ANALYSIS OF MATERNAL AND CHILD HEALTH PROVIDERS OF FOUR HOT SPOT COMMUNITIES

Western New York Maternal and Child Health Environmental Assessment

Report

1.31.14

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EXECUTIVE SUMMARY

The Heath Foundation for Western and Central New York (HFWCNY) has made children's access to care a core part of their mission and grant making. In the last two years, the Foundation has begun to explore the role they might play in improving maternal and child health (MCH) outcomes such as timely access to prenatal care and availability of midwives in the Western New York region. As part of this work, the Foundation conducted a series of interviews with pregnant women and parents to understand their perspectives on the strengths and weaknesses of services. In addition, the Foundation has looked at the MCH data at the zip code level to identify the areas where there is the highest risk for poor outcomes.

As the next stage of the analysis, HFWCNY hired John Snow, Inc. (JSI) to conduct an environmental assessment of the service providers in the "hot spot" areas within the eight counties of Western New York where there are especially poor MCH outcomes. The assessment includes interviews with a sample of service providers, and site visits to a select number of providers based on the preliminary interviews.

A sample of providers was interviewed in four "hot spot" areas in Western New York: Buffalo, Chautauqua/Cattaraugus, Olean, and Niagara Falls. "Hot spots" were defined as areas with two contiguous ZIP codes with a poverty rate greater than or equal to 8.675 percent (the average poverty rate for families in WNY) and a combination of two of three risk indicators: identified as high risk, in the highest quartile for teen pregnancy rate, or in the highest quartile for late or no prenatal care.

Interviewees were identified through an initial list provided by the Health Foundation and through recommendations of interviewees. The culture and community dynamics of each hot spot area is distinct thus our discussion of findings is organized by the hot spot areas.

NIAGARA FALLS

Overall Strengths

- Home visiting programs are available to meet prenatal, parent education, and cultural specific needs. Intensive case management and peer support services for pregnant mothers, new mothers, and newborns geared to ethnic/cultural minority groups as well as the majority white population.

  > *"Community health workers make a great impact. They are trusted more than outsiders. There is a fear of being used i.e. Tuskegee study."*

- New emphasis and resources to address substance use in women of childbearing age.
- St. Mary's and other community providers have a developed a robust referral system (Mom's Net) that provides supportive behavioral health services for postpartum women Strong hospital services, specialty outpatient and delivery services.
- Primary care safety net is integrated with the hospital, facilitating coordination.

Current Concerns

- Provider community is divided between two hospital systems, and this is mirrored in MCH resources. This division and the inherent competition between the provider's limits collaboration and coordination.
- Need for more robust teen pregnancy prevention education in schools and community.
- Need to strengthen the relationship between providers and community-based resources.

> *"There is need for more awareness of the benefits of natural births to prevent high rates of C-sections and late preterm deliveries caused by inductions. Discussion of these options needs to be a consistent message across the providers and community health workers."*

- Many medical specialty services (e.g., for very high-risk pregnancies) require travel to Buffalo.

> *"I believe we are lacking midwives as alternative to OGBYN providers, women that we serve find it difficult to attend appointments out of Niagara Falls due to lack of transportation so are limited to only a few providers."*

- Significant barriers to care related to social determinants (e.g. race, and poverty).

BUFFALO

Overall Strengths

- Collaborative work in the communities to address MCH concerns on several specific topics: breastfeeding, trauma-informed care.

> *"The proliferation of Baby Cafes and focus on breastfeeding has been an important step in increasing the continuity of services for families."*

- Active meeting across organizations on various initiatives (Healthy Start Forum, Healthy Baby-Healthy Moms).
- Full spectrum of services is available (medical, specialty, home visiting, WIC, parenting education).
- Service providers view and engage churches/faith based community as partners.
- Buffalo Public Schools are moving towards strengthened reproductive health education in the schools.

Current Concerns

- Cultural barriers exist to comprehensive and consistent education of teens on pregnancy prevention.
- Buffalo is fortunate to have a large spectrum of services available to pregnant women, mothers, fathers, and children, however because of the large number of organizations involved and the broad range of options, women/families need assistance in navigating what is available and best fits their needs.
- Families are "neighborhood centric" in accessing services and if a service provider is not in their neighborhood they will not be aware of service or travel to it.
- Significant barriers to care related to social determinants (e.g. race, and poverty).
- Grandmothers play a significant role in influencing mothers in their infant care taking and messages from Grandmothers may be inconsistent with those of medical providers and community health workers.
- Refugee families face complex concerns related to language, trauma, cultural barriers, and isolation.
- A divide remains between medical providers and community based providers such as community health workers. While some relationships exist, they are inconsistent and dependent on relationships formed between individual providers.

> *"In the past there have been cases of a certain territorialism across the case managers and care managers and there needs to be better communication. "*

SOUTHERN TIER (CHAUTAUQUA AND CATTARAUGUS COUNTIES)

Strengths

- There have been positive efforts to strengthen access to reproductive health education in schools through the school based health centers in Cherry Creek and Jamestown.
- The Infancy Health Council has become a collaborative community for maternal and child health providers to discuss community level concerns and network among providers.

Current Concerns

- Access to prenatal specialty services is limited and transportation is a concern for women who are required to travel to Buffalo for services.
- Transportation is challenging for families who need to travel to appointments or drop children off at programs.

"Parents must travel all the way from Wyoming County to attend Head Start in Olean, which is major burden for families."

- Access to additional behavioral health services and parenting support for infants and children (0-4) is critical. Behavioral concerns seen by Head Start providers are increasing and parents have inadequate skills.

  "What we are seeing the protective cases are increasing, and the foster care cases are increasing and these are symptoms that we are not providing the adequate resources to the families."

- Families are difficult to engage in care, both with medical services and home visiting. No shows to appointments are a large problem and families are sometimes 'fired" from practices for no-shows. Families require a long time and sometimes multiple pregnancies for home visiting programs to develop a relationship.

  "Pine Valley is so poverty stricken and parents do have some paranoia about enrolling services. We need to build awareness, so that families access the school based health center services."

  "Many of these families are stand offish and they miss appointments. Then you have a family where they are not responsive. They live in a field of problems. Despite a lot of attempts (with home visiting), they may be listening more with the second child."

- Need for evidenced-based programs to address high rates of smoking during pregnancy.
- Substance and alcohol abuse are significant risks for families. There are many families at risk that have concerns with substance abuse and related mental health, and family violence concerns. Current screening and treatment for at risk families is inadequate.
- Current method of hospital based parent education on safe infant sleeping is not effective.
- Need to strengthen relationship between providers and community-based resources.

OVERARCHING NEEDS IDENTIFIED ACROSS COMMUNITIES

- There is a need for strengthened collaboration between medical (hospitals, prenatal providers, and pediatricians) and community-based providers (home visiting, WIC, and others) to better support identification of women in need, developing coordinated and shared plans for families, and coordinating services.

  "We have had relationships with the maternity ward nurses in the past, but once our key point of contact left, I currently don't know anyone in the maternity ward." (one home visiting program)

  "There are some families that think they need every service. It would avoid duplication of services and would be really nice to have team meetings across different service providers. Patients are telling everyone a different story, and it is a social services issue."

