

HEALTHY START IMPACT REPORT

The HRSA Healthy Start grant has been a major catalyst in our efforts to strengthen the system of maternal and child health (MCH) care that serves women/families living in Trenton, and ultimately to reach our overall goal of eliminating health disparities in our city.

Trenton's public-private interagency Healthy Start project, now known as the Children's Futures Initiative (CF), has just completed its first funding cycle. The City of Trenton Division of Health (TDOH) was awarded its first Healthy Start (HS) grant in July 2001 at \$700,000/year. Shortly after TDOH received this HS grant (August 2001), our planning/funding partner Children's Futures, Inc. received a five-year funding commitment from the Robert Wood Johnson Foundation (RWJF). A portion of this RWJF funding (\$1,000,000+/yr) became an important source of supplemental support for full implementation of the CF prenatal and parenting model, allowing Trenton to expand service capacity for families in the city. Thirdly, in May 2002, TDOH was awarded new funding from the New Jersey Juvenile Justice Commission (\$900,000 over three and one-half years) to integrate the Nurse Family Partnership program into the CF model.

These new resources combined with pre-existing in-kind services (prenatal clinics, TDOH Public Health Nurses and Mercer Street Friends Healthy Families program) and the addition and integration of new services (prenatal screening) and new partners (fatherhood, depression, child care) required additional time for careful planning, coordination, hiring and training, thus delaying the start of direct services until July 2002. After completion of just three years of direct services it is still too soon to see reductions in health disparities in our city, however, early indicators provide evidence that we are on the right path.

Our primary strategies include:

- Collaboration with the Trenton HMHB Coalition for our community consortium
- Community outreach from the four neighborhood Parent/Child Centers to identify pregnant women and link them to prenatal care, as well as collaboration with another outreach partner
- Universal screening and risk assessment of pregnant women enrolled in prenatal care for recruitment into HS services
- Central intake and linkage to a home visit assessment
- Case management services for women and families enrolled in intensive home visiting services and home-based health education using two nationally recognized home visiting models—Nurse Family Partnership and Healthy Families Program
- Four new neighborhood Parent/Child Centers for center-based health education and family support to pregnant/parenting families with children up to age three
- Behavioral health consultation services for pregnant/postpartum women
- Fatherhood consultation and support services
- Referral and linkage to quality infant/child care services

This Impact Report will provide a review of our progress toward the goal of eliminating racial and ethnic health disparities in Trenton.

I. Overview of Racial and Ethnic Disparities Focused on by Project

Trenton focused on improving health disparities in both the African-American and Hispanic populations. Since submitting our original application in 2001, the following demographic changes have occurred in our target population: there has been a 5% decrease in the number of Black/African-American women giving birth; and a 20% increase in the number of Hispanic women giving birth (last two columns in Table 1).

Table 1

Race & Hispanic Ethnicity (*duplicated count)	Trenton Population 2000 US Census	Race and Hispanic Ethnicity (unduplicated count)	Trenton Births 3-Yr Ave 1999-2001	Trenton Births 3-Yr Ave 2001-2003
Total Number:	85,403	Total Number:	1500	1501
White (%)	33%	White Non-Hispanic (%)	14%	12%
Black (%)	52%	Black Non-Hispanic (%)	56%	53%
Asian (%)	<1%	Asian (%)	<1%	1%
Other (%)	15%	Other (%)	<1%	<1%
*Hispanic (%)	22%	Hispanic (all races) (%)	28%	33%

Pervasive poverty and its related effects (unemployment, family instability, housing/homelessness, etc.) continue to adversely affect the well-being of Trenton families. With no improvement seen between 1990 and 2000, and a 2003 unemployment figure of 10.1%, these socioeconomic factors will remain a constant challenge to our efforts to improve maternal, child and family health outcomes. See Table 2 below for a summary of economic data.

Table 2

	Trenton - Prior to Healthy Start	Trenton - Most Recent Data
Unemployment Rate	8.8% (Source: NJ Dept of Labor 1999)	10.1% (Source: NJ Dept of Labor 2003)
Per Capita Income	\$11,018 (Source: 1990 US Census) (Note: Mercer County = \$18,936)	\$14,621 (Source: 2000 US Census) (Note: Mercer County = \$27,914)
Female-headed households <FPL	29.3% (Source: 1990 US Census) Note: Mercer County = 17.6%	29.5% (Note: 40% in highest-risk tracts) (Source: 2000 US Census)
Female-headed households w/o husb	26% (Source: 1990 US Census) (Source: 1990 US Census)	27% (Source: 2000 US Census)
Births to Single Women	69% (Source: NJDHSS 1999 MCH data)	72% (Source: NJDHSS 2003 MCH data)
Children (<18yo) in fam w/ income <FPL	27% (Source: 1990 US Census) (Note: Mercer County = 10%)	37% (Note: it's 41% for children < 5yo) (Source: 2000 US Census)
Temp Assistance to Needy Families & General Assistance	90% of Mercer County's TANF recipients live in Trenton. (Source: Mercer County data)	95% of Mercer County's TANF recipients live in Trenton. (Source: Mercer County data)

II. PROJECT IMPLEMENTATION

The overall approach in designing and implementing Trenton's Healthy Start project, now known as the Children's Futures Initiative (CF), was to closely examine and discuss the following elements in our current MCH system:

- What perinatal services existed? Were they being used and how were they working?
- Which funding sources were currently providing support? Were these short or long term funds? Would these funders be willing to provide in-kind support to the project?
- What do providers and consumers see as existing gaps and barriers in the system of perinatal care?
- What was the current MCH system? Could new service components be effectively integrated and linked with prenatal healthcare providers to provide a working continuum of services and supports?
- What were our strengths in terms of relationships with MCH providers, other providers, the community and consumers? Who was missing at the table?

Through joint leadership of the City of Trenton Division of Health, Children's Futures, Inc. and the Central New Jersey Maternal & Child Health Consortium (CNJMCHC), Trenton expanded its MCH collaboration (Trenton Healthy Mothers Healthy Babies Coalition), bringing new partners to the table (addiction, mental health, fatherhood and child care). In addition, input and feedback from community residents and consumers (surveys and focus groups) helped to set the direction and priorities for this project.

Through these collaborative efforts, a comprehensive prenatal and parenting model of service delivery was developed for the Children's Futures Initiative (CF) in Trenton (see diagram in Attachment A). This public health model remains at the core of the project's design for integration of pre-existing and new services. It provides a continuum of maternal and child health services for pregnant/parenting women, fathers/families, and infants and young children. CF's services extend from primary prevention and early intervention, to linkages with case management, health consultation and treatment services, parent education and family supports, and resources for community support.

OUTREACH AND CLIENT RECRUITMENT In Trenton, we regard this category as two distinct items with different strategies in place to address each element.

Outreach

A. Rationale: Trenton has low rates of first trimester entry and adequacy of prenatal care, and high rates of no prenatal care, with greater disparities for African-American women. Outreach activities will continue to hold a central role as we work together to change this pattern and encourage/support women to get into prenatal care early. In our model, outreach services are integrated into our collaboration and are provided by TDOH and partners in-kind from other funding sources. The primary purpose of outreach is to identify women who think they might be pregnant, make sure they know where pregnancy testing is available and, if pregnant, help women get into prenatal care as soon as possible (assisting with appointments, insurance issues, transportation, language barriers, etc.). Following their linkage into prenatal care, women are recruited into program services (program participants).

B. Components and Resources: Outreach has always maintained the core functions of canvassing neighborhoods and reconnecting pregnant women who miss prenatal appointments. In 2004, an unanticipated loss of in-kind funding in this area resulted in

changes in personnel allocations for outreach activities in the last year of the 2001-2005 grant period (described in the next section). With support from HS and RWJF funds, each of the four Parent/Child Centers (PCC) contribute a small portion of their staff time (~10% per person) for outreach activities within the neighborhoods in their respective wards (one-half day per week in each PCC). Based on pregnancy outcome data, high-risk neighborhoods have been identified by CNJMCHC using de-identified electronic birth certificate (EBC) data and GIS mapping. Outreach strategies include door-to-door canvassing, and reaching out to neighborhood businesses, schools, churches, civic groups and interested individuals. PCC staff are culturally diverse and representative of the communities they serve. Each PCC has Spanish-speaking and other appropriate language capabilities (French Creole, Polish/Eastern European).

Special events, with participation from all CF partner staff, are also used as a vehicle for community outreach for our project. These include:

- In 2002-03, Children's Futures, Inc. sponsored a general public awareness campaign with radio ads, interviews, newspaper ads, billboards and a media workshop.
- Children's Futures, Inc. funded Family Affair in June 2003. Over 5,000 parents and children turned out and over 50 community service agencies participated. In subsequent years, CF sponsored a booth and activities at Trenton's annual Heritage Days festival (June 2004 / June 2005)
- CF held two large-scale Outreach Days on 10/3/03 and 6/3/05. A "kick-off" press conference is a part of the event with remarks from the Mayor and personal reflections from participating families. Local media (newspapers, radio and TV) cover the event. And, over 150 staff and volunteers from the four Parent/Child Centers "hit the streets" to knock on doors, and distribute over 5,000 fliers and educational materials to individuals across the city.
- HMHB holds its annual community Baby Shower in October of each year. Over 200 pregnant women, partners and families attend. All MCH hospital and community agencies participate.
- Parent/Child Centers hold a monthly "family night" activity. Attendance averages 25 families, and includes mothers, father and children. Other community-oriented activities are held on a regular basis to recruit women.

In the past year, with consumer input, we carefully reevaluated outreach effectiveness. The results of our efforts are described in the following section.

C. Facilitators and/or Detractors: Our approach to outreach has shifted since inception of the grant project. When we first designed the model, perinatal outreach was a pre-existing element funded by our regional MCH consortium. It consisted of three part-time workers who were employed by one of our hospital partners. These workers (bilingual/bicultural) focused on canvassing neighborhoods and reconnecting pregnant women who missed appointments. Rather than duplicate this effort, we integrated this source of outreach into the model and sought to supplement outreach activities through the Parent/Child Centers (PCC). At start-up the multicultural/ multilingual (Spanish, French Creole, Polish/Eastern European) PCC staff had lots of time for community

outreach and recruitment. Family Support Workers (FSWs) assisted in conducting outreach within the geographic wards that they served. However, by the end of 2003, Nurses, social workers and FSWs had full assessment, home visiting and case management caseloads. Thus, out of necessity, time for outreach became a lower priority.

Six months later, in June of 2004, we received news that funds formerly earmarked for outreach from the CNJMCHC were being reallocated for homeless pregnant women. So, a major reevaluation of this component took place. With the help of our CF Workgroup, an advisory board of provider and consumer representatives, TDOH put together an application for March of Dimes (MOD) funding to support a new design and stronger integration of outreach into the CF model. As a result of this effort, TDOH received a three-year grant (\$50,000/yr) from the MOD in May 2005 for a new and improved design in outreach services, entitled Trenton CARES. This multi-pronged approach will employ a coordinator and three part-time consumers to canvass high risk neighborhoods, outreach to private OB/GYN providers, inform the community about free CF pregnancy testing, follow-up on missed appointments, recruit community volunteers, and ultimately recruit women who need to fulfill their work requirement for TANF (Work First NJ), and survey community residents (women/parents) about their experiences/perceptions with regard to the MCH system and related community services.

In addition, we are excited about new resources to support the addition of two complementary components that will be added in 2005-06 and coordinated with Trenton CARES: 1) a partnership with MEE Productions for a new round of Children's Futures Inc. public service ads that were designed with input from consumer focus groups and will echo the message about the importance of early prenatal care, locations for pregnancy testing and linkages to CF services (in-kind RWJF/CF Inc.). MEE will also recruit Community Action Team (CAT) volunteers (10 to 12 individuals for 8 hours per month) to assist with neighborhood outreach; and 2) a new full-time outreach worker employed by CNJMCHC to work directly with Healthy Mothers/Healthy Babies who will concentrate on outreach through community events (health fairs, high school-based activities, etc.) in the city (in-kind CNJMCHC).

Recruitment

A. Rationale: Since pregnancy is a primary entry point for participation in CF, the outreach process emphasizes the need to get women into prenatal care as early as possible. A core recruitment strategy has been to work closely with Trenton's HealthStart prenatal clinics (and ultimately with private OB/GYN providers) to expand perinatal screening and risk assessment for addiction, depression and domestic violence by linking the screen/consent with the Children's Futures referral process for in-home assessment, home visitation and case management services and other supports for women and families. CF is then able to use the initial prenatal appointment as a recruitment point for participation in CF services. In this way, recruitment for participation in CF services is integrated into the system of prenatal care.

B. Components and Resources: Prenatal providers are central partners in screening and recruiting pregnant women to participate in CF services. CF developed a universal screening tool (sample attached) that is used by the nursing/social work staff at the HealthStart prenatal clinics (~2 FTEs in-kind). Designated clinical staff complete the screening questions at the initial prenatal intake visit. They briefly explain CF services and obtain consent from pregnant women for initial referral and participation in CF. If the woman gives her consent, the screening referral is sent to TDOH Central Intake office to determine eligibility for participation in CF services. Central Intake (1.0 FTE) reviews the consents/screens, checks for duplicate referrals, assigns cases for assessment and tracks follow-up.

C. Facilitators and/or Detractors: All of the CF clinic providers have expressed and demonstrated their strong commitment to CF and the screening process. It is imperative that CF leaders, many of whom have previously worked in a clinical setting, keep an open mind and be realistic and respectful toward all of our partners, especially those at the front lines. We fully understand that staffing changes, high volume and limited resources at the prenatal clinics and private provider offices continue to pose challenges to our partners' ability to screen/recruit all pregnant women. While the screening process is well integrated at three clinic sites, monitoring of screening data shows that one site will require additional staffing support and training to effectively incorporate the screening/recruitment process into their system of clinical care. CF met with the provider partner to discuss the screening process and possible causes for this low screening rate, and staffing support was one of the concerns raised. Resources are currently being reevaluated to bring about this much needed additional support.

CF also needs to give more attention to identifying women who have had no prenatal care and inadequate prenatal care, and who were missed during outreach and not assessed during pregnancy. While we hope this number will significantly diminish with our renewed outreach efforts, most recent MCH data shows that Trenton is not yet there. CF wants to make sure that these highest risk women/families are offered home visitation and case management services. Resources may need to be reallocated to provide project staff to visit these new mothers while they are still at the hospital.

CASE MANAGEMENT

A. Rationale for Approach: Case management is an essential component for women and families with complex health and psychosocial needs. Home visiting is an effective method to provide case management because home visits provide an important opportunity for the worker to observe, assess, teach and support the participant within her home and family environment.

During the planning phase, consensus was reached about the need to study and apply best practices for the provision of home visitation and case management services. We also agreed that since participation is voluntary, it was important to offer women options within a continuum of services that would allow for varying levels of participation (intensive versus occasional; and home versus community setting). As with the other

components discussed in this Implementation Section, we felt it was important to build upon existing resources if those services gave the model added value.

B. Components and Resources: Prior to CF, the city had two funding commitments for case management programs that were linked to home visitation services and coordinated through TDOH: 1) POrSCHe (Prevention-Oriented Services for Child Health) public health nurse home visits [in-kind by TDOH and partially funded by the New Jersey Dept of Health & Senior Services (NJDHSS) MCH Block Grant] and 2) a small Healthy Families (HF) program (60 families) lead by MCH partner, Mercer Street Friends, and funded by the NJ Dept of Human Services (NJ DHS) Division of Youth & Family Services (DYFS). During the CF planning phase recommendations were made to expand home visitation as a form of case management and to use new CF resources (HS and RWJF) for nationally known models with lower caseloads that would allow for tracking and evaluation of outcomes. This was a particular concern in POrSCHe because although POrSCHe clients received less frequent visits, very high caseloads of 100 or more families made it extremely difficult for the nurse to keep a focus on outcome measures.

CF now uses two national models of home visitation to provide intensive case management to about 400 participating women and families. Each model serves a distinctly different subset of the target population and both fit well into the delivery system of care in Trenton.

