for most women in their area. In many cases, service providers articulated different ideas of who women should contact and do contact as the first point of entry into the pre/perinatal service system. In counties with high levels of collaboration, cross-referral, communication among service providers, these conflicting impressions do not pose a problem. In counties lacking this level of coordination, however, such perceptual differences can lead to a difficult, if not frustrating, experience for women who wish to access services but are unsure who to ask for help. Although it seems evident that most PCAP and MOMS-eligible women in the region are finding a way into the pre/perinatal service network and receiving adequate prenatal care, we must be mindful of those who are not. Indeed, it is occasionally the case in this region that a woman will arrive at a hospital to give birth without having received any substantive prenatal care. Given that some women still struggle to find appropriate pre-natal care despite extended outreach efforts by county health departments and CPPSNs, we feel that conflicting ideas of who women should go to as their first point of contact is a limitation to service provision that may require greater attention.

### **Limited capacity of CPPSNs**

Despite the importance of CPPSNs efforts in fostering collaboration among service providers in the area, CPPSNs face a unique challenge in creating these new learning opportunities for resource-limited service providers. Many of the agencies and organizations that provide essential pre/perinatal services in the area do not have enough ‘slack’ in their staffing arrangements to allow for extensive out-of-office training. With the recent economic downturn, many organizations have had to make due with less staff, while also providing more services to an increasing population of eligible clients. Although CPPSNs may identify areas for growth and want to host and encourage new learning and collaboration, it is difficult to bring these opportunities to fruition when their member organizations cannot spare the staff. Simply stated,

CPPSNs can only afford to offer collaborative and learning opportunities when there is a critical number of potential participants, and this can be difficult to achieve when so many service providers do not have the time or slack for ‘extracurricular activities’ in their overburdened schedules.

### **Difficulties in establishing partnerships/collaboration between different types of organizations**

Some of the providers that we spoke with mentioned barriers to effective partnerships and collaboration due to leadership issues (e.g. administrators not recognizing the capacities, needs, and goals of front-line providers) or due to institutional issues (e.g. difficult to collaborate across different agencies and different levels, including federal/state agencies/programs, county agencies/programs, community-based organizations, insurance/managed care companies, hospitals). Although we believe that collaboration is fairly high throughout the region, it is important to recognize the difficulties that front-line providers face as they attempt to create change within their own organizations and as they attempt to partner with larger institutions (such as hospitals and health care organizations).

### **Conflicting perceptions of provider attitudes toward health supportive services**

Service providers in some counties reported difficulties gaining the respect of local medical practitioners, especially with regard to the practitioners describing their services to clients “in the right light.” Some providers noted that although they provide a great deal of services to clients and should be seen as a partner in pre/perinatal service provision, medical practitioners would downplay the importance of the county health department’s health supportive services to clients. This can have the result of reducing the number of clients who engage in the health supportive services, which serve as an essential supplement to the medical care rendered by practitioners.

It is important to note that this observation does not hold for every county in the target service area. Some social service providers remarked that they have been able to effectively demonstrate the value of their role to local medical practitioners, and are viewed as valuable partners in pre/perinatal service provision by the local medical community. In other words, some county health departments have made manifest the many benefits they offer to practitioners (e.g. managing client billing and coordinating supportive education); as a result, doctors and other health care providers promote the county health department’s supportive services to their clients.

This is an important issue that deserves greater attention before any changes to pre/perinatal service provision are made in the area. Although we have not identified a specific policy or programmatic recommendation to directly address this issue, it may be beneficial for the foundation to explore this concern with its local health care partners. Understanding the complexities of this issue will lead to a greater understanding of how any prospective change to pre/perinatal services will actually impact service provision.



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# Recommendations

As demonstrated throughout this report, the interviews conducted throughout the course of this study yielded valuable information pertaining to the service gaps, barriers, challenges, and successes that providers and patients have experienced in this eight-county region. Perhaps of equal importance, however, was the information gained about the ways in which successful strategies could be expanded, the fertile ground for new practices present within the region, and the willingness of service providers to engage in new ideas, take on present challenges, and thoughtfully examine the need for improvement. Many interviewees shared their perceptions about the potential for new programs to be built on existing strengths, and they also demonstrated a willingness to try evidence-based practices that may be new to the region.

In selecting from among myriad options, the Foundation may want to consider a specific set of indicators or outcomes it wishes to impact as a result of its investments. A possible model for this type of outcome-based decision-making is reflected in New York State's Prevention Agenda initiative. Based on the federal Healthy People 2010 effort, the Prevention Agenda identifies ten priority areas for improving the health of all New Yorkers and encourages local communities to establish community planning teams to address these concerns. The ten priority areas include: access to quality health care; chronic disease; community preparedness; healthy environment; healthy mothers, healthy babies, healthy children; infectious disease; mental health and substance abuse; physical activity and nutrition; tobacco use; and unintentional injury.