"This population lacks continuity of care. Residents, nurse practitioners, and attending physicians treat them on an episodic basis. As such, they are focused on specific health issues and not the whole person. Social workers may well be the link, but are overwhelmed. In addition, there is limited conversation between social worker and physicians.

"I'm not very familiar with the community health worker programs." (one medical provider)

- Effective education of families must consider the influence of other role models, most significantly grandmothers, but also peers. Inclusion of fathers in parenting education programs has been successful but there have not been adequate resources to strengthen and expand these types of services.

  "A lot of the problem is that a lot of the pregnant moms are teens. You can tell the girls that they should not be getting pregnant. A lot of times people are falling into the footsteps into of their families and peers."

  "*It would be great to have a peer based program for parent coaching. I think young mothers and fathers would probably be more apt if they had access to more informal and mentoring type education and coaching. I think this is what is needed to engage parents."*

  "We are currently only able to provide father support services for 20% of our families and we would like to expand this program. We have found that even the breastfeeding rates are higher when the father is involved."

- Currently there is limited discussion by community providers on how their current efforts are linked to state and regional maternal and child health planning and initiatives.

- Transportation is a major issue that limits access, thus programs that do outreach and provide home visiting are critical.

- Poverty, health literacy, family stress, lack of employment, and other social determinants of health limit access, hinder outreach efforts, and constrain families' ability to engage in services.

RECOMMENDATIONS

1) The network of MCH providers lacks the systems needed that would link programs, facilitate communication and referrals, and promote consistent sharing of information. . Investigate approaches to build stronger communication linkages between outpatient, inpatient, maternal and child health, and other community-based providers. The coordination of services across public health, community-based, and medical provider is an important topic across all areas of health. This approach could facilitate outreach and identification of families in need of services, build maternal and child health capacity, and also bleed into supporting stronger collaboration across public health and direct medical service more generally.

2) Improve specialty care access in rural communities to reduce the burden of transportation on families. Explore ways to coordinate consults from experts in Buffalo for families in rural areas, through residency/training programs, mid-level providers/counselors. Telehealth is an area of interest to support communities in accessing specialists remotely.

3) Develop a center for best practices in peer and family education. Current approaches to education of women are often narrow in their conception of the family unit and influencers. Programs such as Centering Pregnancy are effective but not yet broadly available in the hot spot communities. In addition, identification of positive peer role models is one component that several interviewees felt is missing from the current approach to supporting at risk families and women.

4) Social determinants of health have an elemental impact on the health of children long term. Addressing poverty and racism as the underlying barriers to many of the disparities in access and health should be a components of any program or initiative.

5) Support local planning efforts with the goal of ensure linkages and aligning plans with state and regional maternal and child health planning and priorities. For example, build on findings from the Maternal Infant and Early Childhood Home Visiting Program Needs Assessment and New York State Maternal and Child Health Title V goals.

6) Explore supporting an existing or developing MCH Coalition in each of the hot spot areas. There is continued need for a common forum to assess and develop strategic plans with clear goals and metrics. Something of this nature would promote collaboration and would allow more targeting on priority issues and continued focused coordination on the other needs identified. For example the forum could further explore what the win win scenarios are between hospitals and community-based providers as well as develop and track metrics of success. There are seeds of MCH providers coming together in each of the hot spot areas such as the Buffalo Prenatal Perinatal Network in Buffalo, the Infancy Health Council in the Southern Tier, and Moms Net in Niagara, but each could use support to be more effective.

7) The cultural norms among teens as well as limited education were mentioned by interviewees as contributing to teen pregnancy. A root cause analysis could be used to delve deeper into this issue and build community wide plans to address teen pregnancy. The Center for Disease Control provides specific resources to support communities in doing this type of analysis.

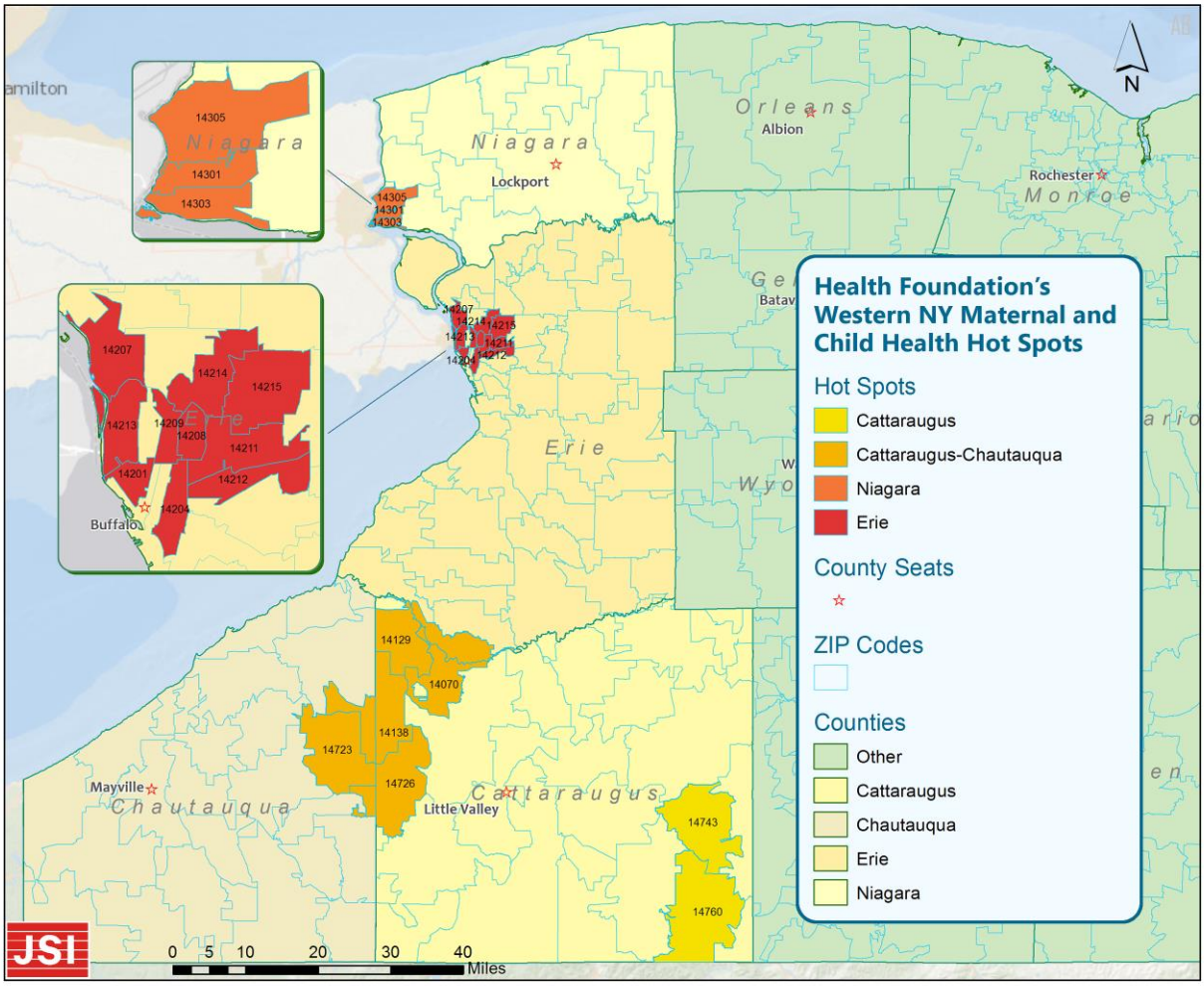
INTRODUCTION

The Heath Foundation for Western and Central New York (HFWCNY) has made children's access to care a core part of their mission and grant making. In the last two years, the Foundation has begun to explore the role they might play in improving maternal and child health (MCH) outcomes such as timely access to prenatal care in the Western New York region. As part of this work, the Foundation conducted a series of interviews with pregnant women and parents to understand their perspectives on the strengths and weaknesses of services. In addition, the Foundation has looked at the MCH data at the zip code level to identify the areas where there is the highest risk for poor outcomes.