1. The Nurse Family Partnership (NFP) is an intensive home visitation program for first-time mothers who are enrolled by 28 weeks of gestation and followed until the child is age two. NFP start-up funds (\$900,000 over three and one-half years) were awarded to TDOH from the NJ State Juvenile Justice Commission. The maximum caseload is 25 families for each full-time nurse. Trenton has four RNs serving 100 families. Visits are every one to two weeks during pregnancy and infancy and then taper over time.
2. The Healthy Families (HF) model is offered to any other pregnant women. This includes first-time moms when NFP caseloads are full or if the woman is beyond the 28-week gestation marker, and any other woman with a subsequent pregnancy. CF has implemented new HF programs at each of the four Parent/Child Centers (PCC)--one in each ward of the city. Each PCC has a total of six staff. Two are professional level staff--Nurse and/or Social Worker who conduct initial assessments; and four are Family Support Workers (FSWs) who conduct the ongoing home visits to women and families from pregnancy to age three. Each of the four PCC HF programs serves ~60 families for a total of ~240 families. Visits are weekly during pregnancy and infancy and then become less intense over time.

The original HF program at Mercer Street Friends (60 families) remains a freestanding program with its own funding. However, it too is integrated into the CF model and gets its referrals through Central Intake.

Another lower intensity case management option is from the POrSCHe public health nurses. POrSCHe has a total caseload of about 200 families and case management is

less frequent (monthly and as needed visits). Because of the newly expanded capacity in NFP and HF, POrSCHe caseloads have been decreased to a more manageable size (~50 families). Pregnancy is not a requirement for participation in POrSCHe and services may begin at any time from pregnancy up to age two. Caseloads are predominantly infants and toddlers, and the average length of services is about one year. POrSCHe also provides case management for lead poisoned children of any age.

Case management activities include a comprehensive assessment of health, psychosocial, and other factors that may impact on disparities in outcomes and care. The case manager works with the family to develop/facilitate the family care plan. The plan is reviewed and revised with the family on a regular basis. The frequency and intensity of home visits is based on gestation or the age of the child, and on the family's needs. The case manager monitors key health and social indicators, health insurance enrollment, linkages to primary health care, preventive health care for the woman and children (prenatal and postpartum care, family planning, well child check-ups, immunizations, lead screening, WIC, etc.). In each program, case managers monitor and document their progress in reaching program objectives. They use a set of standardized assessments that include: Adult-Adolescent Parenting Index (AAPI) for parenting attitudes and beliefs, HOME Scale for parent-child interaction and environment, and Ages & Stages Questionnaire (ASQ) for infant/child growth and development. Cases are reviewed during weekly supervision and include input from other needed consultants/partners--mental health, addictions, fatherhood, etc.

C. Facilitators and/or Detractors: The central intake function at TDOH, supported with HS funds, has been an important facilitator for this interagency model of case management. These three case management models are an asset for Trenton families that provide options for varying levels of intensity and participation. Using two national models for intensive case management provides the benefit of standard training, documentation and national evaluation, but there are challenges as well. Each program has its own slightly different data set and database. This means that we have three different data systems from which to collect core data measures. Documentation is lengthy and we do not have much flexibility to change the documentation process for NFP or HF. To ensure that we can monitor our progress in reaching all of our HS objectives, TDOH/CF partners recently developed a supplemental data form to enable us to track participant measures through the Central Intake office. This data revision is in process (8/2005) and will be used to measure our progress in the 2005-2009 grant cycle.

Staff turnover was a problem after the first year, when some of the workers realized the challenges of this type of work. All four PCCs had to deal with some level of turnover. This meant time lags for completing the hiring process. It also meant delays in service provision, as specialized training is required for new workers before they can assume a full caseload independently. Turnover also causes other problems with case management. Some families will resist a "new" person, making it harder for a new worker to establish a relationship with previously enrolled families. Also, it takes at least six months for new workers to become savvy in engaging families and feeling more

comfortable in their role. So the learning curve is a factor. Fortunately, all partners are currently at full staffing levels. We understand that this is difficult and challenging work and is not for everyone, regardless of her/his credentials. Site directors keep this fact in mind when interviewing, hoping that staffing at their sites will remain relatively stable as the project moves forward.

Other challenges, related to home visiting and case management, include efforts to minimize “not home” visits and to maintain high levels of participation and retention rates. Experienced staffs have more success in engaging families. CF is finally getting to the point where we have some seasoned workers, and this is already beginning to impact missed visits and recidivism.

A related factor deserves attention as we analyze our progress in this area. CF has had disproportionately higher participation rates from Latinas. Our Spanish-speaking workers quickly build trust with their Hispanic moms/families and they are generally viewed as a valuable resource to immigrant families with linkage to services and supports, i.e. translation. All Spanish speaking staff have full caseloads and somewhat lower turnover. Note: NFP does not have a Spanish-speaking nurse, but TDOH has two bilingual RNs that help to pick up overflow cases for Hispanic moms/families.

Conversely, CF has a disproportionately lower rate of participation from African-American women. One factor (though clearly not the whole story) is that Trenton's TANF population is predominantly African-American. Intensive home visitation programs are impacted by State policy regulation changes issued by the NJDHS Division of Family Development (DFD) that required TANF/WorkFirst New Jersey recipients to be in an approved work or school activity by the time their infant turns three months of age. While we have had interest and participation from African-American women, it has been more difficult to keep women in services over the term of two to three years that is recommended by NFP and HF for optimal outcomes. All of the home visitors offer to make evening or Saturday visits, but as you can understand, women are tired at the end of a work day, so home visits may be viewed as more of an intrusion than a support. This is a policy issue that TDOH and other MCH home visiting agencies have questioned in relation to our prior home visitation services and in the early years of our CF project.

Over the past few years, with new DHS leadership (formerly from the City of Trenton and familiar with our work here) and after some very unfortunate high profile child abuse cases, DHS began to look hard at funding priorities and made a stronger commitment to prevention. During this time, CF was asked to present our model to a team of DHS representatives and Children's Futures Inc., representing our partnership, was consulted for several State level meetings. As the process moved forward, more funds were committed to addiction treatment and mental health services; formal linkages were strengthened between DYFS/CPS and county welfare agencies; and along the way, officials began to rethink this measure that gave women/parents the conflicting message that their participation in a formal parenting education and support program,

such as NFP and HF, did not have value as an approved “employment deferred activity.”

We are pleased to say that the State has changed its policy with regard to the latter item. NJDHS-DFD has developed a statewide model that includes the core concepts of intensive home visitation. It also adds options for parents to participate in community-based parent/child/family support services, such as those offered by the CF Parent/Child Centers, and of course it still provides an option for traditional work/school activities. The voluntary new program, known as TIP (TANF Initiative for Parents), will encourage TANF and GA recipients who are pregnant women and new parents (through infancy) to participate in TIP services for up to 12 months. This will meet the WorkFirst NJ requirement of an employment-deferred activity as long as the woman/parent maintains her/his committed participation in TIP program services. *[Note: women/parents may still opt out and move directly into a work or school activity, community-based services or all three.]* For Trenton/Mercer County this change will take effect in October 2005. We are excited by the prospects for integration of services and this new resource for supporting pregnant women and families. TDOH/CF will study the impact of this policy change on participation in both our home and center-based services (screening, recruitment, enrollment and retention) as the project moves forward.

New obstacles faced by home visitation staff include safety concerns and dealing with the prospects of increased gang related activities in Trenton. This is a relatively new problem and somewhat disconcerting because of the unpredictability of street activity with incidents occurring even during daytime hours. In fact, several of our pregnant/parenting clients are partners with gang members or are themselves involved in gangs. We have provided gang-awareness trainings to all workers and personal safety refreshers. We are looking into purchasing two-way radios so that workers will have direct communication with the police radio room should they observe any unlawful or threatening behaviors.

As we entered Year 4 of HS, our third year of direct services, most of the home visitors had full caseloads, because we carry families from pregnancy to age two (NFP), or age three (HF). While recidivism (which of course we try to minimize) and graduation/completion of services creates a flow of a few open slots for new participants, expanding capacity is still a need. Since we have generated community interest in Children's Futures services, and since new policy changes for TANF/Work First NJ recipients may increase participation, our challenge is to continue to look for sustaining resources to expand services to meet the need/demand (more in Sustainability Section).

HEALTH EDUCATION AND TRAINING

A. Rationale for Approach: In our model, health education is integrated into home visiting, case management and center-based services. Our rationale is that educating women/parents is a routine component of our interactions and relationships with

families. Health education is provided to participants in several settings: 1) by the home visitor/case manager on an individual/family basis to program participants in the home setting; 2) at the Parent/Child Centers in family activities and formal classes to community participants; and 3) at Healthy Mothers/Healthy Babies and Consumer Coalition meetings and community events.

CF also holds to the principle that ongoing staff and provider education is a priority. Staff training gives staff information about a variety of health education and case management topics for use in their work with families (and for their personal health). It also serves an important opportunity for staff to get to know their colleagues at other sites and to look to each other as resources and supports in their work.

B. Components and Resources: The case manager assesses key health information needs of the woman/family. Topics include: nutrition, WIC, tobacco use, alcohol and drug use, normal signs and symptoms of pregnancy, factors contributing to low birth weight and infant mortality, importance of prenatal/postpartum appointments, breastfeeding, family planning, women's health, STDs, HIV/AIDS, infant care, Back to Sleep, SIDS, child growth and development, etc. The home visitor reinforces health education elements at each visit. Families are referred for special classes, as needed, e.g. smoking cessation, childbirth education, etc.

The home visitor promotes parent-infant bonding and early infant stimulation. Parent education "lessons" are provided using one-to-one sessions, role-modeling techniques, interactive play and group classes held at the PCC. All staff have been trained in the use of the Nurturing Parenting Skills curriculum and have learned of successful strategies to engage families in learning and using new parenting techniques. Early infant stimulation and normal child development are reinforced during home visits as staff work to ensure a solid parenting foundation for families.

Parents and caregivers are offered opportunities to attend classes/groups at the PCC for health education and support groups. Participating women/families are encouraged to use services offered at the PCC. Parents and children are introduced to the centers through outreach events and are offered health education classes and family activities that promote improved parent-child interaction, e.g. Fun with Books, Music Together.

CF provides staff and community participant health education training sessions in a variety of ways. We use local experts from local community agencies for some topics. For others, we bring in state, regional or national experts. Prevent Child Abuse New Jersey (PCA-NJ) provides the HF staff training (sub-contract). Education is offered in both large group settings (bringing field staff from across programs and disciplines together), as well as in small group settings (site-based staff). Some topics are opened up to other health care providers/partners and to the community at-large.

Staff training topics have covered prenatal care and pregnancy precautions (March of Dimes and CNJMCHC), breastfeeding basics for FSWs and advanced breastfeeding training for RNs (Capital Health System-local hospital), tobacco use during pregnancy

(CNJMCHC), perinatal depression (GT Behavioral Health), fetal alcohol syndrome/perinatal addiction (Dr. Ira Chasnoff-Children's Research Triangle), Nurturing Parenting Skills (Dr. Stephen Bavolek-Family Development Resources), domestic violence (Rebecca Whitehead-Family Violence Prevention Fund), local resources for domestic violence (Womanspace), Ages and Stages training (PCA-NJ), childhood immunizations (NJ-AAP / TDOH), infant & child health issues (TDOH pediatric nurse), special child health services (Mercer County SCHS unit), immigration legal issues (PCA-NJ), and more. Selected sessions are open to other provider partners. However, most provider-oriented training is sponsored by CNJMCHC (in-kind).

C. Facilitators and/or Detractors: A major facilitator is our ability to provide health education in the home setting—as of 5/31/05, a minimum of 450 women/parents received health education from CF. During home visits, parents are able to concentrate on the information being presented and children can be kept busy with play activities.

Center-based education presents a new set of challenges for both parents and the Parent/Child Centers. Parents more easily attend individual classes/activities, but they have a greater difficulty completing an ongoing series of classes due to schedule conflicts with work, school or other family commitments and the need for enabling services. This poses an added cost for centers to provide transportation, childcare, food and incentives. Each PCC averaged about 15 community participants per month; some of these are a duplicated count, i.e. women/parents who come back for other educational classes or topics.

As referenced above, the TIP program for TANF families will give more value to both home and center-based services. We expect that this will have a direct impact on health education, since TIP is placing an emphasis for women/ parents to participate in health related education sessions that include: prenatal health, infant and child health, nutrition, enrolling in health insurance, completing primary care/well child visits, breastfeeding, immunizations, developmental assessment, etc. The health education priorities of TIP are a good fit with CF programs and services.

INTERCONCEPTIONAL CARE (IC)

A. Rationale for Approach: Since CF provides a long-term intervention (pregnancy through age two/three) all of the women that we successfully engage into services prenatally will become interconceptional care recipients. Women begin receiving education about IC services even prior to delivery.

B. Components and Resources: In our model, interconceptional care is closely aligned with health education. The primary setting for interconceptional care in CF is the home setting. Interconceptional women (parents) enrolled in home visiting and case management receive health guidance that includes tracking completion of postpartum visit, linkage to health insurance (if eligible), linkage to a medical home (GYN or other PCP), education about reproductive health (family planning, folic acid, healthy habits, safe sex practices, STD/HIV, annual PAP smear, etc.), and general health issues that

impact on women's health (smoking, obesity, hypertension, diabetes, mental health, etc.). We also place a heavy emphasis on the health of infants and children during IC. Our local evaluation includes specific measures on the completion of the postpartum visits, linkage to a medical home, enrollment in health insurance, if eligible, breastfeeding, and subsequent pregnancies. It also includes child health measures for health insurance, pediatric primary care/well child visits, immunizations, WIC, lead screening, developmental assessments and parent-child interaction.

As noted above the Parent/Child Centers offer another tier of community-based supports and services to parents and families. Many of these offerings pertain to interconceptional care issues—Moms' Support Group (depression), breastfeeding support, infant/child health classes, fatherhood activities, etc.

C. Facilitators and/or Detractors: The facilitators/detractors are similar to the above Health Education Section. Of primary importance is the need to provide enabling services (transportation, translation, childcare) to interconceptional women to ensure compliance with health care visits and activities. If a visit is missed for an active participant, the worker will try to reschedule with the provider ASAP and provide the needed enabling services. Budget (costs) and time limitations make this difficult for existing staff to help families in these areas. We have tried to seek additional funds to expand our ability to provide enabling services, but thus far have been unsuccessful.

DEPRESSION SCREENING AND REFERRAL

A. Rationale for Approach: Trenton adheres to the recommendation that all pregnant women should be screened for depression, addiction and domestic violence, as well as other risk factors that may contribute to poor pregnancy outcomes. To facilitate the prenatal screening, these elements have been integrated into the CF perinatal screening and risk assessment process. At our earliest planning sessions, Trenton providers told us that underlying depression during pregnancy was a concern. They also expressed concerns about related factors that may co-exist or contribute to perinatal depression—addiction, domestic violence and other psychosocial conditions.

Our collaboration was united in wanting to put in place a universal screening/risk assessment tool for all pregnant women in Trenton, knowing that these issues cut across all socioeconomic strata. At about the same time we began our project (early 2002) our regional maternal and child health consortium, the Central New Jersey Maternal & Child Health Consortium was charged with initiating a universal screen throughout our five-county region in NJ. Through committee, a decision was made to adapt the 4 P's Plus (with Dr. Chasnoff's approval) and include screening questions about depression and domestic violence. In Trenton, we added this 4 P's Plus format to our original prenatal screen.

B. Components and Resources: Depression screening is conducted at the prenatal clinic for all pregnant women upon entry into prenatal care. If consent is received for referral to CF, then the home visitor provides follow-up for any at risk women and

makes a referral for a behavioral health assessment, as indicated. Trenton is fortunate to have a behavioral health partner, Greater Trenton Behavioral Healthcare (GT) that is funded by Children's Futures, Inc. with RWJF funds. GT works collaboratively with the home visitors and other providers in our model. All home visitors have received training to continually observe for signs of depression throughout their work with families (up to age three). For positive screens, GT is able to make a home visit with the home visitor to introduce herself and make an initial clinical assessment, using the Beck Depression Scale. Depending on the presenting symptoms, the GT behavioral health specialist makes appropriate treatment recommendations for the woman. GT assists with case management of treatment-related issues and tracks the status and outcome of these cases.

