HRSA
Health Resources & Services Administration

Partnerships to Advance Equity in Title V

State Panel

Title V MCH Federal-State Partnership Meeting

November 7, 2023

Vision: Healthy Communities, Healthy People

NEW JERSEY HUMAN SERVICES

Partnerships to Advance Health Equity- NurtureNJ

Lisa Asare, Deputy Commissioner of Health Services

NJ Department of Human Services

Nurture NJ

is committed to reducing infant and maternal mortality and morbidity and ensuring equitable maternal and infant care among women and children of all races and ethnicities.

Vision: To become the safest and most equitable state in the nation
to deliver and raise a baby

NEW JERSEY HUMAN SERVICES

Maternal and Infant Health Crisis in New Jersey

NJ ranks 27th

Our state ranks 27th in maternal deaths according to the America's Health Rankings.

Preventable

Over 90% of maternal deaths are preventable.

Women of Color

A Black woman in New Jersey is nearly **seven** times more likely to die due to pregnancy complications than a white woman.

Babies of Color

A Black infant is nearly **three** times more likely to die in their first year of life than a white baby.

NEW JERSEY HUMAN SERVICES

“Not about us, without us

Listen to us; do not make decisions that profoundly affect our lives without us at the decision-making table"

NEW JERSEY HUMAN SERVICES

Nurture NJ Programs & Initiatives

Family Festivals

Family Festivals bring together state, county, local resources to our cities with the highest rates of Black maternal and infant mortality.

Annual Black Maternal and Infant Health Leadership Summit

Representatives from across different sectors identify short, medium, and long-term solutions to tackling our inequities in maternal and infant health.

Interdepartmental Meetings

Quarterly Interdepartmental Maternal and Infant Health meetings with 21 state departments and agencies.

Ask an Expert Series

Monthly live-streamed panels with experts who answer questions about health-related topics.

NEW JERSEY HUMAN SERVICES

Nurture NJ Maternal and Infant Health Strategic Plan

is designed to make transformational change in a system that has historically failed our mothers and babies – especially our mothers and babies of color.

Goals

- Reduce maternal mortality by fifty percent over five years
- Eliminate racial disparities in birth outcomes.

NEW JERSEY HUMAN SERVICES

Nurture NJ Strategic Plan Progress – Recommendations + Appropriations

Traditional Partnerships

- Rec. 5.11.1: The Department of Health should update existing regulations that allow only nurse midwives to attend hospital births, expanding to include certified midwives.
  - $1 million for midwifery education and training
- Rec. 5.13.1: The Department of Human Services should continue to improve Medicaid reimbursement for all obstetric providers to reach 100% of the physician rate, and require MCOs to reimburse for, and include, all members of a perinatal care team (including doulas) in their networks.
  - $15 million to raise Medicaid rates for maternity care providers.
- Rec. 5.19: The Department of Children and Families should continue to expand and universally offer evidence-based home visiting programs with focus on those models proven to reduce maternal and infant mortality.
  - $17.4 million for universal newborn home visitation program
- Rec. 7.14: State leaders should increase funding for prenatal and reproductive health care for undocumented women.
  - $19 million for the Reproductive Health Care Fund

Action Areas

1. Build racial equity infrastructure and capacity.
2. Support community infrastructure for power-building and consistent engagement in decision-making.
3. **Engage multiple sectors to achieve collective impact on health.**
4. Shift ideology and mindsets to increase support for transformative action.
5. Strengthen and expand public policy to support conditions for health in New Jersey.
6. Generate and more widely disseminate data and information for improved decision-making.
7. Change institutional structures to accommodate innovation and transformative action.
8. **Address social determinants of health.**
9. Improve the quality of care and service delivery to individuals.

NEW JERSEY HUMAN SERVICES

The Whole of Government Approach
"NJ FAMILY LEAVE ACT"

Non-traditional partners –

NJ Department of Labor and Workforce Development

New Jersey Division of Civil Rights

NJ Office of Innovation

NEW JERSEY HUMAN SERVICES

NJ Department of Labor and Workforce Development – NJ Family Leave Act (NJFLA)

- Limited workers (70%) reported having access and less reported (50%) recognizing programs by name;
- Lower income earning and workers of color reported reluctance to using family leave for fear of retaliation or job loss;
- NJDOL established CARE (Cultivating Access Rights and Equity) Grant – outreach and education of NJFLA
- Grantees include the NJ Breastfeeding Coalition, Migrant Farmworkers Association, Statewide Parent Advocacy Network (SPAN), etc…

NJ DCR POSTERS – Reinforcement

Display of Official Posters of the Division on Civil Rights," which require employers, housing providers, and places of public accommodation, including healthcare facilities to display applicable posters.

