



Syracuse Healthy Start Newsletter

September 2005 Edition 9

Syracuse Healthy Start At a Glance

- Term: refunded for years 2005-2009
- Grantee: Onondaga County Health Department
- Goal: eliminate disparities in perinatal health
- Project area: City of Syracuse
- Target population: pregnant and/or parenting women with children under the age of 2
- Components:
 - Outreach
 - Case Management/Care Coordination
 - Health Education
 - Consortium
 - Addressing depression during the perinatal period
 - Interconceptional Care
- Objectives:
 - conduct intensive outreach to minority women, and women with high risk, to better link them with health and human services;
 - provide integrated case management services to enhance the care coordination, intervention for identified risks, and cultural competence of the services
 - increase provider competence in addressing multifaceted risks faced by participants
 - empower consumers with information
- Commissioner of Health and Principal Investigator: Cynthia Morrow, MD
- Syracuse Healthy Start Interim Project Director: Jean Reilly, CSW
- Syracuse Healthy Start Hotline: 435-2000

Roshana Daniel
Public Health Fellow, Syracuse Healthy Start
Brenda Paul, MPH, MSW
Director Syracuse Healthy Start,
September 2002 - January 2005
Richard H. Aubry, MD, MPH
Obstetrical Advisor, Syracuse Healthy Start
Mary Jensen, MSW

- In collaboration with:
- Onondaga County Health Department
 - Upstate Medical University Center for Maternal and Child Health

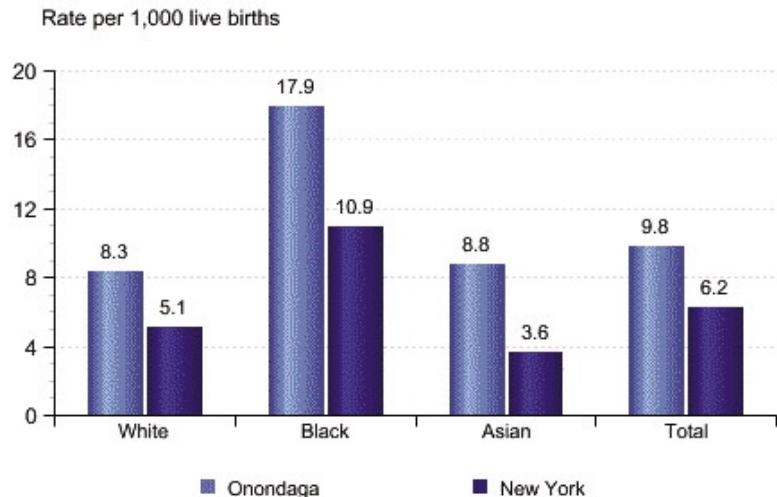
From September 2003 through September 2004, Syracuse Healthy Start of the Onondaga County Health Department hosted *The Elimination of Health Status Disparities Speaker Series*. The goals of the Speaker Series were to: enhance equity in perinatal health among all racial/ethnic subgroups; mobilize community members at all levels to own the persistent gaps in MCH outcomes among racial/ethnic subgroups; provide education to community members at grassroots and professional levels; and engage in community planning with partners committed to broad-based systems change to provide equity to all.

Of all the forms of inequality, injustice in health care is the most shocking and inhumane"

- Dr. Martin Luther King, Jr.

All presenters are recognized experts in areas of maternal and child health (MCH) and/or healthcare disparities. As shown in the graphs below, the disparities in infant mortality here in Onondaga County are notable and worthy of discussion as well as action. This newsletter provides a brief synopsis of each of the presentations.

Infant mortality rates by race: Onondaga and New York State, 1999-2001 Average



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- During 1999-2001 (average), the infant mortality rate (per 1,000 live births) in Onondaga was highest for black infants (17.9), followed by Asians (8.8) and whites (8.3).
- Black infants (17.9) were about 2 times as likely as white infants (8.3) to die during the first year of life during 1999-2001 (average).

Source : National Center for Health Statistics, period linked birth/infant death data. Retrieved March 28, 2005, from www.marchofdimes.com/peristats.