Greater Trenton has provided on-site education/training with workers at each of the PCCs, NFP, PHNs and Fatherhood about the signs and symptoms of perinatal depression. They offer depression training to other perinatal providers and partnering community agencies, e.g. homeless shelters, soup kitchen, etc. In 2004, GT began conducting psycho-educational groups at the Parent/Child Centers as an alternative measure for reaching at-risk pregnant/postpartum women who may be reluctant to participate in individual counseling/mental health treatment. This strategy has been very successful and it continues in each of the PCCs, with groups held in both English and Spanish. Enabling services are provided for mental health services—transportation, childcare, etc., as needed.

In CF, two other screening priorities are emphasized. They are discussed below:

Addiction: CF uses the screening process to identify women who screen positive using the 4 P's Plus. In our original plan, the woman would receive prevention education and an assessment and brief intervention for alcohol, tobacco and drug use. The addiction counselor would assist with referrals for treatment and assist with case management for these women. Unfortunately, in 2004, Trenton lost this important resource due to funding reallocations at the state level. As a result, the number of women screening positive remains steady (26% tobacco, 21% alcohol & drugs), but the number of women assessed and/or entering treatment has drastically decreased. Without the onsite intervention many of these at-risk women never receive the needed counseling and follow-up because they do not readily consent to home visitation services. We are working to get funding reinstated and resume this onsite component (explained in more detail in the next section). CF has provided several training opportunities to home visitors, providers and other community partners. Most notably, in May and July of 2004, Dr. Ira Chasnoff came to Trenton for a HRSA sponsored technical assistance visit and over 100 partner staff and community people attended his training sessions.

Domestic Violence: About 8% of Trenton women screen positive for domestic violence. Women who screen positive are offered information and resources at the prenatal clinics. If they consent, they also receive services from home visitors and other CF partners. All CF have received domestic violence training, from several sources. Most notable are the sessions provided by Rebecca Whitehead of the Family Violence Prevention Fund (HRSA-sponsored), a series of subsequent trainings provided by

Womanspace, Inc, our local partner and an annual special event sponsored by St. Francis Medical Center (local hospital) for a dramatic dinner theater presentation that is open to all providers and CF partners). Through these training and support efforts, CF staff are learning what to look for, and how to approach the subject of domestic violence with women and families. Staff have access to wallet size cards and other resource materials that support their efforts to address domestic violence in our target population.

Other Training:

C. Facilitators and/or Detractors: Gaps in mental health treatment exist for pregnant women in Trenton and this has been a challenge for us. We are fortunate that the GT behavioral health specialist can make home visits. This is a help, but it is not usually the best option. Many issues contribute to the problem of treatment gaps--lack of adequate insurance coverage for services, low reimbursement rates from Medicaid for providers, few providers who accept Medicaid (this makes waiting lists long and thus gives priority status to individuals with more acute/crisis care needs), few providers who speak Spanish and other cost barriers for uninsured women (sliding fee and medication costs).

The other end of this problem is the reluctance of women to actively seek treatment when recommended. Fear, denial, stigma, cultural and societal attitudes and beliefs are only some of the reasons why women resist treatment. The home visitor tries to make the linkage with GT a safe and trusting one; and GT tries to create that same environment during their initial home visit for assessment with the woman. Legally and philosophically, we will not force a woman into treatment. Rather we try to maintain a relationship with her, continue to build trust and try again when she may be more receptive. Of course, we must make an exception to this when someone is an immediate threat to themselves or others (we have been presented with several of these situations and in such cases, a referral is made to our local Crisis Center). The GT mental health specialist holds case conferences and works closely with the home visitors. She helps workers to feel more comfortable in identifying depression/mental health issues and encouraging families to seek help, as needed.

In an effort to address the prevalent resistance to treatment services for depression, GT instituted psycho-educational groups at each of the four PCCs. These small groups are framed as "special time for women" and include arts and crafts, and other interactive activities. However, during the activities, discussion is taking place about stressors and coping strategies. Other PCC coping activities included meditation, exercise and therapeutic massage, and while these alternative strategies have been helpful, the dedicated resources to sustain these activities are not readily available.

Addiction: This was a challenging component to integrate into the CF model. Addiction screening was a pre-existing service that was struggling for viability, due mostly to its agency's inability to make compromises that would better serve women and facilitate its integration into prenatal care. Prior to CF, the sponsoring agency was requiring use of a very lengthy "screening tool" of their design that was really more appropriate for assessment. There was much resistance to screening from prenatal providers, primarily over this issue. With intervention from the City of Trenton (Demand Treatment! Grant)

and support from CF an analysis showed that numbers of screens, assessments and treatment referrals were well below the needs of the target population. Demand Treatment! was making significant headway in negotiating changes in the process and improving perinatal addiction screening rates.

But a primary factor that influenced the process to switch to a more “user-friendly” tool was a NJDHSS recommendation that OB providers, with an emphasis on clinics, use a standardized reliable screening tool. This brought CNJMCHC, our regional MCH consortium, into the process (January 2002) and with input from CF and other perinatal providers, the 4 P's Plus was selected and approved by NJDHSS (July 2002). At this point our addiction provider, the Mercer Trenton Addiction Science Center (MTASC) came on board as a bona fide partner in CF. TDOH/CF worked in collaboration with MTASC frontline staff and successfully mediated the process with prenatal care providers to integrate the 4 P's Plus into the CF screen.

By December 2003 (the first full year of CF services), MTASC was a committed and fully integrated partner working in harmony with prenatal care providers to offer onsite prenatal addiction prevention education and assessment. All was going well until mid 2004, when we learned that Trenton and hence CF would be impacted by a major shift in resources for the onsite assessment and prevention education for perinatal addiction. In July 2004, despite our protests that women will be less likely to enter treatment without the onsite screening, assessment and support (a “warm handoff” to assist with plans to enter treatment), these dedicated funds from the NJDHSS Division of Addiction Services (NJDAS) were reallocated to provide additional perinatal addiction treatment slots in the State. With strong leadership from the Mercer County Department of Human Services, the Trenton contingent has advocated for restoration of the NJDAS funding for screening, prevention education and assessment. The County brought data to show that the number of Trenton women entering treatment dropped significantly since the funding shift, thus leaving treatment slots unfilled and wasting those funding dollars. CF supplemented this information with TDOH Central Intake screening data that showed a continuing high rate of positives on the 4P's Plus indicating the need for prevention education and assessment for those women. These two data sources provided concrete evidence that onsite counseling and education is a key factor in helping women decide to enter addiction treatment. Though it has taken over a year, we anticipate this funding will be restored to Trenton in September 2005 and services will again be integrated into the CF model.

Domestic Violence: Domestic violence services were not well integrated into our original design. Women who screened positive for domestic violence and consented to referral were referred to the CF behavioral health partner. If the woman was in crisis she was directly referred to Womanspace, our local domestic violence agency. Though we were familiar with the work of this agency and providers made referrals for crisis intervention, the project director and other CF partners did not have a direct working relationship with Womanspace, nor did we actively solicit their input into the model. In hindsight, we acknowledge that this was a serious omission. Fortunately, in February 2004, HRSA sponsored a site visit from the Family Violence Prevention Fund (Rebecca Whitehead).

This visit was a major facilitator. The training helped partner staff to voice their frustrations and concerns about their work with women and families impacted by domestic violence. It prompted the project director to invite Womanspace to participate in a workgroup to examine gaps in resources for domestic violence services. As a result of our collaboration, new resources have been forthcoming from Children's Futures Inc. (RWJF funds) for ongoing domestic violence training, and consultation and support to case management and other CF partner staff. This new partnership, established September 2004 with Womanspace, provides a concrete resource for home visitor and provider staff when they identify women/families in need of domestic violence services. Womanspace educators and counselors have conducted extensive training sessions with all home visitors and CF partner staff, and as a result workers feel better supported when handling these complex issues.

LOCAL HEALTH SYSTEMS ACTION PLAN

A. Rationale for Approach: The Children's Futures Initiative is the result of close collaboration with the community—both providers and consumers. Their contribution to Trenton's LHSAP is the basis for the design, implementation and revision of our integrated service delivery model. Through this partnership, we have put together a variety of strategies and services in an integrated, coordinated system of care for pregnant women, parents (mothers and fathers), infants and children that we hope will help Trenton eliminate health disparities and reach the goals that have been set for this initiative.

B. Components and Resources: Trenton's HS grant brings together a partnership of fifteen agencies and programs (directly funded and in-kind) working in collaboration to achieve the overall goals and objectives of the project and address the priority needs identified in the LHSAP. In addition, this project has a commitment to work in collaboration with the members of the Trenton HMHB Coalition, the Consumer Coalition and many other community organizations.

Trenton's four-year LHSAP was developed in 2001 in preparation for our original HS grant. The plan has since been revised and updated with input from the Children's Futures Workgroup, an ad-hoc committee of the Trenton HMHB Coalition. The group meets quarterly to review the progress of CF in carrying out this plan and accomplishing goals and objectives. Interim project updates are provided to our consortium, the Trenton HMHB Coalition, at each bi-monthly meeting, and a formal progress report, reviewing goals and objectives, is made each year.

Trenton's plan was developed after the completion of an extensive needs assessment process that was open to the community and included all key stakeholders in Trenton. This pre-planning needs assessment phase was funded in 1999 by the RWJF through Children's Futures, Inc. It involved extensive outreach and focus groups to all sectors of the community—health, social services, education, faith-based groups, law enforcement, civic organizations, politicians, and many other concerned individuals. Participants represented the racial and ethnic make-up of the city.

Priorities were established as a result of the needs assessment process. The process included a variety of strategies and priority-setting sessions bringing interested individuals and agencies together. When we analyzed the priorities and recommendations from the CF planning process, we were careful to align (where feasible) CF priorities with other established MCH priorities issued by our other planning partners—Central New Jersey Maternal & Child Health Consortium, Healthy Mothers/Healthy Babies Coalition (HMHB) and NJ Department of Health & Senior Services, Title V agency.

C. Facilitators and/or Detractors: Overall, we are extremely pleased with the progress we've made toward implementing the core components of CF into the perinatal system of care. This ambitious initiative requires a level of collaboration and commitment from partners that has never before been tested in our city. Trenton has a deeply committed team of agencies and individuals that are working hard to make this project happen. This is demonstrated not only by the efforts of our funded partners, but also of our provider and social service partners who are committing in-kind and other-funded service elements to help us be successful.

The LHSAP and the service delivery model that we designed for our Healthy Start grant is a direct result of our collaborative assessment and pre-planning process. Its implementation has been greatly facilitated by the CF Workgroup. As the name implies, this is a workgroup that includes representatives from each of the CF partners (in-kind providers and funded agencies) and consumer participants. While attendance is open to any HMHB and Consumer Coalition member, participation is generally around 20 people. This is a good size for a productive discussion of implementation issues and evaluation of our progress. In the past year, we have had more consistent consumer involvement in the process. This consumer involvement becomes even more important as we continue to evaluate/reevaluate our performance, identify successes and shortcomings, and recommend new solutions and advocate for needed changes.

We have faced numerous challenges in the process of moving this project from a plan and model, to a viable interactive service delivery system of care:

In the first year, our project faced implementation delays that were the result of slightly differing timetables and different implementation styles. While TDOH was ready to proceed, our primary funding partner, Children's Futures Inc., needed extra time to handle unavoidable administrative issues. Children's Futures Inc. received its funding commitment from RWJF a month later than the TDOH HS award. They needed to obtain a 501c3 in order to complete the transaction to receive RWJF funds and ran into procedural delays. They also needed to plan a move to larger office space to accommodate more staff, again running into additional delays.

While we were reluctant to delay start-up of direct services, the City of Trenton and TDOH made an administrative decision to move forward in unity with Children's Futures, Inc. We recognized that our actions at this early stage would send an important

signal to the Trenton community about the importance of genuine collaboration and partnership to the success of this unprecedented and far-reaching initiative. During this transition time, we continued our work in planning and meeting with providers to facilitate the process to expand the model from two to four centers. In January 2002, the four-month RFP process began for selection of the four Parent/Child Centers and other core services (behavioral health, fatherhood, childcare). Unfortunately, these delays resulted in a loss of \$96,000 from first-year HS funding, which both TDOH and Children's Futures Inc. have learned from. However, we still maintain that the decision to move forward together was essential to the early successes we are experiencing.

CF had new health and social services partners to work with to get the four Parent/Child Centers physically operating and up to full staff, provide extensive core training, deal with some early staff turnover and build service capacity for both the intensive home visiting and center-based service components. It took additional time and effort for the partners to learn about each other's agency operations and management styles.

The TDOH Central Intake office was set up as a manual tracking system. TDOH had to work out logistical bugs in regard to coordination of screens and referrals, and related issues, i.e. client confidentiality, consent, receiving and assigning screening referrals, paper flow, etc. In 2003, the project director and CF partners spent time in developing a database system to ease tracking and monitoring.

CF has been well received by Trenton's Hispanic population. Unfortunately, although each of the PCCs has Spanish-speaking workers, these caseload slots are all filled. Additional funds are needed for more bilingual (Spanish) workers.

Improved outreach to African American women was a shortcoming in the first grant cycle for reasons discussed in the earlier section on outreach services. We recognize that our success in eliminating racial disparities for Trenton is contingent upon our success in implementing the new strategies recommended in the CF Workgroup process and in continually monitoring our progress. Further, outreach to engage African-American women must be expanded to private OB/GYN offices (Trenton CARES). We suspect that while more Hispanic women (many of whom are undocumented) are using the public clinics, a portion of African-American women enrolled in Medicaid HMOs may have moved from the clinic setting to private OB/GYN physicians.

It is an ongoing challenge to facilitate coordination of core services and maintain clear and timely communication with our core partners and front-line workers. We have monthly site director meetings and try to communicate with each other through office/cell phones, voice mail, and e-mail, but technical problems (e.g. e-mail is down) and busy schedules and competing priorities still result in occasional communication gaps. And, we also worry about folks getting "burned out" with too many meetings.

Staffing shortages in hospitals and community clinic settings are a constant concern since our prenatal clinic partners are central to the success of this initiative. These

providers conduct the initial screen and referral to central intake and are subject to additional pressures from within the health care system and their parent agencies.

An overall challenge is to ensure that the CF staff (sub-contract and in-kind) from within each of our partner agencies feel appreciated and supported, not only by their agency, but by the entire partnership as well. We know that the day-to-day grind can be difficult and often thankless work, whether a clinic nurse, screener, home visitor, data person, etc. So, the leaders of this initiative make a concerted effort to convey frequent words of support and thanks. In January 2004, Children's Futures, Inc. launched an annual staff appreciation luncheon, which has been very well received by staff.

We are getting referrals for some extremely high-risk women/families. Often these women are reluctant to participate in intensive, long-term services, or have such complex needs that our program partners are not the appropriate case managing agency. Therefore, as we move forward we are challenged to look for dedicated funding for high-risk case management, especially for those women/families affected by addiction, chronic mental illness (e.g. schizophrenia), MICA, homelessness, developmental disabilities (of the woman) and partner/father supports and services in any of these same areas.

An essential part of our plan is to show concrete evidence of the effectiveness of the model. In 2003 and early 2004 we had the challenge of designing a Central Data System (CDS) that would allow us to track the status of all screens and not duplicate the data collection requirements of our program service partners, HF and NFP. All core partners have had input into this arduous process. Their commitment and patience in making this a useful tool have been much appreciated. The CF Central Data System is an important source of program data and allows us to give regular feedback to partners about our successes in engaging women/families into services, and more. In this way partners get some concrete positive feedback (not just words of encouragement) about how they are making a difference. CDS is a valuable asset to the project and revisions to the system are made periodically to add new tracking elements, to improve reporting capabilities and to aid us in project evaluation.