Of these priorities, the two most aligned with the Foundation's agenda are "Healthy Mothers, Healthy Babies, Healthy Children" and "Physical Activity and Nutrition." The specific objectives related to the pre/perinatal period found in both of these priority areas include target percentages for low birth weight, infant mortality, utilization of early prenatal care, teen pregnancy rate, and babies who are breastfed at 6 months. These objectives, along with each county's current status, are summarized in Table 12. Numbers appearing in red reflect county performance levels that are below the state recommended benchmarks.

**Table 12: Prevention Agenda Objectives for 2013**

	<b>Cayuga</b>	<b>Cortland</b>	<b>Herkimer</b>	<b>Madison</b>	<b>Oneida</b>	<b>Onondaga</b>	<b>Oswego</b>	<b>Tompkins</b>
<b>Healthy Mothers/ Healthy Babies/ Healthy Children</b>								
Increase the percentage of women living in New York who have received prenatal care in the first trimester to at least 90%. <sup>3</sup>	<b>78.5%</b>	<b>83.4%</b>	<b>77.0%</b>	<b>80.1%</b>	<b>71.2%</b>	<b>76.3%</b>	<b>74.9%</b>	<b>77.5%</b>
Reduce the percent of births that are low birth weight (<2,500 grams) to no more than 5%.	<b>6.3%</b>	<b>8.9%</b>	<b>5.8%</b>	<b>6.9%</b>	<b>8.8%</b>	<b>7.9%</b>	<b>6.5%</b>	<b>5.9%</b>
Reduce New York's rate of infant deaths to no more than 4.5 deaths per 1,000 births.	3.8	<b>7.6</b>	<b>5.6</b>	<b>5.1</b>	<b>6.1</b>	<b>6.5</b>	<b>5.1</b>	3.2
Reduce New York's adolescent pregnancy rate (births, deaths, and induced abortions) to no more than 28 per 1,000 females aged 15-17.	17.2	23.9	19.9	17.4	<b>33.1</b>	<b>33.2</b>	22.4	22.2
<b>Physical Activity/ Nutrition</b>								
Increase the proportion of New York mothers who breastfeed their babies at 6 months to at least 50%.	<b>16.6%</b>	<b>18.8%</b>	<b>21.2%</b>	<b>23.6%</b>	<b>17.7%</b>	<b>13.2%</b>	<b>17.5%</b>	<b>42.2%</b>

Prenatal care, LBW, and IMR data is from the County Health Indicator Profiles, 2007; adolescent pregnancy rate and breastfeeding data is from Community Health Assessment Indicators, 2005-07.

As part of this planning process, every local health department and hospital was asked to identify a subset of the priority areas on which to focus and to develop a community-based comprehensive plan of action to

<sup>3</sup> The Prevention Agenda draws on the data presented in the County Health Indicator Profiles within the New York State Department of Health's Community Health Assessment Clearinghouse. The early prenatal care percentages listed here were taken from the 2007 County Health Indicator Profiles. These percentages are slightly higher than the percentages previously presented in the Service Area Profile section in this report. The percentages listed in Table 5 of the Service Area Profile were calculated by dividing the total number of women receiving early prenatal care by the total number of live births in the county, while the percentage listed in the County Health Indicator Profile was calculated using the total number of women receiving early prenatal care divided by the total number of women for whom prenatal care status is known. The latter method yields a slightly higher percentage as it excludes any missing data on prenatal care usage for live births within the county for a given year.

achieve these priority objectives. All of the counties, except Madison and Tompkins, have ranked “Healthy Mothers, Healthy Babies, Healthy Children” as one of their top priorities. As such, all or most of the counties will need to demonstrate measurable progress in improvement in access to early prenatal care, the percentage of low birth weight babies, the rate of breastfeeding, and infant mortality levels. In addition, Onondaga and Oneida need to reduce teen pregnancy rates. Given the high priority all of the counties have placed on improving maternal and child outcomes, the Foundation’s interest in expanding its efforts to address the needs of low-income pregnant women and newborns is timely and very compatible with local priorities. It also provides a set of common indicators that might be used across the service area to assess progress.

While aligning interventions to the Prevention Agenda is a sensible and appropriate strategy for an assessment perspective, the use of population-based indicators to gauge impacts has limitations. First of all, the specific methodology used to calculate percentages and rates must be carefully examined so as to ensure both accuracy and consistency with others using and referencing these numbers (see Footnote 3 in this section). Additionally, the Foundation may wish to augment the Prevention Agenda benchmarks with other important indicators such as compliance with well-baby visits, repeat pregnancies within the first year of life, and broader infant well-being indicators such as child poverty rates and child abuse and neglect data.