As the next stage of the analysis, HFWCNY has hired JSI to conduct an environmental assessment of the service providers in the "hot spot" areas of poor MCH outcomes in the eight counties of Western New York. The assessment includes interviews with a sample of service providers, and site visits to a select number of providers based on the preliminary interviews.

METHODS

The hotspot analysis of the Western New York Public Health Planning Institute identified maternal and child health hotspots as areas where there two or more contiguous zip codes with poverty levels above the state average, as well as having two of three risk indicators based on poor outcomes in low birth weight, infant mortality, late or no prenatal care, and teen pregnancy rate. Based on these criteria, four hot spots were identified. This includes ten zip codes in Buffalo (Erie County, three zip codes in Niagara (Niagara County), two zip codes in Hinsdale and Olean (Cattaraugus County), and five zip codes that span the border of Cattaraugus and Chautauqua counties.



Based on these identified hot-spots, interviews with service providers were prioritized in Western New York that served these hot spot areas. A list of interviewees was developed by the Health Foundation for Western and Central New York, and additional interviewees were identified through the first round of identified interviews. The intent was not to interview every maternal and child health provider in each hot spot, but to speak with a sample that could provide insight to the service delivery options and the current concerns in the region. With that limitation, our report does not include detailed information on every service provider in each hot spot.

The majority of the interviews were conducted by phone, however a small group was identified for site visits where were in person interviews, and often included more than one person in the organization. An interview protocol was developed and used as the basis for interviews, however each conversation was tailored to the interviewee and their position and role in the maternal and child health service network. A list of those interviewed is included in Appendix A and of the interview guide is included in appendix B.

Following the series of interviews in June-September 2013, in-person meetings were held in Buffalo and Niagara to share out the early findings with the maternal and child health provider community.

The discussions from these meetings, and additional information offered by participants of these meetings is incorporated in the findings of this report.

The report is structured to describe the array of key service providers in each hot spot community, the key concerns brought up by those providers, and a description of the strengths of the community in terms of community assets and active initiatives to address maternal and child health concerns. Throughout these descriptions, illustrative quotes from interviewees are provided. Following the hot spot specific descriptions is a description of several common themes across the community and a list of recommendations based on the interviews.

BACKGROUND

Maternal and child health improvement is supported through federal, state, county, and local initiatives. As context for this assessment, there are a few state initiatives worth mentioning that have supported building the infrastructure to address maternal and child health.

From a public health planning perspective, New York State's State Health Improvement Plan has explicitly called for collaboration to develop community wide public health priorities for collective action. The state has asked each county to develop community goals for public health improvement. While not required, Healthy Babies, Healthy Moms is one of the core areas that communities have chosen. This community wide planning by the health departments is thus one opportunity for communities to bring together hospitals, local health departments, and other health care and community partners to collaborate in planning to bring about measurable progress toward mutually-established goals in maternal and child health.[1]

Maternal and Child health has also had an infusion of resources through the Affordable Care Act to support additional infrastructure. The Maternal Child and Infant Home Visiting program (MIECHV)[2] was authorized under the Affordable Care Act and was designed to improve the well-being and health of at-risk children through evidenced-based home visiting services. The program is administered by the Health Resources and Services Administration (HRSA) in collaboration with the Administration for Children and Families (ACF), both agencies of the U. S. Department of Health and Human Services (HHS). In New York State, fourteen high-risk counties were identified to be part of this initiative. The development of these programs included an online survey to communities to identify referral mechanisms, referral sources, community risk factors and strengths and resources. The effectiveness of these home visiting programs is being evaluated by HRSA to examine how the program models operate in local and state contexts and ultimately learn the program features that have the greatest impact on families.

The HRSA funded State Maternal and Child Health program is the oldest state and federal partnership. The program now funded through Maternal and Child Health Title V block grant, provides resources to the states to address infant mortality, access to prenatal and postpartum

[1] New York State Healthy Mothers, Healthy Babies Strategy Matrix http://www.health.ny.gov/prevention/prevention_agenda/strategies/healthy_mothers.htm

[2] Maternal and Child Health Home Visiting Program http://mchb.hrsa.gov/programs/homevisiting/

New York State 2011 Title V Needs Assessment Priorities

- The number one goal is to improve early access to high quality prenatal care, with a focus on reduction of health disparities
- The third goal is to eliminate health disparities with particular attention to low birth weight and infant mortality
- The fourth goal is reduction of overweight and obesity among infants, children and adolescents
- The fifth goal is to reduce unintended pregnancies and improve adolescent sexual health and development
- The sixth goal is reduce and eliminate use of tobacco, alcohol, and substance use among pregnant women
- The tenth goal is to increase the percentage of infants who are breastfed for at least six months.

care, as well as coordinated services for children with special health care needs. As part of receipt of federal dollars, each state develops a five year needs assessment and through this articulates their priorities and goals for the state. Six of the ten New York State Title V goals address maternal and child health concern for pregnant women and infants. These state goals were used to frame the findings of the assessment that were presented to each of the hotspot areas (Appendix C).

FINDINGS

NIAGARA FALLS

A. DESCRIPTION OF SERVICE PROVIDERS

Community Health Worker Programs: There are three organizations that provide home visiting to families in the Niagara Falls area: Healthy Families Niagara, Niagara Falls Memorial Community Health Worker program, and the Healthy Generations, serving primarily the Native American population. The array of these three programs has slightly different focus in the population they serve and the orientation of their services.

Niagara Falls Memorial Community Health Worker program is focused on improving birth outcomes and maternal health. This program primarily works with providers affiliated with Niagara Falls Memorial Hospital. The program focuses on outreach to identify women who are not engaged in prenatal care and support them through delivery in accessing services. The program

does multi-faceted outreach in the community, which ranges from outreach at the district courthouse, working with the provider community, and participating in community events. They are one of 16 Comprehensive Prenatal-Perinatal Service Networks funded in New York State. They are a strength based program that works with women from the prenatal period up through age 1. The community health workers assess risk factors, provide education, connect women with resources, and will provide transportation to prenatal appointments. They serve a high risk population that includes women with substance use, homeless, and teens.

Healthy Families Niagara is a provider of home visiting services for at risk mothers and children up to age five with a strong focus on parent education. The program is a child abuse prevention model that focuses on three primary risks: mental health, substance abuse, and domestic violence. Several families have all three risks. Women can participate if they are identified at risk or if they are under 21, had late or no prenatal care, are single, and have limited income.