One of our greatest challenges is fully implementing the model and securing the resources needed to continue to build capacity and meet the growing demand for services within our community. The issue of service capacity is a pressing one, since CF works with families up to age three in intensive home visiting. As noted previously, the design of the model incorporated preexisting funding to help sustain core services. TDOH has actively sought supplemental funds to help expand capacity within the model, i.e. Juvenile Justice funding (NFP nurse home visitation/case management), March of Dimes (outreach) and of course, policy level advocacy is essential. More discussion in this area is included in the Sustainability Section.

Through CF and our local planning process, we set high goals for Trenton, with our ultimate goal as the elimination of health disparities for women, infants, children and families in our city. Realistically, we know that this will require the long-term planning

and commitment of our partners and our community. We also know that it will take our continued and combined efforts to change the system of care and maintain this goal over time. The partners of the Children's Futures Initiative are up to this challenge.

CONSORTIUM

A. Rationale for Approach: Since its inception in 1985, the Trenton HMHB Coalition (HMHB) has been an important venue for local health and social service providers to build trust, work together to identify barriers and gaps in services, and design strategies to ensure coordination and collaboration of services. Rather than develop a duplicative/competing consortium structure, it made more sense to continue to use and build upon Trenton's existing HMHB structure to meet the consortium requirement for the Healthy Start grant.

B. Components and Resources: HMHB Coordinator, Brenda Tift, is employed by the Central New Jersey Maternal and Child Health Consortium (CNJMCHC). General meetings of HMHB are held every other month. CF gives a progress report to attendees at each meeting and a more extensive report annually. Meetings also include reports and informational items from partner agencies, and an educational component. Meeting attendance averages about 40 people and includes at least two consumer representatives. A separate Consumer Coalition was developed in 2004 to increase consumer involvement. Attendance at these meetings now average 15-20 parents (including 1-2 dads). As discussed previously, the CF Project Director leads the CF Workgroup, an ad hoc committee of HMHB, that includes provider and consumer representatives.

C. Facilitators and/or Detractors: Trenton's consortium has been evolving since the inception of Healthy Start. Consortium leadership and support for both the general HMHB meetings and the Consumer Coalition is provided in-kind from CNJMCHC. This is a major contribution to the project. Please see Section D that follows for more facilitators and detractors.

D. For Consortium Also Address the Following:

1) The establishment of the consortium, any barriers that emerged and how they were addressed.

Trenton's local consortium had its beginnings in 1985 with the inception of the Trenton Healthy Mothers/Healthy Babies Coalition (HMHB). It was strengthened and expanded in 1996 when the City was awarded a five-year HRSA Maternal and Child Health Bureau, Healthy Tomorrows Partnership for Children Program (HTPCP) grant. The HTPCP Trenton Loves Children (TLC) Home Visitor Project, helped coordinate interagency outreach and strengthen case management services for women/families during pregnancy and through the interconceptional phase (up to age three).

In 1999, the Robert Wood Johnson Foundation identified Trenton as the recipient of a unique study and planning grant, which supported the formation of a new partner,

Children's Futures Inc. During its extensive community needs assessment phase, Children's Futures Inc. called upon the City of Trenton and the Central New Jersey Maternal and Child Health Consortium's Trenton HMHB Coalition to help determine effective strategies and target populations to improve health outcomes for all children. As a result of this work, in 2000, Trenton's local community consortium was expanded to include the mental health and addiction providers and greater community/consumer input. The outcome of Children's Futures Inc.'s work was the development of a ten-year strategic plan focused on four major areas: 1) reduce disparities in birth outcomes, 2) strengthen effective parenting, 3) improve quality in child care, and 4) strengthen local leadership and capacity to improve the likelihood for success. **The Children's Futures Initiative and its collaboration with HMHB and community partners are working to accomplish the first two of these identified focus areas.**

2) Consortium Structure (size, race, gender, agency type, etc).

HMHB now includes over 100 general members and representation has expanded to include the CF Parent/Child Centers, behavioral health, fatherhood, domestic violence, early childcare, consumers and other community representatives. About 75% of current members are active participants, i.e. attend at least 50% of full consortium meetings (3 out of 6 bi-monthly). HMHB membership is overwhelmingly female (98%) and consists of the following organizations and racial/ethnic categories (%):

Community-based organizations (CBO)	21%	African-American	35%
CBO providers contracting w/ HS	29%	White	45%
Private agencies	7%	Asian	0
Public/government agencies	10%	American Indian/Alaskan Native	0
Other providers	20%	Native Hawaiian/Pacific Islander	0
Consumers	3%	Hispanic/Latino	19%

3) Activities utilized to assess ongoing needs, identify resources, establish resource allocation priorities and monitor implementation. Describe relationship with other consortia serving similar populations.

Because of the size of the general coalition and the instability of attendance at the Consumer Coalition meetings, the CF Project Director established a "CF Workgroup" to function in an advisory and working capacity. Participation is open to any HMHB or Consumer Coalition member. Core members include at least one representative from each of the prenatal care providers, the Parent/Child Centers, other CF funded partners, community representatives (i.e. Trenton public schools), at least two consumers and the NJDHSS Title V representative. During the first two years this group met monthly/bi-monthly then meetings tapered to quarterly. Presently CF Workgroup meets twice a year (more often if a funding opportunity or operational issue comes up). The CF Workgroup participates in Healthy Start activities--ongoing needs assessment, data review, LHSAP review and revision, and oversight of implementation, monitoring and evaluation of the CF model, and recommendations for seeking additional resources.

In addition, HMHB is responsible for review and submission of the Trenton portion of the CNJMCHC work plan. This plan is then submitted to the NJDHSS every three years for application in the Title V MCH Work Plan. So, our participation at the local level ensures that we share the same priorities in addressing MCH needs.

Trenton's decision to have HMHB assume the role of the consortium has minimized any problems with competing consortia and agenda. CNJMCHC has a perinatal addiction consortium that encompasses the five-county region that includes Trenton/Mercer County. The CF project director and other Trenton providers are active members of that group.

4) Community strengths that enhanced consortium development.

Trenton is a relatively small city with a core group of committed long-time MCH providers and stable leaders who know and respect each other and each other's organizations. This group has been a good foundation on which to generate new ideas, build new interagency relationships and strengthen provider involvement in the consortium.

Another important strength in the development of the consortium was CNJMCHC's decision in 2003 to hire Brenda Tift as the Trenton HMHB Coordinator. As a former consumer, Ms. Tift looks at these MCH issues from a consumer perspective and she is committed to expanding the involvement of consumers/participants in the workings of the coalition.

5) Weaknesses and/or barriers for consortium to move forward.

One of the biggest barriers for consortium involvement is the growing pressure within partner organizations to do more with less, both in staffing as well as competing priorities. It means that we must be more efficient in how, and how often, we meet and communicate. Usually provider sites send one representative to the HMHB meetings and this person is expected to go back to agency colleagues and update staff. We know that day-to-day demands often prevent this from happening. One way we have tried to keep folks informed is to hold an annual "thank you" luncheon on-site with each of the prenatal care clinic partners. We give the staff (nurses, physicians, midwives, support staff) a CF Update. This has been well received by providers and gives us a chance to maintain relationships with the front-line staff and to meet any new clinic staff. Just as importantly, it gives the providers an opportunity to meet the staff from Central Intake, Parent/Child Centers and the CF consultants (behavioral health, fatherhood, childcare).

We need to improve our efforts in reaching and engaging private providers to contribute to the consortium process. This is an operational objective as we move into our second cycle of HS funding (2005-2009). Strategies to build relationships with the private providers have been incorporated into Trenton CARES, our new outreach grant, and efforts are already underway.

Lack of sufficient resources for enabling services—transportation, translation and childcare—continues to be a barrier for consumer participation and involvement. HMHB provides taxi vouchers for attendees in need and this has helped tremendously. Taxis provide door-to-door transportation, but this still results in waiting time for pick-up and drop-off of families on both ends of the meeting. The result is late arrivals at the start of the meeting and tired families and children waiting to return home afterward. Existing

staff, who have already worked a full day, help with translation and other support functions (security, set-up/clean-up) for the meeting. We have no paid childcare for meetings and this too is a problem. Fortunately, we've been able to rely on the Coordinator's two teens to volunteer to help with childcare, but widely varying ages of children and facility layout (we rotate meeting locations) can pose problems.

If we want participants/consumers to have greater involvement in the development of the consortium, we must offer leadership training opportunities for interested participants who can make a greater commitment of their time and talent. This is also planned for the 2005-2009 funding cycle.

6) Activities to increase consumer participation. Change over time?

While consumer involvement has always been a stated goal of HMHB, meeting attendance has been almost exclusively from provider members. After several more futile attempts to bring more consumers into the general HMHB meetings, a joint decision was made between the Project Director and HMHB Coordinator to try a new approach used in some of the other HS sites. In 2004, HMHB concentrated on strengthening consumer/participant involvement in community consortium activities by starting a separate Consumer Coalition. This has been an enormous success. While attendance still fluctuates, we now have about 20 consumer members and interest continues to grow.

Leadership training for consumers is a part of our LHSAP for 2005-2009, and TDOH and HMHB will work jointly on accomplishing this. Through our Trenton CARES grant we are developing new opportunities for consumer/participant involvement. These include: recruitment of volunteers (stipend) to assist with outreach days in specific target neighborhoods, creation of neighborhood liaisons (stipend) for information and referral in target neighborhoods, and working with the Mercer County One-Stop to develop job training positions for TANF recipients who may be interested in working in neighborhood outreach teams with Trenton CARES staff.

7) How did you obtain consumer input in decision-making?

In prior years, consumer input for HMHB and CF was obtained primarily through one-time focus groups, community outreach and MCH surveys that identified barriers to care and gaps in MCH services. With the launch of the Consumer Coalition in June of 2004, the process changed significantly. The Project Director made a presentation to the new Consumer Coalition, giving consumers background information about how CF came to exist, and an overview of screening, referral and available services, and a review of key data measures for Trenton (e.g. total births, teen births, no prenatal care, LBW, Infant mortality, etc.). The Project Director attends all of the Consumer Coalition meetings and gives consumers a brief update of CF activities and projects. She frequently updates her request for volunteers to participate in the CF Workgroup. In 2004, we were fortunate to have two consumers/program participants who were able to provide input and attend the CF Workgroup meetings.

8) How did you utilize suggestions made by consumers?

Direct consumer input has already had a positive impact on our project. One of the comments we were frequently hearing from providers is how the screening tool is too personal and that women would not want to participate in CF. We reviewed the screening tool with our consumers and explained in simple terms how these questions relate to pregnancy risks (e.g. marital status, income, husband/partner working—may contribute to maternal stress and the relationship between stress and pregnancy outcomes, especially for African-American women). We asked consumers if they felt this information was too personal and would deter them from participating. As you might have guessed, women said that as long as the staff explains (in appropriate language) the reason for such questions they saw no problem with it. In fact, this would be a good way for women to learn more about how these factors contribute to health during pregnancy, and available resources and supports, such as those offered by CF.

This led to a discussion about how women feel they are treated at busy clinics or other public agencies, and we came away with a plan to ask more women these questions in a consumer survey (in our community outreach grant). We also took these consumer concerns back to our clinic partners and asked about their internal process to get customer service feedback. We informed them of the consumer suggestion to develop a community outreach survey and got provider consensus to move forward with this item.

The Trenton CARES outreach grant funded by the March of Dimes was our first collaboration of provider and consumer representatives through the CF Workgroup. The redesign of outreach services proposed for Trenton CARES includes the suggestions made by consumer participants to give consumers/ residents a more prominent role in helping to reach other women in target neighborhoods. Consumer input also influenced our LHSAP revision and 2005 reapplication for HS funds.

COLLABORATION & COORDINATION WITH TITLE V AND OTHERS

A. Rationale for Approach: An important part of our local strategic planning process has been to integrate into our model successful program elements that are Title V funded and that address the priorities we have identified for Trenton, e.g. perinatal outreach, PHN home visits (Tier 1), Black Infant Mortality Reduction and the HMHB Coalition. In addition, we have tried to build upon existing relationships to integrate in-kind services and program elements from MCH partners

B. Components and Resources: TDOH and the CF partnership works closely with two primary MCH planning partners—NJDHSS, the state Title V MCH block grant agency and CNJMCHC, the regional MCH consortium designated by NJDHSS as the planning agency for the five-county area that includes Trenton. As the local health department for Trenton, TDOH has had the opportunity to cultivate these working relationships with our state and regional colleagues through both prior and currently funded MCH initiatives and services.

Trenton's other local planning partners include:

- Children's Futures, Inc. (RWJF funds), lead agency for local policy and service issues and involves local providers, as needed. For example, Children's Futures, Inc. is working with state Medicaid officials to resolve HMO prenatal care provider coverage issues, and they are working with behavioral health providers to advocate for better Medicaid mental health coverage and reimbursement.
- Mercer County Department of Human Services is advocating to the State to reinstate addiction funds for perinatal assessment and brief intervention services at Trenton OB clinics. They are working with CF to rework this part of the model.
- The Mercer County Board of Social Services and other key players called upon CF partners to examine gaps in housing for pregnant women and other local social service issues.
- Sweeping changes in the child welfare system have resulted in state, county and local attention on child abuse prevention services. Children's Futures, Inc. (RWJF funds) and Mercer County Department of Human Services have been at the table along with Prevent Child Abuse-New Jersey and state funding partners (NJ-JJC, NJDHS, NJDHSS) working with state policy makers to explore funding for intensive home visiting programs modeled on those used in our CF model (HF and NFP).

CF has numerous linkages with other entities—hospitals, health centers, social service agencies, schools, churches, etc. Many of these are depicted in the diagram of our CF model. Current linkages include:

- Outreach—In addition to the outreach provided by the four PCCs, CF has new partners—TDOH Trenton CARES (March of Dimes), MEE Productions (CF Inc./RWJF) and CNJMCHC (Title V). The project director is facilitating coordination and integration of these new components into the model.
- Screening, risk assessment & program recruitment—Universal screening for client recruitment takes place at the prenatal clinics (in-kind), using the HF screen and the 4Ps Plus. In-kind partners include:

Capital Health System – Mercer Campus
Henry J. Austin Health Center (FQHC)
Planned Parenthood Association of Mercer Area
Robert Wood Johnson University Hospital at Hamilton

- Healthy Families (Tier 3)—intensive home visitation program based at each Parent Child Center serves 60 families living in their designated ward. Services begin during pregnancy and continue up to age three. CF collaborating agencies for each ward are:

South Ward PCC	El Centro/Catholic Charities
East Ward PCC	St. Francis Medical Center
West Ward PCC	Mercer Street Friends
North Ward PCC	Children's Home Society

In addition, one of our partners (Mercer Street Friends) continues its preexisting Trenton Healthy Families program (funded by the NJ Dept of Human Services).

- Nurse Family Partnership Intensive Nurse Home Visitation—operates out of TDOH (funded by NJ-JJC) and serves up to 100 first-time mothers and their families from pregnancy to age two. TDOH (two RNs) partners with Mercer Street Friends (two RNs) to provide four specially trained NFP nurse home visitors.

- Public Health Nurse (PHN) offer less intensive (monthly) home visits to lower risk pregnant or parenting women and families with children up to age six. These services are provided in-kind by TDOH with both municipal funding and NJDHSS Title V funding for Prevention Oriented Services for Child Health (POrSCHe).

Community Services

- Parent/Child Centers also provide an array of center-based parent support and educational activities in partnership with community organizations.
- The BIBS Partnership is a local collaboration with three faith-based organizations that provide mentoring services to African-American women during pregnancy and up to age one. TDOH is the lead coordinating partner and funding is from the NJDHSS BIMR initiative (Title V and State funds).

