

**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
New Jersey
MCH Block Grant**

**Application for 2018
Due July 2017**

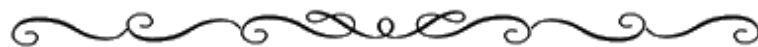


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I. General Requirements

The New Jersey Title V MCH Block Grant Application/Annual Report was developed according to the seventh edition of the Title V MCH Block Grant to States Application/Annual Report Guidance which consists of two documents: 1) Guidance And Forms For The Title V Application/Annual Report; and 2) Appendix of Supporting Documents, which includes background program information and other technical resources.

As with previous editions, this Guidance adheres to the specific statutory requirements outlined in Sections 501 and 503-509 of the Title V legislation and promotes the use of evidence-based public health practices by states/jurisdictions in developing a Five-Year Action Plan that addresses identified MCH priority needs. The revised Guidance also reaffirms the mission of Title V as “to improve the health and well-being of all of America’s mothers, children, and families.”

1. D. Table of Contents

This report follows the outline of the Table of Contents provided in the "Guidance And Forms For The Title V Application/Annual Report," Omb No: 0915-0172; expires January 31, 2017.

1.E. Application/Annual Report Executive Summary

The mission of the Division of Family Health Services (FHS) is to improve the health, safety, and well-being of families and communities in New Jersey. FHS works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations. The Maternal and Child Health Block Grant Application and Annual Report that FHS submits each year to the Maternal Child Health Bureau (MCHB) provides an overview of initiatives, State-supported programs, and other State-based responses designed to address the maternal and child health (MCH) needs in NJ as identified through our continuous needs assessment process and in concert with the Department of Health (NJDOH) strategic plan, the States’ Health Improvement Plan, Healthy NJ 2020, and the collaborative process with other MCH partners.

NJ is the most urbanized and densely populated state in the nation with 8.9 million residents. It is also one of the most racially and ethnically diverse states in the country. The racial and ethnic mix for NJ mothers, infants, and children is more diverse than the overall population composition. This growing diversity not only raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds but also of the need to ensure a culturally competent workforce and service delivery system. Indeed, one of the three priority goals of the FHS Title V program is to increase the delivery of culturally competent services through a well-trained workforce. The other two goals are to improve access to health services through partnerships and collaboration and to reduce disparities in health outcomes across the lifespan consistent with the Life Course Perspective (LCP).

The goals and State Priority Needs (SPNs) selected by FHS are consistent with the findings of the Five-Year Needs Assessment, built upon the work of prior MCH Block Grant Applications/Annual Reports and in alignment with NJDOH's and FHS' goals and objectives. These are (1) Increasing Healthy Births, (2) Improving Nutrition and Physical Activity, (3) Reducing Black Infant Mortality, (4) Promoting Youth Development, (5) Improving Access to Quality Care for CYSHCN, (6) Reducing Teen Pregnancy, (7) Improving & Integrating Information Systems, and (8) Smoking Prevention. Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure building to meet the health of all NJ's families.

Based on NJ's eight selected SPNs as identified in the Five-Year Needs Assessment, NJ has selected the following ten of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period:

NPM #1 Well woman care,
NPM #4 Breastfeeding,
NPM #5 Safe Sleep,
NPM #6 Developmental Screening,
NPM #8 Physical activity,
NPM #10 Adolescent Preventive Medical Visit
NPM #11 Medical Home,
NPM #12 Transitioning to Adulthood,
NPM #13 Oral Health, and
NPM #14 Household Smoking.

During a period of economic hardship and federal funding uncertainty, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services. Thus evaluating existing programs to ascertain effectiveness is also a top priority for the FHS. As a result of our continuing quality improvement and evaluation process, the Access to Prenatal Care (Access) Initiative (2010-2013) was replaced, in 2014, by evidence based models and the initiative re-named Improving Pregnancy Outcomes Initiative (IPO).

The IPO Initiative grants were awarded in 2014 through a request for proposals process. The IPO Initiative which promotes a life course perspective (LCP) targets public health resources to communities with the highest need utilizing two models, Central Intake (CI) and Community Health Workers (CHWs) to improve quality access across three key life course stages: preconception, prenatal/postpartum and interconception care as a means to decrease infant mortality rates. CI Hubs are a single point of entry for screening and referral of women of reproductive age and their families to necessary medical and social services. Standardized screening tools are used and referrals to programs and services are tracked in a centralized web-based system (SPECT - single point of entry and client tracking). The CHW model performs outreach and client recruitment within the targeted community to identify and enroll women and their families in appropriate care. CI Hubs work closely with community providers and partners, including CHWs, to eliminate duplication of effort and services.

Augmenting the IPO Initiative is our participation in the National Governors Association Center for Best Practices' Learning Network on Improving Birth Outcomes (NGA IBO) Initiative. Three major workgroups (Payors, Data, and Wellness) were formed to explore the issues in-depth and develop recommendations for further action. A meeting was held June 2015 with the Commissioner of Health where final recommendations with action steps and specified responsible entities for accomplishing outcomes were present. In January of 2016, the recommendation report was completed and several working groups members have taken the lead in implementing recommendations.

In 2014 FHS also participated in the Collaborative Improvement & Innovation Network to Reduce Infant Mortality (IM CoIIN) sponsored by the MCH Bureau. The IM CoIIN State Team from NJ identified two priority areas - improving maternal postpartum visit rates and smoking cessation for pregnant and postpartum women. The NGA IBO Initiative workgroups will continue as the IM CoIIN Strategy Teams work towards improving birth outcomes and preventing infant mortality. IM CoIIN activities have been extended to July 2017.

The IPO Initiative continues to have a positive impact. Outreach is a major component for the Community Health Workers. They are the boots on the ground, trusted members of the community that provide services in a culturally and linguistically competent manner. For FY 16 the total number of outreach contacts were 52,833. Of those 52,833 contacts 10,823 Community Health Screens were completed for referral to Central Intake Hubs. A Community Doula project is being piloted at one of the CHW sites. It is black women serving black women to improve birth outcomes. For that same time period, Central Intake Hubs screened and referred a total of 22,265 referrals.

Another program promoting the Life Course Perspective and augmenting our efforts to reduce infant mortality, pre-term births and maternal morbidity is the Maternal and Infant Early Child Home Visiting (MIECHV) Program which has expanded Home Visiting (HV) across all 21 NJ counties with 7,096 families participating in HV during SFY 2015. The goal of the NJ MIECHV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness.

Other initiatives that are contributing towards positive outcomes in addressing the state priority areas of reducing teen pregnancy; promoting youth development and improving physical activity and nutrition are the NJ Personal Responsibility Education Program, and the NJ Abstinence Education Program.

To address the obesity epidemic, the ShapingNJ Partnership continues to grow, and currently boasts more than 320 organizations that have signed a formal agreement with ShapingNJ, committing to work to implement 10 obesity prevention strategies throughout the state.

To improve access to health services, the NJDOH has provided reimbursement for uninsured primary medical and dental health encounters through the designated Federally Qualified Health Centers (FQHCs). In SFY 2017 the State is proposing funding of the FQHCs with \$28 million to continue to focus on the needs of the uninsured and particularly those residents not eligible for the Patient Protection and Affordable Care Act (ACA) and/or NJ FamilyCare under Medicaid Expansion who need access to care and meet eligibility requirements.

In the area of children and youth with special health care needs (CYSHCN), the Newborn Screening and Genetic Services (NSGS) Program is helping to ensure that all newborns and families affected by an abnormal screening result receive timely and appropriate follow-up services. NJ newborns currently receive screening for 55 disorders. On June 30, 2014 screening for Severe Combined Immunodeficiency (SCID) was implemented and by end of 2017, implementation of screening for five lysosomal storage disorders will be implemented. NJ remains among the leading states in offering the most screenings for newborns. In addition to disorders detected through heel-stick, NJ's newborns are also screened with pulse oximetry through the Critical Congenital Heart Defects (CCHD) screening program. As of December 2016, DOH has received reports of 26 infants with previously unsuspected CCHDs detected through the screening program.

Given the high rates of autism reported in NJ, FHS implemented the Birth Defects and Autism Reporting System (BDARS) in 2009. BDARS is a tool for surveillance, needs assessment, service planning, research, and most importantly for linking families to services. The BDARS, at present, refers all living children and their families to the Special Child Health Services Case Management Units (SCHS CMUs), which are within the Family Centered Care Services (FCCS) Program.

The FCCS program promotes access to care through early identification, referral to community-based culturally competent services and follow-up for CYSHCN age birth to 21 years of age. Ultimately, services and supports provided through SCHS CMUs, Family WRAP (Wisdom, Resources, and Parent to Parent), Medical Home for CYSHCN, and Specialized Pediatric Services Providers (SPSP) via Child Evaluation Centers (CECs), Cleft Lip/Palate Craniofacial, and Tertiary Care Services are constructs that support NJ's efforts to address the six MCH Core Outcomes for CYSHCN. This safety net is supported by State and Title V funds administered via community health service grants, local support by the County Boards of Chosen Freeholders, reimbursement for direct service provision, and technical assistance to grantees. Through our Title V program partners, FHS continues to address families' social conditions by providing, in addition to quality health care, referrals to support services such as public health insurance options, legal services, food stamps, WIC, employment and public assistance. These are critically important to improve health outcomes and decrease the need for drugs or other medical interventions, improve quality, and reduce costs.

In 2016, CMU staffs continued to build upon quality improvement (QI) initiative initially launched in 2014 to enhance consistency in documentation within individual service plans across the SCHS CMUs, and to

improve upon the Case Management Referral System's (CMRS) data gathering capability. Information garnered from this initiative is anticipated to enhance NJ's efforts to improve performance on the Six Core Outcomes for CYSHCN, as well as targeted improvement in CMRS documentation in the following two areas; transition to adulthood and access to a medical home. The 2014 findings were used as a baseline to compare with New Jersey and the nation's performance as reported on the National Survey, and comparison data is collected annually, beginning in 2015. Results are discussed in Plan for the Application Year - NPM #11 and NPM #12.

The reorganization of State services and supports for CYSHCN by our intergovernmental partners provided an opportunity to realign pathways for families and providers to access a continuum of care across the lifespan. Concurrently, the Affordable Care Act's assurances pose challenges as well as benefits for families with CYSHCN to maintain and optimize access to community-based care. These exciting changes are anticipated to broaden health insurance access. NJ's Title V CYSHCN program diligently collaborates with intergovernmental and community-based partners to ensure that care through these multiple systems will be coordinated, family centered, community-based, and culturally competent. Communication across State agencies and timely training for State staffs, community-based organizations and families with CYSHCN remains a priority to ensure that families are adequately supported during the reorganization of these systems.

Additionally, family and youth input on multi-system access to care is obtained through the Community of Care Consortium, a coalition led by Statewide Parent Advocacy Network, a key partner to NJ's Title V program and comprised of parents of CYSHCN and youth, State agency representatives, and community-based organizations.

Family input is centric to development and evaluation of FCCS programs. During 2014-2015, the Title V program initiated family satisfaction surveys in English and Spanish for all Specialized Pediatric Services Programs (SPSP). Participation was voluntary and 1,783 responses were received. Preliminary results were shared with agencies, and used in review and planning for services. During 2015-2016, the family satisfaction survey for all SPSPs was updated and implemented. Participation was required by all SPSP agencies and 1,793 responses were received, with 291 surveys completed in Spanish. Data was cleaned by the State office and final reports were made available to all SPSP agencies.

The area with the most room for improvement remained consistent across both years. In year 1 "waiting time for appointments" received the lowest score. During year 2, this question was split into two new questions; "wait time in waiting room to see doctor" and "length of time to get an appointment when my family needed it" to gain a better understanding of this issue. Moving forward, agencies have been encouraged to collaborate with one another regarding strategies to reduce overall wait time. While a patient satisfaction survey was not implemented during 2017, the development of a targeted survey assessing the nature of "wait time" and contributing factors to "wait time" is in process. The target audience will be the providers at all SPSP Centers. This will enable agencies to identify contributing factors to prolonged "wait times" and effective measures that resulted in reduced "wait times".

Many agencies have already made changes to their programs based on findings from the Year 1 and Year 2 family satisfaction surveys. 2 Child Evaluation Centers (CECs) and 1 Craniofacial Center changed their clinic hours to the morning based on the responses of the family satisfaction survey requesting clinic hours that would not interfere with extracurricular activities. Many families stated that afternoon and evening hours prevented their children from participating in after school activities that enabled their children to socialize with other children and develop interpersonal skills. The need for Transition to Adulthood Groups also became apparent to several CECs based on the results of the Year 1 and Year 2 family satisfaction surveys. Many families stated that they did not feel prepared for their child's Transition to Adulthood and wanted to learn more. 3 CECs stated that they are in process of developing a "Transition to Adulthood Focus Group" to address this concern.

In 2015, the Department received a 2-year/\$300,000 HRSA State Implementation Grant for Enhancing the System of Services for CYSHCN through Systems Integration D-70 grant opportunity. This project enhances NJ's capacity to improve upon the proportion of CYSCHN who receive integrated care through

a patient-centered medical home. Working in collaboration with community partners including the NJ Chapter of the American Academy of Pediatrics (NJ AAP), the Statewide Parent Advocacy Network (SPAN), SCHS CMUs, NJ Medicaid and others, this initiative addresses access to a medical home through collaborative partnerships across agencies, organizations and programs, and the development of policy and programs to ensure CYSHCN receive the comprehensive services and supports needed. As part of the overall arching goals of the project the partnerships foster (1) development of a shared resource, (2) integration of care for CYSHCN with the goal of working towards creating a comprehensive system of care for CYSHCN, and (3) a strategy to improve cross-system care coordination. Currently the initiative has yielded a comprehensive shared plan of care, continuing education webinar's targeting professionals and families, and improved the mechanism to record documentation within the existing Case Management Referral System (CMRS).

In response to numerous pediatric hearing healthcare inquiries directed to the NJ Early Hearing Detection and Intervention (EHDI) Program audiologist by members of the SCHS Case Management (CM) community, a QI project was initiated in July 2016 to enhance the ability of CM staff to serve children who are deaf or hard of hearing. In partnership with the state EHDI program, SCHS CMUs were surveyed to determine baseline knowledge, and are being provided with monthly topical overviews along with a hypothetical case-study and question related to hearing diagnoses and available statewide supports and services. A post-test survey will be administered in June 2017 to determine changes in knowledge. This educational initiative will help promote progress towards NJ's achievement of the six MCH core outcomes for CYSHCN, and information gained will inform the program of the usefulness of this educational format as well as the need for further educational outreach.

In sum, NJ is actively working on ways to improve outcomes while simultaneously celebrating some already achieved improvements, to the benefit of the women and children served as a result of the strong partnership between the State and the MCH Bureau.

II. Components of the Application/Annual Report

II.A. Overview of the State

The Maternal and Child Health Block Grant Application and Annual Report, submitted annually to the [Maternal Child Health Bureau](#) (MCHB), provides an overview of initiatives, State-supported programs, and other State-based responses designed to address the maternal and child health (MCH) needs in New Jersey. The [Division of Family Health Services](#) (FHS) in the New Jersey Department of Health (NJDOH), Public Health Services Branch posts a draft of the MCH Block Grant Application and Annual Report narrative to its website in the second quarter of each calendar year to receive feedback from the maternal and child health community.

The mission of the [Division of Family Health Services \(FHS\)](#) is to improve the health, safety, and well-being of families and communities in NJ. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

A brief overview of NJ demographics is included to provide a background for the maternal and child health needs of the State. While NJ is the most urbanized and densely populated state in the nation with 8.9 million residents, it has no single very large city. Only six municipalities have more than 100,000 residents.

New Jersey is one of the most racially and ethnically diverse states in the country. According to the 2015 New Jersey Population Estimates, 72.6% of the population was white, 14.8% was black, 9.7% was Asian, 0.6% was American Indian and Alaska Native, and 2.1% reported two or more races. In terms of ethnicity, 19.7% of the population was Hispanic. The racial and ethnic mix for NJ mothers, infants, and children is

more diverse than the overall population composition. According to 2015 birth certificate data, 27.2% of mothers delivering infants in New Jersey were Hispanic, 44.7% were white non-Hispanic, 13.9% were black non-Hispanic, and 11.1% were Asian or Pacific Islanders non-Hispanic. The growing diversity of NJ's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

MCH priorities continue to be a focus for the NJDOH. The Division of FHS, the [Title V agency](#) in NJ, has identified 1) improving access to health services thru partnerships and collaboration, 2) reducing disparities in health outcomes across the life span, and 3) increasing cultural competency of services as three priority goals for the MCH population. These goals are consistent with the Life Course Perspective (LCP) which proposes that an inter-related web of social, economic, environmental, and physiological factors contribute in varying degrees through the course of a person's life and across generations, to good health and well-being.

The selection of the NJ's eight State Priority Needs is a product of FHS's continuous needs assessment. Influenced by the MCH Block Grant needs assessment process, the NJDOH budget process, the [New Jersey State Health Assessment Plan](#), [Healthy New Jersey 2020](#), Community Health Improvement Plans and the collaborative process with other MCH partners, FHS has selected the following State Priority Needs (see Section II.C. State Selected Priorities):

- #1) Increasing Healthy Births,
- #2) Improving Nutrition & Physical Activity,
- #3) Reducing Black Infant Mortality,
- #4) Promoting Youth Development,
- #5) Improving Access to Quality Care for CYSHCN,
- #6) Reducing Teen Pregnancy,
- #7) Improving & Integrating Information Systems, and
- #8) Smoking Prevention.

These goals and State Priority Needs (SPNs) are consistent with the findings of the Five-Year Needs Assessment and are built upon the work of prior MCH Block Grant Applications/Annual reports. Consistent with federal guidelines from the MCH Bureau, Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure services to meet the health of all NJ's families. During a period of economic hardship and federal funding uncertainty, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services.

Based on NJ's eight selected SPNs as identified in the Five-Year Needs Assessment, NJ has selected the following ten of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period:

- NPM #1 Well woman care,
- NPM #4 Breastfeeding,
- NPM #5 Safe Sleep,
- NPM #6 Developmental Screening,
- NPM #8 Physical activity,
- NPM #10 Adolescent Preventive Medical Visit
- NPM #11 Medical Home,
- NPM #12 Transitioning to Adulthood,
- NPM #13 Oral Health, and
- NPM #14 Household Smoking.

State Performance Measures (SPM) have been reassessed through the needs assessment process. Five existing SPMs will be kept, and two old SPMs will be deleted. The existing SPMs which will be continued are:

- SPM #1 Black non-Hispanic Preterm Infants in NJ,
- SPM #2 Children with Elevated Blood Lead Levels,
- SPM #3 Hearing Screening Follow-up,

SPM #4 Referral from BDARS to Case Management Unit, and SPM #5 Age of Initial Autism Diagnosis

The old SPMs to be discontinued and replaced are: Regional MCH Consortia Implementing Community-based FIMR Teams and Overweight High School Students.