In developing each of the following recommendations, we have considered its relationship to the Prevention Agenda as well as examined the value of each recommendation in light of the service strengths, gaps, and limitations discussed in the prior section. In many instances, these recommendations build on existing initiatives in one or more counties, the creativity and suggestions of interviewees, and the enthusiasm and willingness of service providers to take on new initiatives.

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## **Community Health Worker Program model**

Current status: Oneida and Onondaga counties have NYSDOH-supported Community Health Worker Programs (CHWP), through which additional pre/perinatal support services are provided. These workers supplement the county health department public health nurse home visiting program and provide one-on-one outreach, education, and home visiting services by trained outreach workers to women in the area. Outreach workers engage women both inside and outside the home. This is key for women in rural areas who may not have transportation, working women that may need to during a lunch break, or for teens that may need to meet during school. Community Health Workers free-up public health nurses to focus on cases that truly need their clinical expertise.

Proposed intervention: The CHWP could be expanded to other counties to support their own public health nursing programs. The added flexibility of the community health worker program would allow more women to receive health supportive services through a more flexible model. Because the community

health workers can assist women in enrollment in prenatal care, follow-up to ensure women are attending their appointments, manage outside referrals and follow-up, and do perinatal education, they can take on the lower-risk cases so that the public health nurses may then focus their efforts on higher-risk medical or psychosocial cases which need more clinical monitoring, and more intensive outreach and attention. An RFP could be extended to all counties to establish CHWP models and an evaluation component could be attached to this intervention through which the effectiveness of this model could be better assessed. The increased support and education offered by this intervention would address the Prevention Agenda objectives pertaining to prenatal care usage, birth outcomes, and breastfeeding.

Potential drawbacks: The use of paraprofessionals in home visiting programs, as opposed to nurses, has generated a few critiques. One such critique is that paraprofessionals may not be as effective due to their limited clinical and medical expertise. Additionally, although paraprofessionals are arguably more approachable and may have more in common with the client population, the advice of paraprofessionals may not be as strictly followed as that of nurses because they lack the respect and deference that many people impart upon those with a professional title. Finally, only certain counties are eligible for the funding currently available for community health workers. The issue of finding long-term sustainable funding must be considered.

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## **Centering Pregnancy model**

Current status: The SUNY Center for Maternal and Child Health has submitted a funding proposal to the March of Dimes for support in creating an extended version of Centering Pregnancy, a group model of prenatal care. In the Centering Pregnancy model, individual prenatal care is replaced with ten 2-hour prenatal group sessions with 8 to 12 women who share similar due dates (Rising, Kennedy et al. 2004). These women meet as a group with a midwife every two weeks to check clinical indicators (blood pressure, weight gain, fetal heartbeat, etc.) as well as discuss a topic of education such as birthing, breastfeeding, child care, postpartum depression, etc. In the program proposed by SUNY, these women will continue to meet regularly through their child's first birthday so as to continue covering relevant education topics and providing support for one another through the first year.

Proposed intervention: This intervention is well suited for women in urban areas who have the transportation available to attend these meetings every two weeks. Another possible intervention would be to develop a partnership with SUNY to establish a Centering Pregnancy program in counties outside Onondaga, such as Oneida and Tompkins counties, that could run simultaneously, share knowledge, resources, and collaborate on an evaluation component. This program would specifically suit the needs of these counties where there is greater urban population concentration and special populations that could be targeted including refugees, migrant workers, and teens, as well as other women. With sound evaluation of program effectiveness, there is great potential to create an evidence-based model ready for replication.

This long-term intervention would address the Prevention Agenda objectives pertaining to prenatal care usage, birth outcomes, and breastfeeding as well as other infant well-being indicators.

Potential drawback: While there is evidence in other areas and populations that the Centering Pregnancy model has increased participation in prenatal care, it is not possible to know whether or not those results are generalizable to our target population. Therefore, there is no guarantee that this model would be as effective in Central New York where combined barriers of transportation and the challenges among special populations are so unique. While parts of this program would be eligible for Medicaid billing, other funding sources would be required to fully support the program long term.

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## **Enhanced coordination through Comprehensive Prenatal-Perinatal Services Networks**

Current status: Currently Reach CNY, Mohawk Valley Perinatal Network, and Mothers and Babies Perinatal Network provide a coordinating function within the region and serve as an informal liaison between the NYSDOH and individual county health departments. CPPSN staff members coordinate the Maternal and Child Health Committees (one committee per county) and partner with staff from the Regional Perinatal Program at SUNY to plan, coordinate, and co-chair the semi-annual Regional Perinatal Forum. The forum allows staff to share resources and learn about new practices and information. The CPPSNs also aim to better streamline and coordinate services throughout their regions. One example of an effort spearheaded by Mothers and Babies is the creation and marketing of a toll-free number for women to call as a first point of contact in finding services, enrolling in insurance, and navigating the system. Although the CPPSNs remain an important source of coordination and skill development throughout the region, both CPPSN staff and frontline staff at clinics and the health departments mentioned that they already experience time and resource constraints in trying to get together for trainings, meetings, and other networking opportunities.

