Northern Manhattan Perinatal Partnership's
Central Harlem Healthy Start & Comprehensive Perinatal Prenatal Service Network

Presents

MERRY-K MOOS, RN, FNP, MPH, FAAN

Beyond Health Care Reform:

THE ROLE OF INTERCONCEPTIONAL CARE IN REINVENTING MATERNAL & CHILD HEALTH

December 17th 2009 • 9:30 am to 12:30 pm

CONSORTIUM THEMES

1. Place the new CDC and MCH industry focus on preconception and Interconceptional care (PC/IC) in the context of reinventing MCH and life course theory by focusing on women's health whether the women decides to have a child or not!

2. Help professionals in the MCH industry make the transition from a historical focus on prenatal care switch to a focus on a women's health approach to practice in between pregnancy by defining what preconception and Interconceptional care is and why it is necessary today to reduce racial disparities in birth outcomes.

3. Finally, Merry-K, will provide a link or crosswalk to how PC/IC relates to the current debate on health care reform. She will define how aspects of Senator Max Baucus's health care bill will improve women's health and perinatal home visiting programs across the nation!

ADDITIONAL SPEAKERS:

Vrushali Deshumkh, MSW, MPH
Casework Supervisor
Central Harlem Healthy Start Program (CHHS)

Lenora Yates, Member
CHHS Consumer Involvement Organization

Both will provide an update on NMPP's MCHB Interconceptional Care Learning Collaborative

Sabrina Brown, LCSW
Deputy Executive Director, NMPP, Inc.

Provide an Update on NMPP's TASA Cobra Case Management Program for Teenagers

Rashida Moore, President
CHHS Consumer Involvement Organization

This program is FREE and breakfast will be served

Held at:

Northern Manhattan Perinatal Partnership

127 West 127th Street

For more information contact
Segrid Renne at 212-665-2600, ext 324

Creative services provided by NMPP's Social Health Marketing Group 212 665-2600 x 308/Black Cat Design 718 753-0244.

Beyond Health Care Reform:

The Role of Interconceptional Care in Reinventing Maternal & Child Health

December 17th 2009 • 9:30 am to 12:30 pm

Merry-K Moos
RN, FNP, MPH, FAAN

Merry-K. Moos, RN, FNP, MPH, FAAN retired in 2008 as a Professor in the Department of Obstetrics and Gynecology, and Adjunct Professor in both the School of Public Health and the School of Nursing at the University of North Carolina at Chapel Hill.

She was also the creator and director of the Women's Health Information Center at UNC Hospitals Chapel Hill. She and her colleague, Robert Cefalo, wrote the first book on preconceptional health in the US in 1988; the book was revised in 1995. She has been a national pioneer in encouraging the adoption of preconceptional health promotion activities as a basic component of health care and has written and lectured extensively on the topic.

She developed a model program for preconceptional health promotion, first implemented in North Carolina's local health departments and subsequently introduced into many sites throughout the United States and Canada. She also developed programs on preconceptional health that are specifically designed for the workplace and for use with school age children.

Ms. Moos is a member of the CDC Select Panel on Preconception Health and Health Care, a member of its Clinical Workgroup and has created the national curriculum on preconceptional and interconceptional health for clinicians on its behalf. Ms. Moos' current research and programmatic interests center around intendedness of pregnancy, implementation of interconceptional care services and reframing women's care into a continuum model of integrated preventive services.

Northern Manhattan Perinatal Partnership's
Central Harlem Healthy Start (CHHS)
and
Comprehensive Perinatal Prenatal Service
Network (CPPSN)
Presents:

Merry-K Moos, RN, FNP, MPH, FAAN

The Role of Interconceptional Care In Reinventing Maternal & Child Health

December 17 2009

8:30-9:30	**Breakfast/Networking/Slideshow** Segrid Renne, MPA, Moderator
9:30-9:35	**Welcome** Mario Drummonds, MS, LCSW, MBA
9:35-10:00	**Update on ICC Learning Collaborative:** Vrushali Deshmukh, MSW, MPH & Lenora Yeates, CHHS Consumer
10:00-10:10	**TASA Cobra Case Mgt. Teen Program:** Sabrina Brown, LCSW
10:10-10:20	**Interconceptional Care: A Consumer Perspective:** Rashida Moore, CHHS Consumer
10:20-10:30	**Text4Baby New York City** K. Althea Maybank, MD, MPH, NYCDOH/MH
10:30-10:40	**Break**
10:40-10:45	**What Healthy Start Has Done for Me** Eula Young, Former CHHS Consumer
10:45-12:15	**Presentation, Q&A** Merry-K Moos, RN, FNP, MPH, FAAN
12:15-12:30	**Closing Remarks** Mario Drummonds, MS, LCSW,MBA

Northern Manhattan Perinatal Partnership

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Bios

Mario Drummonds, MS, LCSW, MBA
Executive Director/CEO
Northern Manhattan Perinatal Partnership, Inc. (NMPP)
Central Harlem Healthy Start, Principle Investigator
Brief Biographical Sketch

Mr. Mario Drummonds is the Executive Director/CEO of the ***Northern Manhattan Perinatal Partnership, Inc.,*** a Harlem-based maternal and child health agency working to improve the health status of pregnant and parenting women in Northern Manhattan. NMPP is the grantee agency for the ***Central Harlem Healthy Start Program***.

His twenty-nine years of professional experience ranges in the areas of program administration and planning. He brings to the table experiences with child welfare theory, practice and policy development, maternal & child health, social marketing, information technology and public policy development. Over the last twelve years, Mr. Drummonds diversified NMPP's funding base and grew the agency from three small MCH programs and a $800,000 annual budget to an agency with a $8 million dollar budget, five sites, nearly 145 staff members and twenty-three funded programs.

Mr. Drummonds has traveled the nation assisting other Healthy Start projects and state governments to develop sustainability strategies and plans, worked with them to prepare their competitive Healthy Start applications and lectures on the theory and practice of **building a public health social movement** locally to decrease racial disparities in birth outcomes by building ***MCH Life Course Organizations***. He is a member of the faculty at **HRSA's Quality Institute** and a faculty member of the **National Healthy Start Association Leadership Institute**. HRSA has designated the Central Harlem Healthy Start program as a **center of excellence in MCH service delivery** while achieving outstanding birth outcomes.

Mr. Drummonds completed his graduate education at Columbia University within the Schools of Social Work and Business Administration in 1980. Mr. Drummonds graduated from the Johnson & Johnson/UCLA Health Care Executive Program in the summer of 2004 at the John E. Anderson Graduate School of Management at UCLA. He has the ability to blend the best practices within the business, public health and social service fields to transform the lives of his clients and advance the social-economic development of his community. Mr. Drummonds is the winner of the **2008 Johnson & Johnson Community Healthcare Improvement Project (CHIP) Award** for his 2004 marketing plan that successfully expanded market share at Harlem Hospital's new birthing center.

Mr. Drummonds received an award from the U.S. Department of Health & Human Services in 1996 for his work in reducing infant mortality in Central Harlem. Today in Central Harlem the infant mortality rate is 7.4 deaths per one thousand live births in 2005. In 1990, this community's infant mortality rate was 27.7 deaths. NMPP now has embarked on a campaign to reduce the low birth weight rate in Central Harlem and address the mental health needs of pregnant and parenting mothers by developing NMPP's **Harlem Maternal Mental Health Training Institute.**

Ms. Sabrina Brown, LCSW
Deputy Executive Director
Northern Manhattan Perinatal Partnership, Inc

Ms. Brown is a Licensed Clinical Social Worker with experience in domestic violence, child protective services, alcohol and substance abuse and mental health. She also has over eight years experience in quality management and program development. Ms. Brown attended SUNY College at Buffalo and earned her Bachelors in 1990. She then attended SUNY Stony Brook and earned her Master of Social Work degree in 1992.

Ms. Brown is a CARF (Commission on the Accreditation of Rehabilitation Facilities) Surveyor and has participated in the accreditation of over 30 agencies throughout the United States. She maintains a private consulting practice focusing on accreditation, program evaluation, clinical/medical chart auditing and clinical supervision.

In 2003 Ms. Brown co-presented at the Association of Community Living's annual conference, in Bolton Landing, New York. The title of her presentation: Nuts and Bolts of Medicaid Reimbursement.

Ms. Brown is a mentor to female members at her church in Amityville New York and a dedicated volunteer at the YMCA in Bayshore, New York.

Segrid J. Renne, M.P.A.
Director
Northern Manhattan Perinatal Partnership, Inc. (NMPP)
Central Harlem Healthy Start
Brief Biographical Sketch

Ms. Renne has over twenty years experience in public health practice and policy development, maternal & child health, social marketing, and information technology to ensure organizational quality, efficiency, productivity and compliance. She also has extensive experience with regulatory compliance, organizational operations, strategic planning and administration, program development and implementation, team development, P&L management, quality management and revenue cycle management. As a multifaceted leader she has accumulated a strong record of accomplishment adept at decision making, staff development and change management with strong communication, training, organizational, analytical, technical, motivational and interpersonal skills.

Segrid Renne is currently a Program Director for Northern Manhattan Perinatal Partnership/Central Harlem Healthy Start, a maternal and child health program based maternal and child health agency working to improve the health status of pregnant and parenting women in Northern Manhattan; and the Fatherhood Initiative program which promotes the positive social involvement and economic support of non-custodial fathers in the lives of their children.

Ms. Renne completed her graduate degree at Baruch College School of Public Affairs. She obtained a MPA in Policy Analysis and Evaluation. Ms. Renne graduated from the Johnson & Johnson/UCLA Health Care Executive Program at the John E. Anderson Graduate School of Management at UCLA. She is also a graduate of the National Healthy Start Leadership Institute.

Before joining NMPP/CHHS, Segrid worked as part of a team of public health leaders that spear headed the Ambulatory Care Reconstruction Initiative program in the public hospitals in NYC. She has also held several positions as Director for major federally qualified health centers NYC.

She has international experience as a Consultant/Advisor of a two-year project funded by the Inter-American Development Bank to design and implement a national Community Care program as part of the health sector reform in the Republic of Trinidad and Tobago.

Vrushali Deshmukh, MSW, MPH

Social Services Manager

Northern Manhattan Perinatal Partnership, Inc.

Central Harlem Healthy Start

Ms Vrushali Deshmukh earned her Master's in Social Work from the Tata Institute of Social Sciences, Mumbai, India and a Master's in Public Health form Columbia University, New York. As a graduate student at Columbia University, she played a key role in researching the link between Asthma and Obesity among African-American and Latino population in Northern Manhattan.

Currently she holds a dual position as the Social Services Manager with the Central Harlem Healthy Start program and the Program Coordinator for the Mankind Fatherhood program at Northern Manhattan Perinatal Partnership. Prior to this, she was the Clinical Coordinator at Baby Steps, a Healthy Family New York home visiting program, where she was in charge of coordinating and facilitating the wrap around training workshops throughout New York City.

Ms Deshmukh has seven years of supervisory experience and has led and supervised teams with varying professional and educational levels. As the Director of the counseling and training unit in Mumbai she has trained staff nationally on issues of HIV, AIDS and STIs. Ms Deshmukh's interests lie in the field of maternal and child health and HIV/AIDS among communities of color.

Lenora Yeates

Lenora Yeates is currently a member of Central Harlem Healthy Start Consumer Involvement Organization and an active consumer. Currently she is the Director of the Salvation Army After-School Program in Harlem. She is also a licensed Evangelist and a Motivational Speaker and represents the Salvation Army at conferences around the nation. She is very involved in the wellbeing and development of the youth in the Harlem community and lends her time as a Cub Scout Leader and Youth Pastor to assist young people.

Ms Yeates has a certificate in Family Advocacy and is also a Certified Nurses' Aide. She attended Hunter College, City University of New York for two years majoring in Nursing and plans to complete her BSN in the very near future. Ms. Yeates is a wife and mother of two young boys. Her older son is an honor student.

Rashida "Ché" Moore

Rashida "Ché" Moore, a dedicated mother of two, joined the Central Harlem Healthy Start program in July, 2004. She has been a vital source of information gathering and advising other young women on many social and domestic issues. Rashida is the third of eight children born to West Indian parents in Astoria, Queens (New York).

While employed full time at Condé Nast Publications, she earned her Associates Degree in Business Administration from Katherine Gibbs School of Business. Rashida is a constant source of support to her large family, especially to her young nieces and nephews. However, her most important contribution has been to the Harlem community where she and her family reside.

Presentation

The Role of Intercocneptional Care in Reinventing Maternal and Child Health

Beyond Health Care Reform

Well Woman Care: An Upstream Approach to Achieving Better Reproductive Outcomes

Northern Manhattan Perinatal Partnerships' Program

December 17, 2009

Merry-K. Moos, RN, FNP, MPH, FAAN
mkmoos@med.unc.edu

Objectives

- Explain the rationale for changing the perinatal prevention paradigm to include an emphasis on preconceptional/interconceptional health and link the rationale to CDC and MCH initiatives.
- Connect major threats to women's health with major threats to pregnancy outcomes
- Identify three tiers for promoting high levels of preconceptional/interconceptional wellness
- Begin to develop community and clinic-based strategies to view every encounter with a woman of childbearing age as an opportunity for health promotion and disease prevention throughout the life cycle.
- Consider the likely impact of health care reform on the new paradigm and improved health status for women and their children

Disclosure Statement

- I have had no financial relationships with commercial interests related to this topic in the last twelve months

Summary

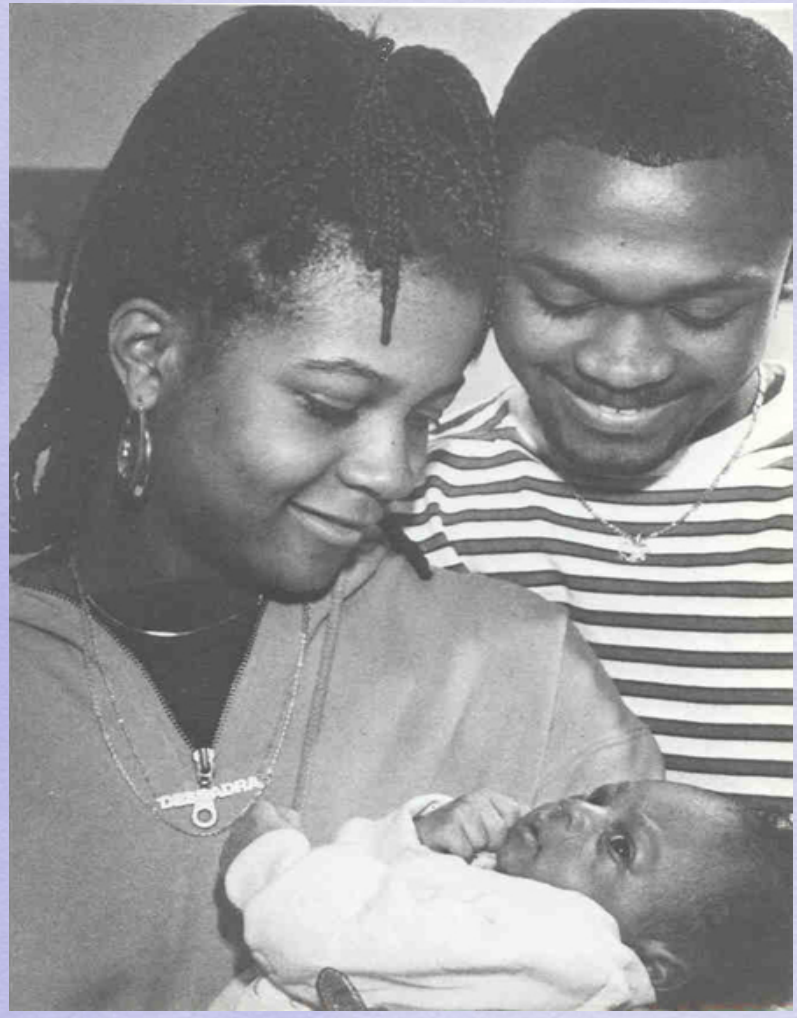
- There is good rationale for the preconceptional/interconceptional health promotion agenda
- To make a difference we need to move away from a prenatal prevention paradigm to embrace women's health, whether before, between or beyond pregnancy.
- Promoting high levels of health in all women is likely to result in preconceptional/interconceptional health promotion for those who become pregnant
- Women who have already experienced a poor pregnancy outcome have declared many risks for their own health and for the health of future pregnancies/infants
- It is possible to work smarter without working harder

Your “homework” in advance: Moving from Rescue to Prevention--

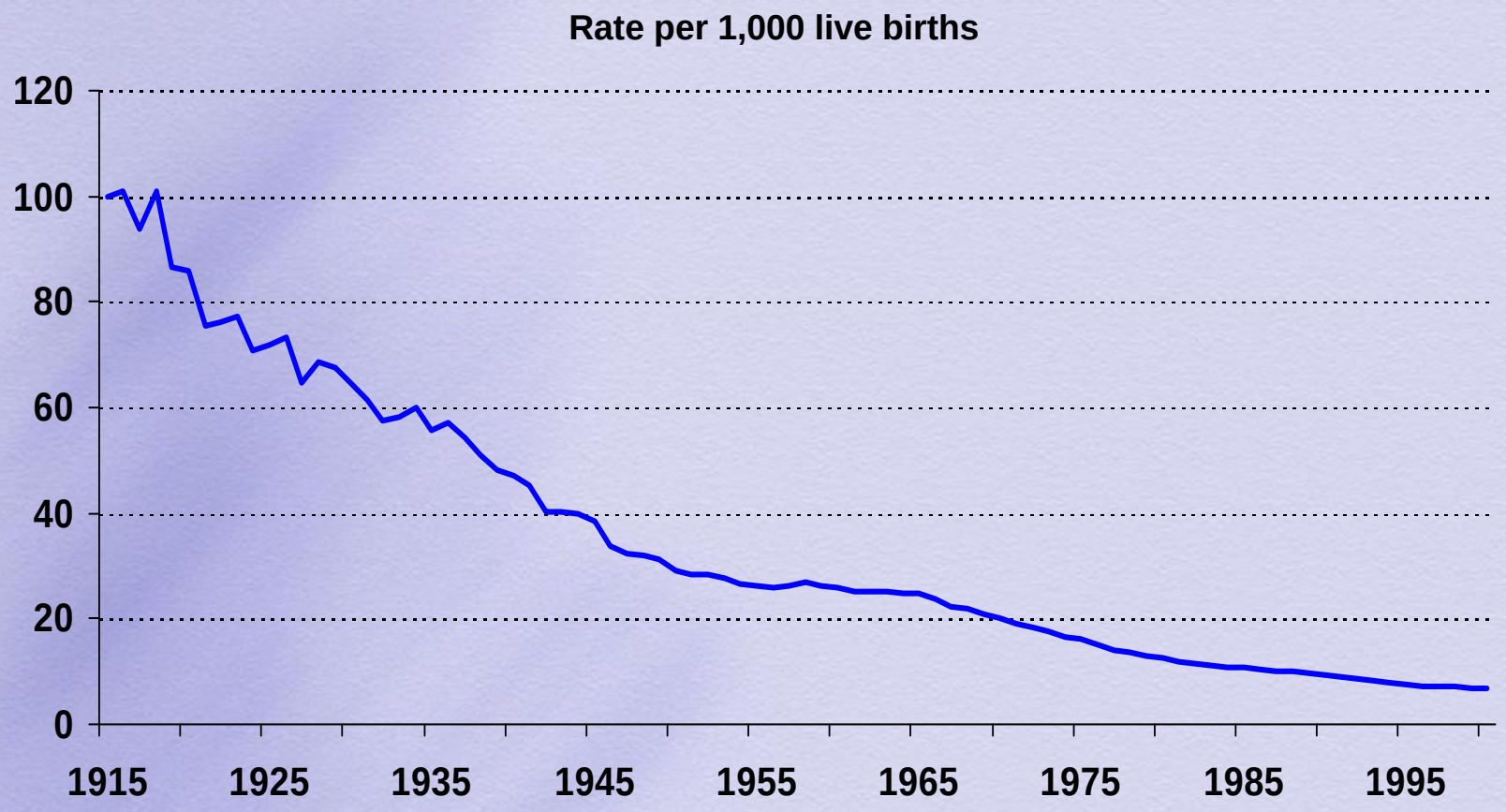
What strategies can you use to reframe the prevention paradigm to move “upstream” for:

- The population-at-large?
- The women you care for?
- Other providers?
- Policy makers?
- Insurers?