This program's goal is to enroll women in the prenatal period and to work with them until a child is eligible for Head Start at age 5. The home visits are scheduled at a standard frequency which is based on evidence. Thus there are more frequent visits early after the delivery and then the visits are spaced out as the child gets older. The staff provide in depth assessments of families and work to connect with them any resources they need including substance use counseling, food pantry, WIC, employment assistance, etc. They provide parenting education based on structured curriculum. These evidenced-based programs include "Parents as Teachers"[3] and "Florida State Partners for a Healthy Baby"[4]. This is supplemented based on tailored education based on parent preferences. In addition to home visits they provide parenting groups throughout the year. This includes support groups, and groups supporting career and job search. They also organize social events for families to celebrate the seasons and holidays.

Prenatal Care: Access to prenatal care for low-risk pregnancies is generally not perceived as a concern. Both Niagara Falls Memorial and St. Mary's offer prenatal care services through OBGYN practices that serve low-income families. Mount St. Mary's Neighborhood health center is located in the high risk area of Niagara Falls. In addition, Niagara Falls Memorial's family practice providers see the low-risk pregnancies.

Parenting Education: In addition to parenting education through Healthy Families, Summit Life is a faith based non-profit which provides education to women on their choices during pregnancy and parenting education. This program is affiliated with St. Mary's and offers women baby supplies as incentives for participating in their educational activities.

Native American Community Services of Erie & Niagara Counties, Inc. operates a series of programs that are open to the population at-large but are especially geared to Native American families living off the Native American Reserves who have children 0 - 5 years old. Services are offered to parents of all ages but some activities target teen parents. Programs work to teach parents about the importance of bonding and attachment, positive parenting, and ways to manage challenging behavior. Parents learn about infant/child development using hands-on activities incorporating Native American culture. The program also provides events for parents to connect with one another

[3] http://www.parentsasteachers.org/

[4] http://cpeip.fsu.edu/PHB/

socially. The program follows the State's Healthy Families model and is extremely well recognized in the community.

Other Community-Based Programs: To address the high rates of substance abuse in the community Niagara Falls Memorial has an initiative funded by the Tower Foundation which focuses on young women and substance abuse. This program, called "Project Runway," employs gender-specific strategies to both heighten awareness and prevent drug and alcohol abuse among young women ages 14-24 who reside in Niagara Falls. Project Runway has a case worker focused on working with women with substance use. Planned Parenthood and WIC are also important resources in the Niagara community.

B. CURRENT CONCERNS

Teen pregnancy. Teen pregnancy is at high rates and the sexual education programs at the schools have been based on conservative values limiting information on safe sex and contraception. Beyond need for additional sexual education, one interviewee noted that she has seen many young teen women desire to become pregnant. This desire may be from lack of other family supports, or a cultural norm of their peers and in their families as young mothers.

Lack of Alignment of Support and Messaging. In terms of supporting young and at risk mothers, some perceive there is lack of alignment across providers in mutually supporting women with healthy behaviors for mother and child. This includes supporting women in a substantive way to making decisions about waiting to deliver until the baby is full term, supporting smoking cessation, and breastfeeding. For example, while the community health worker may provide education on the value of breastfeeding to a new mother, a pediatrician may provide formula and offer different information to the mother. While both have the mother and child's best interest in mind, the lack of consistent messages is confusing to the mother. One person noted the success of Sisters of Charity Hospital in Buffalo in sharing report cards of breastfeeding rates with their providers, and suggested something similar would be beneficial to implement with the pediatric providers in Niagara.

> *"There is need for more awareness of the benefits of natural births to prevent high rates of C-sections and late preterm deliveries caused by inductions. Discussion of these options needs to be a consistent message across the providers and community health workers."*

Limited Collaboration. At the systems level there is limited collaboration across the two major hospitals in the area of maternal and child health. While based in the reality that there is a competitive health care market, several interviewees identified that enhanced collaboration across hospital systems in the area of maternal and child health would better serve the community.

Need for More Integrated, More Accessible Care for High-Risk Pregnancies. For women with high risk pregnancies, there are limited specialist services available in Niagara Falls thus women must travel to Buffalo for maternal fetal medicine and for patients with diabetes- nephrology. For low-income mothers, traveling to see these prenatal specialists is cost prohibitive. Further, in an effort to ensure adequate resources for high risk deliveries, women may be encouraged to deliver at Women and Children's in Buffalo because of the availability of more intensive neonatal services.

Lack of Access to Midwives. At the same time, there is a lack of access to midwives and doulas as an alternative to the medical model of prenatal care and delivery. At one time there were some midwives available in Niagara Falls, but the community has not had any in a number of years.

> *"I believe we are lacking midwives as alternative to OGBYN providers, women that we serve find it difficult to attend appointments out of Niagara Falls due to lack of transportation so are limited to only a few providers."*

Domestic Violence. In the Niagara Falls area, domestic violence is an issue of significant concern. Unlike in Buffalo, there have not been concerted efforts to improve provider education related to trauma, and this is a perceived need.

Lack of Evidenced-based Prenatal Care. Niagara Falls is lacking in several evidenced programs to support prenatal care. Currently there is no Early Head Start program in Niagara Falls and in prenatal care there is no Centering pregnancy through the prenatal providers. The Centering pregnancy model, which is an evidenced-based method to provide prenatal care through peer supports has not yet been made available in Niagara Falls. This program can offer more in depth preventive education than time allows in traditional prenatal care on topics such as smoking cessation, nutrition, and parenting education. Parenting education is a continuing need and the Niagara Falls Memorial Community Health Worker program has been working with Every Person Influences Children (EPIC) to bring additional educational resources to the Niagara Falls area.

Social Determinants of Health. Addressing employment and supporting families to economic self-sufficiency are out of the scope of the current maternal and child health programs. Healthy Families actively works to track and measure employment statistics, and make referrals to employment programs in the area. That being said they are unable to fully address this need, and it is an area where based on the data they have there is a need for emphasis and attention.

C. STRENGTHS

Home-Visiting Programs. Home visiting programs are viewed as the critical resource to addressing the needs of at risk families. The array of programs available is considered important to meet prenatal, parent education, and cultural specific needs. Community Health workers are well received in the community and are available to address the medical access and parent education needs. Intensive case management and peer support services for pregnant mothers, new mothers, and newborns is available and geared to ethnic/cultural minority groups as well as the majority white population.

> *"Community health workers make a great impact. They are trusted more than outsiders. There is a fear of being used i.e. Tuskegee study."*

Active Community Collaboration. While there is always room for improvement, there are active community meetings that bring maternal and child health providers together in the Niagara Falls area. These meetings present a forum for providers/programs to share information and explore

collaboration. As mentioned above, efforts need to be focused on reducing competition and bringing St. Mary's Health System and Niagara Falls Memorial together. Nonetheless, a forum for this collaboration does exist. In addition this forum may present an opportunity for collaboration more regionally, between providers or programs in Buffalo and Erie County. This type of collaboration existed in the past, but has not been active and there is a desire for more regional collaboration among maternal and child health providers.

