I. Overview of Racial And Ethnic Disparity Focused On By Project

Camden, New Jersey, is among the five poorest cities of its size in the United States. Directly across the Delaware River from Philadelphia, Camden’s population peaked in the 1950s at 124,566, but has declined by more than 35% to 79,904, according to the 2000 U.S. Census. Camden City’s population is 15.7% of the total population of Camden County which according to the 2000 U.S. Census was 508,932. There are 37 municipalities in the county and Camden City is the largest city. Racial/ethnic minorities are the majority of Camden City’s population. The 1990 Census reported a total population of 87,492, with African Americans at 56.4% and Hispanics at 31.2%. The 2000 Census shows African Americans as 53.3% of the population and Hispanics as 38.8%. There is a growing population of undocumented Mexican immigrants that providers are noting. One prenatal provider, Osborn, cites that nearly 35% of their prenatal patients are undocumented Mexican immigrants.

According to Camden Kids Count: A City Profile of Well-Being (2004): Slightly more than one-third (35%) of Camden City residents are living in poverty. In five city neighborhoods, household incomes average below $15,000 per year. Overall, Camden City families earned an average of just $20,695 in 1999, far below the county median family income of $56,346. This also falls short of the 2002 self-sufficiency wage of $28,000, the annual income required for one parent to provide one child with adequate food, clothing, housing and other necessities. The per capita income of city residents was $9,815 in 2000. Camden City ranks first in New Jersey for the percentage of children living in poverty. In 2000, 45% of the city’s total child population lived in families that lacked the resources to provide their basic needs. This far exceeded the Camden County rate of 15% and the statewide rate of 11%. The widespread effects of this extreme poverty are staggering. Camden City children are more likely to die in infancy, be born to unmarried mothers, fail statewide tests and drop out of school.

Further, nearly 20% of Camden City’s labor force was unemployed in 2003, compared with 6% statewide. The number of Camden City children receiving welfare plummeted 35.8% from 1999 to 2004, but these children still accounted for 66% of Camden County children living in families on welfare.

CAMConnect’s Camden City Camden Facts (1990-2000) notes that poor education compounds unemployment woes. During the 2002-2003 academic year, the city’s two largest high schools had a dropout rate of 21.9%, versus 1.9% statewide. The city graduation rate for 2002-2003 was 36.7% compared to 80.8% for the state. Among women who delivered between 2001 and 2003, only 39.4% received a high school diploma. In the year 2000, of the 42,746 city residents aged
25 years or older, only 5.4% had a bachelor’s and/or graduate or professional degree. Slightly more than one quarter (28.6%) completed high school or equivalent, another 15% completed some college but have no degree and 2.5% have an associate’s degree. It should be noted, however, that among those with bachelor’s or graduate/professional degrees, are “new” residents --- young, white professionals living and working in neighborhoods near the hospitals and businesses downtown.

One-fourth of employed persons (25%) hold educational, health and social services jobs. (Source: CAMConnect, Camden City: Camden Facts (1990-2000). Camden is home to three major hospitals, a Federally Qualified Health Center with several locations, Rutgers University, Camden County College, as well as city branches of Rowan University and the University of Medicine and Dentistry of New Jersey. Manufacturing and retail trades are the next largest employers, reflective of Camden’s port location and industries such as Campbell’s Soup Company. The industries of construction, accommodation and food services, administration and support and waste management services, wholesale trade, transportation and warehousing also employ about 1,000 people each.

<table>
<thead>
<tr>
<th>Other Economic Indicators</th>
<th>Camden City</th>
<th>Camden County</th>
<th>New Jersey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Rent</td>
<td>$522</td>
<td>$635</td>
<td>$751</td>
</tr>
<tr>
<td>Spending 35% or More on Rent</td>
<td>38.1%</td>
<td>31.9%</td>
<td>29.9%</td>
</tr>
<tr>
<td>Households with No Vehicle</td>
<td>40.6%</td>
<td>12.6%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Households with No Telephone</td>
<td>14.0%</td>
<td>2.7%</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

Source: US Census 2000, Summary Profile 3, Demographic Profiles, Selected Economic Characteristics (DP-3)

Infant Deaths: In 1999 the infant mortality rate in Camden City was 23.3, nearly four times that of the state rate (5.8). Camden City’s 2001 infant mortality rate was 16.1 per 1,000, compared to 9.9 per 1,000 countywide and 6.4 per 1,000 statewide. The black infant mortality rate in Camden City in 2001 was 17.4 per 1000 and babies of Hispanic origin died at the city rate of 16.1 per 1000.

Unmarried mothers accounted for 80% of total 2002 births in Camden, versus 29% statewide.

Low birthweight births in Camden City fell from 13.2% in 1996 to 12.9% in 2001. In Camden County, however, the percentage of low-weight births increased from 8.4% in 1996 to 9.2% in 2001. In Camden, 15.1% of black infants and 10.3% of Hispanic infants were born <2500 grams in 2001. The three year average (1991 – 1993) for infants born < 2500 was 13.6%, nearly twice the state average (7%).

Births with no Prenatal Care from 1996-2002 decreased by 27.8% in Camden City and 10.1 % in Camden County, compared with an 8.5% decline statewide. A significant 4.18% of the city’s births in 1993 were to women who received no prenatal care.

Prenatal Care: During 2002, 50% of Camden City women were enrolled in prenatal care during the first trimester, compared with 70% in Camden County and 75% statewide.
Births to teens fell by 22.1% in Camden City, compared to a 13.6% drop in Camden County, from 1996 to 2002. Teen births still represent 23% of total city births, compared to 12% of births in the county. In 1993 Camden City had the largest percentage of women below age 15 giving birth in the Southern New Jersey region.

Risk Factors for Poor Birth Outcome: In 2000, Camden County’s teen birth rate was 28 per 1,000 females aged 15 to 17, but the rate was substantially higher for non-Hispanic African-Americans (54.2) and Hispanics (77.9) than non-Hispanic whites (9.6). For each indicator for which data were readily available, there were a smaller proportion of healthy birth outcomes in Camden city than in the county or the state. Especially striking is the fact that in Camden, data is consistently higher in Camden for those risk factors that are predictive for poor birth outcome: 80% of all mothers are unmarried, over 15% use tobacco during pregnancy and 7–9% of pregnant women use alcohol or drugs during pregnancy.

<table>
<thead>
<tr>
<th>99-01 Average</th>
<th>WHITE</th>
<th>BLACK</th>
<th>OTHER</th>
<th>TOTAL</th>
<th>HISPANIC ORIGIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Births</td>
<td>776</td>
<td>905</td>
<td>83</td>
<td>1765</td>
<td>741</td>
</tr>
<tr>
<td>Infant Death</td>
<td>13.67</td>
<td>15.57</td>
<td>11.11</td>
<td>14.53</td>
<td>14.25</td>
</tr>
<tr>
<td>Neonatal Mortality</td>
<td>9.41</td>
<td>10.03</td>
<td>3.7</td>
<td>9.47</td>
<td>9.4</td>
</tr>
<tr>
<td>Post-neonatal Mortality</td>
<td>4.27</td>
<td>5.55</td>
<td>7.4</td>
<td>5.07</td>
<td>4.85</td>
</tr>
<tr>
<td>Low Birthweight</td>
<td>4.64%</td>
<td>7.13%</td>
<td>5.22%</td>
<td>5.94%</td>
<td>4.72%</td>
</tr>
<tr>
<td>Births to Teens &lt;18</td>
<td>11.98%</td>
<td>10.28%</td>
<td>112.05%</td>
<td>5.27%</td>
<td>12.55%</td>
</tr>
<tr>
<td>1st Trimester Care</td>
<td>55.54%</td>
<td>49.83%</td>
<td>50.60%</td>
<td>52.41%</td>
<td>55.06%</td>
</tr>
<tr>
<td>No PNC</td>
<td>1.68%</td>
<td>3.76%</td>
<td>1.20%</td>
<td>2.72%</td>
<td>1.48%</td>
</tr>
</tbody>
</table>

Source: Center for Health Statistics 2000

Other Prevalent Factors

Linguistic isolation: Spanish is spoken in 8,647, more than one-third (37%), of Camden’s 24,233 households. Of those Spanish-speaking households, 29% experience linguistic isolation, meaning that no member of the household who is 14 years old or older speaks only English, or speaks a non-English language and speaks English “very well.”

Obesity: The New Jersey Behavioral Risk Factor Surveillance System (BRFSS) conducted in 2000 reports that 36.7% of New Jersey adults are overweight; 17.7% are obese.

Mental health: During FY 2000, 25% of all admissions and 28% of all cases served by state-contracted mental health services were from Camden.
Crime: Despite economic development and $175 million planned for redevelopment (primarily in bricks and mortar), increasing crime rates threaten to halt the city's recovery efforts. In November 2004 Camden was named the most dangerous city in America by Morgan Quitno Press. In 2002 the violent crime rate in Camden was more than three times higher than the county’s and almost five times greater than the statewide rate. According to the FBI Uniform Crime Report, the rate in Camden was even worse in 2003, at 24.2 per 1,000 residents, up from 18.6 in 2002.

<table>
<thead>
<tr>
<th>Crime Rate per 1000</th>
<th>Camden</th>
<th>Camden County</th>
<th>New Jersey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent Crime Rate per 1000</td>
<td>18.6</td>
<td>5.5</td>
<td>3.8</td>
</tr>
<tr>
<td>Non-Violent Crime Rate per 1000</td>
<td>58.3</td>
<td>31.8</td>
<td>27.2</td>
</tr>
</tbody>
</table>

Source: Uniform Crime Report, 2002

Domestic Violence: The 7,377 domestic violence offenses in Camden County in 2001 comprised about 9% of the statewide total. Alcohol or drugs were involved in almost one-third of the domestic violence offenses and children were involved or present in more than 40% of the cases. Camden City Kids Count reports that Domestic Violence Offenses within the city have steadily declined since a high of 3,107 in 1999 to 2,672 during 2003. Camden City represents 37.5% of all reported domestic violence offenses countywide.

Infant/child abuse/neglect: While 6.5% of all children in New Jersey reside in Camden County, 11.3%, of the child abuse and neglect referrals are generated there. There are more referrals for neglect and slightly fewer referrals for physical abuse in Camden County compared to the state. From 1998 to 2002, 14 children in Camden County died as a result of abuse and neglect out of a statewide total of 123. Eight of the families of these children had an open/active case with DYFS at the time of their death.

STD Cases Under 21 Years of Age: Camden City has seen a 23% decrease in sexually transmitted disease cases over the past four years, the State of New Jersey a 12% increase.

HIV/AIDS & Perinatal HIV: Among U.S. states, New Jersey has the fifth highest number of persons living with HIV/AIDS. According to the 2004 Camden Kids Count Report, more than half (56.5%) of the persons in Camden County with HIV/AIDS were Camden residents in 2002. Poverty, substance abuse, STDs and race are factors in the burden of HIV/AIDS which disproportionately affects African and Hispanic Americans.

Additional information on project area data can be found in appendix A.
II. Project Implementation

Outreach and Client Recruitment

A. Prior to Healthy Start, the HMHB Outreach Program canvassed neighborhoods door-to-door to find women in need of assistance. As welfare reform programs were implemented and more childbearing-age women were not at home but in job training and education programs, this strategy became less effective. Therefore, for this phase of Healthy Start, a close partnership with prenatal providers was developed to identify pregnant women at risk and in need of case management services. A uniform screening and referral tool was developed and implemented in every prenatal clinic in Camden City. In the prenatal sites, women were, and continue to be, screened for substance use and perinatal depression using standardized tools. Criteria for referral to specialized case management services were developed and added to the referral tool. A process for sending referrals was developed and systems for consistent communication with prenatal providers were established to inform them of the status of women enrolled in case management. A one-page referral tool was also designed to encourage community-based agencies to refer clients to case management services.

An Outreach case management team, described below, was created to accepted referrals of women lost to care, missing appointments and in need of linkage to community resources. Potential clients also continued to be enrolled through Healthy Start participation in community events and educational programs and self-referrals to case management allow community-based recruitment to continue through word-of-mouth.

B. Components of outreach and client recruitment included the Healthy Start Screening and Referral tool (described above) and community events designed to offer health education and to inform women about Healthy Start programs and services. Health education events and activities are described below. The role of the project’s Health Care Advocates, their relationship to case managers and their role in outreach and client recruitment evolved through the four years of the project. The goal of these changes was to maximize their skills and abilities and to prioritize and focus their time in the community with clients. Their knowledge of the community and their ability to engage clients have been essential to the project. However, challenges were faced because Outreach case managers were providing supervision of Health Care Advocate staff and losing considerable hours of case management time in order to provide that supervision. Revision of these roles through the end of the project period included several attempts to simplify paperwork, activities and the supervision process.

C. Outreach and client recruitment activities were carried out as proposed and were not affected by resource limitations or events in the state or project area. Facilitating factors included CHS’s positive relationships with the prenatal providers and their recognition of the needs of their clients. These factors contributed to the partnerships necessary to develop a uniform system of screening and referral to CHS case management services. In addition, Phase I of the Healthy Start project also promoted partnership with the Board of Education and other
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CBO’s that contributed to the success of outreach education and client recruitment for those activities in the project area.

Case Management

The Case Management component of CHS has evolved and improved since Phase I funding. In Phase II of the project, CHS developed a more comprehensive approach to case management with a goal of serving more high risk women in Camden City through case management services. CHS developed a comprehensive tool to screen all pregnant women for risk of substance use, domestic violence, perinatal depression, and service barriers. This tool was implemented during the first year of the project in all of the prenatal clinics in Camden, and continues to be used to screen all pregnant women for CHS case management services.

CHS case management services are primarily delivered through home visiting and community based contacts. Services provided by CHS CM include assessment, referral and linkages to health and social service agencies, health education, guidance, support, and assistance to facilitate consistent follow up with health and social service providers. The primary goals of CHS CM are to lower the infant mortality rate, reduce the incidence of low birth weight babies, link children and families to a medical home, to improve future outcomes for childbearing families within Camden City and to empower CHS clients and the community.

CHS identifies the primary client as the mother, father, or primary guardian of the child. It is CHS belief that in order to be successful and to facilitate real changes with the client, the needs of the entire family unit must be considered. Minimum standards have been established for client visits based on clients needs. During Phase II, the CHS project developed a web based client record system. The record system allows both the Case managers to analyze client data as well as analyze data based on referral sources. This has been very useful for CHS and has been an incentive for the prenatal providers to screen all of their women for CM services. At this time other Healthy Start programs have shown an interest in the web based system. Success with marketing this product might contribute to sustainability.

A. In Year I, clients were referred to one of the following specialized CHS case management interventions:
   - Perinatal Depression Case Management
   - Adolescent Case Management
   - Risk Reduction Case Management
   - Outreach Case Management
   - Perinatal Loss Case Management
   - High Risk Medical Case Management
   - Male Case Management
   - Highest Risk Case Management

Community-based agencies also refer pregnant women for case management services, and as the services have become known to the community, more women self-refer for services.

In Years II-IV, a variety of factors led to changes in the specialized case management services offered. The rationale and process used to make these changes will be discussed in
section B, below. At the end of the project period, the fourth year, the following specialized case management services were in place with plans to continue those services in Phase III of the project:

- Perinatal Depression Case Management
- Adolescent Case Management
- Risk Reduction Case Management
- Outreach Case Management
- Una Nueva Esperanza (for undocumented pregnant women)

As discussed above, the essential components of CHS case management are the specialized services offered to pregnant women through a city-wide screening and referral process. Following is a description of each specialized service that was offered during the project period:

**Perinatal Depression Case Management** was initially provided through two subcontracts: Cooper Health System and South Jersey Behavioral Health, Inc. Each of these subcontractors hired one case manager and they shared responsibility for covering the project area. In Year II, it was mutually determined that South Jersey Behavioral Health was unable to fulfill the subcontract requirements. To facilitate coordination and to establish a back-up system for case managers, Cooper Health System was offered the opportunity to hire a second perinatal depression case manager. This subcontract remains in place.