Table 1 - Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model (See Supporting Document #1) summarizes the selected ten NPMs and aligns the impact of Evidence-Based Informed Strategy Measures (ESMs) on NPMs and National Outcome Measures (NOMs). The purpose of the ESMs is to identify state Title V program efforts which can contribute to improved performance relative to the selected NPMs. The Logic Model is organized with one NPM per row. The Logic Model is the key representation which summarizes the Five-Year Needs Assessment process and includes the three-tiered performance measurement system with Evidence-Based or Informed Strategy Measures (ESM), National Performance Measures (NPM), and National Outcome Measures (NOMs). The Logic Model represents a more integrated system created by the three-tiered performance measure framework which ties the ESMs to the NPMs which in turn influence the NOMs.

The following is a brief overview of MCH services to put into context the Title V program within the State's health care delivery environment. The Improving Pregnancy Outcomes (IPO) Initiative grants were awarded in 2014 by Reproductive and Perinatal Health Services (RPHS) through a request for proposals (RFP) process. The IPO Initiative which promotes a Life Course Perspective targets limited public health resources to communities with the highest need to improve quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Using two models, Central Intake Hubs (CIH) and Community Health Workers (CHW), the IPO Initiative will work to improve maternal and infant health outcomes including preconception care, prenatal care, interconceptual care, preterm birth, low birth weight, and infant mortality through implementation of evidence-based and best practice strategies across three key life course stages: preconception, prenatal/postpartum and interconception.

Central Intake Hubs (CIH) are a single point of entry for screening and referral of women of reproductive age and their families to necessary medical and social services. The Community Health Worker (CHW) model performs outreach and client recruitment within the targeted community to identify and enroll women and their families in appropriate programs and services. CIHs work closely with community providers and partners, including CHWs, to eliminate duplication of effort and services. Standardized screening tools are used and referrals to programs and services are tracked in a centralized web-based system (SPECT – single point of entry and client tracking).

NJ was awarded the opportunity in 2014 to participate in the National Governors Association (NGA) Center for Best Practices' Learning Network on Improving Birth Outcomes (NGA IBO) Initiative. This initiative enabled NJ to explore evidence-based strategies shown to be effective in addressing poor birth outcomes. Participation in this NGA Learning Network afforded the NJDOH the opportunity to hold an in-state meeting on January 13, 2014 to explore these critical issues and to set the agenda for the future. The meeting of public and private partners provided a wider awareness of NJ's prematurity rates and other related maternal and child health indicators and discussed the steps necessary to further move the needle on these important health indicators. In 2015, IBO working groups have developed realistic recommendations to impact birth outcomes through statewide collaboration, policy change and the implementation of effective programs targeting women, children and families. Since the IBO recommendations have been developed, several external partners have taken the lead in implementing recommendations statewide. In 2017, the National Association Improving Birth Outcomes Report was approved for statewide dissemination.

In 2014 NJDOH was also invited to participate in the Infant Mortality Collaborative Improvement and Innovation Networks (IM CollIN) sponsored by the MCH Bureau with technical assistance from the National Institute for Children's Health Quality. IM CollIN is a state-driven HRSA-coordinated partnership to accelerate improvements in infant mortality by helping states: 1) innovate and improve their approaches to reducing infant mortality and improving birth outcomes through communication and sharing across state lines; and 2) use the science of quality improvement and collaborative learning to

improve birth outcomes. The IM CollIN State Team from NJ identified two priority areas - improving maternal postpartum visit rates and smoking cessation. Since the commencement of IM CollIN, NJ has performed quality improvement activities to improve postpartum visit and smoking cessation rates in NJ.

Another program promoting the Life Course Perspective is the Maternal and Infant Early Child Home Visiting ([MIECHV](#)) Program which has expanded Home Visiting across all 21 NJ counties with 7,096 families participating in HV during SFY 2015 (7/1/2015 to 6/30/2016). The goal of the NJ MIECHV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full implementation of the NJ MIECHV Program is being carried out in collaboration with the Department of Children and Families (DCF) and is promoting a system of care of early childhood (see Support Document #5). NJ is a FY2016 recipient of both a federal MIECHV Formula and Competitive grant. In January 2017, NJ was awarded a MIECHV Innovation Grant to implement and evaluate a training strategy for Home Visitors called Goal Plan Strategy (GPS) in collaboration with the Maryland Department of Health and Mental Hygiene.

The Child and Adolescent Health Program (CAHP) successfully applied in 2010 for two new federal grants to prevent teen pregnancy and promote youth development. In 2016, the NJ DOH was awarded continuing funding for federal fiscal year 2016 and 2017 for both teen pregnancy prevention programs.

The NJ Abstinence Education Program (NJ AEP) will enable the state to continue the success of the last six years of implementing evidence-informed curricula to help youth abstain or delay sexual activity, reduce pregnancy and STDs/STIs and, where appropriate, provides options that may include mentoring, counseling and/or adult supervision. In 2016 and 2017, program reach has been expanded from middle school students to include youth in high schools, up to age 19. NJ AEP also includes program services that incorporate positive youth development (PYD) and a special outreach to vulnerable youth who are runaway or homeless, involved in adjudication, or otherwise in need of alternative learning environments.

The NJ Personal Responsibility Education Program (NJ PREP) is a school- and community-based comprehensive sexual health education program that replicates evidence-based and medically accurate programs proven effective in reducing initial and repeat pregnancies among teens aged 10-19. NJ PREP also seeks to help teens avoid and reduce high risk sexual behaviors through the promotion of abstinence, refusal skills, use of condoms and other forms of birth control. NJ PREP provides education on at least three of the following adult preparation topics: healthy relationships; positive adolescent development; financial literacy; parent-child communication skills; education and employment preparation skills and healthy life skills. In the current funding cycle, the state will continue to build on the success of the last five years in replicating evidence-based programs (EBPs) to help youth, ages 10-19, delay sexual activity and increase condom or contraceptive use in an effort to reduce pregnancy and STDs/STIs through September 30, 2019.

New Jersey's competitive application, to the National Resource Center (NRC) and AMCHP for the 2nd cohort of the Adolescent and Young Adult Health (AYAH) Collaborative Improvement and Innovation Network (CollIN), was approved. Data from a NJ FQHC report identified a greater than 50% disparity for adolescent preventive medical visits at FQHCs (averaging about 45% during the years of 2013-2015) as compared to private physician offices (averaging about 97%). The goal of the NJ AYAH CollIN is to increase the FQHC adolescent visit rate to achieve the Healthy People 2020 goal of 75.6%. A two-day Summit is scheduled on May 9-10th.

To address the obesity epidemic, the [ShapingNJ Partnership](#) continues to grow, and currently boasts more than 230 organizations that have signed a formal agreement with ShapingNJ, committing to work to implement 10 obesity prevention strategies throughout the state. The goal of the ShapingNJ Partnership is to prevent obesity and improve the health of populations that are at risk for poor health outcomes in NJ by making "the healthy choice, the easy choice." The ShapingNJ website reaches consumers as well as professionals and partners with the latest research, information and best practices, as well as toolkits for improving health in each of the 6 settings where New Jerseyans live, work and play: child care centers, schools, communities, worksites and businesses, and healthcare settings.

To improve access to health services, the NJDOH has provided reimbursement for uninsured primary medical and dental health encounters through the designated [Federally Qualified Health Centers](#) (FQHCs) since 1992 under the FQHC-Uncompensated Care Fund. In SFY 2016, the FQHC–Uncompensated Care Fund was funded at \$32.3 million. NJ recently added 1 new licensed FQHC, four licensed ambulatory primary care sites, 2 new FQHCs are pending approval and 1 additional site is pending approval - bringing the total number of licensed sites to 110. In SFY 2017 the FQHC–Uncompensated Care Fund proposed funding is \$28 million.

In the area of children and youth with special health care needs (CYSHCN), the Newborn Screening and Genetic Services Program (NSGS) helps to ensure that all newborns and families affected by an abnormal screening result will receive timely and appropriate follow-up services. In terms of newborn screening for disorders detectable via the heelstick, all newborns receive screening for 55 disorders. On June 30, 2014 screening for Severe Combined Immunodeficiency (SCID) was implemented and by end of 2017, implementation of screening for five lysosomal storage disorders including Krabbe, Pompe, Neimann Pick, Fabry, and Gaucher, will be implemented. Follow-up services include notification and communication with parents, primary care physicians, pediatric specialists and others to ensure the baby has immediate access to confirmatory testing and treatment. NJ remains among the leading states in offering the most screenings for newborns.

NSGS meets and communicates regularly with several advisory panels composed of parents, physicians, specialists, and others to ensure NJ's program is state-of-the-art in terms of screening technologies and operations and it is responsive to any current concerns regarding newborn screening.

Legislation mandating newborn pulse oximetry screening to detect Critical Congenital Heart Defects (CCHD) took effect on August 31, 2011. The inclusion of pulse ox screening questions in the new web-based Birth Defects and Autism Reporting System enable the capability to track individual level screening results. In addition, information on all infants with failed screens is reported by each birthing facility to the Birth Defects Registry via the Pulse Oximetry Module. As of December 2016, NJDOH has received reports of 26 infants with previously unsuspected critical congenital heart defects detected through the screening program. In 2012, NJ was one of six states awarded a 3-year HRSA grant for CCHD Screening. This demonstration grant enabled funding to contract with the NJ Chapter of the American Academy of Pediatrics (NJAAP) for hiring program staff, the development of resource materials, comprehensive educational offerings and support for an evaluation of CCHD screening in the neonatal intensive care unit (NICU). An article describing the collaborative work and lessons learned of the HRSA grantees was published in the Maternal Child Health Journal in January 2017. Since 2016, the CCHD Screening program is funded with State aid and collaboration with the NJAAP continues to implement program activities and provide technical assistance to birthing facilities. Although most states now have mandates or administrative rules requiring screening of newborns for CCHD, many questions remain about effective implementation of screening including screening for infants in the NICU. In 2015, New Jersey DOH partnered with the NJ NICU Collaborative to lead a multi-state evaluation of CCHD screening in the NICU. Twenty-one NICUs in five states (CA, IL, MN, NJ, NY) participated in the evaluation. Results from this evaluation have been presented at many scientific meetings adding valuable contributions to the national discussion and providing further specification to guide CCHD screening in New Jersey.

The Early Hearing Detection and Intervention Program (EHDI) monitors compliance with the NJ universal newborn hearing screening law, and measures NJ's progress in achieving the national EHDI goals of ensuring that all infants receive a hearing screening by one month of age, that children who do not pass screening receive diagnostic testing by three months of age, and that children who are diagnosed with hearing loss receive family-centered, culturally competent Early Intervention Services by six months of age. Hospitals have been very successful in ensuring that newborns receive hearing screening prior to hospital discharge, ensuring that children who did not pass their initial screening receive timely and appropriate follow-up remains an area for continued efforts. The NJ EHDI Program is working with

hospitals, audiologists and physicians to identify “small tests of change” to identify successful strategies for improving outpatient follow-up rates for infants that did not pass initial screening.

NJ continues to have one of the highest rates of autism in the United States. According to the Centers for Disease Control and Prevention’s (CDC) 2012 prevalence figures published in the Morbidity and Mortality Weekly Report (MMWR) on March 31, 2016, cited NJ as having the highest prevalence rate of 24.6 per 1,000, or approximately one in 41 based on studies from four counties in NJ.

The Governor’s Council for Medical Research and Treatment of Autism (the Council) is in the Office of the Commissioner at NJDOH; the Council has 14 members and is legislatively mandated. In 2012, the Council established a Center of Excellence for Autism (NJACE). The mission of the NJACE is to research, apply and advance best practices in the understanding, prevention, evaluation and treatment of Autism Spectrum Disorders (ASDs), enhancing the lives of individuals with ASDs across their lifespans. The NJACE consists of (1) a Coordinating Center, Clinical Research Program Sites, and multiple clinical Research Pilot Projects, including 3 Medical Home Pilots. The NJACE consists of (1) a Coordinating Center, (2) Clinical Research Program Sites, and (3) Clinical Research Pilot Projects. The NJ ACE Coordinating Center provides common management and support functions to unify the NJ ACE Clinical Research Program Sites and Pilot Project grantees, increase efficiency and reduce costs. The five-year Coordinating Center grant was awarded to Montclair State University. The NJ ACE Program Site and Pilot Project grantees will develop and conduct clinical research projects with the potential to improve the physical and/or behavioral health and well-being of individuals with ASDs. The Council is particularly interested in projects with potential direct clinical impact and those that address issues across the lifespan.

On July 1, 2009, the Early Identification and Monitoring (EIM) Program implemented the Birth Defects and Autism Reporting System (BDARS). BDARS is an invaluable tool for surveillance, needs assessment, service planning, research, and most importantly for linking families to services. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928. Since 1985, NJ has maintained a population-based birth defects registry of children with all defects. Starting in 2003, the Registry received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ passed legislation mandating the reporting of autism. Subsequently, with the adoption of legislative rules in September 2009, the Registry added the Autism Spectrum Disorders (ASD) as reportable diagnoses and the Registry was renamed the Birth Defects and Autism Reporting System (BDARS), expanded the mandatory reporting age for children diagnosed with birth defects to age 6, and added severe hyperbilirubinemia as a reportable condition if the level is 25mg/dl or greater. The BDARS, at present, refers all living children and their families to the Special Child Health Services Case Management Units (SCHS CMUs), which are within the Family Centered Care Services Program.

NJ has been very successful in linking children registered with the BDARS with services offered through the county-based SCHS CMUs. However, the system did not further track children and families to determine if and what services were offered to any of the registered children. Added in 2012, the Case Management Referral System (CMRS) is used by the CMUs to track and monitor services provided to the children and their families. It electronically notifies a CMU when a child living within their county has been registered and referred to their unit. Included in CMRS is the ability to create and modify an Individual Service Plan (ISP), track services, create a record of each contact with the child and child's family, create standardized quarterly reports and other reports, and register previously unregistered children. In 2016, efforts were coordinated through the Integrated Systems Medical Grant to enhance SCHS CMUs’ reporting via CMRS regarding CYSHCN’s linkage to a medical home and transition to adulthood. Three SCHS CMUs were selected to collaborate in development of fields and to pilot edits in CMRS documentation. Training was introduced, State staffs are monitoring progress in implementation of those edits, and in fall 2018 the pilot SCHS CMUs are expected to launch regionalized train the trainer initiatives with SCHS CMUs statewide.

CMRS was successfully adopted by all 21 counties and is live statewide. It provides the State Title V program with the opportunity for desktop review referral and linkage to care. As existing cases are

migrated to CMRS, and newly referred cases are entered into the database, it is anticipated that trends in access to care and outcomes will be more measurable and readily tracked. Likewise, the challenges of reconfiguring data reporting and tracking systems, as well as the training and retraining State and community-based agencies, while keeping the needs of CYSHCN and their families center to our mission is our challenge.

The Family Centered Care Services (FCCS) program promotes access to care through early identification, referral to community-based culturally competent services and follow-up for CSYHCN age birth to 21 years of age. Ultimately, services and supports provided through Special Child Health Services Case Management Units (SCHS CMUs), Family WRAP (Wisdom, Resources, and Parent to Parent), Medical Home for CYSHCN (MH), and Specialized Pediatric Services providers (SPSP) via Child Evaluation Centers (CECs), Cleft Lip/Palate Craniofacial, and Tertiary Care Services are constructs that support NJ's efforts to address the six MCH Core Outcomes for CYSHCN. This safety net is supported by State and federal funds administered via community health services grants, local support by the County Boards of Chosen Freeholders, reimbursement for direct service provision, and technical assistance to grantees. Likewise, intergovernmental and interagency collaboration is ongoing among federal, State and community partners and families; i.e., Social Security Administration; NJ State Departments of Human Services' NJ FamilyCare/Medicaid programs, Catastrophic Illness in Children Relief Fund, Children and Families, Labor, Banking and Insurance, Boggs Center/Association of University Centers on Disabilities, NJ Council on Developmental Disabilities, and community-based organizations such as the NJ Chapter of the American Academy of Pediatrics (NJAAP), NJ Hospital Association, and disability specific organizations such as the Arc of NJ, and the Statewide Parent Advocacy Network (SPAN) and the Community of Care Consortium (COCC). Consultation and collaboration with NJDOH programs such as the Birth Defects and Autism Registry, Early Intervention System, the Ryan White Family Centered HIV Care Network, Maternal Child Health, Special Supplemental Nutrition Program for Women, Infants and Children, Primary Care/Federally Qualified Health Centers, and HIV/AIDS, STD, and Tuberculosis, as well as Public Health Infrastructure, Laboratories, and Emergency Preparedness affords FCCS with opportunities to communicate and partner in supporting CYSHCN and their families. One example of this collaboration was having the State Director, Division of Vocational Rehabilitation Services, Department of Labor and Workforce Development speak to SCHS CMU about "Workforce Innovation and Opportunity Act; major changes for the public VR. Furthermore, the transition of CYSHCN formerly enrolled in the Community Resources for Persons with Disabilities waiver and newly identified underinsured CYSHCN into Managed Long Term Services and Supports, and the referral of uninsured transition aged youth into Medicaid expansion or the Marketplace are accomplished through interagency collaboration and linkage with resources across agencies and systems.

NJ remains successful in linking children registered with the Birth Defects and Autism Reporting System (BDARS) with services offered through the SCHS CMUs; CECs including the Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorders (FAS/FASD) Centers; Cleft Lip/Palate Craniofacial Centers; Tertiary Care Centers; and Family WRAP. With CDC Surveillance grant funding, the system is undergoing enhancements to support tracking of CYSHCN referred to SCHS CM, and monitoring of services offered and/or provided to determine client outcomes. In 2014, State Case Management staffs launched a quality improvement project to enhance consistency in documentation within CMRS across the SCHS CMUs, and to improve upon CMRS's data gathering capability. Efforts are ongoing, with FCCS staff presenting QI findings to SCHS CMUs on a quarterly basis, since June 2015. SCHS CMU feedback in turn is incorporated into subsequent CMRS guidance and technical assistance. Information garnered from this initiative is anticipated to enhance NJ's efforts to improve performance on the six core MCHB outcomes for CYSHCN.

