NEW JERSEY DEPARTMENT OF HEALTH

Division of Family Health Services
Reproductive and Perinatal Health Services

Name of Grant: New Jersey's Healthy Women, Healthy Families
(Formerly known as Improving Pregnancy Outcomes Initiative)
Request for Applications (RFA)
Project Period: July 1, 2018-June 30, 2023

Budget Periods: July 1, 2018 – June 30, 2019
July 1, 2019 – June 30, 2020
July 1, 2020 – June 30, 2021
July 1, 2021 – June 30, 2022
July 1 2022 – June 30, 2023

Philip D. Murphy
Governor

Sheila Y. Oliver
Lt. Governor

Shereef M. Elnahal, MD, MBA
Commissioner

TABLE OF CONTENTS

PAGE

I. IMPORTANT DATES

REQUEST FOR APPLICATION RELEASE DATE:	April 23, 2018
APPLICATION OPEN DATE IN SAGE:	April 23, 2018
LETTER OF INTENT SUBMISSION DATE:	May 17, 2018
APPLICATION TECHNICAL ASSISTANCE MEETING	May 1, 2018
APPLICATION CLOSE DATE IN SAGE:	May 18, 2018
NOTIFICATION DATE:	June 15, 2018
ANTICIPATED START DATE:	July 1, 2018

II. EXECUTIVE SUMMARY

i. Eligible Applicants: 1) Agencies that can successfully implement maternal and child health programs that focus on health disparities in preconception, prenatal, and interconception care. These agencies should be able to implement referral and case management activities countywide. 2) Agencies that have successfully implemented or are able to implement community-based programs that focus on reducing black infant mortality in the following municipalities: Atlantic City, Camden, East Orange, Irvington, Jersey City, Newark, Paterson and Trenton.

ii. RFA Type: Grant Application

iii. Approximate Number of Awards: Up to twelve (12) awards. Awards vary by geographical region, proposed project structure, and activities. Please see Table 1 under Eligible Applicants for more details.

iv. Approximate Funding for state fiscal year (SFY) 2019: $4.3 million

v. Approximate funding per budget period: Approximate funding amount will vary by region, structure of the program, and activities of the program. See Table 1 under Eligible Applicants for funding ranges.

vi. Number of years of award: One-year funding with additional 4 yearly continuation based on agency performance of prior years and availability of funds.

III. INTRODUCTION AND BACKGROUND

The New Jersey Department of Health (NJDOH), Division of Family Health Services (FHS), Maternal and Child Health Services is announcing a competitive request for applications (RFA) to support the new Healthy Women, Healthy Families initiative (formerly known as the Improving Pregnancy Outcomes initiative) which is designed for community-based programs to improve and provide quality access to preconception, prenatal and interconception care for women and reduce health disparities in birth outcomes including black infant mortality. Healthy Women, Healthy Families will achieve this goal through collaborations, outreach, education, care coordination, and implementation of programs that have shown to be successful in reducing black infant mortality.

Given limited public health resources, funded programs will target activities to statewide areas of highest need with consideration for where the impact will be most significant, particularly in areas with significant health disparities and focus efforts toward high-risk women. High-risk women include women who are low-income and/or uninsured, women with chronic health conditions, women with multiple social or economic stressors, victims of domestic violence, individuals impacted by mental health issues, alcoholism and/or substance abuse, women with minimal social supports, women with unintended pregnancies, and women who experience any combination of these. These women on average attend fewer prenatal visits and are more likely to experience adverse pregnancy outcomes. Their families are more likely to be without a medical home, are less likely to access consistent, comprehensive preventive and primary care services, and are less likely receive quality care.

Improving maternal and infant health and reducing Black Infant Mortality is a priority within the NJDOH/FHS prevention agenda especially for those experiencing health disparities due to social, economic, environmental/contextual, and behavioral inequities. Key maternal and child health indicators (including low birth weight, preterm births, and infant and maternal mortality) have not improved significantly over the last decade in New Jersey, and significant racial and ethnic disparities persist.

Although the overall infant mortality rate in New Jersey is lower than the national rate (4.7 per 1,000 live births versus 5.9 per 1,000 live births in 2015), the disparity between White, non-Hispanic (NH), and Black, NH, is significant. In 2015, the infant mortality rate for White NH was 3.0 per 1,000 births, while for Black NH, the rate was 9.7 per 1,000 births. The infant mortality rate for Black, NH, is more than three times that of White, NH, and this disparity has remained constant for at least ten years.

Additionally, disparities exist between New Jersey counties and municipalities in terms of Black Infant Mortality rates and other health outcomes (see Appendix A for data). Counties such as Atlantic, Camden, Cumberland, Essex, Hudson, Mercer, and Passaic have Black Infant Mortality rates ranging from 6.5 per 1,000 births to 17.1 per 1,000 births. Further investigation within these counties showed that certain municipalities were really driving these high county rates and therefore efforts within these municipalities will be the main focus of this grant.

There are many potential causes of these disparities, but recent research has highlighted the effects of social determinants of health such as economic disadvantages (i.e., underemployment, or unemployment), limited education (e.g., low educational attainment), environmental barriers (e.g., housing instability, structural racism), and social/behavioral factors (e.g., nutrition and exercise) as major contributors to health outcomes.[1,2,3] Addressing these social determinants of health requires a comprehensive, system-level transformation that begins at the community level.

IV. GOAL/OBJECTIVES, PROGRAM STRUCTURE, ACTIVITIES, OUTCOMES

i. Goal and objectives

The goal of Healthy Women, Healthy Families is to improve maternal and infant health outcomes for women of childbearing age (as defined by CDC as 15-44 years of age) and their families, especially Black families, through a collaborative and coordinated community-driven approach. This will be done using a two-pronged approach: 1) county level activities that will focus on providing high-risk families and/or women of childbearing age access to resource information and referrals to local community services that promote child and family wellness and 2) Black Infant Mortality (BIM) municipality level activities that will focus on Black NH women of child-bearing age by facilitating community linkages and supports, implementing specific BIM programs, and providing education and outreach to health providers, social service providers and other community level stakeholders. The objectives of this RFA are to:

- Reduce health disparities in preconception, interconception, and prenatal care within the targeted community, especially those indicators that are closely linked with maternal mortality and infant mortality.
- Reduce health disparities in birth outcomes and black infant mortality within targeted communities.

ii. Proposed Project Structure

Grants will be awarded for 12 regions of the state. The level of funding for each region will be determined by the structure of the proposed project stipulated in this RFA and the expected activities. The following regions have been established for grant activities:

- Region 1: Atlantic County/Cape May County AND the municipality of Atlantic City
- Region 2: Bergen County
- Region 3: Hunterdon County/Mercer County AND the municipality of Trenton
- Region 4: Burlington County/Camden County AND the municipality of Camden
- Region 5: Essex County AND the municipalities of East Orange, Irvington and Newark
- Region 6: Middlesex County /Somerset County
- Region 7: Monmouth County/Ocean County
- Region 8: Morris County
- Region 9: Passaic County AND the municipality of Paterson
- Region 10: Salem County/Gloucester County/Cumberland County
- Region 11: Sussex County/Warren County
- Region 12: Union County/Hudson County AND the municipality of Jersey City

The proposed project in each region will have a core structure of Central Intake (CI), specifically a Referral Specialist(s), and Community Health Workers (CHWs) that operate countywide. Six regions (Regions 1, 3, 4, 5, 9, and 12) will also have CHWs that will operate at a municipality level, conducting BIM reduction activities. Central Intake will ONLY be countywide. This RFA will only fund Central Intake in the following counties that

are not funded by the Department of Children and Families (DCF): Essex, Middlesex, Somerset, Passaic, Salem, Gloucester, and Cumberland.

Because of the variation in each region's proposed project structure and activities, four pathways (A through D) were designed to give applicants the information needed for each region. These pathways are defined below in Table 1, under Section VI, on page 11.

iii. Proposed Project Activities

Project activities will depend on the region and proposed project structure and best reflect the need of the communities. County ONLY regions will engage in one set of activities. County regions that include a BIM municipality(ies) will conduct the core county activities as well as ALL BIM activities. Specific activities for "county only" regions and "county plus BIM municipality" regions are specified below.

a. Regions with only Counties

- Activity 1: Implementation of a Referral System through Central Intake

This RFA will fund counties that are not funded by DCF for Central Intake. This RFA defines Central Intake as a central location within a region where a referral specialist(s) will be available to refer and link women of child bearing age (15-44 years of age as defined by CDC) and caregivers of young children (0 to 5) to needed services within the region. The referral specialists will be required to work closely with the community health workers within their county and within the BIM municipalities that are part of that county, if applicable.

