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 ICHC Priorities, Strategic Goals– Review of ICHC 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
Infant Child Health Committee (ICHC) 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**

<table>
<thead>
<tr>
<th>Priority Area(s):</th>
<th>Activities/Task</th>
<th>Barriers/Gaps</th>
<th>Stakeholders Responsible</th>
<th>Time Frame</th>
</tr>
</thead>
</table>
| #1: Family/Child Health Wellness  
  - Pre-conception  
  - Prenatal  
  - Infant-Toddler  
  - Young Child  
  - School Age  
  - Parent/Caregiver | Develop strategies for ongoing information sharing a cross sectors, agencies, departments and programs at the state and local level.  
  - ICHC Meetings – Information Sharing  
  - Cross-sector updates & presentations  
  - Health & Wellness Newsletter? Target audience?  
  - Identify topics in target age groups/categories  
  - Establish an “editorial board” to select/approve materials | | ICHC Chair(s) and Partners | Meeting since March 2014 – Qtrly. Mtgs. 2015 |
| #2: Infant & Early Childhood Mental Health (IECMH)  
  - Healthy attachments/relationships | | | | |
| #3: Children and Families with Special Needs  
  - Early Intervention (EI)  
  - Special Child Health Services  
  - Special Education  
  - SPAN (Community of Care)  
  - MAP to Inclusive Childcare | | | | |

**Important Considerations:**
- 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

**Alignment:**
Align tasks with other groups and committees, e.g. NJCYC Family & Community Engagement, Grow NJ Kids, etc.

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

General Strategy: Systems Infrastructure / Service Integration

<table>
<thead>
<tr>
<th>Priority Area(s):</th>
<th>Activities/Task</th>
<th>Barriers/Gaps</th>
<th>Stakeholders Responsible</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1: Family/Child Health Wellness</td>
<td>Development of an integrated EC system of care that connects children and their families with needed services. Continue to identify EC partners to connect/collaborate and integrate services with, at the state and local level.</td>
<td>ICHC</td>
<td>Meeting since March 2014 – Qtrly. Mtgs. 2015</td>
<td></td>
</tr>
<tr>
<td>- ECCS/Help Me Grow</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Project LAUNCH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- County Central Intake Systems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- County Council for Young Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#2: Infant &amp; Early Childhood Mental Health (IECMH)</td>
<td>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.</td>
<td>Physician/Linking Workgroups SPAN –COCC Early and Continuous Screening and Medical Home Phone Line workgroup</td>
<td>Began work March 2013 – ongoing</td>
<td></td>
</tr>
<tr>
<td>- NJ Association for IMH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pyramid Model Workgroup</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Early Intervention (EI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Special Child Health Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Special Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- SPAN (Community of Care)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- MAP to Inclusive Childcare</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Early Head Start/Head Start</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Important Considerations:</td>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Include parents as partners in systems planning and development. Share information that will be relevant to parent’s needs, issues and concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pay attention to literacy levels; Ensure diversity – culturally (broadly defined) and language</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alignment:</td>
<td>Align tasks with other groups and committees, e.g. NJCYC Family &amp; Community Engagement, Grow NJ Kids, CAB’s, County Councils, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accomplishments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 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

<table>
<thead>
<tr>
<th>Priority Area(s):</th>
<th>Activities/Task</th>
<th>Barriers/Gaps</th>
<th>Stakeholders Responsible</th>
<th>Time Frame</th>
</tr>
</thead>
</table>
| **#1: Family Child Health Wellness**  
- Primary care/medical home  
- Prenatal care  
- Dental care  
- Health insurance  
- Early care education  
- Home visiting  
- WIC  
- Early Intervention (EI)  
- Social services | Provide input/feedback for strategies that will help to improve systems linkages and access to care for families and children at the local level.  
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.  
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. |  
DOH/DCF/DOE  
ICHC Partners | Quarterly ICHC mtgs.  
In planning process – EC Phone line December 2015  
In Process – 15 counties  
6 counties to be added -2015 |
| **# 2 Infant Early Childhood Mental Health**  
- Early care settings  
- EHS/HS  
- Home Visiting | 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. |  
DOH and Local Grantees  
DCF and local grantees | Ongoing |
| **#3 Children/Families with Special Needs**  
- Early Intervention (EI)  
- Special Child Health Services  
- Special Education  
- SPAN (Community of Care)  
- MAP to Inclusive Childcare  
- Early Head Start/Head Start | County Councils: that bring parents/families and providers together to learn about available services and supports, identify issues/concerns, and solve problems.  
NJ’s Early Intervention System (EIS)- linkage for early intervention evaluation for children with developmental concerns and/or delays. |  
DOH | Ongoing |