What three actions can you take to “work smarter—not harder” to make a difference for your patients, your practice and your agency?


DESPADRA

Infant Mortality
United States, 1915-2004



March of Dimes
Saving babies, together

Source: National Center for Health Statistics, final mortality data
Prepared by March of Dimes Perinatal Data Center, 2002

INTERNATIONAL COMPARISONS OF INFANT MORTALITY RATES, 2005

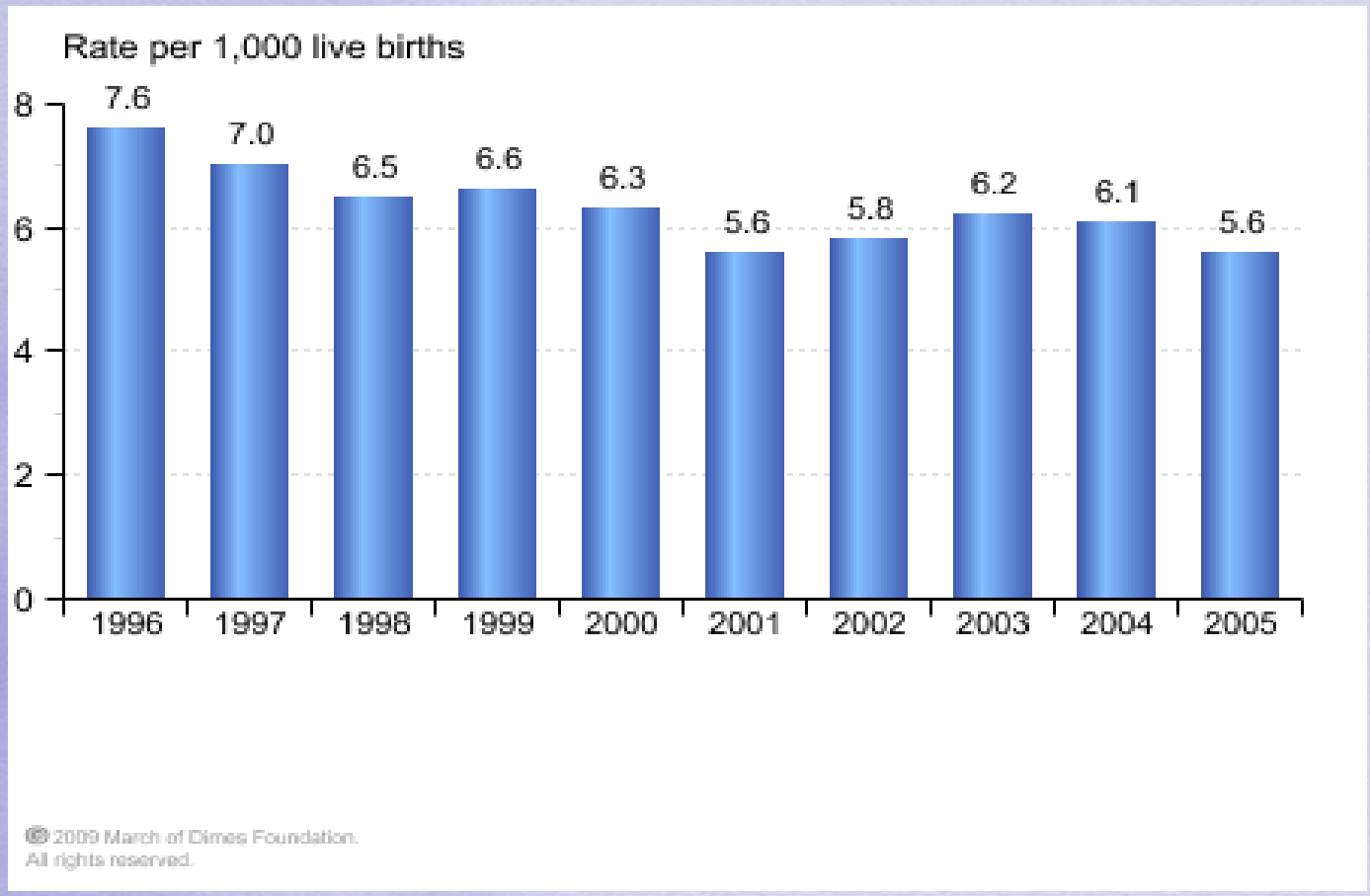
Rank	Country	Rate
1	Singapore	2.1
2	Hong Kong	2.5
7	Czech Republic	3.4
14	Spain	4.1
25	Canada	5.4
	United States, “White”	**5.7**
26	Cuba	6.2
28	Northern Ireland	6.3
30	**United States**	**6.9**

http://www.marchofdimes.com/peristats

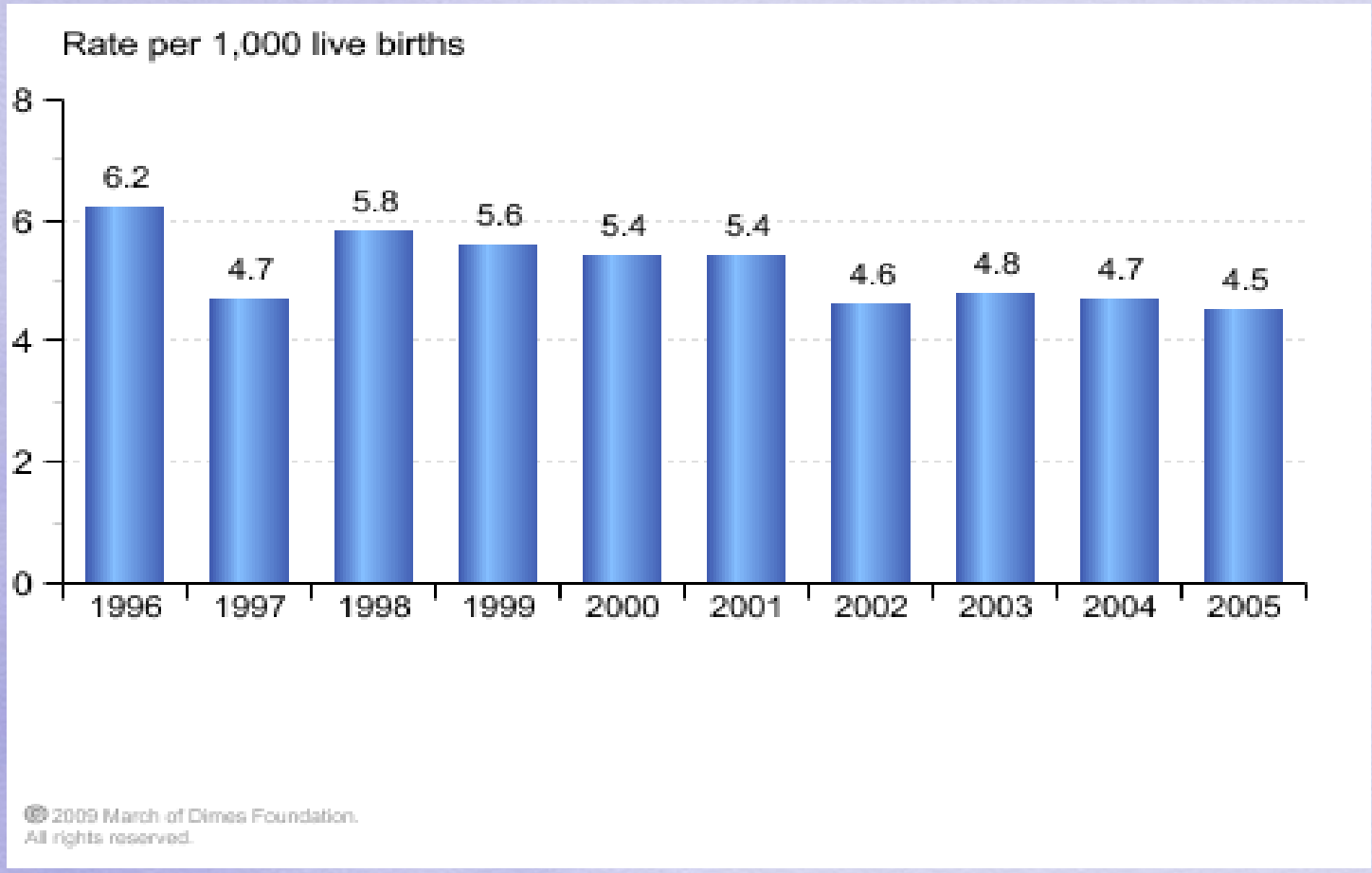
Incidence of Adverse Pregnancy Outcomes, 2005

Spontaneous abortion	20%
Infant Mortality	6.8/1000 live births (2004)
Fetal Mortality	6.2/1000 live births plus fetal deaths (2003)
Major birth defects	3.3%
Low Birth Weight	8.2%
Preterm Delivery	12.7%
Complications of pregnancy	30.7%
Unintended pregnancies	49% (2001)
Unintended births	31% (2001)

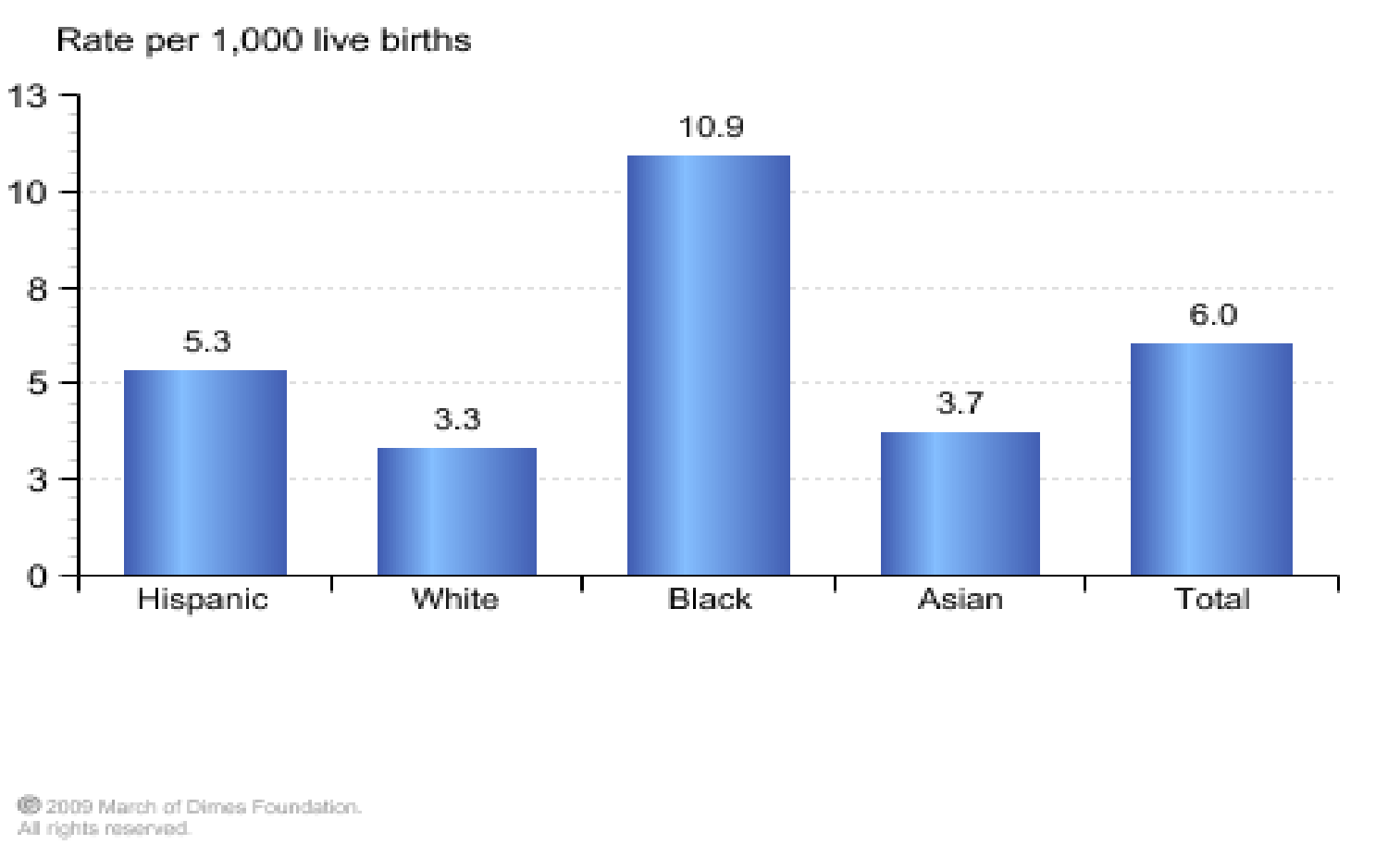
Infant mortality rates: New York City, 1996-2005 (source:Peristats)



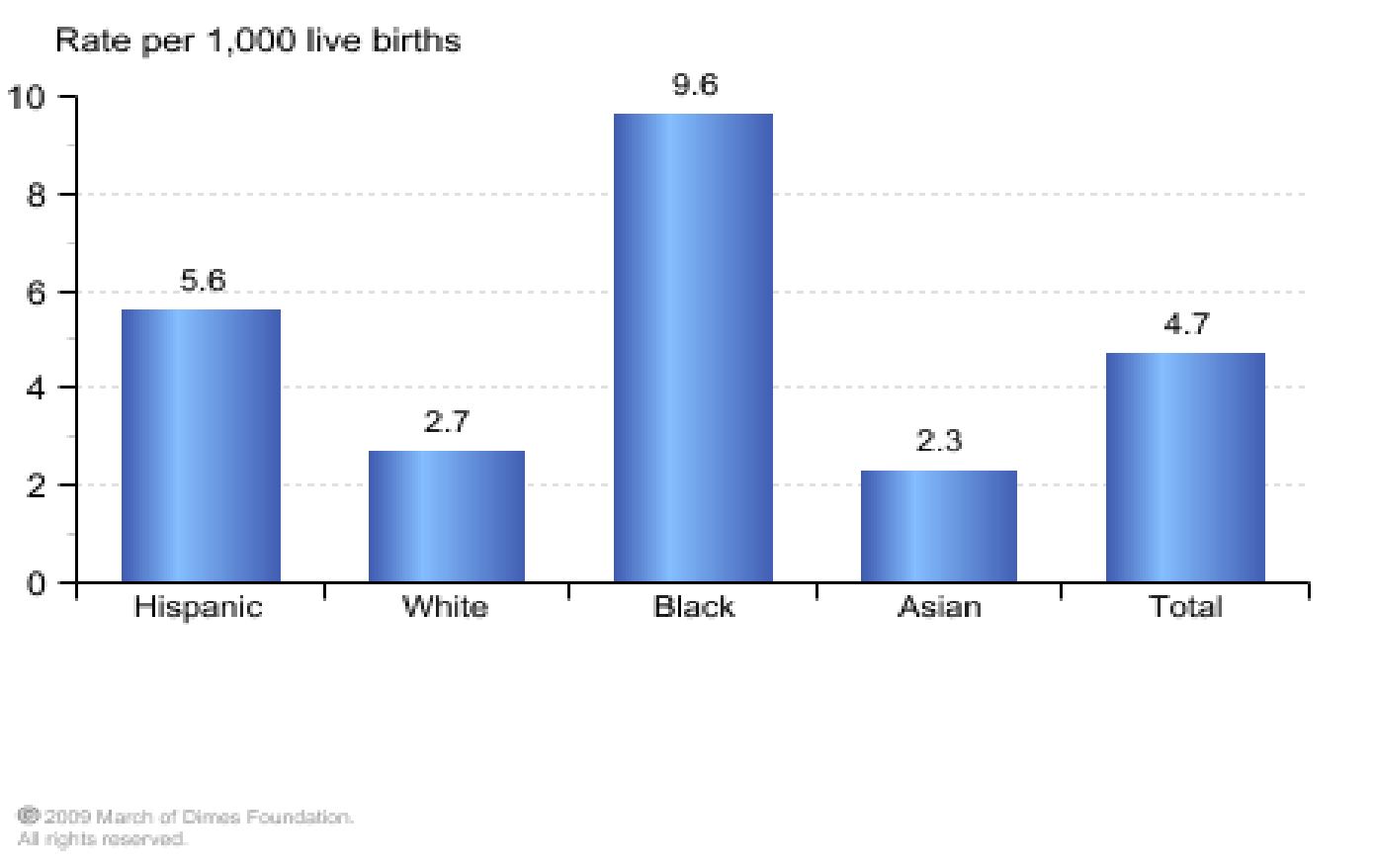
Infant mortality rates: Manhattan, 1996-2005 (source:Peristats)