Other core components funded by Children's Futures, Inc. (RWJF funds) include:

- Behavioral health consultation services for perinatal depression, substance abuse (including tobacco)–Greater Trenton Behavioral HealthCare;
- Domestic violence services with Womanspace;
- Fatherhood support and development services–Trenton Men's Collaborative at Union Industrial Home;
- Child care consultation services for linkage to infant and toddler care, as well as child care provider training to improve quality–Child Care Connection.
- Best Clinical and Administrative Practices (BCAP) initiated by Children's Futures, Inc. to bring together the prenatal clinical providers to identify and address priority areas. In 2003 topics included universal screening, cultural competence, perinatal depression and domestic violence. The topic for 2004 was gestational diabetes. Participation includes the four prenatal clinics and one of our Medicaid/SCHIP HMO providers.
- A collaboration with the NJ American Academy of Pediatrics, Pediatric Council on Research and Education, entitled EPIC (Educating Physicians In their Communities) is working with local pediatricians on several education modules: immunizations, lead poisoning, child abuse and neglect, and developmental assessment/anticipatory guidance.

CF has several recent community linkages that contribute to planning and implementation of services:

- NJDHS Division of Youth & Family Service (DYFS) (child protective services)
- Mercer County DYFS District Office to coordinate services in CPS cases and for new addiction treatment funds for parents
- Mercer County Board of Social Services (MCBSS) for TANF Work First NJ
- NJDHS Division of Addiction Services (funder for perinatal addiction services)
- NJDHS Substance Abuse Initiative to provide treatment services for TANF clients in partnership with MCBSS
- City and county addiction service providers (for non-TANF women & fathers)
- City and county homeless and housing programs/shelters
- NJDHS Division of Medical Assistance & Health Services to explore third party reimbursement and address other MCH related issues (Medicaid & SCHIP)

C. Facilitators and/or Detractors: The regional MCH planning process includes local input from the membership of the HMHB Coalitions. As active participants in the coalition, the project director and other CF partners have the opportunity to contribute to the MCH planning process for Trenton. The recommendations made by the CNJMCHC for the regional plan are in turn linked to the State's five-year needs assessment process. Further, Trenton's Local Health Systems Action Plan (LHSAP) is based on the recommendations and priorities from our regional plan. This ensures that we are all working together toward many of the same goals and objectives.

Effective communication, trust and mutual respect between partners are essential for the success of this collaborative. The City of Trenton Department of Health & Human Services and the Division of Health have built a good foundation of trust with our maternal and child health clinical and social services providers. We have a relatively long history of working together, especially workers at the front lines, to try and tackle issues that adversely impact the families with whom we work. In 1999, Children's Futures, Inc. came to the table as a new player with a planning grant and a mandate to improve health outcomes in Trenton (and a potential commitment of funding from the RWJF). This inclusive public-private partnership quickly gained attention from provider and community leaders.

Like any community there are turf issues, but for the most part CF maintains excellent relationships with the executive leadership of our partner agencies, and holds a quarterly meeting as a forum to discuss issues, share concerns and provide an update on our progress in reaching project goals. When a potential area of conflict arises, we try to address it immediately with those individuals directly involved. To date we have had no major unresolved conflicts to hinder our effort.

We believe that it is important for the core partners to have a written document that outlines and reinforces our commitment to each other, to the goals of the project and to the women, infants, children and families for whom we serve. CF has this in the form of an interagency Letter of Understanding, which includes all of the agencies that are core partners in this effort. The CF Letter of Understanding also outlines our mutual commitment for the protection of patient/client information, which is paramount to building and maintaining trust with our participants and community. CF requires a signed consent from any pregnant/postpartum woman for permission to share her screening information with central intake and allow the initial assessment visit from CF partner. After making this initial contact, additional consent must be given by the participant to enroll in any CF services or refer to any other partner agency. This year our CF Letter of Understanding will be expanded to include our two newest partners, Womanspace and the Mercer County Board of Social Services.

SUSTAINABILITY

A. Rationale for Approach: The CF model was intentionally designed to maximize existing funding and integrate these funds and services with our HS grant funds to build

a coordinated system of care. With our working knowledge of existing funding streams and licensing requirements in our State, we also tried to anticipate possible future sources for support of certain elements in the model (e.g. NFP nurse home visits may qualify for Medicaid third party reimbursement; HF has some support in DHS with DYFS/CPS funding).

B. Components and Resources: Our first charge was to move beyond the start-up period and get all of the core components up and operating efficiently and effectively. With a multifaceted project of this enormity it took a full three years to feel that we had all of the core elements firmly in place. These included: universal screening, central intake (including a computer database and tracking system to measure our effectiveness in reaching objectives), four new Parent/Child Centers, four new Healthy Families programs, one new Nurse Family Partnership program, a working relationship between home visiting/case management and behavioral health services, fatherhood linkages and referral for childcare services, and building consumer participation in the consortium.

While still not at 100% (resources come and go causing us to re-work the process), by 2004 we began to feel confident that we had gotten “over the hump” and began to take a serious look at new capacity issues (demand exceeding available resources) and new gaps in the model (outreach, addiction assessment). With a solid foundation (and some early outcome measures) in place, we were ready to look beyond the day-to-day activities and begin to look at expanding partnerships (Womanspace, Mercer County Office of Addiction Services, NJDHS Division of Youth and Family Services (DYFS), Mercer County DYFS District Office, Mercer County Board of Social Services, Substance Abuse Initiative). We also began to actively seek other funds and resources to fill in existing gaps in services, and to sustain and expand core services.

C. Facilitators and/or Detractors: Two sources of sustainability for local public health services over the past decade have been integrated into our model. Title V MCH Block grant funds and City of Trenton municipal funds support less intensive PHN/PORSCHe home visits. Also, municipal funds support two of four RN positions in the Nurse Family Partnership.

With NJ Juvenile Justice Commission funding set to end September 30, 2005, the remaining two RN positions have been included in the 2005-06 HS budget with the hope that this will be a temporary measure and sustainable funds will be forthcoming from Medicaid and/or other state funding (NJDHS/DYFS) in the next year or so. This will give us time to continue our discussions with NJDHS-Division of Medical Assistance and Health Services (DMAHS) for Medicaid reimbursement of nurse home visits.

After several unfortunate high profile child abuse and neglect cases in NJ, advocacy at the state level includes a serious discussion about costs and effectiveness of intensive home visiting as a prevention strategy. CF partners have been included (either directly or in consultation) in the discussion around some of these meetings. As of this month (August 2005), DHS is laying out plans for an abbreviated home visitation pilot program

for TANF recipients, entitled TANF Initiative for Parents (TIP), which is based on intensive home visitation models (HF and NFP) but only goes through infancy (12 months of age). Children's Futures Inc. has successfully advocated for the roll-out in Mercer County to have a slightly different structure that will better relate to the CF model we currently have in place. Children's Futures Inc. will be the lead agency for this funding in Mercer County and funds will be sub-granted to CF partners through the five HF sites. TIP also includes some funding support for community-based services and the PCCs will be permitted to compete for this funding to strengthen the center-based services component of the PCCs.

The CF Project Director is integrally involved in facilitating the process to integrate TIP into the existing CF model. She has successfully advocated for the Mercer County program to be permitted to offer TIP participation to TANF women who may be enrolled in our other, non-TIP, intensive home visitation programs (HF and NFP). Armed with CF program data, she was able to show that CF already exceeds the number of funded slots that DFD allocated to Trenton (165 compared to 58 funded slots). While this does not bring additional funds to the project at the current time, it does provide continuity and an important benefit to the women/families and their children who are already enrolled in NFP and HF through the prenatal screening process. This work-credit issue may also prove to be a strong incentive for women/families to make the needed long-term commitment to participate and hence improve health outcomes (and reduce disparities). And, in the long run, this policy exception may contribute to sustainability for these services.

One of the main strategies for seeking sustainable funding is the use of reliable project data from our local evaluation to tell our story and provide an analysis of program outcomes and assess gaps in services. While we have used program data successfully in two instances as referenced above (addiction screening and TANF home visits), our continued focus needs to be on outcome data and the results of our work in Trenton.

For Sustainability also address the following:

1) Efforts with managed care organizations & third party billing.

We recognize third party reimbursement as an important strategy to explore for long-term sustainability. As we enter the second four-year funding cycle, we are in a better position to actively pursue this funding option. Our best prospect for third party reimbursement will be with the Nurse Family Partnership. Earlier in 2005, the Project Director and NFP Nursing Supervisor met with Horizon NJ Health, Trenton's largest Medicaid HMO provider, and NJDHS-DMAHS Medicaid officials. Both have expressed an interest in this program for first-time moms and have indicated their willingness to explore the feasibility of payment for NFP nurse home visits for eligible clients. In our pre-planning for NFP, we entered into a subcontract with Mercer Street Friends (a certified home health agency) in anticipation that this might be an important consideration for sustainability of the program. We expect a decision in this matter to take another 9 to 12 months.

With regard to the Healthy Families program, third party billing is probably not an option, since the bulk of the home visits are made by paraprofessional workers. However, Prevent Child Abuse NJ, our training and technical assistance partner for Healthy Families, is working with state officials to look at alternative funding options for this home visitation program.

2) Major factors associated with identification and development of resources to continue key components without HS funding.

The most important factors are to think about sustainability and potential funding right up front while still in the project design mode. Of course this must begin with a careful examination of the needs assessment for your community and target population, and the proposed strategies to address those needs. Then, look hard at where current funding streams are coming from, learn about priorities in your local and state agencies, and try to anticipate future service/funding trends. While there are no guarantees, this at least puts you on the right path should the tides turn your way.

The cornerstone of Trenton's model is home visitation. In our state we knew there was already support for the HF model within DHS (DYFS prevention funds), albeit on a much smaller scale. There was also small-scale support for nurse home visitation in NJDHSS, though not the intensive model of NFP that we had hoped to bring to Trenton women and families. When funding became available from the NJ Juvenile Justice Commission for a pilot NFP program, we aggressively sought out this award because it matched the needs in our community (assessment and planning) and fit perfectly into our model (integration in the system). We were quite familiar with the body of work from David Olds about NFP outcomes for women and families, and were eager to pilot this in Trenton. And, we thought that it was most interesting that this funding was coming from a non-traditional public health partner and that this might have greater implications for future funding priorities in the area of child abuse prevention (NJDHS).

We thought hard about sustainability for NFP, since this is a costly program, and we knew we could not count on a shift of this magnitude in state policy. First, we were fortunate to be able to provide two of our existing PHN staff as an in-kind match, assuring at least some continuation of the program at the conclusion of the pilot. Also, from our experience as nurses in the home health agency sector, we considered that Medicaid billing might be a viable component of our sustainability plan (it would not cover all of the costs but would be an important contribution for at least the Medicaid segment of our target population).

Clearly, policy change is the key for some of these sustainability issues. While we still have more work to do, it turns out some of our efforts are paying off. We know that NJDHS-DYFS and DFD have taken a careful look at NFP as a prevention model (for first-time pregnant women) in addition to their consideration of expanding HF. So, our work with families in Trenton in the new TIP program (integrating this with NFP and HF) will continue to be of interest to our policymakers as they evaluate the impact of their TIP program in other counties throughout New Jersey. CF will continue to stay on top of

policy issues and keep in close contact with our state/county officials, and serve as a resource for policymakers.

3) Were you able to overcome any barriers or decrease their negative impact?

CF has been fortunate to not run into any significant obstacles within our partnership, i.e. with regard to turf or interagency relationships. Elsewhere in this report, we have discussed many of the challenges, big and small, faced thus far during implementation of our model. Some of the major obstacles are summarized here, as follows:

- Lack of consumer participation in the consortium was overcome with a change in the meeting structure.
- Loss of funding for outreach was overcome with partnership input (including consumers), new and improved design for services and new grant funding from the MOD; and two additional components that will complement our efforts 1) CNJMCHC HMHB outreach worker, and 2) MEE Productions CF public education campaign.
- Stigma of women getting mental health treatment services was overcome with a change in service delivery from a primary focus of individual counseling to expanding services to include psycho-educational groups.
- Need for bilingual mental health worker was overcome with the recent hiring of a qualified bilingual mental health worker.
- Loss of funding for perinatal addiction screening and assessment will soon be overcome with advocacy from CF partners and county representatives.
- Lack of integration of domestic violence services was overcome with TA from Family Violence Prevention Fund and Children's Futures Inc. supplemental funding to Womanspace for domestic violence training and consultation.
- Improving participation of fathers remains an ongoing challenge but CF fatherhood partner has strong relationships with the PCCs to reach out to men and overcome this barrier.
- Data collection and tracking CF progress in implementation and outcomes remains an ongoing challenge but we are overcoming this barrier by developing and fine tuning the Central Data System in Central Intake Office.
- Reaching service capacity was addressed but not fully overcome by using PHN/POrSCHe to visit when NFP/HF slots are full (lower level of care).
- High risk families with extremely complex needs remain an ongoing challenge to overcome, but CF is expanding partnerships with other local case management systems, e.g. DYFS, TANF-Substance Abuse Initiative, etc.
- Need for continuation funds for NFP will be temporarily overcome with HS support. Our sustainability plan to overcome this barrier is to seek third party reimbursement through Medicaid/HMO funds.
- Need for continuation funds for HF and other services will require policy changes, e.g. new funds from NJ DFD for TIP services, and/or other sustainable sources.

III. PROJECT MANAGEMENT AND GOVERNANCE

A. Structure of project management for project implementation.

TDOH is the lead agency for the HS grant. Sunday Gustin, RN, MPH, remains in her role as the full-time Project Director for the Children's Futures Initiative. She is responsible for program administration and coordination of all aspects of the CF service model, fiscal management of HRSA Healthy Start grant funds and other TDOH in-kind funding components. Ms. Gustin oversees the staff and activities of the Central Intake office at TDOH. She monitors ongoing progress in reaching program objectives, and ensuring comprehensive care and quality services. She facilitated development of standards of care, program policies and procedures for core services, guidelines for data collection, and coordination of staff training. All of these components have been developed and implemented in collaboration with core partners, HMHB/CF Workgroup, Children's Futures Inc. and CF partner staff.

As an interagency model, CF shares leadership responsibilities with two central partners—1) Children's Futures Inc. (RWJF) which provides supplemental funding for the PCC home visitation services, PCC center-based activities, consultant services for behavioral health, fatherhood, domestic violence and childcare referral and other support services, e.g. public service ads, communications and more; and 2) Central New Jersey Maternal Child Health Consortium / Trenton HMHB Coalition for all activities related to the HMHB and Consumer Coalitions, provider training, EBC data, FIMR, and other regional support services.

It is an ongoing challenge, but an essential one, to facilitate coordination of core services and maintain clear and timely communication with our core partners and front-line workers. This is accomplished through a series of ongoing regular meetings.

Since this is a project that shares leadership functions, TDOH CF (HS) Project Director (Sunday Gustin, RN, MPH) meets regularly with our co-leading partners. Meetings with project leadership from Children's Futures, Inc. (Rush Russell, President and Joyce Kersey, Program Officer) are held one to two times a month, and focus on implementation and oversight of this initiative. Every other month, Ms. Gustin meets with Brenda Tift, CNJMCHC/HMHB Coordinator to discuss consortium issues and prepare for the bimonthly Trenton HMHB Coalition meetings. The CF Project Director gives a report to the Trenton HMHB Coalition at each meeting and CF partner agencies give an update about their services, PCC activities, special events, etc. Ms. Gustin also attends the bimonthly Consumer Coalition meetings and provides an brief overview of CF related programs and activities.

At the implementation level, each funded partner agency or program has a designated director or supervisor as a point person for their program. Ms. Gustin and Ms. Kersey hold monthly site director meetings with this group. We also conduct individual site visits with these partners, now reduced to quarterly, to review objectives and discuss progress, barriers, personnel, training needs, etc. Our visits pertain to the project as a whole, so we're looking at outreach, screens, home visiting, center-based services, health education, parent advisory boards, linkages to services, problems and concerns. Periodically, site visits include the PCC staff (RN/SW/FSW) so that we have an

opportunity to share with each other about our overall progress, concerns and successes.

The PCCs also receive a quarterly site visit from Prevent Child Abuse-New Jersey. PCA-NJ provides technical assistance and training specific to the implementation of the HF program. This contractual relationship has been very beneficial to CF. PCA-NJ staff provides a high level of expertise and needed support to the four PCC HF sites as they work with their staff to implement HF services. PCANJ site visits review HF program policies, supervision, case review, documentation, data management and reporting requirements, and help to prepare sites for the Healthy Families credentialing process. Ms. Gustin and Ms. Kersey meet with PCA-NJ colleagues on a quarterly basis to get updates about how our HF sites are doing.

