

Notice
Competitive Request for Applications

Improving Pregnancy Outcomes Initiative
July 1, 2013 – June 30, 2014



Issued by:

New Jersey Department of Health

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REQUEST FOR APPLICATIONS

Improving Pregnancy Outcomes Initiative

I. Statement of Purpose:

The New Jersey Department of Health (DOH), Division of Family Health Services (FHS), Maternal and Child Health Services is announcing a competitive request for applications (RFA) to support community-based programs to improve and provide quality access to preconception, prenatal and interconception care for women to improve birth outcomes.

Funded programs will work to improve specific maternal and infant health outcomes including preconception care, prenatal care, interconceptual care, preterm birth, low birth weight, and infant mortality through implementation of evidence-based and/or best practice strategies across three key life course stages: preconception, prenatal/postpartum and interconception.

Given limited public health resources, it is necessary to target activities to areas of highest need with consideration for where impact will be greatest, particularly with regard to racial, ethnic and economic disparities in priority outcomes. High-need women include those who are low-income or uninsured; racial, ethnic and linguistic minorities; women with chronic health conditions; women with multiple social or economic stressors; underserved immigrants; victims of domestic violence; individuals impacted by mental health issues, alcoholism and/or substance abuse; and women with unintended pregnancies. These women on average attend fewer prenatal visits and are more likely to experience poorer pregnancy outcomes. Their families are more likely to be without a medical home and are less likely to access consistent, comprehensive preventive and primary care services.(Ref 1- 8)

Improving maternal and infant health is a priority within the NJDOH/FHS prevention agenda. Key population maternal and child health indicators - including early prenatal care, low birth weight, and preterm births - have not improved significantly over the last decade in NJ and significant racial, ethnic and economic disparities persist. The goal of this RFA initiative is to improve maternal and infant health outcomes for high-need women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes through a collaborative coordinated community driven approach.

As a companion to this RFA, a Memorandum of Agreement (MOA) is being issued to establish a new Maternal and Infant Health Center of Excellence (MIH-COE) that supports funded grantees which may include training of Community Health Workers and coordination of specific data management and evaluation activities required of all prospective grantees in this RFA.

The NJDOH/FHS is committed to targeting limited public health resources to populations and communities with the highest need where impact will be greatest to improve population health outcomes and reduce health disparities. The NJDOH/FHS endeavors to use these funds to drive and support innovation to ultimately build a practice base of evidence that is implemented and tested through continuous quality improvement (CQI). To accomplish this, this RFA

incorporates the following key guiding models, principles and approaches within a comprehensive public health framework:

- A Performance Management Approach to measuring, monitoring and improving health. Performance management is the practice of actively using performance data to improve the public's health. The performance management framework centers on a clear and focused aim and the strategic use of performance standards to guide the development and implementation of specific improvement strategies. Applicants will be asked to show how chosen improvement strategies align with core set of performance standards and the needs of their community, and will work with DOH to develop relevant performance measures used to monitor the effectiveness of those strategies. It is expected that grantees will continuously monitor progress in improving defined short-and longer-term outcomes, and refining strategies to improve effectiveness. (Ref 9)
- A Life Course Perspective that promotes optimal women's health throughout the reproductive lifespan. The Life Course Model looks at health as an integrated continuum and suggests a complex interplay of multiple determinants, considering the impact of social, environmental, biological, behavioral and psychological factors on individuals throughout their lives. It builds on recent social science and public health literature that posits that each life stage influences the next and that social, economic and physical environments interacting across the life course impact individual and community health. A Life Course Perspective recognizes that as many as one half of all pregnancies are unintended, underscores the importance of promoting a woman's health regardless of her pregnancy plans, and expands the focus on improving pregnancy outcomes from prenatal care alone to include preconception and interconception care and wellness. (Ref 10)
- A Social Ecological Model approach that recognizes health as a function of individuals and the environments in which they live – including family, peer, neighborhood, work place, community and societal influences. A Social Ecological Model identifies and addresses health determinants at multiple ecologic levels to strengthen individual knowledge and skills; enhance social networks and supports; change organizational practices; mobilize communities; and influence policy. (Ref 11)
- Community Health Workers (CHWs) Model. Also known as *lay health advisors, natural helpers, indigenous helpers or promotoras*, CHWs are paraprofessionals who are trusted members of the target community to whom other community members turn for a variety of social supports. Based on social support and social network theories of health promotion, CHWs have been used across a variety of public health initiatives to enhance multiple aspects of individuals' social networks and supports, which in turn can improve health outcomes by modeling and reinforcing positive health behaviors and practices, buffering the impact of stress, and facilitating access to and utilization of resources, including health care and other community services. Research studies demonstrate that CHWs can improve health outcomes, address disparities, improve the utilization of preventive and primary care services and reduce the need for intensive services among high-need populations. (Ref 12, 13)

Strategies will focus on improving: outreach to find and engage high-need women and their families in health insurance, health care and other needed community services; timely identification of needs and risk factors and coordinated follow-up to address risks identified; the

integration and coordination of services within larger community systems; and, the development of supports, opportunities and social norms that promote and facilitate healthy behaviors across the lifespan.

The two components of this RFA are Component A, Improving Pregnancy Outcomes Initiative and Component B, Central Intake for Maternal, Infant and Early Childhood Services. A community-based agency may apply for either or both components. Separate applications must be submitted for each county and each component the applicant proposes to serve (see Applicant Eligibility section). Priority will be given to applicants targeting the high-risk municipalities listed in Appendix B. The NJ DOH anticipates funding 10-12 Component A projects and 5-7 Component B projects.

Component A: Improving Pregnancy Outcomes Initiatives with Community Health Workers

This Improving Pregnancy Outcomes (IPO) Initiative replaces the Access to Prenatal Care Initiative. IPO Initiatives will develop partnerships with community-based maternal and child health providers/agencies with proven capabilities in implementing activities/interventions within a targeted community and the capability to focus on reproductive age women and their families. The lead agency for the IPO must satisfactorily demonstrate that the effort is collaborative, coordinated, and that the expertise and other necessary resources are available to successfully carry out the proposal to measurable success. This effort shall be coordinated with existing federal and state funded initiatives including but not limited to Healthy Start, Maternal Infant and Early Childhood Home Visitation, Strong Start, Title X Family Planning, Lead Poisoning Prevention, Healthy Homes, Perinatal Addictions Prevention, Postpartum Mood Disorders, Coordinated School Health, WIC, Federally Qualified Health Centers (FQHCs), and the activities of the Chronic Disease Prevention and Control Unit of the DFHS (smoking, diabetes, cardiac, cancer, obesity prevention, physical fitness, hypertension). Applicants should complete Appendix C to document local partnerships with community-based providers.

The Community Health Worker (CHW) model is required for outreach and client recruitment within the targeted community to identify and enroll women and their families in appropriate care. For the purpose of this RFA, CHWs are further defined as trained paraprofessionals working under the direction and supervision of a licensed professional (a public health nurse or licensed social worker with clinical experience). CHWs will perform a combination of community outreach, home visits, group activities /workshops, and community-based supportive services to provide a source of enhanced social support and create a bridge between under-served and hard-to-reach populations and formal providers of health, social and other community services.

Additionally, this RFA provides an important opportunity to expand the role of CHWs, consistent with the commitment to life course and social-ecological models. While the role of CHW has traditionally focused on working with women and infants during prenatal and postpartum periods, through the new IPO initiative the scope of CHWs will be broadened to provide ongoing support during preconception and interconception periods to promote healthy behaviors, including initial and continuous engagement with health and community services,

for high-need women of reproductive age within target communities. To incorporate CHW-led strategies within their programs, prospective grantees will be required to recruit, train and supervise/mentor CHWs in conjunction with the Maternal and Infant Health Center of Excellence (MIH-COE) and NJDOH/FHS staff.

CHW services should be available across all geographic areas targeted by the applicant. Specific required activities related to administration and oversight of local CHW work includes:

- Recruit, engage and support individuals to serve as CHWs, with an emphasis on engaging lay individuals from within the identified target communities and who are themselves representative of the target population(s);
- Recruit, engage and support individuals with appropriate professional licensure and experience to serve as CHW coordinators/supervisors;
- Facilitate participation in training for CHWs, in coordination with the new MIH-COE;
- Provide professional supervision for CHWs; and within this framework, grantees have the flexibility to propose specific local approaches to implement these core required strategies.

While the above examples focus on individual/family level activities, CHWs also may be integrated in strategies targeting change at community or organizational levels, such as:

- Development of community coalitions or collaboration with an existing community coalition;
- Establishment of reciprocal referral networks;
- Integration of CHWs within multi-disciplinary health care teams to serve as liaisons between the medical home and the patient/family; and/or
- Introducing media materials designed to influence social norms related to health and health behaviors to members of target communities.

Neighborhood outreach that is community driven, culturally appropriate and respectful can be an effective strategy to convey prevention education and information about services. Linking women to preconception care if not pregnant and to early prenatal care if pregnant are the priorities of this initiative. Effective outreach will link women to pregnancy testing and bring underserved and at-risk populations into care sooner. The CHW's will provide a visible presence in the community and provide organized consumer education programs. CHW's partner with various community organizations including but not limited to faith-based organizations, WIC sites, Head Start, community centers, Family Success Centers, shelters and other service providers to provide onsite education programs to reproductive age women and their families.

Component B: Central Intake for Maternal, Infant and Early Childhood Services (Central Intake)

Central Intake for mothers and families works closely with partners to eliminate duplication of effort and services, and it maximizes the collective impact and the appropriate utilization of

available and often scarce resources. Centralized coordination simplifies and streamlines the referral process for obstetrical/prenatal care providers, other community agencies, and pregnant women/parents. All screening referrals go through one central agency to determine risk and need for services. Since the goal is universal screening without regard to specific traits or subjective decisions about the need for services, all pregnant women who are screened and consent to referral should be contacted by central intake to provide general information about available resources. Women who are not pregnant would be referred to appropriate preconception, primary care and or social service providers for care. The following counties are funded via contracts with the Department of Children and Families and are NOT eligible for Component B: Central Intake funds: Essex, Passaic, Middlesex, Somerset, Cumberland, Gloucester, and Salem. Counties that are not currently funded will be considered for this funding based on inclusion of high-risk municipalities (see Appendix B).

Central Intake should work closely with community partners to investigate all possible sources of outreach to women and their families and integrate these organizations as partners in the system of care. Through screening and risk assessment, women and their families are offered linkages to appropriate medical providers, home visitation and community-based services. Successful implementation requires local community collaboration, consensus building careful planning and infrastructure development that includes prenatal care clinical providers, outreach programs, home visitation agencies and other community based prevention programs. The need for services is not solely determined by prenatal providers through the screening process. Referrals may come in to Central Intake directly from outreach or other community sources. See Appendix D - Central Intake Flow Chart.

Collaboration and Shared Deliverables:

This RFA is intended to function as a comprehensive initiative with two discrete but integrated components. While applications for Components A: Improving Pregnancy Outcomes and Components B: Central Intake for Maternal, Infant and Early Childhood Services will be reviewed and scored separately, once funded it is an expectation that all funded grantees serving common target areas will actively collaborate with the MIH-COE to achieve the shared goals of the larger initiative, including: the coordination or integration of planning strategies (such as community advisory groups and annual community assessments); the development of improvement strategies; and the ongoing coordination of outreach, screening and referral, service delivery and other systems-building strategies. Should the same applicant organization be selected to receive funding for more than one RFA component (A or B), awards may be integrated into a single grant award and administered as a single contract.

Based on their community assessments, grantees will select and implement relevant evidence-based or best practice activities, and/or develop and implement innovative strategies based upon sound empirical and theoretical frameworks. Using a structured performance management framework, grantees will regularly assess their progress in implementing strategies and achieving desired outcomes, and will continually refine improvement strategies to enhance or expand effective strategies and revise or discontinue those that are less effective. NJDOH/FHS and the new Maternal and Infant Health Center of Excellence (MIH-COE) will provide additional

guidance and technical support to grantees on performance measure development, data collection and reporting systems, and quality improvement methodology.

II. Background:

Improving access to preconception care and early prenatal care is essential to promoting the health of New Jersey mothers, infants, and families. Early prenatal care is an important component for a healthy pregnancy because it offers the best opportunity for risk assessment, health education, and the management of pregnancy-related complications and conditions. Early prenatal care is necessary but not always sufficient to improve birth outcomes and eliminate disparities. Successful pregnancy outcomes have been shown to be directly linked to the basic health of women. Applying the life course approach to improving birth outcomes is recommended by several national MCH organizations.(Ref 10, 14, 15) The life course approach to conceptualizing health care needs and services evolved from research documenting the important role early life events play in shaping an individual's health trajectory. The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, influence health throughout one's lifetime. Comprehensive, accessible medical care should be the foundation of an effective health care delivery system for women in their reproductive years.

Optimizing health and wellness before and between pregnancies benefits women and their families by improving health and pregnancy outcomes. The goal of preconception care is to reduce the risk of adverse health effects for the woman, fetus, or neonate by optimizing the woman's health and knowledge before planning and conceiving a pregnancy. (Ref 16) Because reproductive capacity spans almost four decades for most women, optimizing women's health before and between pregnancies is an ongoing process that requires access to and the full participation of all segments of the health care system.(Ref 17) Although interventions tend to focus on women, these preconception health opportunities are important to both women and men across the life course, regardless of reproductive age or pregnancy intention. Preconception care provides the opportunity for the development of a *reproductive life plan* consistent with a person's values and life goals.