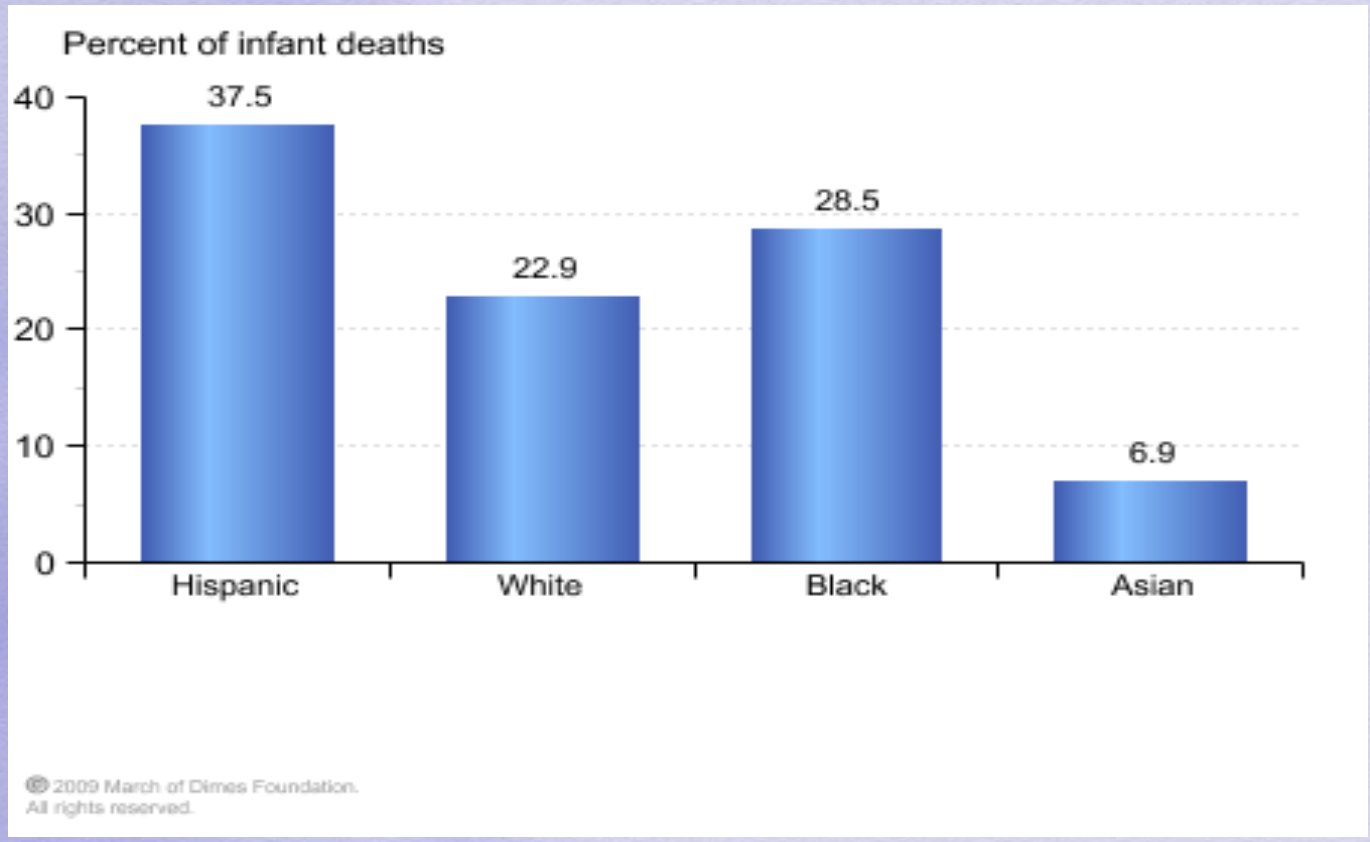
Infant mortality rates by race/ethnicity: New York City, 2003-2005 Average (source:Peristats)



Infant mortality rates by race/ethnicity: Manhattan, 2003-2005 Average



Percentage of infant deaths by race/ethnicity: Manhattan, 2003-2005 Average (source:Peristats)



Selected Reproductive Outcomes Manhatten, 2005-06 with Comparisons ( ) to Healthy People 2010 Goals

• Spontaneous Abortion	20.0%	
• **Infant Mortality Rate**	**4.7**	**(4.5)**
• **Fetal Mortality Rate**	**?**	**(4.1)**
• **Low Birth Weight Rate**	**8.6***	**(5.0)**
• **Preterm Birth Rate**	**13.5***	**(7.6)**
• Congenital Anomalies	3-6%	

* 2006 data

Source: Peristats (MOD)

In obstetrics. . .

most of our outcomes or their determinants are already present before we ever meet our patients

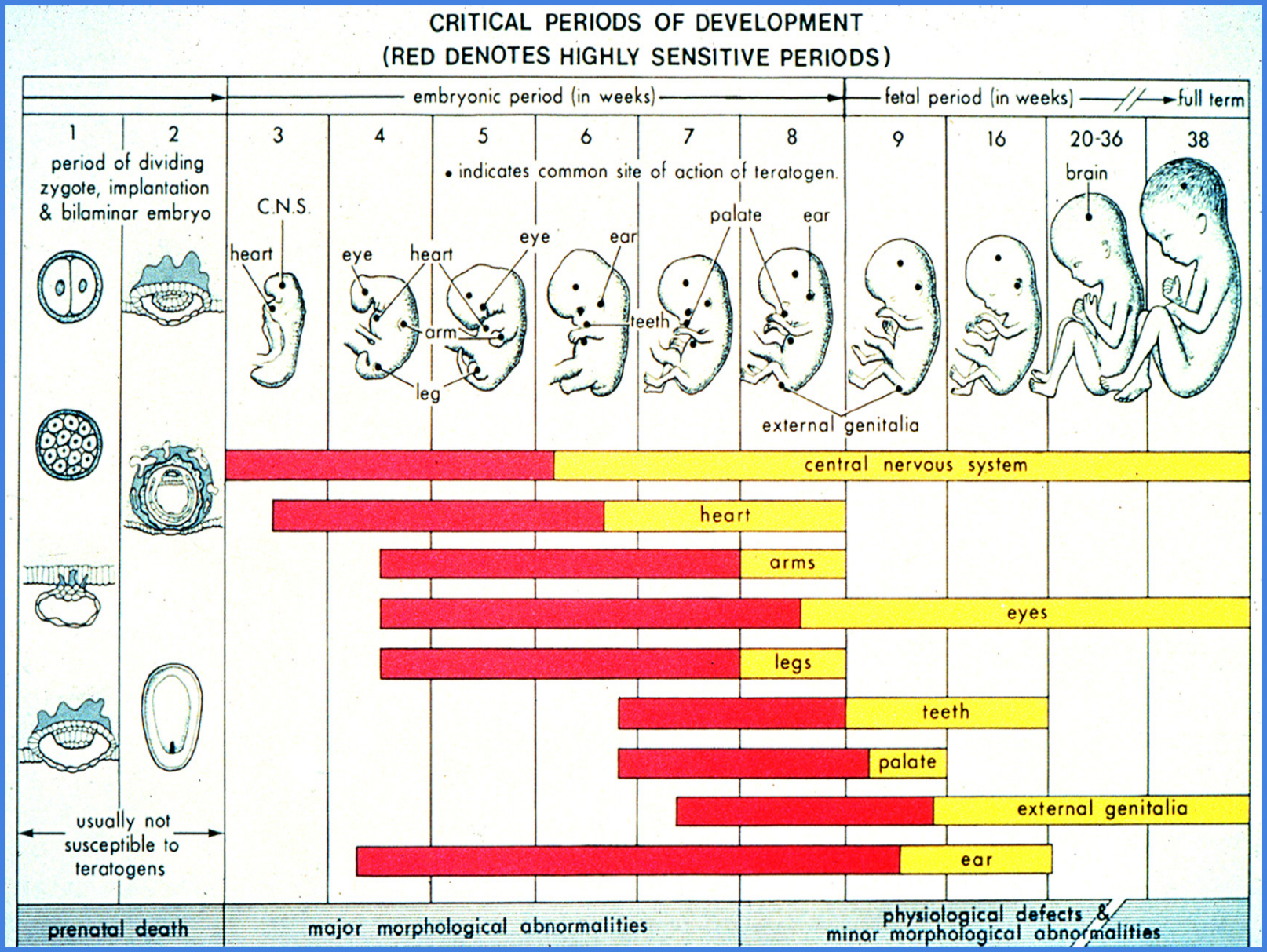
Important Examples

- Intendedness of conception
- Interpregnancy interval
- Maternal age
- Exposure ART/ovulation stimulation
- Spontaneous abortion
- Abnormal placentation
- Chronic disease control
- Congenital anomalies
- Timing of entry into prenatal care

Determinants in outcomes

- Genetic blueprint
- Prenatal care
- **Embryonic/fetal environment—**

(= woman's own health status and exposures)


CRITICAL PERIODS OF DEVELOPMENT
(RED DENOTES HIGHLY SENSITIVE PERIODS)
embryonic period (in weeks)
fetal period (in weeks)
full term
1
2
3
4
5
6
7
8
9
16
20-36
38
period of dividing zygote, implantation & bilaminar embryo
• indicates common site of action of teratogen.
C.N.S.
heart
eye
heart
eye
ear
palate
ear
brain
arm
teeth
leg
external genitalia
central nervous system
heart
arms
eyes
legs
teeth
palate
external genitalia
ear
usually not susceptible to teratogens
prenatal death
major morphological abnormalities
physiological defects & minor morphological abnormalities

Examining What Isn't Working

"As attractive and relatively inexpensive as prenatal care is, a medical model directed at a 6-8 month interval in a woman's life cannot erase the influence of years of social, economic, [physical] and emotional distress and hardship."

Dillard, RG NCMJ 65:3 p147 (2004)

Over time, it has come to be realized that

Preconceptional Health Promotion

provides a pathway to

the PRIMARY PREVENTION of many poor pregnancy outcomes beyond that available through traditional prenatal care

National Summit on Preconception Care

June 21 - 22, 2005

The Atlanta Marriott Century Center
Atlanta, Georgia

CDC

Saving babies, toget

CDC

MMWR™

Morbidity and Mortality Weekly Report

Recommendations and Reports

April 21, 2006 / Vol. 55 / No. RR-6

Recommendations to Improve Preconception Health and Health Care — United States

A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care

INSIDE: Continuing Education Examination

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Select Panel Goals for Improving Preconception Health

- *Goal 1*: Improve the knowledge, attitudes and behaviors of men and women related to preconception health
- *Goal 2*: Assure that all US women of childbearing age receive preconception care services—screening, health promotion and interventions-that will enable them to enter pregnancy in optimal health
- ***Goal 3*: *To reduce risks indicated by a prior adverse pregnancy outcome through interventions in the interconception period***
- *Goal 4*: Reduce disparities in adverse pregnancy outcomes

Common Definitions and Uncommon Usage

Preconception

- Health status and risks before first pregnancy; Health status shortly before **any** pregnancy

Periconception

- Immediately before conception through organogenesis

Interconception

- Period between pregnancies (always defined retrospectively—i.e. after next pregnancy conceived)

How Does Preconceptional Health Promotion Fit into the Work You Do?

If you take care of women of reproductive potential . . .“It’s not a question of whether you provide preconception care, rather it’s a question of what kind of preconception care you are providing.”

Joseph Stanford

FOR A MINUTE THINK ABOUT HOW YOU PERSONALLY INTERACT WITH WOMEN OF CHILDBEARING AGE?

For this talk, preconception and interconception will be used interchangeably . . .

. . .because the foundation for both is helping women achieve high levels of wellness **before** conception.

What IS This Thing Called "PRECONCEPTION"?

- **Giving Protection ***
- **Managing Conditions**
- **Avoiding Exposures**

Giving Protection

- **Examples of giving protection**
  - Protection against unintended pregnancy
  - Folic acid supplementation to protect against neural tube defects and other congenital anomalies
  - Maintenance/achievement of optimal BMI (weight status)
  - Protection against infectious diseases
    - Rubella
    - Varicella
    - Hepatitis B
    - HIV/AIDs

Protection Against Unintended Pregnancy: Why Important

- Women with unintended conceptions have higher likelihood of:
  - Abortion
  - Late prenatal care
  - Risky behaviors in and around pregnancy
  - Preterm birth
  - Parenting problems

What Is “Unintended“ ?

- Includes:
  - Unwanted
  - Mistimed (occurred sooner than desired)

Unintended is **not** a synonym for unwanted!

What We Know About Unintended Pregnancies

- As many as 50% of pregnancies are unintended; account for 31% of births
- 48% of unintended pregnancies occur in a month in which the woman used contraception
- Unintended pregnancy, based on 2002 NSFG data, is likely to go up as more women are putting themselves at risk.

WHY???

Unintended Pregnancy

- How do we impact social norms about childbearing decisions?
- What are steps to impact individual decision making?
- “If it happens, it happens” does not constitute a plan

A possible social marketing message:

If you **CHOOSE** to have sex without using a method of birth control, you **HAVE MADE A DECISION** to have a baby.

Other strategies???

Potential Benefits of Including Reproductive Life Plan Assessments into Routine Care

- Starts a conversation that is patient centered and patient driven
- Empowers women (and men, if included in their care)
- Reframes pregnancy from chance to choice
- Encourages individualized counseling

  (e.g. contraceptive options, interconceptional lengths, fertility considerations, etc)
- May result in higher percentage of pregnancies identified as intended

Encouraging a Reproductive Life Plan: Example of Questions that Could be in RLP

1. Do you hope to have any (more) children?
2. How many children do you hope to have?
3. How long do you plan to wait until you (next) become pregnant?
4. How much space do you plan to have between your pregnancies?
5. What do you plan to do until you are ready to become pregnant?
6. What can I do today to help you achieve your plan?

Precautions

- Reproductive life plans are never right or wrong: they are an approach for helping individuals plan, based on their own values and resources, how to achieve a set of personal goals about having children.

- Reproductive life plans are fluid—they should never be considered set in stone because “life happens”.

- Impacting on the rate of unintendedness is more complex than the content of a single health related encounter
- Addressing and facilitating **INTENTIONAL** decision making around if and when to have children is an appropriate health promotion and disease prevention activity that should be built into all clinical and community health encounters
- Knowing a woman's intentions can focus much of the rest of the encounter

Another Example of Giving Protection: Folic Acid

Folic acid provides ~ 70% protection against neural tube defects

USPHS 1992 Recommendation

"All women of childbearing age in the United States who are capable of becoming pregnant should consume 0.4mg of folic acid per day for the purpose of reducing their risk of having a pregnancy affected with spina bifida or other NTDs"

Comparison Knowledge/Use of Folic Acid to Prevent Birth Defects—Women of Childbearing Age

Year	Knowledge about ↓ NTDs	Knowledge take before pregnant	Non-Pregnant women who take
1995	4%	2%	25%
2000	14%	10%	32%
2004	24%	12%	37%
2007	18%	12%	40%

MODs, 1995, 2000,2004, 2007

What Are Reasons for Such Poor Uptake of this Proven Prevention Opportunity?

Linking Women's Health and Pregnancy Outcomes

NUTRITIONAL STATUS: Specific nutrients

- **Inadequate folic acid intake and Women's Health:**
  - Heart disease
  - ? Colon cancer
  - ? Breast cancer
  - ? Some forms of dementia
- **Inadequate maternal folic acid intake and reproductive outcomes**:
  - Increased incidence of neural tube defects
  - Increased incidence of other birth defects
  - Some anemias—mother and infant
  - ? prematurity

Nutritional Status: Obesity

- **Obesity and Women's Health:**
  - Diabetes
  - Hypertension
  - Cardiovascular disease
  - Disabilities
- **Obesity and Pregnancy:**
  - Glucose intolerance of pregnancy
  - Pregnancy induced hypertension
  - Thrombophlebitis
  - Neural tube defects
  - Prematurity

SUBSTANCE USE: Alcohol

- **Alcohol Use: Women's Health**
  - Risk for MV and other accidents
  - Risk for unintended pregnancy
  - Risk for addiction
  - Risk for nutritional depletions and inadequacies
- **Alcohol Use: Reproductive Health**
  - Increased risk of delayed fertility
  - Increased SABs
  - FAS (only occurs with use days 17-56 of gestation)
  - FAE

SUBSTANCE USE: Tobacco

- **Tobacco Use and Women's Health:**
  - Implicated in leading causes of death for women:
    - Heart disease
    - Stroke
    - Lung cancer
    - Lung disease
- **Tobacco Use and Reproductive Health:**
  - Leading preventable cause of infant mortality
  - Preventable cause of low birth weight and prematurity
  - Associated with placental abnormalities

PERIODONTAL DISEASE

- **Periodontal disease Women's Health:**
  - Heart disease
  - Stroke
  - Serious threat to women with diabetes, respiratory diseases, osteoporosis
- **Periodontal disease and Reproductive Health:**
  - Possibly preventable cause of prematurity

What We Know: Women Are Not Getting Comprehensive Services

Points of Assessment During Routine GYN Care

•Prescription drug use	30%
•Medical history	15%
•OTC drug use	10%
•Domestic violence	10%
•Nutritional assessment	9%
•Dietary supplements	3%

Bernstein, et al. J Repr Med 45, 546-552, 2000

Missed Opportunities Abound

2001 report (NCHS)

- Women ages 15-44 average 3.8 medical visits annually

Missed Opportunities Abound

- In 2005 KFF report:
  - Just over 50% of women surveyed had talked to a health care professional in the last 3 years about diet, exercise or nutrition
  - Fewer than 50% had talked about calcium intake (43%), smoking (33%) and alcohol (20%)
  - Only 31% of women ages 18-44 had talked with a provider about their sexual history in the preceding three years.