Every six months, a contract-monitoring visit is made with funded partners to review budget expenditures for each of the PCC contracts. This is a joint visit that includes the partner agency executive, financial officer and program site director, TDOH CF Project Director and Children's Futures, Inc. President and program staff, including Spencer Lester, Finance Officer.

B. Available resources, which proved to be essential for fiscal and program management.

Ms. Gustin works closely with Chris Stankiewicz, Finance Director for the City of Trenton, and her designee, Elaine Adams, the fiscal grants manager for the City to ensure fiscal accountability and adherence to grant and contractual requirements. These services are in-kind from the City of Trenton to the grant. In addition, TDOH and Children's Futures, Inc jointly monitor fiscal management of subgrants with the PCCs.

Several TDOH in-kind colleagues and HS grant funded staff positions have been essential for implementation of core aspects of the program. June Gray, MS, RN, is the TDOH Nursing Supervisor for Tiers 1 (POrSCHe) and 2 (NFP). Tonya Bellamy is the Central Intake Research Assistant ensuring the flow of screening and referral information from the prenatal care providers to CF partners. She is the central point person for data management and tracking. Janette Rodriguez, HS Program Assistant, provides program and office support, including facilitation of the City's resolution and contract process and budget expense tracking. Lorraine Brooks is in-kind to the project and she helps with client services (e.g. NJ FamilyCare enrollment), outreach and community linkages with the PCCs.

As noted above, Ms. Gustin continues to work in close collaboration with Children's Futures, Inc. on the implementation of all perinatal aspects of the project. Joyce Kersey, Children's Futures, Inc. Program Officer works with Ms. Gustin to monitor the RWJF-funded activities of the project. Spencer Lester is the CF Inc. Financial Officer and he shares a role in monitoring the PCC contract activities and expenses.

In addition, the Site Directors for each of the four funded sponsoring agencies of the Parent/Child Centers and four consultant agencies--behavioral health, domestic

violence, fatherhood and childcare are a valuable resource to CF. They make an important contribution to both the program and fiscal management. The leadership and commitment of these individuals directly impacts on our success in monitoring adherence to program standards, policies and procedures, data collection and reporting requirements, quality of services and customer satisfaction, and assuring the responsible use of grant funds.

C. Changes in project management and governance over time. What prompted changes?

TDOH is fortunate to have had relatively stable project management and governance within CF. Ms. Gustin has been in a leadership position within TDOH for the past 12 years, and within the MCH community five years prior to her work with TDOH. She was the project manager for the HRSA HTPCP grant that preceded this HS application. She is a strong advocate for partnership and collaboration, and integration of services within the system of care. She serves as project manager for all of the current TDOH services that are integrated into the CF model. Ms. Gustin has been integrally involved in the CF pre-planning process (RWJF funds) from its inception in mid-1999 and has contributed to the design of the current model.

Children's Futures, Inc. continues with long-term leadership from Rush Russell, President and Melinda Green, Vice President. They had one major staffing change in mid-2004 after the departure of long time Project Coordinator, Samirah Abdul-Fattah. Joyce Kersey replaces her as the Children's Futures, Inc. Program Officer and assumes oversight of the RWJ funded components of the Children's Futures Initiative. CNJMCHC had a change in the Executive Director but the new Director was promoted from within the agency and therefore was well acquainted with the CF project and Healthy Start grant. She continues to give her agency's support for the collaboration. As noted elsewhere, the new HMHB Coordinator, Brenda Tift, brings a strong consumer perspective and this has been an asset to building consumer participation. Core CF-funded partners have had stability within their leadership as well. These include the CF PCC Site Directors (one departure, but the sponsoring agency promoted a qualified candidate from within the PCC) and consultant partners.

D. Process to assure appropriate distribution of funds and what happened with the process over time.

The project director is responsible for developing the annual budget for HS grant funds and TDOH municipal and grant in-kind funding. Funding allocations within these funding sources are made as a result of the planning and workgroup process, which helps to reassess program priorities for the Local Health Systems Action Plan. Other considerations include opportunities for securing additional supplemental funds for needed service components, e.g. outreach, and our matching and in-kind funding commitments, i.e. RWJF funds through Children's Futures, Inc. and other CF partners.

Distribution of funds for the initial contracts for the four Parent/Child Center contracts (joint HS and RWJF funds) and other Children's Futures, Inc. funded consultant services were subject to a full Request For Proposal process which took four months to

complete. As discussed earlier, delays in the start-up process with our co-funder, Children's Futures, Inc. (RWJF), combined with this lengthy RFP process resulted in a net loss of \$96,000 from our first year grant award. This was indeed a painful lesson for Ms. Gustin, the CF Project Director, and it is one that will not be repeated under her tenure. It also served to educate our co-funder about potential consequences that come with project timeline delays. Since that incident, no further fiscal problem has been encountered with the HS grant funding or any other TDOH in-kind funds.

These PCC contracts are renewed annually in partnership with Children's Futures, Inc. and are contingent on the satisfactory performance of the designated agency. The HS grant contract for PCC services is issued to Children's Futures Inc. and then funds are sub-granted jointly (HS and RWJF funds) to the designated PCC agencies. A special contract for training and technical assistance for the Healthy Families Program was issued directly to the designated state vendor, Prevent Child Abuse NJ.

E. What additional non-HS resources obtained for QA, program monitoring, service utilization and TA became important as contractors were funded or additional staff hired.

The CF Project Director provides technical assistance for integration of HS core strategies and takes the lead on quality assurance, service utilization and program monitoring across all CF services. This includes the integration of non-HS in-kind components. The Central Data System is an important tool for program monitoring and service utilization.

As referenced above, the PCC and other partner directors, a portion of whose time is in-kind from their sponsoring agencies, are committed to the success of this initiative within their organizations and within the project as a whole. They are active partners in monitoring adherence to program standards for service utilization. These are key individuals who encourage and guide their staff in meeting program data collection and documentation requirements, and help to assure quality services and customer satisfaction. One of the four PCC HF sites (Mercer Street Friends) recently met the requirements for certification from Healthy Families America. A second (Children's Home Society) is currently undergoing the certification process through the Council on Accreditation (COA), and the remaining two PCC HF sites are scheduled in late 2005 (Catholic Charities) and 2006 (St. Francis Medical Center).

The contribution from Children's Futures, Inc. (RWJF) for 50% of the Healthy Families training and technical assistance contract with Prevent Child Abuse NJ (PCANJ) was extremely important for accurate implementation of HF and the required PIMS data system at the four PCC sites. This allowed us to get the sites off to a good start with early insight to training, documentation, supervision, program monitoring, data collection and reporting and PIMS database requirements. It has also been a tremendous asset in preparing sites for their upcoming HF credentialing process.

TDOH had a similar perspective of QA and program monitoring for the Nurse Family Partnership (in-kind through TDOH with JJC funds). The national office in Denver and

the regional TA agency, Public Private Ventures, have provided the same kinds of insights and supports for the NFP. Staff have attended mandatory staff and supervisory training in all aspects of the program, including documentation, and data collection/data system use.

Children's Futures, Inc. assumes primary TA and QA activities for the contracts for behavioral health, fatherhood and childcare. These components are in-kind to the model but are essential services. This oversight helps to ensure integration of these services into the CF model.

F. Was cultural competency of contractors and project staff an issue? If so, how was it addressed? Noticeable benefits realized?

Cultural competency was not an issue for any of the HS-funded Parent/Child Center sites. Each PCC paid careful consideration to hiring culturally representative and/or culturally competent individuals, who are sensitive to the needs of families in our target population. And all four PCCs made sure they had appropriate language capabilities (Spanish, French Creole, Polish/Eastern European/Russian) for the populations they were serving.

One of the RWJF funded partners, Greater Trenton Behavioral Health (GT), had difficulty hiring Spanish-speaking staff at start-up. With the large number of Spanish speaking families served by CF, this became a burden on the bilingual PCC Family Support Workers that were often expected to forego their regular duties to assist with translation for Spanish-speaking clients. GT continued their search and recently they were able to hire a bilingual mental health specialist for CF. This has greatly enhanced their ability to serve all women in need of depression/mental health support services. And the PCCs report that Hispanic women are responding positively to these Spanish psycho-educational groups.

IV. PROJECT ACCOMPLISHMENTS

A. Major strategies implemented and how they relate to program goals and objectives.

Please refer to Attachment B “Final Report – Implementation Plan” for a summary of the Children's Futures Initiative's program goals and objectives, related strategies and accomplishments.

At the completion of the first grant cycle (July 2001 to May 2005), Trenton is extremely pleased with the advances we have made during start-up and implementation of the Children's Futures Initiative. The project's accomplishments and progress in reaching the HS Program Period Objectives set forth in Year 1 accurately reflect the successes and challenges faced by CF during this time.

HS Project Period Objectives 1 through 4. The first four program objectives listed below relate to the CF goal of reducing health disparities in Trenton. As such, these objectives are measured using Trenton citywide MCH health data (not program participant data) for no prenatal care, first trimester prenatal care, low birth weight/very low birth weight and infant mortality, so that we may track the overall impact of our project. Please refer to the table in Attachment B for comparison data measures for these four objectives.

- **Objective 1: By 5/31/05, reduce no prenatal care (NPC) in Trenton by 30%. The disparity between race and ethnicity will not exceed 25%.**
 - Current Data 2001-2003: Trenton's NPC rate improved slightly by 6.5%. Total NPC rate decreased from 3.1% to 2.9%. There was a small improvement in the Black rate from 4.4 to 4.2%. [Note: low numbers make analysis of B/H and B/W ratio unreliable.] Please refer to Attachment B for specific NPC rates by race and ethnicity.

- **Objective 2: By 5/31/05, increase 1st trimester prenatal care in Trenton by 15%. The disparity between race and ethnicity will not exceed 25%.**
 - Current Data 2001-2003: The overall 1st trimester prenatal care rate for Trenton remains essentially unchanged, with a slight drop from 63.3% to 62.7%. During this time the 1st trimester prenatal care rate for Blacks was essentially unchanged (negligible increases) The 1st trimester entry for Whites worsened from 73% to 68%. The result is a closing of the Black/White disparity (under 25% at 13%), but clearly this still represents a negative impact. Refer to Attachment B for specific 1st trimester rates by race and ethnicity.

- **Objective 3: By 5/31/05, reduce the low birth weight rate for Trenton by 15%. The disparity between race and ethnicity will not exceed 25%.**
 - Current Data 2001-2003: Total LBW rate for Trenton improved by ~5%, from 12.0% to 11.4%. There was a small improvement in the Black LBW rate from 14.5% to 13.8%. The Hispanic rate worsened slightly from 8.1% to 8.5%. The Black/White disparity for LBW improved slightly and currently stands at 52% (still well above the 25% objective); however, the Black/Hispanic disparity also improved slightly. Related data--Very Low Birth Weight (VLBW) decreased from 3.7 to 3.4 in the Black population (an 8% improvement). [Note: low numbers make analysis of B/H and B/W ratio unreliable.] Please refer to Attachment B for specific LBW/VLBW rates by race and ethnicity.

- **Objective 4: By 5/31/05, reduce the Black infant mortality rate (BIMR) rate in Trenton by 25%. The disparity between Black infant mortality and other race and ethnicity will not exceed 25%.**
 - Current Data - Infant Mortality Rate (IMR): The most recent complete data for Trenton is for 1999-2001 at 13.6 per thousand. The Black (Non-Hispanic) IMR is 15.1, however, due to low numbers, a comparison rate for Whites (Non-Hispanic) and Hispanics is not reportable.

- **Data Notes for Selected Performance Indicators for Objectives 1-4:** Because we have chosen to use citywide data measures to monitor our impact in CF, there will always be a time lag with regard to these measurements. For example the baseline in our original grant application is for 1996-1998. Of course, the actual baseline for CF is closer to 2000-2002, since direct services did not really begin until mid-2002. In our presentation of measures for these indicators: No Prenatal Care (NPC), First Trimester Prenatal Care, Low Birth Weight (LBW) and Very Low Birth Weight (VLBW), Infant Mortality Rate (IMR), we kept the same 1996-1998 (3-year average) timeframe for baseline data, but used the NJDHSS Center for Health Statistics State Health Assessment Data (NJ-SHAD) interactive website for the NPC, 1st Trimester Prenatal Care, LBW and VLBW figures. In studying this further, we realized that there were slight differences from the baseline data used in the original grant application, which was provided, by the CNJMCHC from EBC data. So, adjustments have been made to baseline data, as appropriate, based on the official figures from NJ-SHAD, which also provides a breakout of these indicators by race and ethnicity. NJ-SHAD data is also used for the comparative analysis to ensure a standard of reliability. *Special note: Regarding infant mortality, municipal level data on NJ deaths, including infant mortality, takes much longer to finalize. Therefore, the most recent reliable data is still for 2002.*

Project Period Objectives 5 through 8. These four objectives pertain to program participants, i.e. women and families receiving intensive home visiting (HF and NFP), and address a total of fourteen specific health measures and outcomes for the women and children who have participated in these CF services. CF has met nearly all of the markers for Objectives 5 & 6. We expect that CF will have a positive impact in the two areas cited in Objectives 7 & 8, as well, however, these two markers are time sensitive, i.e. a period of at least one to two years must elapse before we can measure impact, and more complicated to track. CF is waiting for the completion of a recent modification to the data system, so at present, we are unable to get consistent program measures for these markers across all of the six sites. We expect to have this data available for analysis by December 2005.

- **Objective 5: By 5/31/05, increase to 100% the number of eligible participating women/families enrolled in health insurance and linked with primary health care services. And, uninsurable women/families linked with primary care (free or low cost).**
 - Current Data thru 5/31/2005: CF served a cumulative total of 608 pregnant women/families; CF met the objective of ensuring enrollment in health insurance for eligible children and women, and linking all women and children, including those ineligible for insurance, to a primary care provider. Though the measure for IC women fell short of our objective of 100%, we are extremely pleased to see that 85% of IC women established a linkage with a primary care provider, an improvement of 70% from the baseline estimate. Please refer to the table in Attachment B for comparison data measures for this objective.

- **Objective 6: By 5/31/05, increase to 90% the number of participating women and their children, using primary health care services—**
 - pregnant women who enter care in the first trimester will complete at least 8 prenatal care visits and will be enrolled in WIC
 - postpartum women will complete the six week postpartum health care visit
 - infants and children will be current with immunizations, lead screening, well child visits, developmental assessment, and WIC enrollment.
 - parenting women complete one annual primary care/interconceptional care visit
 - Current Data thru 5/31/2005: We are very pleased with these performance measures that relate to case management and health education. CF achieved the 90% objective rate in six measures, 80% in four others (keeping prenatal visits, postpartum visit, interconceptional visit, WIC enrollment at age two-plus. The lowest rate, 75%, was for childhood lead screening and this is still a very good showing compared to national lead screening rates. Please refer to the table in Attachment B for comparison data measures for this objective.

- **Objective 7: By 5/31/05, reduce by at least 20% the number of unplanned subsequent pregnancies of all participating women.**
 - Current Data thru 5/31/2005: Not yet available—see “Data Notes” below.

- **Objective 8: By 5/31/05, 75% of parenting women/families participating in CF for at least one year will show improvements in parent-child interaction and bonding.**
 - Current Data thru 5/31/2005: Not yet available—see “Data Notes” below.