Proposed intervention: Because the CPPSNs already have contacts and relationships with the health departments and service providers within the counties, they are well positioned to foster continued learning and sharing of effective strategies, lessons learned, and resources across counties. The CPPSNs could form the backbone for more coordinated efforts across the region to promote best practices and improved communication across and within counties. This could include the creation of learning communities through which service providers could receive further training and professional development in given topic areas such as smoking cessation, strengthening relationships with area hospitals, etc. Perhaps more importantly though, the CPPSNs could be responsible for convening opportunities for individual counties and facilities to share their own successful strategies, ideas, and resources, as each county has its own success stories and strengths that could be shared with others. Some of these conversations could be supported by web conferencing and remote access technologies for logistical and scheduling ease. Learning communities could be developed for service providers across the regions or learning

communities among the CPPSNs themselves could be established so that these agencies could learn from one another and share resources and ideas. An intervention of this kind would be flexible enough to address multiple Prevention Agenda objectives that could be determined by the CPPSNs themselves or the Foundation.

Potential drawback: The CPPSN staff members already report that it is difficult to schedule trainings or meetings and ensure attendance due to scheduling and transportation issues. Staff members at the county health departments report that they are already crunched for time with their wide array of responsibilities. This may make presence at additional meetings, whether web-based or not, an insurmountable challenge due to competing priorities and already overburdened staff.

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## **Educational and informational materials**

Current status: Currently, Tompkins and Cayuga counties are at the forefront in the creation of user-friendly literature and resource guides aiding women in system navigation, education, and the connection to support services. Tompkins County ensures that every mom giving birth in the county receives a “Congrats! Welcome Baby” packet upon delivery and discharge from the hospital. This packet includes important educational materials about infant care and safety as well as lists of resources and numbers to call for assistance with any potential problems, from breastfeeding support to poison control. The Tompkins County health department then follows up with new mothers based on risk. Those women considered medium- to high-risk receive a call and home visit within 48 hours of going home from the hospital.

In Cayuga County, as soon as women are enrolled in the MOMS program they receive a binder full of information including health education materials, area services, what to expect throughout prenatal care, and who to call for all types of inquiries from questions about physical symptoms to questions about insurance enrollment. The entire prenatal curriculum used by public health nurses is included in the binder so patients may reference it at any time. The binder is written and organized in a very patient-friendly manner which helps patients figure out how to get their questions answered amidst the often overwhelming network of providers, agencies, and jargon with which they are faced in attempting to navigate the system.

Proposed intervention: The Foundation could provide funding and oversight in the development of a similar binder or resource manual that could be easily added to and tailored to meet the needs of each individual county. Women in each county would then be receiving the same high-quality, user-friendly information that is uniquely modified to include the services, resources, and policies of their home county. The educational elements of this intervention would broadly address the Prevention Agenda objectives pertaining to prenatal care usage, birth outcomes, and breastfeeding. Additionally, this intervention could easily be implemented in tandem with the enhanced coordination through CPPSNs intervention described previously.

Potential drawback: A drawback to this type of intervention is that it may be difficult to determine whether or how these materials will be used by women who receive them and what impact these materials will have on their ability to navigate the system. For the women participating in the MOMS program, questions pertaining to the binder could be incorporated into the overall evaluation they complete upon program discharge. However, it would be quite difficult to conduct a survey and achieve a high response rate among all the mothers giving birth in an entire county who received the Congratulations packet. An additional drawback would be the fact that there would be no way to ensure the quality of additional materials that may get inserted into the binder or packet at the local level.

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## **Strengthen WIC-DOH relationship**

Current status: The county health departments across the region have varying relationships with the WIC providers in their areas. Some are housed in the same location and therefore work very closely with one another, applying for joint funding and collaborating on events and outreach. A prime example of this collaboration is the partnership that the Cayuga County health department has with the local WIC office. Together, they applied for state funding to encourage healthy behaviors by rewarding physical activity with incentives. Joint ventures like these have allowed them to enhance the program quality. In other counties, the local WIC offices and health departments are more loosely related—referring clients to one another is the extent of their collaborations.

Proposed intervention: Increased collaboration between the two entities may be fostered through funding provided for joint projects between the county health department and the local WIC program. These collaborative efforts may include parent support groups, nutrition, smoking cessation, or dental hygiene campaigns and activities,<sup>4</sup> as well as community baby showers through which women receive education, information about local services, and items such as receiving blankets, car seats, books, and toys. These collaborative efforts would further close the gap between the varying agencies that women must interface with in order to get the services and information they need during pregnancy. Additionally, because WIC is often the only agency that women consistently visit and maintain contact with during the postpartum period, these collaborative efforts would increase the amount of services and information available to women after their babies are born. In addition to providing funding for joint projects, technical assistance could be provided so as to encourage improved communication and enhanced collaborative skills. The educational elements of this intervention would broadly address the Prevention Agenda objective on breastfeeding and would also impact other important infant well-being indicators.

