Healthy Beginnings
System

Services at a Glance
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**Healthy Beginnings System Description**

The Children’s Services Council Healthy Beginnings System (HB System) is a voluntary coordinated set of services for prenatal and postnatal women, and families with children birth to age 5. Operational in Palm Beach County since 2009, it is designed to promote healthy births, reduce child maltreatment, and promote children’s kindergarten readiness. Within the Healthy Beginnings System, multiple agencies are strategically aligned so that they work together as a single program to deliver specific services (See Appendix A).

Families enter the Healthy Beginnings System via a screening process to identify risks for a potential poor birth outcome or concerns around infant/child development. Families are universally screened by the Healthy Start Prenatal Risk Screen, the Healthy Start Infant Risk Screen and the Ages & Stages Questionnaire to determine level of risk and likelihood to receive for Healthy Beginnings Services. Based on the nature of the screens used to determine likelihood to receive for system services, we expect that fewer than 25% of families will screen into services due to the number of risk and protective factors that are present. Screening and assessments measure a family’s health (and access to care), stress level, maternal depression, environmental risks, child developmental and social-emotional challenges.

Entry to the Healthy Beginnings System is facilitated by two entry agencies. Healthy Mothers, Healthy Babies is the entry agency that serves the needs of pregnant women; Home Safe is the entry agency that serves the needs of families with children birth through 60 months. These agencies engage families, identify their needs and strengths, and match them with appropriate prevention and early intervention services within the Healthy Beginnings System, as well as other community services.

Prenatal and early childhood intervention services may include: access to a medical provider and facilitating access to a funding source for that care; maternal depression counseling and infant mental health support; nutritional information; childbirth and breastfeeding education; and family support services.

Additional early intervention services may include: home visiting programs to prevent child abuse and neglect and improve parent-child attachment; identification and treatment of children’s physical, developmental, emotional or behavioral issues; and literacy and school-readiness services.

The Healthy Beginnings System consists of:

- 20 agencies
- Providing over 25 services
- To pregnant women and families with children ages birth to age 6 throughout Palm Beach County

Overall, the Healthy Beginnings System seeks to improve birth outcomes by providing access to direct health and social services for pregnant women whose chances of having a healthy baby are hampered by such risk factors as poverty, limited access to health care, poor nutrition, age, substance abuse, homelessness, domestic violence and more. The system also seeks to reach young children exhibiting developmental or behavioral issues that could hamper later school success. Through early intervention, many such issues can be dealt with prior to the child entering the formal school setting, thus improving opportunities for school success.
## Easter Seals - Early Steps

### Purpose
Early Steps, Florida’s early intervention system ensures that infants and toddlers with special needs and their families achieve their full potential in the context of everyday relationships, activities, and places.

### Intended Outcomes
Increased opportunities for infants and toddlers with disabilities to integrate into the community.

### Target Population
Children ages birth to thirty-six months.

### Eligibility Requirements
Children eligible must:
- Demonstrate a delay of **2 standard deviations below the mean** (a score of 70 or below) on a standardized evaluation in one area of development OR 1.5 standard deviations (78 or below) below the mean in **2 or more** areas of development: motor, communication, social-emotional, self-help and cognitive; or
- Have a diagnosed **established** medical condition associated with long term developmental delays. Established conditions fall into one of the following areas:
  - Genetic and metabolic disorders
  - Neurological disorder
  - Autism Spectrum Disorder
  - Severe attachment disorder
  - Significant sensory impairment (vision/hearing)
  - Children with a birth weight of 1200 grams or less will be considered eligible based on an established condition- EC.

### Ages Served
Birth to 36 months

### Languages Offered
English, Spanish, Haitian Creole and translation services for other languages as needed

### Risk Factors
Developmental delays, medical conditions or diagnosis that is associated with developmental delay and atypical behavior, growth or development.

### Program Model:
Services are provided using a Primary Service Provider approach, which is to provide coaching and education to the family/primary care giver as well as to the child.

### Dosage
Service frequency and dosage is defined for each child at the time of eligibility determination and the development of each child’s Individual Family Support Plan (IFSP).

### Duration of Service
Services are provided until the child meets his or her developmental outcomes established on the Individual Family Support Plan or reaches the age of 36 months.

### Location of Service
Home, child care center, public place (i.e. McDonald’s or Public Library)

### Curriculum/Content
Child Development, parent education and support provided by a Primary Service Provider (PSP) Team. Each PSP Team is comprised of a Service Coordinator, Physical Therapist, Occupational Therapist, Speech Therapist and Infant Toddler Developmental Specialist. One member of the Team is selected as the “Primary Provider” and visits the child and parent on an ongoing basis. Parent coaching and education is provided to support the family as their child’s first teacher focusing on how children learn within their everyday routines and activities.

### Critical Components/Elements
Parent education of age appropriate child development. Family follow-through of recommended strategies from IFSP

### Agency Contact(s)
Marissa Barrera, Program Coordinator: (561) 882-6425  mbarrera@fl.easterseals.com
Lori Sang, Program Director: (772-380-9601) lsang@fl.easterseals.com

### Site Locations
Palm Beach County

### Overall Benefit to Families:
Helps children with developmental delays in achieving developmental skills that are closer to their same-aged, typically-developing peers, while providing information that parents/caregivers may use to strengthen their children’s development.
# Esereh Youth and Family Center - Outreach

## Purpose
Outreach activities are designed to target populations that are traditionally underserved or to populations in which barriers to obtaining necessary early identification and intervention services are present. Barriers can include language, cultural beliefs, cultural history, transportation and acculturation.

## Intended Outcomes
- Increase access to knowledge and awareness of the importance of prenatal and developmental screening for pregnant women and for families with children ages birth - 5.
- Increase awareness of the services offered by the Healthy Beginnings (HB) System for pregnant women and for families with children ages birth - 5.
- Refer pregnant women and families with children ages birth - 5 to the appropriate HB Entry Agency for prenatal and/or developmental screenings.
- Increase prenatal and developmental screening rates for target population.
- Educate and refer to community resources and programs, as appropriate.