Michael C. Lu, MD, MPH

*Assistant Professor of Obstetrics & Gynecology
UCLA School of Medicine*

Dr. Lu’s research focuses on racial-ethnic disparities in birth outcomes. He discussed our moral responsibility as a nation and as a locality to bring equity to all segments of our society. Dr. Lu noted that “disparities in birth outcomes result from harmful differential exposures

to the physical and social environments over the **life course.**” He described how “social inequality prematurely ‘weathers’ populations and impacts health status through young and middle adulthood.” (Weathering Hypothesis – Geronimus AT 1996.) Finally, Dr. Lu maintained that “the cumulative effects of a life of disadvantage cannot be erased or overcome by nine months of good prenatal care.” However, Dr. Lu ended his presentation on a positive note. He suggested that our community could unite and establish “green spaces” (small park-like settings or community gardens) in poor neighborhoods, as well as, develop and implement a list of “101 Acts of Kindness Toward Pregnant Women.”

While it is true that other US racial and ethnic minorities have suffered economic and social discrimination, few, if any, have faced these exposures for as long as have African Americans, nor have they faced them standing on an economic and cultural base that was systematically undermined by the larger society. *James (1993)*

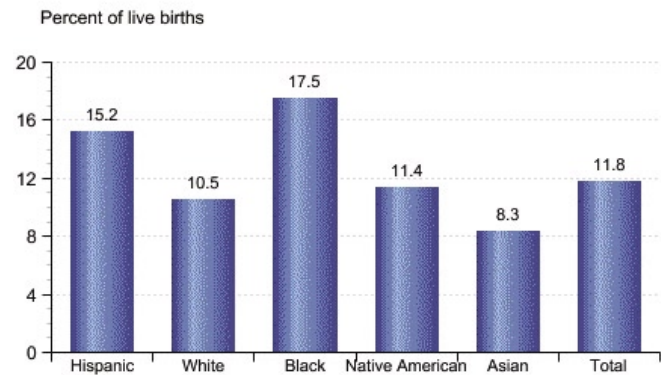


Vijaya K. Hogan, MPH, DrPH

*Clinical Associate Professor
UNC-Chapel Hill, School of Public Health and School of Medicine*

Dr. Hogan’s presentation was entitled “Disparities in Preterm Birth: How Current Trends in Risk, Diagnosis, and Treatment of Bacterial Vaginosis Contribute.” Here she demonstrated the implications of Bacterial Vaginosis (BV) in health status disparities between African American and Caucasian women. She spoke of the importance for providers to screen for and treat BV in all pregnant women. She noted that BV, as well as, low pregnancy weight, a history of infertility problems, previous preterm delivery, and/or low socioeconomic status (SES) are implicated in preterm delivery. Dr. Hogan identified research strategies in the area of BV to better understand the impact of behavioral interventions during pregnancy for different groups of women and to assess their long-term value in prevention. She stressed that behavioral and social interventions offer great promise to reduce morbidity and mortality.

Preterm Birth by race/ethnicity: Onondaga, 2000-2002 Average



- During 2000-2002 (average) in Onondaga, the Preterm birth rate was highest for black infants (17.5%), followed by Hispanics (15.2%), Native Americans (11.4%), whites (10.5%) and Asians (8.3%).
- Black infants (17.5%) were about 2 times as likely as Asian infants (8.3%) to be born Preterm during 2000-2002 (average).
- In the United States, Prematurity /low birthweight is the second leading cause of all infant deaths (during the first year of life) and the leading cause of infant death among black infants.

Source National Center for Health Statistics, final natality data. Retrieved March 30, 2005, from www.marchofdimes.com/peristats.



Karla Damus, MSPH, PhD, RN

*Associate Professor of Obstetrics & Gynecology
Director of Community Programs in Women’s Health, Albert Einstein College of Medicine*

Dr. Damus discussed the March of Dimes’ National Prematurity Campaign and heralded a local call to action. She noted several contributing factors that can result in health care disparities including neighborhood violence; food insecurity; housing instability;

lack of transportation; use of the ER for primary care. She suggested that the health care delivery system could make some relatively simple changes to aid in the elimination of disparities: 1. Use of the Healthy Start Registry as a tool for real-time identification of elevated risks. 2. In-hospital identification of low birth weight (LBW). 3. Improve Interconceptional Care, for example, make the first postpartum visit more comprehensive. In addition, she suggested that women with medical histories that include LBW, smoking, short interpartum spacing, vaginal infections/STI’s, and obesity should be targeted for additional medical interventions. She ended by suggesting that providers also consider and remove potential barriers to care such as: hours of operation, scheduling of appointments, transportation, language, and the atmosphere in the waiting room.



Thomas LaVeist, Ph.D.