NEW JERSEY HUMAN SERVICES

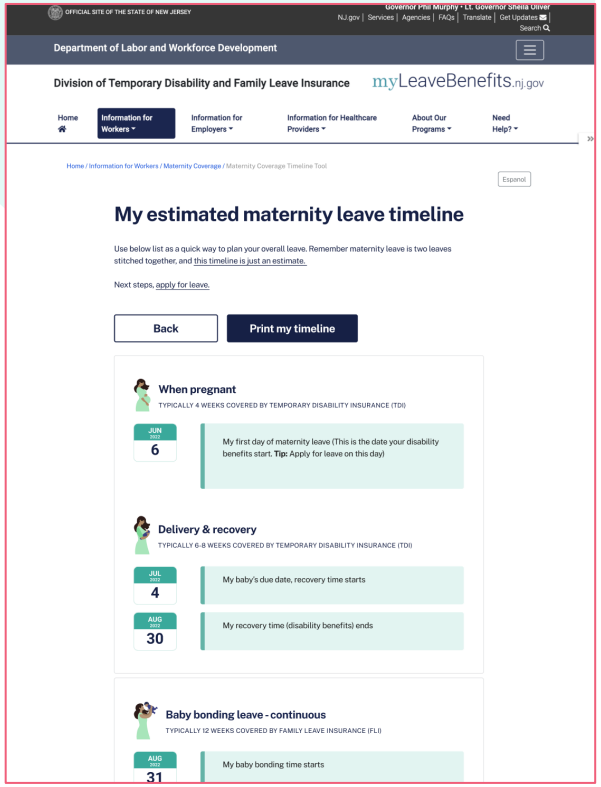
NJ Office of Innovation- Maternity coverage timeline tool

- Designed, developed and launched initial version in ~7 weeks (May 2022)
- Includes a human-translated Spanish version
- Made minor improvements since launch, with a more substantive round of updates in progress
- Continuing to get the word out through partner networks (thank you!)

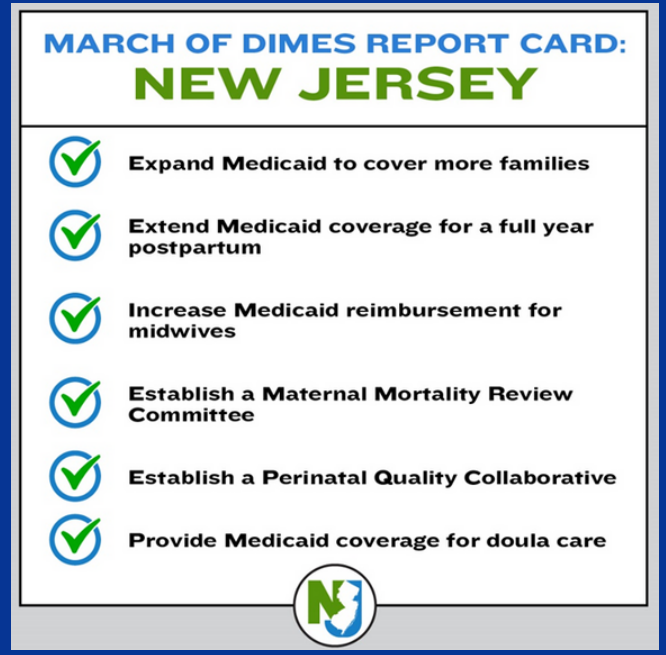
myleavebenefits.nj.gov/timeline

"It is very helpful to have all of the information I need in one place. Calculating how long I can be on leave with my baby was great."
- New Jersey Resident
October 5, 2022

~30,000
Timelines created



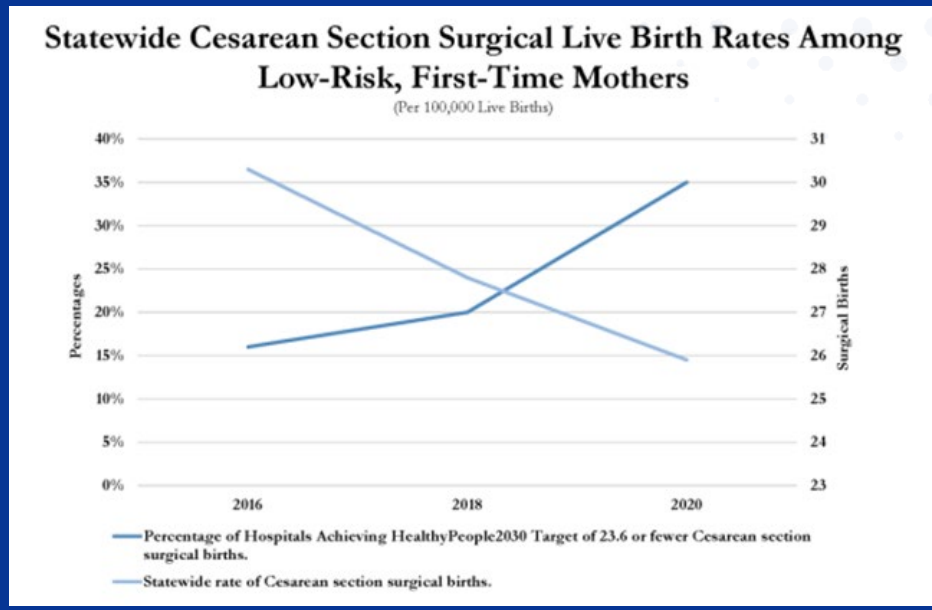
NEW JERSEY HUMAN SERVICES



Last year, March of Dimes released a report that noted that between 2016 and 2021, New Jersey's preterm birth rate fell from 9.9% to 9.2%.