## Target Population:
The target population will be Haitian/Haitian-American pregnant women and families with children birth to 5 years old who are at risk for:
- Poor birth outcomes
- Child maltreatment/abuse/neglect
- Child exhibiting possible development delays (motor, cognitive/problem-solving, language, social emotional)
- Poor parent/child attachment/relationships

## Eligibility Requirements
- Pregnant women and children aged 0-5

## Ages Served
- Pregnant women and children aged 0-5

## Languages Offered
- Haitian Creole, French & English

## Risk Factors
- Pregnant women at-risk for poor birth outcome; Children at-risk for poor developmental outcomes

## Program Model:
N/A

## Dosage
N/A

## Duration of Service
Depends on the amount of engaging that is needed

## Location of Service
Throughout Palm Beach County

## Curriculum / Content
Ages and Stages Questionnaire-3/Developmental screening

## Critical Components / Elements
Targeted Outreach and referral for at risk families.

## Agency Contact
Evelyne LaFalaise Tel: 561-357-5630 email: elafalaise@esereh.org

## Site Locations
2200 N. Florida Mango Road, Suite 301, West Palm Beach, FL

## Overall Benefit to Families:
Better birth outcomes, reduced risk of child abuse and neglect, early detection of developmental delay, improved parent/child attachment / relationship
<table>
<thead>
<tr>
<th><strong>Purpose</strong></th>
<th>To provide a statewide system of voluntary, community-based home visitation services that strengthen families, promote positive parent-child relationships and optimize the health and development of children.</th>
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</thead>
</table>
| **Intended Outcomes** | • Prevent the incidence of child abuse and neglect  
• Enhance parents’ ability to create stable and nurturing home environments  
• Increase parents’ ability to develop positive parent-child relationships  
• Promote child health and development  
• Ensure that families’ social and medical needs are met |
| **Target Population:** | Families residing in targeted geographic areas: 33404, 33407, 33409, 33411, 33415, 33435, 33462, 33430, 33493, 33476, 33460, 33461 |
| **Eligibility Requirements** | Those scoring 3 or more on the Healthy Start Prenatal Risk Screen (PRS), using Healthy Families scoring are eligible for administration of the Healthy Families Florida Assessment Tool (HFATT). Also, those whose response to the question on the PRS “is this a good time for your to be pregnant?” is “no” and the response to the question on the PRS “thinking back just before you got pregnant did you want to be pregnant now, pregnant later or not pregnant?” is “not pregnant” will be also be eligible for administration of the HFATT. Families must score 13 or more on this assessment to be offered the program. |
| **Ages Served** | Prenatal to 5. Entry to the program can take place anytime in the prenatal period through 3 months. |
| **Languages Offered** | English, Spanish, Haitian Creole |
| **Risk Factors** | Low-income, single parents, less than a high school education, socially isolated, late or inadequate prenatal care |
| **Program Model:** | Curriculum based (Growing Great Kids), services provided in accordance with Healthy Families America Standards. |
| **Dosage** | Varies based on level. Most intense is at least once per week with the least intense being once per month |
| **Duration of Service** | Up to 5 years |
| **Location of Service** | Home |
| **Curriculum/Content** | Healthy Families Florida uses the Growing Great Kids curriculum |
| **Critical Components/Elements** | • Services are initiated during pregnancy or shortly after the baby is born.  
• Services are voluntary and include a voluntary risk assessment.  
• Services are intensive and are provided for up to five years.  
• Services are provided in a way that respects the culture of the population.  
• Services are offered during flexible hours.  
• Services focus on supporting parents and their families.  
• Families are connected to a medical provider.  
• Families are linked to additional service in the community, as needed.  
• Caseloads are up to 25.  
• Intensive supervision is provided to staff.  
• Intensive pre-service and on-going training is provided for staff.  
• Strong collaborative partnerships are established in the community. |
| **Agency Contact** | Kathy Tancig – Families First Tel: (561) 721-2802 x222 email: ktancig@familiesfirstpbc.org |
| **Site Locations** | 3333 Forest Hill Blvd, West Palm Beach and 1500 NW Avenue L, Belle Glade, FL |

**Overall Benefit to Families:** Enhance parents’ ability to create stable and nurturing home environments, increase parents’ ability to develop positive parent-child relationships, promote child health and development, ensure that the families’ social and medical needs are met, ensure families are satisfied with services and prevent child abuse and neglect in high risk families.
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<th><strong>Healthy Mothers, Healthy Babies - CenteringPregnancy™</strong></th>
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<td><strong>Intended Outcomes</strong></td>
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<td><strong>Agency Contact</strong></td>
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<td><strong>Site Locations</strong></td>
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**Overall Benefit to Families:** Through this unique model of care, women are empowered to choose health-promoting behaviors. Health outcomes for pregnancies, specifically increased birth weight and gestational age of mothers that deliver preterm, and the satisfaction expressed by both the women and their providers, support the effectiveness of this model for the delivery of care.
### Purpose
As the Prenatal Entry Agency for The Healthy Beginnings System, Healthy Mothers, Healthy Babies provides screening and assessment services for pregnant teens and women who may need to be linked to prevention and early intervention programs within the Healthy Beginnings System.

### Intended Outcomes
- Improved access to Prenatal Care
- Increased access to payor source for prenatal care
- Improved health outcomes and savings in health care costs
- Increased referrals to appropriate health and social services
- Increased healthy births in Palm Beach County
- Increased System education
- Increased Prenatal screening & assessment

### Target Population:
**Pregnant women and expectant families**

### Eligibility Requirements
Pregnant women residing in Palm Beach County

### Ages Served
12-56 years (women of childbearing age)

### Languages Offered
- English
- Spanish
- Haitian Creole
- Kanjobal
- French

### Risk Factors
As identified on Screening and Assessment tools

### Program Model:
The program design consists of activities and services within the community that supports and enhances the community’s ability to promote optimal health and developmental outcomes for all pregnant women and babies born in Florida.

### Dosage
One to three contacts to establish payor Source, medical home and for referrals to appropriate services; additional contacts may be necessary depending on the intensity of needs

### Duration of Service
90 days approximately

### Location of Service
Office Visits in WPB, Lantana and Delray Beach, Home visits, health department clinics, and community locations, schools, Healthy Beginnings System agencies

### Curriculum / Content
- Prenatal Risk Screen and Healthy Start Standards and Guidelines
- Assessment- various
- Referrals and Linkages to Healthy Beginnings System and Community Resources
- Education (health, parenting, nutrition)
- Triple P Parent Education
- Baby Basics

### Critical Components/ Elements
- Screening
- Assessment
- Navigation
- Service Coordination
- Referral and Linkage
- Education
- Outreach

### Agency Contact
Lisa Greenwood, Director of Data and Quality Assurance
Tel: 561-665-4515 or email: lgreenwood@hmhbpb.org

### Site Locations
Northern, Southern, Central and Western Areas of Palm Beach County partnered with Healthy Beginnings Community Hubs

### Overall Benefit to Families:
Healthier birth outcomes and increased ability to access services for families in Palm Beach County
### Healthy Mothers, Healthy Babies - MomCare