Mom's Net. Within Niagara County, a particular area for collaborative action is the further development of "The Mom's Net" which is a resource guide for pregnant and new mothers to address and connect them to resources. Mom's Net grew out of the need for post-partum depression services but is now a system for comprehensive referral for maternal and child health resources. The program was initiated out of the Mental Health Association in Niagara County Inc. Mom's Net lost its funding from the Mental Health Association and thus it was dormant without funding until St. Mary's decided to re-invest in it. St. Mary's has been looking to grow the resource guide to provide a system for making referrals and sharing information electronically across providers. Their long term plan is to make a referral system available across the county through partnership with the other major hospitals in the County, Niagara Falls Memorial. They plan to have a social worker connected with the medical providers, and conduct case conferencing across providers. The hope is that they provide seamless service coordination that is invisible to the client but provides a lot of value to the providers.

Substance Abuse. Niagara Falls Memorial is actively working to improve substance abuse services for women of child bearing age. This initiative will provide more resources in the form of case management for women with a substance use disorder. While this program is not focused on addressing maternal and child health outcomes specifically, it can be used to address the needs of this high need group and may be a model to further enhance current home visiting services for high risk women.

Involvement of Fathers. Involvement of fathers in parenting has been a program in place at Healthy Families for more than five years. This is an evidenced-based program to engage fathers with a standard curriculum. The Father Advocate position can currently serve only 20 of the approximately 90 families Health Families works with at any given time. They would like to expand this program.

BUFFALO

A. DESCRIPTION OF SERVICE PROVIDERS

Community Health Worker Programs: There are a number of community health worker and outreach programs available in the Buffalo area. The Buffalo Prenatal/Perinatal community health worker program targets specific zip codes on the east and west sides of Buffalo that correspond with the zip codes (14201, 14204, 14207, 14208, 14209, 14210, 14211, 14212, 14213, 14214, 14215). These zip codes have been targeted because they are known to have especially poor maternal and child health outcomes for infant mortality and low birth weight. The program does door-to-door outreach to families to ask if there are pregnant women or children without access to health care or insurance. They also do street outreach at the malls and transportation centers. Finally, they provide case management and home visiting to all women who enter the program. The

community health workers will accompany women on their first prenatal appointment and will provide assistance with transportation if needed.

Jericho Road is a social service agency and medical provider that focuses on the refugee population. They have developed a program called the Priscilla Project that works with pregnant women and new moms. The program provides intensive care management, translation, and doula services. The program provides an important cultural bridge between the women who are participating and the medical providers that are serving them and is particularly well respected by the hospital providers.

In addition to these programs, the Federally Qualified Health Centers conduct outreach and offer supportive services through community health workers.

Prenatal Care: Access to prenatal care is generally perceived as good in terms of number of providers available. Catholic Health Systems, Kaleida Health, and the federally qualified health centers in Buffalo all provide access to prenatal care. The challenge for these providers is not total capacity, but to offer continuity of services for women who have many barriers to accessing care.

Parenting Education Programs: The parenting education resources in the Buffalo area are rich in their variety and tailoring to specific populations. The hospitals are the primary providers of childbirth education. After birth, the community health worker programs and Early Head start provide early parenting education. EPIC (Every Parent Influences Children) is a non-profit which offers parenting education in the hospitals and staffs a teen mom support group in the Buffalo high schools, known as the "Lunch Bunch."

In addition there are several sources for education on breastfeeding. The breastfeeding initiative supported by the United Way, the P2 Collaborative and the Erie Department of Health has promoted breastfeeding supports from the continuum of providers and organizations that have relationships with prenatal care and new moms.

Head Start and Early Head Start play a major role throughout Buffalo with more than 25 community site locations. They provide services to children age 0-5 and expectant mothers.

Other Community Based Programs: The Comprehensive Adolescent Pregnancy Prevention Program is run by the Buffalo Federation of Neighborhood Centers and works with youth age 10-21. This program actively engages youth to provide education to reduce pregnancy and transmission of sexually transmitted diseases. They have an evidenced-based curriculum on HIV/AIDs, puberty, and understanding your body. The evidenced-based programs they offer include the CDC programs "Be Proud and Be Responsible" and "Freedom to Choose." These programs supplement the information available at the Buffalo public schools. In addition to hosting their workshops at schools they provide their education and outreach courses through faith-based organizations and community organizations. As an organization connected with the youth community they often will make referrals to other resources for pregnant youth. They have established relationships with Kaleida Health and can ensure young women have access to appointments if needed. They partner with a number of organizations in the community including The American Red Cross, Buffalo Prenatal-Perinatal, and Erie Department of Health.

The Family Justice Center provides comprehensive services for victims of domestic violence and their children. They are located with 13 partner agencies and work to comprehensively address

their needs. Their partners provide legal assistance with divorce, medical assistance, child advocacy, and mental health. They conduct extensive outreach in the community through speaking engagements whenever possible, and distributing materials through healthcare, schools, faith based and local business partners such as Wegman's. Through their domestic violence work they are actively working to improve mental health counseling access through partnership with the American Red Cross and the University at Buffalo.

The Family Help Center provides parenting education programs that are targeted to prevent child abuse and support healthy child and parent relationships. Many women are referred into the Parenting Wisely program through department of social services. They also offer a daycare service that is primarily for court mandated families. The center offers a 24/7 helpline to support parents and to connect them with resources. This group has been engaged with the Breastfeeding Support Initiative in the County and offers certified lactation consultants to women.

WIC has been an instrumental player in parenting education on breastfeeding as well as nutrition. They are one of the partners that have been working diligently to integrate into the hospital systems and connect with women and families through their providers. They have also been part of the campaign to work with physicians to create “breastfeeding” friendly practices.

Family planning resources have been under some changes in the last year, and Planned Parenthood has planned expansions.

B. CURRENT CONCERNS

Consumer Engagement. Availability of prenatal care and social supportive services is not generally perceived as a problem in the Buffalo area. The challenge is supporting the most vulnerable women to connect with these services. Transportation continues to be an issue and location is a concern for services because Buffalo is very neighborhood centric. Several people identified that services may be available, but families are not likely to travel outside of their neighborhoods to access them. One example of this is the Family Help Center, which offers parenting education. It is located on the East side of Buffalo, and families living on the West side are not willing, comfortable, or able to travel to access these services.

Women with a history of substance use are a particular population that is difficult to engage in prenatal services because they fear that child protective services will take their children away. Providers recognized that the system of services has perpetuated this fear, and the ultimate impact is that these women don’t come in for medical services due to lack of trust. Other engagement in care concerns include fear and need of support among youth, and barriers such as child care, health literacy, and difficulty arriving to appointments on time.

Some interviewees identified that providers could do more to elevate their customer service orientation to better support patient engagement. In this regard they cited examples of long waits in the waiting room, canceling women who are late to appointments, and no accommodation for women who must bring their children with them to appointments. Access to services is stymied for women with children and in need of childcare. There has been some discussion at Catholic Health Systems about how to provide childcare to women while they are at prenatal appointments as a solution. However this has been difficult to put in place.

Health Literacy/Cultural Competence and Challenges with Refugee Population. The refugee population in Buffalo is particularly vulnerable and in need of enhanced maternal and child health support. Refugee women have different care seeking behaviors, need additional support in navigating the health care system, and often face language and cultural barriers.

Education on Sexual Health. Several interviewees noted that education on sexual health and pregnancy prevention has historically been stymied by resistance in the schools to offering comprehensive and consistent curriculums.