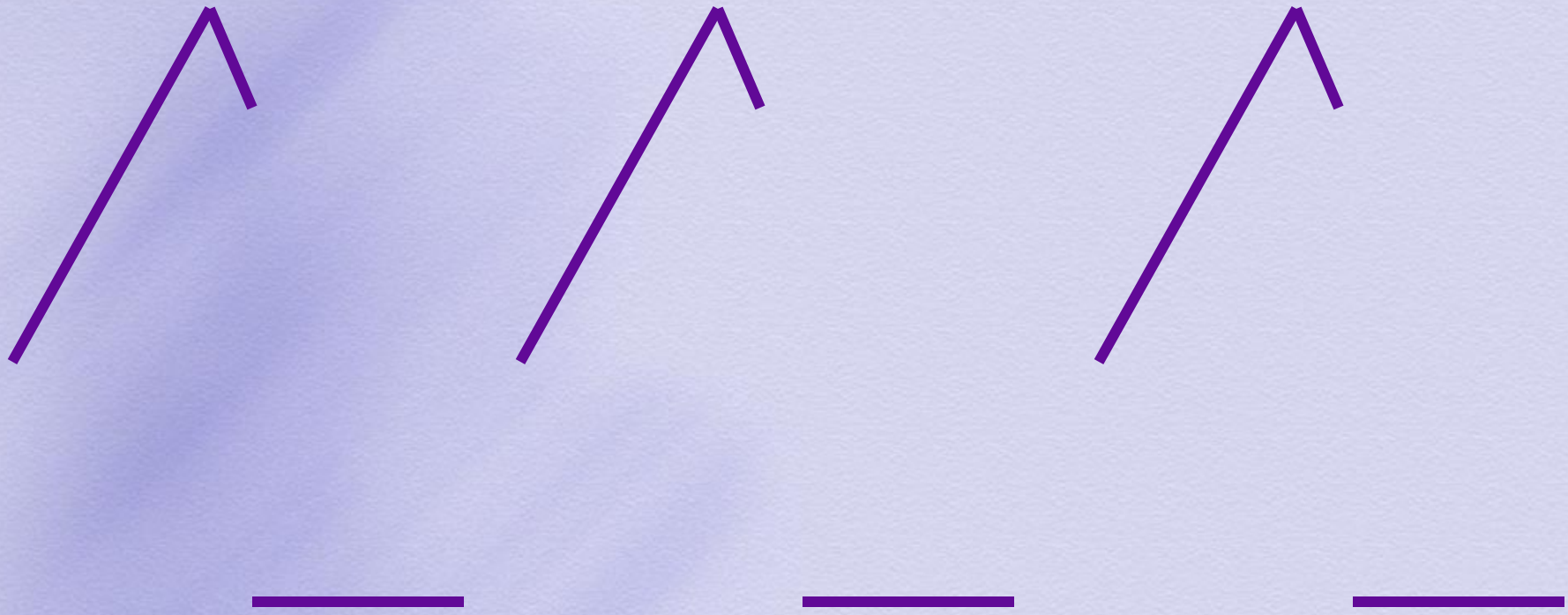
Discussion of more specific topics was even more rare:

- STDs (28%)
- HIV/AIDS (31%)
- Emergency contraception (14%)
- Domestic and dating violence (12%)

Some Explanation for So Many "Missed Opportunities"

- Prevention isn't a national priority (and isn't likely to be if and when "health care reform" passes)
- We place people in silos and provide clinical and community based care from very narrow perspectives

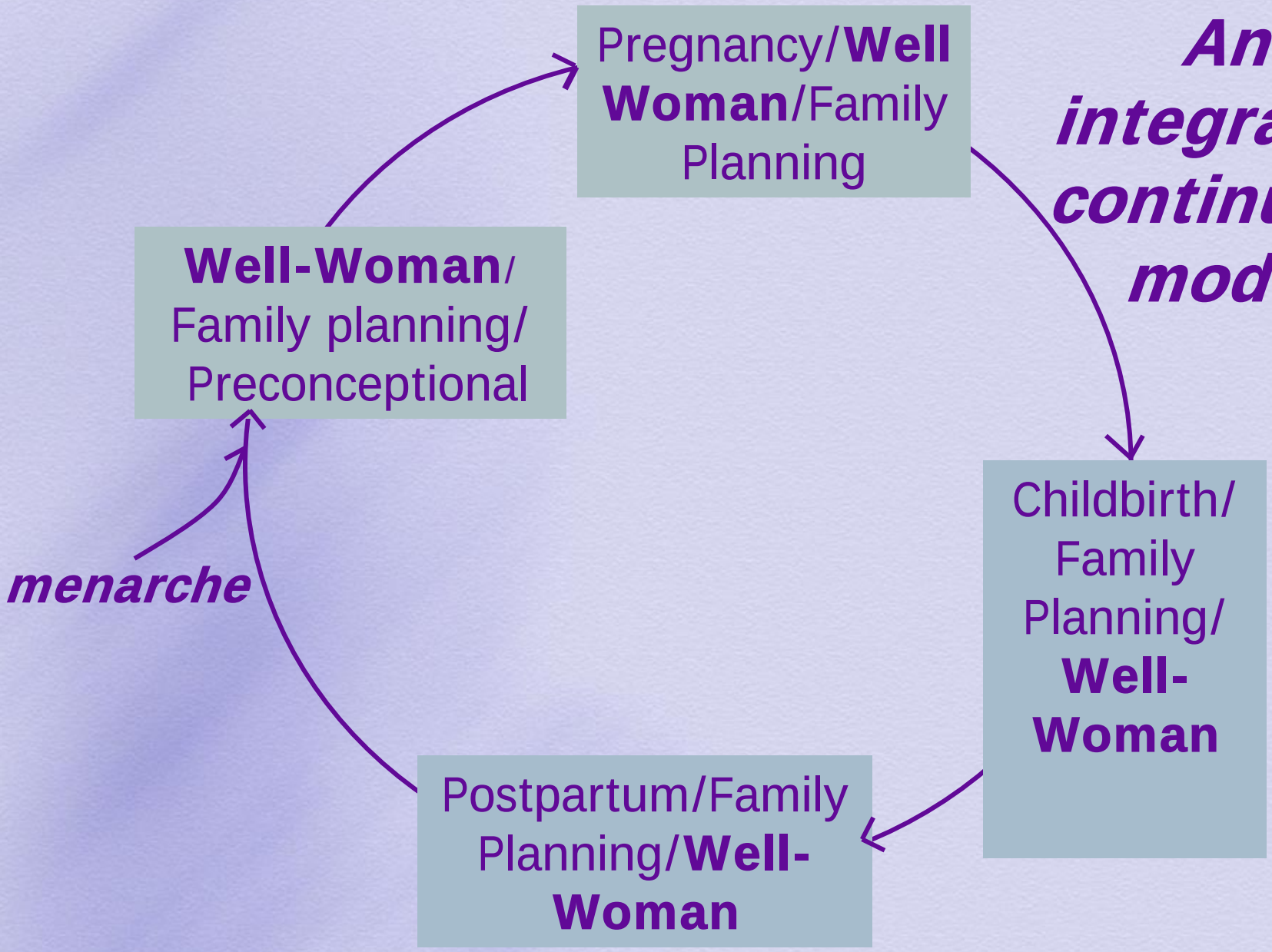
The Medical Approach to Reproductive Health: *"Business As Usual"*



Dominant Perinatal Prevention Paradigm

- Features categorical focus with little integration with woman's preexisting care or with her future health needs
- Initiated at first prenatal visit with
  - Risk assessment
  - Health promotion and disease prevention education
  - Prescription for prenatal vitamins
- Ends with the postpartum visit

An integrated continuum model



A Life Course or Integrative Model

- Builds on a continuum
- Emphasis is on health promotion throughout the lifespan (from “womb to tomb”)
- Emphasis on primary and secondary disease prevention
- Emphasis on woman, first, rather than her reproductive status

Now, focusing on special opportunities/needs of interconception period. . .

Interconceptional Period

- Provides an important opportunity to address risk factors identified in the last pregnancy relative to
  - Woman's lifelong health status
  - Potential impact on future pregnancies

Pregnancy is a "stress test" for life

Examples of Maternal Health Risks/Problems Identifiable from a Previous Pregnancy

- Anemias and hemoglobinopathies
- Hypertensive disorders
- Thromboembolic disease
- Depression, Domestic violence
- Periodontal disease
- Preexisting obesity/Excessive weight gain
- GDM
- Smoking, alcohol or other drug use/exposures
- Immune status

Examples of Predictive Significance for Maternal Health

- Glucose intolerance
  - -Risk of developing overt diabetes in next 5 years over 50%
- Hypertensive disorder
  - Risk of developing chronic hypertension (RR + 1.4-3.98)
  - PIH may represent underlying chronic disease

Examples of Predictive Significance for Pregnancy Outcomes

- Previous preterm delivery
  - One previous PTD
    15% recurrence risk
  - Two previous PTD
    41% recurrence risk

- Potential actions
  - Appropriateness to evaluate for uterine anomalies, for suitability for cerclage
  - Counseling to stop smoking/other drugs
  - Discussion of likely recommendation in subsequent pregnancy to avoid heavy work

Examples of Predictive Significance for Pregnancy Outcomes

- Previous pregnancy affected by ONTD
  - One previous ONTD (as isolated birth defect) 3-5% recurrence risk
  - Two previous ONTDs (as isolated defect) 6-9% recurrence risk
- Appropriate actions
  - Counsel about importance of intended and planned pregnancy
  - 400 mcg of Folic Acid supplementation daily to be increased to 4000 mcg daily one month before intended conception to 3 months after

- LaQuisha had a 1500 gm infant 7 months ago and is presenting for a new ob visit. During her previous pregnancy she was noted to be
  - Underweight (BMI 17.5)
  - Smoker at 1 ppd
  - Experiencing an unintended pregnancy
  - Depressed

As you review her record you note that none of these issues has been revisited since her last delivery—despite a routine postpartum visit

What and Where Were Missed Opportunities?

Interconception Needs:

Important Emphases for Postpartum Care (the beginning of interconceptional care)

- Obtaining a postpartum visit Postpartum visits (in 2003, 80.3% of those with commercial plans and 55.3% of those with Medicaid obtained these visits)
- Maintaining health promoting behaviors of pregnancy (e.g. daily vitamin; smoking cessation, etc)
- Addressing medical/health needs that surfaced during pregnancy (e.g. htn, diabetes, depression, etc.)
- Avoiding short interconceptional spacing
- Avoiding/minimizing postpartum weight retention (a gateway to obesity)

Some Thoughts on Changing the Reproductive Prevention Paradigm So We Can All Work Smarter!

Three Tier Approach to Achieve Higher Levels of Well Woman/Preconception Wellness

- General Awareness (Social marketing)
- Routine Health Promotion (“Every woman, Every time”)
- Specialty care

GENERAL AWARENESS

Issues in General Awareness

- The concept “preconceptional” means nothing to the general public
- Interconception means even less than nothing!
- Few (professionals, patients, men, future grandmothers, etc.) understand how important the earliest weeks of pregnancy are
- Women most in need of preconceptional health promotion are often those least likely to have intended conceptions

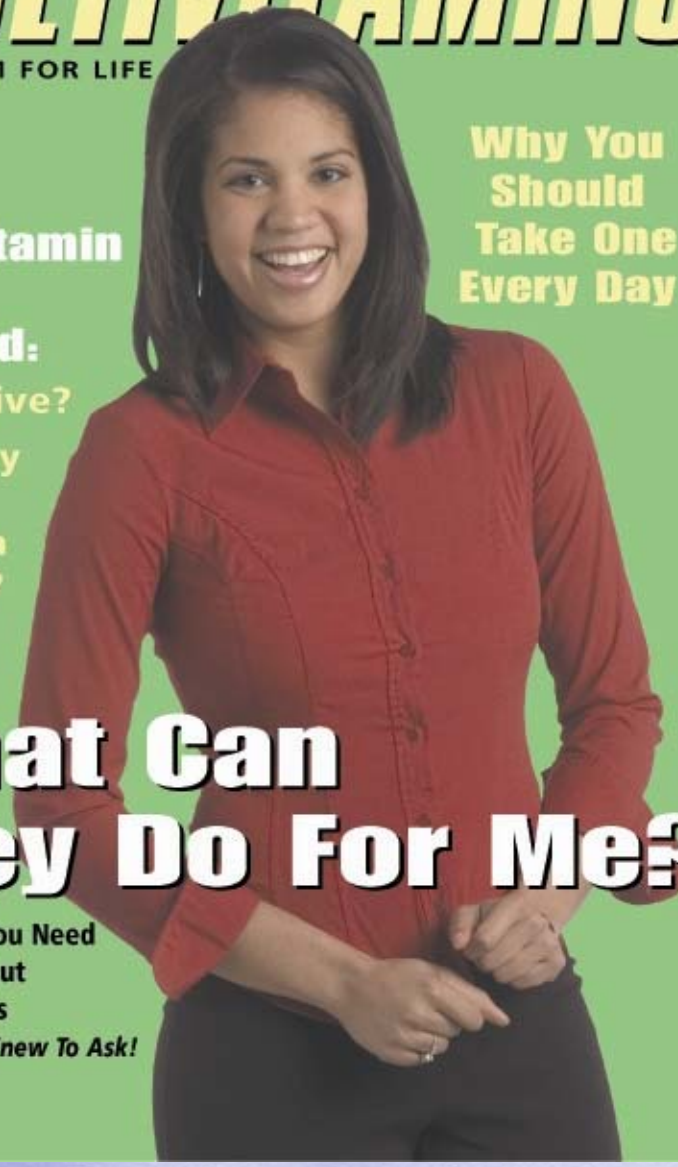
Insights from Research

(from Prue/Biermann presentation at CDC Expert Panel Meeting, 2007)

- Need to avoid “vessel” communications
- “Just in case” is not compelling
- Want non-pregnancy related reasons for performing many preconception health behaviors

MULTIVITAMINS

TAKE THEM FOR LIFE



Why You Should Take One Every Day

Multivitamin Myths Exposed:

Expensive?

Will They Make Me Gain Weight?

What Can They Do For Me?

Everything You Need To Know About Multivitamins

— But Never Knew To Ask!

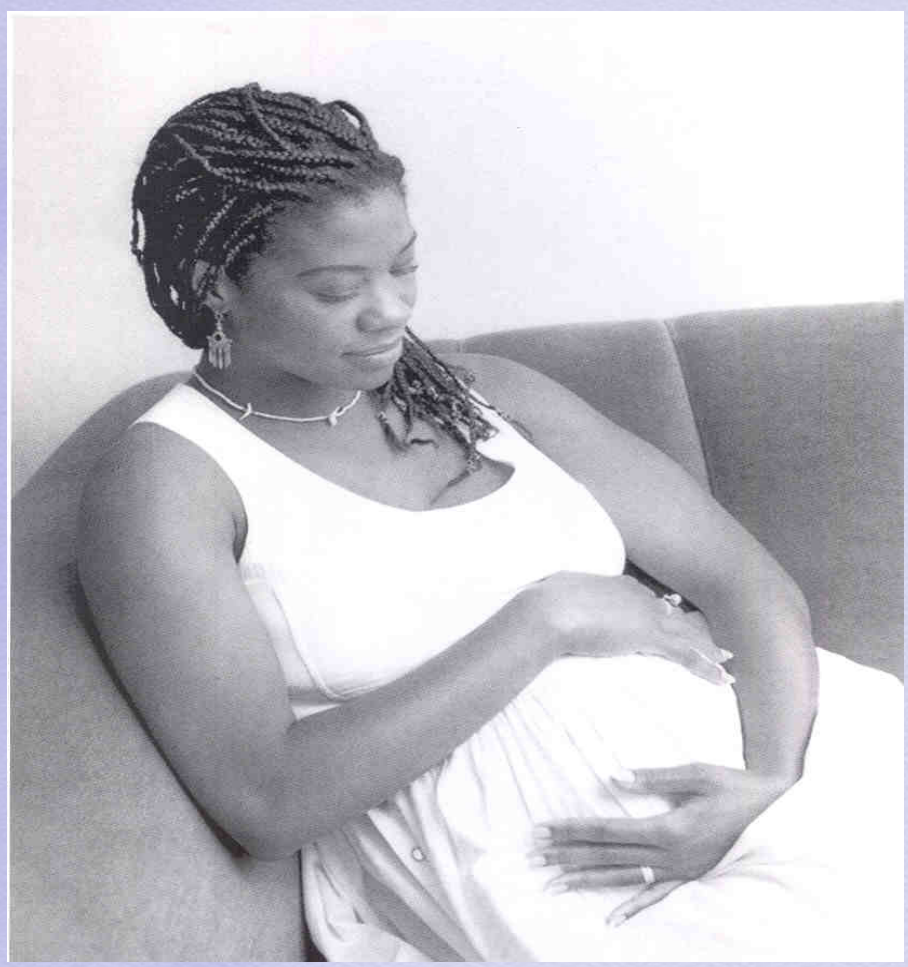
Take Control of Your Life, Take Care of Yourself.

There are lots of great reasons to take multivitamins. Along with a balanced diet and regular exercise, they're a good way to stay in good health. For just pennies a day, multivitamins may help lower your risk of cancer, heart disease and osteoporosis as well as prevent some birth defects. For a healthy, happy you, take a multivitamin every day. To learn more, call 1-800-367-2229 or visit www.getfolic.com.

MULTIVITAMINS

TAKE THEM FOR LIFE

Need to carefully assess the messages we give:



What Are Opportunities for Social Marketing in the Community?