To improve pregnancy outcomes, the needed medical care must include general medical care, as well as prenatal care. Other services including: mental health assessment, domestic violence assessment, dental assessment, HIV counseling and testing and substance abuse counseling must be included in the plan of care. Women with chronic pre-pregnancy conditions such as diabetes and hypertension known to benefit from early pregnancy management have not experienced increases in first trimester prenatal care. Preconception care is needed to provide health promotion, screening and interventions for women of reproductive age to reduce a woman's risk factors, especially where pregnancies have not been planned.

Prenatal care is integral in helping to prevent poor birth outcomes such as preterm birth, low birth weight and infant mortality. In addition to improving maternal health and birth outcomes, early and adequate prenatal care promotes preventive care for young children. Access to prenatal care is extremely important; yet many factors are barriers to early prenatal care, including

unintended pregnancies, lack of awareness of a pregnancy and lack of insurance. These can delay the initiation of early prenatal care.

Health risks and modifiable behaviors that are known to adversely affect pregnancy outcomes can be addressed by preconception and interconception care, and include the following prevalence rates among New Jersey women using data from the NJ Pregnancy Risk Assessment Monitoring System (PRAMS). (Ref 18)

- 44.5% of mothers were overweight or obese (BMI >25) prior to pregnancy
- 18.1% of mothers used tobacco immediately before or during pregnancy
- 23.1% of mothers drank alcohol weekly before pregnancy
- 52.5% did not take a multivitamin daily prior to pregnancy
- 22.4% of mothers were uninsured prior to pregnancy

According to New Jersey 2010 Pregnancy Risk Assessment Monitoring System data, one in every three pregnancies (36.1%) in New Jersey is unintended (mistimed or unwanted). Unintended pregnancies may result in delayed access to prenatal care and a reduced opportunity for screening and interventions for negative health behaviors, such as tobacco or alcohol use, that can lead to poor birth outcomes. High rates of unintended pregnancy can lead to serious socioeconomic consequences and contribute to significant disparities in reproductive health and pregnancy outcomes, particularly among young, poor, and minority women. PRAMS data shows that even of intended pregnancies, only 40% of mothers reported receiving preconception counseling. National and New Jersey data show no significant decline in the overall proportion of unintended births (mistimed or unwanted).(Ref 19)

New Jersey Behavioral Risk Factor Surveillance System (BRFSS) data indicate the following prevalence rates of other high risk conditions among New Jersey women of ages (18-64 yrs.) that can cause adverse birth outcomes. (Ref 20)

- 7.6% of women (18-64 yrs) reported diabetes
- 11.2% of women (18-64 yrs) reported current asthma
- 12.8% of women (18-64 yrs) reported no health care coverage

These rates are concerning because the critical periods of fetal development occurs before a woman is aware of her pregnancy and prior to her initial prenatal visit. Although early and regular prenatal care is important, planning for pregnancy and being at optimal health prior to pregnancy are keys to improving a woman's chance of having a healthy pregnancy and baby. The purpose of this RFA is to increase the identification women who are at high risk and link them to preconception care and or prenatal care aimed at improving preconception health and pregnancy outcomes through central intake and a community health worker model.

Description of Problem and Need

Efforts to improve access to early prenatal care must take a multi-pronged approach in order to reduce barriers. Despite major expansions of health care access, many women giving birth in

New Jersey still failed to receive first trimester prenatal care. Mothers most likely to benefit from early prenatal care because of their higher risk of poor birth outcomes remain even less likely to receive it.

In 2008, a Task Force of stakeholders was convened to identify an approach for improving New Jersey's rate of first trimester prenatal care. The Task Force produced a report highlighting goals and objectives along with a list of recommended actions to work towards improving rates of early prenatal care.(Ref 21) To address some of the recommendations related to access to early care, nine agencies in high risk areas were identified and awarded grant funds to implement evidence-based programs that focused on improving access to early prenatal care.

The overall trend in first trimester prenatal care for New Jersey mothers has increased slightly since the release of the Prenatal Care Task Force Report in 2008. The rate of first trimester prenatal care for New Jersey mothers for the first half of 2011 was about 81%, an improvement of 3.8 % since 2008 (provisional EBC data). While improvements in rates of first trimester prenatal care have occurred across all groups, significant racial/ethnic disparities persist.

Appendix B presents a prioritized list of target municipalities based on the NJ Population Perinatal Risk Index, a population-based index developed by Maternal Child Health Epidemiology Program which applies model-based effects to community sociodemographic profiles (Ref 23). Appendix B also presents municipality level birth outcomes including: Low Birth Weight, Preterm Births, Early Prenatal Care, and Perinatal Mortality. Statewide trends in birth outcomes are presented in Appendix A.

Community Assessment:

The Department released a report entitled “Improving the Health of New Jersey’s Communities” that identified high priority health issues identified by twenty-two public health partnerships through outreach to their public health care partners. The report is on the Department’s website (Ref 24). Each partnership developed a Community Health Improvement Plan (CHIP) that identifies methods to address the individual health issues. Representatives from hospitals, community services organizations, government, educational institutions, faith-based organizations, medical, social services and non-profit groups, participated in the project.

The results of the report are being used by local health agencies statewide to develop specific plans to address the high-priority public health issues. The public health issues identified in the project were:

- Substance abuse – including alcohol, tobacco, and other drug use –
- Mental health
- Obesity, Nutrition and Physical Fitness
- Access to Care
- Cancer; and
- Cardiovascular Disease.

All of these public health issues affect reproductive age women and their families. This IPO RFA serves as a means to support women of reproductive age and their families in the target communities.

III. Funding Information

It is expected that for the first year, a total of up to \$4.5 million will be available for funding for the two components (A & B) of the IPO Initiative. These funds are available from a combination of state and federal funding. The award of grants under this announcement is contingent upon the continued receipt of these state and federal funds by the DOH/FHS. The Department anticipates funding 10-12 Improved Pregnancy Outcome Initiatives (Component A) awards, ranging from \$250,000 to \$350,000 to applicants who can successfully meet the program and project criteria described in this announcement. The Department anticipates funding 5-7 Central Intake for Maternal Infant and Early Childhood Services (Component B) awards, ranging from \$75,000 to \$100,000 to applicants who can successfully meet the program and project criteria described in this announcement. Population size and geographic distribution will be considered in determining award levels.

This competitive RFA is for a period of three years (July 1, 2013 through June 30, 2016.) Year 2 and 3 Budget Periods will be for one year and are dependent upon the availability of funds. In subsequent years, the agency must submit a noncompetitive multi-year health service grant application. Each year continuing funding is contingent upon the availability of funds; timely accurate submission of reports; an approved annual plan; and satisfactory progress toward completion of the current years contract objectives.

Awards will be made based on the quality of the applicant proposal(s) and pending the availability of funds. Funding decisions will be made to ensure the broadest possible coverage, in terms of both geography and prioritized target populations to be served.

Target Population:

The applicant shall clearly delineate the population to be served through the grant period; targeting the high risk municipalities in a county for improvement in perinatal indicators including access to preconception, prenatal, and interconception care. The project area is defined as the specific municipality or municipalities within a county in which the proposed services are to be implemented. A project area must represent a reasonable and logical catchment area. High risk municipalities include those identified using the Population Perinatal Risk Index for New Jersey. Priority will be given to applications targeting the municipalities listed in Appendix B. Racial and ethnic disparities in health outcomes in the target municipality must be addressed.

Applicant Eligibility

The awarding of grants is on a competitive basis and is contingent on proposals deemed fundable according to a review of public health officials and compliance with:

- The DOH Terms and Conditions for Administration of Grants

- Conditions stated in this RFA

Eligible applicants include but are not limited to local health departments, not for profit agencies and other agencies that provide dedicated maternal and child health services and that meet the requirements of this RFA.

Applicants may propose to target more than one county. However, a separate application must be submitted and will be reviewed and scored separately for each county the applicant proposes to serve.

All applications that meet the minimum requirements will undergo a review process, as described below. Any agency or program that has been disbarred or is under suspension by the DOH or other governmental agency is not eligible.

All information submitted with your application is subject to verification during pre-decisional site visits and review by DOH staff. Verifications may include, but are not limited to, review of client records without identifiers, credentials of staff, progress reports submitted to funders, fiscal policies, procedural policies (including cultural competency policy) and procedures, etc. Submission of unverifiable information in this proposal may result in an agency not receiving any funds.

Perinatal Risk Assessment (Required for Component A and B)

The Perinatal Risk Assessment (PRA) is intended to promote early and accurate identification of prenatal risk factors and to reduce administrative burden on busy obstetric practices. Risk assessment is conducted during pregnancy during the first prenatal visit to identify women who are at high risk for fetal or infant death or infant morbidity. The goal of risk assessment is to prevent or treat conditions associated with poor pregnancy outcome and to assure linkage to appropriate services and resources through referral. Early identification and intervention are keys to prevention, therefore risk assessment is conducted at the first prenatal visit and updated throughout the course of prenatal care. The PRA is a standard two-page screening form that determines demographic, medical and psychosocial risk factors during pregnancy. The PRA includes the *4 P's Plus* to screen for tobacco, alcohol and other drug use; perinatal depression and domestic violence (see Appendix E).

Positive screens are based on objective data in three key areas: 1) demographic factors, e.g. age, municipality, marital status; 2) medical risks, e.g. parity (prior pregnancies and live births), prior birth outcomes (fetal/infant death, preterm, low birth weight); current positive screen for alcohol, tobacco and other drug use, depression, domestic violence; and 3) economic and psychosocial factors, e.g. TANF, WIC, insurance status, housing, language/cultural barriers. The PRA will be used by providers as a referral form for home visitation or other needed community services and supports.

Component A: Improving Pregnancy Outcomes Initiative

The focus of the IPO Initiative will be to increase the number of women receiving preconception care as well as earlier and regular prenatal care, increase parenting education, and increase the number of women and children receiving primary care and health promotion. The initiative will ensure that the identified vulnerable population obtains the full range of prenatal and delivery care services they need, and promotes well child care and appropriate parenting skills. This will be accomplished through outreach/retention/case management.

The IPO projects will include the following components:

- Link women to medical providers for provision of preconception and interconception care.
- Link women to prenatal providers for provision of early prenatal care.
- Use of the Perinatal Risk Assessment and identification of needed risk reduction services and referrals.
- Risk appropriate care per American College of Obstetricians and Gynecologists/American Academy of Pediatrics guidelines;
- Link families to the following health and social support service:
 - Services aimed at preconception and interconception care;
 - Services for pregnant women; post-partum women/families;
 - Enhanced clinical and health support services (nutrition, WIC, health education, psychosocial assessments/guidance counseling and referral, smoking cessation);
 - Outreach, client recruitment and follow-up for: preconception care, pregnant women, pediatric well baby services and immunizations; home visitation;
 - Immunizations referral/follow-up;
 - HIV assessment, counseling referral for testing;
 - Substance abuse screening/referral;
 - Family planning services/referrals;
 - Community health education programs;
 - Social support services.

Required model: Community Health Worker

The core public health strategy required for Component A is the use of community health workers (CHWs). Also known as *lay health advisors*, *natural helpers*, *community health representatives*, *indigenous helpers* or *promotoras*, CHWs are paraprofessionals who are trusted members of the target community to whom other community members turn for a variety of social supports.

Based on social support and social network theories of health promotion, CHWs have been used across a variety of public health initiatives to enhance multiple aspects of individuals' social networks and supports, which in turn can improve health outcomes by modeling and reinforcing positive health behaviors and practices, buffering the impact of stress, and facilitating access to and utilization of resources, including health care and other community services.

Well-designed CHW initiatives have the potential to provide multiple dimensions of social support, including informational, tangible, and emotional support. At a community/systems level, CHWs also can be effective in mobilizing and coordinating community resources. Recent studies demonstrate that CHWs can improve health outcomes.

CHWs supported through this initiative will implement a range of local strategies to find and engage high-need women in health insurance, health care and other supportive services; to identify specific needs and risk factors of clients; and, to improve the practice of health-promoting behaviors among target populations. CHWs may target preconception, prenatal/postpartum, and interconception women and their families, with a strong focus on high-need women who are not currently engaged in health care or other supportive community services.

CHW services should be tailored to the needs of clients and the community, and be coordinated with and integrated in larger community-wide health and community service systems. For example, CHW services should be a part of a continuum of maternal, infant and child health home visiting services, serving as a safety net for those high-risk clients that may not be eligible for other programs because of eligibility criteria, capacity issues or who may graduate out of those programs. CHW activities targeting preconception and interconception women should incorporate activities related to offering and arranging for family planning services.

Thus, all applicants need to propose strategies to find, engage and provide social support to high-need individuals and families within the target communities using CHW.