Care Coordination and Navigation of Health System. As a resource rich area, Buffalo struggles not with lack of services, but with women and families' ability to navigate services and to communicate effectively across service providers. Several people mentioned the need for better systems to engage and educate families on the range of services available. Even among the agencies that have good relationships with each other, they find there could be improvements in how referrals are managed. One new resource to address this concern is the development of a 211 phone information line, which provides information on maternal and child health services. But as one person noted, the 211 line does not currently have the capacity to triage calls and identify programs that are the best fit for an individual family situation.

> *"In the past there have been cases of a certain territorialism across the case managers and care managers and there needs to be better communication. "*

C. STRENGTHS

Access to Prenatal Care. The number of prenatal service providers in the region, is adequate based on the availability and access to services. The access to prenatal appointments and providers was not identified as a concern in the Buffalo area. There are many safety-net providers that offer prenatal care. The one concern for some is the continuity of service in seeing a single provider can be a concern for some locations. For this population in particular developing the relationship with a prenatal provider is viewed as important. There is also some expansion of services available through Nurse Midwives to the low-income population. Catholic Health Systems and some of the federally qualified health center locations are currently offering comprehensive prenatal services with midwives. This is a type of services that has not been historically available to low-income families in the County.

Consumer Engagement and Outreach. Despite the challenges mentioned above, several organizations have been working to improve access to trauma informed care for youth and women, which have led to better consumer engagement. This has been a priority of the Adolescent Pregnancy Prevention Program and the Family Justice Center. In addition Catholic Health Systems has been internally evaluating how to better engage families in prenatal care, in ways such as offering child care for women during prenatal appointments.

Across service providers it is widely recognized that connecting with the faith-based community is important part of outreach, information sharing on programs, and general education. The providers in the community identified this as important as part of their work to address teen pregnancy, breastfeeding education, and domestic violence and they are actively making these connections in the community.

There are a variety of community health worker programs that are doing active outreach in the community. These programs are specific to the neighborhood and race and ethnicity of the community. The work of these programs is regarded across the MCH community as essential and effective in reaching families. Further, the community health workers are well received by the community and are seen as partners.

> "*The community health worker model has broken down the barriers, gotten the rides to appointments, kept the consistency with the providers. They (Community Health Workers) are trained to speak to medical providers, and they help women speak up for themselves. It is invaluable having an advocate for prenatal care."*

Need to focus on the Whole Family. Grandmothers play a significant role in education of moms and child rearing. Traditional parenting education models on the importance of breastfeeding, safe infant sleeping have failed to consider the whole family in the education process. When grandmothers and fathers are not included, moms do not have the support they need to practice behaviors that are encouraged by medical and community service providers.

Breastfeeding. Active community wide efforts to improve breastfeeding rates have been a focal point for collaboration across Buffalo. Through a CDC grant to address obesity the Erie Department of Health, the P2 Collaborative, United Way and others have joined together in a community wide effort to enhance breastfeeding rates across the community. This effort has included outreach to hospitals, pediatricians, and community OBGYNs. They have also engaged the range of MCH providers in Buffalo, to increase the number of certified lactation consultants available, as well as peer certified lactation consultants. The program has been successful in diversifying the lactation consultants available to include women who are African American and Latino. Formal evaluation data is not available, however these efforts were mentioned by almost all of those interviewed, and there is clear enthusiasm and energy around collaboration on this topic.

> *"The proliferation of Baby Cafes and focus on breastfeeding has been an important step in increasing the continuity of services for families."*

As mentioned in the areas of concern, teen pregnancy education has been limited in the past; however recent activity indicates that the Buffalo Public Schools have been actively working to improve the health education curriculum to be more comprehensive and consistent with respect to reproductive health.

Community meetings and discussions on maternal and child health have brought together many individuals. The Health Start Forum held in May 2013 had as many as seventy-five participants and generated a great deal of ideas on how to improve maternal and child health. (http://prezi.com/yhzlti7ic0nt/healthy-start-follow-up-628/). Community collaboration and meetings are clear in the Buffalo area, however based on the October meeting in Buffalo sharing the findings of this report, there is continued need and desire for local and regional forums for collaboration across providers.

SOUTHERN TIER: CHAUTAUQUA AND CATTARAUGUS COUNTIES

A. DESCRIPTION OF SERVICE PROVIDERS

Home visiting Programs: In the Southern Tier the county health departments play a significant role in providing home visiting services. The second major player is the Healthy Families of Allegany and Cattaraugus Counties which covers the Cattaraugus hot spot. There is not a Healthy Families program in Chautauqua County. The health department in Chautauqua County recently received the state funding to provide the Medicaid Obstetrical and Maternal Services (MOMS) program which includes home visiting. Previously this program operated out of Chautauqua Opportunities, the county Community Action Agency. The health department is excited to take on this role and sees many opportunities to providing connections to women to the other services such as WIC, Early Intervention, and immunizations that the County health department offers. The MOMs program includes assistance with health insurance, prenatal care, psychosocial services, nutrition, HIV counseling, and health education. The referrals to the County MOMs program come from prenatal providers, pediatricians, the hospitals, and social services.

In Cattaraugus County, the health department home visiting program accepts referrals from a number of sources, but most referrals come from the MOMs program providers. They would like to have more referrals from the hospital maternity nurses, but they currently do not have that relationship with the hospitals. They actively identify families at risk through review of birth certificates of all children and try to contact high risk families defined as mothers with drug use and those with multiple births. They reach out to the families to provide general information on lead screening and safety. If they identify through the phone calls that a family is struggling, the public health nurse contacts the family's physician and may initiate home visiting. They find that many of the high risk families they contact are already engaged with social services. The current capacity of the program is at most 35-40 families as the County only has one maternal and child health nurse.

The Resource Center is a multi-service provider in Chautauqua County that is a major provider of primary care, behavioral health services, and is managing two of the school based health centers in the County. As multi-service provider they are working very hard to be holistic in their services to families. They provide parenting education services to families, and are critical treatment provider for those families with substance abuse and mental health needs.

Prenatal Care: Between Cattaraugus and Chautauqua Counties there are differences in prenatal access. Cattaraugus providers did not find that basic prenatal services were difficult to find, whereas in Chautauqua County prenatal, OBGYN, and pediatric services for the Medicaid population continue to be a challenge. The expansion of OBGYN services at WCA Hospital in 2012 was recognized as an important addition to prenatal care services in the community, however at the same time several private OBGYNS have retired so access remains an issue regardless of a woman's insurance type.

Parenting Education: In Cattaraugus County, Healthy Families, Head Start, and Cattaraugus Community Action are the three programs that offer parent education. Healthy Families home visiting program is an evidenced-based program that enrolls pregnant women and works with families on parenting education up to age five. They visit the families in the home and work to improve child and parent interactions, as well as connect families with resources. The Cattaraugus Head Start program provides early intervention services, and some limited home visiting parent education. They have been very focused on the topic of parent engagement and are looking for evidenced based and innovative ways to connect with families.

In Chautauqua County, Chautauqua Opportunities and The Resource Center both provide parenting education. Chautauqua Opportunities offers the Early Head Start program as well as other parent education resources, and the family development training program to educate frontline workers on working with families. The programs at the Resource Center are focused on families who have a child with special health care needs, in particular autism and developmental concerns, but are open to all families.