The reorganization of State services and supports for CYSHCN by intergovernmental partners; Department of Human Services; Division of Medicaid and Health Services (DMAHS) and Division of Developmental Disabilities; the Department of Children and Families' Divisions of Children's System of Care and Division of Family and Community Partnerships, and the Department of Health's Division of Aging and Community Services realigned pathways for families and providers to access a continuum of care across the lifespan. Concurrently, the Affordable Care Act's assurances pose challenges and

benefits for families with CYSHCN to maintain and optimize access to community-based care. Title V is collaborating with DMAHS in its comprehensive evaluation and revision to its data administration system that will support NJ's efforts to optimally address Federal mandates including the Health Information Technology (HIT) Health Information Exchange (HIE) requirements, the Health Information Portability and Accountability Act of 1996 (HIPAA) transaction and code sets, International Classification of Diseases version 10 (ICD-10), and the requirements of the Patient Protection and Affordable Care Act (PPACA.) These exciting changes are anticipated to broaden health insurance access, and to improve cross systems collaboration on implementation of the Asthma/Cystic Fibrosis component of the Fee for Service program. NJ's Title V CYSHCN program diligently collaborates with intergovernmental and community-based partners to ensure that care through these multiple systems will be coordinated, family centered, community-based, and culturally competent. Communication across State agencies and timely training for State staffs, community-based organizations and families with CYSHCN remains key to ensuring that families are adequately supported during the reorganization of these systems.

In addition to the health care system changes described above, in 2012 the extremely dangerous and damaging Superstorm Sandy (SSS) affected NJ CYSHCN and their families. Significant recovery has been achieved. However, its catastrophic effects challenged our State's infrastructure and ability to maintain an integrated safety net of providers, mobilize and share resources, as well as to support evacuation, relocation and long-term recovery. It also provided opportunities for the Title V program to promote resiliency for CYSHCN and their families by providing information, training, referral and supports to families, as well as technical support to colleagues in federal, State and local agencies. Through June 30, 2015, SCHS CMUs provided enhanced capacity case management for Sandy-impacted families of CYSHCN that resided in 10 coastal counties through Social Services Block Grant funding. Transition planning for CYSHCN was completed June 2015 to ensure continuity of supports with their SCHS CMU and long-term recovery groups. Looking back, strategies to sustain and improve resilience were learned through the challenges of SSS and are used to strengthen Title V's resilience in the advent of hurricane season. These tactics include ongoing collaboration among local and State emergency preparedness services to facilitate the sharing of information and resources with families of CYSHCN, updating and maintaining written and electronic consumer and professional resources on programs and services, and planning with families for future needs.

II.B. Five-Year Needs Assessment Summary Updates

The NJ Title V Program, the Division of Family Health Services (FHS), has not altered its Five-Year Needs Assessment that identifies consistent with health status goals and national health objectives the need for: preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children; and services for children and youth with special health care needs (CYSHCN).

For the 2018 MCH Title V Block Grant Application/Annual Report there were no changes to State Priority Need (SPN) Findings or the selection of National Performance Measures (NPM) selection.

The MCH Population Needs remain unchanged.

The Organizational Structure of the NJ Department of Health and the Division of Family Health Services (FHS), the NJ Title V agency, remains unchanged. Lisa Asare MPH was appointed the Assistant Commissioner for FHS in 2015.

The Agency Capacity of FHS remains unchanged with the continuation of all major federal grants. Efforts continues toward Workforce Development and Capacity.

Expanded partnerships, collaborations, and coordination of MCH programs continue especially involving the Improving Pregnancy Outcomes Initiative and the MIEC Home Visiting Program.

The emerging issue of Zika virus and its potential for Zika virus infections and related birth defects emphasizes the need to continue strengthening and expanding partnerships.

The Early Identification and Monitoring program is extensively involved in the Zika response at the state level. The EIM program is expanding and strengthening its partnerships with internal and external stakeholders through collaborations and educational opportunities regarding Zika prevention, referral, and follow-up of Zika exposed infants. The EIM program is working closely with the Centers for Disease Control and Prevention (CDC) to report the necessary information of infants identified as exposed to the Zika virus at birth, two, six and 12 months of age.

II.B.1. Process

The NJ Title V Program, the Division of Family Health Services (FHS), has prepared the following Five-Year Needs Assessment Summary that identifies consistent with health status goals and national health objectives the need for: preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children; and services for children and youth with special health care needs (CYSHCN). NJ has prepared this statewide Five-Year Needs Assessment Summary according to Title V guidelines.

The completion of a comprehensive needs assessment for the Maternal and Child Health (MCH) population groups is a continual process that the FHS performs in collaboration with many other organizations and partners. The needs assessment process is consistent with the conceptual framework in Figure 1 MCH Needs Assessment, Planning, Implementation, and Monitoring Process in the guidance. The ultimate goals of the needs assessment process are to strengthen partnerships and collaboration efforts within FHS, the NJ Department of Health (NJDOH), the MCH Bureau, and among other agencies and organizations involved with MCH and to improve outcomes for the MCH populations.

The goals and vision that guide the Needs Assessment originate from the mission statement of the Division of Family Health Services (FHS). Leadership for directing and completing a comprehensive

needs assessment is provided by the Assistant Commissioner of FHS, Service Directors in FHS, and the Program Managers in FHS. The overall needs assessment methodology is similar for each of the three population groups - preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children; and services for children with special health care needs. Though many of the functions occur simultaneously the sequential process is described below. This is a continuous and on-going process throughout the year.

II.B.2. Findings

The selection of the NJ's eight State Priority Needs (SPNs) is a product of FHS's continuous needs assessment. Multiple processes contribute to the overall needs assessment process including: the MCH Block Grants needs assessment process, the [NJ State Health Assessment](#) process, the NJDOH budget process, Departmental strategic planning, assessment of the [Healthy New Jersey 2020](#) objectives, the [Public Health accreditation process](#), the NJ Preventive Health and Health Services Block Grant, Community Health Improvement Plans, grant-driven needs assessments (MIECHV, Healthy Start, PREP...), public comment on the MCH Block Grant Application, and the collaborative process with other MCH partners. As a result of the overall needs assessment process, FHS has selected the following State Priority Needs for the MCH Block Grant (see Section II.C. State Selected Priorities):

SPN #1) Increasing Healthy Births,
SPN #2) Improving Nutrition & Physical Activity,
SPN #3) Reducing Black Infant Mortality,
SPN #4) Promoting Youth Development Programs,
SPN #5) Improving Access to Quality Care for CYSHCN,
SPN #6) Reducing Teen Pregnancy,
SPN #7) Improving & Integrating Information Systems, and
SPN #8) Smoking Prevention.

Some of these priorities have been longstanding priorities (SPN #3 Decreasing Black Infant Mortality, SPN #6 Decreasing Teen Pregnancy, SPN #7 Improving and Integrating Information Systems, and SPN #5 Improving Access to Quality Care for CSHCN). Others are priorities that broadly address several areas or population groups (SPN #4 Promoting Youth Development Programs, SPN #1 Increase Healthy Births, and SPN #8 Smoking Prevention). A priority focusing attention on the more recent public health issues of obesity is SPN #2 Improving Nutrition and Physical Fitness. The selected SPN reflect ongoing and new statewide public health initiatives. SPN #1 has been a recent focus of several new initiatives including the Improving Pregnancy Outcomes Initiative, the NGA Improving Birth Outcomes, the IM CollIN and the MIEC Home Visiting Program.

Based on NJ's eight selected SPNs as identified in the Five-Year Needs Assessment, NJ has selected the following ten of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period:

NPM #1 Well woman care,
NPM #4 Breastfeeding,
NPM #5 Safe Sleep,
NPM #6 Developmental Screening,
NPM #8 Physical Activity,
NPM #10 Adolescent Preventive Medical Visit
NPM #11 Medical Home,
NPM #12 Transitioning to Adulthood,
NPM #13 Oral Health, and
NPM #14 Household Smoking.

State Performance Measures (SPM) have been reassessed through the needs assessment process. Five existing SPMs will be kept, and two old SPMs have been deleted. The existing SPMs which will be continued are: SPM #1 Black non-Hispanic Preterm Infants in NJ, SPM #2 Children with Elevated Blood Lead Levels, SPM #3 Hearing Screening Follow-up, SPM #4 Referral from BDARS to Case Management

Unit, and SPM #5 Age of Initial Autism Diagnosis. The old SPMs to be deleted are: Regional MCH Consortia Implementing Community-based FIMR Teams and Overweight High School Students.

Table 1a - Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model (See Supporting Document #1) summarizes the selected ten NPMs and aligns the impact of Evidence-Based Informed Strategy Measures (ESMs) on NPMs and National Outcome Measures (NOMs). The purpose of the ESMs is to identify state Title V program efforts which can contribute to improved performance relative to the selected NPMs. The Logic Model is organized with one NPM per row. The Logic Model is the key representation which summarizes the Five-Year Needs Assessment process and includes the three-tiered performance measurement system with Evidence-Based or Informed Strategy Measures (ESM), National Performance Measures (NPM), and National Outcome Measures (NOMs). The Logic Model represents a more integrated system created by the three-tiered performance measure framework which ties the ESMs to the NPMs which in turn influence the NOMs.

As required in the first-year Application/Annual Report (FY 2016/FY 2014), **Table 1b** - Findings of the Five-Year State Needs Assessment (See Supporting Document #1) presents a focused summary of the findings of its Five-Year Needs Assessment. Table 1b: Findings of the Five-Year Needs Assessment provides this summary in tabular form. Highlighted in this summary are the health status of the MCH population (indicated as improving ↑, unchanged ↔, or worsening ↓) relative to the state's noted MCH strengths/needs and the identified national MCH priority areas, organized and presented by each of the six population health domains. Also summarized are the adequacy and *limitations* of the NJ Title V program capacity and partnership building efforts relative to addressing the identified MCH population groups and program needs. Specific partnership and collaborative efforts are listed, along with descriptions of promotion of family/consumer engagement and leadership, coordination with other MCHB and federal, state and local MCH investments.

II.B.2a. MCH Population Needs

Table 1c - Summary of MCH Population Needs (See Supporting Document #1) displays the health status for each of the six population health domains according to the 10 selected NPMs. The table provides a summary of population-specific strengths/needs and identifies major health issues for each of the 6 population health domains which came from identified successes, challenges, gaps and areas of disparity identified during the needs assessment process.

II.B.2b. Title V Program Capacity

II.B.2b.i. Organizational Structure

All Maternal and Child Health (MCH) programs including programs for Children and Youth with Special Health Care Needs (CYSHCN) are organizationally located within the Division of Family Health Services (FHS). All Title V services are under the direction of Lisa Asare MPH, Assistant Commissioner, Division of FHS. In April 2017, Dr. Marilyn Gorney-Daley, Director of Special Child Health and Early Intervention Services, Division of FHS, was appointed to the role of Title V Director of Maternal and Child Health.

II.B.2b. ii Agency Capacity

This section describes Family Health Service's capacity to promote and protect the health of all mothers and children, including children and youth with special health care needs (CYSHCN). The Maternal and Child Health Services (MCHS) and Special Child Health and Early Intervention Services (SCHEIS) Units ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care through collaboration with other agencies and private organizations and the coordination of health services with other services at the community level.

The mission of the [Division of Family Health Services \(FHS\)](#) is to improve the health, safety, and well-being of families and communities in NJ. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

The statutory basis for maternal and child health services in NJ originates from the statute passed in 1936 (L.1936, c.62, #1, p.157) authorizing the Department of Health to receive Title V funds for its existing maternal and child services. When the State constitution and statutes were revised in 1947, maternal and child health services were incorporated under the basic functions of the Department under Title 26:1A-37, which states that the Department shall "Administer and supervise a program of maternal and child health services, encourage and aid in coordinating local programs concerning maternal and infant hygiene, and aid in coordination of local programs concerning prenatal, and postnatal care, and may when requested by a local board of education, supervise the work of school nurses."

Other statutes exist to provide regulatory authority for Title V related services such as: services for children with Sickle Cell Anemia (N.J.S.A. 9:14B); the Newborn Screening Program services (N.J.S.A. 26:2-110, 26:2-111 and 26:2-111.1); genetic testing, counseling and treatment services (N.J.S.A. 26:5B-1 et. seq.); services for children with hemophilia (N.J.S.A. 26:2-90); the birth defects registry (N.J.S.A. 26:8-40.2); the Catastrophic Illness in Children Relief Fund (P.L. 1987, C370); childhood lead poisoning prevention and screening (Title 26:2-130-137); and the Sudden Infant Death Syndrome (SIDS) Resource Center (Title 26:5d1-4). Recent updates to Title V related statutes are mentioned in their relevant sections.

Table 1d – Title V Program Capacity and Collaboration to Ensure a Statewide System of Services (see Supporting Document #1) summarizes according to the six MCH population health domains the collaborations with other state agencies and private organizations, the state support for communities, the coordination with community-based systems, and the coordination of health services with other services at the community level.

II.B.2b.ii. Preventive and Primary Care for Pregnant Women, Mothers and Infants

The mission of Maternal and Child Health Services (MCHS) within FHS is to improve the health status of NJ families, infants, children and adolescents in a culturally competent manner, with an emphasis on low-income and special populations. Prenatal care, reproductive health services, perinatal risk reduction services for women and their partners, postpartum depression, mortality review, child care, early childhood systems development, childhood lead poisoning prevention, immunization, oral health and hygiene, student health and wellness, nutrition and physical fitness and teen pregnancy prevention are all part of the MCHS effort. The population domains addressed by MCHS include 1, 2, 3, 4, and 6.

Reproductive and Perinatal Health Services (RPHS), within MCHS, coordinates a regionalized system of care of mothers and children in collaboration with the Maternal and Child Health Consortia (MCHC). The MCHC were developed to promote the delivery of the highest quality of care to all pregnant women and newborns, to maximize utilization of highly trained perinatal personnel and intensive care facilities, and to promote a coordinated and cooperative prevention-oriented approach to perinatal services. Continuous quality improvement activities are coordinated on the regional level by the MCHC.

NJ successfully applied in 2010 for the Maternal, Infant and Early Childhood Home Visiting Program (MIEC HV) Formula and Competitive Grants to the Health Resources and Services Administration. The goal of the NJ MIEC HV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full implementation of the grant project is being carried out in collaboration with the Department of Children and Families (DCF). Currently evidence-based home visitation services are provided by 66 Local Implementing Agencies (LIAs) providing three national models (Healthy Families America, Parents As Teachers and Nurse Family Partnership) in all 21 NJ counties serving 7,096 families in SFY 2015.

II.B.2b.ii. Preventive and Primary Care for Children and Adolescents

The Child and Adolescent Health Program (CAHP) within MCHS focuses on primary prevention strategies involving the three MCH domains of Child Health, Adolescent/Young Adult Health, and the Life Course.

A priority in Child Health is the prevention of lead poisoning among children under six years of age (SPM #2) through collaborative, prevention-oriented outreach and education to parents, property owners, and health care providers. The Childhood Lead Poisoning Prevention (CLPP) Projects use a home visiting model to provide nurse case management and environmental investigations for children less than six years of age with confirmed elevated blood lead levels. Thirteen sites throughout the State receive funding to provide monitoring of retesting of elevated blood lead levels, to perform household education and conduct residential property inspections to identify and abate lead hazards. The goal of the CLPP Projects is to promote a coordinated support system for lead poisoned children and their families through the development of stronger linkages with Special Child Health Services, Medicaid Managed Care Organizations (MCOs), DCF, DOE, Department of Community Affairs, and community-based agencies that provide early childhood services.

Since July 2010, Adolescent Health has been implementing School Health NJ, which utilizes the framework of CDC's Whole School, Whole Community, Whole Child ([WSSCC](#)) model. The CDC model provides a framework for organizing school health into 10 components: 1) Health Education, 2) Physical Education, 3) Health Services, 4) Counseling, Psychological and Social Services, 5) Nutrition Services, 6) Staff Wellness, 7) Healthy Physical School Environment, 8) Healthy Social-Emotional School Climate and Culture, 9) Family Engagement, and 10) Community Involvement. School health programs promote healthy behaviors and health is critically linked to academic performance. Self-reported health behaviors (alcohol, tobacco and other drug (ATOD) use; healthy food choices; physical activity; sexual activity; and, violence, injury and safety) of high school youth are surveyed every other (odd numbered) year using the NJ Student Health Survey. Since SFY2016, regional school health grantee agencies have partnered with Sustainable Jersey for Schools. In SFY2017, DOH funded 30 schools a total of \$120,000 to implement one of 13 health and wellness actions. Partnership opportunities with the Johnson & Johnson/Rutgers sponsored School Health Leadership Program and the NJ State School Nurses Association are anticipated for SFY2018.

The CAHP successfully applied for and was awarded in 2010 two new federal grants to prevent teen pregnancy. In SFY2018, five NJ Personal Responsibility Education Program (NJ PREP) grantees continue to replicate evidence-based programs with proven effectiveness in delaying sexual activity, increasing condom or contraceptive use for sexually active youth, and reducing pregnancy among youth. These programs are: Making Proud Choices; Reducing the Risk; and the Teen Outreach Program (TOP). NJ PREP funding also provides education on at least three of the following adult preparation topics: healthy relationships; positive adolescent development; financial literacy; parent-child communication skills; education and employment preparation skills and healthy life skills. In SFY 2016, NJ PREP was successfully implemented by six sub-grantees at more than 68 locations (24 community-based organizations and 44 school-based organizations) in 29 municipalities and 11 counties throughout the State to reach about 2,000 unduplicated youth participants.

The NJ Abstinence Education program (NJ-AEP) funds four grantees to provide sexual risk avoidance education to adolescents that are at high-risk for teen pregnancy, STDs/STIs and HIV/AIDS. The NJAEP is a primary prevention strategy that provides 10- to 19-year-olds the knowledge and skills to avoid the high-risk behaviors of early sexual activity and promotes abstinence from sexual activity and, where appropriate, provides options that may include mentoring, counseling and/or adult supervision. NJ AEP is implemented in eight counties in New Jersey, in 52 public schools, and five community-based and 11 faith-based settings, reaching annually more than 11,000 youth. In addition to classroom instruction, grantees provide after-school clubs, peer mentoring, media training, and community service learning opportunities.

The NJDOH established the NJ Children's Oral Health Program (COHP) in 1981. The program provides a variety of interactive, age-appropriate oral health education activities for children in grades K through 12. The Program is regionally implemented in the twenty-one counties of the State with each region having an Oral Health Coordinator and multi-disciplinary program staff that implement oral health activities. The oral health topics addressed include: good oral hygiene practices, fluoride as a preventive measure, dental sealants, healthy food choices, periodontal disease, tobacco cessation, prevention of oral injury and the importance of regular dental exams. Classroom presentations include interactive discussion and audio-visual presentations. All program activities are adaptable for children with special needs. Education initiatives are also conducted for parents, teen parents, Women, Infant, Children (WIC) clients and pregnant women. In-service and workshop programs for non-dental professionals, including school nurses, public health nurses, teachers, WIC Coordinators, multi-disciplinary obstetric and pediatric staff, social workers and nursing students are also conducted.

