



NJ Council for Young Children (NJCYC) – Infant-Child Health Committee (IHC)

- ◆ NJ Early Childhood Comprehensive Systems/Help Me Grow (ECCS/HMG)
- ◆ NJ Project LAUNCH (NJPL) Statewide Meeting
- ◆ Home Visiting (HV) Workgroup
- ◆ Infant Early Childhood Mental Health
- ◆ Services for Children with Special Needs

Agenda - Wednesday, March 18, 2015, 9am-12:30pm

Location: The DCF Professional Center 30 Van Dyke Ave. New Brunswick, NJ 08901, RM. 103

Conference Line #: (877) 336-1829, Access code: 9852163

Committee Purpose: To ensure a comprehensive system of care that supports the health & wellness of pregnant women, infants & young children, and their parents/families.

Agenda

- 9:00am** **Arrival, Networking, Information/Sharing Table, Refreshments**
- 9:30am** **Welcome and Introductions** – Ericka Williams and Sunday Gustin, Chair and Co-Chair
- 9:45am** **Recap IHC Priorities, Strategic Goals– Review of IHC Identified Barriers/Gaps – Next Steps -Ericka**
- 10:00am** **Updates on NJ Project Launch Partnership Survey-subgroup findings-** Kristen Ojo/Constance Mercer- JHU, (NJPL) Evaluator
- 10:15am** **DCPP/FCP Essex County Project** – Sunday Gustin
- 10:30am** **Presentations: Healthy Start Grantees**
- ❖ Newark Community Health Centers, Newark –Ava Rose
 - ❖ Partnership for Maternal and Child Health of Northern New Jersey, Newark Shazia Aslam
- 11:10am** **Break**
- 11:20am** **Presentations continued...**
- ❖ Southern New Jersey Perinatal, Pennsauken – Diane Brown
 - ❖ Children’s Futures, Trenton – June Gray
- 12:00pm** **Partner Announcements/Updates: (Brief- 2 minutes each)**
- ECCS/HMG – Ericka Williams
 - Central Intake updates- Anna Preiss
 - NJ PL- Andrea O’Neal/Karen Benjamin
 - Pyramid Model – Tonya Coston
 - Infant Early Childhood Mental Health (IECMH) – Gerry Costa/Kaitlin
 - Home Visiting (HV) - Maura Somers-Dughi/Lenore Scott
 - Services for children with Special Needs:
 - State Services--Early Intervention, Special Child Health Services, Preschool Special Education (Terry Harrison/Barbara Tkach)
 - Statewide Parent Advocacy Network (SPAN)-Community of Care Consortium - Malia Corde/Diana Autin
 - Map to Inclusive Care –Sandy Sheard
 - Any other partner updates
- 12:30pm** Meeting Adjourned

*** Next Meeting: June 17, 2015, 9am - DCF Professional Center 30 Van Dyke Ave. New Brunswick, NJ**

The NJCYC Infant-Child Health Committee is affiliated with:



Infant Child Health Committee (IHC) of the NJ Council for Young Children (NJCYC)

Strategic Plan 2014 – 2015 (Working Document)

Goal 1: Share Information to strengthen coordination of direct services that improve pregnancy outcomes and promote healthy infant child growth and development.

General Strategy: Information Sharing and Messaging

Priority Area (s):	Activities/Task	Barriers/Gaps	Stakeholders Responsible	Time Frame
<p>#1: Family/Child Health Wellness</p> <ul style="list-style-type: none"> • Pre-conception • Prenatal • Infant-Toddler • Young Child • School Age • Parent/Caregiver <p>#2: Infant & Early Childhood Mental Health (IECMH)</p> <ul style="list-style-type: none"> • Healthy attachments/relationships <p>#3: Children and Families with Special Needs</p> <ul style="list-style-type: none"> • Early Intervention (EI) • Special Child Health Services • Special Education • SPAN (Community of Care) • MAP to Inclusive Childcare 	<p>Develop strategies for ongoing information sharing a cross sectors, agencies, departments and programs at the state and local level.</p> <p>IHC Meetings – Information Sharing</p> <ul style="list-style-type: none"> • Cross-sector updates & presentations • Health & Wellness Newsletter? Target audience? • Identify topics in target age groups/categories • Establish an “editorial board” to select/approve materials <p>Explore use of technology to promote health and wellness</p> <ul style="list-style-type: none"> • Well view System, Text for Baby, Let’s Play (Zero to 3), etc. • Links to websites – NJCYC, NJ Parent Link, Grow NJ Kids <p>Increase public (parents and professionals) awareness about early brain development and social-emotional health</p> <ul style="list-style-type: none"> • Keeping Babies & Children in Mind (KBCM) • Strengthening Families Protective Factors • IMH Endorsement • Pyramid Model – pilot in Essex County?? (LAUNCH) • IECMH Consultation – pilot in Essex County?? (LAUNCH) <p>Widely promote prevention, early identification, early intervention</p> <ul style="list-style-type: none"> • Work with existing partners to educate constituents and align messages—EI, SCHS 	<p>Time Cost?</p> <p>Expertise, Time, Cost?</p>	<p>IHC Chair(s) and Partners</p>	<p>Meeting since March 2014 – Qtrly. Mtgs. 2015</p> <p>Well view exploration begin June 2014 – June 2015</p>
<p>Important Considerations:</p>	<ul style="list-style-type: none"> • Keep a cross-sector focus – Health, Nutrition/WIC, Home Visiting, EBPs, Early Head Start/Head Start, Childcare, Family Child Care, Education, EI, Special Needs, Child Behavioral Health, Child Welfare, Social Services, and Family Support (e.g. Family Success Centers), etc. • Include parents as partners in developing and delivering messages • Pay attention to literacy levels; Ensure diversity – cultural (broadly defined) and language 			
<p>Alignment:</p>	<p>Align tasks with other groups and committees, e.g. NJCYC Family & Community Engagement, Grow NJ Kids, etc.</p>			
<p>Accomplishments:</p>				

Goal 2: Continue to build state and local partnerships to strengthen integration, and align related early childhood priorities.