Supervision of Cooper’s case managers is provided by the CHS Case Management Coordinator with consultation from the Department of Psychiatry at Cooper. In this service, clients receive information about the signs and symptoms of perinatal depression through individual case management interventions provided at home or in the community. Clients who score high on perinatal depression screening tool are referred to mental health treatment providers in the community for further assessment, diagnosis, counseling and medication. It is not unusual for depressed clients to miss appointments or to refuse initial referrals to treatment. The case manager visits the client at home or at the prenatal provider’s office to encourage follow-through with appointments. Access to mental health services has also been an obstacle for case managers and their clients. CHS has worked collaboratively to improve this and other barriers to care for pregnant women at risk for perinatal depression through the Mental Health Workgroup and by providing professional education forums in the project area.

**Adolescent Case Management** has been provided through a subcontract with Planned Parenthood of Southern New Jersey for the entire project period. In addition to case management supervision by a CHS Case Management Coordinator, these case managers receive supervision and consultation from Planned Parenthood. Births to teens fell 22.1% in Camden City, compared to 13.6% in Camden County, from 1996 to 2002. But teen births still represent 23% of total city births, compared to 12% of births in the county. CHS targets pregnant adolescents at risk due to multiple pregnancies, not attending school, past history of abuse, and unstable home environment. Adolescents have unique service barriers to child care and financial assistance. CHS case managers work with these adolescents to solve problems, continue their education and to increase their skills to achieve independence.
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Risk Reduction Case Management: In Years I through III of the project period, risk reduction case management was carried out through a subcontract with Alcove/Virtua Health System. Alcove was a substance abuse treatment provider in Camden. When Alcove closed and the subcontract ended in Year III, Southern New Jersey Perinatal Cooperative (SNJPC) assumed responsibility for the service and hired one case manager. The decision to hire one case manager was made due to falling caseloads as a result of the addition of a new substance abuse case management service offered to TANF clients. Funds for the second position were used to hire an additional case manager for the Outreach case management team as caseloads in this specialty area were growing beyond capacity.

All CHS program participants are screened for substance use risk using the 4P’s Plus Screening Tool, part of the Camden Healthy Start Screening. Program participants who screen positive or are identified as having a substance use problem, are referred for treatment and assigned to the Risk Reduction CM to link them with essential services. This population is at risk of having low birth weight babies and complications after birth and consistent follow up is necessary to increase the chance of a positive birth outcome. The Risk Reduction Specialist develops a plan for ongoing case management to address the problems identified during assessment. All program participants who are not using substances are supported, encouraged to continue their sobriety and given education about the dangers of using alcohol, tobacco and other drugs and encouraged to continue to avoid them.

Highest Risk Case Management: The Healthy Start Highest Risk Case Management Program was established to improve case management of families with extensive and complicated issues. CHS’ initial proposal included a plan to develop a multidisciplinary forum to provide case review of these clients. This was never initiated because individual case management strategies were proven more effective and timely. Instead, the highest risk case manager developed a caseload of clients referred directly from prenatal providers and from other CHS case managers. These clients required intensive follow-up due to medical and social needs crossing over multiple specialty case management interventions. For this reason, the caseload was lower and the case manager also began to function as a consultant to the other CHS case managers in Years I-III. As a result, by Year IV, this case manager was directed to have more responsibility for case review and supervision of subcontractors’ cases and for case coordination within the CHS case management system.

Perinatal Loss Case Management This case management service was established to address pre-conceptional issues of pregnant women who have had a previous pre-term loss, because of their increased risk of having repeated preterm loss. Camden County Department of Health received a subcontract to provide this service. As referrals were received and followed up, the primary issue for most clients was bereavement. Most were reluctant to discuss or plan for future pregnancies and refused or were difficult to engage in services after initial grief was past. The nurse, employed by the county, chose to leave her job mid-way through Year II and the county was unable to fill the position with a qualified candidate due to a hiring freeze. After an evaluation of the program needs at the time, a decision was made to create a new position for a case manager to follow undocumented pregnant women, a fast-growing population at risk in the city.

Una Nueva Esperanza: Hispanic childbearing families, including a growing population of immigrants from Mexico, experience significant barriers to care related to cultural, linguistic and economic factors. Within this population are subgroups of pregnant women who are at
greatest risk for negative birth outcomes. The need for specialized intervention for this target group became evident in Year II of the project period. Undocumented women, who lacked family support, entered prenatal care late in pregnancy or not at all. Providers saw a need for advocacy, health education and referral to community resources for this group. A case management position was added to SNJPC’s staff to follow undocumented pregnant women, replacing the terminated subcontract for Perinatal Loss. This service continues to be very successful and an additional case manager will be added in Phase III to meet the growing case load. Health education forums for these clients have been a very effective intervention in providing information and the support network needed by these pregnant women who are far from their native home and in precarious legal status.

High Risk Medical Case Management This case management specialty was established to assure follow-up of pregnant women with medical complications in the project area. CAMcare Health Corp., the federally qualified health center (FQHC) in Camden, was awarded a subcontract for this service. CAMcare employed a registered nurse, whose responsibilities were to follow clients referred from all prenatal sites. Despite various attempts to modify referral systems and staff activities, the service continued to serve only FQHC clients and the focus of staff time was high risk newborns. Although the service was needed and worthwhile, CHS objectives were not being met. Upon staff resignation in Year II, CAMcare relinquished their contract by mutual agreement and case management hours were deferred to SNJPC to provide services to the increasing numbers of clients in need of Outreach case management. As described in lessons learned, it often requires a great deal of effort to assure that subcontracted services will meet program objectives.

Male Case Management Services: Planned Parenthood was the subcontractor for this service which sought to improve the health, educational and socio-economic well being of families through work with the male partners of pregnant women enrolled in Healthy Start. Many challenges faced the case manager of this service as he tried to engage men in an ongoing relationship and to support them in the pursuit of these goals. Men were less likely to be at home during the day and more likely to be living in a different home than their partner and children, which made contact difficult. In Year IV of this intervention, a decision was made to change the focus and the methods to a health education model, with outreach to other community-based agencies.

Outreach Case Management Outreach case management services were designed to serve women who miss prenatal or postpartum appointments, lack or have problems with insurance, access prenatal care late or not at all during their most recent pregnancy, have housing or domestic violence issues, or children who have missed pediatric appointments. This service also follows women who self-refer or who are engaged through CHS staff participation in community events and are determined to be in need of case management services. In Year I of the project period, SNJPC employed 3 case managers and 6 health care advocates. These staff worked in teams, with case managers in the lead, to connect with and follow women referred through the mechanisms above. Through attrition of health care advocate staff, and with the vacancy established by the discontinued Alcove contract, case management positions were increased and health care advocate positions were decreased. Case management positions were added to this service because of increasing caseloads and a
recognition that in order to address client needs, the program needed staff with a minimum of an Associates degree. At the end of the project period, there were six outreach case managers and 4 health care advocates on the SNJPC staff.

B. In general, case management activities were carried out as proposed. But as described above, program changes, based on caseload numbers and staffing issues, were made in order to meet client needs. Resource limitations or events in the state or project area did not directly affect program services except to limit the available treatment slots available to women in need of mental health and substance abuse services. These limitations required more skill and creativity on the part of CHS case managers, who learned how and where to send clients to effectively meet their needs.

Health Education and Training
A. The Health Education and Training component of Camden Healthy Start has five interventions that evolved and improved over the grant period: Reduced Stress for Baby’s Best (RSFBB), “It’s a Family Thing” Higher Risk Adolescent Reproductive Health Education Program, Fathers on Track, Case Management Client Education for One-on-one Sessions and Groups, as well as Training and Development of staff.

Reduce Stress for Baby’s Best (RSFBB) was originally developed by the New Jersey Black Infant Mortality Reduction Resource Center. CHS conducts RSFBB to deal with a major risk factor associated with Black Infant Mortality and the disparity of perinatal health. Studies are demonstrating an association of stress with low birth weight and preterm births. The possible biological impact of the chronic stressors of racism and sexism on African American women is thought to be associated with perinatal disparities. RSFBB is a three session program originally targeting African American pregnant women ages 18-40 who are in their first and second trimester, and follows them throughout their pregnancy. This culturally sensitive program teaches stress reduction techniques and crisis management. The Perceived Stress Scale (Cohen et al, 1983) is used as a measure of stress levels and is part of the evaluation of the program. Reduced Stress is offered through a subcontract with Sikora Center, an outpatient drug treatment facility for women in Camden. As a result of the popularity of this project, and in order to increase its impact, CHS expanded RSFBB to serve any interested pregnant woman in Camden in her first or second trimester.

The second intervention is the Reproductive Health Education Program for Higher Risk Teens - “It’s a Family Thing” curriculum. As seen in CHS first phase of funding, a significant segment of pregnant and parenting teens have conflicted feelings about their sexuality and unrealistic expectations about their future sexual behavior. This serves as a major barrier to successful family planning. A Reproductive Health Education Specialist was hired through a subcontract with the Camden City Board of Education (BOE) to develop and facilitate a secondary prevention education curriculum targeting pregnant and parenting teens. The BOE works closely with Planned Parenthood.

The third and fourth interventions are standardized client education and the Training and Development of staff which is done by the Training and Development Specialist for Health
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Education (TDSHE). The TDSHE is responsible for ensuring that all clients receive consistent, accurate health education and provide training to our staff around maternal child health topics. These components were developed with the understanding that health education is an important part of the Healthy Start project, and that staff need guidance and support to provide this service to clients.

In 2005 CHS added another component to its Health Education and Training service. The Fathers on Track intervention, previously a case management service, transitioned to a Health Education service to provide fathers with group support and based on the common interests/needs of male clients.

B. Reduce Stress for Baby’s Best (RSFBB) is conducted by a full time RSFBB Coordinator. Other resources needed for RSFBB includes client incentives related to stress management, including stress management tapes, literature, and nutritional supplements during group sessions. As previously cited RSFBB expanded to serve all ethnicities. Another change that was made was to offer RSBB to individuals as well as to groups to accommodate the needs of clients who could not attend group. With this change, the RSBB Coordinator is able to schedule appointments with clients before or after their prenatal appointments at their clinics. Additionally, clients are welcome to bring their children and partners to the sessions if this will assist them in attendance. Clients of RSBB are being followed every six months after completion of the program. Evaluation of the program shows that women who complete the program use the tools and strategies they learn in RSBB during pregnancy and delivery, and that the majority of them view the program as positive. The Program Coordinator of RSBB has remained constant throughout the grant period.

The second component, Reproductive Health Education Program for Higher Risk Teens, uses the curriculum, “It’s a Family Thing”, which was developed by the Healthy Start Reproductive Health Education Specialist in collaboration with staff from School Based Youth Services and Planned Parenthood. This curriculum was completed in 2003 and piloted by the Camden City Board of Education. Since then it has been widely used with pregnant and parenting teens through the Camden City schools and in community-based programs. The Reproductive Health Education Specialist began a group at a prenatal clinic for teens not enrolled in school. This group met every other week. The participants were welcome to bring their children to the group. Other resources used for this intervention included transportation, lunch and items for the children to play with. Health Care Advocates (HCA’s) assist clients during transportation provided by a subcontracted bus service and interact with the children during the sessions. HCA’s are a resource for other CHS client education groups. Incentives are also used to encourage attendance at the groups. The goal of the curriculum is to provide adolescents with knowledge and information regarding their health and their rights, to encourage the adolescents to practice self love, respect, adequate communication skills, demonstrate proper reproductive health care, learn how to set and respect social and intimate boundaries and to demonstrate good parenting skills, and ultimately to prevent additional pregnancies before adulthood.

The position of Training and Development Specialist for Health Education (TDSHE) was originally filled in the fall of 2003. The TDSHE researched home visiting health education
curricula before choosing the *Partners for a Healthy Baby* curriculum from Florida State University. She began training the staff about this curriculum before leaving the position in the spring of 2004. In October 2004, a new Training and Development Specialist was hired. The position was changed from 1.0 FTE to .70 FTE, due to budget changes. The TDSHE has been working to create a standardized system for delivering health education to clients during home visits using the FSU curriculum. Resources required for this intervention include folders, binders, and health education materials in addition to the FSU materials. In 2005, case management staff began receiving training through monthly workshops on maternal child health topics (see attached list of training topics). Also in 2005, an adult client education group was started (see attached list of workshop dates and topics). There was an average of 13 participants at each group session. Transportation, lunch and childcare were provided at each session, and incentives were provided to participants.

*Fathers on Track* is a new part of the Health Education service of Healthy Start. It was begun in the spring of 2005 to better meet the needs of fathers in Camden. This program now offers group education every week on topics such as health issues, parenting, employment skills, and much more. *Fathers on Track* also incorporates the national MELD Fathers curriculum and the Fathers on Track Coordinator is a trained MELD coordinator who can train others. The Fathers on Track Coordinator also coordinates outings for fathers and their children to local attractions such as baseball games and community events.

C. CHS received free FSU curriculum materials from HRSA worth $18,500 which greatly impacted our ability to adapt this curriculum. CHS also received free materials from the SIDS Center of New Jersey and the US Department of Health and Human Services (Back to Sleep Campaign), which have become a part of the standardized education for all clients.

The following organizations have provided free workshops for CHS staff: Mom’s Quit Connection, SIDS Center of New Jersey, and March of Dimes. (Please see attached list of training topics.)

Early in the adaptation of the RSFBB program the NJ Black Infant Mortality Resource Center (BIMR Center) was very helpful in sharing information. One component of the original RSFBB model was the use of lab tests for assessing cortisol levels of participants pre/post intervention. Cortisol is a stress related hormone. The BIMR Center had a special relationship with a lab and physician in North Jersey to coordinate this aspect that Sikora was unable to duplicate in Camden. Therefore, cortisol testing was not incorporated as an evaluation tool. Because Sikora is an outpatient drug treatment center, CHS adapted RSFBB for substance abusing pregnant women.

An overall facilitative factor for CHS health education is the close partnership with the provider community, especially prenatal providers, who help promote CHS and its health education services.

The Camden BOE utilized its resources in funding the training of the Fathers on Track Coordinator for the MELD program and in funding the annual MELD certification which allows the use of the MELD curriculum.
SNJPC receives other grants from the March of Dimes and the NJ Department of Health and Senior Services that provide resources for the development and distribution of health education materials utilized by CHS.

CHS did not experience any factors such as system issues or local events that detracted from implementation of health education. Staff vacancies slowed the process, particularly the vacancy in the Training and Development position.

**Interconceptional Care**

A. Interconceptional care is not viewed as a separate intervention by CHS. It is integrated into the CHS Case Management intervention and our Health Education Programs. Therefore, all case managers provide education, referrals and follow-up of appointments during the interconceptional period. Educational topics, guidance regarding primary care needs and other anticipatory guidance provided to clients is focused on prevention needs specific to the interconceptional period.

B. Interconceptional clients are followed until the youngest child in the home has a second birthday. The initial goal after a woman delivers is to link a woman back to care for a postpartum appointment and to address family planning. During the interconceptional period CHS case manager’s work closely with clients to ensure consistent family planning and address any system barrier that may be present. Case managers also offer education and personal goal setting to help women make healthy choices for themselves and their families. CHS case managers work with clients towards increasing stability in their daily lives. There is an emphasis on linkage and the importance of primary medical care, dental care, well baby care, immunizations, and continued family planning. Standardized health education is a key component of interconceptional care. Health education covers the major MCH topics and health behaviors. The continued education helps keep clients engaged in case management services over the two year period.

C. Case managers express continued concern that many clients are unable to get medical needs met during the interconceptional period because they do not have Medicaid coverage. While sliding fee services are available in some outpatient family practice centers, women do not have prescription coverage for birth control and often use the emergency room for their primary care. Women who are not enrolled in TANF programs are not eligible for continued Medicaid coverage unless they are pregnant. The focus of case management is, therefore, to encourage TANF participation, or to seek work in companies that provide health care coverage, or to give guidance regarding sources of care for the uninsured. This is a state policy issue that affects the childbearing population served by CHS.