<table>
<thead>
<tr>
<th><strong>Purpose</strong></th>
<th>To improve birth outcomes and infant health by helping women who are newly eligible for Medicaid to receive early and regular prenatal care.</th>
</tr>
</thead>
</table>
| **Intended Outcomes** | • Increase Healthy Start Screening rates  
• Increase participation in WIC  
• Improved access to Prenatal Care  
• Increased access to payor source for prenatal care and newborn  
• Increased referrals to appropriate health and social services |
| **Target Population:** | Pregnant Women who applied for SOBRA or Medicaid for their pregnancy  
Pregnant women residing in Palm Beach County and Medicaid eligible |
| **Eligibility Requirements** | Ages Served  
12-56 years (childbearing women)  
Languages Offered  
English, Spanish and Haitian Creole  
Risk Factors  
As identified on Screening and Assessment tools  
Program Model:  
A program to ensure pregnant women are screened for risk, and have access to health care services and care management services during their pregnancy. Women who are eligible for Medicaid during pregnancy receive assistance in selecting a health care provider; keeping medical appointments; and obtaining nutritional services and other Healthy Start services. |
| **Dosage** | Contact attempt within 30 days of enrollment: followed by contacts throughout pregnancy |
| **Duration of Service** | Duration of pregnancy or Medicaid eligibility |
| **Location of Service** | Office |
| **Curriculum / Content** | • Facilitate Prenatal Risk Screen  
• MomCare/SOBRA program guidelines  
• Referral to the HMHB Prenatal Entry Program  
• Referral to community resources  
• Education (health, parenting, nutrition) |
| **Critical Components / Elements** | Identify clients at risk for poor outcomes due to limited or no access to prenatal care  
Eligibility issues concerning access to prenatal care  
Referrals for additional services through the HMHB Prenatal Entry Program |
<p>| <strong>Agency Contact</strong> | Carla O’Donovan, Program Manager, 561-665-4527 or <a href="mailto:codonovan@hmhbpb.org">codonovan@hmhbpb.org</a> |
| <strong>Site Locations</strong> | Northern, Southern, Central and Western areas of Palm Beach |
| <strong>Overall Benefit to Families:</strong> | Healthier birth outcomes and increased ability to access services for families in Palm Beach County |</p>
<table>
<thead>
<tr>
<th><strong>Purpose</strong></th>
<th>Provide screening and assessment services for the Healthy Beginnings System through subsidized child care centers, maternity hospitals, and other community entry points. Child and family services include initial screening, second level evaluations, eligibility determination, developmental monitoring, parent education, referral, linkage and system navigation for Healthy Beginnings System Participants.</th>
</tr>
</thead>
</table>
| **Intended Outcomes** | • Improved access to appropriate services  
  • Increased referrals to appropriate Healthy Beginnings Systems  
  • Increased opportunities for children birth through age 5 to receive regular and proper child development screening and assessments. |
| **Target Population:** | Postpartum women and children ages birth to five |
| **Eligibility Requirements** | Postpartum women and children ages birth through age 5 who score in on standardized screens and assessments as defined below. |
| **Ages Served** | Children birth through age 5 |
| **Languages Offered** | English, Spanish, Haitian Creole |
| **Risk Factors** | Social-Emotional, Cognitive, Speech, Behavioral, Literacy or Developmental Delays |
| **Program Model:** | The program adheres to the Healthy Start Standards and Guidelines by providing screening and assessment services in the community that supports and enhances the community’s ability to promote optimal health and developmental outcomes for all babies born in Florida. |
| **Dosage** | Home Visit to obtain program consents and administer assessments; additional visits, if necessary to complete Triple P |
| **Location of Service** | Hospitals, home visits and community locations, schools, or other location convenient to family’s needs. |
| **Curriculum / Content** | Standardized Screening and Assessment tools include: Healthy Start I Infant Risk Screen, Postnatal Addendum, Ages and Stages Questionnaire-3 (ASQ-3), ASQ:SE, Edinburgh Depression Screen, CES-Depression Screen, Child Behavior Checklist and Language Survey (CBCL) Batelle Screener, Parent Stress Index (PSI), and Modified Checklist for Autism in Toddlers (M-CHAT). Triple P level two |
| **Critical Components / Elements** | • Birth to five screening and assessments  
  • Home Visits  
  • Service Coordination  
  • Outreach  
  • Navigation  
  • Parent education  
  • Referral and Linkage |
| **Agency Contact** | Paloma Prata, MS, Director of Prevention Services 561-383-9800 x1702  
  2840 6th Avenue South, Lake Worth, FL 33461; palomaprata@helphomesafe.org |
| **Site Locations** | **Home Visits** in the Northern, Southern, Central and Western Areas of PB County.  
  **9 Maternity Hospitals in Palm Beach County:** St Mary’s, Jupiter, Good Samaritan, Wellington, Palms West, Lake Side Medical, Bethesda, Boca Regional and West Boca.  
  **4 Entry-Agency Satellite Offices Include:** Lake Worth; West Palm Beach (co-located with HMHB); Boca Raton, and Belle Glade (co-located with DCF). |
| **Overall Benefit to Families:** | Helps newly delivered moms and children who score below standardized norms to access the appropriate services to help them work toward achieving better birth outcomes, reducing child abuse and neglect, and enter kindergarten on their developmental trajectory. |
### Home Safe – Growing Smart

<table>
<thead>
<tr>
<th>Purpose</th>
<th>A developmental surveillance program that uses the ASQ-3/ASQ:SE screen at developmental stages during the first two years of life to identify possible developmental/behavioral problems that may otherwise have eluded early detection. If children score at risk on the ASQ-3/ASQ:SE at any time during the program, they will be referred to the Entry Agency for second level assessment and, if needed referred to the appropriate Healthy Beginnings service.</th>
</tr>
</thead>
</table>
| Intended Outcomes | • Parents will demonstrate increased knowledge of children's developmental stages on the Knowledge of Infant Child Development Inventory  
• Two-year-old children will receive age-appropriate vaccinations. |
| Target Population: Eligibility Requirements | Parents with social risk factors with children who are 0 – 2 months old at time of intake  
• Clients who score low risk (3 or less) on the Healthy Start Infant Risk Screen (IRS) or IRS score becomes low risk after mitigation combined with one or more of the following:  
• No high school or GED diploma  
• 2 Children or more (newborn is second child)  
• Parent with no/little social support |
| Ages Served | Birth – 24 months; time at intake is 0 – 2 months |
| Languages Offered | English, Spanish, Haitian Creole |
| Risk Factors | See Eligibility Requirements |
| Program Model: | • The Developmental Support Specialist (DSS) will conduct home visits to educate parents on developmental milestones and provide activities appropriate to the corresponding stage using the ASQ-3/ASQ:SE.  
• At designated intervals (in lieu of a home visit) the DSS will mail ASQ-3 to the parent/guardian with a return envelope. Parents will be encouraged to complete the questionnaire(s) and return the score sheet(s) to the DSS, who will analyze the scores and send a response and/or contact the parent/guardian informing them of the results of the screen. The DSS will follow up with the parent/guardian to review the results and provide any recommended supportive activities to conduct at home and/or further need for assessment and services  
• In addition, an immunization chart will be provided to parents to ensure their child is up to date. DSS will offer breastfeeding support when needed. |
| Dosage | The Developmental Support Specialist (DSS) meets with the family 6 – 7 times in two years for approximately 90 minutes per session, to complete and discuss the results of the ASQ-3/ASQ:SE. The DSS communicates with the parent/guardian on a regular basis to discuss the completion of the ASQ-3/ASQ:SE. |
| Duration of Service | 2 years |
| Location of Service | Client's home |
| Curriculum / Content | Ages and Stages Questionnaire - 3/Ages and Stages Questionnaire – Social Emotional screens are used to identify possible developmental delays in the following domains: communication, gross motor, fine motor, problem solving and personal-social. |
| Critical Components / Elements | • In two years, 13 ASQ-3s are completed and 4 ASQ:SEs are completed. |
| Agency Contact | Home Safe – Paloma Prata 561-383-9800 x1702; palomaprata@helphomesafe.org |
| Site Locations | Palm Beach County |