General Strategy: Systems Infrastructure / Service Integration

Priority Area (s):	Activities/Task	Barriers/Gaps	Stakeholders Responsible	Time Frame
<p>#1: Family/Child Health Wellness</p> <ul style="list-style-type: none"> • ECCS/Help Me Grow • Project LAUNCH • County Central Intake Systems • County Council for Young Children <p>#2: Infant & Early Childhood Mental Health (IECMH)</p> <ul style="list-style-type: none"> • NJ Association for IMH • Pyramid Model Workgroup <p>#3: Children and Families with Special Needs</p> <ul style="list-style-type: none"> • Early Intervention (EI) • Special Child Health Services • Special Education • SPAN (Community of Care) • MAP to Inclusive Childcare • Early Head Start/Head Start 	<p>Development of an integrated EC system of care that connects children and their families with needed services.</p> <p>Continue to identify EC partners to connect/collaborate and integrate services with, at the state and local level.</p> <p>Infant Child Health Committee –state and local partners- cross sector, parents/families, collaboration, integration, information sharing, planning and recommending strategies to support EC systems integration.</p> <p>Physician Health Provider, Linking Protocol Workgroup (WG), (SPAN) Early and Continuous Screening and Medical Home WG Improve systems connections for children and families with health care providers (medical home/neighborhood), community services, early intervention, child care, home visiting etc.</p> <ul style="list-style-type: none"> •Expand screening (prenatal & child development) in health care, and early care & education settings. •Increase access & linkages to EC information, referral, services and consultation •Improve quality & availability of EC services • Develop Part C guidance for providing IDEA services within the Routines in an Inclusive Community Setting <p>Central Phone Line workgroup – fact finding, planning and implementation for a statewide early childhood central phone line</p> <p>State Central Telephone Line (HMG Line) that links families to local CI systems as a single point of entry to provide easy access for information, referral, assessment, and further consultation.</p> <p>Local County Councils – parent and community provider council, identify needs, gaps, barriers and strategies to problem solve at the county level.</p> <p>Central Intake (CI): county-level systems to support local service linkages across sectors—health providers, Early Intervention (EI), Home Visiting (HV), Early Head Start (EHS), Child Care Centers, Family Childcare, Preschools; IECMH, Family Support; and with parents and families.</p>		<p>ICHC</p> <p>Physician/Linking Workgroups SPAN –COCC Early and Continuous Screening and Medical Home</p> <p>Phone Line workgroup</p> <p>DOH/DCF/DOE IPO (Improving Pregnancy Outcomes) Central Intake Community Health Workers Project LAUNCH Workgroups</p>	<p>Meeting since March 2014 – Qtrly. Mtgs. 2015</p> <p>Began work March 2013 – ongoing</p> <p>Began work March 2013 – December 2015 (<i>until state EC PL implemented</i>)</p> <p>Funded Nov. 2014 – implementing 2015</p> <p>Funded 2013 – Begin implementing in 2014. 6 additional sites to be expanded by RTT funds in 2015.</p>
Important Considerations:	<ul style="list-style-type: none"> • Keep a cross-sector focus – Health, Nutrition/WIC, Home Visiting, EBPs, Early Head Start/Head Start, Childcare, Family Child Care, Education, EI, Special Needs, Child Behavioral Health, Child Welfare, Social Services, and Family Support (e.g. Family Success Centers), etc. • Include parents as partners in systems planning and development. Share information that will be relevant to parent’s needs, issues and concerns • Pay attention to literacy levels; Ensure diversity – cultural (broadly defined) and language 			
Alignment:	Align tasks with other groups and committees, e.g. NJCYC Family & Community Engagement, Grow NJ Kids, CAB’s, County Councils, etc.			
Accomplishments:				

Goal 3: Improve access to information regarding child health/wellness education and resources for parents, families, pregnant women and children.

General Strategy: Access to Care

Priority Area (s):	Activities/Task	Barriers/Gaps	Stakeholders Responsible	Time Frame
<p>#1: Family Child Health Wellness</p> <ul style="list-style-type: none"> • Primary care/medical home • prenatal care • dental care • health insurance • early care education • home visiting • WIC • Early Intervention (EI) • social services <p># 2 Infant Early Childhood Mental Health</p> <ul style="list-style-type: none"> • Early care settings • EHS/HS • Home Visiting <p>#3 Children/Families with Special Needs</p> <ul style="list-style-type: none"> • Early Intervention (EI) • Special Child Health Services • Special Education • SPAN (Community of Care) • MAP to Inclusive Childcare • Early Head Start/Head Start 	<p>Provide input/feedback for strategies that will help to improve systems linkages and access to care for families and children at the local level.</p> <p>Statewide Early childhood Phone line – to link to county level Central Intake (CI) system. State Central Telephone Line (HMG Line) that links families to local CI systems as a single point of entry to provide easy access for information, referral, assessment, and further consultation.</p> <p>Development of state wide Central Intake (CI) system-county level access to services. DOH, DCF and DOE alignment Local CI hubs for direct access to local prenatal/parent and early childhood services & supports.</p> <p>Improving Pregnancy Outcomes (IPO) - Community Health Workers – increase access to care with hard to reach populations. Link in with local level CI hub for additional linkage and tracking.</p> <p>County Councils: that bring parents/families and providers together to learn about available services and supports, identify issues/concerns, and solve problems.</p> <p>NJ’s Early Intervention System (EIS)- linkage for early intervention evaluation for children with developmental concerns and/or delays.</p>		<p>ICHC Partners</p> <p>DCF/ECCS/HMG</p> <p>DOH/DCF/DOE</p> <p>DOH and Local Grantees</p> <p>DCF and local grantees</p> <p>DOH</p>	<p>Quarterly ICHC mtgs.</p> <p>In planning process – EC Phone line December 2015</p> <p>In Process – 15 counties 6 counties to be added -2015</p> <p>Ongoing</p>
<p>Important Considerations:</p>	<ul style="list-style-type: none"> • Keep a cross-sector focus – Health, Nutrition/WIC, Home Visiting, EBPs, Early Head Start/Head Start, Childcare, Family Child Care, Education, EI, Special Needs, Child Behavioral Health, Child Welfare, Social Services, and Family Support (e.g. Family Success Centers), etc. • Include parents as partners in improving strategies to provide better access to care. • Pay attention to how parents access care and strategies that support their needs.; Ensure diversity – cultural (broadly defined) and linguistics 			
<p>Alignment:</p>	<p>Alignment of existing service providers, phone lines and services.</p>			
<p>Accomplishments:</p>				