Examples of potential strategies that may be implemented through CHWs include:

- Conduct neighborhood “on the ground” outreach and networking to find and connect with high-need individuals, with particular emphasis on those not yet engaged in mainstream service systems;
- Use client-centered approaches to identify individual client and family needs, goals, strengths and challenges. Where available and appropriate to level of training, this should incorporate the use of validated screening or assessment tools to identify client risks or needs;
- For clients that are not enrolled in other home visiting programs, offer and provide regular home visits that include client-centered provision of health information, modeling and demonstrating skills, and reinforcing positive health choices and behaviors;
- Refer and provide direct 1:1 assistance to help clients obtain and consistently utilize health insurance, primary care and/or prenatal care services, family planning services and other needed community services such as WIC, substance abuse, domestic violence, mental health, etc. Examples of activities may include: assistance in completing applications, finding service providers or scheduling appointments; helping clients arrange child care or transportation; and accompanying clients to visits;
- Provide and disseminate written and oral information about available family planning health services in the community to prevent unintended pregnancies and promote spacing of subsequent pregnancies. This could include assisting individuals with arranging visits to family planning providers;

- Provide individualized social support to encourage and reinforce health promoting behaviors by clients, including personal and family health behaviors;
- Establish relationships with other health and human service providers in the community to identify and refer individuals who may benefit from CHW support services;
- Link families to other family resources within the community such as: Family Success Centers, Child Care Resource and Referral agencies, and breastfeeding support groups; and
- In collaboration with CHW coordinators, convene or arrange group educational sessions for expectant and new families.

Within this framework, grantees have the flexibility to propose specific local approaches to implement these core required strategies.

While the above examples focus on individual/family level activities, CHWs also may be integrated in strategies targeting change at community or organizational levels, such as:

- Development of/or becoming members of community coalitions;
- Establishment of reciprocal referral networks;
- Integration of CHWs within multi-disciplinary health care teams to serve as liaisons between the medical home and the patient/family; and
- Introducing media materials designed to influence social norms related to health and health behaviors to members of target communities.

Selection of high need populations should be guided by an initial and ongoing community needs assessment. CHW services should primarily target low-income, Medicaid-eligible women and families, with particular emphasis given to reaching individuals and sub-groups who are traditionally underserved and/or disconnected from mainstream services, as identified through the community needs assessment.

Linking women to preconception care if not pregnant and to early prenatal care if pregnant are the priorities of this initiative. In this proposal, Community Health Workers will recruit women into services to assist women and their families through the various health and social service systems.

Women recruited through this outreach and education initiative may be referred to other health and social service providers via the Central Intake Process. Risk assessment documentation will be reviewed allowing women and their families to be offered the most appropriate services. Women and their families who are referred to and accept Home Visitation models will be discharged from the CHW's case load.

Some clients recruited via outreach and education may require additional assistance navigating the health and social service agencies in their municipality/county. These clients would be retained and offered case management services. Community Health Workers who provide case management services would retain a patient load requirement: an average of 75 clients provided

case managed preconception and or prenatal through 3 months postpartum. CHWs required case loads will be determined by a considering increasing levels of service intensity for women with preconception, interconception and prenatal care needs based on standardized risk assessment.

Case management includes regular contact via telephone or face to face (minimum: monthly first trimester, biweekly second trimester, weekly third trimester, biweekly post partum; additional visits as needed based on assessment). Documentation of all contacts to be maintained including calendar of visits and notes regarding follow up on all referrals.

In an effort to leverage State and Federal funding, clients' participation in the Maternal, Infant and Child Early Home Visiting Programs would not be eligible to receive Component A CHW case management services concurrently. Clients served simultaneously by both projects could be perceived as a duplication of effort and funds. Note that clients once referred and served by federally funded projects including Healthy Start, Eliminating Disparities in Perinatal Health and Strong Start are not eligible for Component A CHW case management services. Use of the PRA within the Central Intake Model would allow for the best match of client needs to services.

Required : Advisory Board

Applicants funded for Component A are required to convene a community-based advisory board of individuals and partner agencies. Representation must include a partnership of consumers (program and community), providers of services, community organizations, and groups, with a working interest in maternal and child health issues. The Central Intake agency for the county must be a member of this Advisory Board. It is required that consumers of services will be active participants in decision making regarding the direction of the project. This Advisory Board will meet at least quarterly to discuss significant issues including barriers to care identified by the participants and the Community Health Workers in attaining services for clients. If such a community-based board exists, this IPO Initiative component may be implemented as a collaboration.

Component A - Performance Standards

The applicant should work to develop performance standards that will enhance, develop or implement the Community Health Worker model to increase access to preconception, prenatal and interconception care. All IPO grantees will be expected to collect, review and report a set of defined performance standards to monitor and assess the implementation and effectiveness of improvement strategies. The specific performance standards will be developed as part of Year 1 implementation in close consultation with NJDOH/FHS and the new MCH-COE. The following table illustrates potential Performance Standard for Component A.

Component A - Performance Standards		
Performance Standards Label	Definition	Definition of Measurable Improvement
Prenatal Care	Adequacy of prenatal care - based on clinical visits & trimester of entry into prenatal care (Kotelchuck/APNCU Index)	Improvement over time in the proportion of participating mothers who enroll in prenatal care no later than 13 weeks gestation with adequate prenatal care
Screening for maternal depressive symptoms	The completion of a recognized depression screening tool (PRA, 4 P's Plus or Edinburgh) during the initial month of enrollment	Increase over time in the proportion of mothers with a completed depression screening tool
Maternal use of alcohol, tobacco, or illicit drugs	The completion of the PRA (recognized ATOD screening tool) during the initial month of enrollment	Increase over time in the proportion of mothers with a completed PRA screening tool
Breastfeeding	Mothers who breast feed their 6 week old infants	Increase over time in the proportion of mothers who breast feed their 6 week old infants
Preconception health	Women attending at least one medical visit for preconception risk assessment within the prior 12 months	Improvement over time in the proportion of participating women who receive preconception risk assessment
Health insurance before pregnancy	Women with documented health insurance 3 months prior to current pregnancy	Improvement over time in the proportion of participating women who have health insurance 3 months prior to pregnancy
Interconception care	Postpartum (PP) mothers with required follow-up medical/reproductive health visit by 8 weeks postpartum	Improvement over time in the proportion of participating mothers completing a postpartum medical visit
Inter-birth intervals	Education on the appropriate length of time in days between successive births	Increase or maintain over time in the proportion of participating mothers who receive education on birth spacing
Folic Acid Supplementation	Women who report that they took a multivitamin, prenatal vitamin or folic acid vitamin every day of the week during the month before they got pregnant	Increase over time in the proportion of participating mothers who reporting taking folic acid supplementation

The applicant must demonstrate how the initiative will increase access to services for women in their reproductive years. A comprehensive approach that integrates social, clinical and economic components including racial and ethnic disparities in health outcomes in the target municipality must be addressed.

Component B: Central Intake for Maternal Infant and Early Childhood Services

The Central Intake for Maternal Infant and Early Childhood Services focuses on additional strategic efforts to assure that the specific needs of individuals and families are identified and addressed effectively within community-wide service systems. The beneficial services of

preconception and prenatal care on both maternal and infant health outcomes include: early and comprehensive screening to identify risk factors; preventive counseling to promote and reinforce healthy behaviors and reduce risky behaviors; management of chronic or emergent medical conditions such as diabetes and hypertension; and, linking high-risk individuals to key supportive services such as WIC, home visiting and smoking cessation programs. Postpartum care visits provide an additional opportunity to assess maternal medical, behavioral and psychosocial risks, provide information on infant care and birth spacing, and assure ongoing health care and management plans are in place for preexisting or developing chronic conditions. (Ref 25, 26)

NJDOH/FHS is looking to place a significant emphasis on building and strengthening a collective system to assure that risk factors are systematically and routinely identified, documented and addressed through Central Intake. These efforts should focus both on improving systems within health care practices and on building reciprocal linkages between health care and other community providers that serve high-need families, including WIC, home visiting, early child care and education, mental health and substance abuse, domestic violence, income assistance and many other services.

Thus, the focus of Central Intake is to assist women and their families in accessing the most appropriate services in an efficient manner. Central Intake works closely with partners to eliminate duplication of effort and services, and it maximizes the appropriate utilization of available and often scarce resources.

Based on the information provided on the PRA screening form, pregnant women/parents should receive prevention education and early linkages to services. Women/families receiving a preconception health initial assessment may be offered alternative supports and services as available in the community. Central Intake may initiate a direct referral of a woman/family in consultation with a provider (or a participant) when a more serious or urgent need is identified (e.g. depression, domestic violence, addiction, housing, etc.)

Community-based services include support for:

- Maternal Infant and Early Childhood Home Visiting Programs
- Health Care (prenatal care, reproductive health care, and adult and pediatric primary care)
- Behavioral Health Care (mental health intervention, tobacco cessation, addiction treatment)
- Domestic Violence Shelters and Support Services
- Educational Attainment – Literacy, GED, ESL, Vocational, College
- Family Social Support / Fatherhood Support Programs
- Financial Assistance / Employment Training / Life Skills Development
- Infant and Child Care / Early Childhood Services / Early Intervention
- And other available community services and supports

Central Intake Functions:

- Promotes universal screening of pregnant women

- Puts agreements in place with prenatal providers for receipt of referrals
- Implements a system to receive screens/referrals (in collaboration with providers)
- Coordinates training of participating providers/agencies in how the screen is used and transmitted to Central Intake, including 4 P's Plus, depression screening; and how clients/patients will be linked to available resources.
- Implements a feedback mechanism to referring providers, especially prenatal providers, for their records
- Ensures that intake staff are well-trained to make an initial determination of the woman's needs, including:
 - prevention education
 - perinatal health
 - behavioral health
 - social issues and family support
 - financial needs and eligibility / public assistance (TIP eligible)--GA, TANF, Food Stamps, emergency assistance, SAI, MHI, NJ FamilyCare, etc.
- Implements triage criteria for linkage to an initial assessment
 - Coordinates with outreach to locate women/families without telephones
 - Provides linkages for an initial assessment for assessment/medical care
 - Preconception
 - Prenatal
 - Women's health (primary care)
 - Pediatric/well child care
- Provides linkages for an initial assessment for home visiting (home or center-based)
 - Nurse Family Partnership (NFP)
 - Healthy Families
 - Parents as Teachers (PAT)
 - Early Head Start/Head Start
 - Other Home Visiting Programs – HIPPO, Parent-Child Home, etc.
 - Family Success Centers / Family Resource Centers
 - Infant/Toddler Childcare Centers
 - Pre-K or other childcare centers
- Coordinates a plan for outreach and education (either directly and /or thru partners)
 - to pregnancy testing sites
 - key prenatal/reproductive health providers
 - to behavioral health providers
 - to welfare and other social service agencies
 - to schools
 - to community agencies
 - to pregnant women/families in the community
 - to the general public
- Implements and maintains a standardized data tracking system
- Convene a designated advisory board consisting of MCH providers, social service agencies and consumers that meets quarterly. Must include representation from the IPO project.

Component B - Performance Standards for Central Intake for Maternal Infant and Early Childhood Services:

The applicant should work to develop objectives that will enhance, or implement the Central Intake model. All Component B grantees will be expected to collect, review and report a set of defined performance standards to monitor and assess the implementation and effectiveness of improvement strategies. The specific performance standards will be developed as part of Year 1 implementation in close consultation with NJDOH/FHS and the new MCH-COE. It is anticipated that performance standards will include a set of uniform core performance standards for the entire IPO initiative that will be reported by all grantees, as well as additional process and outcome measures specific to each IPO project. Data sources for performance standards likely will include a combination of Perinatal Risk Assessment data and data collected and reported directly by grantees to NJDOH (e.g., client-level data from community health worker activities) and data analyzed and reported to grantees by NJDOH (e.g., community-level vital statistics or Medicaid enrollment/utilization data).

The following table illustrates potential performance standards for Component B.

Performance Standards for Central Intake for Maternal Infant and Early Childhood Services		
Performance Standard Label	Definition	Definition of Measurable Improvement
Number of women identified for necessary services	Number of participating women identified for necessary services (need list of necessary services)	Increase over time in the proportion of women screened for necessary services by a standardized assessment tool (PRA).
Number of women needing services & receiving a community resource referral	Number of participating women identified as requiring a service by a standardized assessment tool and who received a referral to an available community resource.	Increase over time in the proportion of participating women identified as requiring a service and who received a referral to an available community resource.
Number of MOUs with other social service agencies in the community	Number of MOUs with other social service agencies in the community	Increase or maintain over time in the number of MOUs each provider has with health/service agencies
Information sharing: Number of agencies where provider has a specific contact w/ collaborating community agency	Number of agencies with which the provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies	Increase or maintain over time in the number of agencies with which each provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies
Number of completed referrals	Number of completed referrals (completed individual family referrals documented by a report of the service provided).	Increase over time in the proportion of completed referrals (completed individual family referrals documented by a report of the service provided)

Evaluation:

All grantees will be expected to incorporate Quality Improvement (QI) activities to critically review the effectiveness of chosen strategies. Once performance standards and accompanying data sources have been defined, data should be reviewed on a “real-time” basis to provide rapid-cycle feedback about performance to promote continuous quality improvement. These QI activities should lead to adjustment of improvement strategies as needed to optimize their effectiveness. Grantees will be required to submit quarterly reports that reflect critical review of progress and performance standards data and any resulting changes to improvement plans. Improvement plans will be formally updated annually as a condition of continued grant funding. IPO partners should be fully engaged in these activities. Improvement plans should reflect engagement of the target population in development of strategies and assessment of progress. Through these activities, the IPO initiative will help develop a body of “practice-based evidence” related to improving maternal and infant health outcomes among high-need populations and communities.