**Overall Benefit to Families:** It provides in-home visits to provide brain development education and developmental monitoring to promote optimal child growth during the critical developmental years.
**Literacy Coalition- Parent-Child Home Program (PCHP)**

Subcontracted Agencies: Aspira of Florida, Inc./ Boys Town NOAH, INC./ The Guatemalan-Maya Center

<table>
<thead>
<tr>
<th>Purpose</th>
<th>PCHP prepares young children for school success by increasing language and literacy skills, enhancing social-emotional development, and strengthening the parent-child relationship</th>
</tr>
</thead>
</table>
| Intended Outcomes | • Promote parent-child verbal interaction and parent-child bonding.  
• Increase nurturing and effective parenting skills  
• Increase cognitive & emotional development  
• Increase school readiness |
| Target Population: | Families facing multiple obstacles to education and economic success (see risk factors below) |
| Eligibility Requirements | • Children entering the program should be between 21-42 months of age.  
• At-risk families |
| Ages Served | 2- and 3-year-olds |
| Languages Offered | Multiple languages, including English, Spanish, Haitian Creole, Mayan Dialects |
| Risk Factors | Low-income, single-parent, low educational level, cultural/language barriers, limited language stimulation in home, limited access to educational opportunities, homeless, teenage parents, families with multiple risk factors |
| Program Model: | Evidence-based home visitation model, where professionals use modeling behaviors to enhance child development and encourage parent engagement in the learning process. |
| Dosage | Per program year: 1/2 hour home visits, conducted twice per week for 23 weeks or 46 visits per program year. |
| Duration of Service | 2 years (if client enters the program at age 2) |
| Location of Service | Home |
| Curriculum / Content | Home visitors bring a carefully-selected book, educational toy or developmentally appropriate activity to each home visit. In the home visit, the home visitor models verbal interaction, reading and play activities. This demonstrates the use of books and toys to cultivate language and emergent literacy skills that promote school readiness. |
| Critical Components/ Elements | • Parent-Child Home Program training  
• Parent participation |
| Agency Contact | Lead Agency – Literacy Coalition of Palm Beach County  
Kristin Calder, Chief Executive Officer - (561) 279-9103 kcalder@literacypbc.org  
Cobi Dunn, Director of the Parent-Child Home Program - (561) 279-9103 CDunn@literacypbc.org |
| Site Locations | N/A |

**Overall Benefit to Families:** Provides toys and books and activities in homes that lack these interactive, stimulating items for children, facilitating increased communication and attachment between parents and children.
| **Literacy Coalition – Reach Out and Read (ROR)** |
|---|---|
| **Purpose/Mission** | Reach Out and Read (ROR) is an evidence-based program that promotes early literacy and school readiness in pediatric exam rooms nationwide by giving new books to children and advice to parents about the importance of reading aloud. The Literacy Coalition of Palm Beach County adheres to the model as promulgated by the Reach Out and Read National Center and manages the program in Palm Beach County. Reach Out and Read builds on the unique relationship between parents and medical providers to develop critical early reading skills in children. |
| **Intended Outcomes** | Children Enter Kindergarten Ready to Learn. |
| **Target Population:** |  |
| | • Pediatric healthcare medical providers at public health care centers and in private pediatric practices, preferably serving a high percentage (>50%) of Medicaid recipients.  
| | • Children, ages 6 months to 5 years, and their parents. |
| **Eligibility Requirements** | The program begins at the 6-month checkup and continues through age 5, with a special emphasis on children growing up in low-income communities. |
| **Ages Served** | Children, ages 6 months to 5 years, and their parents. |
| **Languages Offered** | Most of the public health care centers and private practices where Reach and Out and Read is implemented have bi-lingual staff. |
| **Risk Factors** | Low-income household, and probably low literacy skills in the household. |
| **Program Model:** | Reach Out and Read participating Pediatric healthcare medical providers, in the exam room, speak with parents about the importance of reading aloud to their young children every day, and offer age-appropriate tips and encouragement. Moreover, the Pediatric healthcare medical providers give every child 6 months through 5 years old a new, developmentally-appropriate children's book. This is limited to each well child check-up visit. |
| **Dosage** | A child receives an age appropriate book at each well child check-up visit (6 months through age 5). |
| **Duration of Service** | Five years |
| **Location of Service** | Pediatric healthcare medical providers at public health care centers and in private pediatric practices. |
| **Curriculum / Content Critical Components/ Elements** | Age appropriate books  
| | • ROR participating site creates a literacy-rich environment in its waiting room by displaying information and providing books to families.  
| | • Pediatric healthcare medical providers (including pediatricians, family physicians, and pediatric nurse practitioners) are trained in the three-part Reach Out and Read model to promote early literacy and school readiness.  
| | • Pediatric healthcare medical providers, in the exam room, speak with parents about the importance of reading aloud to their young children every day, and offer age-appropriate tips and encouragement.  
<p>| | • Pediatric healthcare medical providers give every child 6 months through 5 years old a new, developmentally-appropriate children's book. This is limited to each well child check-up visit. |
| <strong>Agency Contact</strong> | Molly Felmet, Reach Out and Read Coordinator. Tel: (561) 767-3364 email: <a href="mailto:MFelmet@literacypbc.org">MFelmet@literacypbc.org</a> |
| <strong>Site Locations</strong> | Belle Glade, Boynton Beach, Delray Beach, Jupiter, Lantana, Lake Worth, Pahokee, Palm Beach Gardens, Palm Springs, Riviera Beach, Royal Palm Beach, West Palm Beach |
| <strong>Overall Benefit to Families:</strong> | Reach Out and Read helps families and communities encourage early literacy skills so children enter school prepared for success. |</p>
<table>
<thead>
<tr>
<th>Purpose</th>
<th>The Healthy Beginnings Nurses will provide a wide range of services prenatally and postnatally as part of the system of care.</th>
</tr>
</thead>
</table>
| Intended Outcomes | • Smoking Cessation  
• Improved Prenatal Health  
• Increase the number of healthy births  
• Increase health literacy  
• Prevention of child abuse and neglect |
| Target Population: | Clients that are being served by one of the Healthy Beginnings Nurses models  
| Eligibility Requirements | Pregnant women and infants |
| Ages Served | Any |
| Languages Offered | English, Spanish and Haitian Creole. |
| Risk Factors | Varies – see below |
| Program Model: | None, varies according to the service |
| Dosage | Varies according to the service see attached models |
| Duration of Service | Varies according to the service see attached models |
| Location of Service | Varies according to the service see attached models |
| Curriculum / Content | Varies according to the service see attached models |
| Critical Components / Elements | • **Breast Feeding Support and Counseling**  
• **Parenting Class**  
• **Smoking Cessation**  
  **Description:** Tobacco Education and Cessation is an enhanced service that complements core services it is not a service expected to stand alone.  
  **Curriculum:** *Make Yours a Fresh Start Family*, is a program which uses the 4 A’s (Ask, Advise, Assess and Assist); and quit lines.  
• **Childbirth Education**  
  **Description:** Childbirth Education is an enhanced service that complements core services it is not a service expected to stand alone.  
  **Delivery Method:** Childbirth classes will be provided in English, and Spanish in a variety of locations. Fathers/male partners should be encouraged to attend classes with at least one breakout session facilitated by a male.  
  **Location:** Health Departments  
• **Nurse of the Day Advice Line**  
  **Description:** Healthy Beginnings Nurses will operate an advice line to answer general non-emergency questions regarding basic health care for young children during working hours.  
• **Nurse Consults**  
  **Description:** Healthy Beginnings Nurses will be available for consultations with any of the core service providers on health related issues or concerns. Nurses may confer with the core service provider or accompany the provider to meet with the client. These requests for assistance should go through the Entry Agency. |
| Agency Contact | Christine Englestad, Division Director Maternal Child Health – Florida Health Palm Beach County (561) 671-4151 christine.englestad@flhealth.gov |
| Site Locations | Palm Beach County |