Goal 4: Strengthen education and training related to health and wellness for early childhood professionals

General Strategy: Education and Training (Workforce Development)

Priority Area (s):	Activities/Task	Barriers/Gaps	Stakeholders Responsible	Time Frame
<p>#1: Family/Child Health & Wellness</p> <ul style="list-style-type: none"> • <u>Health</u> - Physician Practices, Medical Education, Nursing, Public Health, Health Educators • <u>Early Care</u> - Home Visiting (HV), Infant/Toddler Centers, Parent Linking Program (PLP), Project TEACH, and other EBPs (Active Parenting, Incredible Years, Circle of Security, Zippy's Friends) • <u>Early Learning</u> - Grow NJ Kids (GNJK), EHS/HS, Child Care Centers, Family Child Care, Preschools • <u>Family Support</u> – Family Success Centers (FSC) <p>#2: Infant and Early Childhood Mental Health</p> <ul style="list-style-type: none"> • Cross Sector <p>#3: Children and Families with Special Needs</p> <ul style="list-style-type: none"> • Special Child Health (SCHS) • Early Intervention (EI), • Preschool Special Education • Child Behavioral Health/DD • CP&P Child Protective Services 	<p>Provide input for NJ Early Learning Training Academy (ELTA) core training topics--to include priorities #1 Infant/child health & wellness, #2 IECMH, and #3 Children with special needs.</p> <ul style="list-style-type: none"> • Recommended Early Care & Education (ECE) Guidelines • Caring for Our Children (AAP health/safety guidelines) • Caring for Infants-Toddlers in ECE guidelines • NJ Birth to Three Standards • SF Protective Factors (family strengthening) <p>Infant/Child Health & Wellness-systems and supports</p> <p>Local Systems Linkages (cross-sector)</p> <ul style="list-style-type: none"> • Central Intake – local resources for families/children • PRA Screening - 4 P's Plus • Community Health Workers – Community Screen <p>Child development - screening (cross-sector / GNJK Level 3)</p> <ul style="list-style-type: none"> • ASQ and ASQ:SE core trainings • EPIC (Educating Physicians in the Community) <p>Well Child Care-Medical Home (cross-sector)</p> <ul style="list-style-type: none"> • AAP Bright Futures Guidelines <p>Special topics (TBD) – e.g. Perinatal Health, Healthy Sleep/SIDS, Shaken Baby Syndrome, Nutrition/WIC, Breastfeeding, Obesity Prevention, Let's Move, Injury Prevention, and more</p> <p>IECMH Foundational Training - across sectors</p> <ul style="list-style-type: none"> • Keeping Babies and Children in Mind (KBCM) • Pediatric Partnership Initiative (PPI) • Pyramid – training & TA pilot (Essex?) <p>Children with Special Needs core training/curriculum topics:</p> <ul style="list-style-type: none"> • Understanding EI, SCHS, others - to be determined • IDEA Guidance for EI and Community Care settings 		<p>Interdepartmental Planning Group</p> <p>ICHC Partners</p> <p>ELTA - Rutgers</p> <ul style="list-style-type: none"> • Health Coordinator • Disabilities Coordinator <p>Quality Improvement Specialists (QIS)</p> <ul style="list-style-type: none"> • CCR&Rs • Head Start/EHS • Pre-K <p>Montclair State University NJ-American Academy of Pediatrics</p> <p>Pyramid Model Leadership Team DOH (Part C) and DOE (Part B)</p>	<p>In Process</p>
<p>Important Considerations:</p>	<ul style="list-style-type: none"> • Keep a cross-sector focus – Health, Nutrition/WIC, Home Visiting, Evidence Based Practices (EBPs), Early Head Start/Head Start, Childcare, Family Child Care, Education/ Schools, EI, Special Needs, Child Behavioral Health, Child Welfare, Social Services, and Family Support (e.g. Family Success Centers), etc. 			
<p>Alignment:</p>	<p>Align tasks with other groups and committees, e.g. NJCYC Family & Community Engagement, Grow NJ Kids, etc.</p>			
<p>Accomplishments:</p>				



Camden
HealthyStart

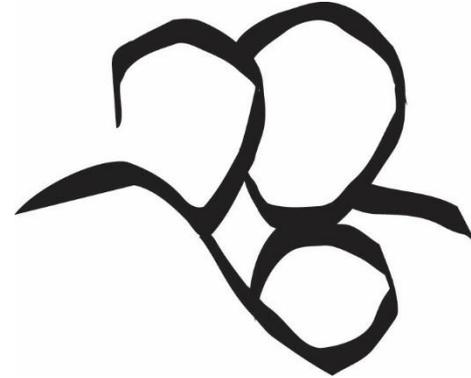
**INFANT CHILD HEALTH COMMITTEE
NJ COUNCIL ON YOUNG CHILDREN
MARCH 18, 2015**

Dianne Browne, PhD, CFLE Project Director

Camden Healthy Start

Agency

Southern New Jersey
PERINATAL COOPERATIVE



CHS Project Director

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What is Healthy Start

The goal of the model is to:

- reduce the infant mortality rate;
- provide services to women before, during and after pregnancy;
- help families care for their children during the first two years of their lives; and
- engage providers, city agencies, community organizations, leaders and consumers to improve women's health through the collective impact model.

Healthy Start Participants

- Women who live in the city of Camden
- African American and Latina women
- Men who are fathers or partners of women engaged in the program interested in receiving services related to before during or after the birth of the child.
- Children between the ages of birth and age 2 whose mother and/or father are enrolled in the program.

How does Healthy Start work?

- Receives referrals from Central Intake.
- Community Health workers engage families in the community.
- Women are linked with services or resources.
- High risk cases are referred for case management.
- Focuses on 5 core activities:
 - Improve Women's Health
 - Promote Quality Services
 - Strengthen Family Resilience
 - Achieve Collective Impact
 - Increase Accountability

Improve Women's Health

For women before, during, and after pregnancy, provide intervention to improve:

- insurance coverage/enroll in health care;
- access to care;
- health promotion and prevention;
- routine well woman care, and
- routine care for women with high risk conditions.