*Founding Director, Morgan-Hopkins Center for Health Disparities Solutions
Johns Hopkins University*

Dr. LaVeist's presentation on "Racial Disparities and the Role of Trust in Healthcare," focused on the importance of the issue of trust and its impact on the patient – provider relationship. He reminded medical professionals that patients are "inherently

vulnerable within medical encounters." He asked them to consider the fact that "the consequences of this encounter are far greater for the patient, that the patient usually has less knowledge about the situation, and the patient may also need to rely on multiple institutions and providers for assistance." He pointed out that the patient must believe the providers are competent and that they are acting in the patient's best interest. Dr. LaVeist cited research that indicated men, minorities, and highly educated people tend to be less trustful of medical providers. He noted that this is a very important issue given that a patient's behavior such as compliance, use of health services, and willingness to sue, are all related to their level of trust.

In addition to the above, Dr. LaVeist provided information from several areas that he has researched. Early in his career, he was part of a study that looked at disproportionate levels of alcohol advertisements in black neighborhoods. This is a complex issue due to the "dependence of many organizations on donations from alcohol and tobacco industries." He concluded, "quality of life issues cannot be disentangled from the issues of health, wealth and education." Something as simple as the lack of fresh produce in corner stores can effect the health of neighborhood residents. Dr. LaVeist suggested that public health departments need to take "lessons from the alcohol and tobacco industries," in the area of marketing strategies. The public health messages should "appeal to" rather than "nag" the population.



Brian Smedley, Ph.D.

*Division of Health Sciences Policy
Institute of Medicine of the National Academies*

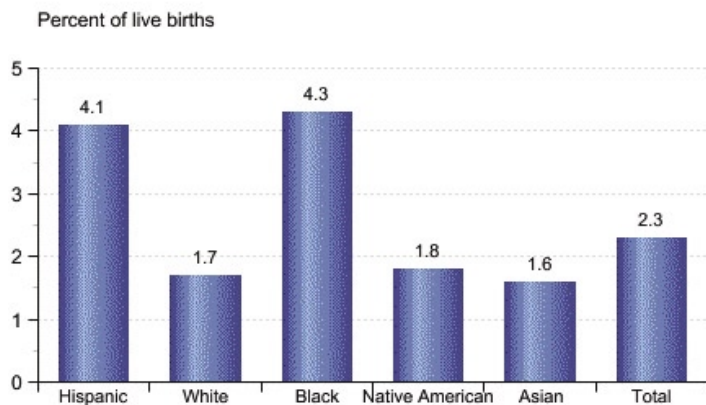
Dr. Smedley is a Senior Program Officer in the Division of Health Sciences Policy of the Institute of Medicine (IOM), where he most recently served as Study Director for the IOM report, **Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.**

Dr. Smedley's presentation provided some insight into the IOM report findings of "persistent disparity in healthcare diagnosis and treatment among minority populations." The report notes that "minorities receive a lower level of health care, even when access is available." He discussed the IOM's recommendations including: education about the existence of disparities to providers, patients, payors, health plan purchasers, and the general public; improved access to care through provision of interpretation services; increased participation of underrepresented minorities in the healthcare workforce; and finally, the development of economic incentives for practices that improve provider-patient communication and trust.

A broad and intensive strategy to address social-economic inequality, concentrated poverty, inequitable and segregated housing and education...individual risk behaviors as well as disparate access to medical care is needed to seriously address racial and ethnic disparities in health status" IOM: Unequal Treatment p 35-6

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Very Preterm birth by race/ethnicity: Onondaga, 2000-2002 Average



- During 2000-2002 (average), the very preterm birth rate in Onondaga was highest for black infants (4.3%), followed by Hispanics (4.1%), Native Americans (1.8%), whites (1.7%) and Asians (1.6%).
- Black infants (4.3%) were about 3 times as likely as Asian infants (1.6%) to be born very preterm during 2000-2002 (average). Very premature babies who survive may suffer lifelong consequences, including cerebral palsy, blindness and other chronic conditions.

National Center for Health Statistics, final natality data. • Retrieved March 30, 2005, from www.marchofdimes.com/peristats.



Camara Jones, MD, MPH, Ph.D.

Dr. Jones is Research Director on Social Determinants of Health in the Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Dr. Jones is a family physician and epidemiologist whose work focuses on the impact of racism on the health and well being of the nation. Her presentation highlighted the impact of racism and, in particular, the “lost potential to the nation and the world” as a result of this disparity (discriminatory

treatment). She provided an outline of solutions to this problem including: “naming racism,” joining grassroots organizations, and creating structural changes to eliminate intergenerational poverty (e.g. funding primary education equitably).”

Please see the insert for a published work in which Dr. Jones uses the image of two flower boxes to illustrate the three levels of racism that she discussed.

For more information about the series, any of the speakers, or presentations, please contact SHS at 435-2000.