- Advancing the importance of the woman's health today, tomorrow and throughout her future
- Promoting deliberate decisions about childbearing
- Encouraging routine use of folic acid—unrelated to pregnancy plans
- Advance healthier BMIs
- Others

ROUTINE HEALTH PROMOTION:
"Every woman, Every time"

Built upon encounters with individuals rather than entire populations

- Outreach
- Clinical encounters
- Reinforcement between clinical and community messages

"Every Woman—Every Time" is Opportunistic Care

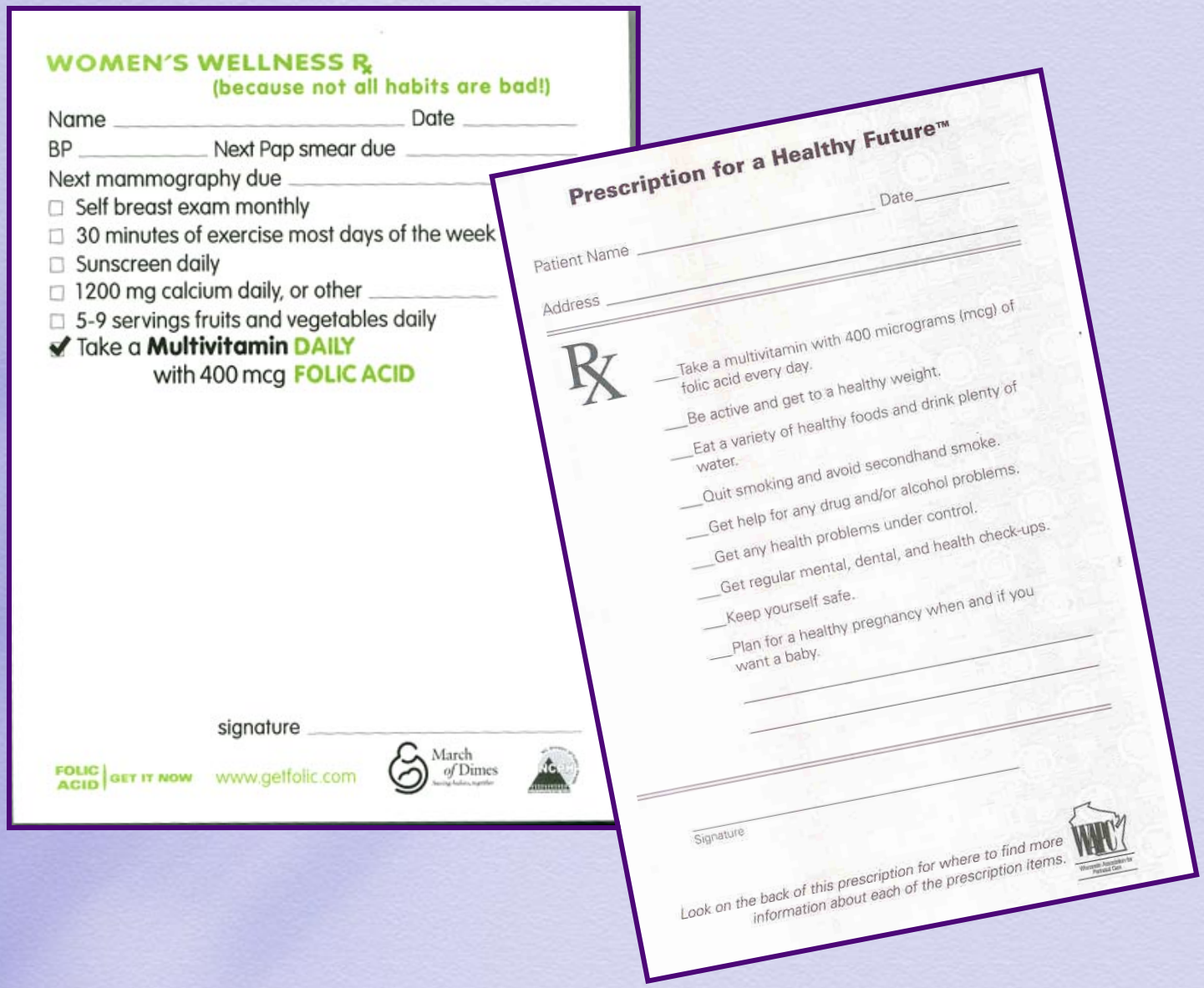
- Takes advantage of all health care encounters to stress prevention opportunities throughout the lifespan
- Recognizes that in almost all cases preconceptional wellness results in good health for women, irrespective of pregnancy intentions
- Addresses conception and contraception choices at every encounter
- Involves all medical specialties—not only those directly involved in reproductive health

Key Content of Every Woman, Every Time

- Do you provide **EVERY** woman (including the 13 year old, the 45 year old and everyone in between) with a clear message of the benefits of exogenous folic acid? And a clear message to start taking **NOW**?

What about clear messages on:

- Importance of planning when desire to become pregnant
- Nutritional status (are you calculating and explaining BMIs on every woman at every visit—and offering meaningful strategies to impact?)
- Tobacco cessation
- Other substance use and exposures
- Exercise habits
- Calcium intake
- Periodontal disease
- STI Risks



WOMEN'S WELLNESS Rx

(because not all habits are bad!)

Name _____ Date _____

BP _____ Next Pap smear due _____

Next mammography due _____

- ☐ Self breast exam monthly
- ☐ 30 minutes of exercise most days of the week
- ☐ Sunscreen daily
- ☐ 1200 mg calcium daily, or other _____
- ☐ 5-9 servings fruits and vegetables daily
- ✔ Take a **Multivitamin DAILY** with 400 mcg **FOLIC ACID**

signature _____

FOLIC ACID | GET IT NOW www.getfolic.com March of Dimes

Prescription for a Healthy Future™

Patient Name _____ Date _____

Address _____

Rx

___Take a multivitamin with 400 micrograms (mcg) of folic acid every day.

___Be active and get to a healthy weight.

___Eat a variety of healthy foods and drink plenty of water.

___Quit smoking and avoid secondhand smoke.

___Get help for any drug and/or alcohol problems.

___Get any health problems under control.

___Get regular mental, dental, and health check-ups.

___Keep yourself safe.

___Plan for a healthy pregnancy when and if you want a baby.

Signature _____

Look on the back of this prescription for where to find more information about each of the prescription items.

TARGETED CARE

Targeted Services for Those At Risk

- Case-finding for the woman at risk and appropriate guidance, referral, follow-up
  - Based on health profile
  - Based on previous poor pregnancy outcome
- **The biggest short term return on investment will be attending to interconceptional needs of women who have declared their risks**

How can your Healthy Start Interconception Project get the biggest return on its efforts?

Organization of Services

What We Know

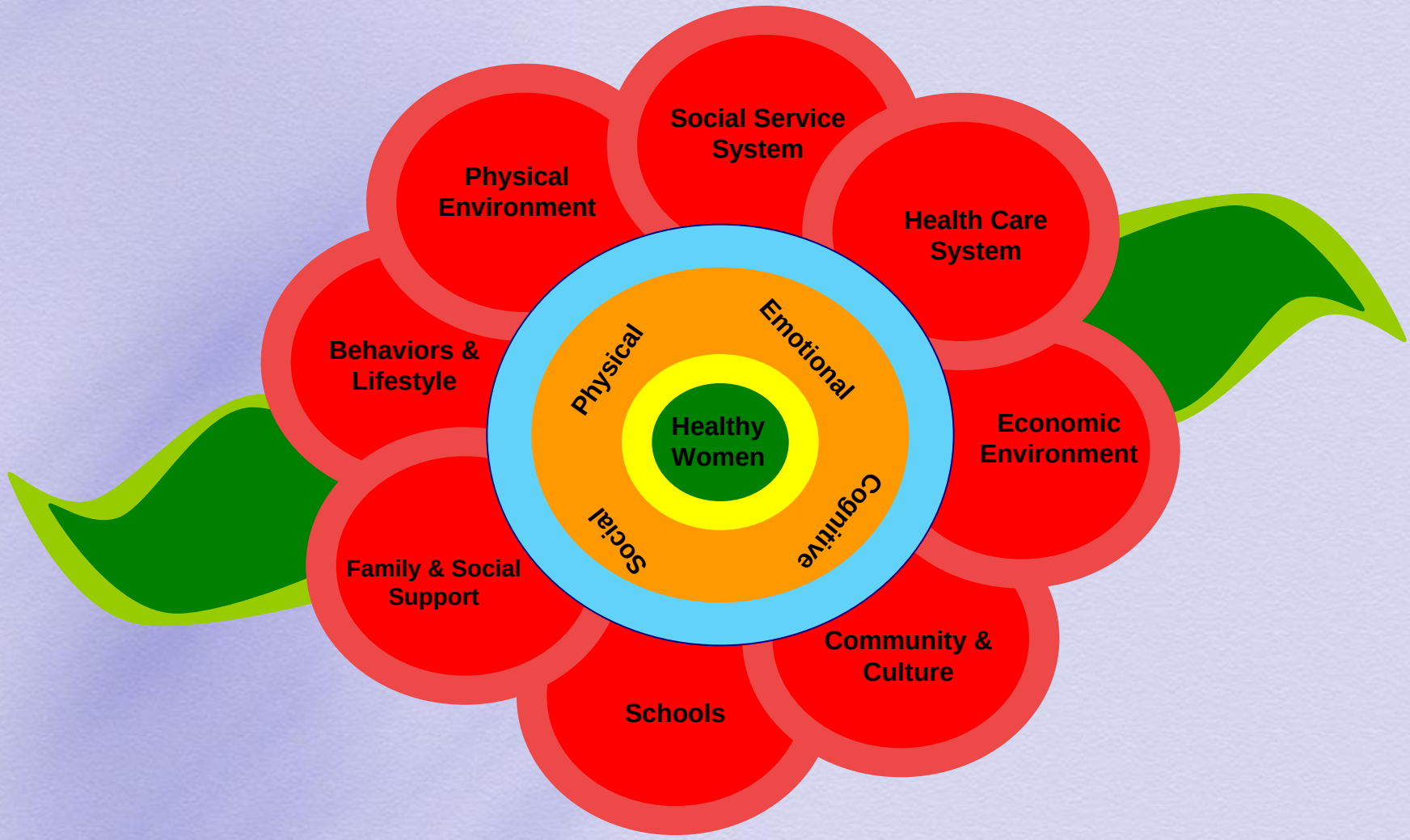
- We've been doing it the same way for a long, long time
- Our reproductive outcomes fall short of our goals
- Women's health status is often poor
- We are working harder but not smarter

What We Don’t Know

- If restructuring our health care approach for women will impact on outcomes for women, pregnancies and infants
- If health care reform will actually benefit prevention

Case in Point. . .

- How will the current “health care reform” proposals impact the obesity epidemic in this country. . .and it’s impact on women and their pregnancies?



Used with permission of The Nemours Foundation, Division of Health and Prevention Services. Adapted from the 2005 Delaware Children's Health Chartbook.

Moving Forward

People won't change their priorities or behaviors until it makes a difference for them to do so . . . (this includes consumers, providers and

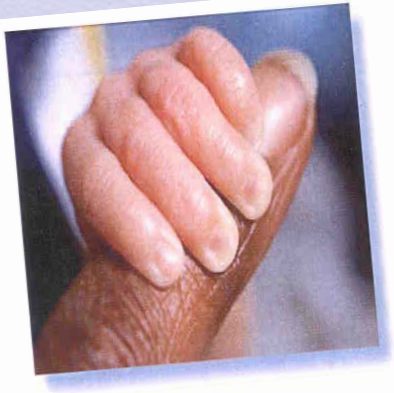
. . .YOU!)

Moving from Rescue to Prevention--

What strategies can you use to reframe the prevention paradigm to move “upstream” for:

- The population-at-large?
- The women you care for?
- Other providers?
- Policy makers?
- Insurers?

What three actions can you take to “work smarter—not harder” to make a difference for your patients, your practice and your agency?

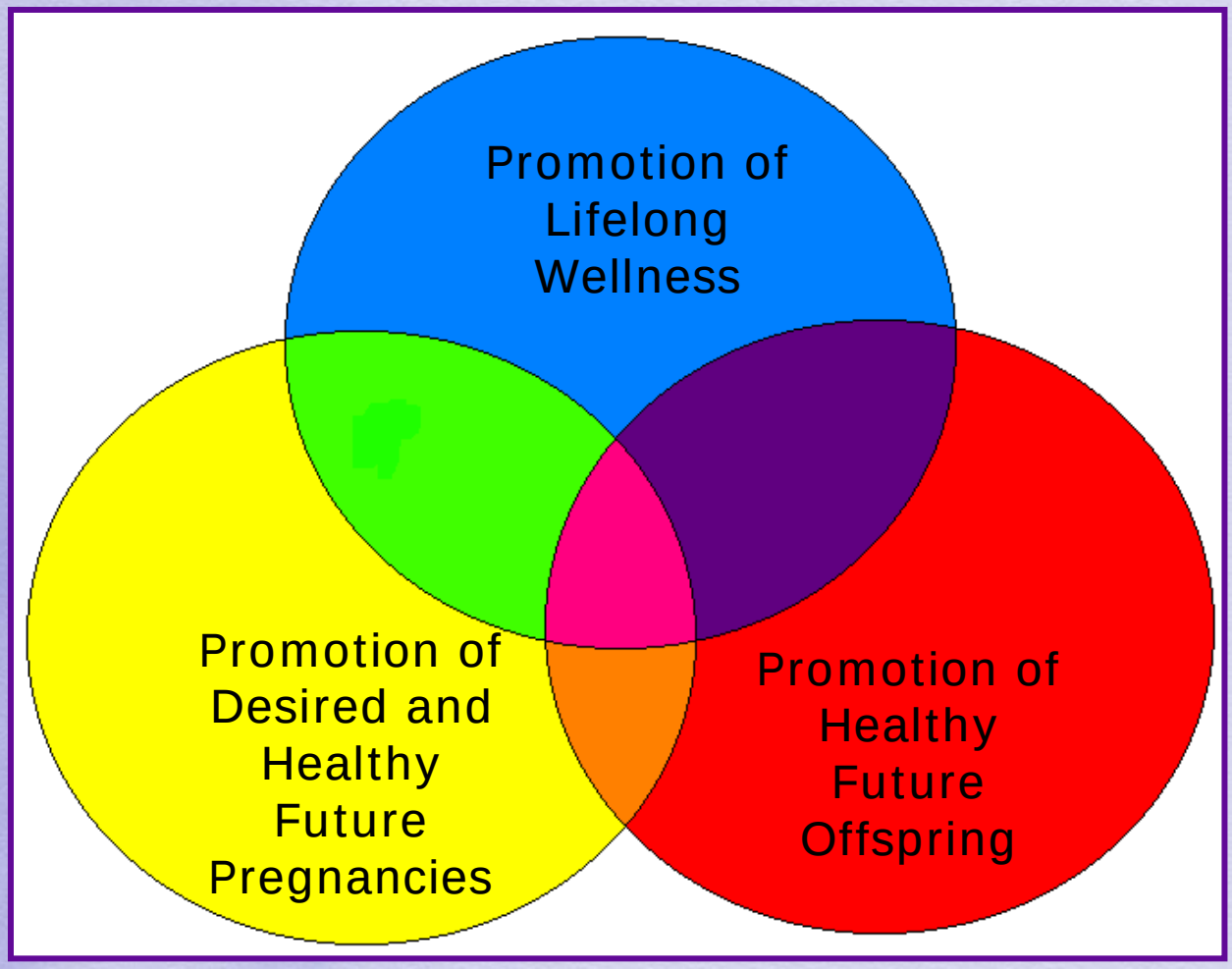


INFANT DEATH IN OUR COMMUNITY

Summary

- There is good rationale for the preconceptional/interconceptional health promotion agenda
- To make a difference we need to move away from a prenatal prevention paradigm to embrace women's health, whether before, between or beyond pregnancy.
- Promoting high levels of health in all women is likely to result in preconceptional/interconceptional health promotion for those who become pregnant
- Women who have already experienced a poor pregnancy outcome have declared many risks for their own health and for the health of future pregnancies/infants
- It is possible to work smarter without working harder

The Goal: Making a Difference for Today and Tomorrow



Articles

A Wonderful Mystery

Black infant mortality has plummeted in one Wisconsin county. Why?

By **Eve Conant** | Newsweek Web ExclusiveÂ

OctÂ 22, 2009

Last fall epidemiologist Cynthia Ferre got some of the best, but most mystifying news of her career. Ferre, who works for the Centers for Disease Control and Prevention, knows all too well that the U.S. has one of the worst infant-mortality rates in the developed world, with preterm African-American babies almost four times as likely to die as infants than white babies. So why had the black-white infant-mortality gap apparently disappeared in one county in Wisconsin, a state with some of the worst infant-mortality rates in the nation for blacks? *(Article continued below...)*

Even an isolated improvement in infant mortality could have far-reaching ramifications for the nation's overall health and health-care costs, but only if authorities can figure out what's actually been happening in Dane County. "This is a very big deal; we've never seen this before," says Ferre, who has been tracking infant-mortality disparities and maternal health issues for the CDC for 18 years.

America's infant-mortality rate has long been both a black mark on the reputation of our health system, and a financial burden. The U.S. ranks 29th in the world, tied with Malta and Slovakia for the second-worst infant-mortality rate among developed nations. In most poor countries infant deaths are often caused by treatable infections like diarrhea, pneumonia, or malaria. But in developed countries the deaths are more often caused by extreme prematurity or birth defects. According to a report by the Institute of Medicine, the annual cost associated with preterm birth in the U.S.â€”at its bare minimumâ€”is $26.5 billion. It's a grim picture, and nothing really seems to have helped in recent years. Except, it turns out, in Dane County, whose 470,000-odd residents are mostly divided between the capital, Madison, and the surrounding rural areas of southern Wisconsin.

Dr. Thomas Schlenker, director of public health for Madison and Dane County, is leading the investigation into the turnaround, with help from the University of Wisconsin School of Medicine and Public Health and the state Department of Health

Services. When Ferre first got an e-mail from Schlenker last fall, she was skeptical. "We're really not used to seeing improvements like this," she admits. She pored through the Dane County numbers, which were small, but consistent over time. Between 1990 and 2001, the county recorded 73 black infant deaths. The figure dropped to 17 between 2002 and 2007, representing an incredible 67 percent decline from 1990. It is the first known example of the black-white gap closing in any one state or county.

What was behind this extraordinary improvement? "We've got dozens of lines of investigation out," says Schlenker. The first thing he and his team of investigators looked at was an obvious lead. In the '90s, the Healthy Start Program in Wisconsinâ€”Medicaid for pregnant womenâ€”was expanded to include almost all low- and middle-income pregnant women. That would seem at first to be the answer, especially since the change was widely advertised in Dane County. But it applied statewide, and other parts of Wisconsin with populations similar to Dane County still have dismal infant-mortality rates. At 17.6 per 1,000 births, Wisconsin's infant-mortality rate for African-Americans is among the highest in the nation, and is just below that of the Gaza Strip. In certain citiesâ€”Racine, for instanceâ€”it is a staggering 23 per 1,000 births.