- **Data Notes for Selected Performance Indicators for Objectives 5 thru 8:** The baseline data for Objectives 5 and 6 are estimates based on TDOH internal sources, e.g. WIC enrollment, immunizations (retrospective study), lead screening (local study); or other county/state data sources, e.g. health insurance enrollment, PCP (in all cases where estimations are used, data are probably higher than actual figures). The participant data provided for the measures in Objective 5 and 6 are preliminary data provided by the sites either from their program specific databases or from manual counts. Once the data revision is complete Central Intake will run reports to verify the site-specific data for all of the measures in Objectives 4 through 8. The primary data source for screening and assessment data is from the current version of the CF Central Data System (CDS). For background purposes, we want to explain where we are in the data collection process. CF has two intensive home visitation/ case management programs (NFP and HF) that have their own unique databases. CF had only a manual data collection system from July 2002 through February 2003. With little data support, the TDOH project director assembled a workgroup and hired a consultant to assist with database design and development standard data set for screening, assessment, and enrollment in CF services. This initial phase of the CDS was in development from September 2003 through January 2004, with minor revisions along the way to add several additional tracking items. CDS gave Central Intake greater capability to track screens and monitor disposition

of cases and generate several key reports. Once we got all of the bugs out (August 2004), we began planning for two additional data sets for all enrolled families (women and target children) to monitor key measures tied to our HS objectives as well as other related measures that will help us measure program impact. This was a lengthy, collaborative process that included all of the partners. We began in September 2004 with a paper-based plan and sites underwent a manual review of data sets from their existing required databases. From November 2004 to May 2005, we made several revisions to the paper system before moving ahead with the latest CDS revision in June 2005. The revision was completed in mid-August 2005 and data entry for all of the back data for enrolled women and children is currently underway. We anticipate a two-three month debugging phase and expect data to be retrievable for analysis by November/December 2005.

- **Additional Notes on Selected Performance Indicators for Objectives 7 & 8:**
Unplanned Pregnancy: We knew at the outset that no baseline was available for unplanned pregnancies within our target population. It was naïve and unrealistic to think that this would be a simple measure. It was also not the highest priority in CY 2003, while we were still dealing with the basics of the home visitation models--staffing, training, etc. and still learning the differences in the data sets that were required by each model—NFP and HF. So, it was not until 2004 that the partners came together to look at reliable methods to collect data and demonstrate impact in this area. In a 2004 revision of our internal program objectives, we decided to use inter-pregnancy interval (minimum 18 months) as the primary measure for this objective and decreasing teen births (< age 19) as a secondary measure. We have since made the required revisions to the Central Intake data collection forms and the database is being revised to help us track this. We expect to have some early data by December 2005.
Parent-Child Interaction: Again, we knew that baseline data would need to be collected as the project moved forward. CF uses two tools that will help us with measures in this area--AAPI, administered only to HF participants, and HOME scale, used by both HF and NFP. Measures of impact in parent-child interaction require long-term (12-24 months) assessment. For the same reasons stated above, our system to collect and analyze the data did not begin until recently. So results for this objective will not be forthcoming until December 2005.

Discussion of Successes and Barriers

Objectives 1 through 4: As referenced in earlier sections of this document, start-up of the direct service components of the Children's Futures Initiative was delayed until July 2002, with a phase-in of services leading to full-scale service delivery in December 2002. Notably, this delay, (along with other unanticipated factors summarized below) has affected our ability to fully impact upon these citywide objectives. However, we remain optimistic that the extended planning time was an important investment for the responsible use of HS and RWJF dollars, and will ultimately position Trenton to achieve the overarching goal of eliminating racial and ethnic health disparities for pregnant women, parents (moms and dads), infants and children in our city.

The supplemental funding dollars received from RWJF necessitated additional planning time to ensure bona fide integration of services. CF project leaders and partners knew that long-term sustainability within a system of care would require a strong foundation with real partner/ provider buy-in and commitment. Most importantly, careful planning was essential to preserve the integrity of the model and facilitate needed system changes to establish a continuum of care from primary prevention and early identification, to supportive and treatment services. This additional planning time led to our successful NFP grant application, another critical component of the CF model, and to other system and policy successes described throughout this report.

A summary timetable of events is presented here to aid the analysis of our progress and clarify the reasons for delayed project implementation:

- **HS funds awarded in July 2001 (through TDOH).** Development of a system of MCH care in partnership with prenatal care providers and community health & social service agencies. Specific funded components: prenatal screening (ATOD, depression and domestic violence), central intake, two Parent/Child Centers with two HF sites and center-based activities.
- **RWJF funds awarded in August 2001 (through Children's Futures Inc).** Supplemental funds for two additional Parent/Child Centers with two HF sites and corresponding center-based activities—for a total of four PCCs (one in each ward). Other RWJF funds were allocated for behavioral health, fatherhood support and childcare referral and linkage.
- **Major in-kind contributions from partners:** consortium development (CNJMCHC/HMHB), outreach (St Francis), screening & risk assessment (four OB clinic providers), addiction screening/assessment (Mercer-Trenton Addiction Science Center/UMDNJ), PHN/POrSCHe services (TDOH) and a pre-existing HF program (Mercer Street Friends).
- **September through December 2001.** CF planning continues with expansion from two to four PCCs and consultant services and plans to integrate in-kind components. Drafts of CF RFPs were written and sent for review/commentary, and final edits made. HMHB finalizes decision to assume consortium responsibilities for the project.
- **January through April 2002.** Joint CF RFP process (TDOH-HS funds and Children's Futures Inc.-RWJF funds) includes community wide technical assistance sessions, proposal review and site visits to potential candidates, issuance of awards.
- **NJ Juvenile Justice funds awarded in May 2002 (through TDOH).** RFP for NFP pilot announced April 2002 (at completion of RFP process for CF PCC and consultant services) and TDOH sought funds to integrate NFP into CF model. TDOH committed additional in-kind support (two RNs) as evidence of our confidence that NFP would enhance CF, and ensure success in helping first-time moms and their infants.
- **May through July 2002.** Seven new CF-funded partners go through extensive interviewing and hiring process for site director and designated professional and paraprofessional staff.
- **NFP training and start-up July 2002.** Phase-in of direct services for NFP July and August. Full-scale NFP September 2002.

- **July & August 2002.** MSF HF Citywide (preexisting program) enters partnership with CF. Six new CF partners complete hiring and begin extensive agency/service orientation.
- **August & September 2002.** CF Workgroup begins bi-weekly implementation meetings with new partners and clinic providers to facilitate interagency partnership, establish specifics of screening, client recruitment, referral, central intake, assessment, etc.
- **October & November 2002.** PCA-NJ conducts mandatory HF trainings, CF conducts a community wide introduction/orientation to CF model and services, CNJMCHC assists with training for perinatal screening/4 P's Plus.
- **December 2002.** Full-scale implementation of screening, including 4 P's Plus, consent, referral, central intake, assessment and case management at four new HF sites. Consultant services begin.
- **Calendar Year 2003.** First full year of CF integrated service model. Intensive home visiting still affected by learning curve for new staff with new service delivery model.
- **May 2004.** St Francis Medical Center learned that they would not receive continuation funding for perinatal outreach services. Three part-time outreach workers left for new employment opportunities.
- **June 2004.** Mercer Trenton Addiction Science Center/UMDNJ learned that they would not receive continuation funding for onsite perinatal addiction screening. Three full-time staff left for new employment opportunities.

As you can see from this brief summary of major events, CF was in an extended planning process to finalize the service delivery model, clearly delineate partner roles and ensure integration of HS funded components, in-kind partner resources, and new RWJF funded resources. The focus shifted to implementation with the phase-in of intensive home visitation services beginning in July 2002 and full-scale services in operation by December 2002.

Since we used 2001-2003 data for our impact measures, we recognize that CF had only limited time to impact these measures—part of 2002 and CY2003. We also included 2000-2002 data primarily for our internal study (FYI) to look at where the rates were moving from HS baseline (pre-CF) to the actual CF baseline that tells us where Trenton was just prior to start-up of direct program services. CF certainly had some early influence/media attention in educating the community and partners about pregnancy outcomes; and, we have had a very positive response from the Hispanic community, in part due to a leading Hispanic-oriented partner (El Centro) at our South Ward site. In addition, our largest clinic/hospital partner (Capital Health System) implemented a special effort to reach pregnant Hispanic women through a customer-friendly/culturally appropriate program (CUNA). The point here is that it really takes the partnership--all of us working together--to have the greatest combined impact to eliminate disparities in our city. As CF enters its second grant cycle, we are excited by the possibilities of our continued work together, with providers and consumers, to study the data, and analyze the possible contributing factors and the effectiveness of our strategies.

Discussion of Successes and Barriers for Objectives 5 and 6: With only two and one-half years of direct services in CF, we are most pleased with the work of our partners in home visiting and case management. While we did not completely reach the objectives for all of these measures, the progress in each area was significant. We expect an even stronger showing as the project moves forward. Probably the greatest barrier for these two objectives is the need for more support at the program level for transportation services to help families get to scheduled appointments. We are fortunate to have several community sources for transportation and workers make good use of these. Also, staff in some of the partner sites are permitted to drive clients, but they cannot spend all of their time transporting or else case management for other families will be curtailed.

Discussion of Successes and Barriers for Objectives 7 and 8: The primary barrier here is the lack of the data system to aid with these measures. The staff are tracking these measures in the course of their work with families. So it will be a matter of entering the data into the revised CDS. We expect this to be completed in the next few months.

Planning and implementation for a project of this enormity requires a tremendous amount of time, energy, commitment, creativity, patience and optimism. All of the CF partners, leaders and staff, funded and in-kind, have readily contributed to this process. The successes we have described here are attributed to their concerted efforts to work in true collaboration to improve the health and well being of Trenton infants, children, parents and families.

B. Mentoring or Technical Assistance: Trenton did not receive any direct technical assistance or mentoring from other HS grantee sites. However, two HRSA-sponsored TA visits were extremely helpful for our work with families.

- February 2004 – Domestic Violence, Family Violence Prevention Fund (Rebecca Whitehead).
- May and July 2004 – FAS/Perinatal Addiction and the 4P's Plus, Chicago Research Triangle (Dr. Ira Chasnoff). Dr. Chasnoff conducted four sessions during his visits to Trenton—1) CF working TA meeting (2 sessions) that included county and state officials and a visit from our Camden colleagues to share their experience in using the 4 P's Plus; a full-day community-wide training open to all CF prenatal providers and other partners (over 100 attendees); and, an OB provider training (co-sponsored by CNJMCHC). In addition, CF worked with the NJDHSS to schedule a TA session with Dr. Chasnoff for the statewide workgroup of perinatal addictions coordinators during his visit to Trenton.

The HS grant budget supported two major training and technical assistance visits for use of the Adult-Adolescent Parenting Index (AAPPI) and the Nurturing Parenting Skills curriculum for use by our HF sites. In January 2004, a two-day Nurturing Parenting training was given by Dr. Stephen Bavolek, and in May 2004, a five-day facilitator training was conducted (Donna LaTour-Elefante). We hope to be able to have Dr.

Bavolek return in our new grant cycle and open up attendance of this powerful presentation to our other partners in prevention—county and state level child protective services officials (NJDHS-DYFS/DFD and NJDHSS), Mercer County Board of Social Services, childcare and family daycare workers, etc.

We received mandatory training and technical assistance from the University of Colorado Health Sciences Center National Center for Children, Families and Communities for start-up of the Nurse Family Partnership. We receive periodic site visits from Public/Private Ventures the regional NFP project management office. We also contracted with Prevent Child Abuse New Jersey for mandatory training and technical assistance for implementation of the Healthy Families program.

We have also found both the HRSA MCHB Annual Meetings and the National Healthy Start Association annual meetings to be very helpful in networking and in learning about the services and partnerships of other projects. Especially useful were the sessions about strengthening consumer involvement in the consortium.

The CF Project Director has had requests from other programs for copies of our prenatal screening tool and information on how our central intake process works. Trenton (S. Gustin and R. Russell) was a presenter at the 2004 Annual HRSA MCHB All Grantee Meeting--The Power of Partnerships. We were one of several projects included in the plenary session, "Solos to Symphonies: MCH Partners Working Together." Following the meeting, the Project Director received e-mails from several attendees with requests to share information about the screening and central intake components of our model, and copies of the screening tool and consent form.

V. PROJECT IMPACT

A. Systems of Care:

1. Describe the approaches utilized to enhance collaboration.

The Children's Futures Initiative has had a positive impact on the maternal and child health system of care in Trenton. No single agency or organization has the resources to meet the very complex needs (physiological, emotional, and socio-economic) of families in our city. Even in this relatively early stage, CF exemplifies the effectiveness of a model of collaboration and partnership.

As we have discussed throughout this report, the Children's Futures Initiative is based on mutual trust and respect between partners. Relationships are the key in our approach to enhance collaboration. In our role as the local public health agency, TDOH has a long history of collaboration, facilitating partnerships (as per our earlier reference to the HRSA Healthy Tomorrows grant) and good working relationships with all of the clinic providers that serve Trenton women.

Our co-leading partners Children's Futures, Inc and CNJMCHC/HMHB bring their own set of strengths as well, with each having a slightly different focus, e.g. health, policy and planning, community and consumer outreach. Assessing those strengths and sharing leadership is vital to the work of diverse community partnerships.

One of the keys to sustaining the partnership is to develop a shared goal and unity of purpose. We have done this very successfully in CF. Early on we had a mini-retreat to bring directors and key staff together to get to know each other and to firmly establish our shared goals. We also had a large-scale community "orientation" to the CF model and services. Each year we go to the prenatal provider sites and hold a "thank you luncheon" to let them know that we appreciate their work as partners with us. And we give them an update on how we are doing, what's new, etc. We invite the entire staff of all of the assessment and home visiting programs. And the clinics bring their staff (including physicians and midwives. This gives workers a chance to put a name to a face and it benefits the workers on both ends. While we try to be sensitive as to the frequency of meetings, they are necessary and usually beneficial. This opportunity for personal communication (not email or voicemail) is essential to the relationships and partnerships we are striving to maintain.

2. Identify the extent to which structured changes, such as procedures or policies, have been established for the purpose of system integration.

CF has written policies and procedures for all of the key components—perinatal screening, consent, 4 P's Plus, referral, central intake, feedback to providers, assigning cases for assessment and case management. Each of the national models we use for case management has its own set of policies for health education and curricula. This year, the Trenton CARES outreach grant will be developing outreach procedures and protocols for their program.

As noted previously in the report, CF has developed a Letter of Understanding that is signed by all fifteen of the core partner agencies, both in-kind and funded. This ensures that we each have a basic understanding of the commitment and services that the provider will provide to the initiative. This year we will be adding two new partners—Mercer County Board of Social Services and Womanspace.

3. Describe key relationships that have developed as a result of Healthy Start efforts covering the following areas:

a. Among health service agencies; between health and social services; and with community-based organizations

As noted above, CF is a multi-agency, multidisciplinary model. A full listing of these partners is included in the section on collaboration. We are especially pleased about the integration of mental health, fatherhood, domestic violence and childcare into this model. All of the key partners are represented on the CF Workgroup, and many also attend general HMHB meetings. This year, Trenton needs to work more closely with private OB/GYNs to bring them into the partnership. The Trenton CARES grant has as an objective a plan to start a physician advisory group this year. The project director will present an overview of CF model, and goals and objectives, and a summary of the birth outcome data for Trenton.

b. Involvement of consumers and/or community leaders with any of the agencies/ organizations listed above or any additional agencies.

As referenced earlier, CF is improving consumer involvement. HMHB Coordinator is a former consumer and she has taken the lead in developing the Consumer Coalitions. This has led to consumer representation on the CF Workgroup and direct input from consumers on the LHSAP and in providing feed back to providers about services. Trenton CARES will be conducting a community survey that will be used to establish additional priorities for the project. Trenton CARES has just hires three consumers to conduct outreach and additional consumer participants will re recruited to function as community liaisons in specific neighborhoods. Additional participants will help to

Also, the Parent Child Centers each have a local advisory board that includes several program participants. This is a mechanism for consumers to contribute to the centers programming and to provide feedback on quality of services.

4. Describe the impact that your HS project has had on the comprehensiveness of services particularly in the following areas:

a. Eligibility and/or intake requirements for health or social services;

CF has had a major influence on the design of linkages between healthcare providers and community services. As we have noted in an earlier section, the screening and risk assessment and consent process is integrated into the prenatal clinic system. The woman's consent is what generates a referral for linkage to CF services. This universal screening process remaoves the subjective decision that someone needs services. We have stressed to providers that the screen is a service that benefits all pregnant women and links them not just to "social services," but also, to a system of health education and support. This model provides a comprehensive set of MCH services to families and providers have really come to understand this.