The MIH-COE will be charged with developing and implementing an evaluation of the IPO initiative, including assessment of the implementation and effectiveness/ impact of specific required strategies on performance standards and associated performance measures. As a condition of funding, grantees will be required to participate in any evaluation activities directed by the NJDOH/FHS. It is anticipated that these evaluation activities will build directly upon the performance management activities described above.

System of Administering Grants Electronically (SAGE)

The Department of Health (DOH) requires all grant applications to be submitted electronically through our System of Administering Grants Electronically (SAGE) using font: Times New Roman -12, single space and no special characters.

Grant Application Timeline:

- An email “Notice of Intent to Apply” must be sent to the Program Manager no later than 5:00 p.m. on April 26, 2013. Contact information is provided below:

Sandra M. Schwarz, Program Manager
Improved Pregnancy Outcome, component A or B
Sandra.Schwarz @doh.state.nj.us

- A Bidder’s Conference/ Technical Assistance Meeting will be held for all eligible applicants on **May 10, 2013**. Location details will be provided, via email, by April 26, 2013.
- Applications must be submitted **no later than 5:00 p.m. on June 3, 2013**.

Paper submissions will not be considered. **Incomplete grant applications will not be considered and will be disqualified.** Applications that do not meet the above criteria will not be considered and will be rejected. **Selected applicant will be notified of funding decisions on or about June 30, 2013.**

In order to submit a proposal online, via the **System for Administering Grants Electronically (SAGE)**:

- *If your organization is already registered in SAGE, you will be able to logon and begin the application process once the application is available (date will be provided at the Bidders’ Conference/ Technical Assistance Meeting).*
- *If your organization has never registered in SAGE, you will be sent guidance for gaining access after your “Notice of Intent to Apply” has been received.*

Other Requirements

Progress and expenditure reports addressing work plan activities to be submitted are located in the NJSAGE system:

- Progress Reports must be submitted within ten (10) business days of the end of the program period quarter.
- Expenditure Reports are due at the end of each quarter.
- Budget revisions can be submitted until forty-five (45) days prior to the end of the program period.
- A narrative of the final summary report on the agency’s activities under the grant and Final Expenditure Reports are due thirty (30) days after the end of the budget period.

Section 1 – Background/Organizational Capacity (20 points)

Organizational Structure - Applicants should provide:

- a. A brief description and history of the organization;
- b. An organizational chart that describes the location of this program within the organizational structure; and
- c. Describe the experience of the applicant organization in providing quality coordination of resources and community services in the proposed county.
- d. Describe the major linkages with community (public and private) organizations (e.g., other health care programs, human service agencies, health professional education programs, integrated service networks, school systems, housing programs, etc.).

Section 2 – Needs Assessment (10 points)

- a. Identify the proposed target population and service area.
- b. Describe how the proposed program is most appropriate and responsive to the women of childbearing age and their families in improving access to prenatal, preconception and interconception care and address barriers to care.
- c. Describe the extent to which project activities are coordinated and integrated with the activities of other community programs serving the same populations(s).
- d. Describe both formal (attach Letter of Agreement) and informal arrangements.
- e. Include a time specific project plan that demonstrates that the agency/organization will be operational within 60 days of receipt of grant award.

Section 3 – Project Plan for Service Delivery (50 points) Component A Improving Pregnancy Outcomes Initiative

- Describe the organization’s general approach to meeting community/target population of the women of childbearing age and their families.
- Describe the proposed service project model and the services to be provided.
- Describe the proposed staffing and agency readiness of the program.
- Describe how the proposed projects are most appropriate and responsive to the identified issues related to access to prenatal care, preconception and interconception care.
- Describe the extent to which project activities are coordinated and integrated with the activities of other federally funded, State and local health services delivery projects and programs serving the same population(s).
- Describe, in cases where the site is already operational, how grant funds will augment/supplement existing services, resources and providers to expand accessibility and availability of primary health care services to underserved populations.

Section 3 – Project Plan for Service Delivery (50 points) Component B Central Intake for Maternal, Infant and Early Childhood Services

- Describe the organization’s general approach to meeting community/target population of the women of childbearing age and their families.
- Describe the proposed staffing and agency readiness of the program.
- Describe how screening referrals will be completed and submitted to the Central Intake Unit.

- Describe the implementation process to comply with the functions of the Central Intake as listed in this RFA
- Describe the extent to which project activities are coordinated and integrated with the activities of other federally funded, State and local health services delivery projects and programs serving the same population(s).
- Describe how grant funds will augment/supplement existing services, resources and providers to expand accessibility and availability of primary health care services to underserved populations.

Section 4 – Budget and Justification (20 points)

- a. The budget should be developed based on the estimated funding needs to accomplish the proposed project. Health Service Grant Application Schedule A, B, and C must be completed.
- b. Identify the number of full time equivalents regardless of funding source that will be providing services for the program.
- c. The budget should be accompanied by a complete and comprehensive budget justification that provides an explanation for each budget line item; and
- d. The budget should be reasonable and appropriate based on the scope of the services to be provided.
- e. Identify all state and federally funded initiatives in the project area which your agency is funded.

REVIEW PROCESS:

1. Applications received by the deadline will be screened for compliance with the mandatory requirements by Maternal and Child Health Services staff.
2. Applications that are incomplete or do not conform to the grant requirements will be disqualified.
3. Applications that meet the screening requirements will be presented to a review committee.
4. The review committee will assess each application according to the Evaluation Criteria described below.

EVALUATION CRITERIA:

Applications will be reviewed in accordance with the Evaluation Criteria contained in the Request for Applications.

- Background/Organizational Capacity (20 points)
- Needs Assessment (10 points)
- Project Plan for Service Delivery (50 points)
- Budget and Justification (20 points)

After applications have been scored and ranked by the review committee, DOH/FHS staff will review the budget request. An application must receive a minimum score of 70 points to be eligible for funding. The DOH/FHS may negotiate specific line items that it determines to be inappropriate, excessive or contrary to the DOH/FHS grant policy.

References:

- ¹ Perloff J and Jaffee K. Late entry into prenatal care: the neighborhood context. *Social Work* 1999;44(2):116-128.
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- ¹⁰ U.S. Department of Health and Human Services Health Resources and Services Administration, Maternal and Child Health Bureau, “Rethinking MCH: The Life Course Model as an Organizing Framework, Concept Paper,” November, 2010 Version 1.1.
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- ¹² Bartholomew LK, Parcel GS, Gerjo KI, Gottlieb NH. (2006). *Planning Health Promotion Programs: An Intervention Mapping Approach (1st Ed)*. San Francisco: John Wiley and Sons, Inc.

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- ¹⁵ Lu MC, Kotelchuck M, Hogan V, Jones L, Wright K, Halfon N. Closing the black-white gap in birth outcomes: A life-course approach. *Ethn Dis* 2010; 20(1) Supplement 2: S2-62-76.
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Appendix A (4 pages)

Statewide Birth Outcomes by Race/Ethnicity (Early PNC, LBW, Preterm, IMR) (4 pages)

Appendix B (4 pages)

Priority High-Risk Municipalities based on NJ Population Perinatal Risk Index with Municipality level Birth Outcomes (LBW, Preterm, Early PNC, Perinatal Mortality)

Appendix C

Table of programs and services applicant is to complete to document partnerships

Appendix D

Central Intake Flow Chart

Appendix E (2 pages)