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<sup>4</sup> Programs addressing these health needs that have been used elsewhere in the state include Eat Well Play Hard ([http://www.nyhealth.gov/prevention/nutrition/resources/docs/2003-2006\\_ewph\\_community\\_intervention\\_projects.pdf](http://www.nyhealth.gov/prevention/nutrition/resources/docs/2003-2006_ewph_community_intervention_projects.pdf)), the Preventive Dentistry Program ([http://www.nyhealth.gov/prevention/dental/high\\_risk.htm](http://www.nyhealth.gov/prevention/dental/high_risk.htm)), and the Smoke-Free Home campaign (<http://www.nyc.gov/html/doh/html/pr2007/pr087-07.shtml>).

Potential drawbacks: Simply providing joint funding to be shared between organizations does not necessarily imply that communication and collaborative efforts will be improved and enhanced across all areas. However, the technical assistance that could also be provided would aim to promote an increased awareness of the other areas through which these two organizations could collaborate and the skill development necessary to do so.

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## **Developing a standard risk assessment**

Current status: The health department in Tompkins County currently collaborates with the local hospital to conduct a risk assessment of all new mothers and babies and performs outreach and home visits based on risk.

Proposed intervention: Creating a systematic way to review a family's needs at the time they become pregnant or shortly after giving birth in a non-stigmatizing manner is considered preferable to an approach which singles out only some families as being likely to require additional support to care for their children or avoid child maltreatment. As the Foundation moves forward in advancing its interests in expanding services for pregnant women and newborns, facilitating the development and implementation of such an assessment tool within its target communities offers a promising approach.<sup>5</sup>

Another benefit of a consistent risk-assessment process for all pregnant women or newborns is its potential to provide a more accurate profile of the new parent population in a given service area. On balance, the data generated by such a tool is perceived as providing more accurate information regarding the frequency of various presenting problems than is generated by focusing only on a subset of women or families who access public health services or other community supports. If broadly implemented, a standardized risk-assessment tool can provide community planners with more accurate and time-sensitive information regarding the key service needs and challenges facing all new parents within their area.

As an initial step, the Foundation might work to establish a team of local providers and agency directors interested in the concept of a universal risk assessment. This group might review the current assessment

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<sup>5</sup> A range of assessment tools have been developed and used in other early intervention systems that incorporate systematic assessments of a broader population for purposes of identifying families at greatest need. Some examples include the Family Stress Checklist, developed initially for the Hawaii Healthy Start Program and later adapted by the Healthy Families America program; the set of protective factors promoted by the Strengthening Families initiative being developed by the Center for the Study of Social Policy; a risk assessment tool developed by colleagues at Duke University to govern the allocation of services through their Durham Connects outreach program offered to all new parents giving birth in Durham County; and a Life Skills progression inventory based on the process NFP follows in determining case objectives for their program participants. Various screens are also used in pediatric practice, Kathryn Barnard's Difficult Life Circumstances measure, and screens administered by local and state health departments to focus their maternal and infant care efforts.



tools being used by various programs to determine participant eligibility and potential risk, selecting from among these options a tool most compatible with the interests and capabilities of local providers. This tool could be pilot tested in one or more counties for purposes of determining its implementation potential. Based on the results of this pilot test, the Foundation, in partnership with local providers, may elect to develop a more comprehensive implementation plan.

The broad scope of this intervention would address the Prevention Agenda objectives pertaining to breastfeeding as well as all other infant well-being indicators.

Potential drawbacks: The majority of existing risk assessment tools are very limited and focus on a small number of core risk factors commonly cited in the literature as contributing to an elevated risk for child maltreatment or adverse child health outcomes (e.g., lack of adequate pre-natal care, single parent status, young maternal age, history of child welfare involvement, substance abuse, homelessness, and domestic violence, among others). In some instances, these characteristics are “factual” in nature such as maternal age, marital status, educational level, general income level, and pre-natal history. In other instances, these characteristics ask participants to make judgments about their situation with respect to such issues as mental health, domestic violence, substance abuse, and level of social support.

Prevention strategies or systems using some type of risk assessment to allocate services have focused on key demographic characteristics (such as NFP) or have gathered this information from potential respondents through a structured interview process. The primary objective of these interviews is to determine if a family is in need of and would benefit from more intensive services—the goal is not to provide a precise assessment of a participant’s well-being in every domain of interest. For the risk assessment process to function in this capacity, however, the screening tool needs to have strong reliability and validity and be administered to all or most of the intended target population. Based on the experiences of other communities, developing such a tool will take considerable time and will need to engage a broad range of actors. Also, it often can be difficult to adequately train direct service providers to administer the tool in a consistent manner, particularly when providers are uncertain as to the value of the tool in improving their work with families.