Of the 53 states and territories evaluated, 47 declined, one stayed the same, and only four improved – Kansas, Montana, North Dakota, and New Jersey.

According to DOH, the percentage of hospitals achieving the national target of 23.6% or fewer c-sections has increased from 16% in 2016 to 35% in 2020.



Our Progress

NEW JERSEY HUMAN SERVICES

Maternal and Infant Health Innovation Center

Vision

The Center is intended to catalyze new innovations to drive improved maternal and infant health outcomes and to serve as a central hub for New Jersey's stakeholders dedicated to improving the health of New Jersey's babies and mothers through equitable delivery of health care services.

Rec. 3.3

Establish a Center in the State Capital that focuses on innovation and research in maternal and infant health through partnerships with the state's academic, funder, business and faith communities.

NEW JERSEY HUMAN SERVICES

The Center will be a hub for multiple types of programs and services

- Pre- & Post-Natal Clinical Services
- Perinatal Workforce Education & Training
- Social Services and Wrap-around Supports
- Policy, Research, & Data Collaborative
- Maternal & Infant Health Innovation Incubator

NJEDA Issued RFQ for Three Lead Entities

NJEDA SEEKING SERVICE PROVIDERS FOR TRENTON-BASED MATERNAL AND INFANT HEALTH INNOVATION CENTER

NJEDA issues RFQ for three service providers to anchor first-of-its-kind center; advance First Lady Tammy Murphy's Nurture NJ strategic plan

NJEDA also seeking expressions of interest from community partners

TRENTON, N.J. (April 3, 2023) – The New Jersey Economic Development Authority (NJEDA) today took its next step toward developing the Trenton-based Maternal and Infant Health Innovation Center, which is central to First Lady Tammy Murphy's Nurture NJ initiative, by issuing a Request of Qualifications (RFQ) for three anchor tenants to lead the Center. The NJEDA is seeking a health care services provider, an Institution of Higher Education (IHE), and a Trenton-based Multi-Service Organization (MSO) to serve as initial anchor tenants at the Center. These three Lead entities will work collaboratively to provide services to New Jersey expectant and new parents and babies, advance the growth and development of the perinatal workforce, and deliver maternal and infant health policy, research, and innovation focused on eliminating racial disparities in maternal and infant health outcomes.

RFQ and subsequent RFP process will select three anchor tenants that will enter into long-term lease:

- Lead Health Care Services Provider
- Lead Institution of Higher Education (IHE)
- Lead Trenton-Based Multi-Service Organization (MSO)

Read more: Request for Qualifications

NEW JERSEY HUMAN SERVICES

Lisa Asare, Deputy Commissioner
Lisa.Asare@dhs.nj.gov

Thank you!

Nurture NJ: www.nj.gov/nurturenj

NNJ Strategic Plan: www.nurturenj.nj.gov

NEW JERSEY HUMAN SERVICES

NJ Title V Programs Utilizing Non-traditional Partners in Pursuit of Health Equity

November 7, 2023

NANCY SCOTTO-ROSATO, PHD

ASSISTANT COMMISSIONER

DIVISION OF FAMILY HEALTH SERVICES

NEW JERSEY DEPARTMENT OF HEALTH

Presentation Objectives

- Maternal Health Programs & Non-Traditional Partners
  - Colette Lamothe-Galette Community Health Worker (CLG-CHW) Institute
  - Community Doulas & Doula Learning Collaborative (DLC)
  - Healthy Women, Healthy Families (HWHF)
- Medicaid Unwinding & Title V

New Jersey's Maternal/Infant Mortality Rates & NurtureNJ

- NJ has significant racial and ethnic disparities in maternal and infant mortality.
- A Black NH mother in New Jersey is seven times more likely than a White NH mother to die of pregnancy-related complications.
- A Black NH baby is about three times more likely than a White NH baby to die before their first birthday.
- For Hispanics, Hispanic women are 3.5 times more likely to die from pregnancy related deaths compared to White NH women and Hispanic infants are 1.6 times more likely than non-Hispanic infants.
- Title V programs cover many Nurture NJ Objectives but primarily focuses on:
  - Addressing SDOH through Collaboration & Support community infrastructures for power-building

Perinatal Workforce: Colette Lamothe-Galette Community Health Worker Institute

Colette Lamothe-Galette
Community Health Worker Institute
NJ Health

- Since October 2020, the Colette Lamothe – Galette Community Health Worker Institute (CLG-CHWI) has trained over 400 CHWs in New Jersey.
- Secured partnerships with six county community college that deliver a standardized, virtual core competencies training.
  - 144 classroom hours, 240 on-the-job hours
- 13 Competencies include: . Effective communication, Individual and Community Assessment, Outreach Methods and Strategies, Cultural Responsiveness and Mediation, Education to Promote Healthy Behaviors, Care Coordination & Systems Navigation, Public Health Concepts and Approaches, Advocacy and Community Capacity Building, Documentation, Professional Skills and Conduct, Covid-19 Education, Training and Safety, Health Equity and Disparities, Impact of Adverse Childhood Experiences.
- Efforts are underway to create specialized tracks in chronic disease, genetic screening, mental health and substance use, and maternal and child health.