PRA form

Appendix F

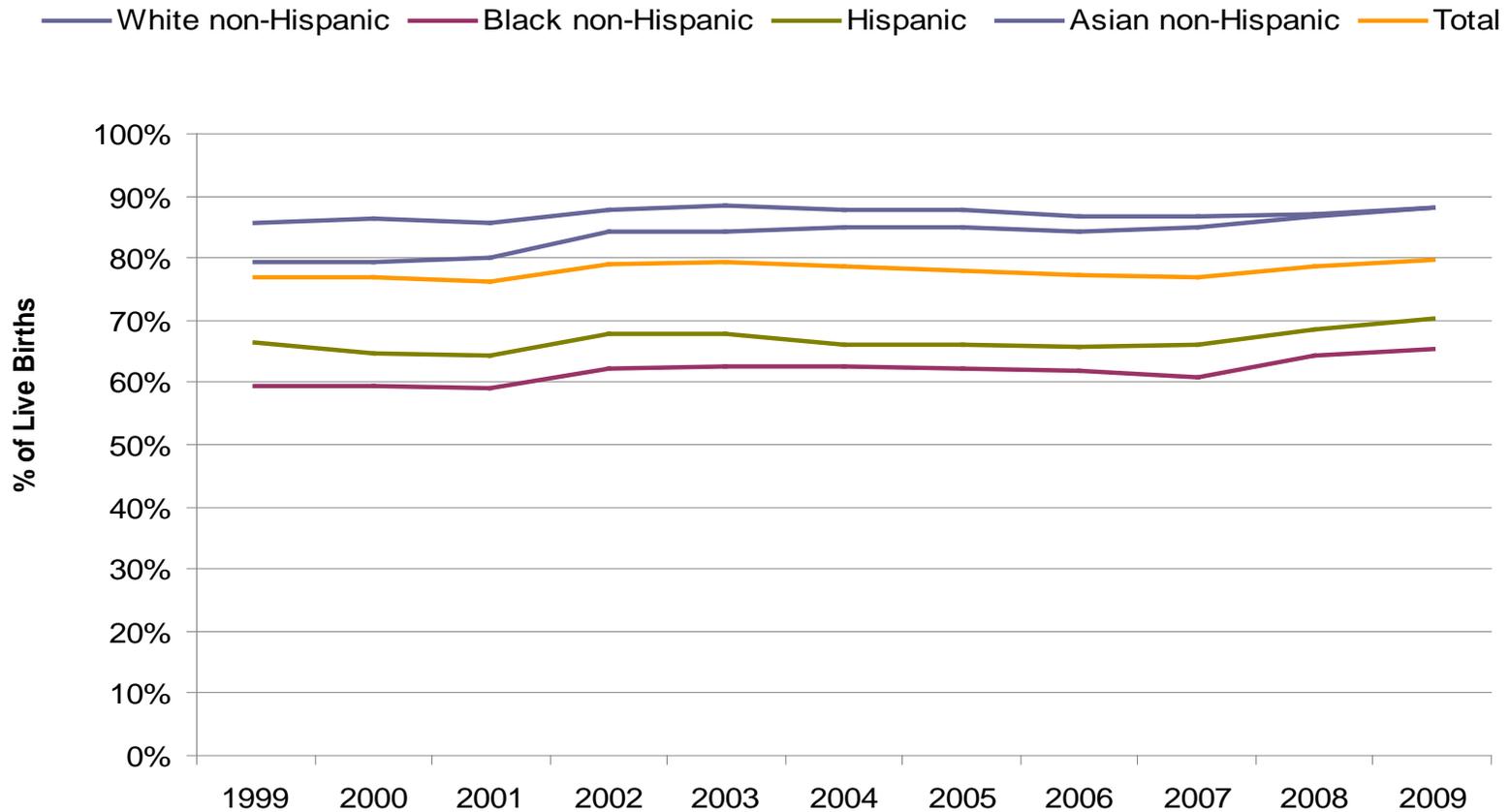
Logic Model

Appendix G

Glossary

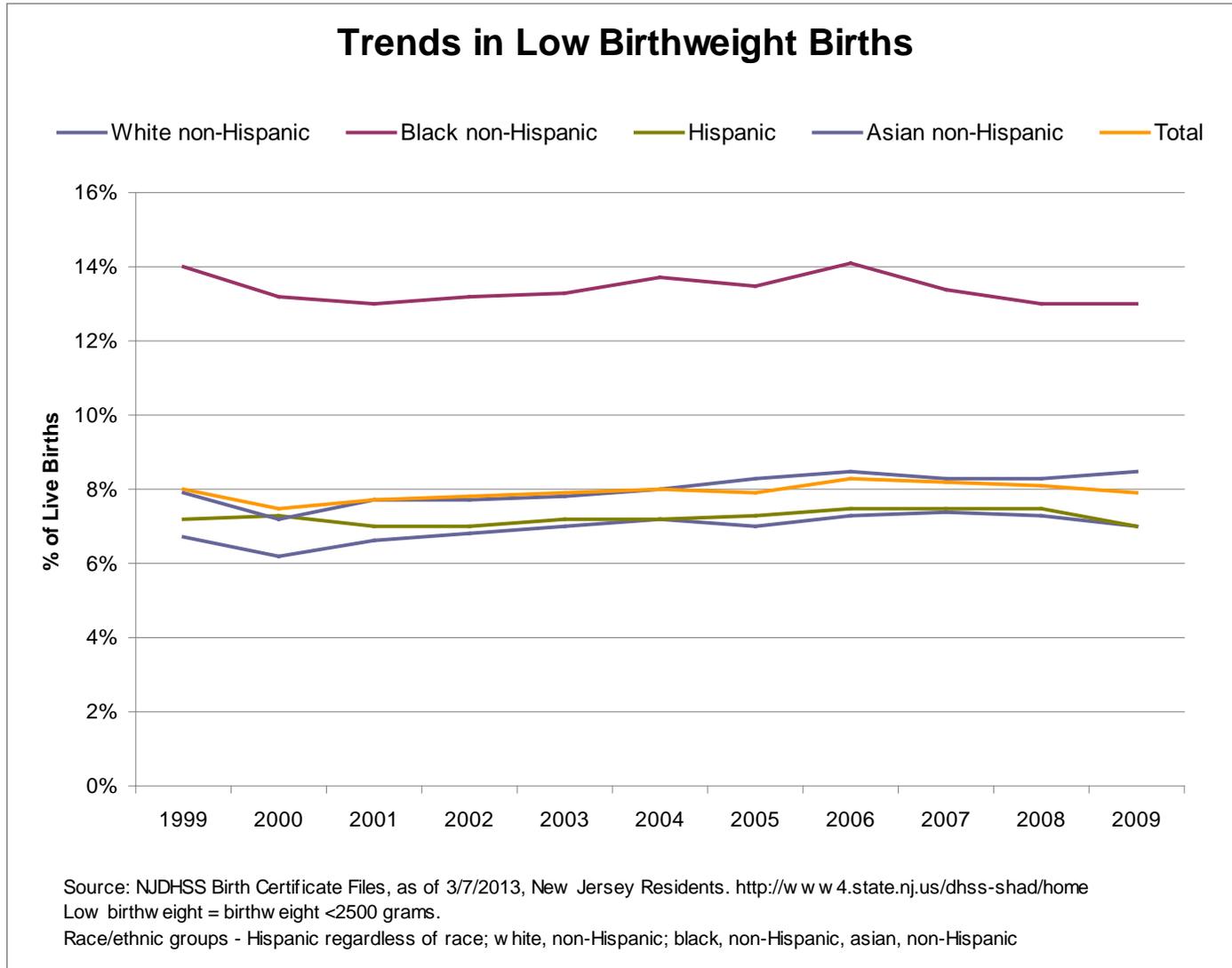
Appendix A – Graph 1

Trends in First Trimester Prenatal Care

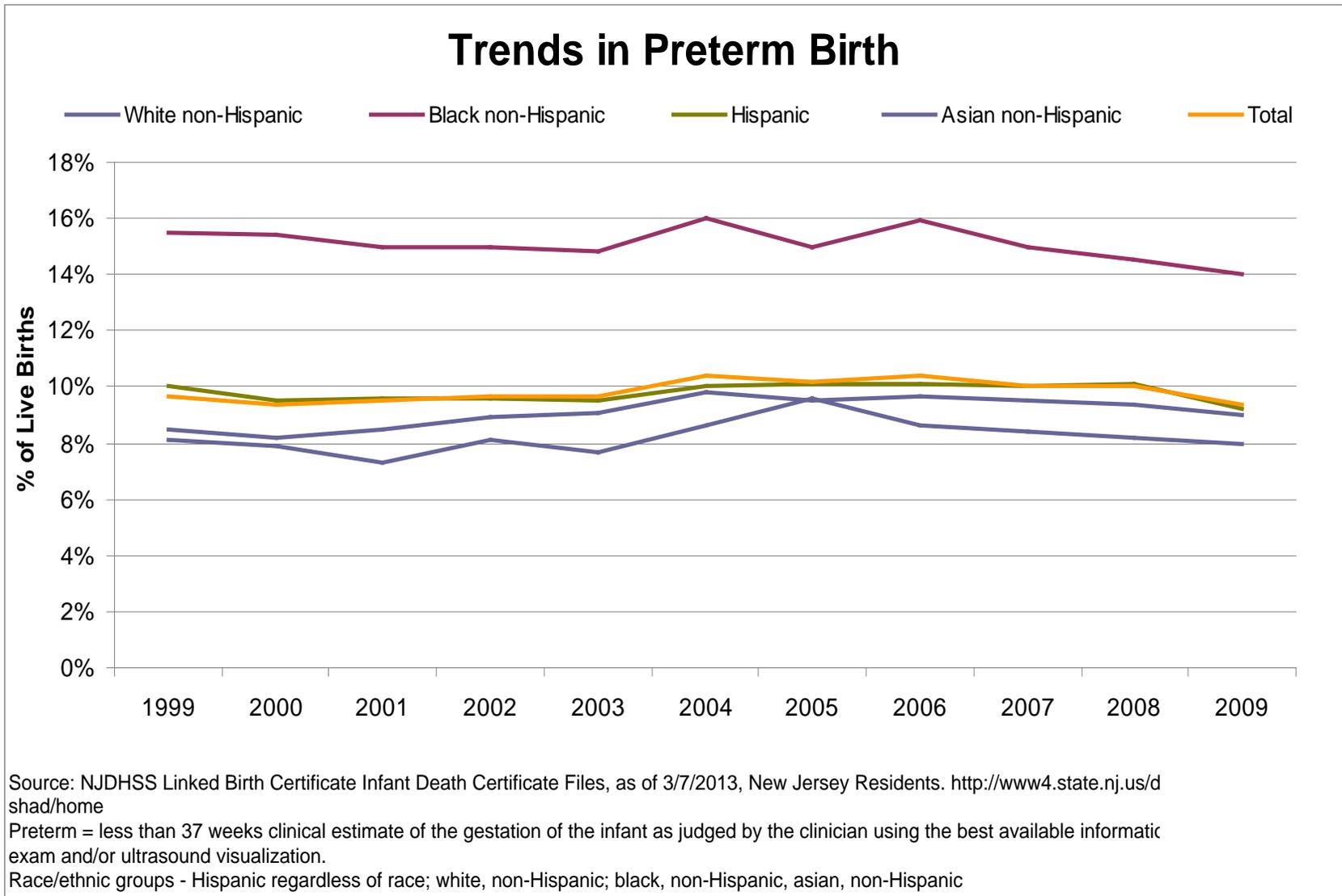


Source: NJDHS Birth Certificate Files, as of 3/7/2013, New Jersey Residents. <http://www4.state.nj.us/dhss-shad/home>
 *Initiation of prenatal care self-report as within first 13 weeks on BC.
 Race/ethnic groups - Hispanic regardless of race; white, non-Hispanic; black, hispanic, asian, non-Hispanic

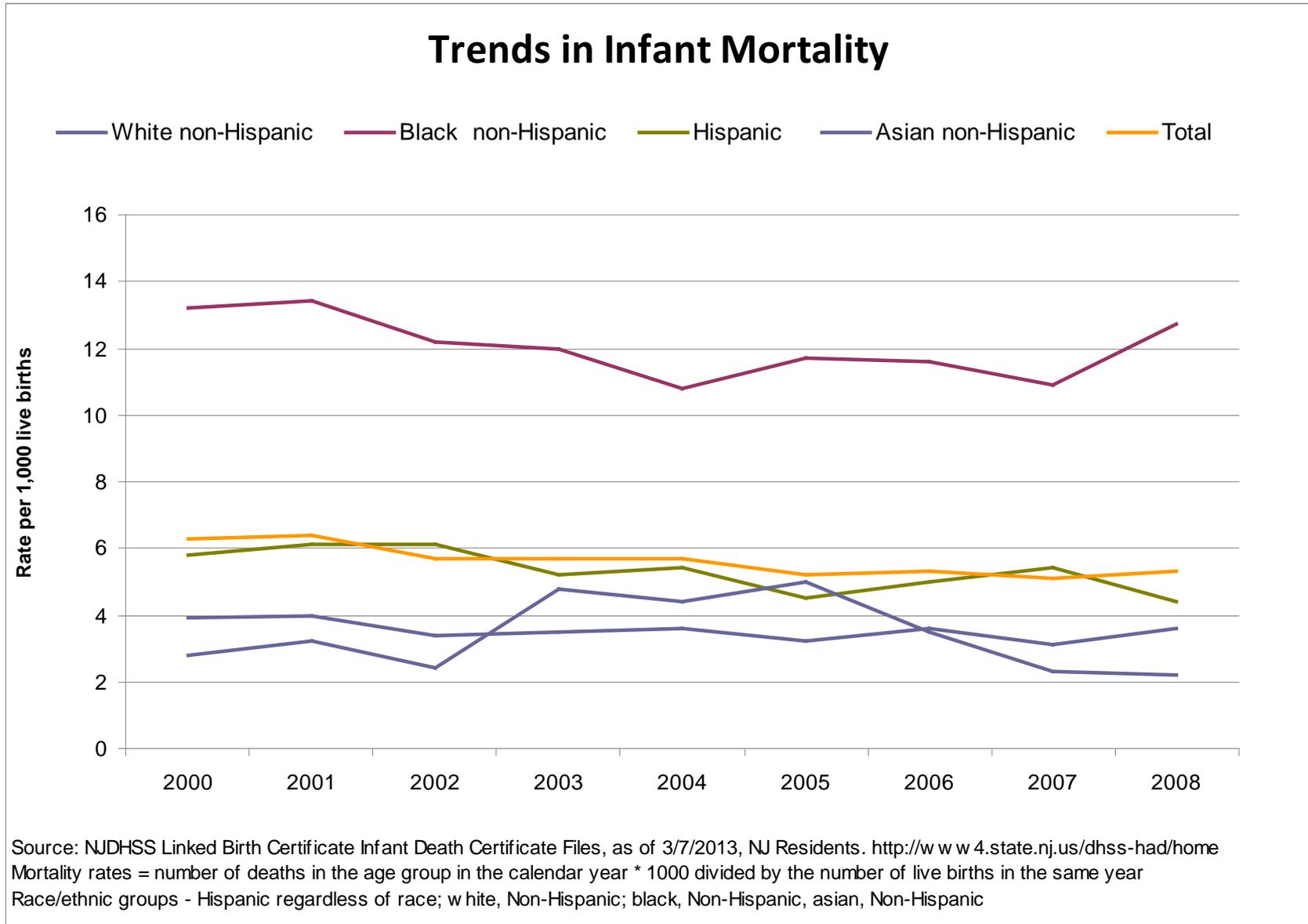
Appendix A – Graph 2



Appendix A – Graph 3



Appendix A – Graph 4



Appendix B - Priority High-Risk Municipalities based on NJ Population Perinatal Risk Index

HIGH RISK MUNICIPALITIES		All Live Births	Risk index (Predicted rate LBW)	Volume estimate	*Low Birth Weight <2500g	*Preterm Births <37wks	*1st Trimester PNC	Perinatal Mortality 2006-08	Predicted Rate of Preterm	Predicted Rate of Perinatal Mortality	PNC not in 1st trimester	PNC 3rd/ none
East Orange City	ESSEX	2,814	11.4%	320.8	13.3%	13.5%	60.4%	2.2%	12.4%	2.0%	39.6%	9.7%
Willingboro Township	BURLINGTON	1,003	11.1%	111.3	10.6%	12.0%	72.4%	1.6%	12.2%	1.8%	27.6%	5.7%
Irvington Township	ESSEX	2,769	10.8%	299.1	11.7%	12.6%	58.5%	1.9%	11.9%	1.9%	41.5%	10.9%
Camden City	CAMDEN	4,690	10.2%	478.4	10.6%	11.4%	67.9%	1.8%	11.2%	1.5%	32.1%	6.3%
Newark City	ESSEX	12,970	10.2%	1322.9	10.7%	12.6%	59.6%	2.0%	11.4%	1.5%	40.4%	10.8%
Asbury Park City	MONMOUTH	872	10.2%	88.9	10.9%	12.0%	67.7%	1.9%	11.3%	1.5%	32.3%	5.9%
Trenton City	MERCER	4,752	10.1%	480.0	11.1%	12.2%	60.0%	1.9%	11.2%	1.5%	40.0%	8.5%
Atlantic City	ATLANTIC	2,198	9.9%	217.6	9.6%	8.6%	58.7%	1.7%	10.9%	1.4%	41.3%	7.6%
Orange City	ESSEX	1,615	9.7%	156.7	10.7%	11.5%	58.3%	1.9%	10.9%	1.7%	41.7%	8.6%
Neptune Township	MONMOUTH	934	9.5%	88.7	9.7%	11.0%	81.2%	0.9%	10.9%	1.4%	18.8%	3.1%
Roselle Borough	UNION	817	9.5%	77.6	9.4%	10.5%	72.9%	1.1%	10.9%	1.5%	27.1%	6.7%
Hillside Township	UNION	742	9.4%	69.7	9.3%	11.1%	79.1%	1.5%	10.8%	1.5%	20.9%	4.7%
Pleasantville City	ATLANTIC	1,079	9.2%	99.3	8.5%	9.2%	62.9%	2.1%	10.5%	1.4%	37.1%	6.8%
Pennsauken Township	CAMDEN	1,323	9.1%	120.4	8.5%	8.5%	76.2%	1.9%	10.4%	1.2%	23.8%	4.1%
Winslow Township	CAMDEN	1,535	9.1%	139.7	10.0%	12.0%	79.3%	0.8%	10.7%	1.2%	20.7%	5.0%
Bridgeton City	CUMBERLAND	2,100	9.1%	191.1	9.0%	9.0%	64.4%	1.4%	10.4%	1.2%	35.6%	6.2%
Millville City	CUMBERLAND	1,458	9.1%	132.7	11.4%	13.0%	69.3%	1.9%	10.5%	1.2%	30.7%	5.8%
Burlington City	BURLINGTON	542	9.0%	48.8	7.4%	10.0%	77.1%	2.8%	10.3%	1.3%	22.9%	3.9%
Lindenwold Borough	CAMDEN	955	9.0%	86.0	11.2%	11.9%	73.5%	1.1%	10.3%	1.3%	26.5%	4.1%
Jersey City	HUDSON	10,485	9.0%	943.7	9.6%	11.1%	76.6%	1.3%	10.0%	1.2%	23.4%	5.3%
Glassboro Borough	GLOUCESTER	622	8.9%	55.4	7.4%	8.1%	77.9%	1.1%	10.5%	1.1%	22.1%	5.4%
Plainfield City	UNION	2,562	8.9%	228.0	8.6%	10.2%	70.1%	1.0%	10.2%	1.4%	29.9%	5.7%
Burlington Township	BURLINGTON	586	8.8%	51.6	6.3%	8.2%	84.3%	1.1%	10.4%	1.1%	15.7%	3.5%
Maplewood Township	ESSEX	770	8.8%	67.8	8.1%	12.1%	86.5%	1.3%	10.7%	1.1%	13.5%	3.1%
Paterson City	PASSAIC	7,981	8.8%	702.3	9.8%	11.0%	69.4%	1.1%	10.1%	1.3%	30.6%	6.1%
Montclair Township	ESSEX	892	8.7%	77.6	7.3%	10.0%	86.8%	1.1%	10.5%	1.1%	13.2%	2.0%
Ewing Township	MERCER	841	8.7%	73.2	10.4%	10.1%	82.0%	1.3%	10.2%	1.2%	18.0%	3.7%
Carteret Borough	MIDDLESEX	852	8.7%	74.1	8.2%	6.9%	73.8%	0.9%	9.8%	1.1%	26.2%	4.9%
Linden City	UNION	1,332	8.7%	115.9	9.3%	10.5%	79.4%	1.7%	10.2%	1.2%	20.6%	4.6%
Rahway City	UNION	942	8.7%	82.0	9.3%	11.6%	81.1%	0.8%	10.2%	1.2%	18.9%	3.4%
Piscataway Township	MIDDLESEX	1,766	8.6%	151.9	7.9%	8.4%	92.3%	0.8%	9.2%	1.0%	7.7%	1.2%
Franklin Township	SOMERSET	2,509	8.6%	215.8	8.2%	9.7%	92.9%	0.8%	9.7%	1.1%	7.1%	1.5%