**Depression Screening and Referral**

A. CHS interventions were designed to serve pregnant women at risk in Camden and their children. Because women affected by depression and mental health issues were determined to be a priority population, this intervention is also described, in detail, under the case management heading of this section. One of the health system issues of concern at the outset
of CHS was the absence of a uniform screening process to identify pregnant women at risk for substance use or perinatal depression. To address this issue, CHS initiated a uniform screening process in all prenatal sites in the city and chose The Four P’s Plus Screening and Referral Tool to screen pregnant women for substance use and the Burns Depression Inventory to screen for perinatal depression. Prenatal providers were included in the process of choosing these tools and were active participants in the design of a Camden Healthy Start Screening and Referral Tool that incorporated the above tools as well as criteria to be used to refer to CHS for other case management interventions that targeted pregnant adolescents, pregnant women at risk for medical reasons including previous perinatal loss and undocumented pregnant women. This process engaged the prenatal providers in the city in the CHS project and most important, it established a consistent approach to screening and referral for women at risk for substance use and depression. Case management services have been offered to all pregnant women who screen positive to facilitate their enrollment and follow-through with necessary treatment services. Once screening and case management services were established, the challenges of getting women into the limited treatment slots available and assuring culturally competent treatment became a focus for service providers and the Coalition.

B. The components of the Perinatal Depression intervention included screening and referral, described above, and case management. Perinatal Depression Case Management Services are also described above and are carried out by two case managers through a subcontract with Cooper Health System. It was determined after the first year of the project that it was essential that one of these case managers be bilingual. Until a new hire was necessary, this issue was resolved through co-management with other bilingual case managers and translators. There were no other significant changes in this intervention.

C. There were no significant resource issues or events that detracted from or facilitated this intervention. CHS continues to advocate for additional mental health resources for the target population, especially for those without insurance coverage.

Local Health System Action Plan

A. HMHBC developed a Local Health System Action Plan (LHSAP) at the outset of the Healthy Start Project. The LHSAP was developed from an assessment of gaps in the local maternal and child health system of care and outlines action steps planned to address those system issues. HMHBC revises and augments this action plan annually. Camden City FIMR findings are also integrated each year to define a comprehensive community-based action plan. Healthy Start staff, consortium members, public and private agency partners/subcontractors and key community partners and consumers were actively involved in the development of the LHSAP. All of these Healthy Start consortium members were, and will continue to be, active on committees and the FIMR case review team. These stakeholders have been instrumental in the needs assessment, prioritization of issues and development of strategies necessary to address gaps in the system of care.
B. There were several mechanisms for identifying priorities and changing priorities in the LHSAP during the grant period. 1) HMHBC committees were charged with identifying gaps in services and barriers to care, including lack of necessary services, cultural issues, transportation, educational needs and coordination issues. These system issues were addressed through the committees or reported to the Coalition for assistance with advocacy at the city, county or state level. 2) the FIMR case review team identified system issues and made recommendations to HMHBC committees; 3) The HMHBC Evaluation committee, in collaboration with stakeholders mentioned above, reviewed and analyzed population and project data, and contributed to planning and prioritizing needs. 4) Regular meetings were held with provider stakeholders, focus groups were held on specific issues with clients and consumers and discussions with community-based agencies were ongoing in order to maintain a current and focused LHSAP.

The LHSAP was used to set priorities for Healthy Start programming, which is consistently done through the consortium structure of committees. The LHSAP also provided direction for consortium priorities chosen for advocacy efforts and consumer and professional education activities. SNJPC and HMHBC have been successful in addressing system needs and changes by collaborating with other stakeholders on the development of solutions.

HMHBC worked closely with the Camden County Healthy Department, the Community Planning and Advocacy Council (CPAC) and developed a relationship with the Camden City Health Department, established in 2004. None of these organizations have developed a Health System Plan for Camden City focused on maternal and child health. Therefore, HMHBC engaged stakeholders in a needs assessment and planning process to prepare for the Camden Healthy Start project. In addition to the LHSAP, HMHBC has contributed, every three years, to the revision of The SNJPC Perinatal and Pediatric Plan for the seven county region of southern New Jersey. HMHBC input on existing gaps in services and updated information on the listing of provider services and programs was a valuable contribution to the regional planning process.

C. Most of the goals of the LHSAP were achieved as the plan was tailored to address gaps in the local system of care by augmenting existing services. Challenges to achieving the goals of the LHSAP included: 1) Inability of local agencies to hire and retain qualified staff to fulfill Healthy Start subcontracts. SNJPC addressed this challenge by discontinuing some subcontracts and hiring three staff members to fill the jobs. 2) Staff changes in referring prenatal sites required more time of Healthy Start management and case management staff in order to train, orient and develop relationships to maintain referrals. Healthy Start staff continued to work with providers to efficiently provide training, by coordinating with multiple sites to manage staff time. It has been a challenge to keep professionals engaged and available to attend meetings and educational sessions because of limited staffing in all health and social services agencies. Efficient and effective meetings and trainings were planned with providers to maximize staff time. 3) Lack of existing specialized, reimbursable services for women and children that cannot be offered through the Healthy Start project, such as mental health services, substance abuse services and housing has challenged case managers’ ability to engage clients in necessary treatment. Improvements in the form of a
new drug treatment service for women and additional slots for mental health treatment did occur as a result of advocacy on the part of HMHBC.

Collaboration and Coordination with Title V

A. The Camden Healthy Start Initiative is integrally linked and coordinated with State and local maternal and child health programs. SNJPC is a licensed maternal and child health consortium (MCHC) and recipient of NJDHSS administered grant funds. This formal relationship has enabled close ties to be fostered between the HMHBC and the New Jersey Department of Health and Senior Services. The Maternal, Child and Community Health Unit and the Special Child, Adult and Early Intervention Services Units of the Division of Family Health Services are directly involved in project activities. Other state agencies, such as the Department of Human Services (DHS), Department of Education and Community Affairs, have been engaged in the Healthy Start project. In 2004, the Division of Addictions Services was moved from DHHSS to DHS. Because DHS also administers Medicaid in New Jersey, it is also necessary for SNJPC to communicate and collaborate on many issues relevant to Healthy Start.

B. Communication with State agencies regarding Healthy Start activity is accomplished by staff/member participation in State forums and by State staff representation on Consortium committees. NJDHSS staff members regularly participate in consortium activities. They have contributed data for this proposal and have reviewed the proposal for congruence with the statewide MCH goals and objectives. The Assistant Commissioner of Health and Senior Services, Family Health Services has committed the support of NJDHSS to the successful implementation of this project. Involvement of SNJPC and HMHBC in statewide MCH activities insured that the perinatal and childhood service needs identified in the FY 2001 MCH Title V - Five Year Comprehensive Needs Assessment and Block Grant Plan reflect information compiled in the SNJPC Perinatal and Pediatric Plan and the HMHBC annual workplans. Title V Block grant objectives are described as “Priority Needs” by NJDHSS Division of Family Health Services. Those that are addressed in this proposal include:

- Improve Access To Utilization of Preventive and Primary Care Health Services
- Reduce Adolescent Risk-taking Behaviors
- Reduce Black Infant Mortality
- Reduce Teen Pregnancy
- Improve Access to Quality Care for Children with Special Health Care Needs
- Increase Healthy Births

SNJPC collaborated with NJDHSS Title V to carry out the following programs in Camden, considered integral to the Healthy Start initiative:

- **Fetal and Infant Mortality Review (FIMR)** (1994-present; NJDHSS/TitleV funds)
- **Fetal Alcohol Syndrome (FAS) Prevention Project** (1989-present; NJDHSS/TitleV funds)
- **Healthy Mothers, Healthy Babies** (NJDHSS funding since 1993) The HMHB Coalition in Camden is the consortium for the Healthy Start project.
Camden Healthy Start Impact Report
June 1, 2001 – May 31, 2005

- NJ FamilyCare Project (NJ SCHIP) (1999-present; NJDHSS/NJHS funds):
- NJWIC Breastfeeding Initiative (1995-present NJDHSS funds): Lactation consultants and Peer counselors are made available to WIC clients in the project area
- Maternal and Child Health Epidemiology Program (ongoing) SNJPC works closely with NJDHSS MCH Epidemiology staff to analyze regional and statewide MCH data and conduct quality assurance activities.
- Black Infant Mortality Reduction Initiative
- Special Child and Early Intervention Services (SCAES)
- Lead Poisoning Prevention Initiative

SNJPC and HMHBC are active participants in many other ongoing statewide public health prevention initiatives in the project area including “Back to Sleep”, Shaken Baby Syndrome prevention, Mom’s Quit Connection (smoking cessation), adolescent pregnancy prevention and immunization public awareness and outreach education campaigns. SNJPC’s organizational mandate for 20 years has been to improve perinatal outcome through the collaborative efforts of hospitals, public health agencies, professionals, and consumers. By identifying problems and creating solutions to meet the needs of mothers and infants, SNJPC’s regional collaborative approach has led to cost-effective delivery of perinatal services. SNJPC has historically provided staff support to HMHBC and county-based MCH coalitions, securing funding for many new services in the project area and throughout the region through Title V funding, foundations and other sources.

Formal and informal partnerships in the project area are, therefore, the driving force of the SNJPC Healthy Start initiative. SNJPC established subcontracts with hospitals and community-based agencies to provide core Healthy Start case management and education services. SNJPC also initiated the development of provider agreements between case management providers and prenatal providers to facilitate confidential communication about case managed clients. Healthy Start services and educational activities are carried out in collaboration with and on the premises of community-based organizations such as OEO, housing developments, community centers, schools and churches. In addition to direct service provision, community stakeholders, agency staff and hospital staff are also engaged in HMHBC committees and the FIMR process.

C. SNJPC and CHS close ties to the Title V agency, as described above, have enhanced the projects’s ability to anticipate changes in the health system and to recommend changes in policy and program development at the state level. Changes are sometimes beneficial and sometimes detrimental, but the ability to communicate with policy-makers has enabled project staff to anticipate and prepare for reasonable transitions when change has been necessary.

Core Systems-building: Consortium

A. Approach:
The Healthy Mothers, Healthy Babies Coalition of Camden City (HMHB Coalition) has been in existence since 1985 promoting MCH issues and activities. The New Jersey Department of
Health and Senior Services (NJDHSS) has provided level funding to the HMHB Coalition since 1985, initially through grant support to the Camden County Department of Health and Human Services, and since 1991 to the Southern New Jersey Perinatal Cooperative (SNJPC). Historically, the HMHB Coalition conducted a community HMHB Outreach Program which consisted of a bachelors level Coordinator and four paraprofessional Outreach Workers.

The HMHB Coalition involved a membership with representation from hospitals, and other healthcare and social services providers. Healthcare and social services providers in the Camden service area have historically worked well together to maximize existing resources and to develop referral mechanisms. The HMHB Outreach Program has been an integral component to Camden’s service system. Providers historically utilize HMHB referral forms to find childbearing families who drop out of care or to engage them into initial services. Therefore it was logical for the HMHB Coalition to expand and become the Healthy Start Consortium. SNJPC received a HRSA Healthy Start grant in 1997 on behalf of its HMHB Coalition of Camden City. This grant supported significant expansion of services and the Coalition membership. This included ongoing HMHB Coalition member recruitment activities, orientation, training and periodic consensus building retreats. Expansion of stakeholder involvement included: Camden City government, Empowerment Zone representatives, community based organizations and more types of consumers such as school district parent coordinators. The Coalition also already involved members from the Camden County Department of Health and Human Services (CCDHHS), including its early intervention program, and the NJ Dept of Health and Senior Services (NJDHSS – Title V).

B. Consortium Structure:

The HMHB Coalition oversees the Camden Healthy Start (CHS) Project through its standing committees and Executive Committee (see HMHB Governance Chart in Appendix B). Each Healthy Start intervention has a HMHB standing committee responsible for its oversight, including conducting collaborative problem solving on the intervention’s identified system issues. The standing committees and their respective Healthy Start intervention(s) are as follows:

- Mental Health Work Group (MHWG) – Perinatal Depression Case Management.
- Substance Abuse Committee and its Substance Abuse Leadership Team (trained by Dr. Chasnoff/Chicago Research Triangle) – Risk Reduction (substance abuse) Case Management.
- Community Network- HMHB Outreach Program, will add in 2005 *Una Nueva Esperanza* (undocumented women) Advisory Committee as a subcommittee.
- Fatherhood Committee – Oversight of Fathers on Track, sponsors annual fatherhood celebration, problem solving system issues that impact fathers.
- Executive Committee – consortium leadership body, all committees report to, also oversight of consortium building.
Camden Healthy Start Impact Report
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• Evaluation Committee – Oversight of all interventions’ evaluation components, FIMR is a subcommittee.
• Public Information – support all committees, consortium building.

Plans continue to include the recruitment of an advisory subcommittee for the Una Nueva Esperanza (undocumented) Case Management intervention to deal with the unique systems issues/barriers of this population. Although consortium building is supported by all staff, it is the primary function of the Assistant Director of Community Development. One major change during this phase of CHS was the creation of this position during FY 0405 which responded to the need to have a higher skilled professional than the Community Liaison to oversee consortium building. SNJPC and the HMHB Coalition decided that at least a bachelors level (masters preferred) professional with a skill set in community development, volunteer recruitment, training and management was important for a full time position dedicated to consortium building. Another lesson learned concerning consortium building is to strategically plan consortium building activities that support the project’s overall goals. For example, one overall project goal is to increase the percentage of pregnant women who access prenatal care in their first trimester. Consortium building will entail recruitment of members who are engaged with middle school-aged girls, a population identified as accessing prenatal care late because of lack of support and restrictive policies within middle schools for pregnant students.

C. Resources/Events:

HMHB staff vacancies have slowed the process of consortium building during the later part of this phase of CHS as these vacancies involved both the Community Liaison and Assistant Director of Community Development positions. The Community Liaison left in April 2004. This position was later eliminated. Staff support activities for consortium building was a refocused activity for the HCA’s. The HCA’s were put directly under the supervision of the Assistant Director of Community Development. The hiring of an Assistant Director of Community Development occurred in November 2004, seven months later. Many consortium building activities, such as updating the new member orientation program, and implementation of new strategies to increase consumer participation at general HMHB Coalition meetings were put on hold during this transition. Attendance at Coalition meetings had declined during the second phase of CHS. Consortium building is an ongoing, labor intensive process. A vacancy of the Assistant Director of Community Development position occurred in April 2005, after only being filled for six months, meaning further delays in the process.
D. Consortium

1) Highlight how the Consortium was established, what barriers emerged and how they were addressed.

As stated above the CHS consortium was developed through the expansion of the longstanding HMHB Coalition. This included adding new standing committees to oversee CHS interventions, recruitment of new stakeholders, conducting consumer/provider teambuilding and consensus building retreats and trainings and refocusing general HMHB Coalition meetings. The refocused meetings integrated presentations of consumer-identified educational topics. General meetings took place in the evening at community sites and also had less of a business focus. The HMHB Coalition Rules of Procedures were revised to reflect a balance of power between consumers and providers. There are an equal number of elected provider and consumer slots for the HMHB Executive Committee and alternating consumer/provider HMHB chairpersons. There are types of consumers (primary and secondary). Primary consumers are CHS clients. Secondary consumers are city residents who do not work in healthcare and may represent stakeholder categories such as school district parent coordinators, clergy, city government, etc. All these changes took place during CHS first four-year grant cycle.

2) Describe the working structure of the Consortium, its demographics etc.

During 2001 Bimonthly HMHB Coalition and Executive Committee meetings, along with monthly standing committee meetings, were essential to the implementation of Healthy Start services and consortium building activities. The development of Neighborhood Advisory Boards or NABs was a major endeavor in expansion of the HMHB Coalition. The NABs related to their respective neighborhood based HMHB Outreach Program Teams and served to provide local input about services and needs. The HMHB Outreach staff in 2001 had teams of one case manager/supervisor with three HCA’s and each team was deployed in an area of Camden. The team supervisor had the primary role of organizing a NAB, which was a subcommittee of the Community Network Committee that oversees the HMHB Outreach Program.

In 2001 the HMHB Coalition had a membership of 513, of whom 59% were a type of consumer. Continuing into 2002 each HMHB Coalition meeting and Neighborhood Advisory Board (NAB) meetings were focused on updating consortium members with the latest information pertinent to maternal and child health. Periodic consumer surveys gather input for topics of interest.