**Overall Benefit to Families:** Provides health literacy, breast feeding support, smoking cessation to families and consultative support to network providers.
### Purpose
The Prenatal Plus program is a voluntary program that provides case management, nutrition counseling, and psychosocial services to pregnant women who are at risk of having a low birth weight baby or other poor birth outcomes. Prenatal Plus services are in addition to a woman’s regular prenatal care.

### Intended Outcomes
- Improve birth outcomes by reducing the number of low birth weight babies
- Assist in developing and maintaining a healthy lifestyle during pregnancy and beyond- especially discouraging the use of tobacco, alcohol and illicit drugs.
- Increase their ability to appropriately use medical and social services

### Target Population: Eligibility Requirements
Pregnant women who are at risk of a poor birth outcome

Pregnant women at 28 weeks gestation or less who score a 6 or more on the Prenatal Risk Screen or who are eligible based on other risk factors.

### Ages Served
n/a

### Languages Offered
English, Spanish, Haitian Creole

### Risk Factors
Low income, teen mothers, prior poor birth outcome, unmarried, social isolation, lack of education

### Program Model:
- **Dosage**: No less than ten face-to-face home visits prior to the birth of the baby
- **Duration of Service**: Prenatal through 8 weeks post-partum
- **Location of Service**: In the home, community, or other location that is convenient for the pregnant mother
- **Curriculum / Content**: Prenatal Plus and Partners for a Healthy Baby
- **Critical Components / Elements**: Prenatal Plus is a service delivery framework comprised of a care coordinator, mental health professional and registered dietitian who work as a team in support of positive maternal and infant health outcomes. Partners for a Healthy Baby curriculum is used to strengthen home visiting models and improve birth outcomes, reduce rates of child abuse, increase intervals between pregnancies, strengthen families, enhance child health outcomes and support maternal self-sufficiency.

### Agency Contact
Christine Englestad, Division Director Maternal Child Health Division – Florida Health Palm Beach County
(561) 671-4151 christine.englestad@flhealth.gov

### Site Locations
Palm Beach County

### Overall Benefit to Families:
Improved maternal and infant birth outcomes and strengthened families
| **Florida Health Palm Beach County - Healthy Beginnings Nurses**  
**Nurses Supporting Families (infants and mothers)** |
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Purpose</strong></td>
</tr>
</tbody>
</table>
| **Intended Outcomes** | • Improved prenatal health  
• Increase the number of healthy births  
• Improve parent-child interaction  
• Increases in children’s school readiness  
• Increase health literacy |
| **Target Population** | Pregnant women who are not otherwise eligible for the Prenatal Plus program |
| **Eligibility Requirements** | Nurses Supporting Families: Prenatal clients that score 6 or higher on the Prenatal Risk Screen or are eligible based on other risk factors. Nurses Supporting Families accepts clients up to 32 weeks gestation. The program also serves new infants that score 4 or more on the Infant Risk Screen or are eligible based on other risk factors |
| **Ages Served** | Nurses Supporting Families: Prenatal up to 3 years |
| **Languages Offered** | English, Spanish and Haitian Creole |
| **Risk Factors** | Low income, teen mothers, low educational status, unmarried, socially isolated, etc., poor prior birth outcome, medical complexity |
| **Program Model** | Based upon the Florida Healthy Start Standards and Guidelines |
| **Dosage** | Exact dosage of home visits is based upon the Healthy Start Standards and Guidelines. Evaluation will be completed after one year of birth to evaluate if program is still needed and/or what other Healthy Beginning services may be appropriate. |
| **Duration of Service** | Prenatal clients are completed eight weeks post-partum, unless the infant scores a 4 or more on the Infant Risk Screen, or the nurse serving the family recommends ongoing service. Infant clients are generally served up to age one, but the service can continue to 3 years old, as needed. |
| **Location of Service** | In the home, community, or other location that is convenient for the family |
| **Curriculum / Content** | Partners for a Healthy Baby through the pregnancy and infancy, toddlerhood. Triple P is also used. |
| **Critical Components / Elements** | • To promote healthier pregnancies and safer deliveries.  
• To foster effective communication and partnership between providers and their patients within the prenatal health care community.  
• To empower pregnant women to engage and act upon health information, thus learning to care for themselves and their infant.  
• Reduce rates of child abuse  
• Increase intervals between pregnancies  
• Strengthen families  
• Enhance child health outcomes  
• Support maternal self sufficiency |
| **Agency Contact** | Christine Englestad, Division Director Maternal Child Health – Florida Health Palm Beach County  
(561) 671-4151 christine.englestad@flhealth.gov |
| **Site Locations** | Palm Beach County |
| **Overall Benefit to Families**: Education and support to families with or without medical complexities and care coordination services for families to reduce stress, help to improve birth outcomes and prevent abuse and neglect. |
### Florida Health Palm Beach County - Healthy Beginnings Nurses  
**Interconception Care**