Continued Appendix B - Priority High-Risk Municipalities based on NJ Population Perinatal Risk Index

HIGH RISK MUNICIPALITIES		All Live Births	Risk index (Predicted rate LBW)	Volume estimate	*Low Birth Weight <2500g	*Preterm Births <37wks	*1st Trimester PNC	Perinatal Mortality 2006-08	Predicted Rate of Preterm	Predicted Rate of Perinatal Mortality	PNC not in 1st trimester	PNC 3rd/ none
Union Township	UNION	1,798	8.6%	154.6	10.3%	11.3%	85.7%	1.4%	10.0%	1.2%	14.3%	3.5%
Englewood City	BERGEN	937	8.5%	79.6	9.6%	11.0%	74.4%	1.4%	9.9%	1.1%	25.6%	3.5%
Fort Lee Borough	BERGEN	865	8.4%	72.7	7.1%	8.3%	85.8%	0.7%	9.2%	0.8%	14.2%	2.6%
Vineland City	CUMBERLAND	2,432	8.4%	204.3	9.1%	9.1%	73.7%	1.2%	10.0%	1.1%	26.3%	4.2%
West Orange Township	ESSEX	1,588	8.4%	133.4	9.6%	11.0%	83.9%	0.8%	10.0%	1.1%	16.1%	3.4%
North Brunswick Town	MIDDLESEX	1,760	8.4%	147.8	8.7%	9.8%	93.0%	0.7%	9.4%	1.0%	7.0%	1.9%
Plainsboro Township	MIDDLESEX	837	8.4%	70.3	7.1%	6.8%	94.1%	1.2%	8.9%	0.8%	5.9%	1.3%
Edison Township	MIDDLESEX	4,066	8.4%	341.5	9.0%	9.6%	90.2%	0.9%	8.9%	0.8%	9.8%	1.9%
South Brunswick Town	MIDDLESEX	1,073	8.4%	90.1	7.9%	8.7%	94.9%	0.6%	9.2%	0.9%	5.1%	1.2%
Elizabeth City	UNION	6,169	8.4%	518.2	8.2%	8.8%	68.5%	1.4%	9.9%	1.2%	31.5%	7.5%
Hamilton Township	ATLANTIC	990	8.3%	82.2	8.4%	9.0%	76.9%	1.2%	9.9%	1.0%	23.1%	4.2%
Palisades Park Borou	BERGEN	695	8.3%	57.7	8.1%	8.8%	80.3%	0.5%	8.9%	0.8%	19.7%	3.5%
Bloomfield Township	ESSEX	1,707	8.3%	141.7	8.9%	10.4%	82.2%	0.9%	9.9%	1.1%	17.8%	4.2%
West Windsor Townshi	MERCER	653	8.3%	54.2	9.3%	9.2%	95.7%	0.4%	9.5%	0.8%	4.3%	0.5%
Galloway Township	ATLANTIC	984	8.2%	80.7	9.0%	8.2%	80.7%	0.7%	9.7%	1.0%	19.3%	4.4%
Hackensack City	BERGEN	1,879	8.2%	154.1	9.5%	11.0%	78.5%	1.6%	9.5%	1.1%	21.5%	3.9%
Pemberton Township	BURLINGTON	845	8.2%	69.3	8.3%	9.9%	81.4%	1.3%	9.7%	1.0%	18.6%	3.9%
Long Branch City	MONMOUTH	1,525	8.2%	125.1	7.5%	9.4%	75.5%	1.1%	9.8%	1.0%	24.5%	3.1%
Teaneck Township	BERGEN	1,159	8.1%	93.9	8.7%	9.9%	86.6%	1.0%	9.8%	1.0%	13.4%	1.6%
Gloucester Township	CAMDEN	1,511	8.1%	122.4	7.1%	9.1%	84.2%	0.8%	9.8%	1.0%	15.8%	2.9%
Lawrence Township	MERCER	1,025	8.1%	83.0	7.5%	8.5%	88.3%	0.7%	9.4%	0.9%	11.7%	2.3%
New Brunswick City	MIDDLESEX	3,021	8.1%	244.7	7.7%	11.2%	81.5%	1.1%	9.6%	1.1%	18.5%	3.8%
Sayreville Borough	MIDDLESEX	1,664	8.1%	134.8	8.4%	8.3%	87.7%	0.9%	9.3%	1.0%	12.3%	3.0%
Woodbridge Township	MIDDLESEX	3,585	8.1%	290.4	8.1%	8.8%	86.0%	0.7%	9.0%	0.9%	14.0%	2.3%
Egg Harbor Township	ATLANTIC	1,483	8.0%	118.6	7.9%	7.4%	76.7%	1.3%	9.6%	0.9%	23.3%	4.7%
Voorhees Township	CAMDEN	684	8.0%	54.7	6.7%	10.1%	87.6%	1.0%	9.5%	0.9%	12.4%	2.2%
Middle Township	CAPE MAY	619	8.0%	49.5	6.6%	6.8%	81.4%	0.5%	9.6%	0.9%	18.6%	3.6%
Bayonne City	HUDSON	2,148	8.0%	171.8	9.6%	10.5%	78.1%	0.9%	9.6%	1.0%	21.9%	5.0%
Secaucus Town	HUDSON	552	8.0%	44.2	10.1%	10.1%	83.9%	0.9%	9.1%	0.8%	16.1%	3.4%
Metuchen Borough	MIDDLESEX	515	8.0%	41.2	8.6%	9.7%	91.5%	0.6%	9.5%	0.8%	8.5%	1.4%
South Plainfield Bor	MIDDLESEX	707	8.0%	56.6	6.5%	7.5%	91.2%	1.1%	9.3%	0.9%	8.8%	2.1%
Parsippany-Troy Hill	MORRIS	1,567	8.0%	125.4	8.9%	8.9%	91.7%	0.7%	8.9%	0.8%	8.3%	1.5%

Continued Appendix B - Priority High-Risk Municipalities based on NJ Population Perinatal Risk Index

HIGH RISK MUNICIPALITIES		All Live Births	Risk index (Predicted rate LBW)	Volume estimate	*Low Birth Weight <2500g	*Preterm Births <37wks	*1st Trimester PNC	Perinatal Mortality 2006-08	Predicted Rate of Preterm	Predicted Rate of Perinatal Mortality	PNC not in 1st trimester	PNC 3rd/ none
Bernards Township	SOMERSET	612	8.0%	49.0	7.8%	11.9%	96.2%	0.9%	9.9%	0.8%	3.8%	0.7%
North Plainfield Bor	SOMERSET	949	8.0%	75.9	8.0%	9.9%	79.8%	0.8%	9.5%	1.1%	20.2%	3.3%
Somerville Borough	SOMERSET	507	8.0%	40.6	8.3%	11.2%	85.6%	1.5%	9.5%	1.0%	14.4%	2.4%
Maple Shade Township	BURLINGTON	681	7.9%	53.8	6.9%	9.0%	81.5%	1.5%	9.3%	1.0%	18.5%	1.6%
Belleville Township	ESSEX	1,346	7.9%	106.3	9.1%	10.6%	78.6%	1.2%	9.5%	1.0%	21.4%	4.8%
Monroe Township	GLOUCESTER	1,175	7.9%	92.8	7.3%	9.9%	83.4%	0.7%	9.7%	0.9%	16.6%	3.4%
Monroe Township	MIDDLESEX	730	7.9%	57.7	7.6%	9.6%	94.2%	0.6%	9.5%	0.8%	5.8%	1.0%
South River Borough	MIDDLESEX	611	7.9%	48.3	5.4%	8.2%	89.3%	0.7%	9.5%	0.9%	10.7%	2.3%
Freehold Borough	MONMOUTH	825	7.9%	65.2	5.3%	7.5%	78.3%	1.1%	9.6%	1.0%	21.7%	3.3%
Randolph Township	MORRIS	672	7.9%	53.1	6.7%	8.8%	92.7%	0.6%	9.4%	0.8%	7.3%	1.6%
Passaic City	PASSAIC	4,147	7.9%	327.6	6.8%	8.1%	71.7%	1.0%	9.6%	1.0%	28.3%	5.9%
Bridgewater Township	SOMERSET	1,135	7.9%	89.7	7.8%	11.1%	95.5%	0.6%	9.4%	0.8%	4.5%	0.6%
Elmwood Park Borough	BERGEN	657	7.8%	51.2	7.6%	10.2%	84.8%	0.7%	9.3%	0.9%	15.2%	3.5%
Garfield City	BERGEN	1,194	7.8%	93.1	7.8%	10.2%	80.0%	1.4%	9.4%	0.9%	20.0%	3.6%
Mount Laurel Townshi	BURLINGTON	1,176	7.8%	91.7	7.2%	9.5%	88.0%	0.4%	9.5%	0.9%	12.0%	1.8%
Cherry Hill Township	CAMDEN	1,632	7.8%	127.3	6.7%	9.4%	87.8%	0.6%	9.4%	0.9%	12.2%	1.7%
Livingston Township	ESSEX	644	7.8%	50.2	10.6%	13.4%	96.0%	1.2%	9.5%	0.8%	4.0%	0.8%
Hamilton Township	MERCER	2,604	7.8%	203.1	7.9%	9.0%	83.1%	1.5%	9.5%	1.0%	16.9%	3.4%
East Brunswick Towns	MIDDLESEX	1,096	7.8%	85.5	8.4%	10.1%	95.0%	0.8%	9.3%	0.8%	5.0%	1.6%
Old Bridge Township	MIDDLESEX	1,444	7.8%	112.6	9.0%	12.0%	90.4%	0.6%	9.4%	0.9%	9.6%	2.5%
South Amboy City	MIDDLESEX	511	7.8%	39.9	7.2%	9.8%	83.8%	1.9%	9.4%	0.9%	16.2%	4.7%
Marlboro Township	MONMOUTH	733	7.8%	57.2	7.9%	11.3%	95.2%	0.6%	9.6%	0.8%	4.8%	0.4%
Matawan Borough	MONMOUTH	615	7.8%	48.0	8.6%	11.1%	84.4%	0.7%	9.5%	0.9%	15.6%	2.9%
Ocean Township	MONMOUTH	746	7.8%	58.2	8.3%	9.8%	86.8%	0.6%	9.5%	1.0%	13.2%	1.2%
Red Bank Borough	MONMOUTH	789	7.8%	61.5	5.1%	7.7%	76.8%	1.5%	9.6%	1.0%	23.2%	2.3%
Bergenfield Borough	BERGEN	798	7.7%	61.4	6.1%	7.9%	85.6%	0.2%	9.1%	0.9%	14.4%	2.1%
Cliffside Park Borou	BERGEN	752	7.7%	57.9	7.6%	9.5%	78.2%	0.5%	9.2%	0.9%	21.8%	3.7%
Lodi Borough	BERGEN	857	7.7%	66.0	9.3%	12.6%	84.5%	0.9%	9.2%	1.0%	15.5%	3.4%
Ridgewood Village	BERGEN	557	7.7%	42.9	8.1%	8.1%	93.2%	1.3%	9.9%	0.8%	6.8%	0.9%
Deptford Township	GLOUCESTER	723	7.7%	55.7	9.5%	9.8%	83.2%	0.6%	9.3%	0.9%	16.8%	3.4%
West Deptford Townsh	GLOUCESTER	562	7.7%	43.3	8.5%	9.6%	86.7%	0.8%	9.5%	0.9%	13.3%	2.2%
East Windsor Townshi	MERCER	903	7.7%	69.5	6.9%	8.9%	84.9%	1.0%	9.2%	0.9%	15.1%	3.7%