CHW Partnership with DHS (Medicaid)

- The state's approved section 1115 demonstration includes a CHW pilot program that earmarks $25 million over the five-year waiver period for Managed Care Organizations (MCOs).
- Other Home and Community Based Services opportunities-training CHWs to work with individuals with mental health and and/or developmental disability.

NEW JERSEY COMMUNITY DOULA PROGRAM

- Equip Doulas to meet the needs of Medicaid populations and under-served communities.
- Provide continuous labor support
- Provide culturally competent and community-based care.
- Focus on the reduction of maternal stress and basic physical and relational needs.
- Facilitate positive communication between the mother and health professionals.
- Support early attachment and mothering behaviors

NJ Health
New Jersey Department of Health

Perinatal Workforce: Community Doulas & the Doula Learning Collaborative

- Built on a successful doula pilot program
- Program combines public and private funding and collaborative input from several partners, including Medicaid.
- The Community Doula Program, through the Doula Learning Collaborative, provides guidance, standardized training, and support to new and practicing community doulas
  - Accepts multiple certification pathways, and provides supplemental NJ-specific training to prepare community doulas
  - ~80 community doulas newly registered as Medicaid providers since 2021
  - Medicaid billing support
  - Building awareness at hospitals, and creating hiring pathways at Community Based Organizations (CBOs)

HEALTHY WOMEN, HEALTHY FAMILIES

The main goal of the HWHF is to improve maternal and infant health and reduce health disparities.

Original HWHF implemented 4 activities to address the maternal and infant health crisis in NJ: Doula pilot, Centering Pregnancy, Fatherhood Program, and Breastfeeding education.

HWHF 2.0 implements new activities focusing on addressing issues in the postpartum period by providing

1. Non-Traditional Group Breastfeeding Education (partners, fathers, grandparents, teens, etc.)
2. Post Partum Doula Care

These novel activities are focused in 8 key municipalities with high rates of Black and Hispanic Maternal and Infant Mortality.

1. CHWs continue to act as a bridge integrating community, healthcare, and social services to support birthing women. This activity is offered STATEWIDE.

2. Post-partum Doulas will provide care during the "4th trimester" and ensure postpartum follow-up to increase postpartum health.

3. Breastfeeding initiative will continue to help support and educate breastfeeding mothers and their support systems to ensure prolonged and successful breastfeeding continuation.

NJ Health
New Jersey Department of Health

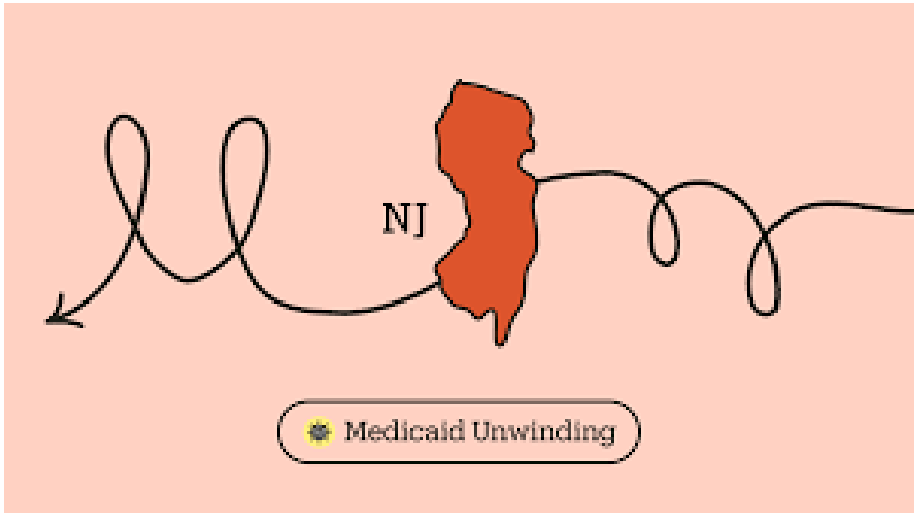
Healthy Women, Healthy Families (HWHF) & Partnerships

- One major component of the HWHF initiative is creating non-traditional partnerships between the HWHF grantees, community organizations, and community members to serve as a resource to birthing populations and to partner on maternal and child health (MCH) activities.
- Requirement that at least 10% of funds need to be sub-contracted to local, community-based partners such as local churches, libraries, and other community-based groups.
- Convene Community Advisory Boards (CABs) consisting of MCH partners/grantees and community members to ensure that the birthing population, community organizations, grantees, and other MCH stakeholders can participate equally at the same table, make informed decisions that reflect community values, and ensure community voices are highlighted.