<table>
<thead>
<tr>
<th><strong>Purpose</strong></th>
<th>The primary purpose of this program is to educate and inform women about health behaviors that will help to reduce risk and improve subsequent birth outcomes.</th>
</tr>
</thead>
</table>
| **Intended Outcomes** | - Improved Prenatal or Preconception Health  
- Increase the number of healthy births  
- Increase healthy literacy |
| **Target Population:** | Women in Palm Beach County who have experienced a fetal or infant loss or poor prior birth outcome. |
| **Eligibility Requirements** | Based on the postnatal addendum, a woman might be eligible for services if all four of the following are true:  
- The woman resides in Palm Beach County and is capable of becoming pregnant in the future  
- The *Interconception Health Education* intervention is likely to reduce risk for another poor birth outcome. (Example: it might not in the case where the prior birth was a unique condition as in a multiple birth; or if the woman is already being seen by a specialist).  
- The woman speaks English and able to interact directly with Healthy Beginnings Nurse  
- The woman desires the service and at least one of the following needs exists:  
  - Previous poor birth outcomes as defined by previous birth weight 2000 grams (4 lb. 7 oz.) or less, gestational age less than 35 weeks or congenital anomalies of infant  
  - Neonatal or fetal death (includes miscarriage, spontaneous abortion, death of infant to one year of age)  
  - Infant adopted or removed from home  
  - Infant was admitted to ICU with continuing unresolved illnesses that requires on-going medical care  
  - Chronic illness of infant  
  - Chronic illness or maternal infection of mother that would impact future pregnancy.  
  - History of pregnancy related illness.  
  - Body Mass Index (BMI) less than 18.5 or more than 35  
  - Advanced maternal age (35 and older) at time of first pregnancy |
| **Ages Served** | Perinatal clients |
| **Languages Offered** | English |
| **Risk Factors** | Fetal or infant loss or poor prior birth outcome. |
| **Program Model:** | 10 module curriculum – Interconception Health Education |
| **Dosage** | Education via the Healthy Beginnings Nurses. Only relevant modules will be offered to eligible women. Up to 10 modules. |
| **Duration of Service** | 6-12 weeks. Exceptions will be made only as described in the ICC Program. |
| **Location of Service** | Home, school, public places |
| **Curriculum / Content** | The curriculum builds upon the Florida Health approved curriculum and is tailored to be delivered by nurses, to meet the needs of Palm Beach County participants |
| **Critical Components / Elements** | Education and information health behaviors that will help reduce risk and improve subsequent birth outcomes |
| **Agency Contact** | Christine Englestad, Division Director Maternal Child Health– Florida Health Palm Beach County (561) 671-4151 christine.englestad@flhealth.gov |
| **Site Locations** | Palm Beach County |

**Overall Benefit to Families:** Education on a variety of topics to help improve future birth outcomes and increase health literacy.
### Palm Beach County Health Department - Healthy Beginnings WHIN Nurses

<table>
<thead>
<tr>
<th>Purpose</th>
<th>This is an intensive nursing home visitation model that will be available to the Black Population living in Zip Codes 33401, 33403, 33404, &amp; 33407. The model is intended to reduce racial disparities in the target population.</th>
</tr>
</thead>
</table>
| Intended Outcomes | • Decrease racial disparities  
• Improve Prenatal Health  
• Increase the number of healthy births  
• Improve parent-child interaction  
• Improve nutrition  
• Increases in children’s school readiness  
• Increase health literacy |
| Target Population: | Black Population living in Zip Codes 33401, 33403, 33404, & 33407 |
| Eligibility Requirements | Clients will typically screen in on the HS Risk screen and postnatal addendum for risk of child maltreatment. All teens are eligible for intensive home visiting services. Typical clients may be teens who enter prenatal care after 28 weeks; teens/clients for whom this is a subsequent birth; or women with an infant more than 3 months of age (ineligible both for NFP and Healthy Families). |
| Ages Served | Prenatal to 2 years |
| Languages Offered | English |
| Risk Factors | Low income, teen mothers, low educational status, unmarried, socially isolated, etc. |
| Program Model: | Partners for a Healthy Baby framework and Healthy Start Interconception model. |
| Dosage | Intensive nursing home visitation with services initiated for clients either prenatally or after the infant is born and continuing until the child is up to 2 years of age. Clients will receive nutrition services, dental care and interconceptional education. |
| Duration of Service | Prenatally until the child is up to 2 years old as needed. |
| Location of Service | Home, school, public places |
| Curriculum / Content | Partners for a Healthy Baby through the pregnancy, infancy and toddlerhood, Triple P postnataally and as indicated Promoting Maternal Mental Health for pregnant women exhibiting depression concerns. |
| Critical Components / Elements | • Service Coordination  
• Depression Screening  
• Developmental Surveillance  
• Interconception Care  
• Health Education |
| Agency Contact | Christine Englestad, Division Director Maternal Child Health– Florida Health Palm Beach County  
(561) 671-4151 christine.englestad@flhealth.gov |
<p>| Site Locations | Palm Beach County |
| Overall Benefit to Families: | Decrease racial disparities, Improved Prenatal Health, Increase the number of healthy births, Improve parent-child interaction, Improve nutrition, Increases in children’s school readiness, Increase health literacy |</p>
<table>
<thead>
<tr>
<th>Purpose</th>
<th>To improve pregnancy outcomes, child health and development, and self-sufficiency for eligible, first-time parents- benefitting multiple generations</th>
</tr>
</thead>
</table>
| Intended Outcomes | - Improved Prenatal Health  
- Fewer childhood injuries  
- Fewer subsequent pregnancies  
- Increased intervals between births  
- Increased maternal employment  
- Increases in father involvement  
- Increases in children's school readiness |
| Target Population: | Pregnant women in Palm Beach County |
| Eligibility Requirements | First time mothers. The mothers must begin the program prior to the 28th week of pregnancy. |
| Ages Served | Prenatal to 2 years |
| Languages Offered | English and Spanish |
| Risk Factors | Low income, teen mothers, low educational status, unmarried, socially isolated |
| Program Model: | Nurse Family Partnership, national evidenced based model |
| Dosage | Weekly home visits during the first month of enrollment;  
Bi-weekly home visits up until the birth of the child;  
Weekly home visits during the postpartum period;  
Bi-weekly home visits up until 21 months;  
Monthly home visits until the child is 2-years-old |
| Duration of Service | Approximately 2 ½ years |
| Location of Service | Home |
| Curriculum / Content | NFP designed Weekly Visit Guidelines which incorporates the Partners in Parenting Education (PIPE) curriculum, reflective practice and the development of therapeutic relationships. |
| Critical Components / Elements | - Preventive health and prenatal practices for the mother  
- Health and development education and care for both the mother and child  
- Life coaching of the mother and her family  
- NFP training |
| Agency Contact | Christine Englestad, Director Maternal Child Health Division – Health Department (561) 671-4151 christine.englestad@flhealth.gov |
| Site Locations | Palm Beach County |
| Overall Benefit to Families: | Improved birth outcomes, abuse and neglect prevention and support to become knowledgeable and responsible parents |
### Palm Beach County Health Department/ Health Council of Southeast Florida

#### Fetal and Infant Mortality Review (FIMR) Project

**Purpose/Mission**
The Fetal Infant Mortality Review (FIMR) Program is a community-based, action-oriented program designed to enhance the health and well-being of women, infants, and families through the review of individual cases of fetal and infant death. The purpose of the FIMR Program is to understand how a wide array of social, economic, health, educational, environmental and safety issues relate to fetal and infant loss on a local level. The Palm Beach County Health Department provides the FIMR case abstraction component and the Health Council of Southeast Florida provides program administration for the project.

**Intended Outcomes**
- Purpose of reviewing the causes and factors of fetal and infant loss will serve as tools to empower communities to implement safeguards against future losses.
- Data derived from the reviews will be used to identify fetal and infant trends as well as preventable contributing factors that will allow system stakeholders and communities to respond to the needs that are identified by the reviews.
- Qualitative information will be used for direct planning efforts to improve birth outcomes and lower mortality rates.
- Identify gaps in health and support services.
- Increase awareness and knowledge among providers, health professionals and the community on contributing factors to fetal/infant deaths.
- Provide a platform for parents that experience a loss to “have their voice heard” in a meaningful way that may contribute to systemic change.