Continued Appendix B - Priority High-Risk Municipalities based on NJ Population Perinatal Risk Index

HIGH RISK MUNICIPALITIES		All Live Births	Risk index (Predicted rate LBW)	Volume estimate	*Low Birth Weight <2500g	*Preterm Births <37wks	*1st Trimester PNC	Perinatal Mortality 2006-08	Predicted Rate of Preterm	Predicted Rate of Perinatal Mortality	PNC not in 1st trimester	PNC 3rd/ none
Perth Amboy City	MIDDLESEX	2,589	7.7%	199.4	7.7%	9.2%	65.6%	1.1%	9.4%	1.1%	34.4%	6.9%
Mount Olive Township	MORRIS	863	7.7%	66.5	8.3%	10.1%	89.7%	0.7%	9.4%	0.9%	10.3%	2.4%
Roxbury Township	MORRIS	663	7.7%	51.1	8.3%	10.0%	91.7%	0.7%	9.5%	0.8%	8.3%	2.0%
Clifton City	PASSAIC	3,160	7.7%	243.3	7.9%	10.3%	81.4%	0.9%	9.3%	0.9%	18.6%	4.6%
Hillsborough Townshi	SOMERSET	1,190	7.7%	91.6	7.4%	9.4%	92.9%	0.7%	9.3%	0.8%	7.1%	1.0%
Scotch Plains Townsh	UNION	802	7.7%	61.8	7.2%	10.1%	93.9%	0.7%	9.7%	0.9%	6.1%	1.5%
Summit City	UNION	760	7.7%	58.5	7.4%	8.6%	92.2%	0.8%	9.7%	0.9%	7.8%	1.6%
Westfield Town	UNION	828	7.7%	63.8	6.5%	8.0%	96.0%	0.4%	10.0%	0.8%	4.0%	0.5%
Mahwah Township	BERGEN	531	7.6%	40.4	9.2%	10.2%	93.8%	1.0%	9.4%	0.8%	6.2%	0.8%
Harrison Town	HUDSON	567	7.6%	43.1	5.5%	6.3%	75.4%	0.2%	8.9%	0.9%	24.6%	3.7%
Tinton Falls Borough	MONMOUTH	545	7.6%	41.4	8.4%	12.1%	91.9%	1.1%	9.7%	0.9%	8.1%	2.6%
Morristown Town	MORRIS	1,223	7.6%	92.9	8.0%	10.4%	88.0%	1.2%	9.3%	1.0%	12.0%	2.6%
Wayne Township	PASSAIC	1,228	7.6%	93.3	7.1%	9.9%	91.0%	1.0%	9.5%	0.8%	9.0%	1.9%
Fair Lawn Borough	BERGEN	834	7.5%	62.6	7.7%	10.1%	92.4%	0.8%	9.2%	0.8%	7.6%	1.4%
Lyndhurst Borough	BERGEN	666	7.5%	50.0	9.2%	10.4%	86.6%	0.5%	9.3%	0.9%	13.4%	2.0%
Delran Township	BURLINGTON	619	7.5%	46.4	5.3%	7.9%	87.2%	1.0%	9.2%	0.9%	12.8%	1.1%
Evesham Township	BURLINGTON	1,294	7.5%	97.1	8.6%	9.3%	91.0%	0.9%	9.4%	0.8%	9.0%	1.6%
Lower Township	CAPE MAY	576	7.5%	43.2	5.9%	7.5%	82.6%	2.1%	9.2%	0.8%	17.4%	4.3%
Nutley Township	ESSEX	907	7.5%	68.0	8.4%	11.1%	90.0%	0.6%	9.2%	0.8%	10.0%	2.8%
Mantua Township	GLOUCESTER	516	7.5%	38.7	7.4%	7.8%	85.6%	0.0%	9.2%	0.8%	14.4%	2.8%
Washington Township	GLOUCESTER	991	7.5%	74.3	8.7%	9.4%	85.8%	0.5%	9.4%	0.9%	14.2%	2.7%
Freehold Township	MONMOUTH	836	7.5%	62.7	7.7%	10.2%	91.0%	1.1%	9.5%	0.9%	9.0%	1.7%
Manalapan Township	MONMOUTH	876	7.5%	65.7	7.1%	10.8%	91.9%	0.7%	9.5%	0.8%	8.1%	2.1%
Dover Town	MORRIS	892	7.5%	66.9	5.0%	5.6%	77.3%	1.2%	9.1%	1.0%	22.7%	3.8%
Jefferson Township	MORRIS	566	7.5%	42.5	6.7%	7.8%	93.6%	1.3%	9.3%	0.8%	6.4%	0.9%
Rockaway Township	MORRIS	550	7.5%	41.3	7.1%	10.5%	95.1%	0.6%	9.5%	0.8%	4.9%	0.7%
Dover Township	OCEAN	2,830	7.5%	212.3	8.9%	10.3%	83.5%	0.8%	9.4%	0.8%	16.5%	2.7%
Jackson Township	OCEAN	1,430	7.5%	107.3	9.1%	12.5%	88.6%	0.8%	9.5%	0.9%	11.4%	2.2%
Barnegat Township	OCEAN	621	7.5%	46.6	7.1%	9.0%	84.2%	0.7%	9.3%	0.9%	15.8%	2.9%
Springfield Township	UNION	523	7.5%	39.2	5.4%	7.7%	95.2%	0.7%	9.1%	0.8%	4.8%	1.5%
Hammonton Town	ATLANTIC	651	7.4%	48.2	5.8%	7.2%	83.1%	1.1%	9.3%	0.9%	16.9%	1.7%
Hoboken City	HUDSON	1,876	7.4%	138.8	7.4%	8.8%	90.0%	0.6%	9.4%	0.8%	10.0%	1.4%

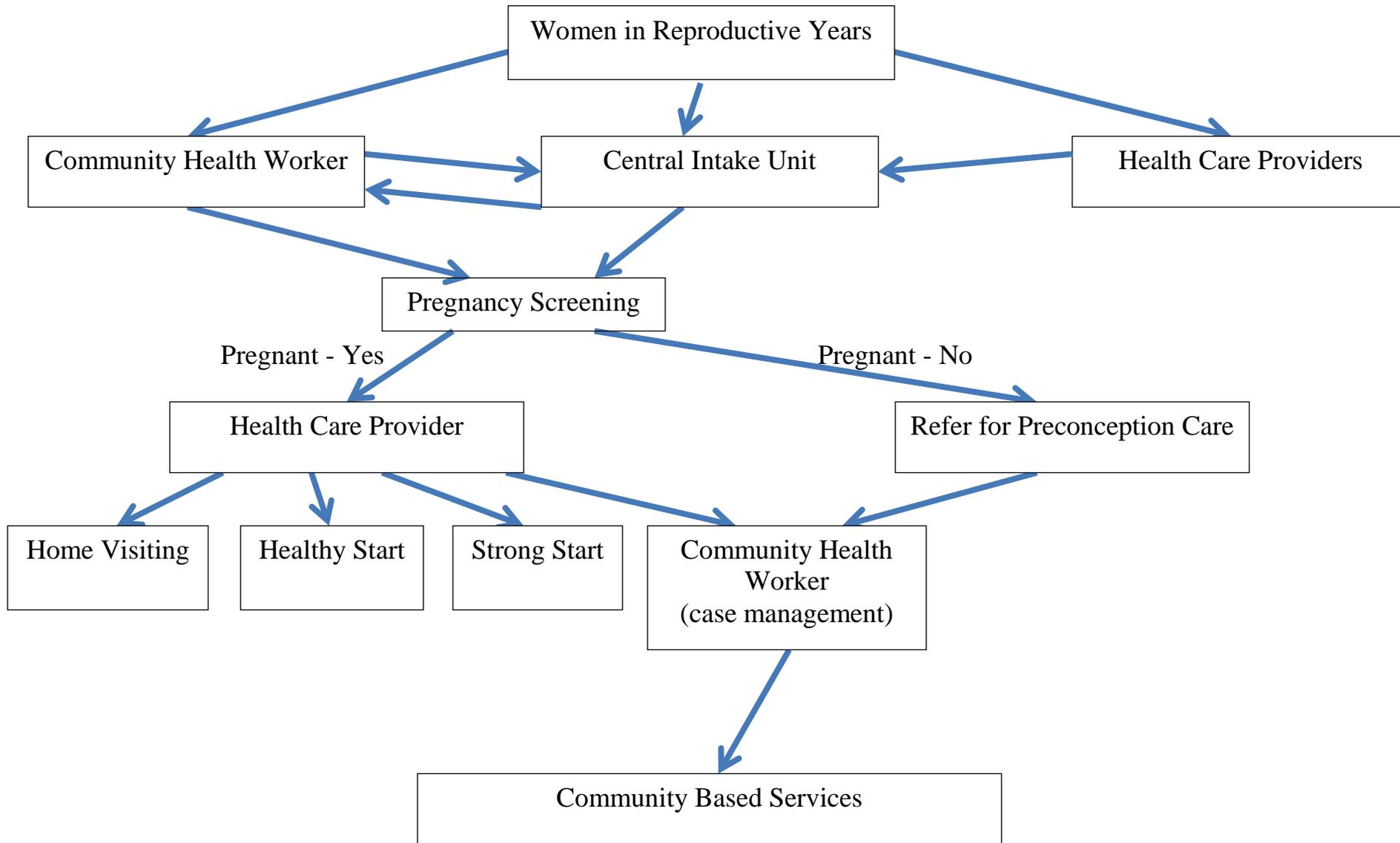
Continued Appendix B - Priority High-Risk Municipalities based on NJ Population Perinatal Risk Index

HIGH RISK MUNICIPALITIES		All Live Births	Risk index (Predicted rate LBW)	Volume estimate	*Low Birth Weight <2500g	*Preterm Births <37wks	*1st Trimester PNC	Perinatal Mortality 2006-08	Predicted Rate of Preterm	Predicted Rate of Perinatal Mortality	PNC not in 1st trimester	PNC 3rd/ none
Kearny Town	HUDSON	1,289	7.4%	95.4	7.4%	9.0%	77.7%	0.5%	9.2%	0.9%	22.3%	4.6%
Howell Township	MONMOUTH	1,189	7.4%	88.0	7.6%	10.4%	89.6%	0.6%	9.4%	0.8%	10.4%	2.4%
Brick Township	OCEAN	2,057	7.4%	152.2	7.1%	9.6%	84.6%	0.7%	9.3%	0.8%	15.4%	2.2%
West Milford Townshi	PASSAIC	691	7.4%	51.1	9.3%	13.0%	91.3%	0.6%	9.5%	0.8%	8.7%	1.2%
Bound Brook Borough	SOMERSET	538	7.4%	39.8	8.6%	9.1%	84.5%	0.9%	9.1%	1.0%	15.5%	2.2%
Cranford Township	UNION	628	7.4%	46.5	7.5%	9.4%	95.7%	0.8%	9.5%	0.8%	4.3%	0.2%
North Bergen Townshi	HUDSON	2,160	7.3%	157.7	7.3%	9.2%	80.1%	0.7%	9.0%	1.0%	19.9%	2.6%
Union City	HUDSON	3,036	7.3%	221.6	6.4%	7.9%	76.6%	1.0%	9.0%	1.0%	23.4%	3.5%
West New York Town	HUDSON	2,206	7.3%	161.0	6.1%	7.8%	77.6%	0.9%	8.9%	1.0%	22.4%	3.0%
Middletown Township	MONMOUTH	1,589	7.3%	116.0	6.7%	10.1%	94.3%	0.4%	9.6%	0.8%	5.7%	0.9%
Berkeley Township	OCEAN	639	7.3%	46.6	8.1%	8.8%	83.4%	0.9%	9.2%	0.8%	16.6%	2.7%
Point Pleasant Borou	OCEAN	533	7.3%	38.9	8.6%	11.1%	86.4%	0.6%	9.4%	0.8%	13.6%	1.7%
Fairview Borough	BERGEN	565	7.2%	40.7	6.2%	9.4%	66.3%	0.8%	8.8%	0.9%	33.7%	5.9%
Lacey Township	OCEAN	774	7.2%	55.7	6.6%	7.9%	87.7%	0.8%	9.2%	0.8%	12.3%	2.3%
Little Egg Harbor To	OCEAN	504	7.2%	36.3	5.6%	6.7%	86.5%	0.5%	9.0%	0.8%	13.5%	2.6%
Stafford Township	OCEAN	652	7.2%	46.9	9.5%	8.9%	87.4%	0.7%	9.2%	0.8%	12.6%	3.2%
Hawthorne Borough	PASSAIC	621	7.2%	44.7	8.4%	11.4%	91.9%	0.3%	9.2%	0.8%	8.1%	1.3%
Lakewood Township	OCEAN	11,006	7.1%	781.4	4.4%	5.0%	76.4%	0.5%	9.2%	0.9%	23.6%	2.2%
*Calculations based on the cumulative 2009-11 Electronic Birth Certificate file.												