- Activity 2: Implementation of Case Management Services Through Community Health Workers

All grantees must utilize Community Health Workers (CHWs). The Health Resources and Services Administration (HRSA) describes CHWs as "lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve."[4] CHWs will be required to perform a combination of community outreach and education, home visits, case management, group activities/workshops, and community-based supportive services to provide a source of enhanced social support and create a bridge between under-served and hard-to-reach populations and formal providers of health, social and other community services. They will be trained on the availability of resources within the municipality, county, and the state and gain knowledge on how to navigate different service systems so that they can be a resource to the community they are serving. Additionally, CHWs will assist in promoting health insurance/Medicaid enrollment so that families in need are connected to these resources and case manage participants up to three (3) years from the time of enrollment or until the participant voluntarily terminates from the program. Case management will include, but not be limited to, providing ongoing follow-up and assessment of need. CHWs will be required to collect data on ALL the participants they

are serving and work closely with the referral specialist(s) within their region. Applicants should apply for a specific number of CHWs based on documented need and funding availability.

- Activity 3: Diverse Community Partnerships

Grantees must develop diverse community partnerships with non-traditional community-based providers/agencies with an interest in improving maternal and child health and mental health by being a resource in implementing project activities/interventions. At least 10% of the grantees' total budget must be subcontracted with community level organizations such as minority/multicultural/advocacy organizations, faith-based organizations, libraries, community centers, family planning agencies, and other community driven agencies. These partnerships are very critical and essential to enhance the resources available to carry out measurable success and create community support that is critical to vulnerable, high risk women and children. These community level partnerships should be formal and sustainable beyond the grant period.

- Activity 4: Diverse Community Advisory Boards

Grantees will be required to convene a diverse and inclusive community-based advisory board of individuals and partner agencies. The representation must include traditional and non-traditional partnerships of consumers, providers of services, community leaders, and organizations, including faith-based organizations, with a working interest in maternal and child health issues and can contribute to reduction in health disparities and related indicators. It is required that at least 25% of members are consumers of services to be rendered as stipulated in this RFA and who will be active participants in the decision making regarding the direction of the proposed project. The Advisory Board will meet at least quarterly to discuss significant issues including barriers to care identified by the participants and develop strategies to overcome these barriers at a community level. These meetings must be conducive to public participation and must be documented through taking minutes and electronically posting these minutes in an accessible way.

- Activity 5: Workforce Development

Grantees will be required to participate in all workforce development opportunities, including trainings by NJDOH and its regional, statewide, federal, and other partners. Grantees will be expected to partner with the One Stop Agencies to recruit staff for the proposed project as well as link with the Rutgers Health Care Talent Network (HCTN) or other institutions of higher education to assist in building workforce needs. All staff must be trained to perform the required job duties, especially new components such as case management of Healthy Women, Healthy Families participants.

- Activity 6: Data Collection and Evaluation

Grantees must create an evaluation plan that incorporates both process and outcome measures. The evaluation plan must include a LOGIC model and include both process and outcome measures in the form of inputs, activities, outputs, and short term/mid-term, and long-term outcomes (see Appendix B for a LOGIC model template). As part of their evaluation plan, grantees must also demonstrate that they have the capacity and ability to

collect data using tools and methods prescribed by NJDOH and enter this required data within a statewide system.

 Activity 7: Program Monitoring and Quality Improvement

Grantees must incorporate Quality Improvement (QI) activities to critically review the effectiveness of chosen strategies using a Plan-Do-Study-Act (PDSA) methodology (see Appendix C for information on this methodology). These QI activities should lead to adjustment of improvement strategies as needed to optimize their effectiveness. Grantees will be required to participate in NJDOH training and evaluation of these targeted initiatives.

b. Regions with Counties AND BIM Municipalities

Grantees applying in regions that include a BIM municipality will employ all activities listed above as well as the following additional activities:

 Activity 8: Implementation of BIM focused programs

Grantees (or their sub-grantees) must implement at least 2 BIM programs that are evidence-based and have shown to be successful in other states or communities to reduce black infant mortality and other disparities. These programs include:

- Group prenatal care such as "Centering" – which provides women with a supportive forum and a longer visit with their health provider and/or their staff.
- Doula program
- Fatherhood initiatives which involves fathers during prenatal and interconception care and promotes family engagement.
- Breastfeeding support groups for Black NH women.

Go to Appendix D for more specific information and strategies on implementing the proposed projects. Grantees must select one (1) program (Group Prenatal Care or Doula) and one (1) support group (Fatherhood support group or breastfeeding) from the list in Appendix D. If a BIM municipality already has a program/support group being implemented, applicants must indicate that in the application and explain how these funds will be used to enhance, change, expand, or renew these programs for maximum impact. This will be especially important for the four municipalities that currently have Healthy Start grants: Camden, Trenton, Newark, and Irvington. Healthy Start is a federal initiative that aims to reduce the rate of infant mortality and improve perinatal outcomes in areas with a high annual rate of infant mortality.

Grantees can implement these programs themselves or subcontract some or all services to other capable agencies. Grantees are encouraged to leverage their resources to collaborate with other community agencies such as family planning agencies for outreach, education, enrollment, and supports.

- Activity 9: Community Partnerships to Facilitate Community Supports and Address Community level, Structural Racism

Within the BIM municipality, Activity 3 will be expanded to include partnerships that specifically focus on creating community engagement and supports for Black NH women and their families. These partners must have an interest and the ability to improve Black NH maternal and child health and mental health and have an understanding of the link between health outcomes and community level, structural racism that exists within their communities. These partnerships must include non-traditional agencies such as minority/multicultural/advocacy organizations, faith-based organizations, libraries, community centers, family planning agencies, and other community driven agencies. At least 20% of the total budget must be subcontracted with these non-traditional partners. These partners must have the ability to create a supportive system for Black NH women and their families. These community level partnerships should be sustainable beyond the grant period.

- Activity 10: Provide Health Equity/Cultural Competence Training

Grantees must participate in all trainings offered by NJDOH and its sub-grantees, especially trainings that include information on health inequities and root causes of black infant mortality such institutional racism, neighborhood segregation, poverty and the impact of these stressors on health outcomes. In addition, grantees are required to educate local health care providers, service providers, and other stakeholders on cultural competent services and on available resources for high risk pregnant women. These trainings can be performed at an individual level or as part of a broader outreach.

iv. Specific measurable outcomes for the following project structures:

a. Programs that include Central Intake and Community Health Workers OR Community Health Workers Only Programs

The specific outcomes that need to be addressed by applicants include:

Preconception care

- Decrease prevalence of chronic diseases (diabetes, hypertension, asthma, and, obesity) for by 10% annually.
- Decrease the prevalence of sexually transmitted infections by 10% annually.
- Decrease the prevalence of substance use by 20% annually.
- Decrease the percentage of women who experience unintended pregnancies by 10% annually.

Pregnancy and Birth outcomes

- Increase the percentage of women who receive First Trimester prenatal care by 10% annually.
- Increase the percentage of women who receive adequate prenatal care by 10% annually.
- Decrease the percentage of women who deliver pre-term (less than 37 weeks) babies by 10% annually.

- Decrease the percentage of women who deliver low birth weight (less than 2500g) babies by 10% annually.

Interconception Care

- Increase the percentage of women who breastfeed exclusively for at least 3 months by 10% annually.
- Decrease the percentage of women who bedshare with their babies often by 5% annually.
- Decrease the percentage of women who do not put their babies to sleep on their backs by 10% annually.
- Increase the percentage of women who practice birth spacing of 18 months or more by 10% annually.

Long Term Outcome

- Increase healthy births.

b. BIM municipality programs

The specific outcomes that need to be addressed by all applicants include:

Preconception care

- Decrease prevalence of chronic diseases (diabetes, hypertension, asthma, and, obesity) for Black NH women by 10% annually.
- Decrease prevalence of sexually transmitted infections for Black NH women by 10% annually.
- Increase the percentage of Black NH women who receive treatment for a mental health problem by 10% annually.
- Decrease prevalence of substance use by Black NH women by 20% annually.
- Decrease prevalence of unintended pregnancies among Black NH women by 20% annually.

Pregnancy and Birth outcomes

- Increase the percentage of Black NH women who receive First Trimester prenatal care by 10% annually.
- Increase the percentage of Black NH women who receive adequate prenatal care by 10% annually.
- Decrease the percentage of Black NH women delivering pre-term (less than 37 weeks) babies by 10% annually.
- Decrease the percentage of Black NH women who deliver low-birth-weight (less than 2500g) babies by 10% annually.

Interconception Care

- Increase the percentage of Black NH women who breastfeed exclusively for at least 3 months by 10% annually.
- Decrease the percentage of Black NH women who bedshare with their babies often by 5% annually.

- Decrease the percentage of Black NH women who do not put their babies to sleep on their backs by 10% annually.
- Increase the percentage of Black, NH women who practice birth spacing of 18 months or more by 10% annually.

Long-term outcome

- Decrease Black infant mortality rates within the targeted communities.

V. TARGET POPULATIONS

The target populations for the county level activities include high-risk women of reproductive age (15-44 years of age as defined by CDC) and caregivers of young children (0-5). The target populations for the BIM Municipality activities are Black NH women of reproductive age who are pregnant, about to be pregnant or post pregnancy and Black NH caregivers of young children (0-5).