Other Community Based Programs: Family planning in Chautauqua County is primarily offered through the County health department. There are two school based health centers in the County and they are able to provide a limited amount of information and resources on sexual health.

There is an active WIC program in both Chautauqua and Cattaraugus counties that operates out of each respective county health department. These programs collaborate with the hospitals, Healthy Families, and the health department home visiting programs. In Cattaraugus County, it was noted that while good collaboration exists, there is room for more cross referral across programs.

In addition to WIC, another resource for families is Cornell Cooperative Extension which provides education on family budgeting and preparing healthy meals and nutrition.

B. CURRENT CONCERNS

Behavioral Health Issues. A major concern in the Southern Tier is the need for more skills among childcare providers and parents to address behavioral needs of youth. The need for more skills among parents and other childcare providers to address behavioral health needs of youth was identified both by Head Start staff and the P2 Health Equity Coalition working in Gowanda. The P2 Health Equity Coalition identified youth development as the number one concern. Through the P2 Equity Coalition conversations, many parents requested a curriculum for training educators to work with behavioral concerns for children age 2-4. In response to this concern, they are working to bring a counselor trained in the age 2-4 population to the community. They are also working with Cattaraugus Community Action to bring more behavioral health resources to older children in the community in the elementary and middle schools. From the Head Start program's perspective, the needs of children age 2-4 have increased, and they are seeing more children who have more intensive behavioral health needs than they have the capacity to address. They suggested that the increase of technology into family's lives has had some impact in limiting parent's communication with their children and children are arriving with more severe communication challenges than ever before.

> *"What we are seeing the protective cases are increasing, and the foster care cases are increasing and these are symptoms that we are not providing the adequate resources to the families."*
>
> *"The parent education piece is still needed. We need more education before it is court mandated. We are now seeing 2nd and 3rd generation families related to counseling and parenting. Parenting education is an issue."*

Need to focus on the Whole Family. Traditional parenting education models have not been effective, and several interviewees suggested that this is in part due to the failure to consider the whole family in the education process. One specific area mentioned was co-sleeping. Hospitals are consistently providing information on the dangers of SIDS and co-sleeping with infants, however the message is not getting through to families. Sadly, co-sleeping has been a cause for several infant mortalities in the Southern Tier.

Consumer Engagement and Outreach. The health departments in both counties have found it can be difficult to engage parents for home visiting. They may make several attempts but it is not until the second child that the family may be willing to work with home visiting. The referrals to home visiting from providers are often to address parent engagement in services. Parents will not respond to phone calls, miss appointments, and then their phones are turned off so the physician asks home visiting to go check on the family.

> *"Families are connected but they are resistant to services, and takes some time to build their trust and may take multiple pregnancies."*

Transportation is challenging for families who need to travel to appointments or drop children off at programs. Cattaraugus Head Start has several office locations throughout Cattaraugus County but they site transportation as a continuing barrier to family accessing their programs.

> *"Parents must travel all the way from Wyoming County to attend Head Start in Olean, which is major burden for families."*

Home visiting resources are not always available when families are ready to engage with services. In Cattaraugus County, if a family declines services the first time Healthy families may not be able to engage with them with their second child. The health department home visiting focuses on medical needs only and does not have the resources to address the social service needs. The 90 day postpartum window for enrollment in Healthy Families is another barrier to enrolling families who may be identified as in need of the parenting education and social service needs. Healthy Families notes they receive a lot of referrals after the 90 day window post-delivery. The reason for not taking families after 90 days is that the evidence shows higher success rate when families are engaged early. The program requirements make it essential for early identification and referrals to Healthy Families. At the same time, a family may be doing well but in the third or fourth month of the baby's life the family situation changes. In these cases, there are not resources for the family.

Need for Improved Coordination. There is a need for coordination of service providers for a single family. Without such coordination families may be receiving duplicative and unnecessary services, and tying up resources that would be best applied to another family. The coordination needs to happen with child protective services, the County public health nurses, and the medical providers. The need for this coordination is not only duplication of services, but that each service provider may be getting different information from the family.

Improved Transportation. It is important to bring the resources to the families because with the transportation barrier, unless the services are brought to them they often cannot access the service.

Specialty services for prenatal care require travel to Buffalo, and transportation can be a barrier for even more local services in the County.

Substance Abuse and Smoking. Drug and alcohol use are a persistent concern and are viewed as a problem for pregnant women and use among parents that will impact the child environment and home. Social services and the County health departments noted that it is the underlying concern that contributes to unplanned pregnancy and parent's ability to care for their children. Treatment for substance abuse is challenging because many times families have to travel to Buffalo.

> *"One of the biggest problems is drugs in the community. This seems to be an untouchable problem. The police are making busts, and you see a lot of developmental problems with the kids. The dads are coming from Buffalo and deal, and they leave the Mom with a baby and then they are gone. That is the start of the poverty cycle."*
>
> *"For drug and alcohol treatment, families have to go to Buffalo. Women are often referred to Dr. Updike in Buffalo and getting women there is a long-shot."*

High rates of smoking during pregnancy is another major concern. Both Cattaraugus and Chautauqua Counties have had "Baby and Me Tobacco Free" programs in place to encourage quit rates through incentives of free diapers. However, this program alone has not been sufficient, and both counties are looking for evidenced based programs, and ways to bring attention to the impact of smoking on infant health.

Poverty and Lack of Employment. Supporting at risk families to be financially stable and self-sufficient was a concern of several service providers, as they often see financial insecurity as a root cause to many other risk factors in the family such as substance use and child abuse. Healthy Families in Cattaraugus County tracks a great amount of data for the County based on their programs. The area they identify as most challenging is supporting families to be financially independent. There is low enrollment among parents in educational programs, and continued dependence on social security benefits. Their experience is that many parents don't have a desire to enroll in educational programs which would be a path for them to financial security.

C. STRENGTHS

Breast Feeding, Immunization, Lead Assessments, Access to Medical Care for Low Income Families. Healthy Families in Cattaraugus County tracks a large amount of data for the County based on their programs. The areas that they see going well include breast feeding rates, immunization rates, lead assessments, and access to medical providers. They also have found that access to health insurance for moms and availability of prenatal providers has not been difficult in Cattaraugus.

Community-wide Meetings. As rural communities with relatively small providers and service networks, Chautauqua and Cattaraugus have the potential to be very effective and collaborative. In light of this, a number of community coalitions or recurrent meetings have been established that have been effective. The Healthy Infancy Council has initiated community wide meetings and planning efforts to address maternal and child health. These meetings have brought together a range of service providers to discuss their priorities for collective action.

The P2 Health Equity Coalition in Gowanda is addressing behavioral health needs for youth. The Coalition has been effective at identifying it as a priority and is working collectively to address this growing concern among youth.

Teen Pregnancy. Teen pregnancy, a concern in all of the hot spot areas, has a strong ally and potential partner in the school based health center located in the Cherry Creek hot spot area that spans Cattaraugus and Chautauqua. While there is resistance in this community as in many others to comprehensive sexual education, the school based health center is a ready partner for education, and connects pregnant teens with resources and parenting education.