Ferre is also trying to solve the mystery. Looking for possible causes, she wondered if it might be traced to the way fetal-death trends were talliedâ€”if, for example, a baby was born but classified as a fetal death even though it had been outside the womb for several minutes before dying. "That would artificially reduce the rate of infant death," says Ferre. But she says that appears unlikely because fetal and infant deaths were both going down at the same time. She asked about any major changes to the population. Research indicates that foreign-born African immigrants have significantly better birth outcomesâ€”closer to whitesâ€”than U.S.-born black women. But while the county's African-American population has doubled in the past 20 years, Schlenker has found that only 10 percent of the newcomers were foreign-born. "That wasn't it, either," says Ferre. Nor was it due to improvements in protocols at local hospitals. Schlenker's team found "no significant changes in the local health care systems, infrastructure or practice that corresponded to the improvements," according to a CDC paper written by Schlenker and his colleagues and reviewed prepublication by Ferre. "They also have a decrease in the number of teen mothers and pregnant black women who smokeâ€”all established risk factors that support the outcome," says Ferre. "But that is unlikely the whole answer."

Somehow, Dane County had achieved the holy grailâ€”a reduction in the infant-mortality rate. But why? Another positive trend is almost certainly playing a role. "We're also seeing a big decline in the number of very early preterm births, which is unusual because nationally that rate is very stable and resistant to change," says Ferre. The Dane County decreaseâ€”from 2.8 percent to 1.1 percentâ€”is dramatic, and no doubt related to the infant-mortality drop. Elsewhere in the U.S., the rate of preterm birthâ€”a leading factor in infant mortalityâ€”has increased 36 percent over the past quarter century (to 12.7 percent), in part due to women having babies later in life and reproductive techniques that increase the chances of multiples, but also because black women across the country have a much higher risk of preterm delivery than whites. However, when Schlenker and his team examined some 100,000 Dane County birth and death records from 1990 to 2007, exploring birth weight, gestational age, prenatal care, and other infant-mortality risk factors, they found a decrease in the number of births below 28 weeks' gestation, and a drop in newborn mortality for babies weighing less than 3.3 pounds. In other words, black babies were being born later, gaining weight faster, and surviving. But, againâ€”why?

There is no quick or simple answer, not yet at least. But one area of interest is a former strip mall in a low-income part of Madison that, in the early '90s, was transformed from a bowling alley (and a cluster of jewelry and sub sandwich shops) into a hugely popular one-stop shopping zone for maternal care. Asked to name the facility, members of the community dubbed it South Madison Health & Family Centerâ€”Harambee, Swahili for "pulling together." Harambee, first created out of community grant funds and private donations, has developed and shifted over time, but is currently a collaboration of five different entities: three medical clinics, including county and city public-health clinics and Planned Parenthood; Head Start; and a public library. Some 600 patients a day visit the dozens of nurses and doctors at the clinics, or come for social programs, which range from parenting classes for soon-to-be fathers, breast-feeding seminars, and even bereavement groups for women who have lost infants or miscarried. Community volunteers, including elders, read to children in waiting rooms. "What is different in Dane County," says former Madison mayor Paul Soglin, who was instrumental in creating Harambee, "is that here a 19- or 25-year-old black woman finds a facility that is not the white man's institutionâ€”it's hers." As the center and the community around it began to grow, infant-mortality rates started to drop (though no data have yet proved that one caused the other). Does Ferre see a link? "Yes, I do. When you look at data from other one-stop centers, like in D.C. or Harlem, you'll see their infant-mortality rates have decreased too. I'm suspicious that this type of clinicâ€”Harambeeâ€”could have affected the rate." (She points out that not all such one-stop clinics have these great

rates, however, which warrants further investigation into what does and does not work in the one-stop-shopping plan for maternal care.) For his part, Schlenker doesn't think Harambee "is the whole answer by any means, but it is certainly part of the answer. It got agencies to work in a synergistic way, drew the community together, and made people feel valued."

Lorraine Lathen of the University of Wisconsin has been canvassing the women of Dane County for answers. "We're finding some non-health-related factors that actually seem to influence outcome," she says. Those factors involve a complex web of relationships between expectant parents and local medical care that Soglin (who is also investigating the Dane County results) describes simply as "access plus trust." Trust, in the words of many of the young black mothers Lathen interviewed, seems to translate into the absence of racial stereotypes. (The women, some of whom have lost babies, talk of feeling prejudged when they lived in other parts of the stateâ€”one mother says it might surprise people that black women "do have families," and that the father of her child, for example, is her husband, not "my baby daddy.") The more a woman feels like she's being cared for, says Ferre, the greater the lines of communication, and the more likely she'll want to go back for further appointments.

Other factors may have certainly played a roleâ€”including a system of devoted home nurses who work under Schlenker. There are some 60 public-health nurses in the county; at any given time a dozen are on duty for home visits before and after birth for high-risk pregnancies. But no one is exactly sure yet what did the trick. What they do know is that by 1996, says Schlenker, premature-birth rates in the area started to go down, and by 2002 the infant-mortality rate began to drop. Looking at a chart, Schlenker says, "The past six years have been a straight-down precipitous drop, like falling off a cliff." He still can't believe his own data. "It's shocking, for two reasons. One, you almost never see a graph like that in medicine. The second shock is that it's good news." When Schlenker flew to Atlanta last February to present his findings, the CDC reserved 70 conference dial-in lines for state and local health officials. But they filled up so quickly that the specialists had to double- and triple-up in their offices.

Other one-stop centers in the U.S. that aim to involve the community and focus on the maternal health of black women have seen significant successes. Washington, D.C.'s Developing Families Birth Center (DFBC), run by 82-year-old MacArthur fellow and nurse-midwife Ruth Lubic, was founded in an old Safeway and includes everything from birthing rooms to nutrition classes. It has reported that while D.C.-wide data for preterm births among African-Americans in 2006 was 15.6 percent, the

women who received care from DFBC had rates closer to 5 percent. "We treat people like fellow human beings," says Lubic, whose staff follows the theory that infant mortality is not a medical condition, but a social condition with medical consequences. That same philosophy can be found in New York's Harlem, where Mario Drummonds, executive director of the Northern Manhattan Perinatal Partnership, has overseen one-stop health and career programs targeting high-risk areas. His program has seen infant-mortality rates in the area plummet from 27.7 infant deaths per 1,000 live births in 1990 to a figure now hovering closer to eight.

Ferre has been assigned by the CDC as an adviser to the Dane County investigation, which will take two more years to complete. Meanwhile, centers like Harambee and DFBC are facing budget pressures in the tough economic climate. "Right as we are learning the results of innovative techniques, we have the recession, and these places are starting to lose funding," worries Ferre. But the effort to unlock the wonderful mystery of Dane County continues. Lathen says, "We don't know yet what has happened in Dane, but whatever it is, we want it to be replicated."

November 2009

Issue: 8

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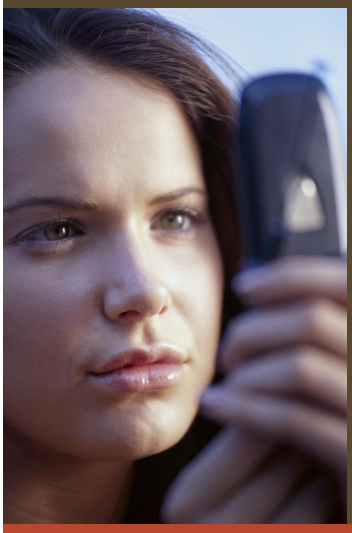

Preconception Health and Health Care Update

Greetings
This is a monthly communication for individuals interested in improving the health of women and infants through preconception health and health care. We welcome your readership and contributions.

Before and Beyond: Preconception Curriculum Online

Before, Between and Beyond Pregnancy, the national preconception curriculum and resources guide for clinicians, continues to evolve and expand. Module have been updated recently. The online initiative can be accessed at www.beforeandbeyond.org

Designed to promote evidence-based care, the site provides access to professional education opportunities, key articles, and clinical guidance for specific high risk conditions, practice supports, breaking news, links to state preconception and interconception initiatives and access to patient care resources.

To date three CME modules have been created specifically for the national curriculum and can be accessed only through this site. Two more modules are under development.

1. "Preconception Care: What It is and What It Isn't" (1 AMA PRA Category 1 credit)
2. "Every Woman, Every time: Integrating Health Promotion into

In This Issue

Facts on Medicaid and Women

More than 17.2 million women under age 65 were uninsured in 2008.

Failure to provide Medicaid poor adults is a major force in this statistic.

Even among those who have children, Medicaid eligibility levels in 12 states were set at ***less than half*** of the federal poverty level in 2009.

Routine Care" (1.5 AMA PRA Category 1 credit)
3. "Maximizing Prevention: Targeted Care for Those with High Risk Conditions" (1.5 AMA PRA Category 1 credit, pending).

Modules are being developed by experts Merry-K. Moos, RN, FNP, MPH, of the University of North Carolina, and Peter Bernstein, MD, MPH of Albert Einstein College of Medicine.

CME credits are available to physicians, nurse midwives, nurse practitioners and physicians' assistants. Additional links to other continuing education opportunities are posted on the site. Members of all groups involved in the clinical care of women and men of reproductive age are encouraged to visit the Professional Education section of beforeandbeyond.org to identify resources appropriate to them.

The Key Articles and Guidance section of the site provides links to articles about preconception care, including three journal issues that were dedicated to the topic. In addition, clinical options for the care of women with specific conditions is offered. Other features of the site include links to practice supports for the busy clinicians.

This resource could not exist without the volunteer commitment of Montefiore College of Medicine, which is supplying the CME credits, the UNC Center for Maternal-Fetal Health, which provides web space and design, and Ms. Moos and Dr. Bernstein, who have provided or vetted all of the content. The CDC Select Panel on Preconception Care is indebted to them for their efforts to advance evidence-based preconception health and health care. Unfortunately, there is no marketing budget to promote visits to this labor intensive resource. Please do what you can do to promote the site by becoming familiar with the site and by marketing it to the clinicians in your setting, your professional organizations and your state.

Expecting Prevention -- Heidi Murkoff Promotes Preconception Health

In the Huffington Post, November 17, 2009, Heidi Murkoff, author of "What to expect when you're expecting" promoted the use of preconception health and and health care as a means to improve the health of our children and our nation. She wrote:

It doesn't take a brain surgeon...or a cardiologist...or a pediatrician...or even a policy wonk to figure out that a

penny's worth of preventive care is worth many dollars of sick care. That the best Rx for American health is also the best Rx for out-of-control health care costs. In a word we all get: prevention.

...Let's leave no child behind when it comes to health care, but let's also remember that health begins before birth -- and that health care should, too....The science of preconception -- and how a couple's health at the time of conception can affect not only the health of a pregnancy and the health of a baby, but the health of a baby much later in life -- is still in its infancy. But what we've learned even in the five years since the CDC first got the preconception party started -- by launching the first preconception initiative ever in 2005 -- is pretty persuasive stuff...That is why preconception planning should be an integral piece of that healthy baby prescription.

Combine comprehensive, across-the-board prenatal care with routine preconception counseling, and the benefits multiply exponentially. Short-term: significantly lowered pregnancy risk and significantly lowered pregnancy cost. Long-term: a physically and fiscally healthier America. In short, it's a health care combination that writes the ultimate prevention prescription. Unarguably life-saving, incalculably cost-saving.

So let's say we give more babies a healthier start in life, right from the beginning. Or maybe...even sooner.

Place Matters

In their landmark book Place Matters, authors Peter Dreier, John Mollenkopf, and Todd Swanstrom, described how economic segregation between rich and poor have been shaped by short-sighted government policies. Today, communities are gaining new insights into what strategies to change communities and increase health equity.

Epidemiologist Cynthia Ferre of the Centers for Disease Control and Prevention, and Dr. Thomas Schlenker, director of public health for Madison and Dane County, are leading an investigation into the progress in reducing black infant mortality in one Wisconsin County. Newsweek has reported on this story. While final results are not in, they suspect that state program and policy improvements combined with centers for health care grounded in the community and the cultural context for African American families are central to this success. Other community centers in the U.S. focused on the health of African American women have seen substantial successes, including Washington, D.C.'s Developing Families Birth Center and the Northern Manhattan Perinatal Partnership in Harlem. In 102 communities, federally funded Healthy Start are focusing on interconception health for women and infants, not just prenatal care, for the highest risk

families.

Place Matters is also the groundbreaking program of the Joint Center for Political and Economic Studies Health Policy Institute -- a nationwide initiative designed to improve the health outcomes and to address the social factors that determine health in participating communities. The Place Matters initiative aims to address this gap by cultivating new leadership and advancing the Fair Health Movement- one community at a time.

The acclaimed PBS documentary series, Unnatural Causes, broadcast by PBS, is helping to ground the efforts of organizations around the country to tackle the root causes of our alarming socio-economic and racial inequities in health. In the "Place Matters" episode, viewers are reminded how health worsens as social conditions deteriorate in neglected urban neighborhoods and how that can be changed.

Syndey Australia commits to PLaN Clinics

In Sydney, Australia, health authorities are focused on preconception health care to prevent birth defects and pregnancy complications that can arise from obesity, diabetes and poor lifestyle and nutrition habits. An experienced midwife will run the new state-government-funded PLaN (preconception, lifestyle and nutrition) clinics. "We know that increasing numbers of people are looking to have children and this service aims to help put them on a path to a healthy pregnancy before they conceive," said New South Wales Health Minister Carmel Tebbutt. (From: The Sunday Telegraph , November 21, 2009)

Nurses Work To Prevent Infant Mortality In U.s.

A study released in November confirms that prematurity in babies is the reason the U.S. scores so poorly in infant mortality compared to other developed nations — a truth most health experts say is a national disgrace. After decades of improvement, the U.S. infant mortality rate plateaued from 2000 to 2005 and had an insignificant decrease in 2006 from 6.86 to 6.71 per 1,000 live births, despite numerous national, state, and local efforts.

The study, released by the National Center for Health Statistics, compared data on infant deaths from the United States and Europe. Even when the study corrected for differences in the way countries report infant deaths, the adjusted U.S. rate of 5.8 was nearly twice that for Sweden and Norway (3.0), the countries with the lowest infant mortality rates, the report stated. Infant mortality rates for Hungary, Poland, and Slovakia were higher than the U.S. rate.

“The primary reason for the United States’ higher infant mortality rate when compared with Europe is the United States has a much higher percentage of preterm births,” the report concludes. “These data suggest that preterm birth prevention is crucial to lowering the U.S. infant mortality rate.”

“The study backs up what we already knew and suspected,” says Diane Ashton, MD, MPH, deputy medical director for the March of Dimes.

About one in eight babies is born before 37 weeks in the U.S., according to the March of Dimes. But preventing prematurity has been an elusive goal for maternal and child health practitioners and public health policymakers. Prematurity is caused by complex factors, including an increasing number of multiple births resulting from fertility treatments and delayed child bearing, a rising number of unnecessary cesarean sections and inductions, teenage pregnancy, and the gaping economic, social, and health disparities between whites, blacks, and other minority women, according to the March of Dimes.

In the past 20 years, maternal and child health experts have learned good prenatal care alone is not enough to ensure a healthy pregnancy for women at risk of poor outcomes because of poverty, lack of education, discrimination, poor health, and domestic or substance abuse. The traditional medical model of care in which pregnant women receive care from an obstetrician for nine months doesn’t work, these experts say. Even expanded nonmedical models of prenatal care with education and referrals are insufficient.

Nurses Lead Innovative Programs
Maternal-child health should be a team approach that includes dieticians, mental health providers, social workers, and nurses, with RNs taking a much more prominent role than they now do, says Michael Lu, MD, associate professor of obstetrics and gynecology and public health at the University of California, Los Angeles. “You can’t expect OBs to sit with patients and talk about nutrition, stress, and environmental exposures at length,” he says.

If fact, some of the most innovative models of care have been pioneered by nurses, such as Ruth Lubic, RN, CNM, EdD, founder of the Developing Families Center in Washington, D.C.; Sharon Schindler-Rising, RN, CNM, MSN, who pioneered the Centering model; and Merry-K Moos, RN, FNP, MPH, FAAN, who pioneered the concept of preconceptional health 20 years ago, he says. w

"We should be paying more attention to [these models]," says Lu. "If we want to close the infant mortality gap, nurses need to play a strong leadership role."

Moos, who recently retired as a professor in the Department of Obstetrics and Gynecology at the University of North Carolina at Chapel Hill, says women's healthcare, particularly for poor women, should be approached as a continuum and not broken up into episodic periods, such as for pregnancy. She believes that if the healthcare system focuses on keeping women well through prevention and education long before they become pregnant, then healthy babies will follow.

Healthcare providers should use every interaction with a woman to educate her and start her thinking about decisions related to future childbearing, says Moos. A woman's health also needs to be followed in between pregnancies, especially if she already has had a miscarriage, still birth, diabetes, etc., to help prevent future complications — a concept called interconception care.

Despite the discouraging U.S. infant mortality statistics, public health experts are hopeful the trend can be turned around. "Am I discouraged?" asks Moos. "Not at all. The conversation is happening, and there is so much going on."

Focus on Minority Babies
In October, a small group of community activists, nurses, physicians, state officials, and family members gathered at a community center in Racine, Wis., to launch a public awareness campaign to lower the state's infant mortality rate in its black population.

"We have a major health problem going on here," said Karen Timberlake, Wisconsin Secretary, Department of Health Services. "This problem should not be true in Wisconsin."

The uncomfortable truth in Wisconsin is that while it has one of the lowest rates of infant mortality for white babies, it has one of the highest rates of death for black babies, with only Delaware and the District of Columbia having worse rates. A black baby born in Wisconsin is three times more likely to die in its first year of life than a white baby.

When federal and Wisconsin state health officials decided to take action against the state's glaring disparity in infant mortality rates, experts from across the country were called in for advice, including Mario Drummonds, MS, LCSW, MBA, from New York.

Drummonds is the executive director and CEO of the Northern Manhattan Perinatal Partnership (www.sisterlink.com), a network of community-based programs that has helped New York City become a national success story in lowering the infant mortality rate, particularly in impoverished neighborhoods such as Harlem.

Lu is the lead proponent of the Life Course Perspective theory, which views birth outcomes as the product of the entire life course of the woman leading up to her pregancy. The plan includes providing interconception care to women with prior adverse pregnancy outcomes, strengthening father involvement in black families, and investing in community building and urban renewal.