II.B.2b.ii. Preventive and Primary Care for Children with Special Health Care Needs

NJ maintains a comprehensive system to promote and support access to preventive and primary care for CYSHCN through early identification, linkage to care, and family support. Title V partially supports this safety net which is comprised of pediatric specialty and sub-specialty, case management, and family support agencies that provide in-state regionalized and/or county-based services. It is designed to provide family-centered, culturally competent, community-based services for CYSHCN age birth to 21 years of age, as well as to enhance access to medical home, facilitate transition to adult systems, and health insurance coverage. The Specialized Pediatric Services Programs (SPSP) agencies are a significant resource of pediatric specialty and subspecialty care in NJ, and are used widely by CYSHCN including Medicaid recipients. Although clients are screened for their ability to pay for clinical services, the support provided by Title V enables all CYSHCN to be served regardless of their ability to pay. There is no charge for SCHS CM and family support.

Section II.F.2. MCH Workforce Development and Capacity provides more detail on Family Health Service's capacity to promote and protect the health of all mothers and children, including children and youth with special health care needs (CYSHCN).

B.2b. iii MCH Workforce Development and Capacity

This section describes the strengths and needs of the state MCH and CSHCN workforce, including the number, location and full-time equivalents of state and local staff who work on behalf of the state Title V programs. Included in **Table 1e** - Staffing for MCHS and SCHEIS (See Supporting Document 1) are the names and qualifications (briefly described) of senior level management employees who serve in lead MCH-related positions and program staff who contribute to the state's planning, evaluation, and data analysis capabilities. Also included in the summary are the number of parent and family members, including CSHCN and their families, who are on the state Title V program staff and their roles (e.g., paid consultant or volunteer.) In addition, MCH workforce information such as the tenure of the state MCH workforce is included in the summary.

Maternal and Child Health Services (MCHS) is comprised of three program managers, 16 professionals, and 6 support staff. All staff members are housed in the central office. Dr. Marilyn Gorney-Daley was appointed Service Director for the Maternal and Child Health Unit in April 2017. Dr. Gorney-Daley, a physician with a Master in Public Health and Board Certification in General Preventive Medicine and Public Health, is also continuing to serve as the Service Director for Special Child Health and Early Intervention Services until a new Director is hired.

Reproductive and Perinatal Health Services (RPHS) is staffed by 10 professionals and 3 support personnel and a Program Manager. A new Program Manager, Nancy Mimm, was hired in 2016. The program is responsible for the regional MCH Consortia, Certificate of Need rules and MCH Consortia regulations, morbidity and mortality reviews, Title V Liaison with the Healthy Start projects, Family Planning, perinatal addictions and fetal alcohol syndrome prevention projects, postpartum mood disorders initiative, Improving Pregnancy Outcomes Initiative, and preconceptional health. Several professional staff members participate in the various subcommittees of the Home Visiting Work Group and work collaboratively with the March of Dimes Healthy Babies are Worth the Wait. The Healthy Mothers, Healthy Babies Coalitions and Black Infant Mortality Reduction Initiative were rolled into the Improving Pregnancy Outcomes Initiative. Resources for staff have been from federal MCH Block Grant, MIECHV, and the Preventive Health and Health Services Block Grant.

The Child and Adolescent Health Program (CAHP) is staffed by 9.5 employees - 5 in Child Health (Coordinator, three professional staff and one MIS Technician) and 2.5 in Adolescent Health (Health Projects Coordinator, PREP Coordinator and .5 FTE special services AEP Coordinator), 1 administrative support staff and the Program Manager. Effective July 1st, the AEP Coordinator will be vacant in addition to the vacant professional position in School Health. CAHP staff have varied professional backgrounds including nursing, adolescent health, nutrition, health education, research and data analysis. Funding resources include both federal (MCH Block Grant, CDC cooperative agreement for lead poisoning surveillance and primary prevention, ACF's Title V Abstinence Education Program [AEP] and Personal Responsibility Education Program [PREP]) and state (MCH and Lead childhood lead poisoning) funding. All staff are housed in the Trenton office. The CAHP Manager has oversight responsibilities for childhood lead poisoning and prevention, the Teen Pregnancy Prevention (TPP) project (PREP and AEP) and the School Health NJ project which utilizes the framework of the CDC- Whole School, Whole Community, Whole Child (WSCC) model in public schools, grades six and above.

Community Health and Wellness Services in the Division of FHS was awarded the CDC 1305 cooperative agreement: State Public Actions to Prevent Chronic Disease ...and Promote School Health, for basic and enhanced components.

The Children's Oral Health Program (COHP) is comprised of 1 professional staff who reports to the Medical Director, Division of Family Health Services. Dr. Beverly Kupiec-Sce directs program activities which are implemented through regional based programs strategically located in the north, central and south regions of the State. As COHP Director, Dr. Sce maintains a gubernatorial appointment to the NJ State Board of Dentistry and is one of 19 doctoral prepared nurses nationwide serving on the National Nursing Workgroup on Oral Health a component of the National Inter-Professional Initiative on Oral Health. The role of the National Oral Health Nursing Workgroup is to shape nursing's role in advancing a national oral health agenda and serves as an expert advisory committee providing input related to nursing's role in improving oral systemic health outcomes as well as expanding access to and reducing disparities in oral health.

The Maternal and Child Health Epidemiology Program (MCH Epi) provides MCH surveillance and evaluation support to MCHS. The mission of the MCH Epi Program is to promote the health of pregnant women, infants and children through the analysis of trends in maternal and child health data and to facilitate efforts aimed at developing strategies to improve maternal and child health outcomes through the provision of data and completion of applied research projects. The MCH Epi Program promotes the central collection, integration and analysis of MCH data. MCH Epi is comprised of three research professional positions. One professional staff position is supported entirely by resources from the MCH Bureau's State Systems Development Initiative (SSDI) grant. The Pregnancy Risk Assessment

Monitoring System (PRAMS) survey is coordinated by the MCH Epi Program. Ingrid Morton retired as Program Manager for MCH Epi in Jan 2017. One of two research professional positions is currently vacant.

Special Child Health and Early Intervention Systems

Special Child Health and Early Intervention Systems (SCHEIS) consist of the following programs and services: Early Identification and Monitoring, Newborn Screening and Genetic Services Program, Family Centered Care Services, and the Early Intervention System.

Dr. Marilyn Gorney-Daley is the Director of SCHEIS. Dr. Gorney-Daley is board certified in General Preventive Medicine and Public Health, with a Master of Public Health in Healthcare Organization and Administration. She has over 15 years of experience with NJDOH and previously served as the Medical Director of SCHEIS. All SCHEIS staff members are housed in the central office.

The Early Identification and Monitoring (EIM) Program is responsible for the reporting and monitoring of children with birth defects, special needs, and pulse oximetry screening fails, Autism, and the Early Hearing Detection and Intervention Program. The EIM Program is comprised of a staff of 8 professionals, 6 support staff, and a Program Manager, Joy Rende who holds a Master of Science in Hospital Administration, a National Certification in Maternal Child, ANCC Certification in Nurse Executive and a Certification Public Health Management. Ms. Rende has 25 years of leadership experience and a Neonatal Intensive Care clinical background. Resources for staff come from the MCH Block Grant, a HRSA grant for universal newborn hearing screening, and 2 CDC cooperative agreements (EHDI and Birth Defects Surveillance), and the Autism Medical Research and Treatment Fund.

The Newborn Screening and Genetic Services Program is responsible for the follow-up of newborns with out-of-range screening results. This program also provides partial support through its grants to specialty care centers and facilities for metabolic and genetic services, pediatric endocrine services, pediatric hematologic services, pediatric pulmonary services and specialized confirmatory and diagnostic laboratory services. The Newborn Screening and Genetic Services Program is currently comprised of a staff of 11 professionals and 3 support staff.

The Family Centered Care Services Program (FCCS) is responsible for funding, monitoring, and evaluating services provided by the 21 Title V funded Case Management Units, Family WRAP family support services, 9 Child Evaluation Centers which include 4 FAS Diagnostic Centers, 5 Cleft Lip/Cleft Palate centers, 3 Tertiary Care Centers, 2 Organ Donor and Tissue Sharing Donor awareness education programs, and the 7 Ryan White Part D funded Statewide Family Centered HIV Care Network sites. Resources for staff come from the MCH Block Grant and from the HRSA AIDS Bureau under Ryan White Part D. This program is comprised of a staff of 6 professionals, 2 support staff, and a Program Manager, Mrs. Pauline Lisciotto, RN, MSN. The Coordinator of Special Child Health Services, Case Management is Ms. Felicia Walton, BA. Ms. Linda Barron, RN-CPN, MSN, coordinates SPSP, and Mrs. Ellen Dufficy, RN, M.Ed. coordinates Ryan White Part D.

The Early Intervention System is headed by Terry Harrison, Part C Coordinator. This System provides services to infants and toddlers with disabilities or developmental delays and their families in accordance with Part C of the Individuals with Disabilities Education Act.

All programs within SCHEIS have staff with varied professional backgrounds including nursing, medicine, physical therapy, epidemiology, speech pathology, public health, research, statistics, family counseling, education, and genetic counseling. Both senior level and support staff include parents of children with special health care needs such as developmental delay, seizure disorder, specific genetic syndromes, and asthma.

To promote and provide culturally competent approaches in its services delivery across programs, NJ actively:

- (1) Collects and analyzes data according to different cultural groups (e.g. race, ethnicity, language) and use the data to inform program development and service delivery.
- (2) Ensures the provision of training for staff, family leaders, volunteers, contractors and subcontractors in the area of cultural and linguistic competence.
- (3) Collaborates with informal community leaders/groups (e.g. natural networks, informal leaders, spiritual leaders, ethnic media and family advocacy groups) and families of culturally diverse groups in needs/assets assessments, program planning, service delivery and evaluation/ monitoring/quality improvement activities.
- (4) Secure allocation of resources to adequately meet the unique access, informational and service needs of culturally diverse groups.
- (5) Develop and implement performance standards for staff and contractors that incorporate cultural competence practices and policies.
- (6) Provide policies and guidelines that support the above identified items and approaches.

A table (Table 1e - Staffing for MCHS and SCHEIS) has been attached (see Supporting Document #1) which summarizes the names and qualifications of senior level management employees who serve in lead MCH-related positions and program staff who contribute to the state's planning, evaluation, and data analysis capabilities.

Title V SCHEIS staff are active participants and represent the NJDOH on the NJ Statewide Network on Cultural Competence (NJSNCC) to ensure that there is access to equitable and quality services for individuals, families, and communities through culturally and linguistically appropriate service delivery. As part of their mission, the NJSNCC holds an annual conference for service providers, policymakers, researchers and other stakeholders on culturally competent care. The theme of the recent annual conference held December 8, 2016 was "Achieving Equity in Maternal, Child and Family Health: A Call to Action". Dr. Michael Lu, Assistant Administrator of HHS, HRSA, Maternal & Child Health Bureau, was the keynote speaker. He discussed the blueprint goals and strategic objectives for advancing health equity in maternal and child health, in line with CDC's vision of achieving health equity, eliminating health disparities, and improving the health of all Americans. Workshop presentations were centered on addressing health and mental health-related issues with three population types: families with special needs, maternal/fetal health, and infant, child and adolescents.

Some of the workshops included:

- Use of a Genogram to identify strengths, resources and challenges in culturally diverse families of children with special needs.
- Considering culture in Autism screening.
- A toolkit for providers, bilingual staff, and community interpreters who work with Hispanics in high-risk OB.
- Fatherlessness in America.
- How stigma and the lack of education and resources open the door to sexual violence among LGBTQ youth.

Two of the afternoon workshops discussed best and promising practices in supporting military families of children with special health care needs, and reducing health disparities in Asian Indians with special needs children.

A poster session was held for the first time this year, addressing issues relating to the three tracks on families with special needs, maternal/fetal health, and infant, child and adolescents.

Continuing Education Credits of 5.25 CNEs were offered to RNs at this conference.

The NJSNCC continues to conduct hour long webinars on a quarterly basis for service providers and other interested individuals that focus on cultural competence.

Webinars presented in 2016 included:

- **Immigrant Integration: A Challenge for our Time.** In this webinar, the meaning of immigrant integration was discussed, why it is deserving of careful attention by policymakers and practitioners, how the U.S. compares to other countries in its integration outcomes, and what policies and practices show promise of fostering immigration inclusion and participation.
- **Cultural Implications of Screening for Families from Diverse Backgrounds.** This webinar was aimed to enhance the leadership and advocacy skills of every parent within their family and their community in order to promote systems change. The presenter shared information about the cultural implications of screening for families from diverse backgrounds as well as lessons learned from projects funded by the US Centers for Disease Control & Prevention and the NJ Governor's Council for Medical Research and Treatment of Autism.
- **The Impact of Cultural Competence in the Delivery of Disability Services and Supports.** This webinar discussed how parents from different cultural backgrounds shared ways that culture impacts the utilization of services for their children, and explored the values and belief systems that shape the behavior of various ethnic groups and ways that various cultures affect the understanding of disabilities, services and supports.
- **A Collaborative Approach to Providing Effective Fire and Emergency Services to Diverse Groups.** This webinar was conducted by the Fire Chief of Clifton, who spoke about providing services to displaced occupants after a fire, how diverse the neighborhoods have become, and how these services should be more responsive to these diverse communities. Continuing education credits were offered by the NJ Office of Emergency Management Services (OEMS) for this program.

Another upcoming Conference is planned for December 2017. The focus of this annual conference will be on: "Improving Health and Mental Health Literacy in Diverse Communities: Why Partnerships Matter". The NJSNCC is looking to form a new partnership with the National Network of Libraries of Medicine/Midatlantic Region (NNLM/MAR) for this conference, in addition to the other partnerships already formed from previous years.

FHS recently evaluated its current and future workforce requirements for the State's MCH Services. The evaluation resulted in reclassification of titles to meet the needs of the changing roles and requirements and keeping aligned with the DOH's strategic plan. FHS hired employees and are hiring new employees in the title series of Health Data Specialist and Analyst, Research and Evaluation to support MCH Epidemiology Program and SCHEIS Program. Additionally, we are preparing to hire additional Quality Assurance Specialists. Hiring employees in these titles will improve effectiveness and efficiency of the public health system especially in the MCH programs. The vacant positions were related to retirements, resignations and promotions.

DOH recently planned a Performance Management Training. Two classroom training sessions were held in June, in addition to a webinar that was available to all staff. This training will provide staff to oversee and improve the actions that it takes to enact health policies and plans, to assess health outcomes of at risk maternal and child health communities and to adapt or change policies in order to better achieve the desired outcomes. The establishment and implementation of a Performance Management System is also a sound operation and management practice and a requirement for successful Public Health Accreditation as the Department seeks to become a nationally accredited health department.

II.B.2.c. Partnerships, Collaboration, and Coordination

This section summarizes the relevant organizational relationships which serve the MCH populations and expand the capacity and reach of the state Title V MCH and CSHCN programs. **Table 1f** - MCH Organizational Relationships with Partnerships, Collaboration, and Cross-Program Coordination (See Supporting Document #1) summarizes the partnerships, collaborations, and cross-program coordination established by the state Title V program with public and private sector entities; federal, state and local government programs; families/consumers; primary care associations; tertiary care facilities; academia; and other primary and public health organizations across the state that address the priority needs of the MCH population but are not funded by the state Title V program.

Sections II.F.2. and II.F.3. describes relevant organizational relationships between FHS and the State Human Services agencies (mental health, social services/child welfare, education, corrections, Medicaid, SCHIP, Social Security Administration, Vocational Rehabilitation, disability determination unit, alcohol and substance abuse, rehabilitation services); the relationship of State and local public health agencies (including MCH Consortia) and federally qualified health centers; primary care associations; tertiary care facilities; and available technical resources which enhance the capacity of the Title V program.

Section II.F.2. also describes the plan for coordination of the Title V program with (1) the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), (2) other federal grant programs (including WIC, related education programs, and other health, developmental disability, and family planning programs), and (3) providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for services.

NJ has prided itself on its regionalized MCH services and programs, which are coordinated through the [Maternal Child Health Consortia \(MCHC\)](#), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. The MCHC are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs. The three MCHC are located in the northern, central and southern regions of the state, with the northern region representing the largest number of births.

The Federally Qualified Health Centers (FQHCs) operate in all of NJ's 21 counties. The 21 FQHCs have a combined 110 licensed satellite sites throughout the State. As a consequence of expansion and capacity-building initiatives overall growth in the number of uninsured visits reimbursed has been exponential. In SFY 2014, almost 212,000 uninsured residents were serviced and over 522,000 uninsured visits reimbursed. In SFY 2015, the FQHC–Uncompensated Care Fund was funded at \$31.5 million. In SFY2015, the FQHCs served a total of 160,456 uninsured residents and 406,267 uninsured visits were reimbursed. The decrease in the number of uninsured residents is a result of the Affordable Care Act and Medicaid Expansion. In SFY 2016 the FQHC–Uncompensated Care Fund was funded at \$32.3 million.

The NJ Title V CYSHCN Program, also referred to as Special Child Health and Early Intervention Services (SCHEIS), located in the NJDOH, partners, collaborates, and coordinates with many different governmental and nongovernmental entities, on federal, state, and local levels, as well as parents, families and caregivers, primary care physicians, specialists, other health care providers, hospitals, advocacy organizations, and many others to facilitate access to coordinated, comprehensive, culturally competent care for CYSHCN. The Title V CYSHCN program works with programs within DHS and DCF in addressing many needs facing CYSHCN including medical, dental, developmental, rehabilitative, mental health, and social services. DHS administers Title XIX and Title XX services and provides critical supports for ensuring access to early periodic screening detection and treatment for CYSHCN. The State DHS Medicaid, Children's Health Insurance Program Reauthorization Act (CHIPRA) NJ FamilyCare Program, and the Division of Disability Services afford eligible children comprehensive health insurance coverage to access primary, specialty, and home health care that CYSHCN and their families need.

In order to ensure access to health insurance and benefits to enrolled CYSHCN, SCHEIS collaborates with the Department of Banking and Insurance (DOBI), Division of Insurance colleagues in the development of policy and procedure; i.e., Grace's Law, EIS, and Autism. Likewise, DOBI partners participate with SCHEIS in provider and consumer education and advocacy and regularly provide technical assistance and training at the SCHS quarterly meetings.

The DCF is focused on strengthening families and achieving safety, well-being, and permanency for all NJ's children. Current priorities focus on child welfare, safety, health, family strengthening, and the establishment of foster homes. DCF is also engaged in reengineering child abuse prevention, building capacity in the child behavioral health system, and improving the system of health care for children in the State's care. Collaboration between State SCHEIS, local agencies implementing CYSHCN health and

related support services, and the statewide DCF system are ongoing to ensure access to health and related services to the most vulnerable CYSHCN.