VI. ELIGIBLE APPLICANTS

There are four pathways to becoming a Healthy Women, Healthy Families grant recipient.

Table 1: Pathways for Applicants

	Pathway A	Pathway B	Pathway C	Pathway D
Structure	Central Intake (e.g. Referral Specialist) & Community Health Workers	Community Health Workers	Community Health Workers and BIM program	Central Intake (e.g., Referral Specialist), Community Health Worker, and BIM program
Eligible Regions	• Monmouth/Ocean • Bergen • Morris • Sussex/Warren	• Middlesex/Somerset • Salem/Gloucester/Cumberland	• Essex & East Orange City /Irvington/ Newark • Passaic & Paterson City	• Union/Hudson & Jersey City • Hunterdon/Mercer & Trenton • Burlington/Camden & Camden City • Atlantic/Cape May & Atlantic City
Activities	• Implementation of Referral Specialist • Implementation of Case Management Services for up to 3 years • Community Partnerships • Community Advisory Board • Workforce Development • Data Collection and Evaluation • Program Monitoring and QI	• Implementation of Case Management Services for up to 3 years • Community Partnerships • Community Advisory Board • Workforce Development • Data Collection and Evaluation, • Program Monitoring and QI	• Implementation of Case Management Services for up to 3 years • Community Partnerships • Community Advisory Board • Workforce Development • Data Collection and Evaluation, • Program Monitoring and QI • Implementation of BIM program (e.g., Doula) • Community Partnerships that focus on supports for Black NH women • Cultural Competence/Healthy Equity Training	• Implementation of Referral Specialist • Implementation of Case Management Services for up to 3 years • Community Partnerships • Community Advisory Board • Workforce Development • Data Collection and Evaluation, • Program Monitoring and QI • Implementation of BIM program (e.g., Doula) • Community Partnerships that focus on supports for Black NH women • Cultural Competence/Healthy Equity Training
% of Budget to Community Partners	10%	10%	20%	20%
Funding Ranges	75,000 to 350,000	250,000-300,000	400,000 to 1,000,000	350,000 to 600,000

Applicants can apply for multiple regions and as a result, multiple pathways. The pathways described above are dependent on the region, proposed project structure, and activities. Pathway

A includes regions where applicants must create a program that includes Central Intake and Community Health Workers. Pathway B includes regions that require applicants to create a project that includes Community Health Workers only. Pathway C includes regions that require an applicant to create a project that includes both county level and municipality level Community Health Workers and BIM projects (from Appendix C) and community supports for Black NH women/families. Pathway D regions require applicants to create a project that includes everything from Pathway C with the addition of Central Intake. For a visual depiction of the regions and pathways, go to Appendix D.

The selection for grant awards is a competitive process and is contingent on the potential grantee's ability to meet the following eligibility requirements:

- Agree with NJDOH Terms and Conditions for Administration of Grants
- Agree with conditions stated in this RFA.
- Have the capacity in terms of workforce and expertise and reach to implement this program.
- Eligible applicants include but are not limited to not-for-profit agencies, local health departments and other agencies that provide dedicated maternal and child health services and that meet the requirements of this RFA.
- All applications that meet the minimum requirements will undergo a review process, as described below.
- Any applicant that has been disbarred or is under suspension by the NJDOH or other governmental agency is not eligible.
- All information submitted with the application is subject to verification during the review by NJDOH staff.
- Verifications may include but are not limited to credentials of staff, progress reports submitted to funders, fiscal policies, procedural policies (including cultural competency policy) and procedures, etc. Submission of unverifiable information in this proposal may result in an agency not receiving any funds.

VII. PROJECT REQUIREMENTS

Infrastructure

Depending on the regions selected, applicants will structure their project according to the pathways described in Table 1, Section VI. Applicants may apply for multiple regions and hence use multiple pathways; however, all applicants must incorporate community health workers within their project structure.

In addition, applicants must demonstrate the ability to administer and oversee the program by:

- Recruiting, engaging, and supporting individuals as CHWs and train them appropriately.
- Facilitating participation in workforce development by all staff, including CHWs;

- Case managing participants up to 3 years or until participants voluntarily terminate from the project.
- Creating community level supports/partners that are funded, formal and informal and effective and sustainable.

Those applicants with Central Intake will be required to use the Single Point of Entry Client Tracking (SPECT) System to refer women and families to county and municipality level resources.

Implementation

The work plan, with timeline, should be included in the application. The work plan should address the specific objectives that are based on the measurable outcomes stipulated above as well as how each activity stipulated above will be incorporated effectively.

All grantees will provide screening, linkages, and follow-up to services that address inequities in a number of areas including the following (adapted from Healthy People 2020):

- Availability of resources to meet daily needs (safe housing and local food markets are examples)
- Access to education and job opportunities
- Access to appropriate health care services
- Quality education and job training
- Availability of community-based resources in support of community living and opportunities for recreational activities
- Transportation options
- Public safety, social support
- Management of stressful conditions, including stressors related to low socio-economic conditions.
- Access to culturally and linguistically appropriate educational materials that enhances health and mental health literacy.
- Access to mass media and emerging technology.

VIII. REQUIRED APPLICATION COMPONENTS AND INFORMATION

Needs Assessment

The applicant must provide a needs assessment as part of their application that includes the following information:

- Racial and ethnic distribution within the county or municipality of all people, women of child bearing age (age range 15 to 44), and all births.
- Any health disparities that may be present within the targeted areas and these should be based on the outcome measures named above.
- Specific census track that applicants will target within the municipality.

- Socio-economic characteristics of targeted regions, split by census tract.
- Anticipated case load for targeted region(s).
- Number of Community Health Workers anticipated for the targeted area(s).

Objectives

Objectives must be related to this RFA's outcomes and activities as stipulated in section IV above.

Organizational/Agency Capacity

Describe the organization's capacity and any current and proposed partners and collaborations. Letters of support from these organizations and agencies must be provided.

Methods

The methods must describe the activities and procedures to support the objectives. Applicants must provide a clear and concise description of methods that will be used to address each objective. A workplan with timelines for each proposed activity must be included.

Evaluation

The Healthy Women, Healthy Families initiative must have all components required by the NJDOH for evaluation measures for each method. Applicants must propose a plan for evaluating the project which must include both process and outcome measures and address Activity 6, Section iii above. A LOGIC model with inputs, outputs, activities, short-term, mid-term, and long-term outcomes must be included (see Appendix B for Template).

All grantees will be required to incorporate Quality Improvement (QI) activities to critically review the effectiveness of chosen strategies using a Plan-Do-Study-Act (PDSA) methodology. These QI activities should lead to adjustment of improvement strategies as needed to optimize their effectiveness. Additionally, grantees will be required to participate in NJDOH evaluation of the Healthy Women, Healthy Families initiative.

Budget and Justification

- The budget should be reasonable and appropriate based on the scope of work to be provided.
- The budget must include a justification for each budgeted line item.
- Indirect costs are an allowable expense. If indirect costs are requested, an indirect cost letter is required to be included in the application.
    - Allowable costs include personnel and fringe, personal protective equipment, sub-grants, educational materials, translation services, travel, in-state staff continuing education courses, in-state trainings, out-of-state staff continuing education courses, and computer equipment for in-office and outreach activity use
    - The purchase of computer equipment for outreach activities should include mobile broadband service with touchscreen capability and be impact resistant.
- The NJDOH must approve any sub-grant entered by the grantee. Reimbursement for services provided by sub-grantees will not be authorized unless the contract for such

services has been approved by the NJDOH. The grantee agrees to be responsible for managing funds awarded to a sub-grantee to ensure adequate financial controls are in place and the sub-grantee complies with the terms and conditions of the sub-grant.

After applications have been scored and ranked by the reviewers, then the budget request will be reviewed, and specific line items may be negotiated if determined to be inappropriate, excessive or contrary to NJDOH grant policies.

Attachments

The following documents must be included with the application submitted through the System for Administering Grants Electronically (SAGE) system. Failure to provide the required attachments will result in the application being deemed non-responsive.

- Organizational chart
- Resumes for existing staff that will be involved with Healthy Women, Healthy Families
- Job description(s) of vacancies of Healthy Women, Healthy Families staff with applicant hiring policies and proposed hiring timelines
- Computer security policy
- Annual audit report
- Tax Clearance Certificate—applications can be obtained at http://www.state.nj.us/treasury/taxation/busasst.shtml
- Indirect cost rate if indirect costs are requested
- Letters of commitment from proposed sub-grantees indicating the specific services to be contracted

Additional (attach in SAGE under Miscellaneous Attachments section)

- Contact list of all Healthy Women, Healthy Families staff that will perform case management, translation services, support services, supervision, financial services and/or grants management for services provided under this RFA must be submitted to NJDOH within 60 days of the award. The contact list must include each staff person's name, job title, role, email address, office phone number, fax number, and cell phone number. If the position is vacant, include a job description and an anticipated hiring date.
- Letters of commitment from other local agencies (such as transportation and housing), if the applicant is awarded, indicating support to enter into cross-jurisdictional agreements.