Promote Quality Services

Deliver quality intervention services

- Link families to a medical home
- Focus on health promotion and prevention
- Advance service coordination and systems integration
- Support improved access to these services
- Follow up with families

Promote Quality Services

Educate all families, support for women at risk:

- SIDS prevention
- Benefits of breastfeeding (continue for 6 months)
- Smoking cessation
- Birth spacing of at least two years with choice of a family planning method
- Routine well child care
- Importance of full term pregnancy
- Early entry to prenatal care and consistent attendance at prenatal appointments

Strengthen Family Resilience

- Support the ability of an individual, family, and community to cope with adversity and adapt to challenges or change.
- Support fatherhood or partner involvement.
- Educate staff and community about the importance of trauma
- Provide opportunities for community providers to improve service delivery impacted by trauma

Achieve Collective Impact

- Maximize opportunities for community action to address social determinants of health
- Support coordination, integration, and mutually reinforcing activities among health, social services, and other providers and key community leaders
- Use effective communication platforms to develop targeted public awareness / education campaigns about women's health and infant mortality
- Create a unified community voice in support of needed change to improve infant mortality

Increase Accountability

Increase accountability through Quality Improvement, Performance Monitoring, and Evaluation

- Conduct ongoing assessments and observations of project activities.
- Collect and analyze project data to determine project effectiveness and make adjustments when necessary.
- Engage in program evaluation activities to identify best practices, demonstrate implementation of evidence-based practices, and report on results.

Level of Service

- Project goal is to reach 1,000 participants each year.
- 500 of the participants will be pregnant women.
- The 1,000 includes non-pregnant women (preconception) and women parenting children (post partum wellness)

Staffing

- Health Education Specialist
- Resiliency Coordinator
- Fatherhood Program Coordinator
- Community Development Specialist
- Community Health Worker Coordinator
 - Three Community Health Workers
 - One Health Educator
- Clinical Coordinator
 - Three high risk case managers

Core Partners

- Medical Homes
 - Lourdes Medical Center
 - Cooper Medical Center
 - CamCare (FQHC)
- Community Partners
 - Camden Coalition of Healthcare Providers
 - Planned Parenthood of Southern New Jersey
 - Nurse Family Partnership
 - Parent as Teachers
 - Healthy Families
 - Various community based organizations

What is different in HS for 2014-2019

Level 3 Programming - Leadership and Mentoring

- Develop state, regional, national programs and policies
- Participate with other Leadership and Mentoring HS grantees and the Healthy Start Institute
- Create a HS Collaborative and Innovation Improvement Network (HS CollIN).

Support from local/state partners

- Create an awareness of infant mortality as a public health issue
- Educate partners on the risks associated with infant mortality
- Talk about the importance of prenatal care
- Invite staff from SNJPC to speak about women's health to groups or organizations you know.

Camden Healthy Start

**What questions
do you have?**





Children's Futures

Healthy Start Presentation

March 18, 2015



Children's Futures Project Officer

June R. Gray, MSN, RN

Director of Family Support Interventions

16 West Front Street, Suite 220

Trenton, NJ 08608

Phone 609 -695-1977, ext. 110

Fax 609- 695-5392

Website www.childrensfutures.org



Target Population



Women, children and families living in Trenton with a history of racial/ethnic disparities in healthcare, health, infant mortality and adverse perinatal outcomes, especially in African American and Latino individuals

800 women of which 400 are pregnant women



Program Objectives



- Improve Women's Health
- Promote Quality Services
- Strengthen Family Resilience
- Achieve Collective Impact
- Increase accountability through quality improvement, performance monitoring and evaluation



Core Services



- Home Visitation
- Parent/Child Center-based Activities
- Outreach
- Mental Health Counseling
- Fatherhood Activities
- Reach Out and Read Program



Level of Service



- Improve Women's Health
- Promote Quality Services
- Strengthen Family Resilience
- Achieve Collective Impact
- Increase Accountability
- FIMR/ICRT involvement
- Community Collaboration



Staffing



- Project Director
- Nurse Family Partnership Nurse
- Parent/Child Center Case Manager
- Outreach Worker
- Evaluator



Core Partners



- Nurse Family Partnership program
- Mercer Street Friends Center
- Family Guidance
- UIH Family Partnership
- Reach Out and Read program
- Dr. Schlosser
- Central Intake



Collaboration and Communication



Thank You



Partnership for
Maternal &
Child Health
OF NORTHERN NEW JERSEY

Healthy Start Program

Shazia Aslam, MPH
Program Director

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Program Overview

- Healthy Start Model
- Service Area
- Target Population
- Staffing Structure
- Core Program Components
- Community Partners
- Collaboration with Central Intake



HEALTHY START

A PROGRAM OF THE PARTNERSHIP FOR MATERNAL AND CHILD HEALTH OF NORTHERN NEW JERSEY

Targeting Black women of child-bearing age and their families, residing in Newark and Irvington

Once enrolled, you may receive the following services through the Healthy Start Program:

- ❖ Case management and social service referrals
- ❖ Free pregnancy testing
- ❖ Health education workshops
- ❖ Screenings and counseling for depression
- ❖ Parenting education
- ❖ Fatherhood groups and activities
- ❖ Home visits
- ❖ Special events, gifts, and incentives



Partnership's Healthy Start Program is funded through a multi-year grant by the Health Resources and Services Administration, Maternal and Child Health Bureau.

Receive referrals for food, housing, rental assistance and furniture

Attend classes on healthy pregnancy, childbirth, breastfeeding and infant care

Become part of a support group or attend special activities for fathers

Get assistance with job search or completing your GED

Enroll in health insurance

HEALTHY START

50 Union Avenue,
Irvington, NJ 07111

Call for an appointment
(973) 868-4270

Open Monday – Friday
9 am – 5 pm

www.partnershipmch.org

Healthy Start Model

- Healthy Start ensures access to community based, culturally sensitive, family-centered and comprehensive health and social services to women, infants, and their families
- Healthy Start utilizes a life-course approach and targets women during the 4P's: **P**reconception/Interconception, **P**renatal, **P**ostpartum, and **P**arenting stages
- Addresses disparities in infant mortality and perinatal health outcomes through:
 1. Improving women's health
 2. Promoting quality services
 3. Strengthening family resilience
 4. Achieving collective impact
 5. Increasing accountability