Drummonds believes New York has had such success because the perinatal network has been able to tightly coordinate and control numerous programs modeled on the Life Course perspective and targeted to individuals, neighborhoods, and policymakers, including the local health systems. In 1990, Central Harlem had the highest rate of infant mortality in the U.S., with almost 28 babies out of every 1,000 live births dying. The rate was down to 5.1 deaths by 2004.

Wisconsin officials hope to start doing the same. Timberlake's agency has started an intervention program called "Journey of a Lifetime," based on Lu's Life Course Perspective. Meanwhile, the University of Wisconsin's School of Medicine and Public Health has launched a companion effort, the Healthy Birth Outcomes Initiative, with funding from its Wisconsin Partnership Program.

"We're letting the community lead," says consultant Lorraine Lathen, who has been hired to implement Lu's Life Course Perspective in Wisconsin. She set up focus groups in Milwaukee, Racine, Kenosha, and Beloit counties, where more than 90% of the black infant deaths occur.

Richard Allan Aronson, MD, MPH, director of the Humane Worlds Center for Maternal Child Health, says the programs that appear to work best are those that involve the community from start to finish. "It's essential to include the voices of the women and family members who are in the midst of this," he says.

Lu's theory also posits that the chronic stress black women experience throughout their lives from institutionalized racism, poverty, unemployment, inadequate housing, and violence causes wear and tear on multiple physiologic systems, which in turn predisposes their bodies to delivering premature infants.

Researchers are finding that even when black women are better educated and have higher social and economic standing, their babies still are more likely to die or have low birth weights than white women.

Gwen M. Perry-Brye, RN, APNP, a nurse practitioner with the Kenosha County Division of Health in Wisconsin, says it is important for nurses to recognize the stress black women face in their lives and how that can lead to poor birth outcomes. Perry-Brye helped found the Black Health Coalition of Greater Kenosha in 2006, which focuses on infant mortality, along with other health disparities.

Drummonds says that while racism and discrimination can help explain the high infant mortality rates in black women, it cannot be used as an excuse to say "we can't do anything about it. We have to be willing to make incremental, transformational steps, or we will be wedded to the past."

Janet Boivin, RN, is a staff writer for www.Nurse.com.

For further information on the Developing Families Center, visit www.nurse.com/article/MakeStrides. Additional information about the centering pregnancy model is available at www.centeringhealthcare.org.

To comment, e-mail editorNTL@gannetthg.com.

N.M.P.P
At a Glance

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Northern Manhattan Perinatal Partnership
Maternal Health from Womb to Tomb

In 1990, the infant mortality rate in Central Harlem was the highest in the United States. Almost 28 babies out of every 1,000 live births died before they reached the age of one, more than three times the national average. Northern Manhattan Perinatal Partnership (NMPP) was born in response to this public health crisis. Over the past 15 years, NMPP has developed a range of programs designed to improve the health of pregnant and parenting women and their children. It works with networks of hospitals, health care providers and community based organizations to reach and serve some of the City's poorest and most vulnerable women. Partly as a result of its work, northern Manhattan's infant mortality rate has been reduced by more than 80%. By 2004, its rate of 5.1 deaths per 1,000 live births was actually below the national average of 6.5. Quite a turnaround!

"We believe that every newborn has a right to live past their first birthday," says Mario Drummonds, NMPP's Executive Director.

"NMPP's mission is to save babies by helping women take charge of their reproductive, social and economic lives."

NMPP began as a vision of Dr. Georgia McMurray, New York City's first Commissioner at the Agency of Child Development. In 1991, McMurray joined the New York Urban League and launched a Healthy Start maternal health program. Healthy Start is a federal initiative designed to identify and develop community-based approaches for reducing infant mortality and improving the health and well-being of women, infants, children and their families. There are now more than 96 Healthy Start programs operating nationwide with five programs, including NMPP's Central Harlem Healthy Start, in New York State. In 1995, NMPP became its own 501c3 nonprofit corporation and Drummonds took the helm a year later.

Healthy Start provides case management and health education for pregnant women or mothers of children under the age of two. A dedicated outreach worker looks for women at high risk of poor birth outcomes through contacts with local hospitals, clinics, CBOs, churches, food pantries and shelters. The program's case managers conduct assessments of the mother's health status. Is she receiving prenatal care? Does she have health insurance; a regular physician? What is her general state of health? Does she have specific risk factors; medical conditions like obesity or diabetes? Is there an issue with substance abuse or HIV/AIDS? Does the woman have emotional or mental health challenges? Case managers also do a broader assessment looking at parenting and home making skills as well as financial and housing issues.

The case managers meet a client's needs through referrals to appropriate community services – doctors, mental health programs, food stamps, substance abuse programs, etc. "We provide parents with various incentives to go to appointments," says Segrid Renne, Director of the Healthy Start Program. "We offer food vouchers and shopping vouchers at various department stores. We also provide them with emergency pampers and formula. We have a whole array of things that pregnant women and mothers need. We can give them strollers and play pens."

The Healthy Start program has a staff of four case managers – each with a caseload of 25 women or families -- as well as a case management supervisor. "The majority of work is done by going out to the client to make sure their needs are met," says Renne. "Case managers meet with the women a minimum of twice a month and more often when needed."

The program also features a Health Educator who provides one-on-one counseling and group sessions for women on how best to care for themselves and their child. Developmental assessments of newborns are done regularly to identify any problems or concerns early on.

"A large portion of our clients are homeless," says Renne, a factor which complicates the woman's ability to access prenatal services and Healthy Start's ability to monitor her care.

Healthy Start serves over 200 women and their children each year. Women typically stay with the program for a two year period.

"HRSA (The Federal Health Resources Services Administration within the Department of Health and Human Services which administers Healthy Start) has designated us a Center of Excellence," says Drummonds. "This summer, we and six other programs will receive the award. HRSA wants to replicate our program models in other parts of the country."

Healthy Start is just one of several perinatal program models funded by either the federal or state government to address the health needs of women who are pregnant or parenting young children. There are similarities among them. They typically incorporate case management services, home visiting, health education, developmental screenings, etc. There are also some differences in eligibility criteria and service delivery. NMPP offers the full menu, targeting different programs to specific community catchment areas across northern Manhattan.

The Community Health Worker Program dates back to 1991. The program serves 200 pregnant and parenting families in East Harlem. "The idea is to work with high risk women, not only healthwise but in other ways, immigration status, homeless women, people who don't know how to navigate the system," says Maria Guevara, Director of the program. "We do outreach in our community in all places we can think of -- beauty parlors, supermarkets, churches, shelters. Most of our clients are Hispanic, new immigrants from Latin America. These populations are easy to engage. They are more needy."


Mario Drummonds

The Community Health Worker Program is funded by New York State's Department of Health. The focus is on engaging pregnant women. "75% of the caseload is supposed to be pregnant," says Guevara. Children are only served up to the age of one.

Similar to Healthy Start, Guevara's four case managers assess a client's needs and make referrals to appropriate services. "We develop an assessment and a service plan," says Guevara. "Let's say a woman is five months pregnant and not going to a doctor for prenatal care. We have to engage her in clinical services, call to make appointments, get all the documentation she needs and bring her to the clinical care provider. It is a lot of work. In the beginning, we might see her once or twice a week."

Once again, New York's shortage of affordable housing is a significant complication for women who are pregnant or have recently given birth. "We have instances where the

Northern Manhattan Perinatal Partnership's Social Health Marketing Group develops public information campaigns for government agencies.

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kids are delayed because of the environmental conditions," says Guevara. "We recently had an eight month old baby with some motor skills difficulties because she was always in the stroller. They were living in a tiny room with just space for one bed and the stroller."

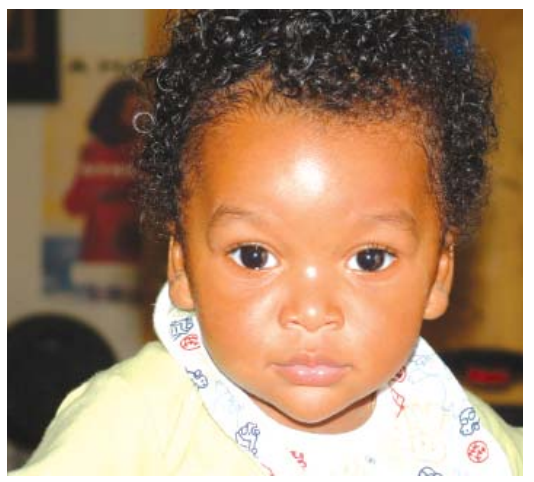
Serving families who are living doubled or tripled up can be difficult. "It is hard to provide health education and family planning counseling when you have three different families living in the same apartment," says Guevara.

The program's community-based office at 126th Street between Lexington and Park Avenues provides a base for group activities and networking. "We have enhanced the program to provide educational workshops once a week," says Guevara. "We have a support group that brings a lot of clients to the office. It has been very successful. If you only do the home visits, the women remain isolated. They need to meet other people and provide support for each other."

"BABY STEPS" is another State-funded home visiting and case management program through which NMPP serves central Harlem. Administered by the Office of Children and Families, Baby Steps is one of 28 programs across the state which utilize the Healthy Families America service model to improve maternal and child health and safety. (See "Healthy Families New York", *NYNP* March 2006.)

The SisterLink CAPC Initiative specifically targets pregnant women with HIV/AIDS who are at risk of transmitting the infection to their babies. SisterLink is different than NMPP's other perinatal programs in that it focuses on street outreach to exceptionally high-risk women and refers clients to other appropriate providers rather than offering ongoing case management services itself. (See box above.)

SisterLink



SisterLink is all about outreach. It targets pregnant women with HIV/AIDS who are at risk of transmitting the infection to their newborn children and connects them with lifesaving health and social services. "These are women who are on the edge," says Dawn Schuk, Director of the Program. "We literally take them off the streets." In 2005, the program was in contact with almost 2,000 women.

SisterLink is a CAPC (Community Action for Prenatal Care) program funded by New York State's AIDS Institute. The program functions as a network of more than 75 health and human service providers coordinated by NMPP. Outreach is done by Outreach Workers at these network organizations. They are recruited by Schuk, trained by Program Associate Mariam Husamudeen and receive a quarterly stipend for their work.

"These are people who have outreach experience. They know their areas. They go to SROs, shelters, transitional housing programs," says Schuk. "They work really hard. They go out at night to the worst of the worst places because they know that is where they are going to find their clients.

"This is not just handing out pamphlets," Schuk continues. "There is a lot of relationship building. We try to meet their most immediate needs first – food, clothing, Metrocards -- even before we start talking about the pregnancy."

SisterLink does not provide case management services itself. Rather, it refers clients to case managers at the most appropriate of its network agencies. Still, Schuk, Husamudeen and Program Liaison Nakisha Davis continue to be there for clients. "They feel comfortable," says Schuk. "They know they know us."

The Power of Partnership

While these directly provided perinatal programs are at the heart of NMPP's service mission, the agency has significantly expanded its impact through a series of network and consortia in which it plays a key role.

The NMPP's Comprehensive Prenatal-Perinatal Services Network (CPPSN) is funded by a NYSDOH to coordinate perinatal services in Northern Manhattan. "We are responsible for surveying all of Northern Manhattan and looking for gaps in care and service," says Drummonds. "We have been funded for this since the early 90s. We do a lot

NMPP continued on next page

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of training and are responsible for completing a needs assessment on a regular basis. We collaborate with all the major hospitals -- Mount Sinai, the Health and Hospitals Corporation, Presbyterian hospital and Cornell Weil."

With a budget of barely $5 million, NMPP is a CBO "David" in a land of hospital "Goliaths". Early on, however, the agency came to the conclusion that it needed to step up and work with the big boys. "We were too small an organization not to hook up with hospitals and build strategic partnerships with them," says Drummonds. "We have built several partnerships with hospitals in the City."

One of the first was its collaboration with HHC's Harlem Hospital on development of the Dr. Georgia McMurray Birthing Center. "We could see the demographic data," says Drummonds. "Women were coming into Harlem who had a history of having their children naturally. We knew that if we were going to bring these women into our care system, we had to develop a clinical infrastructure that catered to their cultural and clinical needs." NMPP helped to plan and finance the new facility which opened in 2003. "Representative Rangel gave us $400,000. Then Borough President C. Virginia Fields gave us over $1 million. Once we set up the operation it went straight to Harlem Hospital. We are not in the clinical care business," says Drummonds.

In another collaboration, NMPP partnered with New York Presbyterian Hospital to develop a second Community Health Worker Program. The hospital, which is one of the largest in the country and is based in Washington Heights, had an interest in expanding services in East Harlem. "We jointly submitted a proposal," says Drummonds. The program operated for several years before funding dried up. NMPP recently partnered with New York Presbyterian once again on a NYSDOH Office of Minority Health project designed to address diabetes conditions in Northern Manhattan and the South Bronx. "There were only two proposals funded in New York City," says Drummonds, "ours and Lutheran Medical Center in Brooklyn. This is all based on building relationships with senior leaders of the hospitals."

In several cases, NMPP has won programs which might otherwise go to significantly larger institutions. For example, after previously serving as a subcontractor to MHRA on the Healthy Start Project, NMPP won the lead agency grant for the project in 2000. New York City's other Healthy Start lead agencies are the City Health Department itself and Columbia University School of Public Health. "I felt that we as a nonprofit were strong enough to compete against the likes of Columbia and the City Health Department," says Drummonds. "We had a unique style of work and a unique population. It was a risky decision. We could have been out of the business all together."

Advocacy

NMPP has been an active advocate in the effort to expand perinatal health services in New York City. In 2001, the agency helped to launch the Citywide Coalition to End Infant Mortality. "Up until that point, most perinatal programs had been funded by the federal or state governments," says Drummonds. "There was no City tax levy dollars supporting perinatal care in New York." The Coalition brought together over 60 community-based agencies delivering maternal and child health services and went on the offensive both at City Hall and in local media. "We talked about the problem of infant mortality, not only in Central Harlem but in eight or nine neighborhoods around the city where it was very high – Brownsville, Bedford Stuyvesant, certain communities in the South Bronx," says Drummonds.

As a result, the Coalition won City Council allocations of $5 million annually beginning in FY2002. Two years ago, the allocation increased to $7.5 million and now funds 40 different perinatal providers in New York City. NMPP uses its own $300,000 allocation from the City Council to enhance its existing programs and undertake new projects.

City Council monies have helped to support NMPP's growing focus on perinatal depression and other pregnancy-related mental health issues. NYCDHMH Harlem Strategic Action Committee Social Support Subgroup All Healthy Start programs are required to do depression screening and monitor the mental health of clients. "There are biological changes that take place during pregnancy which can trigger mental health issues for women," says Drummonds. However, there are relatively few clinicians trained to assess or treat these perinatal mental health problems.

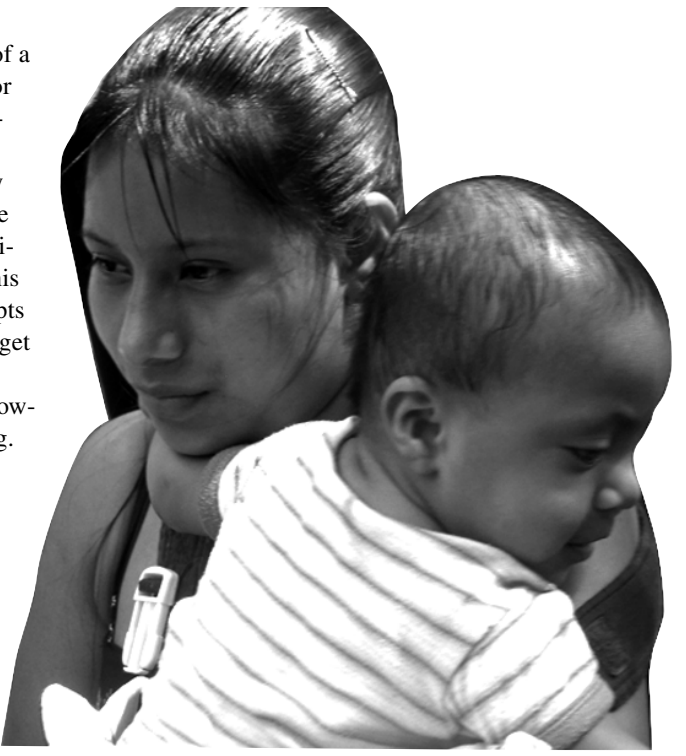
Since 2003, NMPP has participated in an initiative by the New York City Department of Health and Mental Hygiene (DHMH) to address this issue. A DHMH-funded Harlem Strategic Action Committee and its Social Support Subgroup, of which NMPP is a member, has taken several steps to strengthen the service system for women suffering with perinatal depression.

A "Grand Rounds" project has identified a panel of clinicians who are experts in perinatal depression. "Over the past three years, we have trained over 400 doctors, social workers, psychiatrists, psychologists, midwives and nurses on how to screen, diagnose and treat perinatal depression," says Drummonds. The Harlem Strategic Action Committee is also creating a complete mental health provider directory to identify clinicians trained to do this work in Northern Manhattan. "A lot of places can do screenings but they don't have the skill sets to do ongoing treatment," says Drummonds. "People don't know where to send women for treatment."

A Big Picture Look at Maternal Health

Most perinatal health programs traditionally focus on the period of pregnancy and up to a year or more in the life of the newborn baby. That is not enough, says Drummonds. "The pregnancy is only nine months. That is a very small snapshot of a woman's health history. The only way we can reduce racial disparities in birth outcomes is to manage the health of a young child from the womb to the tomb. That is the programmatic thrust here at NMPP."

Drummonds envisions a continuum of services which begins caring for mothers even before they get pregnant. "It is known as Interconceptional Care," he says. "Data shows that if we can improve the health of a mom when she is a teenager or young adult -- if we can control her weight, her diabetes, her cardiovascular issues -- by the time she gets pregnant she is going to have much healthier outcomes." As part of this trend, Healthy Start now accepts women who are planning to get pregnant.



Interconceptional Care, however, is only the beginning. "Perinatal programs need to be involved in early childhood work," says Drummonds. "We want to manage the health care of the mother and child. We want to get them enrolled in Child Health Plus. When they reach the teen years, we definitely want to talk about sexuality and health. So, by the time that the young child is ready for reproductive life we will have managed her health since before she was born."

Drummonds envisions the integration of this lifelong continuum of perinatal, early childhood and teen services as creating a Center for Infant and Women's Development.