IX. FUNDING

It is expected that for the first year, a total of up to $4.3 million will be available for funding for the Healthy Women, Healthy Families Initiative. Funding amounts will be dependent on the region(s) selected, project structure, and activities.

This competitive RFA is for a period of five years (July 1, 2018, through June 30, 2023). Budget periods 2 through 5 are dependent upon the availability of funds. In subsequent years, all grantees must submit a noncompetitive multi-year health service grant application. Continuation of funding for subsequent years is contingent upon the

availability of funds; timely accurate submission of reports; an approved annual plan; and satisfactory progress toward completion of the current years' grant objectives.

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

X. TECHNICAL ASSISTANCE MEETING

It is recommended that potential applicants attend the technical assistance meeting to be held on May 1,2018 at 11:00 am at the PHEAL Building at 1040 River Road, Ewing, NJ. Pre-registration is preferred by email and must include the name of the applicant and any additional attendees. Supplemental documents (slides and Q&A) will be updated after the technical assistance meeting and will be emailed to all attendees and interested parties. Any questions beyond the 5/1 TA meeting, should be directed to HWHF@doh.nj.gov. Questions will be answered until May 11, 2018 at 4 pm. Interested parties can request slides and Q &A documents via the following email: HWHF@doh.nj.gov.

XI. HOW TO ACCESS AN APPLICATION

An organization that intends to apply for this program will need to express its interest by contacting HWHF@doh.nj.gov to have an electronic application made available. This email expression of interest must be received on or before May 17, 2018.

The NJDOH requires all grant applications to be submitted electronically through the System for Administering Grants Electronically (SAGE) at www.sage.nj.gov. If your agency does not have an existing account in SAGE, an account will need to be created to apply for this grant.

AGENCIES WITH NO SAGE ACCOUNTS: If you are a first-time NJDOH applicant whose organization has never registered in the NJDOH SAGE system, you must contact the SAGE System Administrator, Cynthia Satchell-Gore at Cynthia.Satchell-Gore@doh.nj.gov or at (609) 633-8009 immediately. A new agency form must be completed and submitted to the NJDOH. When approved, the organization's status will be activated in SAGE. The SAGE System Administrator will grant permission via email or a phone call to the organization's Authorized Official informing them they are authorized to access the application in SAGE.

Paper submissions of the application or any attachments will not be accepted. Potential grantees must notify the program manager immediately via email if accessing SAGE is delayed due to NJDOH processes. SAGE will automatically not permit application submissions after the closing date listed in the RFA. No extensions will be granted.

XII. OTHER REQUIREMENTS

Grant awards will be made on a competitive basis and is contingent upon meeting the requirements stipulated in this RFA and the NJDOH Terms and Conditions for Administration of Grants which are located at http://nj.gov/health/grants/ . Healthy Women, Healthy Families grantees will be required to submit:

- Quarterly progress and expenditure reports in a format provided, or approved, by the NJDOH/FHS.

- Within one month of award notification, executed cross-jurisdictional agreements and/or sub-grantee contracts.

XIII. NJDOH/FHS CONTACTS

- Grants Management Officer (Fiscal and SAGE Information)
  Caroline Woodrow
  Caroline.woodrow@doh.nj.gov
  (609) 984-1315

- Program Management Officer (Program Information)
  Loletha Johnson
  Loletha.Johnson@doh.nj.gov
  (609) 292-5616

XIV. EVALUATION AND SCORING CRITERIA

Applications will be reviewed, evaluated and scored in accordance with the following evaluation criteria:

Section 1 – Background/Organizational Capacity (30 points)

a. Describe the overview, mission and brief history of the organization and the location of the proposed project within the organizational structure. Supply an organizational chart that depicts the location of the proposed project within the organizational structure.
b. Describe the staffing plan, including required education or certification, the number of full-time equivalents, and readiness for implementation including ability to hire qualified staff and secure facility space/location.
c. Describe the experience of the applicant organization in providing quality coordination of resources and community services in the target counties/municipalities.
d. Describe how the proposed project will be integrated and coordinated with other federally/state funded programs and how the proposed project will enhance those programs.
e. Describe how the proposed project will be integrated and coordinated with other local and state community/faith-based organizations providing services to the target populations, and how the proposed project will enhance those services.
f. Articulate (include letters of support) any past, present and future collaborations of traditional and non-traditional partners, including community/advocacy/faith-based organizations, and libraries.

Section 2 – Needs Assessment (20 points)

a. Identify the proposed target population(s) and service area(s) and describe the need within those areas and populations as well as any health disparities that may be present and these should be based on the outcome measures named above.

b. Describe how the proposed project is most appropriate and responsive to the women (or Black NH women) of childbearing age and their families in improving access to prenatal, preconception and interconception care and address barriers to care.
c. Describe the gaps in service needs within the target area(s) and how the proposed project will fulfill those needs.
d. Describe how the proposed project will complement existing services in the community and the anticipated case load for each of your proposed project within the targeted community(ies).
e. Articulate and justify the number of Referral Specialists and Community Health Workers anticipated for the targeted area(s).

Section 3 – Methods and Evaluation: Project Plan for Service Delivery (30 points)

a. Describe the implementation methods for all interventions including locations.
b. Describe the applicant organization's approach to recruiting from within the community/target populations of the women of childbearing age and their families.
c. Describe the plan to participate in and lead multi-sector partnerships or coalitions to support the goals/objectives.
d. Describe how organizations providing letters of support will be actively engaged in an on-going basis to support the proposed project.
e. Describe within a workplan, each proposed project activity and associated timeline(s).
f. Describe how the applicant organization will monitor grant activities and evaluate your progress using both a process (formative evaluation) and outcomes evaluation process.
g. Include a LOGIC model.

Section 4 – Budget and Justification (20 points)

a. The budget must be developed based on the estimated funding needs to accomplish the proposed project. Health Service Grant Application Schedule A, B, and C must be completed.
b. Identify the number of full-time equivalents regardless of funding source that will be providing services for the project.
c. Identify the budget allocation for all subcontracted non-traditional agencies.
d. The budget must be accompanied by a complete and comprehensive budget justification, explaining each budget line item; and
e. The budget must be reasonable and appropriate based on the scope of the services to be provided.
f. Identify all initiatives in the proposed project area(s) receiving State and Federal funding.

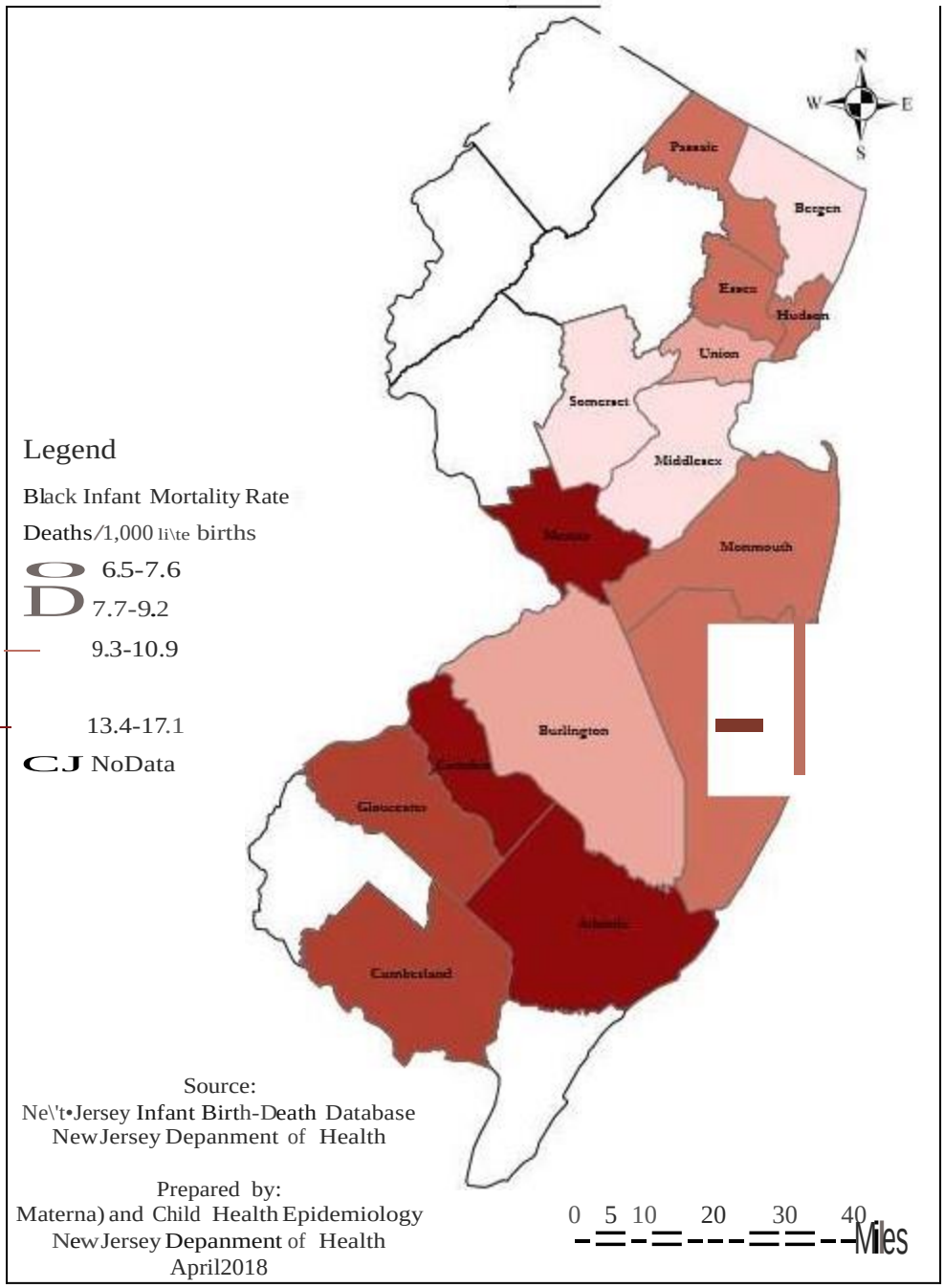
REVIEW PROCESS:

1. Applications received by the deadline will be screened by NJDOH for completeness and compliance with the mandatory requirements.
2. Applications that are incomplete or do not conform to the mandatory grant requirements will be disqualified.

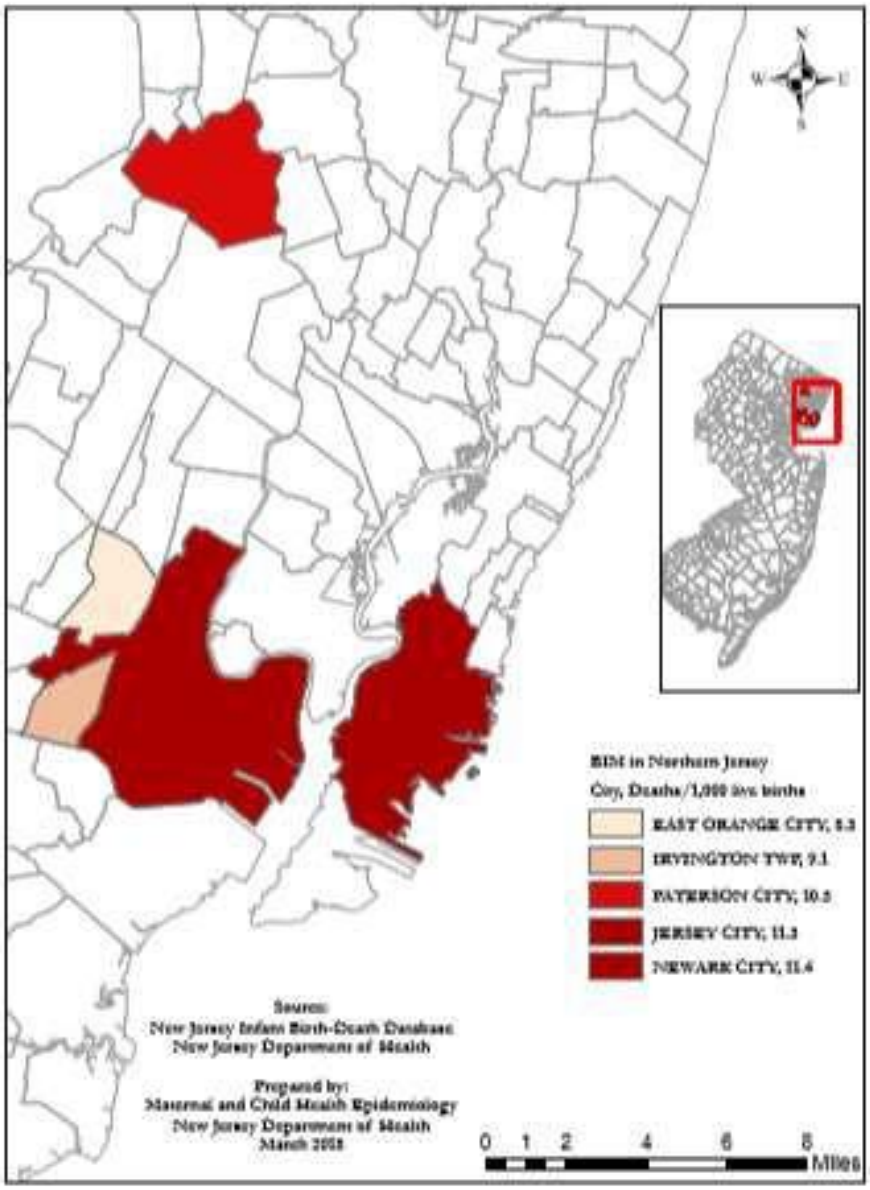
3. Applications that meet all the screening requirements will be presented to a review committee.
4. The review committee will assess each application according to the Evaluation Criteria described in Section XIV above.
5. An application must receive a minimum score of 70 points to be eligible for funding.
6. The NJDOH/FHS may negotiate specific line items determined to be inappropriate, excessive or contrary to the NJDOH/FHS grant policy.

Appendix A

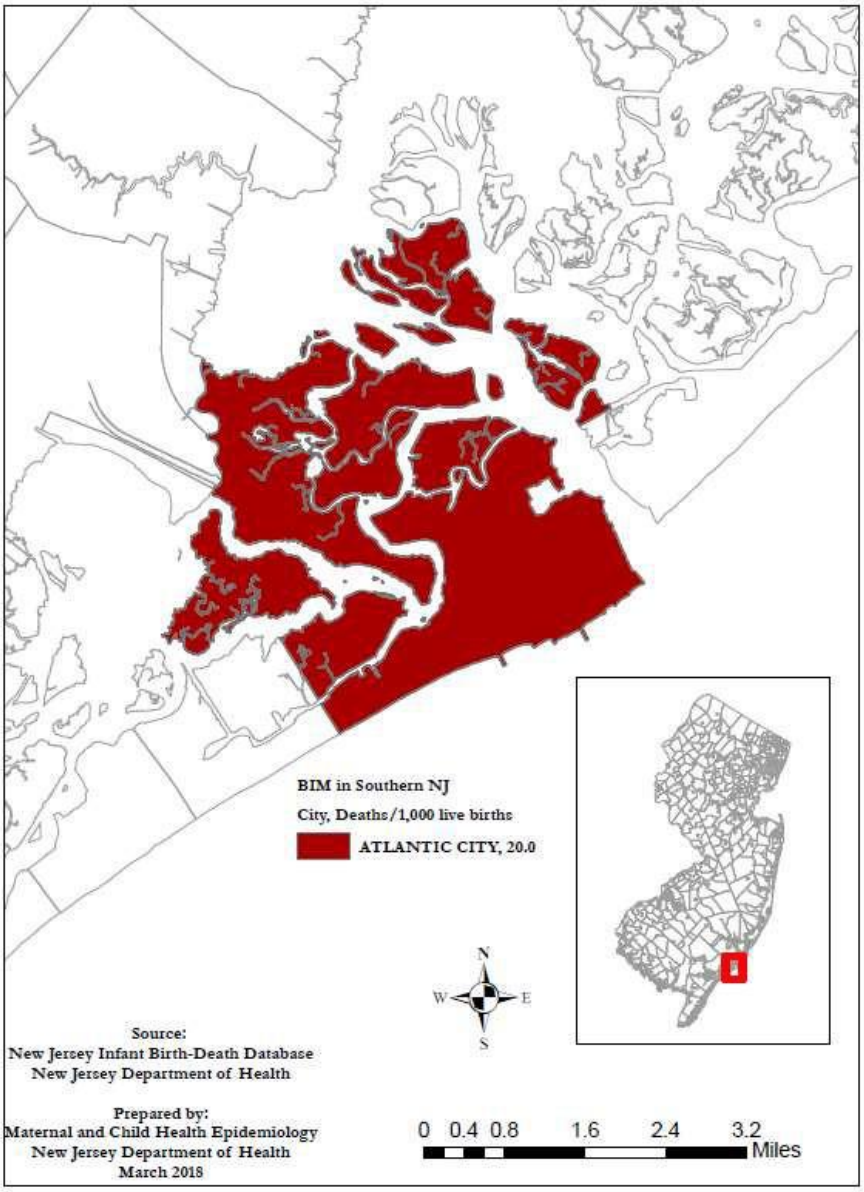
Black Infant Mortality by County, New Jersey, 2005-2015