Goals and Objectives



- **Funding:** Health Resources and Services Administration (HRSA) – MCH Bureau
- **Goals:** To reduce Black infant mortality, improve maternal and child health outcomes, and reduce health disparities.
- **Objectives:** The program focuses on the following
 1. Health insurance coverage
 2. Preconception education and reproductive life plan
 3. Postpartum visits
 4. Linkages to medical home
 5. Well-woman and well-child visits
 6. Positive parenting behaviors such as safe-sleep practices and reading daily to their children
 7. Breastfeeding rate
 8. Abstinence from cigarette smoking
 9. Pregnancy spacing and elective delivery rate before 39 weeks
 10. Perinatal depression and intimate partner violence
 11. Father/partner involvement

Target Population



➤ Service Area:

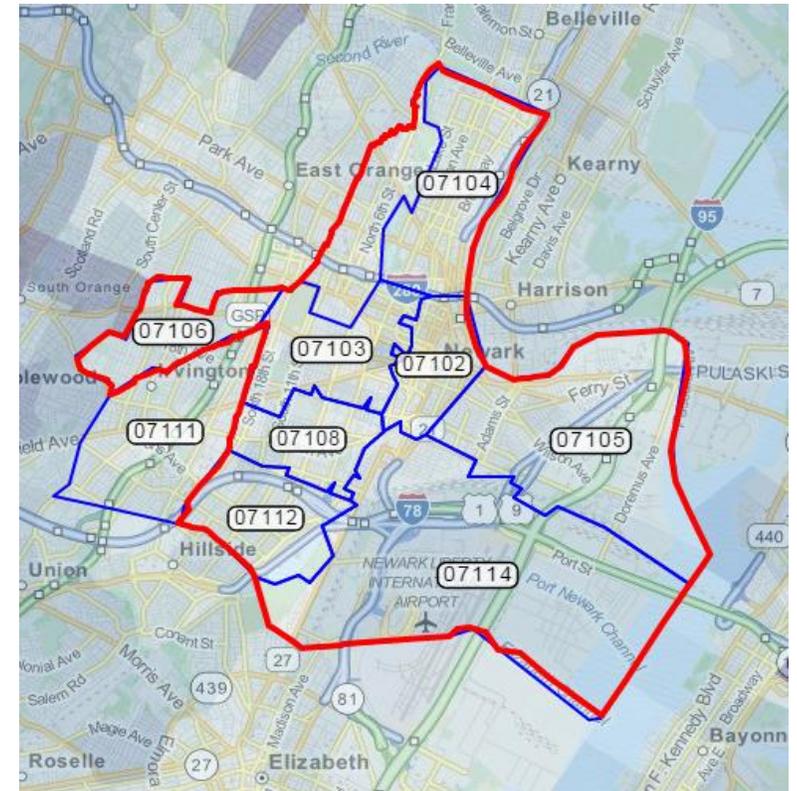
- Newark (zip codes 07102, 07106, 07108, and 07112) and Irvington (zip code 07111).

➤ Target Population:

- Black pregnant women or mothers with children up to two years of age.
- Women that are not pregnant receive preconception/interconception education. Fathers/father figures receive men's health education and participate in fatherhood involvement activities and education.

➤ Program Target:

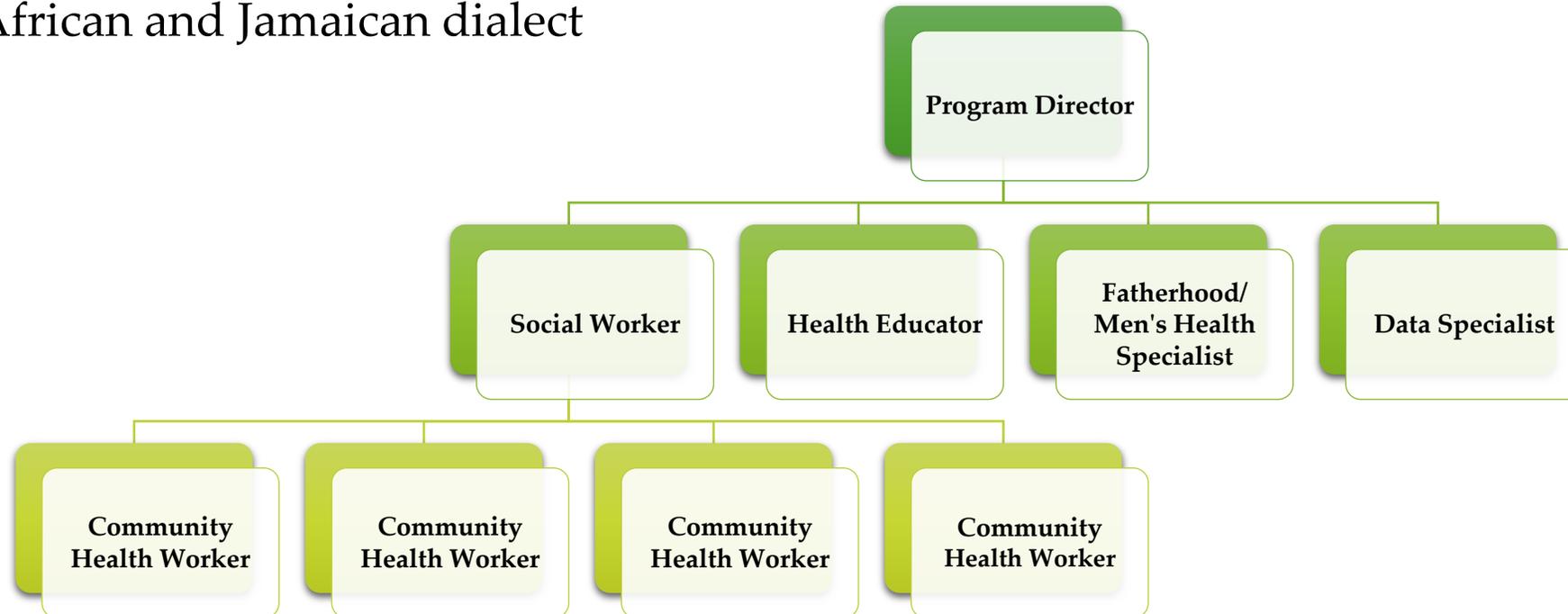
- 500 Black women, 50% of which must be pregnant.