Early Childhood Programming

NMPP has already begun putting much of this service continuum into place. In 2000, NMPP moved into the field of early childhood education when it opened a Head Start and Universal Pre-Kindergarten program in Washington Heights. "We now serve 80 families," says Drummonds.

"If we were going to have a relationship with mothers beyond the pregnancy period, we needed to get into businesses and programs where we can see the mother," says Drummonds. "One of the best ways is Head Start and UPK."

NMPP attempts to integrate its perinatal and maternal health services into the early childhood programs. "We take our staff to Washington Heights and meet with parents in the classrooms," he says. "Our Asthma program staff help them to prepare asthma action plans. When a parent gets pregnant again, the Head Start Family Worker makes a referral to Healthy Start."

Drummonds acknowledges that making the transition into Early Childhood Education hasn't been easy. "We have some weaknesses and we have some strengths," he says. "We want to turn our weaknesses into strengths in terms of how we deliver Head Start services." NMPP has applied for an expansion of its Head Start program.

Even more importantly from a continuum of care standpoint is NMPP's application to the federal government for an Early Head Start program which would serve children from 0-3 and would fill the missing link in NMPP's services. "We want to complete the cycle," says Drummonds.

Teen Services

NMPP currently has two programs which serve young women during their teenage years. An Abstinence Program recently funded by the NYS DOH works with girls during the pre-teens and young teenagers. "We want to go for young children who have not yet been influenced by the youth culture," says Drummonds. "It is controversial. There is debate about whether abstinence works. Here at NMPP we are open to looking at all models of intervention."

The agency also operates a Club Moms program, funded by the State's Office of Children and Family Services (OCFS), which works with pregnant or parenting teens.

"We try to prevent the next pregnancy by getting the mom back into the educational system and establishing a better relationship between the teen mom and her own mother and family," says Drummonds.

Saint Nicholas Family Life Support Network

NMPP has also broadened its programmatic focus with the Saint Nicholas Family Life Support Network, an Administration for Children's Services-funded foster care prevention program which targets the 14-building, 5,000-resident, St. Nicholas Housing Development in Central Harlem.

"We use a public health approach," says Drummonds. "We started out by going door to door to find women who were having problems managing the care of their children. Many doors were slammed in our faces. But, we continued to make efforts to reach those families and find out what their needs are." While the NMPP program does take ACS referrals from the broader Harlem community, its micro involvement with the St. Nicholas Housing Development appears to be in close harmony with ACS' evolving community initiatives strategy.

Looking Ahead

Drummonds has seen NMPP's budget grow by a factor of five since coming to the agency ten years ago. Its first two programs have grown to become 18. "I don't know if we want to grow any further at this time unless it fits into our mission and programmatic thrust," he explains. "Everything we have fits into our orbit, that perinatal health pipeline that follows a woman throughout her life."

Northern Manhattan Perinatal Partnership

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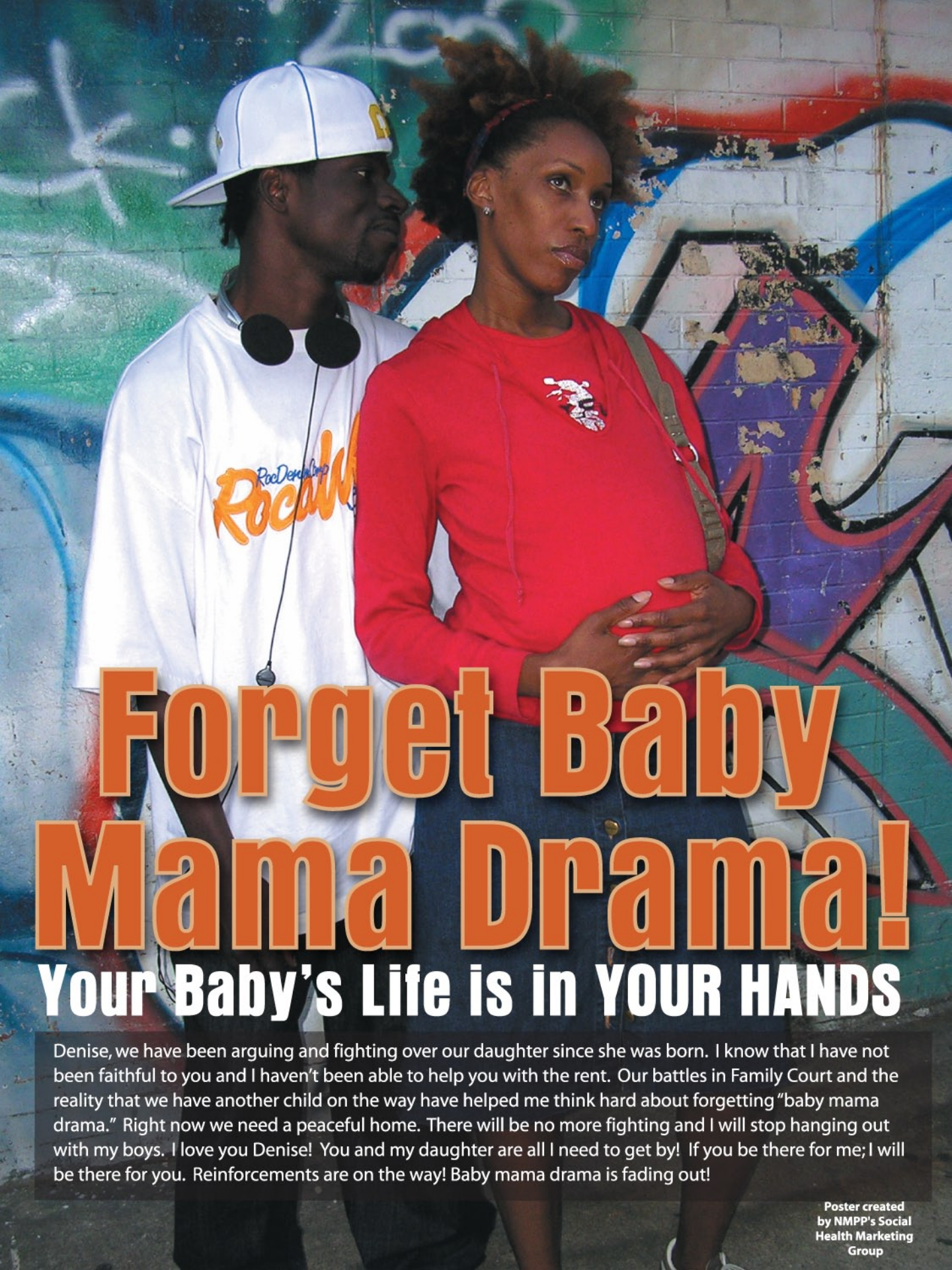

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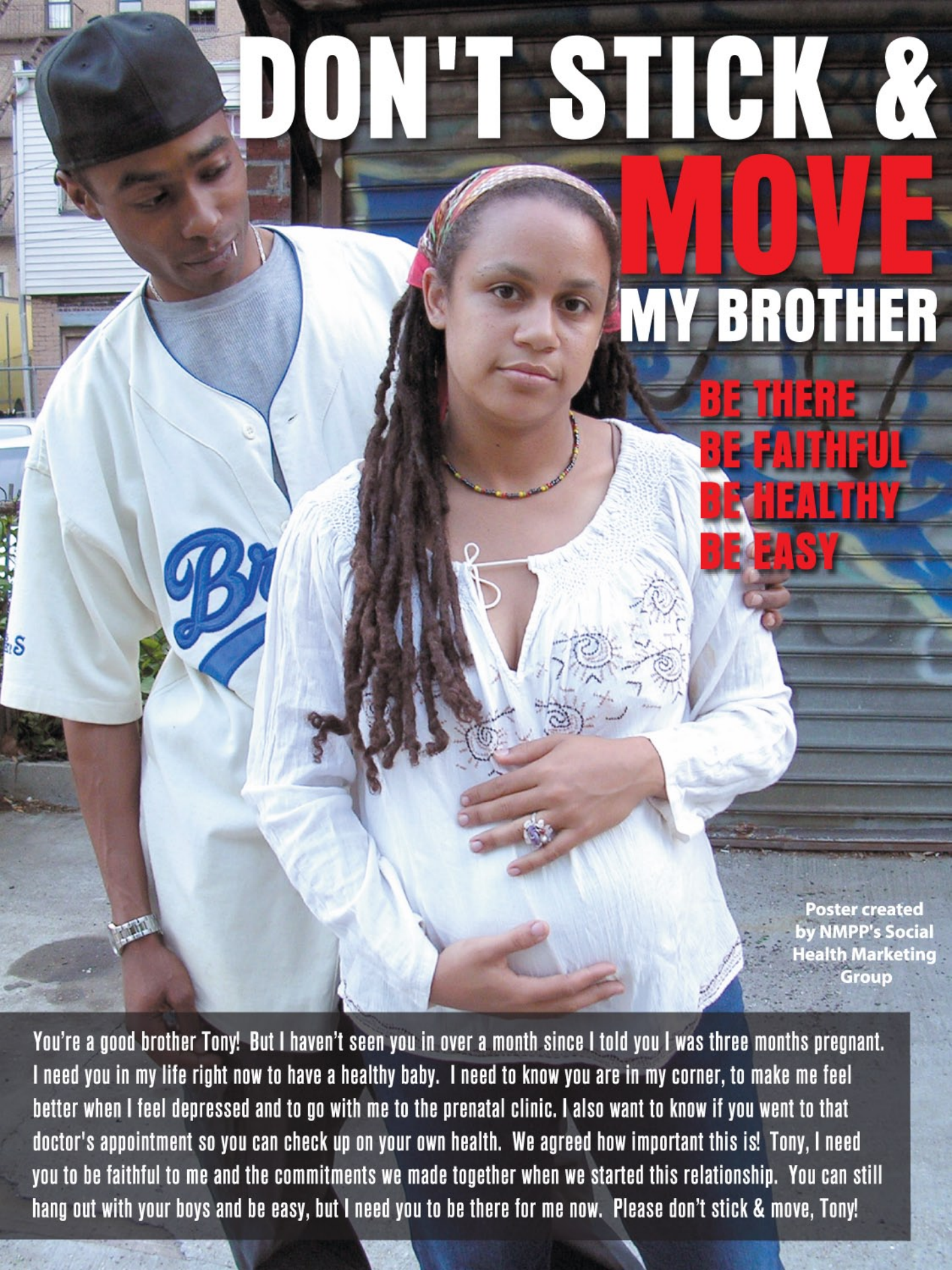
Poster created by NMPP's Social Health Marketing Group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BE FAITHFUL
BE HEALTHY
BE EASY
Poster created by NMPP's Social Health Marketing Group
You're a good brother Tony! But I haven't seen you in over a month since I told you I was three months pregnant. I need you in my life right now to have a healthy baby. I need to know you are in my corner, to make me feel better when I feel depressed and to go with me to the prenatal clinic. I also want to know if you went to that doctor's appointment so you can check up on your own health. We agreed how important this is! Tony, I need you to be faithful to me and the commitments we made together when we started this relationship. You can still hang out with your boys and be easy, but I need you to be there for me now. Please don't stick & move, Tony!

time to register your child now!

The Center for Preschool and Family Learning
Head Start/Universal Pre-K II

Half Day Head Start
531 West 155th Street
New York, New York 10032

(212) 926 8264

FREE!

The Center for Preschool and Family Learning Head Start takes pride in the services we provide to our children and their families. We offer a high quality early childhood learning program to children ages three to five years old, and social services support for the families if needed.

Our classrooms are staffed with a group teacher and two assistant teachers. We strongly encourage parents to be involved in their child's Head Start experience. Our parents volunteer on a weekly basis in class-rooms, on trips and for parent meetings.

Registering Children born in the year	
2005	**Head Start**
Head Start Sessions	
Morning	**8:30 am - 11:30 am**
Afternoon	**1:00 pm - 4:00 pm**

- Dental and Mental Health Services
- Speech and Hearing Testing
- Individualized Teaching Program
- Mandatory Parent Involvement
- Services for Children with Special Needs
- Snacks and Meals Provided

Sponsored by Northern Manhattan Perinatal Partnership, Inc.
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NYCDOH's Harlem Strategic Action Committee
NMPP's Harlem Maternal Mental Health Training Institute

Grand Rounds Series 2007

Wednesday April 4, 2007
1:00 - 2:00 pm (EST)

"PSYCHIATRIC DISORDERS DURING PREGNANCY & THE POST-PARTUM PERIOD."

This online program is being presented by NYCDOH's Harlem Strategic Action Committee and Northern Manhattan Perinatal Partnership's Maternal Mental Health Training Institute with the services of Clinical Directors Network Inc., CDN.

Online Training Presented by

Margaret Spinelli, MD

Associate Professor of Clinical Psychiatry
Columbia University College of Physicians & Surgeons

Webcasting for Clinicians

Application for CME has been filed with the American Academy of Family Physicians for up to 1 prescribed credit.
Determination of Credit is Pending

To Register for this event, please visit www.CDNetwork.org, click on "Upcoming Webcasts" title of the event and follow the directions.

Click this link to register!

http://guest.cvent.com/i.aspx?1Q,M3,30c2cab3-7b35-4df9-8f10-9498c860df39

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Northern Manhattan Perinatal Partnership (NMPP) & the Harlem Strategic Action Committee

Presents:

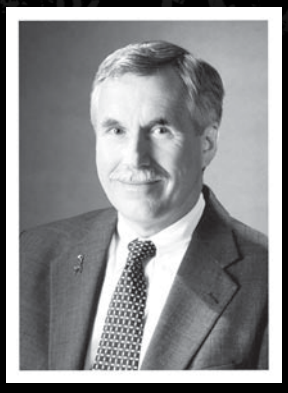
Proposing Solutions to the Maternal Mental Health Capacity and Financing Issues Webcast

June 5, 2008 • 1:00 PM to 2:00 PM EST

Featured Panelists:

Dr. Sherry A. Glied

Department Chair, Health Policy and Management, Mailman School of Public Health, Senior Economist for Healthcare and Labor Market Policy to the President's Council of Economic Advisors, under both President Bush and President Clinton. Co-Author of the 2006 book: Mental Health Policy in the United States since 1950,Better But Not Well



Dr. Michael Hogan

Commissioner, New York State Office of Mental Health. Dr. Hogan served as Director of the Ohio Department of Mental Health from 1991 to 2007 where he led Ohio to the top ranking in the 2006 rating of state mental health systems by the National Alliance on Mental Illness (NAMI). In 2002 Dr. Hogan received the Distinguished Service to State Government Award from the National Governors' Association and the Distinguished Service Award from The National Alliance for the Mentally Ill.

Moderator of Web Cast:

Mario Drummonds, MS, LCSW, MBA
Chairperson, Social Support Workgroup
Director of NMPP's Harlem Maternal Mental Health Training Institute

For more information contact: Mario Drummonds at (347) 489-4769

To Register for this event, please visit www.CDNetwork.org, click on "Upcoming Webcasts" title of the event and follow the directions or click the link below:

http://web.memberclicks.com/mc/community/eventdetails.do?eventId=168991&orgId=cne

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A New Group Talk Session

CLUB MOM

For all teens who are pregnant or have a child under two years of age and live in the following zipcodes:

10026, 10027, 10029, 10030, 10031
10035, 10037 & 10039

JOIN US

We Talk About:

Relationships	**Infant Nutrition**
Family	**Education & Careers**
Marriage	**Money**
Birth Control	**Parenting Issues**
Child Support Schools	**& More!**

All participants are given a Free Metrocard and Gifts!

Meetings Held At:
Northern Manhattan Perinatal Partnership
127 West 127th Street
(Between Lenox and 7th Ave.)
New York, NY 10027

For More Information Call Ajuwa Simpson at 212 665-2600 x317

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Northern Manhattan Perinatal Partnership, Inc.

Practice Matters LLC

Invest in Our Ideas … Practice Matters Returns Results!

Plan

Anticipate, Analyze, Execute … Results … Learn

Practice Matters, LLC is a full-service management consulting firm dedicated to meeting the strategic, marketing and organizational development needs of maternal and child health private and governmental agencies. We assist agencies who seek to innovate and become game changers by reinventing their policy, program and practice approaches to serving the needs of mothers and babies.

NMPP decided to start-up Practice Matters because a multitude of consulting assignments were offered to NMPP by HRSA/MCHB starting in 2006 due to our ability to reduce infant mortality in Harlem from 27.7 deaths per one thousand live births in 1990 to 5.1 deaths by 2004. HRSA/MCHB in 2006 designated NMPP a "Center of Excellence" in delivering maternal and child health services and requested that NMPP replicate our model in various cities and small towns across America.

The firm started-up on December 15, 2007 and has a cadre of consultants who have professional, theoretical and day-to-day experience providing solutions to a variety of programmatic, strategic and fiscal challenges social service and healthcare agencies face daily. The practice specializes in retooling marketing, health education and case management systems. The firm has several clients who are health departments in the states of Wisconsin, Nebraska, Texas, Illinois, Florida and California.

Specific Core Competencies:

- Developed a Proven Strategy & Tactics to Reduce Infant Mortality in Large Cities and Rural Areas
- Outcome Case Management Theory & Practice
- Developed a Unique Point of View to Professionalize MCH Outreach Tactics by Utilizing Private Sector Marketing Techniques
- Since 1997, Developed the Social Health Marketing Group that has over Twelve Years of Practice Developing Ground Breaking Marketing Campaigns for Diverse Customer Segments
- Leader in Connecting Social Movement Theory and Community Mobilization Tactics to Develop Public Health Social Movements to Reduce Racial Disparities in Birth Outcomes
- Taking our Lessons Learned in NYC by Integrating Child Welfare/MCH/Early Childhood Systems of Care in Wisconsin, Illinois, Nebraska & Texas
- Developed the Concept of the "MCH Life Course Organization to Operationalize Dr. Michael Lu's Life Course Theory. Assisting clients across the country to build this new type of organization in their town
- Possess Core Competencies in the Areas of Reproductive Psychiatry/Social Support Theory & Practice
- Coach Agencies to Develop MCH Economic Development Strategies
- Sustainability As Organizational Development: Diversifying Funding Streams
- Consumer Development & Leadership Training
- Leadership & Management Studies

While theory, strategy and policy formation are essential, practice matters!

To learn more about Practice Matters and find out how you can transform your organizational problems into solutions, contact **Mario Drummonds, MS, LCSW, MBA** at **347-489-4769.**