The Statewide Parent Advocacy Network (SPAN) and the NJAAP are key partners with the Title V Program in NJ in many initiatives and projects to better serve CYSHCN and empower families. The Statewide Community of Care Consortium (COCC), a leadership group of SPAN, dedicated to improving New Jersey's performance on the six core outcomes for CYSHCN and their families, includes three co-conveners from Title V, SPAN and NJAAP. This group also includes DHS, DCF, the NJ Primary Care Association, and over 60 statewide participating stakeholder organizations. The COCC partners are continuing to work to improve the access of children with mental health challenges to needed care, and to improve the capacity of primary care providers to address mental health issues within their practice. A Family Guide to Integrating Mental Health and Pediatric Primary Care has been developed and shared with families. COCC co-conveners continue to meet with New Jersey's child protection agency, DCF Division of Protection and Child Permanency, about addressing challenges for children with mental health needs under their care.

In addition, the SPSP initiated a collaboration with NJAAP, DCF, Child Evaluation Center/Fetal Alcohol Syndrome/Spectrum Disorder (FASD) Center providers, and parents on the development of three webinars targeting the early identification, diagnosis and linkage to care for FASD providers and consumers. The webinars were presented "live" during the fall and presented at grand rounds in regionally located hospitals during fall 2016. Continuing education credits were offered to nurses, social workers and physicians. A total of 280 individuals participated in the "live" streaming of webinars 1-3. All 3 webinars were recorded and are available as enduring material on the NJ AAP website.
<http://njaap.org/events/webinars/>

Section II.F.3. Family/Consumer Partnerships provides more detail on the relevant organizational relationships which serve the MCH populations and expand the capacity and reach of the state Title V MCH and CSHCN programs.

II.C. State Selected Priorities

The State Priority Needs selected by NJ for its Title V Program during the 5-year reporting period have been determined by a thorough examination of the findings from the state’s 5-Year Needs Assessment, as highlighted in the Needs Assessment Summary of the first-year Application/Annual Report. This section describes the relationship of the State Priority Needs, the National and State Performance Measures, and the capacity and resources of the State Title V Program.

Table 10 - State Priority Needs from Five-Year Needs Assessment Form 9

State Priority Needs (SPNs)	New (N), Replaced (R) or Continued (C) Priority Need for this 5-Year Reporting Period			Rationale including National and State Performance and National Outcome Measure
	N	R	C	
1) Increasing Healthy Births			X	NPM 1,2,3; NOMs 1,2,3,5,6,7,8,21,22; SPM 1
2) Improving Nutrition & Physical Activity			X	NPM 8; NOM 9,11,13
3) Reducing Black Infant Mortality			X	NPM 1,2,3,4,5; SPM 1; NOM 1-9
4) Promoting Youth Development			X	NPM 6,10,11,12; NOM 10,11,13,15,16,17
5) Improving Access to Quality Care for CYSHCN			X	NPM 11,12; SPM 3,4,5; NOM 18,19,20,23
6) Reducing Teen Pregnancy			X	NPM 11
7) Improving & Integrating Information Systems			X	All NPMs, SPMs, NOMs
8) Smoking Prevention	X			NPM 14

SPN #1. Increasing Healthy Births is a long-standing State Priority Need (SPN) that encompasses reducing low birth weight, preterm births, infant mortality, and increasing first trimester prenatal care adequate prenatal care, and Maternal/Women's Health. SPN #1 addresses the needs of the population domains of Maternal/Women's Health and Perinatal/Infant Health and is impacted by the NPMs 1, 2 and 3. Several initiatives address healthy births including the Home Visiting Program, Healthy Start outreach activities, Community Action Team projects based on FIMR findings, the Perinatal Addictions Prevention Projects and most recently the Improving Pregnancy Outcome Initiative.

Demonstrating its prioritization of Increasing Health Births, RPHS released in 2014 a competitive request for applications to improve perinatal outcomes, called the Improving Pregnancy Outcomes (IPO) Initiative that requires incorporation of the Life Course Theory and uses the services models of Community Health Workers and Central Intake. The IPO Initiative is coordinated with existing federal and state-funded initiatives including but not limited to Healthy Start, MIECHV, Strong Start, Title X Family Planning, Childhood Lead Poisoning Prevention, Healthy Homes, Perinatal Addictions Prevention, Postpartum Mood Disorders, Coordinated School Health, WIC, Federally Qualified Health Centers (FQHCs), and the activities of the Community Health & Wellness Service Unit of the FHS (smoking, diabetes, cardiac, cancer, obesity prevention, physical fitness, hypertension).

SPN #2. Improving Nutrition and Physical Activity is a relatively recent SPN to address the obesity epidemic. The SPN #2 addresses needs in the 4 population domains of Maternal/Women's Health, Perinatal/Infant Health, Child Health, and Adolescent/Young Adult Health and impacts on NPM #8 and NOMs 9 and 11. NJ had one of the highest obesity rates among low-income children 2 to 5 years of age at nearly 18 percent in 2008. The obesity epidemic is taking a toll on the future health of our children by contributing to the rise in related chronic diseases and disabilities, and adding billions of additional dollars in health care costs. Children who are obese are at grave risk of lifelong, chronic health problems like heart disease, asthma, arthritis and cancer.

In SFY2017, regional DOH School Health grantees, in collaboration with Sustainable Jersey for Schools supported the following nutrition and physical activity actions with \$120,000 in small grants to public schools, grades six and above, to implement: 1) Breakfast After the Bell; 2) Healthy Food Choices Beyond the Cafeteria; 3) Create or Expand a School Garden; 4) Access to Healthy Water; 5) Create or Strengthen Policies to Promote Physical Activity; and, 6) Programs to Promote Physical Activity.

Below are the number of schools with approval of their completed nutrition action. The number of schools with approval of their completed physical activity action is provided in the National Performance Measure #8, Physical Activity report section.

Nutrition Actions	# Schools Approved			
	2016	2017	2018	2019
Access to Healthy Water	5			
Breakfast After the Bell	5			
Healthy Food Choices Beyond the Cafe	9			
School Gardens	6			

SPN #3. Reducing Black Infant Mortality has been a long-standing priority for MCHS with special emphasis in 1985 when the Infant Mortality Reduction Initiative was initiated. SPN #3 addresses the needs of the population domains of Maternal/Women's Health and Perinatal/Infant Health and is impacted by the NPMs 1, 2, 3, 4, and 5.

In 2013 NJDOH was invited to participate in the third round of the National Governors Association Learning Network on Improving Birth Outcomes Initiative (NGA IBO Initiative). NJDOH created three working groups to develop key recommendations regarding the improvement of birth outcomes. In 2014 NJDOH was also invited to participate in the Infant Mortality Collaborative Improvement and Innovation Networks (IM CoIIN) sponsored by the MCH Bureau with technical assistance from National Institute for Children's Health Quality. IM CoIIN is a state-driven HRSA-coordinated partnership to accelerate improvements in infant mortality by helping states: 1) innovate and improve their approaches to reducing infant mortality and improving birth outcomes through communication and sharing across state lines; and 2) use the science of quality improvement and collaborative learning to improve birth outcomes. The multi-sector IM CoIIN State Team from NJ identified two priority areas - improving postpartum rates and smoking cessation. The NGA IBO Initiative workgroups will continue as the IM CoIIN Strategy Teams to develop recommendations for improving birth outcomes and preventing infant mortality.

In 2014 RPHS implemented the IPO Initiative as a means to prevent infant mortality in the highest risk communities. The IPO Initiative through a collaborative coordinated community-driven approach will work to improve maternal and infant health outcomes for high-need women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes. The IPO Initiative with a Central Intake model and Community Health Workers will be collaborating with the IM CoIIN to implement the recommendations. The IPO Initiative goal is to work towards reducing and eliminating disparities by utilizing community health workers from the community they serve and implement innovative programs to eliminate disparities such as the Community Doula Program which is black women serving black women.

SPN #4. Promoting Youth Development utilizes a strength-based approach to meet the needs of the Adolescents and Young Adults domain. This approach has been demonstrated to impact multiple risk behaviors. The Teen Outreach Program (TOP) implemented by NJ PREP is an evidence-based youth development program. A proposal is under discussion as a result of its submission to DCF for TOP implementation in 20 middle schools with SBYSs. A follow-up meeting took place on April 3rd. TOP implementation is anticipated to begin September 2017. SPN #4 includes NPMs 7, 8, 10, 11 and 12, and NOMs 9, 11, 15, 16 and 17. In addition, ACF's Title V Abstinence Education Program (AEP) grantees

are incorporating youth development activities such as community service learning (CSL) and the evidence-based program Photovoice.

Upon achieving full staffing capacity, defined as one FTE position in each of the three adolescent health projects, the Adolescent Health section will undertake the development of a statewide youth engagement plan amongst DOH youth-serving programs.

SPN #5. Improving Access to Quality Care for CYSHCN is prioritized through collaboration and partnership building, targeting resources and efforts to maintain capacity, and comprehensively addressing the six MCHB core outcomes for CYSHCN and State Performance Measures (#3, 4, & 5, and impacts National Performance Measures 11 and 12.

The network of specialty providers, linkages with enabling services provided by Special Child Health Services Case Management Units (CMUs), collaboration with intergovernmental agencies and community-based organizations (refer to stakeholder list), and leadership from the State agency strengthens the safety net of access to care for NJ's CYSHCN. Although many of NJ's CYSHCN have access to primary care, the coordination of care for medically fragile children is often managed through their specialty providers; Child Evaluation Centers (CECs), Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder (FAS/FASD) Centers, Cleft Lip/Palate Craniofacial Anomalies Centers, Tertiary Care Centers and Ryan White Part D HIV Care Network, and NJ is attempting to reverse that trend. SCHEIS is working with the New Jersey Chapter, American Academy of Pediatrics (NJAAP) and the Statewide Parent Advocacy Network's (SPAN's) efforts to promote medical home initiatives developed to encourage collaboration between pediatric subspecialists and primary care providers. NJ is working toward all CYSHCN receiving high-quality, comprehensive care through a medical home that assures timely access to necessary pediatric specialty and subspecialty care, community supports, and transition to adult care when appropriate. In 2015, the FCCS program received a HRSA Integration Systems Grant (ISG) to address the overarching goal of increasing medical home for CYSHCN by 20%. Partners of this project include SPAN, NJ-AAP, and SCHS CMUs.

Title V efforts to improve quality of care included continued collaboration with many partners in addressing the 6 core outcomes for CYSHCN through parent-professional medical home initiatives. Using a multi-county approach, outreach was conducted to pediatric and family practices and FQHCs throughout all of NJ. The SCHS CMUs provided lists of providers that routinely served CYSHCN in their caseloads, and SPAN and NJAAP invited practices to "Kick Off" events providing an overview of the medical home/SIG initiative. Title V provided consultation on specialized pediatric services and case management, presented at medical home learning collaborative meetings and care coordination webinars, and provided resources to practices.

NJ continues to collaborate with Consortium of Care partners to address the 6 core outcomes through Consortium of Care activities and improve quality of care such as medical home training and consultation with providers. Participants share updates in programs and services to facilitate appropriate referrals resulting in access to care, including Perform Care, services for CYSHCN with developmental disabilities through DCF, and the DHS Division of Developmental Disabilities. Likewise, State staffs will continue to provide technical assistance and monitoring of Title V service providers including interviews of clients that have received services. The electronic BDARS and CMRS provides opportunities to view client referrals and service outcomes, and reinforce the SCHS CM-client interactions.

State FCCS staffs and health services grantees attend trainings on health care reform, NJ FamilyCare and Medicaid expansion, participate in CMS webinars, and collaborate with community-based enrollment agencies. They also educate clients and their families about the benefits of health care reform for CYSHCN and their families, and link them to enrollment counselors as appropriate. Anecdotally, the information gained through trainings was particularly of interest for uninsured parents and extended adult family members of CYSHCN.

SPN #6. Reducing Teen Pregnancy has been identified as a priority by several Departments including: DOH, DOE, DHS and DCF with several inter-agency initiatives developed to address this priority.

Teenage childbearing can have long-term negative effects on both the teenage mother and the infant. Infants born to teen mothers are at higher risk of being low birthweight and preterm. They are also far more likely to be born into families with limited educational and economic resources. Although teen pregnancy and birth rates are at historic lows, there were 3,678 teen births in NJ in 2013 and the teen birth rate was 13.1 births for every 1,000 adolescent females aged 15-19 years.

Preventing teen births in NJ translates to significant savings for NJ taxpayers. The teen birth rate in NJ declined 51% between 1991 and 2010, saving taxpayers an estimated \$339 million in 2010. The total costs of teen childbearing include those sometimes incurred by the children of teen mothers (public health care insurance programs, primarily Medicaid and CHIP, increased child welfare participation, and increased risk for incarceration among adolescents or young adults) and the associated lost tax revenue due to decreased earnings and spending.

In SFY 2016, NJ PREP was successfully implemented by six (6) grantees at 59 locations (23 community-based organizations and 46 school-based organizations) in 23 municipalities and 11 counties throughout the State reaching 2,046 unduplicated youth participants.

Grant funds for Title V AEP was awarded to 4 grantees, 2 in the northern region, 1 in central and the fourth in the southern region. Abstinence-focused curriculum taught in after-school programs provides adult supervision as well as peer support.

SPN #7. Improving and Integrating Information Systems involves multiple efforts by the MCH Epidemiology Program, FHS and the NJDOH to improve and integrate public health information systems in order to promote public health surveillance and to improve the delivery of public health services and programs. Activities are related to almost every NPMs, SPMs and NOMs. Improving and Integrating Information Systems is a significant priority for the MIEC Home Visiting Program and the IPO Initiative. Improving the MCH system of care will depend on quality data from an integrated information system. Examples of improving access to and integration of public health information are discussed in sections specific to the performance measures and health systems capacity indicators.

The Electronic Birth Certificate (EBC) System is in the process of being upgraded to a web-based Electronic Birth Registry System (EBRS). In addition to improving the timeliness, quality, and security of NJ's birth data, the adoption of a web-based EBRS would also facilitate real-time linkages to other data sets, thus laying the groundwork for the development of an electronic child health registry or integrated MCH information system. The MCH Epidemiology Program is working with the NJ DOH Center for Health Statistics to improve the availability of MCH related public health data through the interactive online NJ State Health Assessment Data (SHAD) system.

SP #8. Smoking Prevention

Smoking prevention has been a long-term NJDOH priority. The Five-Year Needs Assessment identified smoking prevention as a SPN from past MCH Block Grant Applications, the annual NJDOH Budget Planning process, and monitoring Healthy People 2020 objectives. Recent involvement of FHS in the NGA Improving Birth Outcomes Initiative and the IM CoIIN has increased the recognition that smoking prevention plays in improving birth outcomes, preventing prematurity and reducing infant mortality. FHS has several programs that include a smoking prevention component that could be strengthened with further collaboration with the Community Health and Wellness Service Unit.

II.D. Linkage of State Selected Priority Needs with National Performance and Outcome Measures

NJ has selected the following National Performance Measures (NPMs) based on the State Priority Needs and the findings of the Five-Year Needs Assessment. The selected NPM will be addressed over the next five-year period of the Title V program. Over the next year Evidence-Based / Informed Strategy Measures (ESMs) will be finalized which directly impact the selected NPMs and in turn drive the improvement of NOMs.

Performance Measures Framework from Appendix E

NPM #	National Performance Measure (NPM) Priority Areas	MCH Population Domains	Rationale: NOMs
1	Well woman care	Women/Maternal Health	1, 2, 3, 5, 6, 7, 8, 9, 10, 11
4	Breastfeeding	Perinatal/Infant Health	1, 3, 4, 5, 6, 8, 9, 10, 20, 22
5	Safe sleep	Perinatal/Infant Health	8, 9, 9.5, 15
6	Developmental Screening	Child Health	13, 17, 18, 19
8	Physical Activity	Child and Adolescent Health	19, 20
10	Adolescent Well Visits	Adolescent Health	13, 16, 17, 18, 19, 20, 21, 22
11	Medical home	Children and CSHCN	13, 15, 16, 17, 18, 19, 20, 21, 22
12	Transitioning to Adulthood	Children and CSHCN	17, 18, 19, 20, 21, 22
13	Oral health	Cross Cutting/Life course	14, 19
14	Smoking	Cross Cutting/Life course	Most

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

NJ has selected the following 5 State Performance Measures (SPMs) to address the unique MCH needs of the State. Selection of the SPMs is based on the findings of the Five-Year Needs Assessment, past MCH Block Grant Annual Applications/Reports, the monitoring Healthy People 2020 objectives process, and the annual NJDOH Budget Planning process.

NJ Selected State Performance Measures:

#	Selected State Performance Measure (SPM)	Domain	Related NOM
1	Black Preterm Births	Perinatal/Infant Health	1 to 11
2	Children with Elevated Blood Lead Levels	Child Health	4, 5, 13, 19
3	Hearing Screening Follow-up	CSHCN	13, 19
4	Referral from BDARS to Case Management	CSHCN	13, 17, 18, 20, 21, 22
5	Age Initial Autism Diagnosis	CSHCN	13, 17, 18, 21

II.F. State Action Plan and Strategies by MCH Population Domain

II.F.1. Introduction

The NJ Five-Year State Action Plan was developed from the Five-Year Needs Assessment. This Action Plan serves as the Application/Annual Report narrative discussion for NJ on the planned activities for the Application year and the activities that were implemented in the Annual Report year. Activities will be discussed in terms of the state’s targeted performance and its achievements around the NOMs, NPMs, ESMs and SPMs. The State Action Plan includes a discussion of the health status/outcome and performance measures for each of the six population health domains. The Five-Year Action Plan is also represented in the attached Supporting Document #1 – Table 1a NJ Five-Year Needs Assessment Framework Logic Model.

The Five-Year Action Plan is a tabular representation of the narrative for the Five-Year Action Plan, organized by the six population health domains and each selected NPM. For each selected NPM the related ESMs, NPMs, and NOMs represent the integrated three-tiered performance measurement system from the Logic Model.

This Table should be considered a planning tool to be used in the development of the Five-Year Action Plan that aligns the identified priority needs with the program strategies and performance measures.