Staffing Structure



- A culturally diverse team of 9 staff members with language proficiencies in:
 - Haitian Creole and French
 - Spanish and Portuguese
 - Some African and Jamaican dialect



Core Components



➤ Community Outreach:

- Targeting Black women of childbearing age and their families, who may be disenfranchised from traditional healthcare system through:
 - 1) canvassing the community
 - 2) targeted outreach
 - 3) free pregnancy testing

➤ Case Management:

- Screenings and counseling
 - 1) Perinatal Risk Assessment
 - 2) Edinburgh Postnatal Depression Scale
 - 3) Ages and Stages Questionnaire
 - 4) Men's Health Quiz
- Coordination of care – Clients at standard risk are case managed by the CHWs, whereas, high risk clients are case managed by the Social Worker and have more frequent contacts
- Home visits



Core Components



➤ **Health Promotion and Education:**

- One-on-one and group education on a variety of maternal/infant/family care topics
- Interconception education and reproductive life planning
- *Becoming A Mom* – Curriculum developed by March of Dimes on prenatal, childbirth, postpartum care, and infant care education; 9 2-hr sessions and a graduation; 10-20 clients
- *Effective Black Parenting* – Parenting curriculum developed by Center for the Improvement of Child Caring and the topics include: culturally specific parenting strategies, social learning, child development and independence, parent-child communication, effective praise and discipline methods, and special topics including single parenting and prevention of alcohol, tobacco, and drug use; 14 2-hr sessions and a graduation; 8-20 clients

➤ **Fathers Empowered to Learn, Lead, and Achieve Success (F.E.L.L.A.S.):**

- Fatherhood initiative to promote father involvement and improve men's health through:
 - 1) *24/7 Dad* – Curriculum developed by National Fatherhood Initiative aimed at increasing self awareness, compassion, and responsibility of good parenting; 12 2-hr sessions and a graduation; 8-10 clients
 - 2) Support groups
 - 3) Men's Health Quiz – Health assessment tool developed by AHRQ

Core Components



➤ ACA Health Insurance Marketplace Enrollment:

- All Healthy Start staff are trained Certified Application Counselors
- Enrollment events

➤ Other Ancillary Services

- Transportation assistance
- Emergency baby supplies
- Special events and activities



Community Partners



➤ **Community Action Network:**

- Prenatal, preconception, and interconception care provider agencies
- FQHCs, hospitals, and other primary care providers
- DoH and DCF
- Health departments
- WIC
- Schools
- Child care providers
- Faith based organizations
- Other community based organizations
- 25% consumer representation
- Quarterly meeting

➤ **Collaboration with Central Intake:**

- PRA/SPECT
- Referral and linkages



PARTNERSHIP'S HEALTHY START CASE MANAGEMENT INTERVENTIONS

Social, economic, cultural, health, environmental conditions, and individual behaviors

 Preconception
 Prenatal
 Postpartum
 Parenting
 Kids (0-24 m)
 Fathers

Screenings	Health Education	Linkages
<ul style="list-style-type: none"> Behavioral Health Domestic Violence 	<ul style="list-style-type: none"> Becoming A Mom HIV/STI Prevention Reprod. Life Plan 	<ul style="list-style-type: none"> Pregnancy Testing Medical Home Health Insurance Teen Prep
<ul style="list-style-type: none"> Substance Abuse Domestic Violence Behavioral Health 	<ul style="list-style-type: none"> Becoming A Mom HIV/STI Prevention Nutrition Counsel Oral Health 	<ul style="list-style-type: none"> Home Visiting Prog FIMR Smoking Cessation
<ul style="list-style-type: none"> PPD Domestic Violence 	<ul style="list-style-type: none"> Healthy Weight Infant Attachment Breastfeeding 	<ul style="list-style-type: none"> Childcare WIC Medical Home
<ul style="list-style-type: none"> Behavioral Health Domestic Violence 	<ul style="list-style-type: none"> EBP Curriculum Stress Mgmt Newborn Care 	<ul style="list-style-type: none"> Job Search Housing Educ. Opportunity
<ul style="list-style-type: none"> ASQ 	<ul style="list-style-type: none"> Growth & Dev. Healthy Home Env, Immunizations 	<ul style="list-style-type: none"> Project Launch Early Interventions Well-Child Visits
<ul style="list-style-type: none"> Men's Health Quiz 	<ul style="list-style-type: none"> 24/7 Dad Healthy Relations HIV/STI Prevention 	<ul style="list-style-type: none"> Medical Home Health Insurance Job Search Support Groups

Outcomes

Improve maternal and child health outcomes and reduce health disparities in communities

Specific Outcomes

- Decrease low-birth weight births
- Increase use of prenatal care in 1st trimester
- Decrease # of women having missed scheduled appointments
- Increase utilization of medical home by entire family
- Increase # of women who breastfeed
- Increase # of children having age appropriate immunizations

NEWARK COMMUNITY HEALTH CENTERS, INC.

We Care. Your Health Comes First With Us.



HEALTHY START INITIATIVE

NCHC

A Legacy of Caring and Service

29th Anniversary

CONTACT INFORMATION

Contact: Ava Rose, MSW

Title: Program Coordinator
Healthy Start Initiative – Level I

Organization: Newark Community Health
Centers, Inc. (NCHC)