There was a need to continuously identify strategies to maintain NABs’ participation level of residents. Team supervisors did not have background in volunteer recruitment and management. They also needed to spend increasing time around case management of clients. The Community Liaison utilized strategies such as trying to collaborate with churches and CBO’s to engage residents in the consortium. This had worked for a period but then interest faded. The Community Liaison also tried to engage day care providers in organizing NAB activities. However, day care providers faced similar problems in engaging their parents in day care sponsored activities.
In 2002 the overall membership, in spite of the unstable NABs, had continued to grow, with membership at 549 (up from 513 members), of whom 60% were a type of consumer. Membership breakdown by some key stakeholder categories were as follows. There were 489 Camden City residents (89% of membership), some of whom work in healthcare and are considered providers. There are 92 men (17% of membership), 17 government workers (3%), 28 school district parent coordinators and staff (5%) and 10 religious organizations/representatives (2%). Of the new members recruited during 2002, seventy-five percent were from a consumer category. The total number of members who had attended general Coalition meetings on a regular basis in 2002 were 180 or 33%. Most members participated on a standing committee or in events and may not come on a regular basis to general consortium meetings, held bimonthly. One major barrier to getting more Healthy Start clients (considered primary consumers) to attend meetings and events is the lack of transportation, as many are not comfortable using public transportation at night, but who are unavailable during the day because of work or school. However, categories of consumers, other than clients, did participate at general consortium meetings at greater numbers than providers, who tend not to want to stay in the city for evening meetings.

In 2003/2004 there were 579 members, up from 549 in 2002. Sixty percent were a “type of consumer”. The HMHB Coalition tracks types of stakeholders to determine where gaps exist in representation and to target recruitment efforts. Membership breakdown by some key stakeholder categories were as follows. There are 452 Camden City residents (78% of membership), some of whom work in healthcare and are considered providers. There are 64 men (11% of membership), 17 government workers (3%), 28 school district parent coordinators and staff (5%) and 10 religious organizations/representatives (2%).

During 2003/2004 the ethnic/racial breakdown for the consortium was:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>53% (307)</td>
</tr>
<tr>
<td>White</td>
<td>24% (141)</td>
</tr>
<tr>
<td>Latino</td>
<td>22.4% (130)</td>
</tr>
<tr>
<td>Asian</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

The total number of members who attended general Coalition meetings on a regular basis in 2003 were 205 or 35% (this was a slight increase from 2002 in which 33% of membership attended regularly). Many members continued to participate on a standing committee and or in events and may not come on a regular basis to general consortium meetings held bimonthly. It is important to note that clients and general membership had increased their participation in HMHB Coalition sponsored events. The annual Client Appreciation Day had 100 participants. Previous event attendance had been thirty client families. The event, held December 4, 2003, also had a significant increase in fathers, most of who were the clients of the Fathers on Track program. This event incorporated many incentives such as gift bags, two drawings for $100 gift certificate, a storyteller with free books for the children and an opportunity to get a family picture with Storky Stork, the HMHB mascot.

In 2004 the membership was maintained at 400. The racial/ethnic breakdown, which is close to that of Camden City, for the consortium was:
3) Describe activities utilized to assess ongoing needs; identify resources; establish priorities and monitor implementation. Describe relationship with other consortia.

The HMHB Coalition assesses ongoing needs, identifies resources; establishes priorities for allocation of resources; and monitors implementation through its standing committees and Executive Committee. The Executive Committee consists of elected members, subcontractors and chairpersons of the standing committees. During the first four-year funding cycle the consortium conducted a major retreat to look at needs and priorities. This was a 2-day retreat on August 23-24, 2000, “Precious Gems Of The Community…Sustaining The Healthy Start Initiative”, with 120 HMHBC members participating, of whom 39% (47) were primary consumers. There were 10 youth who participated and the age range of all attendees was 11 to 70 years old. The report from this retreat, which outlined a shared vision for future HMHBC programs and activities, continues to be reviewed. The HMHB Substance Abuse Committee’s Leadership Team, trained by Dr. Ira Chasnof and the Chicago Research Triangle in 2001, developed a Leadership Strategic Plan for needs assessment, priorities and resources related to risk reduction and pregnancy. This is periodically reviewed, updated and continues to guide the HMHB Substance Abuse Committee. The Community Network Committee gives input into the annual HMHB Outreach Program Work Plan which establishes priorities for this intervention. Representatives from health care and social services providers, along with consumers active on Community Network share information related to barriers to care and decided to work on housing issues as a major barrier to care in Camden City. Most organizations must deal with the transience of clients due to lack of safe, affordable housing. Community Network Committee sponsored a housing forum that brought housing resource providers to the table with healthcare and social services provider to discuss ways to better collaborate.

CHS has both staff and volunteer representatives that participate on the other major consortia in the Camden Area. This includes Camden Healthy Futures, CAMConnect, Community Linkages, the Learning Collaborative for a Healthier Camden, the Southern Region Lead Poisoning Prevention Coalition, the Camden Youth Services Commission and the Camden City Blueprint for Healthy Children Coalition. In this way, the CHS and its HMHB Coalition participate in needs assessments, data collection, and reporting concerning local health issues, including maternal and child health. As a member of CAMConnect, CHS can access various city data on everything from local crime statistics, housing, education, employment, health, and other socioeconomic and demographic information, often by neighborhood. CHS and its HMHB Coalition participates in various ongoing citywide assessments. Often CHS staff are asked to be a part or be separate focus groups because of its work with residents. Camden Healthy Futures, submitted to the Mayor a community health analysis and plan to be incorporated in the Camden Master Plan in 2001. This consortium serves as the Mayor’s Healthcare Cabinet. The CHS/HMHB Project Director sits on this consortium. This consortium is currently conducting an updated health needs assessment which CHS is participating in. Health Visions, the CHS local subcontracted evaluator, is a part of the Community Planning and Advocacy Council (CPAC),
4) Describe the community’s major strengths which have enhanced consortium development.

Camden City is a relatively small city with a wealth of social service providers, healthcare providers and community based organizations. These entities have historically worked well together to maximize existing resources and to develop referral mechanisms. They understand when to put turf issues “in the closet” and come together to bring funding and other resources into the City. This ability to collaborate is part of the social fiber of Camden.

Although Camden like many other urban areas has experienced a loss of residents, especially its middle class, many former residents still have close ties to the city. These non-residents often live right outside of Camden City. Having grown up in Camden they still have strong allegiance to the city because their relatives and friends still live in Camden or they themselves work or go to church in the city.

The consortium has strengthened its partnership with the City of Camden by utilizing the city’s Community Development Block Grant (CDBG) which supported for the first two years of this past phase the work of the HMHB Risk Reduction Activities Coordinator. Salary, educational materials for both providers and consumers, printing of the screening tools were all funded with support of the CDBG grant. Representatives from city government participate on the Substance Abuse committee and it’s Leadership Team.

The New Jersey Department of Health and Senior Services (NJDHSS) and its Title V program has a longstanding working relationship with SNJPC and the HMHB Coalition. The regionalization of perinatal services supports this strong partnership and is a strength for consortium building. NJDHSS has used the experience of the HMHB Coalition in its implementation of risk reduction activities statewide. The HMHB Camden Healthy Start project’s experience in implementing universal screening in prenatal clinics and involvement of other providers in a referral system has been very influential in the development of the statewide version of a screen to identify pregnant women at risk for Domestic Violence and Substance Use. The Risk Reduction Specialist with the Perinatal Addictions Prevention Project (funded by Health Service grants from the NJDHSS to SNJPC) worked closely with members of the Camden HMHB Substance Abuse Committee, Camden city prenatal providers and substance abuse treatment providers, as well as Camden Healthy Start case managers. NJDHSS and the Camden County Department of Health and Human Services (CCDHHS) participate on many of the HMHB Coalition committees. In turn, CHS/HMHB staff participates on many of the committees of the NJDHSS and the CCDHHS. The CHS subcontracted with the CCDHHS for the CHS perinatal loss intervention during the beginning of this past funding cycle. The strong collaboration between MCH consortia with the NJDHSS and CCDHHS is a community strength statewide for consortium building.
The perinatal providers, long time HMHB Coalition members, some of whom are founding members for the HMHB Coalition, view CHS and the HMHB Coalition activities as an extension of their services. Prenatal providers are willing to be at the table and help develop and conduct the CHS universal screening. Although not the recipient of Healthy Start funds, they conduct the CHS screening, and are willing to have quarterly site visits for quality assurance and quarterly provider meetings to problem solve screening issues. Their representatives are active on consortium standing committees active in problem solving system issues. This spirit of collaboration is a major community strength.

The Camden City School District’s Parent Advisory Council and Community School Coordinators provides another resource for consortium building and involvement of consumers. Many HMHB consumer trainings, HMHB Coalition events and service promotion has the participation of parents via the District’s Parent Center and Advisory Council. A well known Community School Coordinator spearheaded parent involvement in the HMHB Coalition and served as the HMHB Coalition Chairperson for two terms.

5) Describe weaknesses/barriers which had to be addressed in order for the consortium to be moved forward.

Consortium building is a labor intensive, ongoing process with many challenges. Membership is affected by life changes such as changes in employment and increased family responsibilities. SNJPC recognizes the need to have a full time staff person with experience in community networking, volunteer recruitment/engagement and retention. Having the right staff person to coordinate consortium building is a must for success. A major weakness for CHS consortium building during this past four-year funding cycle was having a Community Liaison without the necessary skill set to move consortium building beyond trainings, events and meetings and to the level of proactive strategic planning. It was identified that a higher skill set, including formal assessment of stakeholder gaps, recruitment strategies and timelines, as well as development of membership retention plans was needed. As previously stated, the creation of the Assistant Director of Community Development position addressed this weakness, but this position was vacant for much of 2004. A lack of an electronic database to enable easy periodic tracking of stakeholder gaps was another weakness. Currently attendance sheets are maintained for all consortium meetings and these sheets note if participants are Camden City residents and if they work in healthcare to see how many consumers are active at meetings. An electronic database needs to be developed that would include revised meeting attendance sheets to track other stakeholder categories. SNJPC is purchasing a membership database program that would include tracking membership meeting attendance and membership categories (including percent of consumers by stakeholder type such as clergy) as well as track ethnic/racial breakdown. This will assist in ongoing consortium building efforts.

SNJPC reorganized HMHB staff to move consortium building forward. HCA’s now have a refocused role for consortium building. The maintenance of NABs (Neighborhood Advisory Boards) was a challenge in terms of staff time and resources, as the need to revamp general HMHB Coalition meetings arose due to declining attendance in spite of changes to more of a town meeting atmosphere with consumer friendly presentations rather than a business meeting. This illustrates the ongoing nature of the consortium building process. Strategies may be effective for awhile, but overtime community interest may wane and continuous assessment is
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needed to develop new strategies for engagement. The HMHB Executive Committee decided to discontinue NABs which were also experiencing decreased attendance and integrated remaining NAB members within the general Coalition and its standing committees.

Previously cited staff vacancies in the Community Liaison position (now eliminated) and the key position of Assistant Director of Community Development hindered implementation of consortium building strategies. The HMHB Executive Committee brainstormed strategies to improve attendance that have yet to be tried due to the staff vacancies. Some new ideas that will be tried include hosting consortium meetings at public housing complexes to engage tenants and incorporating organized activities for children during consortium meetings that may interest parents. The HMHB Coalition had been incorporating free flea markets during consortium meetings in 2004, which allow residents to select used clothing, toys and other donated items. Also clients receive incentives for attendance at consortium meetings. These strategies have met with limited success.

The HMHB Executive Committee will continue to monitor stakeholder membership gaps and try recruitment methods to engage these stakeholders. There is a need to recruit representatives from the business sector, to re-engage representatives from managed care and continue recruitment of more Latino members to reflect their growing percentage of the city’s population.

6) Discuss activities/strategies employed to increase resident/consumer participation.

Use of incentives for clients’ participation in consortium meetings has met with limited success. The incorporation of presentations based on consumer identified topics at consortium meetings, and changing the format, time and locations of consortium meetings resulted in some attendance increase, but overtime this proved to be inconsistent for high attendance of clients (primary consumers). However secondary consumers continued to participate. The incorporation of events during consortium meetings such as hosting Clients Appreciation Day has resulted in high attendance. Providing a bus to pick clients up has been most successful. The 2005 Annual HMHB Meeting had nearly 200 participants, with the vast majority being clients and their families because for the first time buses were used to pick clients up and bring them home. SNJPC is subcontracting with a transportation company to bring clients to group health education sessions and consortium meetings/events. The HMHB Una Nueva Esperanza intervention for the undocumented pregnant/parenting clients has been very successful in the engagement of clients in planning and attending meetings and events. The unique needs of this immigrant population fosters mutual support and peer leadership. These participants not only attend meetings/events as part of Una Nueva Esperanza, but many attend general consortium meetings/events. They often car pool among themselves, as well as take advantage of the consortium transportation.

7) and 8) How was consumer input obtained in the decision-making process? How were consumer suggestions utilized?

The role of consumers, whether they be clients of Healthy Start services, their relatives, friends and neighbors, or other key consumer categories, is to give their perspectives as residents concerning the service strengths, gaps, needs and enablers related to family well-being. This role
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is enhanced and had expanded through consumer education/training designed to empower consumers as equal partners. *Una Nueva Esperanza.* During the first three years of this funding cycle each HMHB Coalition meeting and Neighborhood Advisory Boards’ meetings focused on updating consortium members with the latest information pertinent to maternal and child health. HMHB Coalition events integrate health education and health promotion in community engaging activities. During 2001 a total of thirty-six (36) presentations and educational consortium events were conducted, reaching 707 residents. Topics covered included: nutrition, infant car seat safety, varied community resources including Healthy Start services, women empowering themselves, lead poisoning and depression.

There were two consortium trainings during 2001 which were part of HMHB Coalition meetings, and conducted by Horner Associates. At the 11/12/01 Coalition Meeting the topic “Stress and Depression” was presented. Pre/post surveys were given. This session oriented consumer consortium members and their guests to the importance of mental health’s impact on perinatal and family health. Topic tapes and literature were distributed. At the 1/14/02 Coalition meeting Part 2, “Stress and Depression – What’s the Difference?” was presented, with role play and a panel. Tapes and literature were distributed. A New Coalition Member Orientation session was conducted 10/18/01 to enable new consortium members to understand mission, services and roles of consortium committees.

As previously discussed the philosophy of consumer/provider partnership underlies the very structure of committees, including having alternating consumer/provider HMHBC chairpersons, equal numbers of consumer/provider slots for the HMHBC Executive Committee and a consumer/provider HMHBC co-chairpersons mandated within HMHBC Rules of Procedures. Bi-monthly HMHB Coalition and Executive Committee meetings, along with monthly standing committee meetings have been essential to the implementation of Healthy Start services and consortium building activities and continues. Many secondary consumer stakeholders have been active in these meetings. Standing committee meetings expedite consortium member communication, participation and oversight of the health care system for childbearing families. The goal of these meetings is to increase members' understanding of community needs, to identify health system issues, and to monitor and evaluate the effectiveness of new and existing services. SNJPC Healthy Start Staff and other SNJPC staff provide staff support for all meetings and forums.

The development of Neighborhood Advisory Boards or NABs was a major endeavor in the expansion of the HMHB Coalition during 2001 - 2003. The NABs related to their respective neighborhood based HMHB Outreach Program Teams and served to provide local input about services and needs. As caseload requirements increased for the HMHB supervisors/case managers, management of the NABs became a problem and declining participation resulted.

During 2002 a total of thirty-four (34) presentations and educational consortium events were conducted, reaching 800 residents. Topics covered included: nutrition, infant car seat safety, varied community resources including Healthy Start services, lead poisoning, stress and depression, and protecting your family from environmental issues. There were two formal consortium trainings during 2002 which were part of HMHB Coalition meetings, and conducted by Horner Associates. The team building topics were “Group Process and Collaboration” and
“Bump Heads Today and be Buddies Tomorrow”. Pre/post surveys were given. These trainings were designed to continue teambuilding between consumers and providers.