TITLE V ROLE AND MEDICAID UNWINDING

- Education sessions by Medicaid staff was delivered to:
  - Community Health Workers, Community Doulas
  - WIC Local Agencies
  - Special Child Health Case Management Units
  - Home Visiting staff

- Partnering with Medicaid and the SPAN Parent Advocacy Network– (houses Family Voices in NJ) to develop PSA, community outreach, and dissemination of information on re-enrollment, specifically targeting populations most impacted by the disenrollment.



Colorado MCH Addresses SDoH

Lyz Riley Sanders - Title V Deputy Director

MCH Framework

Vision: To Increase Community and Family Resilience

COLORADO
Department of Public Health & Environment

STRATEGIC ANCHORS

- Racial equity
- Community inclusion
- Moving upstream

HEALTH IMPACT AREAS

- Behavioral health
- Access to care
- Nutrition security

PRIORITIES 2021-2025

- Create safe and connected built environments
- Increase prosocial connection
- Promote positive child and youth development
- Improve access to supports
- Increase social emotional well-being
- Reduce racial inequities
- Increase economic mobility

STRATEGIES → **OUTCOMES** → **MEASURES**

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under the Colorado Maternal and Child Health Block Grant B04MC33825. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

4/12/2022

COLORADO
Department of Public Health & Environment

2021-2025 MCH Strategic Anchors

The three strategic anchors that tether the seven MCH priorities to a shared vision. They provide a lens through which every decision is viewed.

Racial Equity

Community Inclusion

Moving Upstream

Racial Equity as a Priority

Goal: To reduce racial inequities for Colorado's families by implementing changes to our MCH program's policies and practices.

- Resources
- Strategies
- Outcomes

Racial Equity as a Strategic Anchor

RACIAL EQUITY is the condition that would be achieved if one's racial identity no longer predicted how one fares in life.

- Individual
- Interpersonal
- Institutional
- Structural

Example: Economic Mobility Priority Area

Goal: Increase equitable economic opportunities and access. Increase economic mobility for Colorado families by addressing racial inequities and disparities in our policies, practices, and systems.

Strategy 1: Identify and implement policy/systems changes that support increased tax credit claims.

Strategy 2: Engage community partners to strengthen and expand common eligibility and enrollment in services that support economic mobility.

Strategy 3: Gather and share data, research and policies related to improved access to economic mobility and the benefits of improved economic mobility among Coloradans.

Atypical Partners

IRS

AmeriCorps

Dept. of Revenue

U.S. Dept. of Labor

Banks

KUVO Jazz 89.3FM

Partner: U.S. Department of Labor

- “Fostering Access, Rights, and Equity” grant
- 8 CBO partners
- 53 VITA sites
- Public awareness media campaign
- Outreach toolkit
- Language justice focus

Lessons Learned: Partnering Effectively

- Answer: Why Public Health?
- Tailor messaging
- Remember common agenda
- Community inclusion is key!

Thank you.

Questions or comments? Email:
lyz.sanders@state.co.us

COLORADO
Department of Public Health & Environment

Housing:
A Community-Identified Priority Need

Noya Woodrich| Child & Family Health Division Director

Minnesota Department of Health

Context: Housing & Homelessness in MN

- Minnesota has one of the largest gaps in homeownership between white and BIPOC residents.
  - Non-Hispanic white Minnesotans own homes at 3.3 times the rate of Black/African American Minnesotans.
- Over half of the lowest-income families in Minnesota spend more than 50% of their income on housing costs.
- Homelessness has a disproportionate impact on marginalized groups in Minnesota. Compared to the non-Hispanic white population:
  - Indigenous people are 30 times more like to experience homelessness.
  - Black/African American people are 12 times more likely to experience homelessness.
  - People of mixed race are 7 times more likely to experience homelessness.
  - Hispanic people are 3 times as likely to experience homelessness.

Context Cont.

- Compared to the general state population:
  - The rate of death is 3 times higher among people who experience homelessness in Minnesota.
  - American Indian people experiencing homelessness in Minnesota have 5 times higher rates of death.
  - Deaths from substance use are 10 times higher among people experiencing homelessness in Minnesota.
- Housing was consistently one of the most reported needs of children, women, and families in Minnesota throughout the 2020 Needs Assessment process.
  - Mentioned 752 times in the Discovery Survey – second most stated need from respondents.

"Access to **safe and affordable housing** is connected to every aspect of people's lives and is **a critical factor** in financial security, academic success, and the **health and wellbeing of children, women, and families**."

Minnesota Title V 2020 Needs Assessment

Housing: Cross-Cutting/Systems Building Priority

- **Objective:** By 2025, decrease the proportion of Minnesota adolescents who report staying in a shelter, somewhere not intended as a place to live, or someone else's home because they had no other place to stay in the past 12 months by 15%.
- **State Performance Measure:** Proportion of Minnesota adolescents who report staying in a shelter, somewhere not intended as a place to live, or someone else's home because they had no other place to stay in the past 12 months.
- **Data Source:** Collected every three years in the Minnesota Student Survey for 8th, 9th, and 11th grade students.