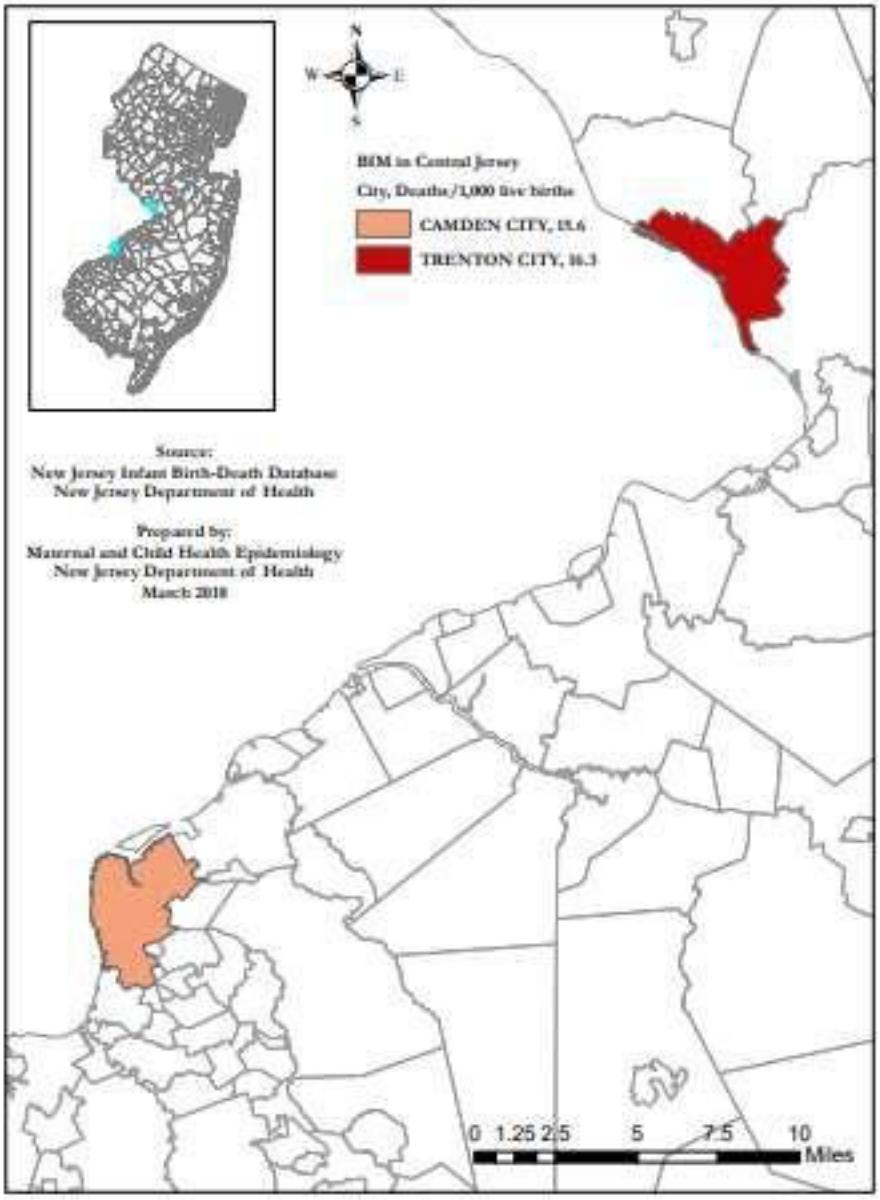
Black Infant Mortality - Northern New Jersey, 2005-2015



Black Infant Mortality - Atlantic City, NJ, 2005-2015



Black Infant Mortality - Camden City and Trenton, NJ, 2005-2015



BIM Municipalities and Key Indicators, 2016

	New Jersey	Atlantic	Camden	Newark	Irvington	East Orange	Jersey City	Trenton	Paterson
Black NH Births (N)	13,639	191	442	1,930	675	728	763	559	502
Teen Births (%)	6.0	5.8	10.9	7.7	4.9	6.2	7.5	8.1	7.8
Medicaid (%)	53.1	85.4	82.3	65.7	60.9	58.3	63.2	64.6	67.7
Gestational Diabetes (%)	6.1	**	4.1	5.1	6.4	5.5	5.2	6.0	3.6
Gestational HBP (%)	7.2	7.9	8.1	7.1	6.7	6.5	5.6	8.4	6.4
Obesity (%)	66.4	71.7	66.9	65.1	65.0	64.9	60.7	69.6	66.1
Late/No PNC (%)	32.2	35.1	33.3	39.5	37.4	35.6	32.6	39.6	32.2
Smoked during pregnancy (%)	6.1	18.3	13.9	6.1	3.6	3.9	6.6	9.2	7.1
Preterm birth (%)	13.6	11.6	15.2	15.6	10.2	11.3	15.3	15.3	16.7
Low Birth Weight (%)	13.0	10.1	15.8	15.3	8.6	12.7	14.9	13.9	14.7
Exclusive BF at discharge (%)	24.8	19.7	29.6	17.7	18.0	24.8	16.5	33.1	14.9
Income below poverty line (%)	9.1	19.3	19.7	15.8	10.6	9.4	12.3	12.0	14.5
Median Household Income ($)	47,299	20,981	25,426	30,429	38,987	39,205	41,427	32,615	32,075
Females (25+ years old) with no High school diploma (%)	12.6	27.3	23.5	16.7	15.8	13.3	13.1	17.4	17.5
Households led by women (%)	44.5	67.8	69.9	57.2	46.6	48.8	50.6	56.0	57.3

Source: New Jersey Birth Certificate Database, New Jersey Department of Health and

American Community Survey 2012-2016, US Census Bureau

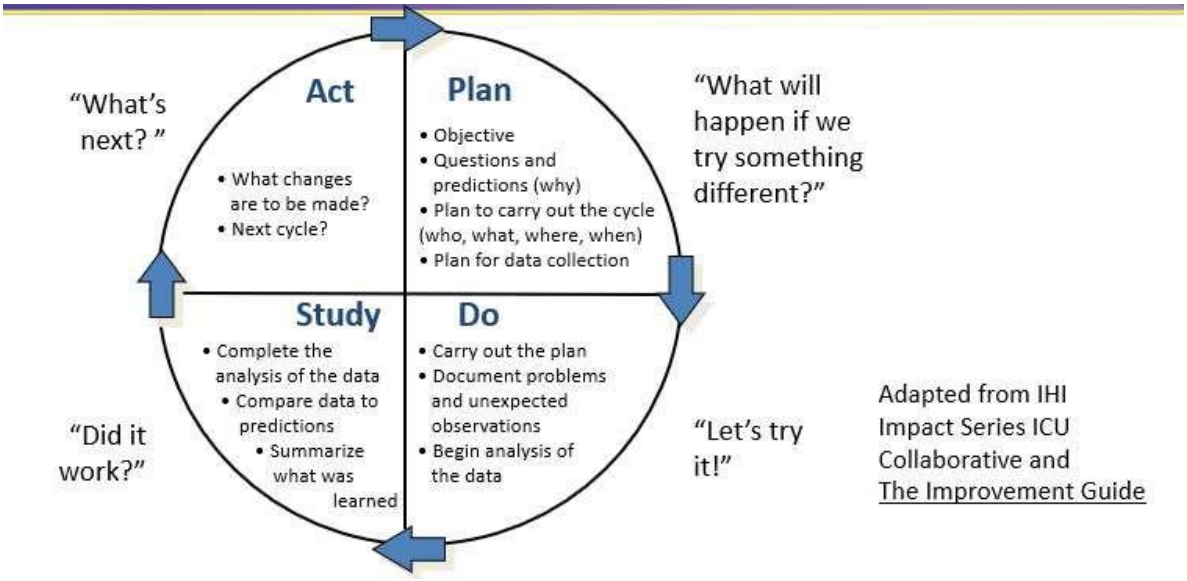
Appendix B

Logic Model for _____ Project

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES		
			Short-term	Mid-term	Longer Term
Definition: Inputs are your Resources. In order to accomplish your set of activities, you will need the following resources. List them here.	Definition: Activities are your processes, methods and services. In order to accomplish your objectives for the program, you need to do these activities. List them here.	Definition: Outputs are the products that you produce. You can monitor your activities by counting or recording these events or products (e.g., 10 breastfeeding support group sessions, 5 educational sessions with Obstetricians)	Definition: These are measurable changes. You expect your project activities will lead to these short-term changes.	Definition: These are measurable changes. You expect your project activities will lead to these mid-term changes.	Definition: These are measurable, longer term changes. You expect the project will eventually lead to these changes.

Appendix C

Plan, Do, Study, Act (PDSA) Cycle



MODEL FOR IMPROVEMENT DATE _____

Objective for this PDSA Cycle:

Is this cycle used to develop, test, or implement a change?

What question(s) do we want to answer on this PDSA cycle?

Plan:
Plan to answer questions: Who, What, When, Where
Plan for collection of data: Who, What, When, Where
Predictions (for questions above based on plan):
Do:
Carry out the change or test; Collect data and begin analysis.
Study:
Complete analysis of data;
Compare the data to your predictions and summarize the learning
Act:
Are we ready to make a change? Plan for the next cycle

For additional information go to:
http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx

Appendix D

A. Group Prenatal Care

Target Population:
Pregnant Women

Description:
The group prenatal care model brings together low-risk pregnant women, who are matched by gestational age, for prenatal care and group learning sessions. After each woman has had an initial, individual prenatal visit, the cohort moves through pregnancy care and milestones together as they meet over 8 to 10 visits, each visit lasting approximately 90 to 120 minutes.