In 2003 R. Horner, training consultant, completed the series of trainings for consumer and provider members. Consortium trainings included: “Group Process and Collaboration Part Two”, “Bump Heads Today and be Buddies Tomorrow Part Two”, “Be a Better Listener” and “Different Strokes for Different Folks”. Other presentations during 2003 at HMHB Coalition meetings continued to provide increase knowledge around MCH issues and included: “Women’s Care Issues”, “Home Safety”, “Lead Poisoning Prevention” and “Keeping Children Safe”. The child safety presentation also included discussion and distribution of fingerprinting kits by the Camden City Police Department.

Periodic consumer surveys continued to be used to gather input for topics of interest.

Standing committees have utilized consumer (clients) focus groups and surveys to receive their input on Healthy Start materials and services since primary consumers (clients) have not attended these meetings. The Substance Abuse Committee did this when it developed a brochure about substance abuse treatment and related resources. Several consumers, including a former client, participated on the Leadership Team of the Substance Abuse Committee. The Adolescent Committee is comprised of secondary consumers who work with youth both within school and community-based programs, gave input into the adaptation of the Youth Risk Survey from the national Youth Risk Behavior Survey. The committee guided the field testing of the survey among at-risk adolescent consumers to ensure its appropriateness for this population. Results of the survey were used in developing the Healthy Start Reproductive Health Education Curriculum for Higher Risk Adolescents- It’s A Family Thing.

Consumer leadership trainings have been conducted and appeared in previous reports. Many of these trained secondary consumers remain involved in consortium meetings and events. Some have become chairpersons of committees and participate on the HMHB Executive Committee. Again, these are mainly “secondary consumers” and not clients/former clients of Healthy Start services. However, they bring legitimate consumer perspective to the table. They provide input into strategic planning, oversight of services and the planning of events. More males have become involved with the consortium with the implementation of the Healthy Start Fathers on Track Program. There is a HMHB Fatherhood Committee which include male consumers and providers who plan the annual “Celebrating Fatherhood … The Other Side of the Belly” event. The event consortium building goal was to increase male consumer participation in the consortium and its work on system issues that impact fathers. Having a Fatherhood Committee as a consortium standing committee is a major consortium building accomplishment during this CHS phase.

E. Sustainability

Sustainability

1. SNJPC is actively seeking reimbursement for Healthy Start services through Medicaid. In particular, staff is discussing the possibility of reimbursement for use of the 4P’s Plus Screening Tool which was introduced in 2002 in all Camden prenatal sites with Healthy Start funding. The successful pilot and continued use of the 4 P’s Plus in Camden led the NJDHSS to rollout the 4P’s Plus statewide in 2003. It is currently used in 55 public prenatal sites in
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New Jersey. Representatives of the New Jersey Department of Human Services, Division of Medical Assistance (DHS/DMAS) are very interested in requiring that the 4 P’s Plus Tool be used by all Medicaid prenatal providers to systematically identify women at risk of substance use during pregnancy. They are exploring the possibility of reimbursing prenatal providers each time a screen is conducted in order to assure compliance with the mandate. A Medicaid mandate would also provide the opportunity for SNJPC to be reimbursed for training Medicaid providers on the use of the tool. SNJPC staff will continue to pursue Medicaid reimbursement for use of the 4P’s Plus tool and for other successful Healthy Start interventions. Timing is optimal for sustainability through Medicaid in New Jersey because DHS/DMAS is currently reviewing statewide programs and grant-funded services for potential Medicaid reimbursement in order to bring more Federal matching dollars to New Jersey.

In addition, SNJPC seeks to sustain case management services through Medicaid or other sources of state funding. An RFP for a Nurse Family Partnership program was released in September. This project, to be funded by the Safe Child Fund of New Jersey, will be a model for statewide replication. CHS case management services mirror the model that is being funded by the Safe Child Fund and SNJPC anticipates that the experience and track record of CHS case management will be a competitive asset in the proposal review process.

2. The success of the development of a web-based centralized client record system during Phase II has also developed into an initiative for project sustainability. The core structure of the client record system has been sold to the City of Cleveland’s Momsfirst Healthy Start project and an annual maintenance contract has been developed. The revenue from this project and the ability to work in collaboration with another project has enabled CHS to share the costs of system development and support the salary of key data management staff.

3. There were no barriers or negative impact that affected the sustainability of this project.

III. Project Management and Governance

A. Structure of the Project Management

The Southern New Jersey Perinatal Cooperative (SNJPC, the "grantee") is a non-profit, perinatal health network designated by the New Jersey Department of Health and Senior Services (NJDHSS) as one of the state's seven regional Maternal and Child Health Consortia (MCHC). SNJPC average number of staff (including its Healthy Start staff) during this four-year period was fifty (50) FTE staff. These include an executive director and managers for clinical projects, prevention programs, outreach programs, and finance/MIS. SNJPC Assistant Director of Administration/MIS spent 60% of time with the Camden Healthy Start project and oversees the database consultant. There was also a MIS Manager at .50% FTE supervised by the Assistant Director of Administration/MIS.

SNJPC’s Executive Director, Director of Human Resources, Director of Finance/MIS, and Director of Regional Programs provided management and support to the Healthy Start project as a service in-
kind. The Camden Healthy Start Project Director, supervised by the Executive Director, had been in place since the project’s inception.

A Community Liaison was responsible for continuity of consortium building for the first three and a half years of this phase. Later this position was eliminated and the position of Assistant Director of Community Development was created in 2004. Other SNJPC management staff for CHS included the HMHB Outreach Program Coordinator who directly supervised the HMHB case managers/supervisors. The HMHB case managers/supervisors were the team leaders for the HMHB health care advocates. The HMHB Outreach Program Coordinator provides the primary staff support to the HMHB Mental Health Work Group and the Community Network standing committees. The Community Liaison oversees the general consortium meetings. And the Community Liaison was responsible with the HMHB case managers/supervisors for the neighborhood advisory boards as subcommittees of the Community Network Committee. The Project Director provides primary staff support for the HMHB Executive Committee, Adolescent Committee and Health Education Task Force. SNJPC’s Director of Prevention Programs oversees the HMHB Substance Abuse Committee, its Leadership Team and FIMR team. The Communications Coordinator provides primary staff support to the HMHB Communications Committee. It should be noted that the subcontracted local evaluator (Health Visions) provides primary staff support for the Evaluation Committee. A Training and Development Specialist for Health Education came on board in October 2003. The position of Coordinator of Healthy Start Case Management to oversee the subcontracted case managers was hired in September 2003.

SNJPC directly administers and monitors the project, including the use of contractors. There were subcontractors for two health education interventions (the Camden Board of Education and Sikora), and seven (7) subcontractors for the case management interventions of risk reduction/substance abuse (Alcove), perinatal loss/preterm labor (CCDHHHS), perinatal depression (Cooper and South Jersey Behavioral Health), medically high risk (CAMcare), higher risk pregnant/parenting adolescent and male partners (Planned Parenthood); and the highest risk level (most complicated needs) intervention (Steininger). SNJPC’s Healthy Start Management Team conducts quarterly site reviews with all subcontractors. The Management Team also coordinated the multi-agency Healthy Start Case Managers Team meetings. A Risk Reduction Activities Coordinator, who oversaw the development and implementation of the CHS Screening and Referral Tool, was in-kind from another grant source for the first two years, and later a percentage of her salary was covered under Healthy Start. The CHS Project Director directly supervised the HMHB Outreach Coordinator, the Coordinator of Healthy Start Case Management, the Training and development Specialist, the Community liaison, the Assistant Director of Community Development and the Risk Reduction Coordinator. She also directly supervised the CHS Administrative Assistant.

SNJPC is a matrix organization. Members of the CHS Management Team supervised areas of activity conducted by staff that relates to their respective specialties. Therefore, the Training and Development Specialist supervises client education and staff training activities.

The SNJPC Healthy Start Management Team work together in conducting quarterly site visits of all interventions (subcontracted and the HMHB Outreach Program), and members of this team conduct daily supervision and formal weekly supervisory meetings. Identified issues are brought to the attention of all relevant management staff, including subcontractors. The SNJPC Healthy Start Impact Report
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Start Management Team also has regularly scheduled bi-weekly meetings to discuss progress and problem solves issues. Regular communication with the SNJPC Executive Director also occurs. In this way, the grantee agency is able to leverage other in-kind supports when appropriate, and integrate CHS into overall agency direction and development.

B. Resources Essential for Fiscal and Program Management

A major resource for the CHS was the receipt of a Camden City Community Development Block Grant (CDBG), a part of the City’s HUD Super Nova funding. SNJPC received CDBG funds from 2001 – 2004. CDBG funds supported the salary, travel, and materials for the Risk Reduction Activities Coordinator. The Risk Reduction Activities Coordinator worked closely with the CHS Management Team in the engagement of all the city prenatal clinics, and in the development, field testing, implementation and quality assurance process of the CHS universal, comprehensive screening and referral system. This is the basis of the CHS multi-agency, multi-disciplinary, integrated case management system. The CHS Screening and Referral Tool resulted from input of consortium committees, the prenatal providers and staff. The Risk Reduction Activities Coordinator coordinated this process. She conducts ongoing provider recruitment, orientation, training and QA for the screening process. This includes quarterly provider record review to identify screening issues, individual provider meetings to give feedback, facilitation of periodic prenatal provider group meetings with the Management Team to problem solve system issues that impact screening and coordinating follow-up action steps. The screening instrument has been revised during this phase of CHS and the screening model has been adapted by the NJDHSS and expanded to other parts of New Jersey under a State Perinatal Addictions and Risk Reduction Initiative. The CDBG funding level for the entire City of Camden was significantly reduced and the amount of the CDBG grant awarded to SNJPC and others experienced significant reductions in FY 0304, with the CDBG grant for SNJPC ending in 2004. The Risk Reduction Activities Coordinator’s salary was picked up by other grants received by SNJPC and she still provides her screening related activities for the CHS as part of her duties.

The NJDHSS has awarded SNJPC level funding to support its HMHB Coalitions. This grant supports salaries of some of the HMHB Outreach staff (case managers, health care advocates), partial support of the salaries of the Community Liaison, later the Assistant Director of Community Development, and the HMHB Outreach Coordinator, and support of the rent for the East Camden HMHB Outreach office. It also helps support cost of staff travel, office supplies and other materials.

SNJPC core budget supports a comprehensive, competitive benefits package that includes tuition reimbursement and an Employee Assistance Program (EAP) which contribute to the recruitment and retention of qualified staff.

C. Changes in Management/Governance

There was re-organization of CHS staff and new SNJPC CHS staff positions due to the attrition of subcontractors during this phase. Five of the original seven subcontractors for case management interventions opted out as subcontractors due to individual agency related reasons. However, they remained active in the consortium as partner agencies. This is further discussed under Project Implementation – Case Management section of this report.
SNJPC was able to hire three new Healthy Start staff with these subcontractor changes: Coordinator of Healthy Start Case Management, Training and Development Specialist for Health Education and Case Manager for Undocumented Pregnant Immigrant Population.

The previous Highest Risk Case Manager moved from Steininger to SNJPC with a new title of Coordinator for Healthy Start Case Management to better reflect her expanded role. There is a need to have a manager to oversee the field operations of the Healthy Start subcontracted case management services and work closely with HMHB Outreach Coordinator and other Healthy Start management staff to ensure ongoing adherence to case management guidelines, policies and procedures. This position also facilitates regularly scheduled meetings involving Healthy Start case management team and provides case management for the highest risk clients.

The Training & Development Specialist utilized previous funds earmarked for the subcontract with the Camden County Department of Health & Human Services (CCDHHS) for a nurse case manager for preterm labor prevention and perinatal loss. SNJPC and the HMHB Coalition identified the need to standardize client education to include preterm labor, the focus of the CCDHHS subcontracted nurse case manager position. The Training & Development Specialist oversees implementation of client education around maternal and child health topics, ensures standardized curriculums/guides, methods and materials, and coordinates evaluation and staff training concerning health education. Training around perinatal loss and associated resources also occur for all Healthy Start staff.

The number of Case Managers increased from three to five based on the increased workload resulting from universal screening within the prenatal clinics and adherence to standardized case management policies/procedures. The Outreach intervention receives the highest amount of referrals. SNJPC also directly hired a Case Manager to work with the undocumented pregnant immigrant population.

The number of Health Care Advocates was reduced from eight to seven to accommodate the need for more Outreach Case Managers during FY 0304. By FY 0405 the number of Health Care Advocates were further reduced to four as their role was refocused and to help accommodate the funding of the Assistant Director of Community Development position. The HCA’s were placed under the supervision of the Assistant Director of Community Development to reflect their refocused role with consortium building, and their becoming more of a shared staff resource across all CHS interventions, including health education.

The database consultant subcontract originated with EdTech Inc. and was moved to Bmk Inc.in year 3.

The major management change for the CHS was an expansion of its CHS Management Team which went from four managers (Assistant Director of Administration/MIS, Director of Prevention Programs, HMHB Outreach Coordinator and the CHS Project Director) to seven managers with the addition of the Coordinator for Healthy Start Case Management, Assistant Director of Community Development and the Training and Development Specialist.
The Project Director works closely with SNJPC Finance Department in overseeing that the subcontractors’ expenses relate to approved programmatic activity and approved budgets. Subcontractors submit monthly reports to the Project Director, Local Evaluator and Assistant Director of Administration/MIS. Monthly invoices are not paid until their respective monthly reports have been submitted and approved.

SNJPC solicits contracts/subcontracts through its consortia membership and key community contacts. In regards to the CHS Project, HMHB Executive Committee members, officers and standing committees discuss opportunities to submit proposals. During the initial program development phase of a Healthy Start funding cycle an RFP is issued and advertised through mailings to consortium members, the general provider community and during consortium meetings. Members are encouraged to spread the word. SNJPC/HMHB hosts town meetings to describe the funding opportunity, distribute proposal guidance and answer questions. This process was done in preparation of applying to HRSA for the first and second funding cycles of CHS. Also, if SNJPC/HMHB is aware of a program or expertise of an organization, individual outreach to that entity is conducted to discuss collaboration; which may mean subcontracting with this entity.

During the first phase funding for CHS, the HMHB PI/Communications Committee oversaw a bidding process for a marketing subcontract for the development of promotional materials, including literature, PSAs and a video. SNJPC Communications Department staff and the Healthy Start Management Team coordinated this process. Marketing firms submitted proposals and gave presentations to the HMHB PI/Communications Committee and SNJPC/HMHB staff.

During development of the CHS grant proposal for the second phase funding cycle, representatives of the HMHB Executive Committee, the local evaluator and SNJPC Healthy Start Management Team reviewed submitted proposals, utilizing an evaluation/scoring tool adapted from the Community Planning and Advocacy Council (CPAC), the parent organization of Health Visions, the subcontracted local evaluator for CHS.

Letters of Agreement/subcontracts are done for training consultants and other consultancy as appropriate. Only the SNJPC Executive Director can execute a contract/subcontract.

SNJPC routinely complies with the reporting requirements of the various funding agencies. To facilitate this process SNJPC has developed internal reporting systems to track monthly expenses and budget variances for each grant program, including the CHS. The status of grant expenditures is reviewed quarterly by the finance staff and program managers. SNJPC refined its tracking procedures and field tested its revised quarterly budget tracking reports during October – December 2003. Full implementation of the revised reporting happened in February 2004. The Finance Department conducts monthly reviews of subcontractor budget status to also monitor areas that may be underspent. This revised budget monitoring process helps to decrease the amount of unobligated budget at the end of the fiscal year.

The SNJPC Finance Committee receives an updated analysis of the organization’s financial status.
bimonthly. The most recent agency external audit identified no deficiencies and no management or internal monitoring issues.

E. Non-Healthy Start Resources

As discussed under section B – Resources for Fiscal/Program Management, the receipt of the Camden City Community Development Block Grant (CDBG) in 2001 - 2004 supported the salary, travel, and materials for the Risk Reduction Activities Coordinator. This position was germane to the quality assurance, monitoring and technical assistance of the comprehensive, universal CHS screening and referral system. Also part of the salaries of some of the CHS management team (including the Director of Prevention Programs, Assistant Director of MIS/Administration, HMHB Outreach Coordinator, Assistant Director of Community Development) were funded with non-Healthy Start monies. The management team performs quarterly site visits, daily monitoring, and technical assistance for quality assurance and service utilization, each manager has specific areas of responsibility (i.e. database oversight, case management, health education etc.).