Strategies

Strategies to reduce housing disparities need to focus on ***addressing the deeply rooted structural barriers surrounding housing policy and access that result from systemic racism****.*

1. Expand Funding Opportunities
2. Promote Person-Centered Approach/Services
3. Create/Innovate Housing
4. Focus on Policy Change

Activities & Partnerships

Activity	Description	Partnership
Promote housing support for families through Homework Starts with Home grant	Community-based grants provided to housing programs working in collaboration with schools and early childhood programs to address homelessness and housing instability among students and their families.	Minnesota Housing and Finance Agency (Homework Starts with Home grant)
Promote Continuum of Care Models to Focus on Homeless Prevention and Assistance	Provide supportive services and/or financial assistance to families with children and youth/ unaccompanied youth who are homeless or at imminent risk of becoming homeless through MN Housing and Finance Agency's Family Homeless Prevention and Assistance Program, in coordination with continuum of care. • During FFY2022 these services were provided through 20 grantees that served all 87 counties in Minnesota. • Funds can be used for direct assistance (rent, utilities and other expenses to address housing crisis) or services (housing navigation, case management, outreach staff, coordinated entry assessment).	Minnesota Housing and Finance Agency; Community Continua of Care

Activities & Partnerships, Cont.

Activity	Description	Partnership
Increase access to safe and affordable housing for people who are pregnant or parenting infants	• Family home visitors provide screening, referral, and support services to clients/families who are experiencing homelessness.	Family Home Visiting Programs
Develop and sustain cross-sector partnerships to support families experiencing homelessness	• Participate in the Calling All Sectors national collaborative – work to address infant mortality disparities in African American/Black and American Indian communities to ensure no child is born into homelessness in Minnesota by generating systems level policy and strategic change. • A sustainability assessment report was developed and will be used to inform strategies and activities moving forward, particularly for the 60+ CAS partners and beyond to integrate within their various professional spaces.	Pew Charitable Trust; Robert Wood Johnson Foundation; MN Department of Health Center for Health Equity; MN Housing and Finance Agency; MN Department of Human Services; MN Governor's Children's Cabinet; Minnesota Indian Women's Resource Center

Activities & Partnerships, Cont.

Activity	Description	Partnership
Provide adequate, dignified shelter options for children and families	• COVID-19 pandemic response priority to address the needs of homeless families • Dedicated team to work with residents and staff of homeless encampments, emergency homeless shelters, domestic violence shelters, board and lodges, transitional housing, and permanent supportive housing to provide routine testing and vaccinations. • Learn more about the current and ongoing housing and homelessness landscape in Minnesota, as well as to engage in conversations, strategic development, and policy change around the interrelated linkages of MCH populations, housing, and homelessness. • Partnering with other government agencies and community partners to support a system of wraparound supportive services and referral pathways for people who are pregnant and/or parenting an infant and experiencing homelessness.	Minnesota Housing and Finance Agency; Minnesota Interagency Council on Homelessness, Local Public Health, and local human services departments

Activities & Partnerships, Cont.

Activity	Description	Partnership
Participate on the Minnesota Interagency Council on Homelessness	MICH developed Heading Home Together, an action plan to prevent and end homelessness, identifying what state agencies can do and is reflective of the input of people who have experienced homelessness, practitioners who work in the field, and Federal policy requirements and guidance.	MN Interagency Council on Homelessness, including 10 additional state agencies, the Met Council, and the Governor's Office
Engage in the Justice Strategic Planning led by the Minnesota Interagency Council on Homelessness	• Phase 1: community-driven process to develop a definition of housing, racial, and health justice for people experiencing homelessness. • Phase 2: focused on developing strategies to advance housing, racial, and health justice.	MN Interagency Council on Homelessness, including 10 additional state agencies, the Met Council, and the Governor's Office
Prioritize the interconnection between health, homelessness, and housing to drive policy and systems change	• The Senior Advisor on Health, Homelessness, and Housing was hired in Spring 2022, and to the best knowledge of MDH and the CDC, is the first position of its kind at a state health department. This position will continue to work with state and local partners on public health and homelessness post-COVID, including as a lead in the MICH work around the Justice Strategic Plan.	MN Department of Health Infectious Disease, Epidemiology, Prevention & Control Division

Activities & Partnerships, Cont.

Activity	Description	Partnership
Partner with the Minnesota Department of Health's Senior Advisor on Health, Homelessness, and Housing to Engage in Strategic Development and Policy Advocacy	Explore opportunities engage in policy change to reduce housing disparities such as increasing efforts to access emergency assistance that can be used for housing and advocating for improved housing policy at local, state, and federal level.	Senior Advisory on Health, Homelessness, and Housing
Partner with the Minnesota Department of Education (MDE) to Improve and Expand Housing and Homelessness Screening for Students and their Families	• Better understand how school districts currently screen students for housing needs and provide housing resources to their families. • Explore how to expand access to grants such as Homework Starts with Hom.	MN Department of Education

HRSA
Health Resources & Services Administration

Partnerships to Advance Equity in Title V

Federal Partner Panel

Title V MCH Federal-State Partnership Meeting

November 7, 2023

Vision: Healthy Communities, Healthy People

Adrienne Babbitt

Field Office Director, NV
Office of Field Policy and Management
Maternal Heath Charter Lead
U.S. Department of Housing and Urban Development
(HUD)