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## Conclusions

Efforts to enhance early child development have experienced steady growth for the past 40 years in light of scientific evidence underscoring the importance of the first few years of life. More recently, this growth has taken an exponential leap, as significantly greater public and private investments have been directed to such services as early home visitation programs for pregnant women and newborns, expanded early education opportunities for young children, and new institutional collaborations around serving the 0–3 population. This increased investment has brought greater scrutiny to how resources are allocated and higher expectations for measurable outcomes.

Our environmental scan found similar priorities in western and central New York as reflected in the strength and quality of the area's pre/perinatal service system. Although not all pregnant women and infants have access to comparable care, particularly following the birth of a child, local stakeholders are committed to improving performance and extending adequate care and support to all of pregnant women and newborns in their services area.

The Foundation has a unique opportunity to partner with these agencies in building a more coordinated and integrated service response. Among the array of questions, Foundation staff and local stakeholders may wish to consider are:

- **What is the appropriate scope for perinatal services?** Should emphasis be placed on targeting assistance to those at highest risk of poor outcomes, or should such targeted efforts be embedded in a more universal system of support for all pregnant women and newborns?
- **What is the appropriate balance between service expansion and investing in infrastructure support and systemic change?** To what extent should local communities focus on replicating evidence-based program models, as opposed to creating new institutional alignments and other systemic reforms designed to change the participant identification and service delivery processes?
- **What must parents know, and what services must they have access to, in order to meet the needs of their newborns?** What knowledge and skills do parents require, and what kind of support system will enable them to meet their young children's needs (e.g., formal service systems, informal support systems, or altering normative expectations)?

None of these questions has a definitive or correct answer. Most professionals would argue that movement on all of these fronts is essential for achieving success. Choices, however, will be inevitable as communities face very real fiscal and human capital constraints. As such, discussion of these questions has value not because it will resolve these debates, but rather because it can unearth the range of opinions and concerns essential for making fully informed choices. How a community, funder, or legislative body grapples with these issues, and how the elements of the discussion coalesce, will eventually shape the policy agenda.

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# Appendix A: Key informant interview protocol

**Interviewee:** Interviewee name here

**Interviewer:** Interviewee name here

**Interview date/time:** Date / time (EDT)

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## General introduction

The purpose of this interview is to gather your expertise as a leader in the field of pre/peri-natal health services available to women and infants in the following central New York counties: Cayuga, Cortland, Herkimer, Madison, Oneida, Onondaga, Oswego, and Tompkins.

We'll be talking about your familiarity with available resources and services as well as your perceptions of where and how services could be created, improved, or expanded to better meet the needs of pregnant and parenting women and their infants in these counties.

Please feel free to talk at your own pace, and do let me know if you have any questions as we move along. Also, I should note before we begin that we're specifically interested in services that are offered within the eight-county region, so I'd like to limit our discussion of services to just those counties.

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## Background/context

- **Name of agency/organization:**  
Input response here
- **Which counties does your agency serve?**

Input response here

- **Please tell me about the vision and mission of the agency where you work.**

Input response here

- **What is your role within the organization and how long have you been there?**

Input response here

- **What services do you offer? What other activities does the organization do?**

Input response here

- **With what type of agencies/providers do you partner?**

Input response here

*If their agency serves counties outside the study area, ask them to try to focus only on the counties that overlap with our target counties. For example, if their agency serves Broome County, please do not discuss any services that may be only available to Broome County residents.*

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## **Accessing services**

As an introduction to our broader discussion of services in your area, it might be useful for us to walk through a narrative example to get a sense for the services currently available to pregnant women and mothers of newborns.

- **To start, if you can think of a typical mom-to-be (or recent mom) who might want to utilize services in your area, could you walk me through how exactly she would first become engaged with these services? For example, would she find out about them from her doctor, would she come to your organization first, or would she take some other avenue?**

Input response here

- ***If the answer is that their doctor refers them for services, ask: So for a woman who is not already accessing prenatal care, how would she find out about the services?***

Input response here

- **With all the services offered, do women usually access more than one service? For instance, if a woman took birthing classes, is she likely to also seek breastfeeding support and attend parenting classes or participate in a home visiting program?**

Input response here

- **How much outreach do service providers in your area do? What types of outreach methods do they use (advertisements, websites, flyers, etc.)? Do you think these outreach attempts are effective?**

Input response here

- **Are there waiting lists for these services? Is there sufficient availability to meet demand?**

Input response here

*During your conversation, keep in mind the key services that we expect these providers to discuss – see list below for examples. If by this point in the interview any of these services have **not** been mentioned, probe for further information.*

**Key services that providers are likely to mention:**

- Pre-natal care
- PCAP or MOMS program(s)
- Birthing classes
- Infant care classes
- Breastfeeding support
- Nutrition assistance
- Home visiting program
- Parent support group
- Parenting classes

- **We haven't talked about [insert key service here] yet. Are you aware of these services in the local area?**

Input response here

- **In addition to any of the services you already described that are offered by your agency, what other existing health and support services are you aware of in your area?**

Input response here

- **Are you aware of any other services or resources offered to pregnant/parenting moms and infants in your area?**

Input response here

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## Who is not accessing services?