F. Cultural Competency

Cultural competency was and continues to be a consideration in staff recruitment both for the direct CHS staff hired by the grantee agency and for its subcontractors. And cultural competency related training is ongoing. CHS staff of Health Care Advocates (“HCAs”) and Case Managers (“CMs”) has always reflected the primary racial/ethnic make-up of Camden: being Latino or African American. CMs and HCAs include bilingual/bicultural individuals capable of providing translation and other services to clients whose native language is Spanish, and assist non-Spanish speaking staff when needed. The HMHB Outreach Coordinator is a Latina. The CHS Project Director is African American. To ensure culturally appropriate services, all project staff received Cultural Diversity and Sensitivity and Multicultural Awareness training. Cultural competency is integrated into ongoing training, regardless of its primary topic. For example, trainings around preterm labor or other MCH topics always address relevant differences between population groups in terms of data, beliefs, behaviors and methods of communication.

Women identified as undocumented are assigned to a team that works exclusively with undocumented clients. The subcontracted Coordinator of the “Reduced Stress for Baby’s Best program” has trained bilingual outreach staff so that group sessions can be offered to CHS clients who only speak Spanish.

The undocumented population presents unique challenges and barriers. Lack of trust, resources, insurance, and language barriers are a few. The outreach CM of CHS/HMHB’s *Una Nueva Esperanza* (A New Hope) program has used community ambassadors to engage undocumented women. Trust building has been key to this population and often women refer other women into the program. Many of these families live together in order to "pool" financial resources. Families often mistrust the system for fear of deportation. Many have received incorrect information and are hesitant to enter care. However, since January 2004, the Una Nueva Esperanza program has engaged this population, most of whom are from Mexico. The success of the CHS’ *Una Nueva Esperanza* has been impressive to perinatal and social services providers who view this as a model program. Extensive referrals into *Una Nueva Esperanza* has resulted in the need to hire a second
IV. Project Accomplishments

<table>
<thead>
<tr>
<th>Project Period Objectives</th>
<th>Interventions</th>
<th>Strategy and Activities</th>
<th>Accomplishments</th>
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<tbody>
<tr>
<td>1) Assure that at least 75% of program children under age 2 have received the proper immunizations by 5/05.</td>
<td>All CHS case management interventions</td>
<td>Case managers teach clients about importance of childhood immunizations, refer and assist with linkage to pediatric providers, and track status of immunizations for follow-up. Improved tracking of children in the home was implemented in 2003, as management improves rates are anticipated to approach project goals.</td>
<td>In 2002 204/451 or 45% of children under 2 in families served by CHS were fully immunized for their age. In 2003 288/567 or 51% of children under 2 in families served by CHS were fully immunized for their age. In 2004 475/851 or 56% of children under 2 in families served by CHS were fully immunized for their age.</td>
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<td>2) Increase by 5/05 the percent of women initiating prenatal care in the first trimester of pregnancy and continue with care through the postpartum period at least 30% more than the baseline established after a full 12 months of data collection.</td>
<td>HMHB Outreach Program</td>
<td>Case find through community promotion. Did not implement vouchers to purchase at-home pregnancy testing kits due to logistics of follow-up. Put on hold the neighborhood canvassing of sites frequented by childbearing age women until Assistant Director Community Development position filled. This activity will have a strategic plan coordinated by</td>
<td>In FY 02-03 153/281 or 54% of clients receiving services during their pregnancy received prenatal care in the first trimester. In FY 04-05 155/277 or 56% of prenatal clients entered prenatal care in the first trimester. Additional efforts to increase referrals from non-traditional sources are expected to</td>
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<table>
<thead>
<tr>
<th>Assistant Director.</th>
<th>increase the number of prenatal referrals and new monitoring of multiple pregnancies while in HS service will likely increase the whole numbers and percentages</th>
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<tr>
<td>3) Increase by 30% above baseline to 75%, the number of clients with missed appointments who resume regular health care by 5/05.</td>
<td>HMHB Outreach Program</td>
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<tr>
<td>4) By 5/31/05 increase the percentage of enrollment into NJ Family Care Insurance Program to 100% of eligible HMHB clients.</td>
<td>HMHB Outreach Program</td>
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5) Provide case management services to clients around barriers to care and based on level of risk and be able to show some resolution of problems identified within care plans on at least 60% of case load.

| CHS Case Management Interventions | Work with clients regarding barriers to care and overcoming these barriers. Link with facilitative services and other necessary support and healthcare services. Provide care coordination, health and life skills education. Track all clients for a period of two years to ensure interconceptional care and to document MDS follow up data and care plan information. Use standardized Camden Healthy Start procedures, policies, guidelines, instruments and centralized database. SNJPC/HMHBC will implement ongoing inservices/training around creative problem solving, client advocacy, client engagement and retention. | 470/1015 or 46% of clients with barriers to care received assistance that facilitated the relief of their barrier. |

6) By 5/05, provide intense case management services to 100% of the highest-risk participants with extremely complex cases. Project.

<p>| CHS Highest Risk CM intervention | Regular care coordination and case conferencing meetings are conducted. Coordinator of HS Case Management reviews all HS client referrals for highest risk indices and for need to conduct care coordination between | The work done to facilitate appropriate care focused on maintaining the client’s primary relationship with their case manager with assistance from and supervision by the |</p>
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<th>8) By 5/05 adapt and implement “Reduce Stress for Baby’s Best” (RSFBB) for pregnant substance abusing and non-substance abusing women between the ages of 18 and 40. Enroll at least 100 pregnant women into program, with at least 65% completing all three sessions.</th>
<th>CHS’ Reduce Stress for Baby’s Best (Sikora subcontractor)</th>
<th>Continue conducting RSBB info booths at community sites, prenatal clinics. Conduct targeted outreach and network with nail salons, hair salons, churches for program promotion, continue use of incentives.</th>
<th>Accomplished. A total of 287 women enrolled in RSFBB during the 4 year period with 226 (79%) completing the program. 85% of the 67 substance abusing women completed the program.</th>
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<tr>
<td>9) By 5/31/05, implement culturally appropriate screening tools for testing of program participants to measure individual stress levels. Screen at least 95% of referred HS clients</td>
<td>CHS’ Reduce Stress for Baby’s Best (Sikora subcontractor)</td>
<td>The Perceived Stress Scale (PSS) is used as a pre/post measure for stress levels and is administered every six months as part of intervention.</td>
<td>Accomplished. The Perceived Stress Scale was implemented. Database has been revised to capture the # of referred HS clients so we can determine the number screened for future reports.</td>
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<td>10) By 5/05 demonstrate improved stress management skills in at least 85% of the participants who complete the program.</td>
<td>CHS’ Reduce Stress for Baby’s Best (Sikora subcontractor)</td>
<td>Administer PSS pre-intervention and every six months, post. Include perceived stress questions and question about use of stress management techniques on six-month participant surveys implemented by 1/03. Surveys are also conducted during six month follow-up</td>
<td>Accomplished. 99% of clients strongly agreed or agreed that they were able to recognize sources of stress after the program. 94.5% strongly agreed or agreed that the program helped them respond to</td>
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<td>11</td>
<td>By 5/31/05 at least 70% of perinatal depression intervention clients will show improved scores on the Beck Depression assessment tools.</td>
<td>Perinatal Depression CM (Cooper subcontractor)</td>
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<td>12</td>
<td>By 5/31/05 triage and link at least 95% of assessed high risk perinatal depression clients to the appropriate level of case management/care coordination services.</td>
<td>Perinatal Depression CM (Cooper subcontractor)</td>
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<td>13</td>
<td>By 5/31/05 increase the number of male partners of Healthy Start pregnant clients to at least twenty-five (25) who are in the case management level of service and at least twenty (20) who are in the tracking level of service.</td>
<td>Fathers on Track (Planned Parenthood subcontractor)</td>
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In Phase II 350/570 or 61% of prenatal patients screening positive for risk of postpartum depression were referred by their provider to the depression intervention. During Phase II 52 males were case managed and 23 were tracked.
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<th>14) By 6/05 increase to 90% of participating adolescent pregnant and parenting teens, both male and female, who receive case management services the number who will show increases in parenting skills, life and social skills, primary healthcare services including dental, educational skills, participating in the male clinic, and reductions in risky behaviors.</th>
<th>Higher Risk Pregnant/Parenting Adolescent/CM and Fathers on Track (Planned Parenthood subcontractor)</th>
<th>Collaboration with BOE’s Reproductive Health Educator in conducting curriculum sessions. Administer HS Youth Risk Survey as component of new curriculum, document results over time. Utilize HS MDS and MDS follow-up and client tracking/care plan tools. Participate in training around client engagement, retention strategies.</th>
<th>Of 434 participants under 20, 253 received educational interventions on risk behaviors as part of case management and 50 had specific issues with risky behaviors that were resolved.</th>
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<td>15) Through implementation of a specialized curriculum for higher risk pregnant/parenting teens by 5/31/05: prevent subsequent pregnancies while participants are adolescents in at least 65% of participants exposed to multiple sessions of the curriculum; prevent HIV/STDs/STIs in at least 65% of curriculum</td>
<td>It’s a Family Thing Curriculum (Board of Ed subcontractor)</td>
<td>Conduct the new reproductive health education curriculum by 4/03 and ongoing. Train other HS providers on components of curriculum, be available to conduct program in community, clinics, schools. Act as consultant to others serving higher risk adolescents. Health Education Task Force oversee adherence to evaluation plan and conducts monthly</td>
<td>Partially accomplished. The curriculum has been implemented but data on the prevention of subsequent pregnancies and prevention of STIs is not available because of the length of time required to get curriculum introduced.</td>
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Camden Healthy Start Impact Report  
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| Participants exposed to multiple sessions, improve parenting/life skills in at least 65% of participants exposed to multiple sessions of the curriculum. | Review of progress, troubleshoot issues, work collaboratively with Evaluation Committee. |  
|---|---|---|---|---|
| 16) By 5/31/05 the HMHBC will have maintained a membership of at least 400 members, of whom at least 50% will be a type of consumer. Consumer and provider members will maintain an equal balance of power. | Consortium Building (Assistant Director of Community Development oversee with Project Director, Executive Committee) | Continue consortium training, standing committees’ oversight of Healthy Start interventions, and adherence to Rules of Procedures and other supports for equal power between consumers and providers. Presentations around topics of consumer interest will continue as part of every general consortium meeting, held bimonthly. Consortium satisfaction surveys will continue to be conducted at HMHBC Annual Meetings which have the highest attendance during the year. HMHBC general meetings will continue to rotate sites and new strategies will be tested to assess if this will increase attendance at general consortium meetings. | Accomplished. The HMHB Coalition current membership is 498, of whom, over 65% are a type of consumer. Executive Committee maintains equal number of consumer/provider slots. Also has a consumer Co-chair and alternates between consumer/provider chairperson. |  
| 17) By 5/31/05 the HMHBC will have | Consortium Building | HMHB Coalition conducts an annual satisfaction survey at the annual meeting. | Currently there are 84 males, with a
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<th>Recruited an increase in the number of membership who are representative of at least two major population categories, Latinos and males, increasing their numbers by at least thirty (30) members for each group.</th>
<th>Celebrating Fatherhood event, starting in 2004, which resulted in the development of a HMHB Fatherhood Committee. Fatherhood Committee engages stakeholders interested in system issues that impact males. Una Nueva Esperanza CM intervention has increased Latino membership.</th>
<th>Newly formed HMHB Fatherhood Committee. There are currently 26.4% Latino members. In 2003 consortium membership was only 22.4% Latino with only 64 male membership.</th>
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<td>By 5/31/05 the HMHBC will increase the total number of members who have attended general Coalition meetings on a regular basis to at least 45% of membership.</td>
<td>Consortium Building (Assistant Director of Community Development oversee with Project Director, Executive Committee)</td>
<td>HMHB staff will continue participation in other community meetings and network with CBOs, tenant organizations and other agencies. Assistant Director for Community Development will be hired and work with the consortium leadership, Project Director on a Strategic Plan for Consortium Building. This was placed on hold due to vacancy of Asst. Director position. Once position filled plan will include targeted outreach to Latino organizations, working closely with bilingual/bicultural HMHB staff and existing Latino consortium members. Plan will also include strategies to increase</td>
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<td>In 2003 thirty-five percent (35%) of members attended general Coalition meetings on a regular basis. General Coalition meetings will resume once fill the Assistant Director position. Goal is by 12/31/05, 40% of membership will attend meetings/events regularly.</td>
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<td></td>
<td>attendance at general Coalition meetings</td>
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<td>18) By 5/31/05: 1) to implement in all city prenatal clinics for at least 85% of pregnant clients the substance abuse screening/assessment tool developed at the Children’s Research Triangle as part of a comprehensive instrument which also screens for perinatal depression.</td>
<td>Risk Reduction Activities Coordinator. And Risk Reduction Case Management (was Alcove as subcontractor, SNJPC hired RR CM in 2004 when Alcove closed as an agency).</td>
<td>Risk Reduction Activities Coordinator oversees implementation of CHS screening, which includes substance abuse. Risk Reduction Specialists participate in ongoing inservices/trainings around client engagement/retention. Utilize Substance Abuse Committee/Leadership Team to address system issues, network with treatment providers to facilitate access. HMHBC/SNJPC continue to seek other funds like CDBG grant to support strategies.</td>
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<td>19) By 5/05 link 95% of pregnant women at risk of delivering a drug exposed infant</td>
<td>Risk Reduction Case Management</td>
<td>Risk Reduction Specialists participate in ongoing inservices/trainings</td>
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V. Project Impact

A. Systems of Care

1. Approaches to Enhance Collaboration

SNJPC’s organizational mandate for 20 years has been to improve perinatal outcomes through the collaborative efforts of hospitals, public health agencies, professionals, and consumers. By identifying problems and creating solutions to meet the needs of mothers and infants, SNJPC’s regional collaborative approach has led to cost-effective delivery of perinatal services. SNJPC has historically provided staff support to HMHB Coalition and county-based MCH coalitions, securing funding for many new services in the project area and throughout the region through Title V funding, foundations and other sources.

Formal and informal partnerships in the project area are, therefore, the driving force of the Camden Healthy Start initiative. SNJPC established subcontracts with hospitals and community-based agencies to provide core Healthy Start case management and education services. SNJPC also initiated the development of provider agreements between case management providers and prenatal providers to facilitate confidential communication about case managed clients. Healthy Start services and educational activities are carried out in collaboration with and on the premises of community-based organizations such as OEO, housing developments, community centers, schools and churches. In addition to direct service provision, community stakeholders, agency staff and hospital staff are also engaged in HMHB Coalition committees, which meet at least every other month and the FIMR process.

Collaboration is the primary strategy used by CHS staff to develop, implement, modify and enhance interventions. The project’s success has been built on a foundation of relationships with stakeholders in the project area.

2. Structured Changes and System Integration

Prenatal providers are not reimbursed with Healthy Start funds but are important collaborators in identifying women at risk. A two-page Healthy Start Screening and Referral Tool was developed with input from all of the prenatal providers in the project area.
area and is used with all pregnant women who access care in all (5) Camden prenatal clinics. This tool was implemented at the outset of the project period to assess all pregnant women for their risk of substance use, domestic violence and perinatal depression and to determine which women would be referred for CHS case management services. The tool is completed by clinic staff (nurses or social workers) at entry to care, 28 weeks gestation and at the postpartum visit. This tool has provided a uniform method of risk assessment and referral for services and has served to improve communication regarding client needs and coordination of client services in the city. In addition to a uniform screening mechanism, CHS has developed guidelines for case management services to assure consistency and quality in service delivery among agency case management staff and sub-contracted case-management providers.