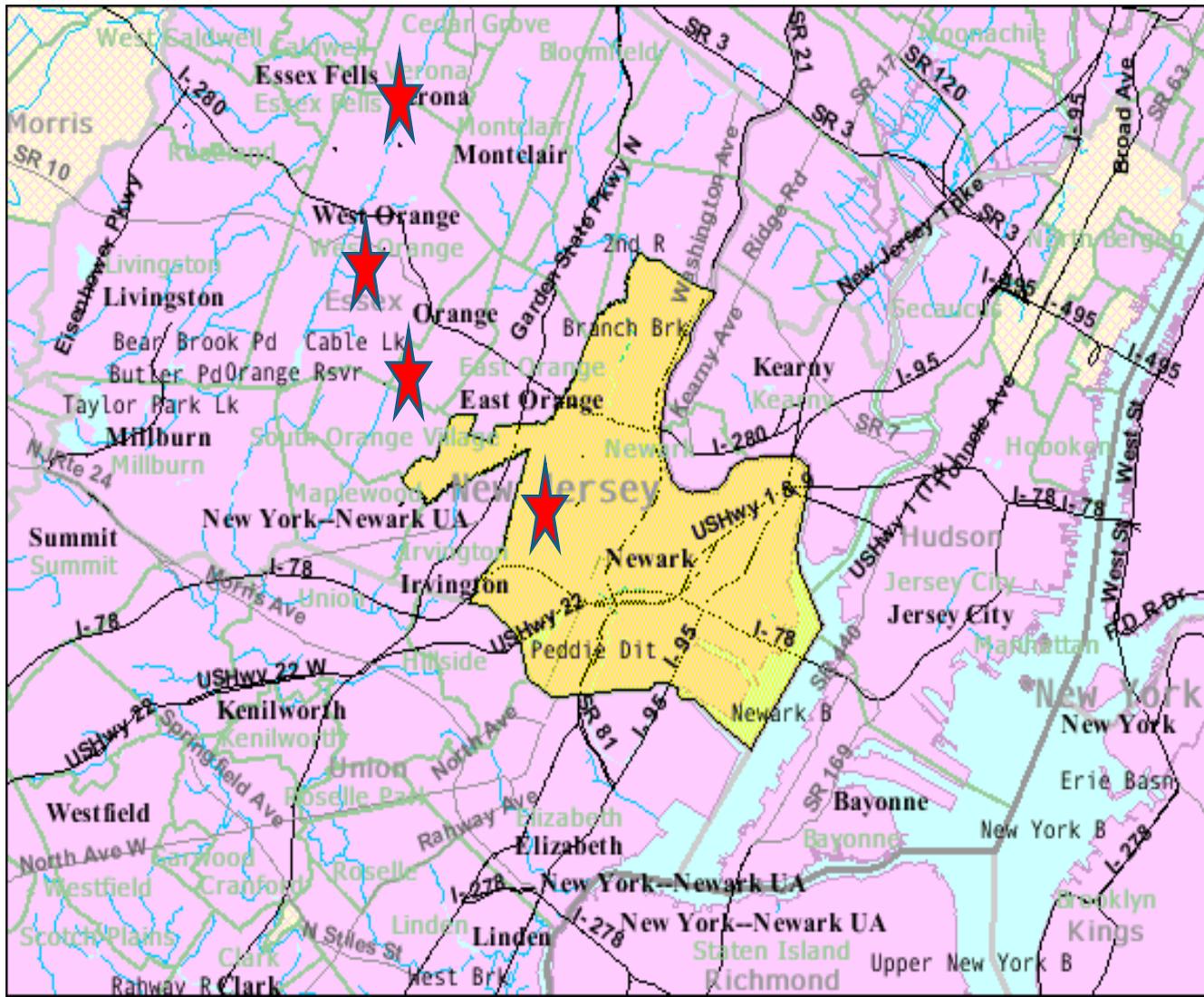
Office: (973) 675-1900 x1235

Email: arose@nchcfqhc.org

Federally Qualified Health Center (definition)

- Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS).
- FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

TARGET SERVICE AREA



- Newark:
 - 07101
 - 07103
 - 07104
 - 07105
 - 07114
- Orange
- East Orange
- Montclair

TARGET POPULATION

Black Women/Families

- Before pregnancy
- During pregnancy
- After pregnancy

Young Children

- Birth – 2 Years

Fathers

TARGET POPULATION

(2007 – 2009)

Target Service Area

❑ Infant Mortality Rate – Black Women

12.48 per 1,000 live births

❑ Infant Mortality Rate – White Women

6.1 per 1,000 live births

New Jersey

❑ Infant Mortality Rate

3.8 per 1,000 live births

U.S.