Now that we have a sense for the types of services available to pregnant women and mothers of infants, we're curious to get a sense for who is *not* able to access these services.

- **To start with, are there women in these counties who are not accessing these services even though they are eligible or may benefit from them? Tell me what you may know about those women. Do they tend to be of a certain age, income, geographic location, etc.?**

Input response here

- **What barriers exist that prevent these women from accessing services? In your opinion, which is the most salient barrier?**

Input response here

- **If not otherwise mentioned, prompt with these examples as potential barriers to care:**

- Transportation
- Time/Scheduling (i.e. services cannot be scheduled around work hours)
- Lack of knowledge of service
- Quality of services perceived as poor
- Service providers perceived negatively (i.e. unfriendly, incompetent, etc.)
- Stigma (i.e. only “poor” people utilize those services)
- Immigration/documentation status
- Language
- Cultural/religious beliefs

- **What role does health insurance status play in accessing services? Are pregnant women aware that they qualify for health insurance?**

Input response here

- **Why do you think some of the barriers you mentioned exist? Have steps been taken by service providers to address any of these issues? If so, what has been the result?**

Input response here



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## Service engagement and retention

Now that we've discussed the women who are not be using services, we're curious to find about the ones who do.

- Are there certain types of women who tend to use services more than others?

Input response here

- Do the women who do access services seem to be satisfied with the services provided? Is this being measured in any kind of systematic way? Is it possible for us to get copies of this information?

Input response here

- Do women who enroll in services remain enrolled for the duration of service availability? (i.e. if it is a 10 week class, do they tend to stick with it through week 10? Are there people that you know show up at the beginning of a program but who you're not able to hold on to through the end?)

Input response here

- Do you know if women often refer one another to the services or recommend services to their friends, family, neighbors, coworkers, etc.?

Input response here

- We're also curious about how service utilization data tracked is tracked for this area. What types of data does your agency collect about service utilization, community needs, or quality of care? How do you use this data? What kind of reports or documents do you produce?

Input response here

- Every program or service agency has its strengths and shortcomings. What is your perception of the quality of services offered in this area? Are some better than others? If so, why?

Input response here

- If any improvements could be made to these services, what do you think those improvements would be? What would be necessary to make these improvements?

Input response here

- As a final question, many services are being impacted by the current state of the economy, or by stimulus funds. Are existing services presently being reduced, cut, or expanded to your knowledge? Are you aware of there any other recent or pending changes to existing services?

Input response here

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## Other contacts

Thank you so much for the opportunity to speak with you – this has been truly helpful. Moving forward...

- Can you think of any other key service providers or other key players in your area who we should speak with about these topics?

Input response here

- If we needed to get back in touch with you, would you be willing to speak with us again?

Input response here

- Also, the next phase of our project involves on-site observations – such as visits to provider sites and focus groups with providers and leaders in the field. Please don't feel obligated, but would you be willing to participate in something like this?

Input response here

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## Appendix B: Overview of key pre/perinatal services available in target service area

### Prenatal care assistance programs

County	PCAP	MOMS
<b>Cayuga</b>	<i>none</i>	<u>Medical services</u> : 3 practices  <u>Health Supportive Services</u> : Cayuga County Health Department
<b>Cortland</b>	1 federally qualified health center (with 4 satellite locations)	<u>Medical services</u> : 3 practices  <u>Health Supportive Services</u> : Cortland County Health Department
<b>Herkimer</b>	Herkimer County Health Department	<i>none</i>
<b>Madison</b>	<i>none</i>	<u>Medical services</u> : 4 practices  <u>Health Supportive Services</u> : Madison County Health Department
<b>Oneida</b>	3 clinics run by 3 local hospitals	<u>Medical services</u> : 3 practices  <u>Health Supportive Services</u> : Oneida County Health Department
<b>Onondaga</b>	1 clinic run by health department 2 clinics run by 2 local hospitals	<i>none</i>

<b>Oswego</b>	1 clinic run by local hospital	<u>Medical services</u> : 1 practice  <u>Health supportive services</u> : Oswego County Health Department
<b>Tompkins</b>	<i>none</i>	<u>Medical services</u> : 2 practices, 8 providers  <u>Health supportive services</u> : Tompkins County Health Department