3. **Key Relationships**

As previously mentioned, the five providers of public prenatal care in Camden have been active and committed consortium members as well as voluntary and consistent partners in the management of the CHS case management intervention. Quarterly prenatal provider meetings facilitated by CHS staff have also enhanced their relationships with each other. Two of the prenatal providers are subcontractors who provide case specialty case management services. In this role, they must provide case management to pregnant women who receive prenatal care at other prenatal sites. This system of services has also enhanced the relationships between providers in the project area. Other key social service providers and community-based agencies have also come to the table at CHS committee and consortium meetings and events to work together to improve the lives of Camden residents. They have provided forums to rally support for better housing, promote the role of fatherhood, and to educate the community and providers on health care issues that affect child-bearing families. The specifics of these events are described in other sections of this document.

Relationships with community leaders developed as they became engaged in project activities. The Coalition has several members from Camden City government, and the current Mayor of Camden City is a long time supporter of the Coalition, participated in the Fatherhood event, and is in the HMHB video as a member of the Executive Committee. CHS/HMHB recognized that support from a variety of community leaders was necessary to support consortium goals and was successful in engaging agency representatives for specific events and activities and to chair consortium committees. However, consortium building has been an ongoing process with many challenges. Consortium membership and participation by consumers continues to be affected by life changes of members such as changes in employment and increased family responsibilities.

4. **Impact on the Comprehensiveness of Services**

Eligibility has not been changed for state and federally funded health and social services as a result of CHS activities. Intake procedures have been changed at the prenatal sites to include the use of a uniform screening and referral tool.
Barriers to substance abuse treatment and mental health services have been addressed, improved and continue to be a focus of CHS committees. Service utilization and awareness of community resources by CHS clients have also improved as a result of case management interventions and advocacy and education provided by case managers and health educators.

As mentioned above and described in the Project Implementation section, care coordination mechanisms have been established for case management services and have been critical to the success of this intervention. Care coordination between Healthy Start case management and health educators has been addressed through the establishment of routine and required referral processes. Coordination with other non-Healthy Start case management services has also been key for case managers and clients. As an example, TANF clients are able to fulfill their work requirement by attending a program sponsored by the Board of Social Services. This program assigns case managers to follow clients at home to assure their compliance with the program, yet does not provide follow-up of medical needs or health education services. Ongoing collaboration and coordination at the program level and at the client level are necessary to assure that services are not duplicated and clients are not confused or overwhelmed by “helping” services.

Quality assurance mechanisms have also been put in place at the provider level and the client level. Providers receive quarterly site visits for a random review of prenatal records to monitor screening and referral practices. This record review also offers an opportunity to review case management documentation that is sent to providers so that feedback can be incorporated into the quality assurance review of case management services. The web-based documentation system developed for case managers also enables supervisors and management staff to routinely monitor case manager performance and compliance with guidelines. Reports are generated by case manager, by intervention and at the program level to facilitate supervision and to assure that project objectives are being met.

Client records are, as described above, maintained electronically. The web-based client record system allows for internal sharing of client records at the supervisory level. In order to access/share client information with providers, provider agreements have been established between case management providers and prenatal providers. These agreements honor HIPAA requirements yet allow for record review and shared communication in a timely, unduplicated and confidential manner.

Coalition members with formal subcontracts to provide case management or education services to Healthy Start clients participate in quarterly, scheduled site visits with Healthy Start management staff. At these sessions, program data is reviewed and problems identified by project staff and by subcontractors are discussed. A plan to address problems is developed and system or client issues that need coalition resolution are forwarded to HMHB Coalition committees. Other opportunities for collection and dissemination of information related to lessons learned are scheduled with prenatal providers. While providers do not receive Healthy Start funding, they have signed provider agreements with Healthy Start case management providers. Provider meetings are hosted quarterly by Healthy Start staff to discuss issues and lessons learned related to screening, referral and follow-up of Healthy Start clients. In addition, a Healthy Start
staff member visits each prenatal site quarterly to conduct quality assurance review of screening tool use and consistency of case manager documentation of follow-up with referred clients. QA data is reported back to the provider and strategies are developed to improve the process between providers and case managers.

B. Impact to the Community

1. Resident’s Knowledge of Resources and How to Access

As discussed under section II, Project Implementation, D – Consortium; during the first three years of this funding cycle each HMHB Coalition meeting and Neighborhood Advisory Boards’ meetings focused on updating consortium members with the latest information pertinent to maternal and child health. HMHB Coalition events integrate health education and health promotion in community engaging activities. These activities always included information about community resources and how to access them. CHS staff participated in community events such as health fairs where information was shared with residents about CHS services and other resources and how to access these. Distribution of CHS literature which describes CHS services (i.e. Camden Healthy Start…Camden City’s Connection to Good Health) is distributed via consortium members, other partner organizations and CHS staff during neighborhood outreach. As a component of the CHS Client Satisfaction Surveys conducted by a student from Rutgers University clients were asked how being a part of the program impacted their knowledge of health resources for them and their children. 82.8% agreed that they knew more about the resources for health care in their community because of the CHS services.

2. Consumer Participation in Establishing/Changing Standards/Policies of Participating Service Providers

School and community-based focus groups of at risk youth were conducted by the subcontracted CHS Reproductive Health Educator in 2001 to further determine the unique psychosocial barriers to reproductive health of this population. This information was shared with providers who serve on the HMHB Adolescent Committee. These providers utilize this information by addressing these concerns as part of their services. Also this information was utilized in developing the CHS curriculum “It’s a Family Thing” for at risk youth. The Reproductive Health Educator also participated in conducting a survey of students from middle school through high school concerning their perceptions on adolescent concerns and community resource barriers as part of the preparations for an adolescent forum for school district staff, “Being A Better Bridge for Adolescents and the Services They Need” held in December 2001 by the HMHB Adolescent Committee. A similar survey was conducted with school district staff to see if and how perceptions differed between adolescents and adults. Results were reported during the forum. Forum participants took this information back to their respective schools and agencies to help them plan ways to improve their services to youth.

Work of the HMHB Substance Abuse Committee engages different consumer stakeholder categories, including clients, when developing advocacy plans and other committee activities. This committee includes substance abuse treatment providers and
prevention program providers, social services providers, CCDHHS representatives, NJ Work First representative, DYFS manager, mental health/behavioral health providers, and consumer stakeholders from the city’s drug court and school district representatives. The committee’s also has special task forces that involve categories of consumers, including a DYFS Work Group to handle relevant problem solving, a Care Coordination Group which is multidisciplinary/multi-agency and a Leadership Team, which has participated with Dr. Chasnoff’s Leadership Institute.

As previously noted during the beginning half of this four-year phase residents from neighborhoods that corresponded with the four neighborhood-based HMHB Outreach Teams participated on the HMHB Neighborhood Advisory Boards that were open to any interested stakeholder, including providers. The NABs gave input into planning of outreach strategies and consortium events, and helped to identify system barriers that the HMHB Community Network Committee should address in its advocacy work.

The HMHB Coalition had formal linkage with The Camden Learning Collaborative and its Coordinating Council in the form of a "compact agreement" which specifies the collaboration between the two consortia. The Camden Learning Collaborative consists of neighborhood-based consumer organizations. HMHBC co-located its Outreach services with the Camden Learning Collaborative, and shared two office sites. Co-sponsorship of community events, special projects such as the education of residents about the importance of participation in the Census and in elections, were part of this collaboration, which maximized the community organization and community development efforts of both organizations. Reduction of funding for The Camden Learning Collaborative and the eventual attendance decline of the NABs changed the formal linkage to one more informal, but this collaboration continues.

Annual HMHBC Membership Satisfaction surveys are conducted and reported on in the annual reports. Survey results are used to assure improvement in education, orientation, training and overall operation of the consortium. The survey also addresses consumer satisfaction with partnership and opportunity for leadership.

The CHS intervention for the Undocumented Immigrant Population, Una Nueva Esperanza (a title selected by the clients) engages these consumers in planning culturally appropriate group activities, education and mutual support since its inception in 2004.

3. Community Experience Working with Conflict Resolution, Team Building

Camden social and healthcare providers have a history of partnerships and collaboration. Camden is a relatively small city which may help in developing partnerships. Most funding streams require that organizations collaborate with each other and this further facilitates conflict resolution, team building and partnerships. Camden’s neighborhood organizations and CBO’s have also been an integral part of these collaborations. The HMHB Coalition conducted shared visioning retreats during its initial phase funding for Healthy Start. During this second Healthy Start funding cycle the Coalition conducted a series of teambuilding trainings cited under the Consortium section of this report, which
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included conflict resolution, dealing with difference, group process and collaboration – conducted by Horner Associates. Consortium committees make decision through consensus.

4. Creation of Jobs Within the Community
SNJPC, the grantee, has been committed to hiring Camden City residents especially as case managers and health care advocates. And SNJPC has encouraged subcontractors to do the same. The majority of the HMHB Outreach Program staff are from Camden and many of the subcontracted positions have been filled by individuals who are from Camden. The HMHB Coalition and its HMHB/CHS staff have participated in community training programs for paraprofessionals (i.e. the Community Health Workers Project) by being topic presenters, sitting on advisory boards and overseeing field placement of trainees. SNJPC has hired some of these trainees upon their completion of these programs.

Impact on the State

As has been stated above the 4P’s plus screening tool, piloted and implemented in Camden Healthy Start partner clinics, has been adopted by the state and in all regional Maternal and Child Health Consortia statewide. This success has increased the level of attention women at risk of substance use during their pregnancy statewide.

New Jersey’s DHSS is also a Healthy Start Grantee for the city of East Orange and as a result of the successes CHS has had in developing effective management systems it selected SNJPC as their local evaluator. This partnership has facilitated important discussions about strategies to have great impact on communities and systems in two cities in NJ in great need of coordination in their efforts to support the health and well being of mothers and children.

D. Local Government Role

E. Lessons Learned

1. Case Management/Outreach
   a. Establishing guidelines for all clients and monitoring them through direct supervision and data management is key to standardization of care. See documents in Appendix C.

   b. Subcontracted case management must be co-managed by the grantee to ensure project goals are monitored and deficiencies related to them are addressed.

   c. Program must use information collected in case management to identify areas of need in the community and adjust the program to fill gaps in services.

   d. Combining case management and outreach, while efficient in some respects, can dilute the effectiveness of each intervention.
e. While case managers and community health workers have an important voice in the shaping of program structure, committees and administrative duties must be minimized in order for them to focus on client care.

f. Collaborating with new and existing programs in our service area strengthens the efforts of all programs and simplifies services for clients.

2. Coalition
   a. The development of the coalition requires the dedication of a full time development professional.
   b. Consumer participation requires several levels of outreach and support to engage recipients of service and community stakeholders in project goals.

3. Data management
   a. Centralized data systems that are easily accessible to project staff improve the information available to the project for analysis and reporting.
   b. All components of the project must be included in like data initiatives to ensure quality and consistency. As a result of keeping health education data in separate data systems developed by different programmers there is not reliable information about the health education interventions in this phase. The centralized data system is being updated to include these interventions at the beginning of Phase III and reporting is expected to improve.

VI. Local Evaluation

Health Education – Impact Report
Conducted by Health Visions

Evaluation of the Health Education components consisted of 1) review of the Minimum Data Set for Health Education clients, 2) analysis of the Reduce Stress for Babies Best Program, 3) analysis of the Board of Education curriculum, and 4) review of the initial collection of Client Satisfaction Surveys which were later supplemented by telephone surveys conducted by staff at the Southern NJ Perinatal Cooperative.

1. Minimum Data Set and Health Education Clients

A total of one hundred eight (108) clients who were served by one of the health education programs (Reduce Stress for Baby’s Best or the Board of Education) were also case managed.
Education
Almost 30 percent have more than a ninth grade education yet no high school diploma, 26 percent have a high school diploma or GED, 17 percent did not respond to this question, nine percent have less than a 9th grade education, nine percent have some college, seven percent have 9th grade education, and two percent have college degrees.

Of the 28 clients who have more than a 9th grade education but no high school diploma or GED, eight (28.5%) are 18 years old or younger.

Age
The sample of those who were served by a health education program and were also case managed ranged in age from 15 to 43 and the mean age was 24 years old.

Impairments
Fifteen women in the sample (14 percent) have some form of impairment including hearing impairments, visual impairments, learning impairments, or physical impairments.

Income
Most (83 percent) did not provide their annual income. Seven percent had no annual income, four percent had annual incomes that fell between $1 - $5,000, five percent had annual incomes that fell between $5,001 - $10,000 and less than one percent had annual incomes that fell between $10,001 - $15,000.

Medical Insurance and Health Information
Almost seven percent of the women (6.5 percent) did not have health insurance. Almost 44 percent (43.5 percent) go to a clinic when they are sick, 17 percent go to a private doctor, 16 percent go to an emergency room, 14 percent did not respond to this question, seven percent do not go anywhere when they are sick, and three percent go to an alternative provider when they are sick. Of the seven women who do not have insurance, six go to an emergency room when they are sick and one does not go anywhere when she is sick.

Contraception and Sexually Transmitted Diseases
Forty-five percent of the sample is not using any means of contraception, 14 percent did not respond to this question, 12 percent are using condoms, seven percent are using an injectable form of birth control, six percent are using birth control pills, six percent are using birth control pills and condoms, and the remaining 10 percent are using another form of birth control or a combination of various forms.
Forty-four percent of the sample has had at least one STD and 14 percent of the sample did not answer this question. Twelve percent currently have an STD and 19 percent did not respond to this question.

Drug and Tobacco Use
Sixteen women (15 percent) currently use an illegal substance (cocaine, marijuana, methadone, opiates). Almost 19 percent (18.5 percent) currently use tobacco. Thirteen percent did not respond to this question.

2. Reduce Stress for Baby’s Best

Enrollment
During the four-year project period two hundred eighty-seven (287) clients were enrolled in the Reduce Stress for Baby’s Best program. Twenty-three clients were enrolled in the first year, 84 clients were enrolled in the second year, 79 clients were enrolled in the third year, and 101 clients were enrolled in the fourth year.

Of the clients enrolled, most (64 percent) were African American, 12.5 percent were Caucasian, and the remaining 23.5 percent were of another race or refused to answer the question. Twenty-five percent reported being Hispanic. Of those who reported being Hispanic, most (94 percent) reported being Puerto Rican. The remaining six percent reported being Mexican, Central or South American, or of another Hispanic origin.

Of the clients enrolled, 32 percent were 20 years old or younger, 28 percent were between the ages of 21 and 25, 21 percent were between the ages of 26 and 30, ten percent were between the ages of 31 and 35, seven percent were between the ages of 36 and 40, and two percent were over the age of 40. The youngest client was 14 years old and the oldest client was 45 years old.
Program Completion

Two hundred twenty-six clients completed the program over the four-year period. Nine clients successfully completed the program in the first year, 66 clients successfully completed the program in the second year, 67 clients successfully completed the program in the third year, and 84 clients successful completed the program in the fourth year. A client successfully completes the program after participating in three group or individual sessions. Before starting the program the client completes a Perceived Stress Scale, which measures the client’s perception of her stress level. The client also completes this scale at the conclusion of the third session.

The number of clients completing the program increased each year. In the first year 39 percent of clients enrolled completed the program. In the second year, 79 percent of clients enrolled completed the program. In the third year, 85 percent of clients enrolled completed the program. In the fourth year, 83 percent of clients enrolled completed the program.\(^1\)

The majority (62 percent) of those who completed the program participated in three group sessions. Twenty-four percent of those who completed the program participated in three one-on-

\(^1\) Two clients were awaiting their third session at the end of the project period.
one sessions. Thirteen percent who completed the program participated in a combination of
group and one-on-one sessions. The sessions took place in approximately 23 locations
throughout Camden City.

Of those completing the program, most (72 percent) were not substance abusers.

Prenatal care
There is data regarding prenatal care for seventy percent of the women. The majority (84
percent) of those clients reported receiving prenatal care in the first trimester. Seven clients did
not or have not sought prenatal care.

Of the seven women who did not have prenatal care, 43 percent did not complete all three
sessions of the program. All spoke English. Three women were in their first trimester, three
women were in their second trimester, and one woman did not indicate how many months she
was pregnant. Four of the women were African American, two women were Puerto Rican, and
one woman was Caucasian. All of the women who did not receive prenatal care were also
substance abusers.