OVERARCHING NEEDS IDENTIFIED ACROSS COMMUNITIES

- There is a need for strengthened collaboration between medical (hospitals, prenatal providers, and pediatricians) and community-based providers (home visiting, WIC, and others) to better support identification of women in need, developing coordinated and shared plans for families, and coordinating services.

  "We have had relationships with the maternity ward nurses in the past, but once our key point of contact left, I currently don't know anyone in the maternity ward." (one home visiting program)

  "There are some families that think they need every service. It would avoid duplication of services and would be really nice to have team meetings across different service providers. Patients are telling everyone a different story, and it is a social services issue."

  "This population lacks continuity of care. Residents, nurse practitioners, and attending physicians treat them on an episodic basis. As such, they are focused on specific health issues and not the whole person. Social workers may well be the link, but are overwhelmed. In addition, there is limited conversation between social worker and physicians.

  "*We have difficulty getting needed test results or documentation of referrals or health issues from pediatric providers to comply with state and federal reporting."*

  "I'm not very familiar with the community health worker programs." (one OBGYN interviewed)

- Effective education of families must consider the influence of other role models, most significantly grandmothers, but also peers. Inclusion of fathers in parenting education programs has been successful but there have not been adequate resources to strengthen and expand these types of services.

  "A lot of the problem is that a lot of the pregnant moms are teens. You can tell the girls that they should not be getting pregnant. A lot of times people are falling into the footsteps into of their families and peers."

"*It would be great to have a peer based program for parent coaching. I think young mothers and fathers would probably be more apt if they had access to more informal and mentoring type education and coaching. I think this is what is needed to engage parents."*

"We are currently only able to provide father support services for 20% of our families and we would like to expand this program. We have found that even the breastfeeding rates are higher when the father is involved."

- Currently there is limited discussion by community providers on how their current efforts are linked to state and regional maternal and child health planning and initiatives.
- Transportation is a major issue that limits access, thus programs that do outreach and provide home visiting are critical.
- Poverty, health literacy, family stress, lack of employment, and other social determinants of health limit access, hinder outreach efforts, and constrain families' ability to engage in services.

RECOMMENDATIONS

1) Investigate methods to build stronger communication linkages between outpatient, inpatient, and maternal and child health community-based providers. At this point there is lack of a "systems' approach to linkage, communication and referrals, and the sharing of information is inconsistent. The coordination of services across public health, community-based providers, and medical is an important topic across all areas of health. This approach could facilitate outreach and identification of families in need of services, build maternal and child health capacity, and also bleed into supporting stronger collaboration across public health and direct medical service more generally. One example of this is the Vermont Children's Integrated Services program which creates a care team for families that develops an action plan for the family, provides resources and services and makes referrals, supports access to child care and/or development programs, and supports transitions to community services. This service is accessed through a 211 number and provides a single location to connect families with resources.

2) Improve specialty care access in rural communities to reduce the burden of transportation on families. Improve specialty care access in rural communities to reduce the burden of transportation on families. Explore ways to coordinate consults from experts in Buffalo for families in rural areas, through residency/training programs, and mid-level providers/counselors. Telehealth is an area of specific interest to support communities in accessing specialists remotely. Specialties identified as challenging to access are maternal and fetal medicine, substance abuse treatment, and for those pregnant women with

diabetes- nephrology. Transportation barriers in the rural communities are often the first barrier to service that comes to mind to both service providers and families. The rural nature of the populations cannot sustain bringing the providers physically to these small populations, but improving technology is promising to bring providers to the patients.

3) Develop a center for best practices in peer and family education. Current approaches to education of women are often narrow in their conception of the family unit and influencers. Often education programs have not taken into account the powerful role of grandmothers and peers, and by limiting education to the Mom have had limited influence with the family. Programs such as Centering Pregnancy and the Nurse Family Partnership are effective but not yet broadly available in the hot spot communities. In addition, identification of positive peer role models is one component that several interviewees felt is missing from the current approach to supporting at risk families and women.

4) Social determinants of health have an elemental impact on the health of children long term. Addressing poverty and racism as the underlying barriers to many of the disparities in access and health should be a components of any program or initiative.

5) Support local efforts and planning in linking and aligning with state and regional maternal and child health planning and priorities. For example, build on findings from the Maternal Infant and Early Childhood Home Visiting Program Needs Assessment[5] and the state Maternal and Child Health Services Title V Block Grant Needs Assessment.[6]

6) Explore supporting an existing or developing MCH Coalition in each of the hot spot areas. There is continued need for a common forum to assess and develop strategic plan with clear goals and metrics. Something of this nature would promote collaboration and would allow more targeting on priority issues and continued focused coordination on the other needs identified. For example the forum could further explore what the win win scenarios are between hospitals and community-based providers as well as develop and track metrics of success. There are seeds of MCH providers coming together in each of the hot spot areas such as the Buffalo Prenatal Perinatal Network in Buffalo, the Infancy Health Council in the Southern Tier, and Moms Net in Niagara, but each could use support to be more effective.

7) The cultural norms among teens as well as limited education were mentioned by interviewees as contributing to teen pregnancy. A root cause analysis could be used to delve deeper into this issue and build community wide plans to address teen pregnancy.

[5] Maternal Infant and Early Childhood Home Visiting Program Needs Assessment http://www.health.ny.gov/community/infants_children/maternal_infant_early_child_home_visit/docs/needs_assessment.pdf)

[6] Maternal and Child Health Services Title V Block Grant Needs Assessment http://www.health.ny.gov/community/infants_children/maternal_and_child_health_services/

The Center for Disease Control provides specific resources to support communities in doing this type of analysis.[7]

REFERENCES AND RESOURCES

- Baby and Me Tobacco Free Program http://babyandmetobaccofree.org/
- Evidence Based Home Visiting Programs: http://homvee.acf.hhs.gov/
- Florida State University http://cpeip.fsu.edu/PHB/
- Parents as Teachers: http://www.parentsasteachers.org/
- Nevada Mentoring program to reduce teen pregnancy with Big Brother Big Sister

  http://dreamrproject.org/meaningful-mentoring-big-brothers-big-sisters-program-helps-local-teens/
- New York State Infant and Early Childhood Home Visiting Program Needs Assessment (http://www.health.ny.gov/community/infants_children/maternal_infant_early_child_home_visit/docs/needs_assessment.pdf)
- New York State Title V Needs Assessment
- Office of Adolescent Health and Center for Disease Control: Teen Pregnancy Prevention Program. Reproductive Health Equity for Youth

  (http://rhey.jsi.com/).

  Conducting a Root Cause Analysis and Action Planning Process: Facilitators Guide

  http://rhey.jsi.com/social-determinants/social-determinants-resources/
- New York State Statewide Needs Assessment: /community/infants_children/maternal_infant_early_child_home_visit/docs/miechv_updated_state_plan_2.pdf
- New York State Healthy Mothers, Healthy Babies Strategy Matrix http://www.health.ny.gov/prevention/prevention_agenda/strategies/healthy_mothers.htm
- Vermont CIS program

  http://dcf.vermont.gov/cdd/cis

[7] Center for Disease Control: Reproductive Health Equity for Youth http://rhey.jsi.com/social-determinants/social-determinants-resources/.