**Target Population**
N/A

**Eligibility Requirements**
Residents of Palm Beach County who experience a fetal or infant loss.

**Ages Served**
All deaths reviewed are less than 12 months old.

**Risk Factors**
Cause of death risk factors are reviewed during the CRT meeting.

**Program Model**
Follows National FIMR recommended framework.

**Dosage**
Case Review Team (CRT) meetings are held monthly.

**Duration of Services**
Cases are reviewed throughout the year/meetings are typically two hours.

**Location of Service**
Case Review Team meetings are held at the Health Council of Southeast Florida.

**Curriculum / Content**
FIMR operational manual will guide the process.

**Critical Components / Elements**
The essential piece of the FIMR review is the depth of the information gathered by the Case Abstractor. The Case Review Team (CRT) then analyzes the information and the Community Action Group (CAG) then makes recommendations to support community change.

**Agency Contact**
Andrea Stephenson, Executive Director  561-844-4220  AStephenson@HCSEF.org

**Site Locations**
Palm Beach County

**Overall Benefit to Families:**
Increased awareness in regards to the factors that contribute to a high infant mortality rate and heightened knowledge surrounding the interventions and services available to support those impacted by loss. Opportunity to speak with families about circumstances and concerns surrounding their fetal or infant loss.
<table>
<thead>
<tr>
<th><strong>Parent-Child Center &amp; Jerome Golden Center – Psychosocial Counseling</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Purpose</strong></td>
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<tr>
<td><strong>Intended Outcomes</strong></td>
</tr>
<tr>
<td><strong>Target Population</strong></td>
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<tr>
<td><strong>Eligibility Requirements</strong></td>
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<tr>
<td><strong>Ages Served</strong></td>
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<td><strong>Languages Offered</strong></td>
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<td><strong>Risk Factors</strong></td>
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<tr>
<td><strong>Program Model</strong></td>
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<tr>
<td><strong>Dosage</strong></td>
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<tr>
<td><strong>Duration of Service</strong></td>
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<tr>
<td><strong>Location of Service</strong></td>
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<tr>
<td><strong>Curriculum / Content</strong></td>
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<tr>
<td><strong>Critical Components / Elements</strong></td>
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<tr>
<td><strong>Agency Contact</strong></td>
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<tr>
<td><strong>Site Locations</strong></td>
</tr>
<tr>
<td><strong>Overall Benefit to Families:</strong></td>
</tr>
</tbody>
</table>
**Sickle Cell Foundation - Community Voice**

| **Purpose** | Grassroots program that utilizes community residents to provide factual perinatal information throughout the community in an effort to reduce African American infant mortality. The, Community Voice program will aim to support behaviors that promote healthy pregnancies by motivating people and encouraging lifestyle changes. The program trains residents to become “Lay Health Advisors” through a series of five classes that address a variety of health concerns such as SIDS, preterm labor and early prenatal care. Community Voice participants engage community members and spread positive health education information through Town Hall meetings, churches, civic organizations, community events and other local venues that are relevant to the fabric of the community. |
| **Intended Outcomes** | • Increase awareness and knowledge regarding the importance of healthy nutrition practices (including folic acid intake), early prenatal care, avoiding alcohol, drugs, and tobacco, and infant care practices.  
• Address and educate about infant mortality rates among the African American community in the high-risk areas and surrounding communities and maintain contacts over time.  
• Reduce black infant mortality.  
• Increase male involvement with the family, especially during the prenatal and postnatal process. |
| **Target Population** | The target population will be the Black/African American community in the high-risk areas of Riviera Beach, Delray Beach, Boynton Beach, West Palm Beach, Lake Park and Belle Glade in Palm Beach County where the black infant mortality rate is significantly higher than the general population. |
| **Eligibility Requirements** | Motivated concerned community residents who live in the high-risk areas of Riviera Beach and Belle Glade in Palm Beach County where the black infant mortality rate is significantly higher than the general population who are able to volunteer to participate in the 5 education classes. |
| **Ages Served** | Teens through Adult are able to participate in classes. |
| **Languages Offered** | English |
| **Risk Factors** | High infant mortality rate in identified targeted areas. |
| **Program Model** | Community Voice staff develop relationships and identify community/faith based leaders as well as influential members of the community to raise awareness about the disparities in health/ birth outcomes in the African American community. Community Voice staff recruit members of the Community to become Lay Health Advisors/ volunteers. |
| **Dosage** | The program trains residents to become “Lay Health Advisors” through a series of five classes that address a variety of health concerns such as SIDS, preterm labor and early prenatal care. Lay Health Advisors’ progress is measured through pre-and post-tests. |
| **Duration of Service** | 5 classes of 2 hours each |
| **Location of Service** | Churches, civic organizations, community events and other local venues that are relevant to the fabric of the community. |
| **Curriculum / Content** | *Taking it to the People* curriculum. |
| **Critical Components / Elements** | The central component of the project is community-based trainings of lay health advisors who reach out to women and men in their personal network to provide information and improve their ability to access resources. |
| **Agency Contact** | Shalonda Warren, CEO Tel: 561-833-3113 Email: SWarren@sicklecellpalmbeach.org |
| **Site Locations** | Riviera Beach, Boynton Beach, Delray Beach, Lake Park, West Palm Beach and Belle Glade |

**Overall Benefit to Families:** Increased knowledge and education regarding healthy nutrition and lifestyle choices that impact birth outcomes in the African American community. Increased male involvement to improve child development.
| Purpose | The First Steps to Success Program (FSTS) is designed to provide in-home services to families of children 0-5 years of age who are at risk for an acquired developmental delay as measured on a standardized assessment tool but do not meet criteria for early intervention programming such as Early Steps or Child Find. Developmental Specialists conduct home visits and use the Battelle Developmental Inventory (BDI-2) and Hawaii Early Learning Profile (HELP) curriculum-based assessment to address infant mental health and developmental concerns of the family. |
| Intended Outcomes | Increased opportunities for infants and toddlers with mild delays to receive services and to integrate into the community. |
| Target Population: | Refer to: eligibility requirements, ages served, languages offered and risk factors to understand this program’s target population |
| Eligibility Requirements | Children 0-5 referred through the entry agency Home Safe, who:  
- Score -1.0 standard deviation below the mean in two or more areas of development or -1.5 standard deviation below the mean in one area of development using the Battelle Developmental Inventory (BDI-2). |
| Ages Served | Birth to 72 months |
| Languages Offered | English and Spanish, Portuguese, French and Haitian Creole |
| Risk Factors | Mild developmental delays, atypical behavior, growth or development, but not eligible for Early Steps or Child Find. |
| Program Model: | Refer to: dosage, duration of service, location of service, curriculum and critical elements to understand this program’s model |
| Dosage | Service frequency and dosage will be determined by Developmental Specialist based on the needs of the family and child. |
| Duration of Service | Services are delivered until child completes intervention plan or reaches the age of 72 months. |
| Location of Service | Home |
| Curriculum / Content | Hawaii Early Learning Profile |
| Critical Components / Elements | - Theoretical foundations of social and emotional development in early childhood  
- Consultation strategies for working with parents and other caregivers  
- Promoting the development of trust and security in infancy  
- Promoting healthy development of self during toddlerhood  
- Understanding and intervening with children’s challenging behaviors  
- Developing and implementing developmental intervention plans for children and caregivers  
- Support sensitive parent-infant interactions and relationships.  
- Support safe environments.  
- Provide assessment and interventions in the real word of everyday experiences and interactions with familiar people in familiar contexts.  
- Encourage and support parents in decision-making at every step of the early intervention process.  
- Include information and activities that are based upon research, and integrated with expert opinion, experiences and professional wisdom about what makes sense.  
- Emphasize the “quality” of the child’s skills and behaviors. |
| Agency Contact | Gretchen Rauch-Herron - (561) 842-3489 Grauch-Herron@arcpbc.org |
| Site Locations | Palm Beach County |
| Overall Benefit to Families: | Helps children to receive services and work toward achieving developmental skills that are closer to their same-age, typically-developing peers, while providing information that parents/caregivers may use to strengthen their children’s developmental skills. |
**The ARC – Healthy Steps**