Table 1a - New Jersey Five-Year Needs Assessment Framework Logic Model – Listed by NPM

Domains (set by HRSA)	State Priority Needs based on Needs Assessment	Strategies (develop into Evidence-Based Informed Strategic Measures (ESM) for 2017)	National Outcome Measures (NOMs) (states select from list)	National Performance Measures (NPMs) & State Performance Measures (SPMs)
1) Women's/ Maternal Health	#1 Increasing Healthy Births	Improving Pregnancy Outcomes (IPO) Initiative; Central Intake (CI) & Community Health Workers (CHW) IM CoIIN; MIEC Home Visiting Program (MIECHV); Office of Women's Health; Perinatal Designation Level regulations, Development of the NJ VON Collaborative, MCH Consortia TQI Activities	1 Infant Mortality; 2 Preterm-related death; 3 Neonatal Mortality; 5, 6, 7, 8, 21 Postpartum hospitalizations with severe morbidity; 22 Maternal Death	NPM #1 Well Women Care
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	Improving Pregnancy Outcomes (IPO) Initiative; IM CoIIN; MIEC Home Visiting Program; NJ SIDS Center activities; Healthy Start; HBWW, SUID-CR; Surveillance (PRAMS, EBC); NJ Baby Box Safe Sleep Education Program	1, 2, 3, 4 Post-Neonatal Mortality; 5 Perinatal Mortality; 6 Sleep-related SUID death; 7 LBW & VLBW; 8 Preterm Birth; 9	NPM #5 Infant Safe Sleep SPM #1 Black preterm births
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	Improving Pregnancy Outcomes (IPO) Initiative; IM CoIIN; MIEC Home Visiting Program; Healthy Start; HBWW, Loving Support© Through Peer Counseling Breastfeeding Program Baby Friendly Hospitals, BF Surveillance (PRAMS, EBC) Breastfeeding and NJ Maternity Hospitals: A Comparative Report	1, 2, 3, 4 Post-Neonatal Mortality; 5 Perinatal Mortality; 6 Sleep-related SUID death; 7 LBW & VLBW; 8 Preterm Birth , 9	NPM #4 Breastfeeding SPM #1 Black preterm births
3) Child Health	#2 Improving Nutrition & Physical Activity	ShapingNJ Whole School, Whole Community, Whole Child (WSCC, CDC) School Health	11 Overweight rate; 9 Kids in very good health; 13 Kids without insurance;	NPM #8 Physical activity SPM #2 Children with Elevated Blood Lead Levels
4) Adolescent/ Young Adult Health and 5) CYSHCN	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	Transition to adulthood needs assessment; SPAN/ISG 1; ARC of NJ	10, 11, 13, 15 Adolescent death 10-19; 16 MVA fatality 15-19 17 Suicide 15-19	NPM #11 Medical home,

<i>Domains (set by HRSA)</i>	<i>State Priority Needs based on Needs Assessment</i>	<i>Strategies (states identify)</i>	<i>National Outcome Measures (NOMs) (states select from list)</i>	<i>National Performance Measures (NPMs) & State Performance Measures (SPMs)</i>
5) CYSHCN and 4) Adolescent/Young Adult Health	#5 Improving Access to Quality Care for CYSHCN	Case Management Services; NJ AAP/PCORE Medical Home Project; Outreach to providers; Hospital level reports; Audits; Provider education CM level reports; Medicaid Managed Care Alliances, Subsidized Direct Specialty and Subspecialty Services, Participation in Medical Assistance Advisory Council, Arc of NJ; SPSP Services	18 CSHNC receiving care in a well-functioning system; 19 % CSHCN & ASD; 20 Kids with a mental/behavioral condition who receive treatment, 23 Timely NBS+ follow-up	NPM #12 Transitioning to Adulthood SPM #3 Hearing screening F/U; SPM #4 Referred from BDARS to Case Management Unit; SPM #5 Age initial autism diagnosis;
6) Life Course		Project REACH, Project PEDS ShapingNJ; MIEC Home Visiting; Dial a Smile Dental Clinic Directory; Miles of Smiles; WIC Newsletter; Special Needs Newsletter;	14 Kids 1-6 with cavities; 9 Kids in very good health;	NPM #13 Oral health
6) Life Course	#7 Improving & Integrating Information Systems	IPO, Central Intake / PRA / SPECT; MIEC Home Visiting SSDI, ECCS Impact; VIP; Master Client Index Project; NJ SHAD;	ALL	ALL NPMs
6) Life Course	#8 Smoking Prevention	SSDI, ECCS Mom's Quit Connection; Perinatal Addiction Prevention Project; IPO, Central Intake / PRA MIEC Home Visiting	ALL	#14 Household Smoking

II.F.1.a. Women/Maternal Health

Improving the domain of Women's/Maternal Health is crucial to the State Priority Need of Increasing Healthy Births (SPN #1) and the National Outcomes Measures (NOMs) related to decreasing infant mortality. The selection of NPM #1 (Well Women Visits) during the Five-Year Needs Assessment process recognizes the impact the life course approach will have on Increasing Health Births and improving women's health across the life span. The Life Course Perspective to conceptualizing health care needs and services evolved from research documenting the important role early life events play in shaping an individual's health trajectory. The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, influence health throughout one's lifetime. NJ has had a long-standing emphasis on improving Women's Health and has promoted several evidence-based strategies to increase preventive medical visits (NPM #1) including: the Improving Pregnancy Outcome Initiative, IM CoIIN, MIEC Home Visiting, Fetal Infant Mortality Review, and Maternal Mortality Review.

Plan for the Application Year - NPM #1

	2011	2012	2013	2014	2015
Percent of women with a past year preventive medical visit	77.0	77.7	77.3	78.8	79.8

Data Source: Behavioral Risk Factor Surveillance System (BRFSS) dat6a in NJ SHAD.
<https://www26.state.nj.us/doh-shad/query/selection/njbrfs/BRFSSSelection.html>

Plans for the coming year to promote NPM 1 (Well Women Care) will include the recommendations of the IM CoIIN regarding postpartum visits. The IPO Initiative with Central Intake Hubs and Community Health Workers will promote the outreach and referral of women for preventive medical visits through standardized Community Health Screenings and referrals to medical care providers. The MIEC Home Visiting Programs and Healthy Start Programs will continue to case manage mothers and assure preventive medical visits through the monitoring of benchmarks which include a reproductive life plan, medical home and well women visits for Health Start participants and prenatal care, postpartum visits and maternal health insurance for Home Visiting.

In 2014, NJ joined a national effort to reduce infant mortality called Collaborative Improvement and Innovation Network (IM CoIIN). IM CoIIN is led by the National Institute of Children's Health Quality (NICHQ) but funded by the Maternal Child Health Bureau (MCHB). The IM CoIIN is a multiyear national initiative to employ quality improvement innovation and collaborative learning. In addition, CoIIN provides a data infrastructure and expert technical assistance to participating states. The goal of IM CoIIN is to engage federal, state, public and private agency representatives and the community from across the U.S. to coordinate, collaborate and innovate.

NJ IM CoIIN has established a multisector State Team collaboration with subject matter experts to address two infant mortality strategic priorities. As part of the CoIIN, NJ selected Smoking Cessation and Preconception/Interconception health with a focus on the postpartum visit as strategic priorities to address infant mortality. The utilization of timely data and rapid-cycle quality improvement activities will inform the next steps NJ will take to reduce infant mortality.

NJ IM CoIIN Smoking Cessation and Preconception/ Interconception Learning Session I Networks convened in March 2015. Since the launch of the learning networks, NJ has conducted multiple rapid-cycle quality improvement activities through statewide collaboration and technical assistance from NICHQ. In July 2015, several members from the NJ's CoIIN State Team attended the launch of CoIIN Learning Network Session II in Boston, MA. In February 2016, the New Jersey State Team participated in Learning Session III via a national webinar. During Learning Session III, Dr. Lu announced that Infant Mortality CoIIN will be extended until July 2017. This extension will give NJ the opportunity to continue activities to promote the importance of the postpartum visit and smoke cessation throughout the state. NJ CoIIN participated in Learning Session IV via webinar. Learning Session V was held in Houston, Texas in February 2017 where NJ conducted a national breakout session and was presented with the **Most Successful in Breaking Silos Award**. NJ is in the final phases of finalizing and postpartum visit brochure for statewide dissemination.

Since the start of the IM ColIN Initiative, NJDOH has initiated the following activities to address NPM 1 (Well Women Care):

1. conducted six statewide Postpartum Visit (PPV) Focus Groups for African-American and Hispanic women to understand barriers to PPV attendance;
2. surveyed health care providers and community health workers to understand barriers to PPV attendance;
3. utilized the State Parent Advocacy Improving Pregnancy Outcomes (IPO) Community Health Worker to promote the Mom's Wellness Visit Brochure;
4. Camden County Healthy Start program conducted a Postpartum Visit pilot;
5. collaborated with Amerigroup Managed Medicaid Organizations, March of Dimes and Maternal Child Health Partners to developed a Mom Wellness Brochure to be disseminated in Women Infant and Children Agencies, Division of Children and Families, Federally Qualified Health Centers, Healthy Start, Medicaid Managed Care Organizations and other Maternal Child Health agencies statewide;
6. implemented a Postpartum Visit Community Health Worker, Central Intake and Healthy Start training statewide as part of the NJDOH Quality Improvement Project;
7. created postpartum visit datasets to the Improving Pregnancy Outcome web-based Single Point of Entry Tracking System for Community Health Workers and Central Intake to track postpartum visit education provided in the community;
8. disseminated a Health Care Provider Smoking Cessation Toolkit and Survey;
9. tested innovative methods to increase enrollment for smoking cessation; and
10. surveyed women about the best method to market smoking cessation programs to peers.

Annual Report - NPM #1 (Percent of women with a past year preventive medical visit)

The Improving Pregnancy Outcomes (IPO) Initiative through the use of Community Health Workers and Central Intake Hubs is focused on improving maternal and infant health outcomes including women's health with preventive medical visits, preconception care, prenatal care, interconception care, preterm birth, low birth weight, and infant mortality. The IPO Initiative is coordinated with existing federal and state-funded initiatives including Healthy Start, Maternal Infant and Early Childhood Home Visitation, Strong Start, Title X Family Planning, Childhood Lead Poisoning Prevention, Healthy Homes, Perinatal Addictions Prevention, Postpartum Mood Disorders, Coordinated School Health, WIC, Federally Qualified Health Centers (FQHCs), and the activities of the Community Health and Wellness Services of the FHS (smoking, diabetes, cardiac, cancer, obesity prevention, physical fitness, hypertension).

Through use of Community Health Workers and Central Intake the IPO Initiative targeted limited public health resources to populations and communities with the highest need where impact will be greatest to improve population health outcomes and reduce health disparities. The IPO Initiative is working to improve women's health by completing standardized Community Health Screenings for participating women including the assessment of health insurance, existing medical conditions, mental health needs, and social service needs. The IPO Initiative through case management will assure that appropriate referrals are made and tracked including medical care referrals to promote NPM #1 (Well Women Visits).

Evidence-Based Informed Strategy Measure (ESM) 1.1 (Increase First Trimester Prenatal Care) was selected for its positive impact on National Performance Measure (NPM) #1 (Well Women Care) and State Performance Measure (SPM) #1 (Increasing Healthy Births).

NJDOH is participating in the Infant Mortality Collaborative Improvement and Innovation Networks (IM ColIN) sponsored by the MCH Bureau with technical assistance from National Institute for Children's Health Quality. The IM ColIN State Team from NJ identified two priority areas - improving maternal postpartum visit rates and smoking cessation. The IPO Initiative will coordinate and collaborate with a variety of community partners to implement the IM ColIN recommendations from these two focus areas.

Included in improving NPM #1 is a focus on preconception care and early prenatal care. Improving access to prenatal care is essential to promoting the health of NJ mothers, infants, and families. Early and adequate prenatal care is an important component for a healthy pregnancy and birth outcome because it offers the best opportunity for risk assessment, health education, and the management of pregnancy-related complications and conditions. Prenatal care is also an opportunity to establish contacts with the health care system and to provide general preventive visits.

Efforts to improve access to early prenatal care must address the factors related to unintended pregnancy and lack of early pregnancy awareness by focusing on women before they become pregnant. Preconception care is a critical component of prenatal care and health care for all women of reproductive age. The main goal of preconception care is to provide health promotion, screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies. Given the relationship between pregnancy intention and early initiation of prenatal care, assisting women in having a healthy and planned pregnancy can reduce the incidence of late prenatal care to promote NPM #1 (Well Women Visits).

The regional quality improvement activities within each of the three Maternal Child Health Consortia (MCHCs) coordinated by RPHS include the regular monitoring of indicators of perinatal and pediatric statistics, fetal-infant mortality review, maternal mortality review, and maternity services reporting through the electronic birth certificate (EBC). Regional quality improvement activities include regular monitoring of indicators of perinatal and pediatric statistics and pathology, including 1) transports with death; 2) non-compliance with rules regarding birth weight and gestational age; 3) cases in which no prenatal care was received; 4) all maternal deaths; 5) all fetal deaths over 2,500 grams not diagnosed as having known lethal anomalies; 6) selected pediatric deaths and/or adverse outcomes; 7) immunizations of children 2 years of age; and 8) admissions for ambulatory care sensitive diagnoses in children.

Quality improvement is accomplished through Fetal-Infant Mortality Review and Maternal Mortality Review systems, as well as analyzing data collected through the EBC. Currently, all hospitals providing maternity services report births through the EBC. The TQI Committee reviews the data and makes recommendations to address either provider specific issues or broad system issues that address multiple providers or consumer groups within each Consortium region.

II.F.1.b. Perinatal/Infant Health

The domain of Perinatal/Infant Health sets the trajectory of the health of a child throughout the Life Course. NJDOH has identified the State Priority Need (SPN) of Reducing Black Infant Mortality and selected the related NPMs 4 (Breastfeeding) and 5 (Infant Safe Sleep) as a result of the Five-Year Needs Assessment process. NJ has implemented several evidence-based strategies related to NPM 4 & 5 which in turn will impact on several NOMs (1, 2, 3, 4, 5, 6, 8, 9, 9.5). Evidence-based strategies related to NPM 4 & 5 are listed in the Logic Model.

Plan for the Application Year - NPM 4:

- A) Percent of infants who are ever breastfed and
- B) Percent of infants breastfed exclusively through 6 months

Promoting breastfeeding has been a long-standing priority for FHS. Breastfeeding is universally accepted as the optimal way to nourish and nurture infants, and it is recommended that infants be exclusively breastfed for the first six months. Breastfeeding is a cost-effective preventive intervention with far-reaching benefits for mothers and babies and significant cost savings for health providers and employers. Breastfeeding provides superior nutrition, prevents disease and enhances infant development. FHS has developed many strong partnerships to strengthen breastfeeding-related hospital regulations, promoting breastfeeding education, training and community support.

The Healthy People 2020 breastfeeding objectives are for 81.9% of mothers to initiate breastfeeding, for 60.6% of new mothers to continue breastfeeding until their infants are six months old, for 34.1% to breastfeed until one year, for 46.2% to exclusively breastfeed through three months, and for 25.5% to breastfeed exclusively through six months. In the [2016 Breastfeeding Report Card](#) (2013 births) from the CDC, 82.0% of NJ newborns were ever breastfed (NPM #4A); 52.6% breastfed at six months; 30.2% breastfed at twelve months; 41.4% exclusively breastfed at three months; and 23.1% exclusively breastfed at six months (NPM #4B).

Table NPM #4

	Born in 2007	Born in 2008	Born in 2009	Born in 2010	Born in 2011	Born in 2012	Born in 2013
Percent of infants who ever breastfed	72.1	75.8	80.5	77.1	81.6	82.0	82.0
Percent of infants breastfed exclusively through 6 months	10.0	11.8	14.0	13.0	22.3	16.7	23.1

Notes - Source – the CDC’s National Immunization Survey.

http://www.cdc.gov/breastfeeding/data/NIS_data/

Efforts to promote Baby Friendly Hospital Initiative (BFHI) designation through training, technical assistance, and mini-grants will continue to promote NPM 4A & B. Surveillance through the Breastfeeding Report Card and the mPINC survey will continue to identify areas of potential improvement.

The selection of ESM 4.1 (Increase Births in Baby Friendly Hospitals) will monitor progress on promoting breastfeeding policies and practices in hospitals which should lead to an increase in NPM #4 (Breastfeeding).

Many hospitals employ International Board Certified Lactation Consultants who provide early support and information to breastfeeding mothers. WIC will continue to provide breastfeeding promotion and support services to pregnant and breastfeeding women who participate in the Program. The CDC State Public Health Actions Grant will continue with webinars and technical assistance calls to the 18 participating hospitals.

Existing FHS programs that promote breastfeeding and include performance measures for increasing breastfeeding include the IPO Initiative and the MIEC Home Visiting Program which now serve all 21 counties and target high-need communities. A Breastfeeding indicator, increase over time in the

proportion of mothers who breastfeed their 6-week-old infants, is included in the MIECHV and Healthy Start performance benchmarks.

Plan for the Application Year - NPM 5: (Percent of infants placed to sleep on their backs)

Promoting infant safe sleep was selected as NPM #5 during the Five-Year Needs Assessment process for its importance in reducing preventable infant deaths and its potential impact on improving NOMs 1, 2, 3, 4, 5, and 6. Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), accidental suffocation and strangulation in bed and unknown causes. Due to the heightened risk of SIDS when infants are placed to sleep in side or stomach sleep positions, health experts and the American Academy of Pediatrics (AAP) have long recommended the back sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. Additional higher-level recommendations include breastfeeding and avoiding smoke exposure during pregnancy and after birth. These expanded recommendations have formed the basis of the National Institute of Child Health and Development (NICHD) Safe to Sleep Campaign.

The selection of ESM 5.1 (Promote Infant Safe Sleep Environments) will monitor and focus attention on the complete safe sleep environment (Healthy Sleep) including back to sleep, no co-sleeping, and no soft bedding.

Table NPM #5

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Percent of infants placed to sleep on their backs	61.1	64.2	61.8	65.6	65.7	67.4	68.9	70.1	69.5	70.8

Notes - Source – NJ PRAMS Chartbook from the MCH Epidemiology Program and NJ SHAD.
<https://www26.state.nj.us/doh-shad/query/selection/prams/PRAMSSelection.html>

Plans for the coming year to promote safe infant sleep include continued safe sleep education through the SIDS Center of NJ (SCNJ), MIEC Home Visiting Program and prevention activities of the Sudden Unexpected Infant Death Case Review ([SUID-CR grant](#)). The SUID-CR Coordinator will be participating in the Infant Mortality ColIN sessions that focus on improving infant safe sleep practices. Evidence-based strategies proposed by the IM ColIN sessions on infant safe sleep will be considered by the SUID-CR Workgroup. Staff from the MIEC Home Visiting Program have all been trained by the [SIDS Center of NJ](#) and will promote the infant safe sleep message during their visits to over 6,800 families annually in NJ.

Currently, DCF with input from the SUID Subcommittee is in the process of creating a safe sleep educational video that will be featured on the Department of Children and Families webpage. The video includes excerpts from safe sleep experts as well as a safe sleep environment modeled by a father. The SUID Subcommittee realizes how important the role of the internet is in today’s society and is hopeful that the safe sleep message reaches a large audience through the internet.