**Important Considerations:**
- 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

**Alignment:**
Alignment of existing service providers, phone lines and services.

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

### General Strategy: Education and Training (Workforce Development)

<table>
<thead>
<tr>
<th>Priority Area(s):</th>
<th>Activities/Task</th>
<th>Barriers/Gaps</th>
<th>Stakeholders Responsible</th>
<th>Time Frame</th>
</tr>
</thead>
</table>
| #1: Family/Child Health & Wellness  
  - Health - Physician Practices, Medical Education, Nursing, Public Health, Health Educators  
  - Early Care - 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)  
  - Early Learning - Grow NJ Kids (GNJK), EHS/HS, Child Care Centers, Family Child Care, Preschools  
  - Family Support – Family Success Centers (FSC) | 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.  
  - 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)  
  Infant/Child Health & Wellness-systems and supports Local Systems Linkages (cross-sector)  
  - Central Intake – local resources for families/children  
  - PRA Screening - 4 P’s Plus  
  - Community Health Workers – Community Screen Child development - screening (cross-sector / GNJK Level 3)  
  - ASQ and ASQ:SE core trainings  
  - EPIC (Educating Physicians in the Community) Well Child Care-Medical Home (cross-sector)  
  - AAP Bright Futures Guidelines 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 IECMH Foundational Training - across sectors  
  - Keeping Babies and Children in Mind (KBCM)  
  - Pediatric Partnership Initiative (PPI)  
  - Pyramid – training & TA pilot (Essex?) Children with Special Needs core training/curriculum topics:  
  - Understanding EI, SCHS, others - to be determined  
  - IDEA Guidance for EI and Community Care settings |  
|   |   |   | Interdepartmental Planning Group  
  |   |   | ICHC Partners  
  |   |   | ELTA - Rutgers  
  |   |   |   - Health Coordinator  
  |   |   |   - Disabilities Coordinator | In Process  
|   |   |   | Quality Improvement Specialists (QIS)  
  |   |   |   - CCR&Rs  
  |   |   |   - Head Start/EHS  
  |   |   |   - Pre-K |  
| #2: Infant and Early Childhood Mental Health  
  - Cross Sector |   |   | Montclair State University  
  |   |   | NJ-American Academy of Pediatrics |  
| #3: Children and Families with Special Needs  
  - Special Child Health (SCHS)  
  - Early Intervention (EI),  
  - Preschool Special Education  
  - Child Behavioral Health/DD  
  - CP&P Child Protective Services |   |   | Pyramid Model Leadership Team  
  |   |   | DOH (Part C) and DOE (Part B) |  

### Important Considerations:
- 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.

### Alignment:
Align tasks with other groups and committees, e.g. NJCYC Family & Community Engagement, Grow NJ Kids, etc.

### Accomplishments:
Camden Healthy Start

Agency
Southern New Jersey
PERINATAL COOPERATIVE

CHS Project Director
Dianne R. Browne, PhD
808 Market Street 2nd Floor
Camden, NJ 08102
856-668-4426
dbrowne@snjpc.org
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 CoIIN).
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.
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
Healthy Start Program

Shazia Aslam, MPH
Program Director

50 Union Avenue, Suite 402
Irvington, NJ 07111
Phone: (862) 438-7387
Email: saslam@partnershipmch.org
Program Overview

- Healthy Start Model
- Service Area
- Target Population
- Staffing Structure
- Core Program Components
- Community Partners
- Collaboration with Central Intake
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: Preconception/Interconception, Prenatal, Postpartum, and Parenting 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
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
<table>
<thead>
<tr>
<th>Preconception</th>
<th>Prenatal</th>
<th>Postpartum</th>
<th>Parenting</th>
<th>Kids (0-24 m)</th>
<th>Fathers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screenings</td>
<td>Health Education</td>
<td>Linkages</td>
<td>Social, economic, cultural, health, environmental conditions, and individual behaviors</td>
<td>Outcomes</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Becoming A Mom</td>
<td>Pregnancy Testing</td>
<td>Improve maternal and child health outcomes and reduce health disparities in communities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>HIV/STI Prevention</td>
<td>Medical Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Reprod. Life Plan</td>
<td>Health Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Becoming A Mom</td>
<td>Teen Prep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>HIV/STI Prevention</td>
<td>FIMR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPD</td>
<td>Nutrition Counsel</td>
<td>Smoking Cessation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Oral Health</td>
<td>Childcare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Healthy Weight</td>
<td>WIC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Infant Attachment</td>
<td>Medical Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPD</td>
<td>Breastfeeding</td>
<td>Job Search</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>EBP Curriculum</td>
<td>Housing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Stress Mgmt</td>
<td>Educ. Opportunity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPD</td>
<td>Newborn Care</td>
<td>Project Launch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASQ</td>
<td>Growth &amp; Dev.</td>
<td>Early Interventions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Growth &amp; Dev.</td>
<td>Healthy Home Env, Immunizations</td>
<td>Well-Child Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASQ</td>
<td>Healthy Relations</td>
<td>Medical Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men’s Health Quiz</td>
<td>HIV/STI Prevention</td>
<td>Health Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men’s Health Quiz</td>
<td>24/7 Dad</td>
<td>Job Search</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men’s Health Quiz</td>
<td>Healthy Relations</td>
<td>Support Groups</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
Thank you
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: 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 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
Reproductive Female

- Outreach
- In-Reach

Enrollment in Health Coverage

Healthy Start Referral

- Pre-Conception Care
- Pre-Natal Care
- Postpartum Care
- Inter-Conception Care
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)
We Love Referrals!