**Purpose**
Healthy Steps for Young Children® (HSFYC®) is a national initiative aimed at enhancing the quality of preventative health care for young children. HSFYC® emphasizes a close relationship between health care professionals and parents in addressing the physical, emotional, and intellectual growth and development of children from birth to age 3.

**Intended Outcomes**
Healthy Steps Families are more likely to:
- Use positive health practices such as ensuring that infants sleep on their backs
- Discuss feelings of depression and anxiety with someone in the child’s medical practice
- Interact with their toddlers in a more positive manner and pay attention to their child’s verbal cues
- Use more positive discipline strategies
- Utilize additional resources

**Target Population:**
Parents with children age 0-3 within targeted Pediatric Offices (see sites for 2013-2014 below under Location of Services)

**Eligibility Requirements**
Patient with Participating HSFYC site with child up to six months old.

**Ages Served**
2 months to 3 years

**Languages Offered**
English, Spanish and Haitian Creole

**Risk Factors**
None

**Program Model:**
Healthy Steps for Young Children

**Dosage**
10-16 interactions from age 0-3

**Duration of Service**
2.5 years

**Location of Service**
- **Seitz Pediatrics:** 2828 South Seacrest Blvd, Suite 214, Boynton Beach, Florida 33426
- **Palm Beach Pediatrics:** 5589 Okeechobee Blvd. Suite 102, West Palm Beach, FL 33417
- **Pediatric Associates:** 2581 Metro Centre Blvd. West Suite 3, West Palm Beach, FL 33407

**Curriculum / Content**
ASQ3/ASQ-SE/Edinburgh/ Developmental Screening/Link Letters/Touchpoints/Reach Out and Read

**Critical Components / Elements**
- Child Development Telephone Information Line
- Links to Community Resources
- Joint Well-Child Care
- Child Development and Family Health Checkups
- Information Materials for mothers and fathers that emphasize prevention
- Parent Groups
- Home Visits

**Agency Contact**
David Tkac, Director
Healthy Steps for Young Children
The Arc of Palm Beach County
1665 Palm Beach Lakes Blvd., Bldg B, Suite 804
West Palm Beach, FL 33401
(561) 842-3489
Email: DTkac@arcpbc.org

**Site Locations**
The Arc of Palm Beach County

**Overall Benefit to Families:** Support and guidance about child development/community resource and referral/Early Literacy Materials/Home safety checks/Parent InfoLine. Parents learn what to expect with each developmental stage.
**Triple P - Positive Parenting Program - Services provided throughout the HB System**

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Triple P is a multi-level, parenting and family support strategy that aims to prevent severe behavioral, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents.</th>
</tr>
</thead>
</table>
| Intended Outcomes | • Enhance the knowledge, skills and confidence of parents  
• Prevent severe behavioral, emotional and developmental problems in children.  
• More realistic expectations of their children  
• More consistent with discipline  
• Reduce Child abuse and neglect (child maltreatment)  
• Increase Positive interactions between parent(s) and child(ren) |
| Target Population: | Parents with children 0-12 and expectant families who have identified particular parenting concerns, including parent of children with special needs. |
| Eligibility Requirements | Level 1 - All parents interested in information about their child's development  
Level 2 - Parents with a specific concern/s about their child's behavior or development  
Level 3 - Parents with a specific concern/s about their child's behavior or development who require consultation or active skills training  
Level 4 - Parents wanting intensive training in positive parenting skills - typically parents of children with more severe behavioral problems  
Level 5 - Parents of children with concurrent child behavior problems and family dysfunction, such as parental depression or stress or conflict between partners |
| Ages Served | Birth – 12 years-old |
| Languages Offered | Multiple languages, including English, Spanish, Haitian Creole |
| Risk Factors | Child behavioral issues/concerns, child development concerns, aggressive/oppositional behavior, parental adjustment/relationship problems, parental depression, parental anger management issues |
| Program Model: | N/A |
| Dosage | Level 2 Selected - 2 times at 15-30 minutes each  
Level 2 Triple P Seminar Series - 3 series, 90 minutes each  
Level 3 – 4 times at least 30 minutes each  
Level 4 Standard - 10 sessions at 1 hour each  
Level 4 Group - 5 group sessions at 2 hours each, 3 15-30 minute telephone sessions  
Level 5 - Up to 10 additional sessions (adjunct to Level 4) |
| Duration of Service | 1 to 20 visits |
| Location of Service | Professional offices, community, home visits |
| Curriculum / Content | Level 1 - Information campaign to promote awareness of parenting issues and normalize participation in parenting programs such as Triple P.  
Level 2 – Incidental contact, providing specific advice on how to solve common child developmental issues and minor child behavior problems.  
Level 3 - Combines advice with rehearsal and self-evaluation as required, teaching parents to manage a discrete child problem behavior.  
Level 4 - Requires intensive training in positive parenting skills and generalization enhancement strategies. Application of parenting skills to a range of target behaviors, settings and children.  
Level 5 - Individually tailored program for families with child behavior problems and family dysfunction. Modules include practice sessions to enhance parenting skills, mood management strategies and stress coping skills, and partner support skills. |
| Critical Components / Elements | • Triple P training, including accreditation  
• Necessary supplies (e.g., tip sheets, parent workbooks, videos/DVDs)  
• Practitioners endorse the principles of self-sufficiency/self-regulation of Triple P |
| Agency Contact | Debbie Newell, Program Director (Parent-Child Center)-(561)841-3500 (Levels 3-5)  
Wanda Baldwin, Triple P Director (CHS Bridges)-(561)868-4360(Lev.2-3)  
Rebecca Matte, Triple P Director (HP Bridges)-(561)308-1585 (Levels 2-3)  
Barbara Hernandez (Center for Family Services)-(561)616-1222 (Levels 3-5) |
| Site Locations | N/A |
| Overall Benefit to Families: | To enhance the knowledge, skill and confidence of parents. |