The group prenatal care model encourages women to be involved in their own care; in some programs, the women measure and record their blood pressure and weight, and calculate their gestational age. Routine physical assessments are often done in a semi-private area of the group space, allowing the provider and patient to assess if there are concerns that should be addressed outside of the group context.

Required Activities:
- Training of staff (either full for new site or advanced for expansion)
- Centering Groups (each gestational group must hold at least 10 sessions in accordance with the Centering Curriculum)
- Self-Assessment (all sessions must include self-checks for weight, blood pressure

Content: All content in the Centering Curriculum is required. A sampling of this information is as follows: group welcome and guidelines, nutrition, healthy lifestyle choices, body changes and care, managing stress, breastfeeding, family dynamics, sex, safer sex, sexuality, fetal development, labor (pre-birth), the birth experience, after the baby is born, family integration, pregnancy to parenting, baby blues/PPMD, newborn care, growth and development, evaluation.)

Objectives/Outcomes:
Short Term:
- Increase the percentage of women enrolled in group prenatal care who report an increased ability to manage stress by 10%.
- Increase the percentage of women enrolled in group prenatal care who report increased knowledge of healthy nutrition and lifestyle choices, breastfeeding, fetal development, birth, newborn care, and healthy child growth and development by 60%.

Medium Term
- Increase the number of women who attend group prenatal care by 10% annually.
- Increase the number of sites offering group prenatal care by 10% annually.
- Increase the number of staff trained in group prenatal care by 10% annually.

Long Term

- MCH-1: Reduce the rate of infant deaths per 1,000 live births to 4.8 for the total population, 1.9 among Whites, 6.0 among Blacks, 4.5 among Hispanics, and 2.2 among Asians.
- MCH-2a: Reduce low birth weight (LBW) to 7.7% for the total population, 6.9% among Whites, 12.4% among Blacks, 7.1% among Hispanics, and 7.9% among Asians.
- MCH-2b: Reduce very low birth weight (VLBW) to 1.4% among the total and Hispanic populations, 1.2% among Whites, 2.9% among Blacks, and 1.0% among Asians.
- MCH-3: Increase the proportion of pregnant women who receive prenatal care beginning in first trimester to 79.4% for the total population, 90.7% among Whites, 67.4% among Blacks, 72.1% among Hispanics, and 90.8% among Asians.
- MCH-6: Increase the proportion of infants who are put to sleep on their backs to 80%.
- MCH-7: Increase the proportion of infants who are breastfed MCH-7a: Ever to 85% MCH-7b: Breastfed exclusively through 3 months to 45% MCH-7c: Breastfed exclusively through 6 months to 25.5%

Best Practice:
CenteringPregnancy

CenteringPregnancy has been shown to nearly eliminate racial disparities in preterm birth. African American women, who are at higher risk for preterm birth in the US, experience lower risk of preterm birth when enrolled in CenteringPregnancy than in traditional care.
Centering empowers patients, strengthens patient-provider relationships, and builds communities through health assessment, interactive learning, and community building.
Centering group prenatal care follows the recommended schedule of 10 prenatal visits, but each visit is 90 minutes to two hours long - giving women 10x more time with their provider. Moms engage in their care by taking their own weight and blood pressure and recording their own health data with private time with their provider for belly check.

Centering Offers:

- Implementation support for system change
- Training in group facilitation and group care
- Site approval for model fidelity and quality assurance
- Practice management and support tools including CenteringCounts™ data collection and reporting
- Curriculum materials and supplies that support providers and patients

Links:
https://www.centeringhealthcare.org/what-we-do/centering-pregnancy
http://mybonsecoursbaby.com/centering-pregnancy-details/

B. Doula Projects

Target Population:
Pregnant or parenting women

Description:
Doula Projects support better birth outcomes by providing practical support to women during pregnancy and beyond.

Several studies show that doula care reduces the likelihood of consequential and costly interventions like cesarean births and increases the likelihood of a shorter labor, spontaneous vaginal birth, higher APGAR scores, and a more positive childbirth experience.

Required Activities:
Doula training involves:

- Watching/attending a series of childbirth education and breastfeeding classes
- Completing required readings
- Attending and completing the in-person hands on training/workshop
- Post training, attending 3 births and provide documentation
- Post training, completing minimum amount of hours of postpartum care for a set number of families with documentation
- If offered, participating in mentorship program
- Completing application packet

Doula activities include:

- Prenatal care visits and education (typically 2 hours)
- Text and phone support during business hours (2 hours)
- Labor and delivery support (average 24 hours)
- Post-delivery follow-up (typically 2 hours

Objectives/Outcomes:
Short Term:

- Increase the percentage of women receiving doula services who report an increased ability to manage stress by 10%.
- Increase the percentage of women receiving doula services who report increased knowledge of healthy nutrition and lifestyle choices, breastfeeding, fetal development, birth, newborn care, and healthy child growth and development by 60%.

Medium Term:

- Increase the number of CHWs receiving doula training by 10% annually
- Increase the number of women receiving doula support by 10% annually.
- Increase the number of policy, systems, and environmental changes implemented by grantees that improve access to and knowledge of doula support services.

Long Term:

- MCH-1: Reduce the rate of infant deaths per 1,000 live births to 4.8 for the total population, 1.9 among Whites, 6.0 among Blacks, 4.5 among Hispanics, and 2.2 among Asians.
- MCH-2a: Reduce low birth weight (LBW) to 7.7% for the total population, 6.9% among Whites, 12.4% among Blacks, 7.1% among Hispanics, and 7.9% among Asians.
- MCH-2b: Reduce very low birth weight (VLBW) to 1.4% among the total and Hispanic populations, 1.2% among Whites, 2.9% among Blacks, and 1.0% among Asians.
- MCH-3: Increase the proportion of pregnant women who receive prenatal care beginning in first trimester to 79.4% for the total population, 90.7% among Whites, 67.4% among Blacks, 72.1% among Hispanics, and 90.8% among Asians.
- MCH-6: Increase the proportion of infants who are put to sleep on their backs to 80%.
- MCH-7: Increase the proportion of infants who are breastfed MCH-7a: Ever to 85% MCH-7b: Breastfed exclusively through 3 months to 45% MCH-7c: Breastfed exclusively through 6 months to 25.5%

Best Practice:
Birthing Project USA and Community Doulas

Birthing Project USA is a National African-American maternal and child health program. They are a volunteer effort that supports better birth outcomes by providing practical support to women during pregnancy and for one year after the birth of their children. The Birthing Project also trains and certifies women to become Community Doulas to provide free pregnancy, childbirth, postpartum and breastfeeding support to mothers.

Links:

http://www.pwnsinc.org/bp-bpusa.php
http://easthoustondoula.com/breakdown-doula-fees/

C. Fatherhood Support Groups

Target Population:
Fathers or Expectant Fathers

Description:
"As part of an overall strategy to improve African American birth outcomes, having fathers actively involved from pregnancy is a critical factor in the social determinants of health. According to the National Fatherhood Initiative, on average, children in father absent homes are at least two to three times more likely to be poor, use drugs, experience educational, health, emotional and behavioral problems, be victims of child abuse, and engage in criminal behavior than peers who live with both parents. A U.S. Census Bureau report on Children's Living Arrangements and Characteristics (2011) found that children in father-absent homes are almost four times more likely to be poor. According to the National Center for Health Statistics infant mortality rates are nearly two times greater for infants born to unmarried mothers than married mothers." (RacÍne/Kenosha community Action Agency Kenosha Father Involvement Planning Project, 2014).

Required Activities:

- Improve tracking of father involvement in prenatal, interconception, postpartum and WIC Appts.
- Increase father involvement prenatally and continued involvement
- increase father/male role model attendance at prenatal, interconception, and postpartum appts Mothers and fathers report satisfaction with services and feeling welcome at appts.

Objectives/Outcomes:

Short Term:

- Increase the number of fathers in attendance who report increased confidence with parenting skills by 60%.
- Improve the perception of breastfeeding among men in attendance by 60%

Medium Term:

- Increase the number of fathers that attend prenatal, interconception, postpartum and WIC appointments by 10%
- Increase the number of fathers who attend well-baby visits by 10%.
- Increase the number of SPECT Database Improvements to improve tracking of father attendance at prenatal, interconception, postpartum and WIC Appts.
- Increase the number of fathers who receive social benefits such as medical insurance by 10%.
- Increase the number of fathers who receive referrals to supportive resources by 10%.