Adrienne.M.Babbitt@HUD.GOV

Whitehouse Blueprint – A whole of Government Strategy

HUD roles outlined

Connect 

Partner 

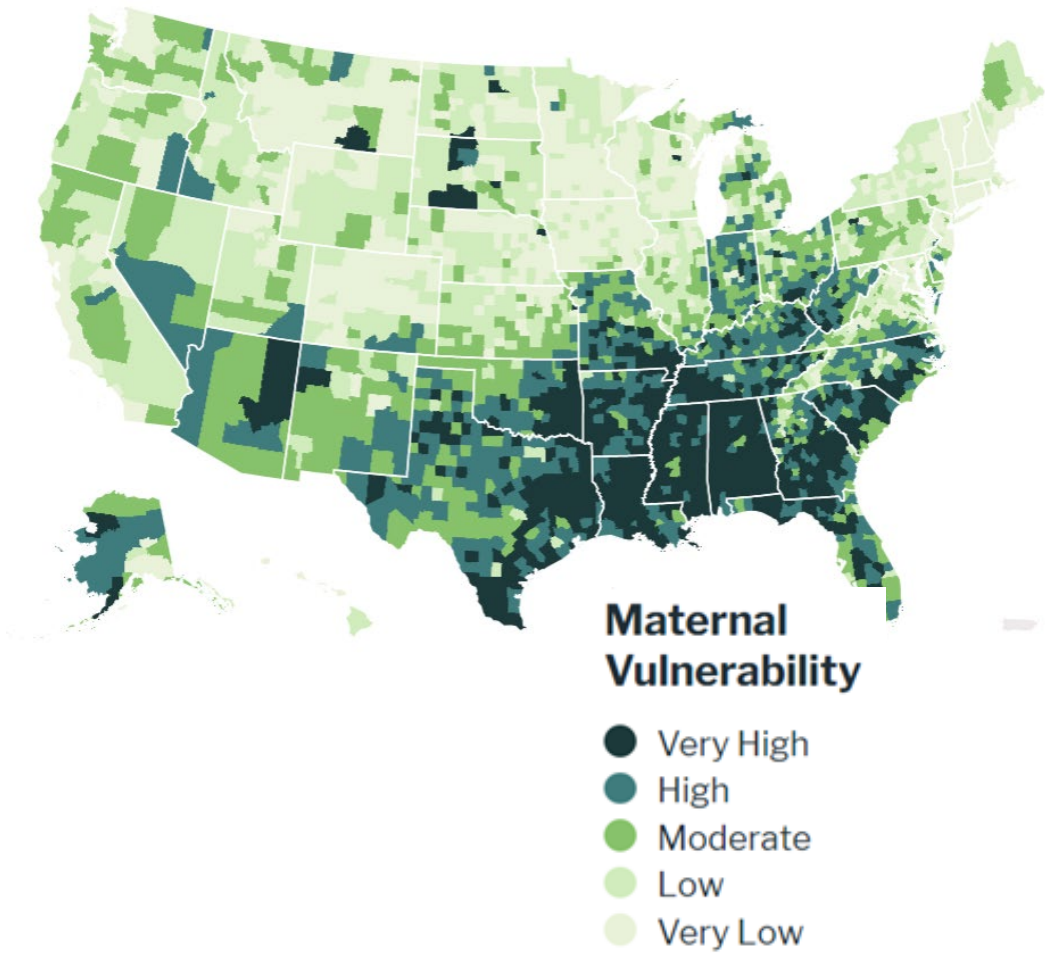
Educate 

HUD Charter - a team formed from several HUD field offices that are geographically dispersed but connected by a common goal or initiative.

HUD TA Identified

Selection Criteria

MOTHER
Maternal Outcomes Through Housing Environments Reimagined



Improve access to maternal health services in targeted communities through action plans implemented by a HUD funded TA provider in partnership with EnVision Centers and key stakeholders.

- **Who**
- **What**
- **Where**
- **When** FY23 & FY24

Homebase Technical Assistance Birmingham, AL Campus of Hope

- HUD Public Housing Authority Partner
- Listening Session with local mothers
- Inventory of Community providers
- Funding Opportunities
- Marketing materials
- Community Action Plan
- DV awareness month
  - VAWA rights
  - Panel of survivors, providers, public safety representatives

Homebase Technical Assistance Jackson, MS – Golden Key

Key Partners:

Local HUD Field Office support

Magnolia Medical Foundation

Jackson Housing Authority

Community Baby Shower

November Diabetes awareness month

Why Partner with HUD?