Outcome of pregnancy
There is data for the births of 71 clients. Sixty-two babies (87 percent) weighted five pounds or
more. Six percent of the babies weighed between four pounds one once and four pounds nine
ounces. Seven percent weighed less than four pounds. Of the five women who gave birth to
babies weighing less than four pounds, three were substance users. All five women completed
the program.

Follow-up Surveys

Six-month follow-up
Seventy-seven clients took six-month follow-up surveys. These clients ranged in age from 14 to
37. Eighty-four percent completed all three sessions, two clients (3 percent) did not complete all
three sessions, and 13 percent did not answer the question. Nineteen percent reported that a
health professional told them that their baby was born too early. Over half (58 percent)
participated in group sessions, 32 percent participated in individual sessions, and 10 percent
participated in individual and group sessions. Of the twelve women who were told their babies
were born too early, nine (75 percent) participated in group sessions, one (8 percent) participated
in individual sessions, and two (17 percent) did not respond to this question.

Most (85.5%) used the deep breathing techniques on their own before they delivered their baby,
46 percent meditated on their own before they delivered their baby, 35 percent used visualization
on their own before they delivered their baby, 33 percent used journal writing on their own
before they delivered their baby, and 29 percent used progressive muscle relaxation techniques
on their own before they delivered their baby.
Fifty-nine clients provided additional comments on their six-month follow-up. Some of these comments include the following:

- The program provided me with techniques that helped me reduce stress (11 women)
- The program helped me cope with different situations (7 women)
- The deep breathing helped me think before relaxing (3 women)
- I thought I would “kill myself” before the class but the class helped me deal
- I was going to abort but the program helped me through pain and stress
- Continues to use even now when she is not pregnant

Twelve-month follow-up
Sixteen clients took twelve-month follow-up surveys. They ranged in age from 18 to 36.

Most (71 percent) used the deep breathing techniques on their own before they delivered their baby, 29 percent meditated on their own before they delivered their baby, 18 percent used visualization on their own before they delivered their baby, 59 percent used journal writing on their own before they delivered their baby, and 6 percent used progressive muscle relaxation techniques on their own before they delivered their baby. One client was pregnant and receiving prenatal care at the time of the twelve-month follow-up survey.

Eighteen and twenty-four month follow-up
Only one client took an 18-month follow-up survey. This client used deep breathing, visualization techniques, and meditation before she delivered her baby, but did not write in a journal or use the progressive muscle relaxation techniques. This client reports that the stress reduction techniques help her be patient with her daughter.

One client took the 24-month follow-up survey. This client used deep breathing, and meditation before she delivered her baby, but did not write in a journal, use visualization techniques, or use progressive muscle relaxation techniques. This client was pregnant and receiving prenatal care at the 24-month follow-up.

RSFBB Client Satisfaction Surveys

The majority (74 percent) strongly agreed that the location of the sessions was convenient, and 26 percent agreed that the location of the sessions was convenient. Only one client did not think the location of the sessions was convenient.

The majority (62 percent) of clients strongly agreed that the program taught them how to recognize sources of stress, and 37 percent agreed that the program taught them how to recognize sources of stress. Only one client felt that the program did not help her recognize sources of stress.
Almost half (46 percent) of the client strongly agreed that the program helped them better respond to stressful situations, and slightly less than half (48.5 percent) of clients agreed that the program helped them better respond to stressful situations. Seven clients (5 percent) did not feel the program met that objective. The vast majority (83 percent) of clients strongly agreed that the program taught them how stress can affect an unborn child, and 15 percent of clients strongly agreed that the program taught them how stress can affect an unborn child. Two participants (1.5 percent) did not feel that the program met this objective.

Forty percent of clients strongly agreed that the stress management handbook was helpful, and 58 percent of clients strongly agreed that the stress management handbook was helpful. Only two clients disagreed that the stress management handbook was helpful. All clients strongly agreed or agreed that the handouts on relaxation techniques were helpful.

Sixty-seven percent of clients strongly agreed that the guided imagery and meditation breathing tape was useful, 32 percent of clients agreed that the guided imagery and meditation breathing tape was useful. Only one client did not find the guided imagery and meditation breathing tape to be useful.

Sixty-three percent of clients strongly agreed that the prenatal literature was helpful, and 36 percent agreed that the prenatal literature was helpful. Only one client did not find the prenatal literature to be helpful.

All clients agreed or strongly agreed that the instructor was able to answer their questions, were well-prepared and demonstrated knowledge of stress reduction techniques. All clients would recommend the program to a friend. Seventeen clients recommended suggestions for the program. Seven clients recommended more sessions. The other clients suggested the following: end sessions before 3 p.m. for those with children, allow more time for physical activity, provide floor mats so clients are more comfortable, help with transportation, have a session after the birth of the child, and have longer sessions.

Results of Perceived Stress Scales

The Perceived Stress Scale (PSS) is the most widely used psychological instrument for measuring the perception of stress.² It is a measure of the degree to which situations in one’s life are appraised as stressful. The PSS ask the respondent about feelings and thoughts that they had during the last month.

Overall Evaluation

A total of 55 clients being served by the Reduce Stress for Baby’s Best Program completed a PSS prior to beginning the program, at the conclusion of the three-session program, and six months after completion of the program. The highest mean score was at the pre test (24.69),

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followed by the post test (19.87). There was little difference between the post and the six-month score (18.51). This sample can be compared to the national norms of the instrument. The average score for women on this measure is 13.7. Therefore clients of the Reduce Stress for Baby’s Best program had significantly higher stress scores compared to the national norms. However, there is a clear downward trend on the stress scores from the pre, post to six month follow ups and this trend is significant (F= 24.06, df = 2, p<.000). There is a significant difference between the pre and post tests, but not a significant difference between the post and six month follow up.

So the women reported significantly lower stress scores after the program than before it. The difference between the post test and the six-month follow up was not significant. So stress levels were about the same six months later than they were after the program. This can be interpreted as showing that the program had some lasting impact on reducing stress levels. Only 16 clients completed a PSS at the twelve-month follow-up. There is a continued downward trend in PSS scores but not a significant difference between the post score and twelve-month follow up score.

Clients Only Served by Reduce Stress for Baby’s Best compared to Clients also Case Managed by Other Healthy Start Programs?

Is there a difference is stress levels between clients only served by Reduce Stress for Baby’s Best compared to clients also cased managed by other Healthy Start programs? Data indicate that clients also case managed by other Healthy Start programs (n=112) have significantly higher stress scores compared to clients only served by Reduce Stress for Baby’s Best (n=136). The mean pre test scores for clients only served by Reduce Stress for Baby’s Best was 21.82 while the mean pre test score for clients also case managed was 24.16. This difference was statistically significant (T = -3.05, df, 246, p<.002 two tailed t-test). The difference remains at the post test as the mean post test score for clients only served by Reduce Stress for Baby’s Best was 17.87, while the mean pre test score for clients also case managed was 19.20. However, this difference is no longer statistically significant (T= -1.42, df=103; p<.158). Repeated measures analysis shows the same general conclusion. There is also a difference of scores between case managed and non case managed clients at the six-month follow-up PSS, with non case managed clients receiving higher scores. Case managed clients had a mean score of 18.03, while non-case managed clients had a mean score of 19.04 at the six-month follow-up. However, this difference is not significant so we do not see an overall effect for case managed versus non-case managed clients at six-month follow-up.
Substance Using versus Non Substance Using Clients

Substance using clients had a significantly higher pre stress score (n=67) compared to non substance using clients but this significant difference disappears at the post PSS (n=57). There is also a difference of scores between substance using (n=20) and non-substance using clients (n=34) at the six-month follow-up PSS. Non-substance using clients had a mean PSS score of 18.94 while substance using clients had a mean score of 18.05 at the six-month follow-up. However, this difference is not significant so we do not see an overall effect for substance using versus non-substance using clients at six-month follow-up.

3. Board of Education

Seventy-eight women participated in the Board of Education program. Fifty (64 percent) were pregnant, twenty-two (28 percent) were parenting and six (8 percent) were high-risk pregnancies.
Seventy-eight percent of the clients were African American, 15 percent either declined to answer or were of another race, and seven percent were White. Forty-one percent self-identified as Hispanic.

Records were entered in the Microsoft Access database for one woman in program in 2002, records were entered in the Microsoft Access database for 13 women in 2003, records were entered in the Microsoft Access database for 34 women in 2004, and records were entered in the Microsoft Access database for 10 women in 2005.

A total of 23 sessions were held between October 2003 and May 2005.

The following sessions were held during this period:
- Contraception and Birth Control Education (six sessions with 25 total participants)
- Female Reproductive System (three sessions with 11 total participants)
- Menstruation Cycle (three sessions with 10 total participants)
- Sexually Transmitted Infections (two sessions with 11 total participants)
- Male Reproductive System (two sessions with 11 total participants)
- Effects of Drugs and Alcohol on Self and Fetus (two sessions with 14 total participants)
- Sexuality and Self-Esteem (two sessions with 11 total participants)
- Effects on Self-Esteem (one session with seven total participants)
- Decision Making and Conflict Resolution (one session with seven total participants)
- Pregnancy and Neo Natal Development (one session with five total participants)

Clients participated in an average of two sessions. Twenty-eight clients participated in one session while seven participated in four or five sessions.

Pre and post tests were administered at each session. A total of 111 pre tests were administered and 103 post tests were administered. On average, post test scores improved by 43.5 points.

**Client Satisfaction Surveys**

**Strategy 1**

CHS attempted to standardize the client satisfaction survey process in year 2 and developed a tool that was distributed by case managers to clients. The expectation was that these would be completed every 6 months throughout a client’s service, however
results were not reliable and many clients were unsurveyed. Below are the results of the surveys received in that process.

Sixty-nine clients completed client satisfaction surveys. Almost half (49 percent) of respondents were African American, 47 percent were Latino, two percent were White and three percent were of another race/ethnicity. Twelve percent of the respondents were between the ages of 14 and 17, 13 percent of the respondents were between the ages of 18 and 20, 49 percent of the respondents were between the ages of 21 and 29, 24 percent of the respondents were between the ages of 30 and 39, and two percent of the respondents were between the ages of 40 and 49.

The majority (66 percent) found out about Healthy Start from a clinic. Twenty-two percent found out about Healthy Start from a friend, neighbor or relative, nine percent found out about Healthy Start from another source, two percent found out about Healthy Start from a hospital, and two percent found out about Healthy Start from a community group.

All clients felt that the case worker or staff was helpful, respectful, and conducted visit(s) in a way that respected their culture or background. All clients would tell a friend about Healthy Start.

The vast majority (85 percent) made positive changes in their lives as a result of Healthy Start. Eleven clients (16 percent) reflected that something stopped them or made it harder for them to get services or help. Seven clients (10 percent) had problems getting services or help because of transportation. Two clients (2 percent) had problems getting services or help because they did not have insurance. One client (1 percent) had problems getting services or help because of childcare.

**Strategy 2**

As a result of the limited success of the initial survey process CHS determined in year 4 that an outsider survey would likely yield more honest and complete information. As a result an intern was employed to conduct phone and in person interviews with 10% of the active caseload in order to get a representative sense of how the program was received and gain some perspective on future initiatives. The following is the analysis of this successful initiative.

During a three week period in July 2005, client satisfaction surveys were conducted by Healthy Mothers Healthy Babies. 61 clients completed surveys, totaling 10% of the client population. 51 of the clients interviewed were randomly selected for participation in the survey. Their surveys were administered via telephone (N=40) or home visitation (N=11). 10 clients were interviewed on-site at Healthy Mothers Healthy Babies groups. 56 clients were verbally interviewed in their preferred language, either English or Spanish. 5 surveys were self-administered by clients during a group. The survey instrument contained a combination of close-ended and open-ended questions and took about 20-25 minutes for a client to complete. It was expanded from an earlier version of a
client satisfaction survey, which 69 clients self-administered during Phase II of the Camden Healthy Start project.

When commenting on their overall experience with Healthy Mothers Healthy Babies, the overwhelming majority of survey respondents had positive things to say. Many women mentioned that Healthy Mothers Healthy Babies helps in general, or in “every way possible”. 93.4% of respondents agreed that working with Healthy Mothers Healthy Babies helps them to be good mothers. 80.4% of respondents agreed that Healthy Mothers Healthy Babies helped them to address the most important issues in their lives, or the ones they needed the most help with. Important to respondents were specific baby items provided by Healthy Mothers Healthy Babies, such as infant formula, baby cereal, diapers, clothing, or other equipment. Most respondents primarily identified Healthy Mothers Healthy Babies with their case manager, and highlighted the ways in which she helped, such as with parenting skills, checking up on their babies, offering advice, being like a “friend”, “companion”, or “family member”, and referrals to other service providers. Services respondents reported to have been linked with included housing, school, welfare, insurance, health care providers, and transportation. Respondents also mentioned Healthy Mothers Healthy Babies groups, events, and classes.

Case management services are at the heart of the Healthy Mothers Healthy Babies program. Many women expressed that the type of case management offered by Healthy Mothers Healthy Babies is unparalleled. Aspects of this case management discussed by respondents include advice or counseling, the case manager doing home visits, and the case manager being genuinely concerned about her clients’ well-being. Respondents suggested that Healthy Mothers Healthy Babies case management services are important because they are tailored to mothers’ individual needs. All survey respondents agreed their case manager had been friendly; 98.3% agreed their case manager had been respectful of their culture and background; and 93.1% of respondents agreed their case manager had been helpful. All survey respondents agreed that their case manager was easy to talk to. 82.8% agreed that they knew more about the resources for health care in their community because of the Healthy Mothers Healthy Babies services. 75.9% agreed that they’d changed how they care for themselves and/or their babies because of their case manager. 98.4% of respondents agreed they would recommend Healthy Mothers Healthy Babies to a friend or relative who needs help.

The findings of this survey were similar to findings from the earlier survey (N=69). In that survey, all clients reported that their case worker or staff was helpful, respectful, and respected their culture and background. 85 percent of clients reported making positive changes in their lives. All clients reported that they would tell a friend about Healthy Mothers Healthy Babies.

VII. Fetal and Infant Mortality Review (FIMR)

SNJPC initiated a FIMR project, funded by ACOG, in 1993. The New Jersey Department of Health and Senior Services received ACOG funds and awarded a three year contract to

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3 Results only reported for applicable cases (N=58), which were those respondents who had seen a case manager.
SNJPC to develop a FIMR demonstration project for the State. Camden City was the first study area developed and now there are two other FIMR study areas in the seven county region served by SNJPC. One of these study areas, the Atlantic/Cape May FIMR study area, is supported with NJDHSS funds. Core funds from SNJPC currently support the continuation of FIMR in Camden and in another, tri-county, study area.

FIMR case review in Camden is limited to the review of fetal and infant deaths. Maternal deaths are reviewed by a statewide, multidisciplinary team and child deaths are reviewed by regional child death review teams. Representatives from SNJPC participate on both of these review teams. Initially, Camden FIMR included a maternal interview component, however, there are currently no sources of funding for this component. Input from Healthy Start case managers is included in the review process, but formal interviews are not conducted.

A modified two-tiered approach to the FIMR review process is conducted in Camden. The Community Review Team has had consistent participation, since 1993, from representatives of the hospitals, prenatal provider system, DYFS, SIDS program, public health nursing, WIC, substance abuse treatment, Healthy Start case management services and other essential community-based organizations. Issues and recommendations from this team are forwarded to Healthy Start committees, including the Healthy Start evaluation committee, for action at the community level.

The FIMR process in Camden has provided valuable information on health and social service system issues and barriers to care that affect pregnant women and infants in Camden, contributing to the development of new services and consortium activities funded by Healthy Start and other sources. It should also be noted that the FIMR case review process, which engages stakeholders in a discussion about the health care system and needs of pregnant women and their children, has resulted in institutional change. Team members report that they initiate changes in protocols and practices in their agencies as a result of case review team discussion.

Perhaps the most important accomplishment to date has been the development of case management services that target high risk pregnant women in the city of Camden. Case review has consistently demonstrated that women affected by drugs and alcohol, teens not in school, and women with multiple children and limited support systems do not seek or follow through with health care services. Healthy Start case management services in Camden are designed to address the needs of these high risk women to prevent poor birth outcomes.