The continuum extends beyond pregnancy to the interconceptional/ parenting period and hopefully will begin to impact on subsequent pregnancies (to be measured in the next grant cycle).

Parents and children that are enrolled in CF are assisted with health insurance enrollment and linkage to a primary care provider, even if they are uninsured. The staff use the NJ Helps website to determine eligibility for health insurance, TANF, food stamps, WIC and other publicly funded services.

b. Barriers to access and service utilization and community awareness of services;

CF resources have lessened the impact of MCH systems barriers-1) each PCC/HF site provides translation for their enrolled families for medical and other essential appointments, 2) transportation-many of the PCC staff are permitted to transport clients in an agency vehicle or in their personal vehicles and TDOH has a van and driver that helps women in NFP with their appointments, 3), child care-though we do not provide babysitting services for families the FSWs will accompany moms to appointments and help with child care in these settings, 4) flexibility—all home visiting/case management staff offer after hours visits for working moms; they also offer the PCC as a setting for a home visit/health education as an alternative for some families. 5) capacity—the community is aware of the CF resources and the demand for home visiting exceeds the current supply new measures (TIP) may be forthcoming to alleviate the problem, 6) additional resources for transportation would be a big help to families. 7) we still need to do a better job of getting the word out about free pregnancy testing – Trenton CARES will take this on as their challenge. 8) father involvement – Trenton still has a gap in services and supports for dads. Children's Futures Inc has been a major supporter but ancillary services are needed for dads too—health care, mental health services, legal services, and the like.

c. Care coordination including descriptions of mechanisms implemented to assure continuity of care, quality improvement and follow up system(s) for client referrals;

CF has a feedback mechanism to notify providers about the status of a referral. For a while, when the database was under going debugging, the feedback forms were not being generated and we heard right away from providers. They really want and need to know the status of a referral that they send over for services. This is a good way to keep communication open with providers and it inform them of the types of services that CF provides to families. The two largest prenatal clinics hold bi-weekly case management meetings and these are open to CF / TDOH staff. The PCC supervisors conduct weekly supervision sessions with the FSWs to assist in case management and review of caseloads. They have consultation meetings with the behavioral health specialist and fatherhood staff on a regular basis.

d. Efficiency of agency records systems and sharing of data across providers (within the confines of confidentiality rules) to reduce the need for repetition.

As noted earlier, one of the administrative barriers for data collection and database development in CF has been the fact that we are dealing with two national models that use unique data systems. In fact the POrSCHe PHN program also uses its own data system. We have tried to overcome this barrier in Central Intake by developing a

tracking system for the screening and referral information. This has been a tremendous help for monitoring the flow of screens and referral to partners.

CF has worked directly with provider partners to ensure that we streamline the referral process. The basis for referral and linkage to CF services is the CF Screen and consent form that has been integrated into the prenatal intake visit at the prenatal clinic or other community provider. When an assessment visit is made the worker has a copy of the screen with her/him so we do not usually have to repeat a request for information from a client.

Thus far, the CF screening, intake and feedback process is working well

5. Describe the impact on enhancing client participation in evaluation of service provision in the following areas:

a. Provider responsibility in maintaining client participation in the system and provider sensitivity to cultural, linguistic and gender (especially male) needs of the community;

CF has three primary areas of consumer participation, 1) the CF Workgroup—consumers contribute to the development and revisions to the LHSAP, CF project goals and objectives; 2) HMHB Work Plan / link to Title V-the March meeting of HMHB is dedicated to annual review of work plan objectives, It is also the time that CF gives an annual report of project progress. Consumers are now taking a more active role in participating in these functions. 3) As noted, Trenton CARES will be developing a significant role for consumer participation and influence on community service delivery. In all of these settings we ensure that we are sensitive to the cultural, linguistic and gender diversity within our community. CF is about partnership and inclusion so we make sure we have Spanish (or other language) translators available, and we do have some dads that attend the meetings.

B. IMPACT TO THE COMMUNITY: Describe the impact the project has had on developing and empowering the community:

1. Residents' knowledge of resource/service availability, location and how to access these resources;

The PPV gives us important information that says that the community is aware of at least some of the services of CF. Children's Futures Inc. will be conducting a second media campaign through MEE Productions to let the community know about core services, e.g. pregnancy testing. CF partners participate in community events (many of these are already listed in the outreach section of the report). The Trenton CARES survey will try to determine how familiar resident are with the PCC neighborhood centers and get feedback from women and families about barriers and other needed services. As we identify new priorities through the survey process,

Trenton CARES and HMHB will work together to develop and hold a consumer leadership training retreat.

2. Consumer participation in establishing or changing standards and/or policies of participating service providers and local governments, that affect the health or welfare of the community, and have an impact on infant mortality reduction.

While our consumer/participant participation had a slow start, we now have a core group of consumers who are excited to be working with the project through the Consumer Coalition. And in the CF Workgroup, we have given consumers a glimpse of how their input/feedback can make a difference to providers. Specific examples of impact include: feedback to the WIC Program about misinformation that was given to a client and the attitude of staff; constructive feedback to the local prenatal clinics about the abruptness of staff (support & professional staff) and how that affected a pregnant woman's willingness to return for services. A third example was the positive response from consumer representatives when the CF perinatal screening tool was shared at a consumer meeting, "That makes a lot of sense when you explain it that way. I think most women would want to know about this (information)." We went back to providers to give them this feedback and reminded them to explain why particular questions are asked, i.e. what is the relationship between a specific risk factor and its potential impact on the pregnancy. We also recognized the need to offer additional training about the screening process. We hope to build on this type of consumer feedback within the Trenton CARES outreach project by having outreach workers/consumers help to develop and conduct an ongoing communitywide consumer survey process to identify (quantitative & qualitative), the issues/concerns that women/parents have about the system of MCH care in Trenton. And then involve consumers to work in partnership with providers to learn more about related issues (e.g. busy clinics, short staffed) and come up with solutions. In our second grant cycle we are planning to conduct leadership training with a group of interested consumers to move this process forward.

3. Community experience in working with divergent opinions, resolving conflicts, and team building activities;

CF will be implementing a consumer leadership training that will incorporate these types of issues and activities. This will be done in partnership with HMHB through the Trenton CARES project. If there are individual, agency or system conflicts we want consumers to have the skills and resources to get to a win-win situation. The leadership retreat will include topics like: framing your message, empathy, assertiveness vs aggressiveness, and negotiation skills; and will include team building, role playing/modeling, and other learning strategies.

4. Creation of jobs within the community. The Children's Futures Initiative was responsible for the creation of about 32 new full-time jobs with benefits. About 50% of these were for Family Support Workers, which do not require a college degree (though many of the staff hired possess a degree or have at least some college).

Secondly, both HF and NFP include a focus on assisting women/parents to develop personal goals. Often these include steps toward completing schooling and/or job training and seeking employment. So indirectly we may be influencing women and families to become self-sustaining. Finally, with the May 2005 grant award for the Trenton CARES outreach project (at the recommendation of our consumers) we have hired three part-time women/participant consumers as outreach workers. These part-time jobs are actually a good fit for the women since all three have other family and school commitments. The grant will also offer job skills training in community MCH outreach and we expect to develop job opportunities in partnership with the Mercer County One-Stop Career Center for WorkFirst NJ (TANF) recipients. Trenton CARES training includes prenatal and parenting education in addition to outreach job training skills so we hope this will have a double impact for interested women and men and their families.

C. Impact on the State: Describe the activities and impact that this approach has had on your relationship to the State Title V and other State agencies.

The City of Trenton has enjoyed tremendous support from our state government colleagues, especially those in NJDHSS. TDOH CF Project Director has excellent relationships at the administrative level within NJDHSS Division of Family Health Services units that include the perinatal services, FAS/perinatal addictions, Title V MCH Coordinator, POrSCHe program, lead poisoning, immunizations and child health. Joan Salay Janusz, Title V representative attends HMHB meetings and CF Workgroup meetings. She facilitates the process for HMHB's contribution to the State MCH work plan. We also have positive working relationship in DHS-DMAHS (Medicaid) from our prior work together on a Medicaid HMO pilot project for lead screening, and for other Medicaid HMO advisory issues. As noted earlier in an earlier section, TDOH and NFP partners are currently working with our leading HMO and our Medicaid colleagues on a feasibility plan for Medicaid coverage of NFP services.

D. Local Government Role: Highlight activities/relationships at the state and local level that facilitate project development. Briefly describe any barriers.

Trenton and CF have also benefited from a series of serendipitous events. In 2002, the City of Trenton unexpectedly lost two of its top officials, Gwendolyn Harris (Trenton Chief of Staff) and April Aaronson (Trenton DHHS Director), to NJ State government posts. Ms. Harris became the NJDHS Commissioner and Ms. Aaronson a NJDHS Deputy Director. Both women were well acquainted with the work of Children's Futures in Trenton and the strong emphasis of the model on prevention. In fact, Ms. Aaronson was intimately involved with CF from the inception of the early planning process. While facing numerous urgent issues in their new roles, one of the most pressing would be reworking the state plan for the child protective services system. These individuals understood the importance of prevention, and while putting out fires, were rallying their staff to actively explore potential statewide prevention models that would emphasize early treatment (addiction and mental health services) and prevention for families. Both of these individuals have moved on, but their impact on State DHS policy appears to be

on firm ground. James Davy, the current DHS Commissioner and his top level staff continue to support the policy of prevention, and have recently issued funding to implement pilot programs in each county to test their effectiveness (i.e. TIP program, mentioned previously). While Ms. Harris moved on the academia side of policy, it is our good fortune that Ms. Aaronson, assumed the position of Mercer County Director of Human Services.

Trenton enjoys solid support from Brian Hughes, Mercer County Administrator and his cabinet. As noted above, April Aaronson is now a cabinet official as the Mercer County DHS Director. In her county role, Ms. Aaronson continues to be an ardent supporter of our efforts here in Trenton. She has advocated on behalf of CF on a number of important issues that will greatly benefit women and families, i.e. allocation of TIP funding to pass through Children's Futures Inc. and on to CF partner agencies for direct services. Along with her Deputy Director, Marygrace Billek (former Trenton Demand Treatment! Coordinator), and a contingent of Trenton partners, the County has led the effort for NJDHS-DAS to restore perinatal addiction screening and assessment funds to Trenton (previously described). The County Office of Addiction Services will provide matching funds to support this effort. They are strong committed partners and much needed advocates for other quality of life issues that impact on health disparities--housing, addiction, mental health, job training and other economic development issues.

This year, Trenton CARES will be developing a new partnership with the County's One-Stop Career Center. This pilot project will offer TANF/GA recipients (consumers) an opportunity to learn new job skills and assist in perinatal outreach activities. CF is establishing a new partnership with the Mercer County Board of Social Services (MCBSS) for the upcoming TIP program, which will help establish better relationships between CF case managers and MCBSS case managers for TANF and GA recipients. CF project director is on a working committee, led by NJDHS, to bring Mercer County partners together for improved coordination between the DYFS Mercer District Office, MCBSS, NJ Substance Abuse Initiative (SAI) and other DYFS contracted addiction providers to ensure that expanded addictions treatment funds now available are used to help at-risk women/parents, many of whom live in Trenton, to get needed treatment services and be able to better maintain their families and keep children safe.

CF benefits from its relationship with leaders and colleagues throughout City of Trenton government, these include Richard Salter, TDOH Director; Carolyn Lewis-Spruill, DHHS Director; other department/division heads; and of course our Mayor, Douglas H. Palmer. The Mayor is a board member of Children's Futures, Inc. and he has a keen understanding of the importance of this project on the future of his city. He is a committed and tireless leader in advocating for the well being of Trenton residents, and is equally disturbed by the persisting problems related to health disparities. Mayor Palmer wholeheartedly supports the need for community collaboration and works hard to facilitate partnerships across the city. As noted elsewhere in this report, the City of Trenton contributes a significant amount of in-kind support to the CF model to ensure a continuum of care that will fill the gaps, and ultimately improve infant, child and family health for all residents.

Our partner, Children's Futures Inc., has a well-established network of relationships at the municipal, county and state level. In addition, Rush Russell brings with him strong linkages to the Robert Wood Johnson Foundation and many contacts that he has established through his prior work at the Foundation, both in the public and private sectors. Children's Futures Inc. has frequently reached out to local, state and national leaders in its policy and advocacy role. They have been strong advocates of researching best practices for our work in developing this model.

VI. LOCAL EVALUATION

Background: When we received our Healthy Start grant and began our formal our partnership with Children's Futures Inc. many of the community partners expressed their strong support not only for the system of care that would be put in place and the potential benefits we saw for families in our city, but we were also excited about the prospect of finally having a professional, independent outside evaluation. For most of us, it would be the first time that a significant amount of dedicated funding would go specifically toward program evaluation, without our needing to struggle to piece together in-kind or other project funds. It would also be a first that we would have dedicated personnel to lead these efforts, so that program managers could focus on the project start-up, implementation and administrative issues so critical to a partnership of this size. We had high expectations for a data driven outcome-focused evaluation and assumed that RWJF would expect the same, since this has come to be a standard requirement from our other state, local and private funders.

The evaluation PPV is conducting for RWJF is quite extensive and more expansive than the CF prenatal/parenting model of care. It encompasses additional community components that are funded by Children's Futures, Inc. with RWJF funds, e.g. improving quality in early childhood education. This RWJF sponsored evaluation is much more formative and process oriented. While PPV does rely on the use of various existing data sources, e.g. state/county/city level data, TDOH/CDS (screen data) and HF and NFP databases, they have not taken the lead in developing a standardized data set (across case management types). The feedback that we get from PPV's six-month site visits and follow-up reports are extremely helpful especially in terms of implementation process and quality issues, partnership interrelationships, and public perceptions of the work of the initiative, and uses our data sources to examine relationships between CF service components and impact using citywide data. A draft copy of the PPV cover memo, Table of Contents and Introduction of the most recent PPV evaluation (final pending) is included in Attachment C (4 pages).

Current: The TDOH CF Project Director, Sunday Gustin, is now designated as the lead person for the CF local evaluation component. The local evaluation is in process and is being designed with input from all of the CF PCC and consultant directors, and key project staff. Other contributors to this process include partners for NFP (June Gray), HF (Prevent Child Abuse NJ), Public/Private Ventures (PPV) (Karen Walker and Amy Feldman) and CF Workgroup participants. From June to October 2004, the CF

Workgroup met to reassess our progress in reaching the goals set forth in the Local Health System Action Plan. The result was a revised set of CF Project Objectives that include all of the HS Program Objectives and several additional process and outcome measures that we deemed to be important to show impact. These were used in our 2005-2009 HS application. The local evaluation is based on these expanded objectives. It will rely heavily on our newly devised common data set and the corresponding revisions to the Central Data System. It will continue through the next HS grant cycle (2005 to 2009). We expect to have early data measures as soon as January 2006.

VII. FETAL AND INFANT MORTALITY REVIEW (FIMR) At this time Trenton does not have its own FIMR process. June Gray, MS, RN is Trenton's representative at the Central New Jersey Maternal and Child Health Consortium's region-wide FIMR meetings. Sunday Gustin, HS Project Director is an advisory group member for the New Jersey Statewide Mortality/Morbidity Review Project.

VIII. PRODUCTS (See Attachment D)

CF Prenatal and Parenting Model
CF Prenatal Screening Form
CF Prenatal Consent Forms (English and Spanish)
CF Outreach Consent Forms (English and Spanish)
CF Information Sheet (English and Spanish)

IX. PROJECT DATA FORMS

For each individual year (**electronic forms submission**)

2001 7/1/2001 to 12/31/2001
2002 1/1/2002 to 12/31/2002
2003 1/1/2003 to 12/31/2003
2004 1/1/2004 to 12/31/2004
2005 1/1/2005 to 5/31/2005

- MCH Budget Details (Form 1)
- Variables Describing Healthy Start Participants (Form 5)
- Common Performance Measures and Intervention Specific Performance Measures (Form 9)
- Characteristic of Program Participant (Table A)
- Risk Reduction/Prevention Services (Table B)
- Major Service Table (Table C)