**Home visitation programs**

<b>County</b>	<b>Health Department, Nurse Family Partnership, Healthy Families</b>	<b>Early Head Start</b>
Cayuga	Cayuga County Health Department Healthy Families Cayuga/Seneca	<i>none</i>
Cortland	Cortland County Health Department	<i>none</i>
Herkimer	Herkimer County Health Department Herkimer County Healthy Families	1 program in Herkimer
Madison	Madison County Health Department Starting Together (Healthy Families/Early Head Start)	1 program in Canastota
Oneida	Oneida County Health Department Healthy Families of Oneida County	4 programs in Utica (1 offers prenatal services) 2 programs in Rome (1 offers prenatal services) 1 program in Ilion
Onondaga	Onondaga County Health Department/ Syracuse Healthy Start Nurse Family Partnership	4 program in Syracuse
Oswego	Oswego County Health Department	<i>none</i>
Tompkins	Tompkins County Health Department Child Development Council	<i>none</i>

**CPPSNs, WICs, Community Health Worker Programs**

<b>County</b>	<b>CPPSN</b>	<b>WIC</b>	<b>Community Health Worker Program</b>
Cayuga	Reach CNY	Cayuga County Health Department	<i>none</i>
Cortland	Mothers and Babies Perinatal Network	Cortland County Community Action Program	<i>none</i>
Herkimer	Mohawk Valley Perinatal Network	Planned Parenthood Mohawk Hudson	<i>none</i>
Madison	Reach CNY	Cortland County Community Action Program	<i>none</i>
Oneida	Mohawk Valley Perinatal Network	Fulmont Community Action Agency, Inc. Planned Parenthood Mohawk Hudson Oneida County Health Department	Oneida County Health Department
Onondaga	Reach CNY	Onondaga County Health Department	Onondaga County Health Department (administered through subcontractor of the Salvation Army)
Oswego	Reach CNY	Oswego County Opportunities	<i>none</i>
Tompkins	Mothers and Babies Perinatal Network	Tompkins County Health Department	<i>none</i>

### Community-based organizations (CBOs)

County	Names of CBOs and services offered
Cayuga	<u>Cayuga Seneca Community Action Agency</u> : Healthy Families, TASA (pregnant and parenting teens program), and care seat distribution <u>Catholic Charities</u> : parenting support program <u>Auburn Memorial Hospital</u> : childbirth classes <u>Finger Lakes Migrant Services</u> : support services for migrant population
Cortland	<u>Cortland County Community Action Program</u> : parent support and education, nutrition services, WIC <u>STEPS</u> : Adolescent pregnancy prevention <u>Catholic Charities</u> : parenting support <u>Finger Lakes Migrant Services</u> : support services for migrant population <u>Family Resource Center</u> : parenting classes and support
Herkimer	<u>Herkimer CDC</u> : Early Head Start <u>Catholic Charities</u> : parenting classes and support groups
Madison	<u>Community Action Program For Madison County</u> : Starting Together home visiting program <u>Oneida Health Care Center</u> : breastfeeding support and baby weight station, birthing and parenting classes <u>Liberty Resources</u> : TASA (teen pregnancy and parenting program)
Oneida	<u>Mohawk Valley Community Action Agency, Inc.</u> : Early Head Start <u>Family Nurturing Program</u> : parenting classes <u>Refugee Resource Center</u> : services for refugee population <u>Healthy Families</u> : Father involvement program <u>Catholic Charities</u> : parent support groups <u>Mohawk Valley Perinatal Network</u> : community baby showers, facilitated enrollments

- Onondaga     Syracuse Community Health Center: (subcontractor of Syracuse Healthy Start parenting support and home visiting program)  
Syracuse Model Neighborhood Facility: (subcontractor of Syracuse Healthy Start parenting support and home visiting program)  
United Way's Success by Six Program: training and support for parents, child care providers, and practitioners  
PeerPlace: web-based information and referral network  
Catholic Charities: parenting classes & services for the refugee population  
Peace, Inc.: Early Head Start  
La Leche: breastfeeding support
- Oswego        Oswego County Opportunities: Migrant health clinic, family planning clinic, WIC, facilitated enrollment, teen pregnancy and parenting program, transportation to medical appointments, breastfeeding support  
Cornell Cooperative Extension: nutrition programs and parenting support  
Adolescent Pregnancy Prevention Program: Educational support and sex education  
Oswego Hospital: birth and parenting classes
- Tompkins      Child Development Council: child care resource and referral, teen pregnancy and parenting support, home visiting for families with a child through age 3  
Faith-based organizations: support groups for mothers  
Cornell Cooperative Extension: nutrition support and parenting support groups and classes  
Catholic Charities: facilitated enrollment and transportation to medical appointments  
La Leche: breastfeeding support  
Cayuga Hospital: birth and infant care classes