❑ Infant Mortality Rate

6.6 per 1,000 live births

PROGRAM OBJECTIVES

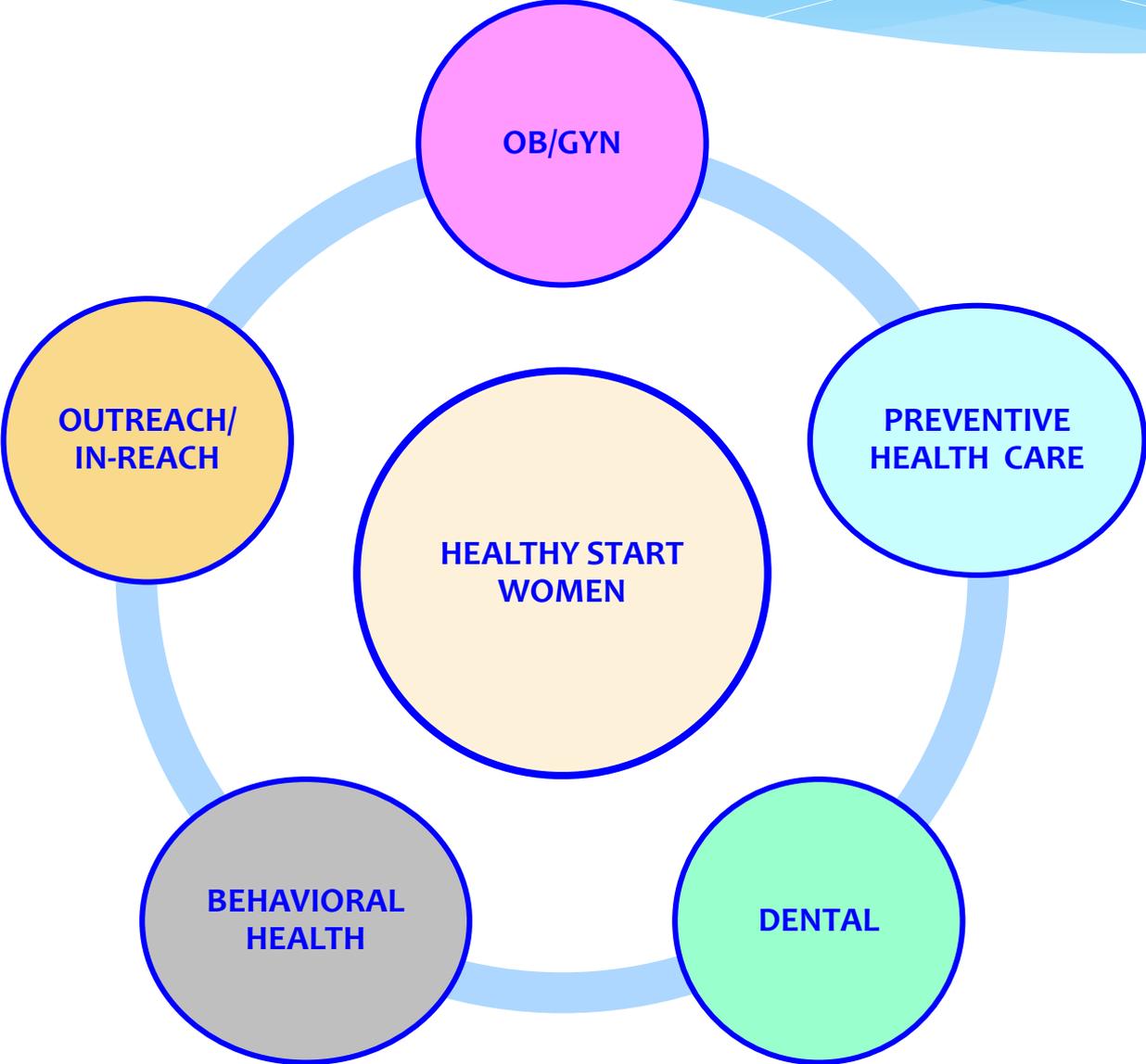
Improve Pregnancy Outcomes

- ❖ Increase access to Pre-Conception Health Care
- ❖ Increase Pre-Natal Care during 1st Trimester
- ❖ Increase Health Literacy

Reduce Black Infant Mortality Rate

- ❖ Ensure health coverage
- ❖ Facilitate screenings, linkage and referrals

**NEWARK COMMUNITY HEALTH CENTERS. INC.
CORE SERVICES**



OB/GYN

**PREVENTIVE
HEALTH CARE**

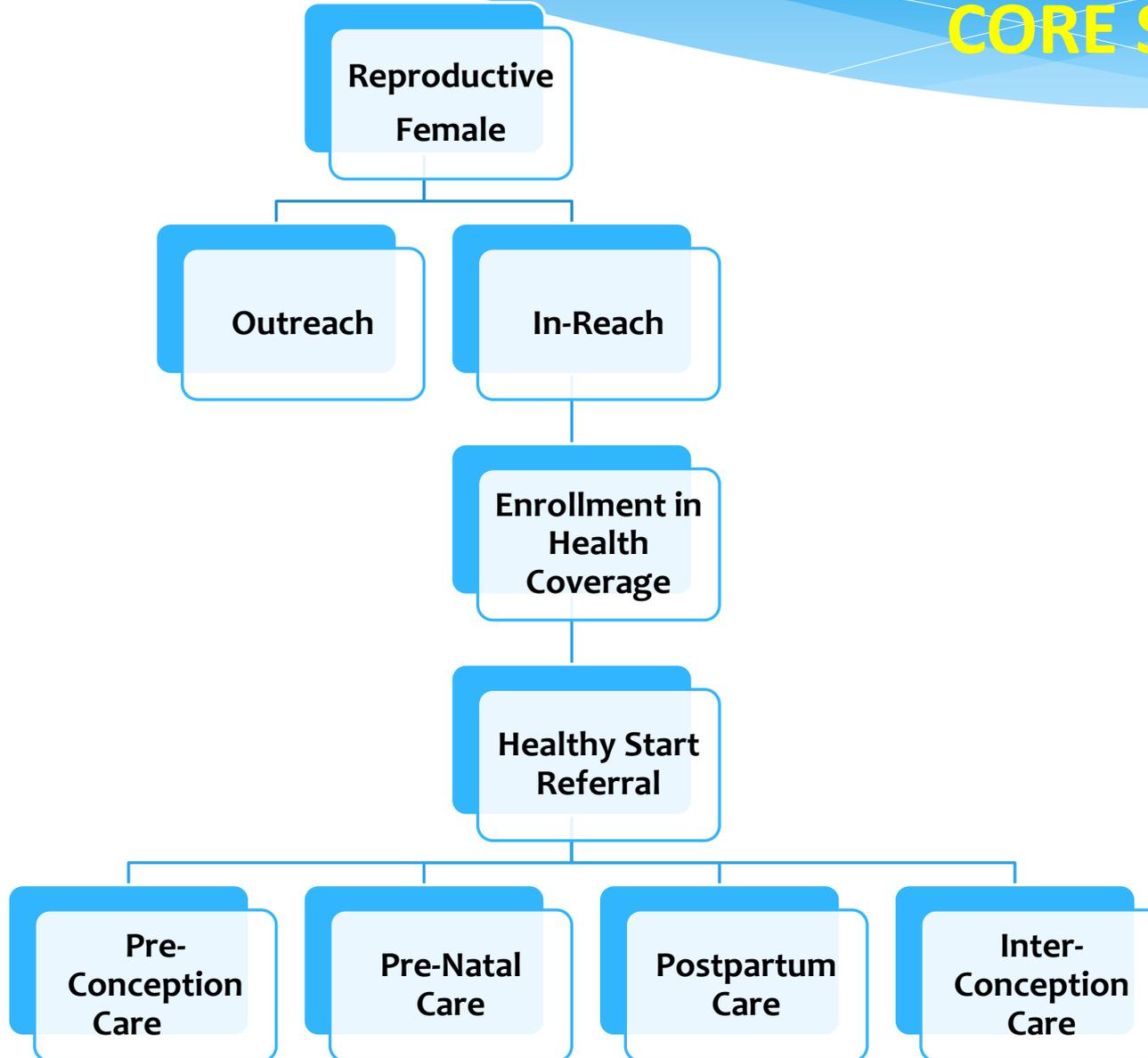
**HEALTHY START
WOMEN**

DENTAL

**BEHAVIORAL
HEALTH**

**OUTREACH/
IN-REACH**

CORE SERVICES



CORE SERVICES

- ❑ Maternal & Pediatric Primary Care
- ❑ Case Management
- ❑ Outreach
- ❑ Health Education
- ❑ Health Promotion
- ❑ Father Involvement

STAFFING & LEVEL OF SERVICE

Healthy Start Initiative Team

Program Coordinator (1)

Social Workers (3)

Health Educators (2)

Case Manager/Outreach Workers (6)

Level of Service

- 250 Pregnant Women
(pre-natal care, case management, care coordination)

- 250 Non-Pregnant Women/Families
(pre-conception/inter-conception care,
case management, care coordination)

- Who are our partners?
- Linkage with Central Intake (EPPC)

PARTNER SUPPORT