Integrate Healthcare & Housing

Focused on equity for underserved populations

Direct access to local communities

Housing is a key social determinate of health

HUD Strong Families

Health Pillar – Nutrition, Fitness, Mental health, addiction, social determinants of health

- Education
- Outreach
- Webinars
- Events

Housing is Healthcare

Partnership Opportunities with HUD

- Public and Indian Housing
- Lead Hazard Control and Healthy Homes
- Multi Family Housing
- Community Planning & Development
- Office of Native American Programs
- Fair Housing Equal Opportunity/VAWA
- Office of Housing Counseling

HUD Links to locate partnerships near you

- HUD Field office
- Continuum of Care
- Community Planning & Development
- Public Housing Authority
- Housing Counseling Agencies
- Office of Native American Programs

Partnerships to Advance Equity in Title V Plenary Session

Healthy Families Community-Based Perinatal Health Initiative

November 7, 2023

Sonsiere Cobb-Souza
Director, Division of Program Operations
Office of Minority Health, HHS

OMH®
U.S. Department of
Health and Human Services
Office of Minority Health

Purpose of the COPHI Initiative

- The Healthy Families Community-Based Perinatal Health Initiative (COPHI) is intended to develop innovative models for integrating community-based maternal support services (COMSS) into perinatal systems of care.
  - **COMSS are social and supportive services that address social determinants of health (SDOH), such as health literacy; pregnancy, childbirth, and parenting education; cultural and linguistic diversity; exposure to trauma, housing; food; and transportation.**
  - **Trained individuals, such as doulas and community health workers (CHWs), provide these services during pregnancy, labor, and delivery, and after delivery.**
  - **Integrate Healthy People 2030 and other measures into the COMSS Integration model**
  - **Identify, utilize, and disseminate best practices**
- OMH expects recipients' innovative models will improve pregnant and post-partum people's health outcomes and reduce racial and ethnic disparities.

PUBLIC HEALTH FOUNDATION ENTERPRISES, INC.

Heluna Health
EMPOWERING POPULATION HEALTH INITIATIVES SINCE 1969

PROJECT TITLE

SHERO “Shaping Healthy Equitable Reproductive Outcomes”

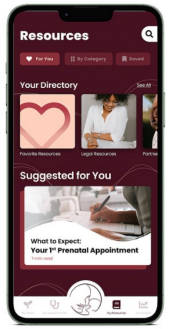
POPULATION OF FOCUS

Black/African American communities in New Orleans, specifically Orleans Parish, Jefferson Parish, Plaquemines Parish, and St. Bernard Parish

BIRTH BY US

APPROACH

The initiative **integrates technology** powered by Birth By Us (pregnancy and postpartum app for Black women). It combines four individually shown interventions to improve Black perinatal outcomes: (1) group care and support, (2) racially concordant care teams, (3) doulas and CHWs, and (4) home visits.



PARTNERS

- Health Centers, including Mental health service providers
- Community–Based Organizations
- Professional Associations

SAINT FRANCIS MEDICAL CENTER

PROJECT TITLE

Bootheel Perinatal Network: Clinical-Community Integrated Care Coordination Model

POPULATION OF FOCUS

People of color in southeast Missouri, specifically Cape Girardeau County and the Missouri Bootheel counties of Dunklin, Mississippi, New Madrid, Pemiscot, Scott, and Stoddard

APPROACH

The initiative focuses on **using doulas and community health workers as active clinical care team members** to expand care coordination and linkage to community-based resources that help address social risk factors for pregnant and postpartum people.

PARTNERS

- Health Centers, including Mental health service providers
- Community–Based Organizations
- Professional Associations

UNIVERSITY OF NEBRASKA MEDICAL CENTER

University of Nebraska Medical Center

PROJECT TITLE

COMSS ADVOCATES:
“The COMSS ADVancing Ongoing Community AcTivities for Equitable Systems”

POPULATION OF FOCUS

- **Minneapolis site:** American Indian and Alaska Native populations
- **Nashville site:** African-American populations

APPROACH

A **multi-phase project** that includes developing coalitions within demonstration sites, identifying healthcare settings, and integrating COMSS into existing healthcare systems and providers with the **support of CityMatCH**, a well-experienced national organization.

PARTNERS

- Health Departments
- Institute of Higher Education
- Health Centers
- Community–Based Organizations
- Professional Associations

WOMEN & INFANTS HOSPITAL OF RHODE ISLAND

PROJECT TITLE

RI COMSS: “Rhode Island Community-based Maternal Support Services Bundle for Advancing Perinatal Health Equity”

POPULATION OF FOCUS

- **Black, Indigenous, and People of Color** in Rhode Island

APPROACH

The project aims to **screen patients for social determinants of health** (SDOH), substance use/behavioral health issues, and high-risk pregnancy factors. If a patient screens positive, care managers, CHWs, doulas, physicians, and community organizations are brought in to **create personalized perinatal health support plans**.

PARTNERS

- Health Centers
- Community–Based Organizations


OMH
U.S. Department of
Health and Human Services
Office of Minority Health

THANK YOU!

USDA Food and Nutrition Service
U.S. DEPARTMENT OF AGRICULTURE

Opportunities for FNS Partnership with Title V

Ruth Morgan, MPH
Branch Chief for Evaluation, USDA FNS Office of Policy Support

Title V Federal State Partnership Meeting

November 7, 2023

FNS Programs

WIC
CACFP
NSLP/NSBP
SNAP-Ed

Partnering with WIC

Co-location of services
Referrals
Data matching
Joint trainings for staff

Thank You!

https://www.fns.usda.gov/research-analysis

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