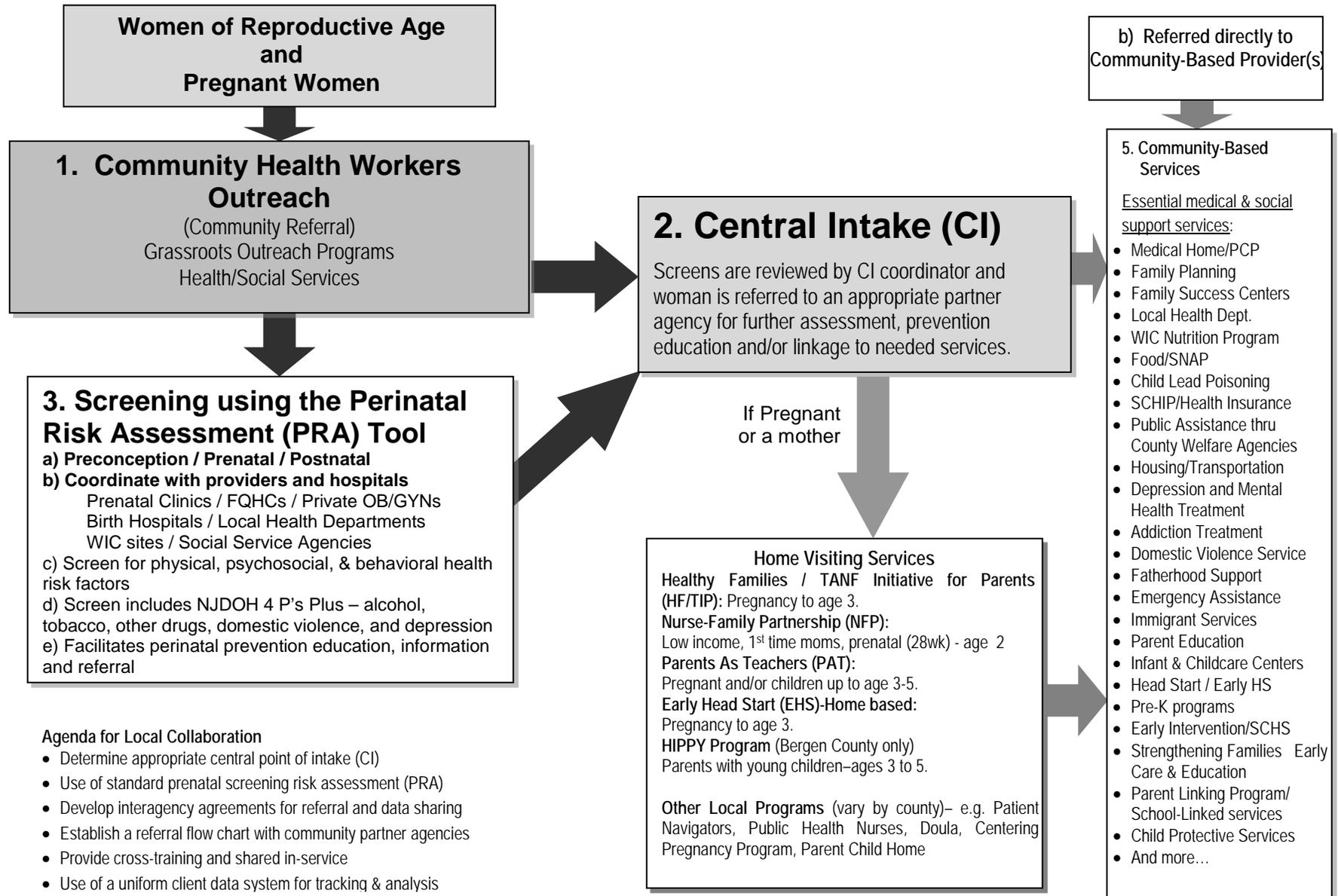
Appendix C – Applicant to complete for local partnerships

Programs and Services:	Provider Name, location	MOU in place
Regional Perinatal Consortia		
Hospitals - specify-OB, pediatrics		
Community Health Center (FQHC) specify OB, peds, adult		
Other Prenatal Clinical Providers		
Pediatric Clinical Providers		
Local Public Health Agency clinics-- specify prenatal, peds, adult		
WIC Supplemental Nutrition Program		
MCH Community Outreach Programs		
Healthy Start		
Title X Family Planning		
Lead Poisoning Prevention/ Healthy Homes		
Perinatal Addictions Prevention		
Postpartum Mood disorders		
Chronic Disease Prevention (diabetes, cardiac, cancer, obesity prevention, physical fitness, hypertension)		
Other: e.g. pregnancy testing		
Home Visitation Programs		
Healthy Families-TIP		
Nurse-Family Partnership		
Parents As Teachers		
Other EBHV Programs e.g. Early Head Start		
Local Public Health Nurses		
Other Home Visit Programs:		
County Board of Social Services		
Other Linkages:		
Domestic Violence		
Family Success/Resource Centers		
Fatherhood Services		
Early Intervention Programs		
Infant/Child Care		
Transportation		
Immigration/Refugee Services		
Other Services Linkages:		

Appendix D: Flow Chart for Improving Pregnancy Outcomes



Appendix D2: Central Intake Flow Chart – need to update and add arrows and decision points





STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PERINATAL RISK ASSESSMENT

PLEASE PRINT CLEARLY

REQUIRED FOR FORM PROCESSING

Date Form Completed: MM - DD - YY SSN: Insurance ID/Medicaid #: Insurance Effective Date: MM - DD - YY

Patient Information: Last Name* First Name* Date of Birth* MM - DD - YY

Street Address* City*

Zip Code* County Home / Cell Phone* Work Phone

Emergency Contact Name* Emergency Contact Phone*

Name of Father of the Baby Father of Baby Involved Yes No
Married Yes No

Provider Information*
Provider FAX # Provider Phone # Provider Zip Code Planned Delivery Site Code
Provider Chart # NPI # / Provider # Screener: First Initial and Last Name

Race/Ethnicity (choose one): African American Multi-Racial Caucasian Hispanic Asian Native American Other
Primary Language (choose one): English Spanish Other (specify) _____
Health Insurance* (Select all that apply): Medicare Medicaid PE Medicaid FFS Medicaid MC NJ Family Care Commercial Uninsured/Self-Pay
MCO* (choose one for Medicaid Eligibles): None Health Net AmeriChoice Horizon NJ Health AmeriGroup University Health Plans

Entry into Prenatal Care: Date of first visit MM - DD - YY, Date of 1st visit under MCO MM - DD - YY, LMP* MM - DD - YY, EDC* MM - DD - YY
Physical Assessment: Blood Pressure, Pre Pregnancy Weight (lbs), Current Weight (lbs), Height (Ft-Inches)
Perinatal History: Gravida* Para*, Date of most recent live birth MM - DD - YY, Weeks Gestation of Preterm loss(es): select any that apply <21 wks 21-34 wks >34 wks, Specify # of Weeks Gestation of most advanced loss:
Oral Health and Referral: Sensitive/Bleeding Gums Yes No, Dental Referral Given Yes No, Patient Education Given Yes No, Visit within the last year Yes No

All Risk Factors Negative

	Current Preg	Prior Preg	Family History		Current Preg	Prior Preg	Family History		Current Preg	Prior Preg	Family History		
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	
Previous Cesarean Section	na	na	<input type="radio"/> Y	<input type="radio"/> N	Multiple Gestation	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	Fetal Genetic/Structural abnormalities	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N
Low Birth Weight (<2500gm)	na	na	<input type="radio"/> Y	<input type="radio"/> N	Fetal Reduction	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	Rh Negative	<input type="radio"/> Y	<input type="radio"/> N	na	na
History of PROM	na	na	<input type="radio"/> Y	<input type="radio"/> N	Macrosomia	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	Hepatitis B	<input type="radio"/> Y	<input type="radio"/> N	na	na
Hyperemesis	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	IUGR	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	Group B Strep	<input type="radio"/> Y	<input type="radio"/> N	na	na
Obesity	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	Oligo/Polyhydramnios	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	Opioid Replacement Treatment	<input type="radio"/> Y	<input type="radio"/> N	na	na
Gestational Diabetes	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	Abnormal Amniocentesis	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	Pyelonephritis	<input type="radio"/> Y	<input type="radio"/> N	na	na
PIH/Preeclampsia	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	Abnormal AFP	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	Urinary Tract Infection	<input type="radio"/> Y	na	na	na
Placenta Previa	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	Maternal Fetal Infection	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	Assisted Reproductive Technology	<input type="radio"/> Y	na	na	na
Cervical Incompetence	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N	Abdominal Surgery	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	Bleeding during current pregnancy	<input type="radio"/> 1st	<input type="radio"/> 2nd	<input type="radio"/> 3rd	<input type="radio"/> No
Ectopic Pregnancy	<input type="radio"/> Y	<input type="radio"/> N	<input type="radio"/> Y	<input type="radio"/> N									

FHI ID: 13264

DO NOT PHOTOCOPY BLANK FORMS

PLEASE COMPLETE AND FAX TO: 856-862-4321

New Jersey IPO Logic Model

		New Jersey IPO Logic Model				
		Inputs What we invest...	Outputs What we do...	Outcomes		
				Short Term	Medium Term	Long Term
Situation	Families	<p>Existing MCH providers OB/GYN providers Preconception service providers Family Planning providers Primary care Providers)</p> <p>State-level agencies: FHS in DHSS (Title V) Department of Children and Families (DCF) Medicaid in DHS</p> <p>Local-level agencies: Local Health Departments MCH Consortia Social Service Agencies Hospitals HV Providers Evaluation team</p> <p>Non-governmental early childhood system stakeholders: Child Care Centers Health Care Providers</p> <p>Evaluation team</p>	<p>Build State Infrastructure Develop, communicate, & build support for a common vision for Maternal and Child Health (MCH) Identify & commit to shared outcomes & priorities Ensure ongoing, open communication among stakeholders Establish policies that encourage collaboration Support evidence-based MCH models Use data-driven process & assessment to select local grantees Promote standard assessments (PRA) and data systems (EHR) Ensure training & TA is available to local partners/stakeholders Provide guidance & support for local infrastructure building Develop program standards & monitoring systems</p> <p>Build Local Infrastructure Translate statewide vision into local priorities Develop shared understanding of roles, responsibilities & outcomes Ensure ongoing, open communication among stakeholders Assess community needs & gaps Build & support a MCH workforce Promote peer-to-peer learning Establish & track measures of fidelity, & use standardized data to drive improvement Develop and enforce systems of accountability Implement standard risk assessment tools & referral system</p> <p>Deliver Evidence-Based MCH Services Identify, engage, enroll & retain families Provide MCH services with fidelity & consistency with vision and values Provide referrals & ensure family needs are met Collect data on families served by the MCH program</p>	Shared vision, priorities, & outcomes are reflected in decisions of partner agencies	MCH system reflects the needs & priorities of stakeholders	MCH resources are used effectively & efficiently
Values				All stakeholders actively participate in planning & implementation activities	Gaps in available services in high need communities are reduced	Reduction in preterm births (O4)
External Factors				State & local partners have a shared understanding of systems of standards & monitoring	Families receive well coordinated services that align with their needs	Reduction in low birth weight (O5)
			Improvement in early prenatal care (O1)	Reduction of infant mortality (O6)		
			Local MCH programs collect and submit complete Performance standard data regarding implementation and outcomes	Disparities in access to preconception and prenatal care are reduced		
			MCH workers are well trained & supported in their role	Increase utilization of a medical home		
			Local communities are aware of & support MCH Enrolled families receive MCH services that meet their needs	Increase in use of preconception services (O2)		
				Increase in use of interconception services (O3)		
				Increase in women receiving a community referral		

Appendix G - Glossary

Sources: <http://www.soph.uab.edu/mch-leadership/GLOSSARYVNov02.pdf>

Central Intake (CI) – in this context, CI refers to a single place or process for women to access the health care, prevention, social service, and/or other services they need. CI includes the following core components: 1) Information so that people will know where or how to access centralized intake; 2) A place or means to request assistance, such as a walk-in center or a call center; 3) A screening and assessment process and tools to gather and verify information about the person and her service needs and program eligibility and priority.

Continuous Quality Improvement (CQI) - a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality services or processes which achieve equity and improve the health of the community.

Community Health Worker (CHW) - a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Infant Mortality - The death of a live-born infant before its first birthday

Interconception care - interventions to maximize women's health or pregnancy outcomes that occur between pregnancies.

Life Course Perspective - A life course approach is based on a theoretical model that takes into consideration the full spectrum of factors that impact an individual's health, not just at one stage of life (e.g. adolescence), but through all stages of life (e.g. infancy, childhood, adolescence, childbearing age, elderly age).

Low Birth Weight - Birth weight less than 2,500 grams

Preconception Care - An organized and comprehensive program of health care that identifies and reduces a woman's risk before conception through risk assessment, health promotion, and interventions. Preconception care programs may be designed to include the male partner by providing counseling and educational information in preparation for fatherhood, such as genetic counseling and testing, financial and family planning, etc. May refer to prospective father or mother.

Performance Management Approach - the strategic use of performance standards to guide the development and implementation of specific improvement strategies

Prenatal Care - interventions to maximize women's health or pregnancy outcomes that occur between pregnancies.

Preterm Births – Birth before the 37th completed week of gestation.

Social Ecologic Model - identifies and addresses health determinants at multiple ecologic levels to strengthen individual knowledge and skills; enhance social networks and supports; change organizational practices; mobilize communities; and influence policy.