Long Term:

- MCH-1: Reduce the rate of infant deaths per 1,000 live births to 4.8 for the total population, 1.9 among Whites, 6.0 among Blacks, 4.5 among Hispanics, and 2.2 among Asians.
- MCH-7: Increase the proportion of infants who are breastfed MCH-7a: Ever to 85%
- MCH-7b: Breastfed exclusively through 3 months to 45% MCH-7c: Breastfed exclusively through 6 months to 25.5%

Best Practice:

RacÍne/Kenosha Community Action Agency Kenosha Father Involvement Planning Project

The purpose of this specific project is to develop a comprehensive, evidence-based Fatherhood involvement Model that will successfully engage and respond to the needs of the fathers of WIC-reliant children, and provide comprehensive fatherhood programming and coordination.

Links:

Final_FI_Report_0.pdf

D. Breastfeeding Support Groups

Target Population:
Breastfeeding mothers

Description:
Black women initiate breastfeeding 86.6% but only 30.5% of black women are exclusively breastfeeding at hospital discharge. Breastfeeding groups will promote breastfeeding to pregnant women and support breastfeeding women.

Activities:

- Attend required breastfeeding training for peer staff.
- Weekly breastfeeding groups aimed at pregnant and breastfeeding African-American women.
- Follow up, if needed, by the appropriate staff.

Objectives/Outcomes:
Short Term:

- 60% of attendees will report increased knowledge of breastfeeding practices after attending session.
- 60% of women will report increased confidence in their ability to breastfeed after attending session.
- 60% of women will report feeling more supported with continuing breastfeeding after attending session.
- 60% of women will report increased awareness of resources available in their community after attending session.

Medium Term

- The number of women attending support groups will increase 30% annually.
- Increase by 40 % the duration and exclusivity of breastfeeding among mothers participating in support groups.

Long Term

- MCH-1: Reduce the rate of infant deaths per 1,000 live births to 4.8 for the total population, 1.9 among Whites, 6.0 among Blacks, 4.5 among Hispanics, and 2.2 among Asians.
- MCH-6: Increase the proportion of infants who are put to sleep on their backs to 80%.
- MCH-7: Increase the proportion of infants who are breastfed MCH-7a: Ever to 85%
- MCH-7b: Breastfed exclusively through 3 months to 45% MCH-7c: Breastfed exclusively through 6 months to 25.5%

Best Practice:
African American Breastfeeding Network (ABN)

This initiative aimed to increase breastfeeding initiation, duration, and exclusivity rates by engaging pregnant women, expectant fathers and their families through health promotion, health education, and social support programs. ABN's mission is to promote breastfeeding as the natural and the best way to provide optimal nourishment to babies and young children in the

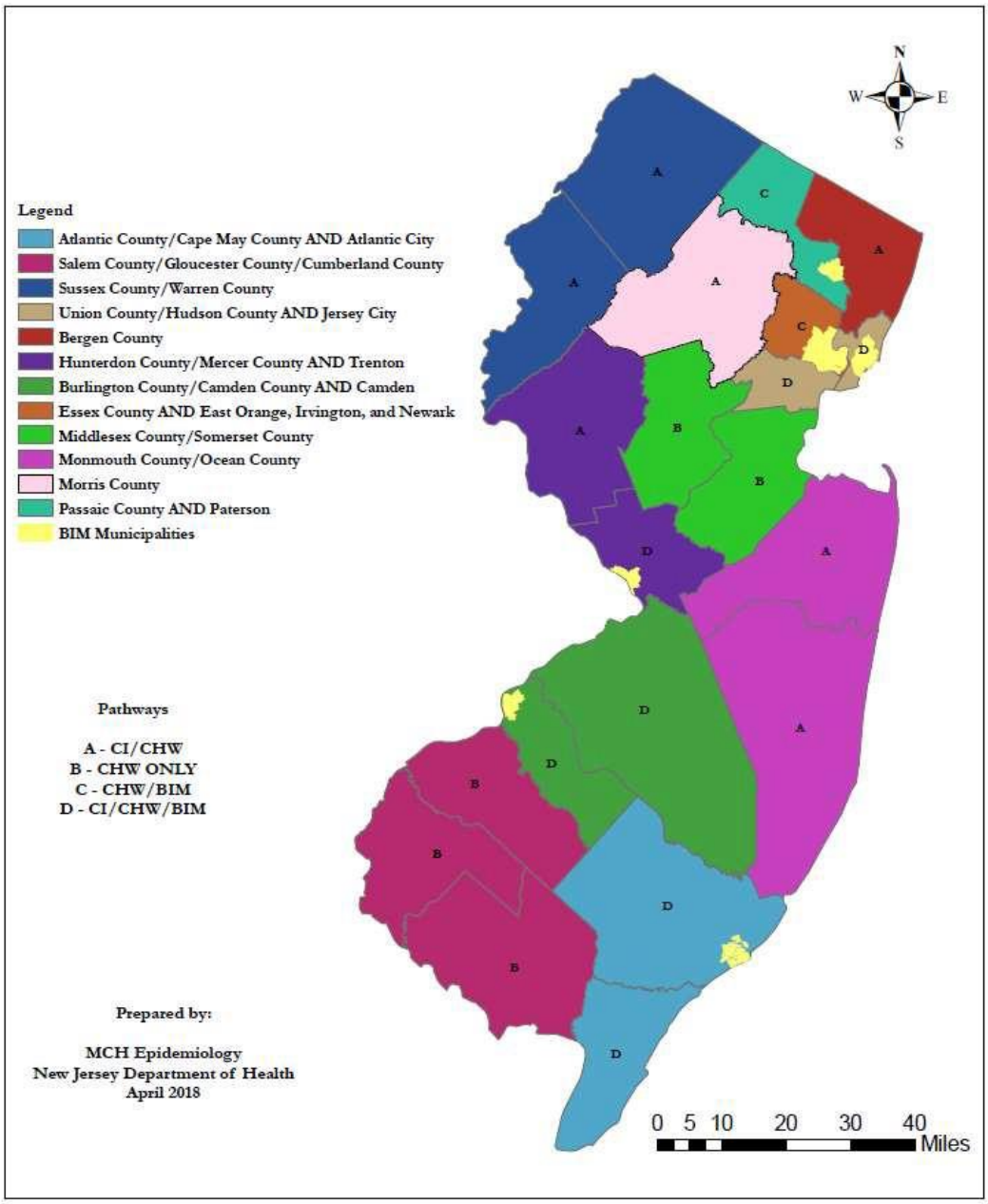
African American community. Peer support is considered vital to breaking down barriers to breastfeeding in a woman's social network, especially among groups with low breastfeeding rates. Training and support for the peer staff is critical for success. Co-location and/or in conjunction with other activities or events are desirable to increase participation.

Links:

http://blackmothersbreastfeeding.org/
https://wicworks.fns.usda.gov/wicworks/WIC_Learning_Online/support/job_aids/bestpractice.pdf https://www.cdc.gov/breastfeeding/pdf/BF-Guide-508.PDF

Appendix E

Healthy Women Healthy Families Regions - SFY 2019



Appendix F

GLOSSARY OF TERMS & REFERENCES

Black Infant Mortality (BIM)- The death of a black infant before his or her first birthday.

Community Health Workers (CHWs)-Trusted members of the community in which they serve. Health Resources and Services Administration (HRSA) defines them as "lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve."[1]

Child bearing/Reproductive age – Women and men who are between the ages of 15 and 44 according to the CDC.

Health Disparities- Can include both health care disparities and health status disparities. Health care disparities are differences in access and availability of resources while health status disparities refer to differences in disease, disability, and health outcomes of various populations and groups.

Infant Mortality- The death of an infant before his or her first birthday. The infant mortality rate is the number of infant deaths for every 1,000 live births.

Interconception care- Refers to the time between pregnancies, including, but not restricted to, the postpartum period.

Low birth weight- An infant's weight at birth of less than 2500 grams (5.5 pounds).

Perinatal Risk Assessment (PRA)-A universal screening tool used by prenatal providers and managed care organizations across New Jersey to identify the risk factors affecting pregnant women. It gives providers the opportunity makes referrals to services based on a patient's specific needs.

Plan Do Study Act (PDSA)- A tool for documenting a test of change. The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).

Preconception care- A set of interventions to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management.

Prenatal care- Health care you receive while you are pregnant.

Preterm birth- Babies born before 37 weeks of pregnancy are completed.

Quality Improvement (QI)- An ongoing effort of activities to achieve improvements in the Healthy Women, Healthy Families Initiative and in the way health care is delivered to clients.

Referral Specialist- The staff member responsible for referring clients and providing linkages to necessary services.

References

[1] Wanda Barfield W, D'Angelo D, Moon R, Lu M, Wong B, Iskander J. Public Health Approaches to Reducing U.S. Infant Mortality. Morbidity and Mortality Weekly Report. 2013;62(31):625-628.

[2.] Lu M, Johnson KA. Toward a National Strategy on Infant Mortality. AJPH 2014; 104(S1): S13-S17.

[3].Lorch AS, Enlow E. The Role of Social Determinants in Explaining Racial/Ethnic Disparities in Perinatal Outcomes. Pediatric Research. 2016 Jan; 79 (1): 141-147.

[4]U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. (2007). Community Health Worker National Workforce Study.