In January 2017, NJ became the first state to distribute free baby boxes to new parents as part of the NJ Baby Box Safe Sleep Education Program which is an initiative of the Child Fatality and Near Fatality Review Board in collaboration with the Sudden Unexpected Infant Death Review grant and the Baby Box Company. Baby boxes are a new parent starter kit that contains important information about antenatal, postnatal, neonatal, continuing care and support programs for both mother and infant. Parents are incentivized to earn a voucher to receive a baby box, which will have additional infant care items in it, after viewing a certain number of short videos on the babyboxuniversity.com website regarding topics such as: postpartum depression, breastfeeding, nutrition, infant care, safe sleep, and substance use. The baby box is certified as a bassinet and can be used as a safe sleep space of infants for the first few

months of life. The program comes in many languages and is free for parents. Distribution sites include the MCH Consortia, community-based organizations, and the MIEC Home Visiting agencies. The baby boxes can also be mailed. Initial response to the NJ Baby Box Safe Sleep Education Program has been very positive with over 13,000 requests during the first 8 weeks.

Through grant funding from NJ DOH, the SCNJ provides public health interventions such as its work with birthing hospitals, as part of the Nurses LEAD the Way initiative, and with local offices of the Division of Child Protection and Permanency. Based on the most recently released data from the NJ Center for Vital Statistics, NJ has one of the lowest SIDS rates and the lowest SUID rate in the US.

There are racial and ethnic disparities in factors that raise the risk of SIDS, and these contribute to disparities in rates. Such factors include disparities in preterm births, access to care, poverty, an important association, and exposure to second-hand smoke, a major contributing factor rising to the level of causality. The SCNJ is focusing on racial and ethnic disparities in factor that raise the risk of SIDS. This is being accomplished by the SCNJ collaborating with Mom’s Quit Connection to link public health messages.

Plan for the Application Year SPM 1: (*The percentage of Black non-Hispanic preterm births in NJ*)

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Annual Indicator	15.0	15.9	15.0	14.5	14.0	13.2	13.0	12.7	12.8	13.3	13.3
Numerator	2,443	2,701	2,589	2,444	2,298	2,105	2,021	1,986	1,930	1,983	1,879
Denominator	16,336	17,012	17,295	16,816	16,402	15,945	15,586	15,692	15,064	14,864	14,169

Notes - Source - Birth Certificate data from the SHAD system
<https://www26.state.nj.us/doh-shad/home/Welcome.html>

The selection of SPM #1 (The percentage of Black non-Hispanic preterm births in NJ) during the Five-Year Needs Assessment process recognizes the persistence of racial/ethnic disparities in healthy birth outcomes in NJ. Infants who are born preterm are at the highest risk for infant mortality and morbidity. The percentage of black preterm births was selected to begin to address the underlying causes of black infant mortality and the racial disparity between preterm birth rates.

Maternal and Child Health Services has a long history of addressing perinatal health disparities with special emphasis on the Black Infant Mortality Reduction Initiative which was initiated in 1985. In February 2008, a Commissioner’s Prenatal Care Task Force was convened to make recommendations to improve access to prenatal care in NJ. Health disparities was identified as a priority. The overall goal of the Access to Prenatal Care Initiative was to increase the rate of first trimester prenatal care in NJ to at least 90% to coincide with the National Healthy People 2010 goal, with emphasis on racial and ethnic disparities.

The Improving Pregnancy Outcomes (IPO Initiative) will develop partnerships with community-based maternal and child health providers/agencies with proven capabilities in implementing activities/interventions within a targeted community and the capability to focus on reproductive-age women and their families. The goal of this IPO Initiative is to improve maternal and infant health outcomes for high-need women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes through a collaborative coordinated community-driven approach. County-based consumer-driven advisory groups for the IPO Initiative and the Central Intake Hubs will meet quarterly to build partnerships and local referral systems.

Thirteen grants were awarded in 2014 for the Community Health Worker (CHW) model. CHWs are paraprofessionals who are trusted members of the target community to whom other community members turn for a variety of social supports. The focus of the IPO Initiative is to increase the number of women receiving preconception care as well as earlier and regular prenatal care, increase parenting education, and increase the number of women and children receiving primary care and health promotion.

Seven grants were awarded in 2014 for the Central Intake model which focuses on strategic efforts to assure that the specific needs of individual and families are identified and addressed effectively within community-wide service systems. Both models will be using the Perinatal Risk Assessment (PRA) and the Community Health Screening tool. The goal of risk assessment is to prevent or treat conditions associated with poor pregnancy outcome and to assure linkage to appropriate services and resources through referral. In July 2015 CI was expanded to cover all 21 NJ counties.

NJDOH will continue to partner with the March of Dimes NJ Chapter in the [Healthy Babies are Worth the Wait](#), a program to reduce preterm births among African American women in Newark and Burlington.

The Department's commitment to reduce black infant mortality will continue through the NGA on Improving Birth Outcomes, the IM CollIN, the MIECHV Program, and the current Improving Pregnancy Outcomes Initiative.

Annual Report - NPM 4:

- 4A) Percent of infants who are ever breastfed and
- 4B) Percent of infants breastfed exclusively through 6 months

FHS has supported Baby-Friendly™ designation through training, technical assistance and mini-grants. The Baby-Friendly Hospital Initiative (BFHI) is a global program that was launched by the World Health Organization and the United Nations Children's Fund in 1991 to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding. BFHI recognizes and awards birthing facilities who successfully implement the Ten Steps to Successful Breastfeeding (i) and follow the International Code of Marketing of Breast-milk Substitutes (ii). Eleven NJ hospitals have earned the "Baby-Friendly" designation. Two of those hospitals were recipients of a \$10,000 mini-grant from FHS.

With a CDC State Public Health Actions Grant #1305, NJDOH and the NJ Hospital Association delivered webinars and technical assistance calls to 18 hospitals and held a Mother-Baby Summit for all delivery hospitals to assist them in addressing barriers to and identifying potential solutions for implementing the Ten Steps to Successful Breastfeeding.

In 2014, FHS updated its report card, "Breastfeeding and New Jersey Maternity Hospitals: A Comparative Report", with 2013 Electronic Birth Certificate data. The Report is endorsed by the NJ Chapter of the American Academy of Pediatrics (NJ-AAP) and the NJ Breastfeeding Coalition. The goal of the report is to present breastfeeding initiation as a quality of care issue and to promote the included self-assessment tools and model hospital policy recommendations as tools for hospitals to improve their breastfeeding policies and practices.

NJ hospitals strongly participate in the Maternity Practices in Infant Nutrition and Care (mPINC) survey, which is a national survey of maternity care practices and policies conducted by the CDC every two years, beginning in 2007. In 2015, 39 of 53 (80%) eligible hospitals participated in the mPINC Survey and the total score was 83. NJ has been gradually increasing its [mPINC score](#) and has improved its state rank to 10 out of 53 in 2015. Ongoing opportunities for improvement include reducing routine supplementation with of breastfeeding formula and providing hospital discharge planning support.

Despite the overwhelming evidence supporting the numerous benefits of and recommendations for exclusive breastfeeding, exclusive breastfeeding rates in the 24 hours prior to hospital discharge in NJ remain low (see Chart 9 of Supporting Document #3), while any breastfeeding (both exclusive breastfeeding and breastfeeding supplemented with formula feeding) rates continued to increase, yielding an overall increase in breastfeeding initiation rates. NJ Birth Certificate data for 2015 shows that exclusive breastfeeding at hospital discharge statewide was 39.5%, while any breastfeeding (exclusive and combination feeding) was 80.5%.

Breastfeeding rates on discharge varied with the minority composition of mothers. Asian non-Hispanic women were most likely to breastfeed (93.2%) while black non-Hispanic women were least likely to

breastfeed (75.0%). White non-Hispanic and Hispanic women initiated breastfeeding at 84.0% and 88.2% respectively.

The exclusive rates were 53.6% for white non-Hispanic women, 45.8% for Asian non-Hispanic women, 35.5% for Hispanic women, and 32.8% for black non-Hispanic women. Further examination of the disparity in these rates will require information of locally available breastfeeding promotional activities, protocols, and the cultural appropriateness of those services.

WIC Services provides breastfeeding promotion and support services for WIC participants through grants to all 16 local WIC agencies. International Board Certified Lactation Consultants and breastfeeding peer counselors provide direct education and support services, literature, and breastfeeding aids, which include breast pumps, breast shells and other breastfeeding aids. WIC staff conducts the *Loving Support*® Through Peer Counseling Breastfeeding Program. WIC breastfeeding staff conducts professional outreach in their communities and education to healthcare providers who serve WIC participants.

Existing FHS programs that promote breastfeeding and include performance measures for increasing breastfeeding include the Improving Pregnancy Outcomes Initiative and the MIEC Home Visiting Program. In SFY 2013, 66.2% of mothers with 6-week-old infants participating in the MIEC Home Visiting Program were breastfeeding.

Close collaboration between Maternal and Child Health Services (MCHS), WIC Services (WIC), and Community Health and Wellness Services is ongoing. All three programs have an interest in breastfeeding protection, promotion and support and have similar constituencies.

In January 2014, the State finalized new Hospital Licensing Standards that require hospitals to develop and implement evidence-based written policies and procedures for obstetrics, perinatal and postpartum patient services, newborn care, the normal newborn nursery, and emergency departments that address breastfeeding and supporting the needs of a breastfeeding mother and child from the point of entry into the facility through discharge. These Standards support the Ten Steps to Successful Breastfeeding.

The NJDOH will call attention to NJ's 18.9% rate for hospitals supplementing breastfed infants with formula before two days of life; this is above the national average of 17.1% (with a Healthy People 2020 Target of 14.2%) and ranks New Jersey 39 out of 52 states. The Joint Commission Perinatal Care Core Measure on Exclusive Breast Milk Feeding (PC-05a) was retired in recognition of the decision some women make to not exclusively breastfeed despite recommendations. PC-05 continues as an accountability measure that is publicly reported on The Joint Commission's Quality Check® website.

Annual Report NPM #5 (infant safe sleep)

To promote infant safe sleep (NPM #5), NJDOH has supported the evidence-based strategies of the American Academy of Pediatrics, the NICHD's [Safe to Sleep](#) Campaign, the activities of the [SIDS Center of New Jersey](#), and the work of the Sudden Unexpected Infant Death Case Review ([SUID-CR](#)) Workgroup. To improve the surveillance of infant safe sleep practices, FHS conducts the PRAMS survey which includes questions on infant safe sleep and participates on the SUID-CR Workgroup.

The SIDS Center of New Jersey (SCNJ) is a program funded by the NJDOH at Robert Wood Johnson Medical School, a part of Rutgers, The State University of New Jersey, New Brunswick and the Joseph M. Sanzari Children's Hospital at Hackensack University Medical Center, Hackensack. SCNJ was established in 1988 through the SIDS Assistance Act. The SCNJ mission is to: 1) provide public health education to reduce the risk of sudden infant death, 2) offer emotional support to bereaved families, and 3) participate in efforts to learn about possible causes of and risk factors associated with sudden infant deaths, including those classified as Sudden Infant Death Syndrome.

SCNJ works with parents, grandparents, physicians, nurses, the child care community, hospitals, first responders, schools, social service agencies, health and education programs and state, federal and national organizations to reduce infant mortality and the racial and ethnic disparities associated with it.

SCNJ follows the guidelines of the AAP when providing risk reduction education. The Safe Infant Sleep guidelines of the AAP are intended to help families reduce the risks that are associated with Sudden Unexpected Infant Deaths including Sudden Infant Death Syndrome and Accidental Suffocation and Strangulation in Bed. [Research](#) conducted by the SCNJ contributed to these recommendations. Since the SCNJ was established, the rate of SIDS in New Jersey has been reduced by 75%.

NJ has participated in the Sudden Unexpected Infant Death Case Review (SUID-CR) Registry grant funded by the CDC since 2006. SUID-CR activities have standardized and improved data collected at infant death scenes and promoted consistent case review, classification and reporting of SUID cases. NJ has participated in the Sudden Death Among Youth registry grant from the CDC since 2014. NJDOH is represented on the multi-disciplinary SUID-CR/SDYR Review Board which meets monthly as a subcommittee of the Child Fatality and Near Fatality Review Board ([CFNFRB](#)). The SUID-CR/SDYR is staffed by the Department of Children and Families and is an important statewide surveillance system for unexpected infant deaths. The SUID-CR/SDYR makes recommendations to the statewide CFNFRB concerning safe sleep and promotes SUID prevention activities.

In November 2014 as part of a grant from the CJ Foundation, infant safe sleep training was provided to First Responders to provide healthy infant sleep education to the people they serve. The training called DOSE (Direct On Scene Education) significantly reduced the number of sleep related infant deaths in Ft. Lauderdale, Florida. After an emergency is handled and the home is identified as having a resident infant, the first responder can ask to see where the infant sleeps. Upon observation of the infant's sleep environment the first responder can make recommendations to improve upon the environment and provide pamphleted information to caregivers. Caregivers are likely to buy-in to the education provided by First Responders since they are widely regarded as heroes and experts in the field of health and safety. With grant funding the DOSE program training was provided during a conference to management level EMT and Fire personnel. The personnel that received the training, in turn, will educate their staff thus reaching a large number of people. The training was centrally located allowing for personnel from all over the state to attend. The training program addressed all risk and protective factors developed by the American Academy of Pediatrics.

Also in 2014, the Child Fatality and Near Fatality Review Board (CFNFRB) in partnership with DCF's Division of Community and Family Partnerships, the NJ Departments of Education and Health, and the federal Centers for Disease Control and Prevention conducted 3 Sudden Unexpected Infant Death (SUID) prevention activities: 1) the "Educating today's babysitters and tomorrows parents" which targeted adolescents, 2) the Practicing Healthy Infant Sleep Environments (PHISE) Poster Contest and 3) the Tote Bag Giveaway. The CFNFRB held a poster contest in New Jersey middle schools; students were asked to create "Healthy Sleep" posters based on the guidelines established by the American Academy of Pediatrics. In addition to a monetary prize, the winning student's poster was silk-screened onto tote bags, creating "walking billboards" for infant "Healthy Sleep" awareness. 4,500 tote bags filled with educational materials on "Healthy Sleep" practices for infants were distributed to Federally Qualified Health Centers (FQHCs), Family Success Centers (FSCs) and Home Visiting (HV) Programs across the state. Specific FSCs, FQHCs and HVs have been identified based on the populations they serve and their locations. Inside the tote bags. There were a children's book by Dr. John Hutton entitled, "Sleep Baby, Safe and Snug," which addresses healthy sleep practices in a gentle, easily understood manner. A SleepSack: an infant sleeper-pajama with a built-in blanket and swaddling cloth, produced by Halo Innovations, Inc, and safe sleep information. The PHISE Poster Contest and Tote Bag Giveaway helped raise awareness of healthy infant sleep environments and practices among a broad swath of New Jersey's citizens: students, educators, healthcare providers, social workers, and parents.

In 2015, as part of the SUID-CR grant, the SUID Sub Committee partnered with Cribs for Kids and distributed over 700 "survival kits" to family success centers as well as child care resource and referral centers located throughout the state. Family success centers and child care resource and referral centers were targeted as these are locations where families regularly seek out assistance and resources. Each child care resource and referral center set up an exhibit of a safe sleep environment. Contained within the survival kits were a pack and play, Halo sleep sack, safe sleep information and age appropriate pacifiers. The SUID Sub Committee also distributed children's books by Dr. John Hutton entitled "Sleep Baby, Safe and Snug" to all 46 local child protection offices in both English and Spanish. These books were shared with mothers of newborns and pregnant mothers to educate about safe sleep practices in an easy to

understand way while also encouraging bonding between mother and child through reading. The SUID Sub Committee also utilized grant funds to provide public education on safe sleep practices that reduce the risk of sleep related death in infants with advertisements within NJ Transit. Throughout the state the advertisements were featured on NJ Transit buses and light rails as well as on train station platforms focusing specifically on the high incidence areas identified through SUID data. The advertisements began at the end of September 2015 and continued through the end of the year.

Through the multiple evidence-based strategies in NJ to promote infant safe sleep and the consistent message to place infants to sleep on their backs, NPM #5 has been slowly improving from 57.8% in 2003 to 70.8% in 2014 according to NJ PRAMS data. The SUID rate has also declined from 0.8 per 1,000 live births in 2000 to 0.3 per 1,000 in 2012 according to the NCHS. Racial and ethnic disparities in NPM 5 persist and are being addressed through more targeted educational messages using home visitor staff in DCF and the MIEC Home Visiting Program.

Annual Report – SPM #1

The Department's commitment to reduce black infant mortality and preterm births has been demonstrated through the Blue Ribbon Panel on Black Infant Mortality Reduction, the Black Infant Mortality Reduction Advisory Council, the BIBS campaign, the Commissioner's Prenatal Care Task Force, the Access to Prenatal Care Initiative, the ASTHO Prematurity Pledge, the MIECHV Program, the NGA on Improving Birth Outcomes, the IM CollIN, and the recent Improving Pregnancy Outcomes Initiative.

II.F.1.c. Child Health

The domain of Child Health includes the State Priority Needs of #3 Improving Nutrition and Physical Activity and the selected National Performance Measures of #6 Developmental Screening and #8 Physical Activity and State Performance Measure #2 (Children with Elevated Blood Lead Levels). NPMs #6, NPM #8 and SPM #2 were selected during the Five-Year Needs Assessment process for their impact on overall child health and for the evidence-based strategies implemented by NJDOH and its partnerships.

Plan for the Application Year - NPM #6: (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)

	2007	2011-2012	2016
6: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	12.67	25.02	NA.

Source – National Survey of Children's Health (NSCH), 2016 data not yet available

Increasing NPM #6 is an important focus in the domain of Child Health to improve overall child health and well-being. Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine-month visit.

The NJDOH will continue to participate as an interdepartmental partner active with the NJ Council for Young Children (NJCYC), the Race to the Top-Early Learning Challenge (RTTT-ELC) grant and CDC's 'Learn the Signs' NJ Team. The NJCYC, Infant Child Health Committee has established a priority of improving system connections for children and families with health care providers, community services, early intervention, child care, home visiting to expand screening (prenatal and child development) in health care and early care and education settings. Grow NJ Kids (GNJK) a Quality Improvement Rating

System (QRIS) developed for early learning programs requires the use of a “state approved” developmental screening at Level 2 of a 5 level rating with the expectation that 90% of high needs infants and children participating in GNJK will receive developmental screening by 2018 with an emphasis on using the parent completed child monitoring system Ages and Stages Questionnaires (ASQ and ASQ: SE) screening tools.

The MIEC Home Visiting Program will continue to promote and monitor parent completed child development screening tools (ASQ and ASQ: SE). In SFY 2015 over 7,000 families with young children participated across all 21 NJ counties. Developmental screening is a required benchmark performance measure and improving developmental screening practices and policies is a current focus on HV evaluation and continuous quality improvement.

NJ has completed a significant amount of work to create an aligned system of early education data through the NJ-EASEL (NJ Enterprise Analysis System for Early Learning). The NJ-EASEL project will link DOE’s Statewide Longitudinal Data System (NJ SMART), DCF’s Licensing System, DHS’s Workforce Registry (NJ Registry for Childhood Professionals, a component of the Grow NJ Kids data system), DHS’s child care system (CASS), DCF’s foster care system (NJ SPIRIT), DOH’s Early Intervention System (NJEIS), DCF’s Home Visiting system, Head Start/Early Head Start program data systems, and other state early learning and development data collections within the parameters of state and federal privacy laws. NJ-EASEL project is designed to be able to measure outcome objectives of the RTTT-ELC including being able to show that early developmental screening has a direct impact on identifying children and referring them to needed services resulting in positive outcomes for children. The NJ-EASEL data warehouse will serve as the repository through which collected data informs the quality improvement and outreach activities “managed” by GNJK.

The selected ESM 6.1 will monitor progress on increasing the use of parent-completed early childhood developmental screening using an online ASQ screening tool and how well early childhood developmental screening is promoted across the Departments of Health, Children and Families, Human Services, and Education which will drive improvement in NPM #6 (Developmental Screening). NJ DCF was funded for the ECCS Impact grant to promote parent-completed early childhood developmental screenings in children less than 3 years old. In 5 NJ counties, the Central Intake Hubs will partner with the County Council for Young Children to promote direct linkages for children and their families to primary health care and developmental screening using the ECCS Impact Collaborative Innovation and Improvement Network (CollIN) approach.

Plan for the Application Year - NPM #8: (Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day)

	2003	2007	2011	2013	2016
8a: Percent of children ages 6 through 11 who are physically active at least 60 minutes per day	23.6	35.5	27.6	NA	NA
8b: Percent of adolescents ages 12 through 17 who are physically active at least 60 minutes per day	19.0	23.0	23.2	27.6*	NA*

Source – National Survey of Children’s Health (NSCH)

*Source – CDC, National Center for Health Statistics

Increasing NPM #8 is an important focus in the domain of Child Health to prevent obesity and improve overall child health and well-being. FHS has been collaborating on and developing partnerships to address this NPM thru ShapingNJ and the CDC WSCC model. Regular physical activity can improve the health and quality of life of Americans of all ages. Physical activity in children and adolescents reduces

the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.

FHS recognizes that positive physical activity and nutritional practices start at a young age and should be addressed as early as possible. Children at greatest risk for overweight and obesity as well as physical inactivity are concentrated in disadvantaged communities. Among the 44 states reporting on low-income childhood obesity, NJ has the highest prevalence in children 2 to 5 years of age at 14.2%, according to the 2011 WIC Pediatric Nutrition Surveillance System.

ShapingNJ, the state public-private partnership for nutrition, physical activity and obesity prevention consists of some 230 organizations working to reduce and prevent obesity in NJ. The work is focused in 6 settings, including early care and education, schools, communities, work sites, health care and faith-based. Funded by the Nemours Foundation, work in the early care and education setting focuses on embedding obesity prevention strategies (access to healthy food, physical activity, reduction of screen time and breastfeeding support) in the larger agenda for NJ's youngest through training and close collaboration with other state lead agencies. In the communities, the NJ DOH is part of a funding collaborative that together supports 45 NJ at-risk communities charged with implementing one healthy food access strategy and one physical activity strategy (**ShapingNJ** strategies) through policy and environmental change. The NJDOH also funds Faith in Prevention, an initiative charged with engaging faith-based organizations in the battle against chronic disease in Trenton, Camden and Newark.

School health objectives aim to: Provide training and technical assistance from 75 of the State's 600+ school districts (K -12) in 2016 to 100 by 2017 to create school environments that provide healthy nutrition and opportunities for physical activity throughout the day including quality physical education.

- NJ Association for Health, Physical Education, Recreation and Dance (NJAPERD), with CDC funding, conducts professional development sessions at statewide and regional meetings on: Physical Education/Physical Activity for K-12 teachers; School Food Service guidelines and nutrition standards for K-12 teachers; Preparing fresh fruits and vegetables for School Food Service staff.
- Center for Supportive Schools (CSS), with funding from the CDC, has convened a statewide school health advisory committee to provide guidance on the development of a model school district *Wellness Policy* and is developing a plan to promote the policy to school districts and other school stakeholders.
- The NJ State Alliance of the YMCA, with CDC funding, continues to provide intensive training and technical assistance in five low-income school districts (including five - K-8 schools per district for a total of 25 schools; 1 high school per district in three districts = 3 high schools) to implement Comprehensive School Physical Activity and improve school nutrition environments.
- Health Corps, with State MCH block funding, supports efforts targeting three high schools. This funding supports three, full time, school-based youth coordinators to serve as peer mentors at the three high school sites to implement nutrition, physical activity and healthy lifestyles activities with students, teachers and the greater surrounding community.

Other nutrition, physical fitness and obesity prevention initiatives within the Office of Tobacco Control, Nutrition and Fitness (OTCNF) that are funded by the CDC - "State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health" support breastfeeding initiation, duration and exclusivity for the first six months of life and healthy communities.

- NJ Hospital Association (NJHA) - The OTCNF provides funding to the NJHA to continue training and technical assistance to eighteen of the 52 NJ maternity hospitals to help move them towards implementation of the WHO/UNICEF's "Ten Steps to Successful Breastfeeding", a program designed to promote exclusive and sustained breastfeeding. In May 2015 and again in September 2016, NJHA convened a statewide training summit for all NJ maternity hospitals. Birthing facilities utilize the 2015 document published by NJHA titled: *Healthy Beginnings NJ: Supporting Breastfeeding Moms and Babies Technical Assistance Guide for Hospital Providers*.
- NJ Prevention Network (NJPN) - The OTCNF provides funding to NJPN's *Get Active NJ* program which provides technical assistance, training and incentives to assist municipalities to find ways to educate stakeholders on different policies that can promote walking and the many benefits that walking may have on their communities. The *Get Active NJ - Walkability Toolkit* created by NJPN, is intended to provide information and examples on how local policies are created at the municipal level to support walkability.
- The Food Trust - The OTCNF contracts with The Food Trust to implement activities and projects to promote policy and environmental change for obesity prevention in local communities. Trainings and technical assistance are provided to corner store owners in order to increase community residents access to healthy foods and beverages, particularly those at high-risk for obesity and other chronic disease. The Food Trust provides on-site technical assistance to a minimum of 20 small retailers to promote healthy retail sales in their stores. Corner stores are targeted through a collaboration with the NJ Department of Health WIC Program, the Community Health and Wellness Unit - OTCNF and The Food Trust. Beyond requiring WIC authorization, participating stores must be located in a food desert as defined by USDA.

The work of the NJ Partnership for Healthy Kids (NJPHK) supports Robert Wood Johnson Foundation's (RWJF) six policy priorities for improving nutrition and increasing opportunities for physical activity, both of which are critical to reversing the childhood obesity epidemic. NJPHK is a statewide program of the RWJF with technical assistance and direction provided by the NJ YMCA State Alliance. The goal of the program is to convene, connect and empower community partnerships across the state to implement environment- and policy-changing strategies that prevent childhood obesity. Community coalitions in Camden, New Brunswick, Newark, Trenton, and Vineland are leading these efforts.

The six policy priorities are:

1. Ensure that all foods and beverages served and sold in schools meet or exceed the most recent dietary guidelines.
2. Increase access to high-quality, affordable foods through new or improved grocery stores and healthier corner stores and bodegas.
3. Increase the time, intensity and duration of physical activity during the school day and out of school programs.
4. Increase physical activity by improving the built environment in communities.
5. Use pricing strategies – both incentives and disincentives – to promote the purchase of healthier foods.
6. Reduce youth exposure to unhealthy food marketing through regulation, policy and effective industry self-regulation.

Since Fall 2015, DOH regional school health grantees annually renew a MOA with Sustainable Jersey for Schools, to continue their work on increasing physical activity and/or improving the built environment. The partnership with Nemours Foundation will continue (funding period 2013-2018) with additional learning collaboratives being launched. Efforts will be planned to integrate this work with the work of other State Departments (Agriculture, Children and Families, Education and Human Services). Child care toolkits to assist providers in improving nutrition and physical activity practices will be disseminated.

The selected ESM 8.1 (Number of schools participating in an activity (training, professional development, policy development, technical assistance) to improve physical activity among children (6-17)) will be monitored to assess progress on promoting physical activity of children 6 through 17 by improving policies and practices in schools regarding physical activity.

Plan for the Application Year - SPM #2: *The percentage of children with elevated blood lead levels (≥ 10 ug/dL).*

SPM #2 was selected to address the issue of childhood lead poisoning which is not specifically addressed by the NPMs or NOMs. Long-term exposure to lead can cause serious health problems, particularly in young children. Lead is toxic to everyone, but unborn babies and young children are at greatest risk for health problems from lead poisoning — their smaller, growing bodies make them more susceptible to absorbing and retaining lead. Lead exposure can cause permanent damage to the brain and nervous system, resulting in hearing problems, slowed growth and anemia. Children with elevated blood lead levels are at increased risk for behavioral problems, developmental delays, and learning disorders. Increased childhood morbidity will result from undetected and untreated lead poisoning.

The CDC Cooperative Agreement Year 2 outcomes determined data-driven primary prevention interventions for Year 3 that are implemented by not only the NJDOH, but its strategic partners and lead and healthy homes grantees. Performance management strategies were incorporated at the Program level to ensure data-driven, evidence-based practices are used.

In October 2016, during national Childhood Lead Poisoning Prevention Week, the NJDOH kicked-off the #kNowLEAD awareness campaign which included a reformatted Child Health webpage, social media presence, and call center for consumers to get their questions answered and referrals to resources.

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Annual Report - NPM #6: (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)

The NJDOH is an interdepartmental partner active with the [NJ Council for Young Children](#) (NJCYC), the [Race to the Top-Early Learning Challenge](#) (RTTT-ELC) grant and CDC's 'Learn the Signs' NJ Team. The NJCYC, [Infant Child Health Committee](#) has established a priority of improving system connections for children and families with health care providers, community services, early intervention, child care, home visiting to expand screening (prenatal & child development) in health care and early care & education settings. Grow NJ Kids (GNJK) a Quality Improvement Rating System (QRIS) developed for early learning programs requires the use of a "state approved" developmental screening at Level 2 of a 5 level rating with the expectation that 90% of high needs infants and children participating in GNJK will receive developmental screening by 2018 with an emphasis on using the parent completed child monitoring system Ages and Stages Questionnaires (ASQ and ASQ: SE) screening tools.

The Boggs Center on Developmental Disabilities, NJ's federally-designated University Center of Excellence on Developmental Disabilities, and the Statewide Parent Advocacy Network (SPAN), the state's federally-designated Parent Training and Information Center (PTI) and Family to Family Health Information Center (F2F) collaborated on the [Act Early State Systems Grant](#) with the shared goal of improving access to developmental screening and referral among underserved children in NJ. One of three overarching objectives of this project included strengthening the collaborative efforts between The Boggs Center and SPAN within the scope of promoting developmental screening using validated instruments at appropriate intervals as well as referral for diagnosis, Early Intervention, and community services and supports at NJ's network of FQHCs and community clinics.

Over the project period, SPAN and The Boggs Center partnered to provide 15 parent-led trainings about developmental screenings to healthcare providers at FQHCs throughout the state, attended by a total of 195 participants. Overall, 7 trained SPAN Family Resource Specialists, each with a child on the autism spectrum, participated in the project and a total of 27 SPAN parents were represented at the 15 trainings.

Early Intervention representatives presented at 9 of the 15 trainings; all but one were parents and one was a sibling.

NJ is part of a national [Project LAUNCH](#) initiative designed to promote the wellness of young children ages birth to 8, and reduce racial and ethnic disparities including an emphasis on routine developmental screening. [NJ Project LAUNCH](#) is targeting urban Essex County and is using a [Help Me Grow](#) systems approach to strengthen the connections between physicians, parents/families, and community providers to address the physical, social, emotional, cognitive, and behavioral aspects of child development. Project LAUNCH ensures that parents/families have access to a continuum of community-based evidence-based programs (EBP) that support parent-child interaction and young child development across a range of settings—health care, home visiting, child care, Early Head Start/Head Start, preschool/school to promote early identification of health and developmental issues that impact child wellness.

Annual Report - NPM # 8: Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day

The ShapingNJ child care workgroup has collaborated on a number of systems efforts. Child care partners continue to offer training and technical assistance at county and statewide trainings to increase center staff capacity for best practices that will prevent obesity in our most vulnerable population. Beginning in April 2013, NJ received funding from Nemours Foundation as part of a six-state early care and education learning collaborative to ensure that licensed child care providers offer children healthy food, breastfeeding support and opportunities for active play. One hundred licensed centers serving 100 or more children were enrolled. Participation in this project will assist centers meet and exceed new licensing requirements. New licensing requirements were adopted by the Office of Licensing (Department of Children and Families) and became effective September 30, 2013 (<http://www.state.nj.us/dcf/providers/licensing/laws/CCCmanual.pdf>). Sustainability efforts can be achieved through participation in a six-state early care and education learning collaborative coordinated by the Nemours Foundation and funded by CDC. A state coordinator was hired to work within the NJDOH and five regional learning collaboratives were established in NJ in year one of a five-year funding that focused on improving skills of child care center staff.

The Child Care Workgroup of ShapingNJ developed and distributed a best practices toolkit to partners at the annual ShapingNJ meeting in June 2013 and was shared with county-level partners through the Office of Local Public Health for more rapid dissemination. It is also posted on the [ShapingNJ.gov](#) website.

As of March 2017, 250 districts and 601 schools have registered for Sustainable Jersey for Schools (SJfS) certification. Of the schools registered, 111 are certified at the Bronze level and 7 are certified Silver. Through the regional school health grantee’s partnership with SJfS, NJ schools are working on the actions listed below:

Actions to Increase Physical Activity or Improve the Built Environment	# Schools Approved 2015	# Schools Approved 2016	# Schools Approved 2017	# Schools Approved 2018
Pedestrian and Bicycle Safety and Promotion Initiatives	3	12		
Policies to Promote Physical Activity	0	6		
Programs to Promote Physical Activity	3	14		
Safe Routes to School District Policy	0	1		
School Travel Plan for Walking and Biking	3	8		

Annual Report - SPM # 2: *The percentage of children with elevated blood lead levels (≥ 10 ug/dL).*

Meaningful progress was made toward SPM # 2 in CY 2016. More than 230,000 blood lead tests were reported on 214,741 children <17 years of age. Of the children tested during CY 2016, 80.4% were under the age of 6 years. Among these children, 0.52% had results ≥ 10 ug/dL and 3% had results ≥ 5 ug/dL. Of all the children tested, 94,909 were between six months and 26 months of age, the ages at which State regulations require children to be screened for elevated bold lead levels. This represents 44.2% of all children in that age group. Looking at all blood lead tests reported since 1999, it is estimated that 79% of children have had at least one blood lead test before the age of three years, and 60% of children have had at least one blood lead test before the age of 2 years.

Table SPM #2

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
<i>The percentage of *children with elevated blood lead levels (≥ 10 ug/dL).</i>	0.7	0.6	0.5	0.5	0.5	0.5	0.5
Numerator*	1,236	1,103	898	793	816	862	889
Denominator*	185,055	182,040	183,215	176,847	171,521	174,887	174,114
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Final	Provisional

*Children ≤ 6 years of age

Notes - Source: Childhood Lead Information Database, MCHS, FHS.

The web-based data and surveillance system, LeadTrax, containing case management and environmental investigation modules continues to be customized, and remained compliant with CDC data requirements.

Ongoing efforts to increase the percentage of laboratories reporting electronically resulted in an increase from 99.60% in CY 2015 to 99.80% in CY2016. NJDOH continued to assist the remaining laboratories to transition from reporting on hard copies to electronic reporting. NJ has legislation that requires children to be screened for elevated blood lead levels. Every primary care provider and health care facility that provides care to children less than six years of age is required to comply with the law.

Collaborative efforts with Medicaid and its contracted managed care providers continued in order to monitor and increase the number of Medicaid-enrolled children screened for elevated blood lead levels. LeadTrax records are matched biannually to the Medicaid Eligibility file to identify lead screening rates and unscreened Medicaid participating children. LeadTrax testing results are included in the NJ Immunization Information System (NJiIS) to provide healthcare providers with screening results and histories.

Monitoring of the Elimination Plan continued to be coordinated by NJDOH to assure that the state is collectively making progress to eliminate elevated blood lead levels. In addition, a Healthy Homes Strategic Plan that was developed to expand the State’s focus to other housing hazards that affect the health of all residents was implemented. Training opportunities for professionals were made available through the NJ Healthy Homes Training Center, a public-private partnership between NJDOH and Isles, Inc, a Trenton-based, non-profit, community development agency.

In NJ’s largest city, Newark, the Newark Department of Health and Community Wellness, continued to administer the Newark Partnership for Lead Safe Children. Three other local agencies continued to administer Regional Lead and Healthy Homes Coalitions with statewide outreach and a focus on primary prevention.

Training on healthy homes principles for staff of local health departments and home visitation-based programs in the Department of Children and Families (DCF) continue. DCF's Home Visiting programs, funded in part by NJ's MIEC Home Visiting Grant, provide services to pregnant women, infants, and young children. In addition, staff that assess the suitability of homes for placement of children who have entered foster care or are registered as family child care homes were targeted for training. Emphasis is placed on developing strategic partnerships with additional home visitation and government-funded home inspection agencies that serve highest-risk, hard to reach populations as identified in the Healthy Homes Strategic Plan. A CDC Cooperative Agreement, awarded in October 2014, focuses on childhood lead surveillance to determine key indicators progress and deficiencies.

II.F.1.d. Adolescent / Young Adult Health

The domain of Adolescent/Young Adult Health includes focuses on NPM #10 (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year), NPM #11 (Percent of children with and without special health care needs having a medical home) and NPM #12 (Percent of children with and without special health care needs who received services necessary to make transitions to adult health care). Because reporting on NPM #11 and #12 overlap the two domains of Adolescent/Young Adult Health and SCHCN, the narrative for NPM #11 and #12 will be presented in this Adolescent/Young Adult Health section and not repeated in the CYSHCN Section. This section serves as the state's narrative plan for the Application year and as the Annual Report for the reporting year. Planned activities for the Application year are described and programmatic efforts summarized that have been undertaken for the Annual Report year, with primary emphasis placed on the performance impacts that have been achieved. The strategies and activities to address the identified priorities from the Needs Assessment Summary are further described.

Plan for the Application Year - NPM #10:

Improving NPM #10 (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year) is an important performance measure in the domain of Adolescent/Young Adult Health and is related to SPN #4 Promoting Youth Development. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease.

The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to improve patients' and providers' experience of care and the quality of care for all children. Promotion of the medical home is a strategy to improve NPM # 10 (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year). Providing a medical home means offering care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective (AAP, Policy Statement, July 2002). A medical home is a place where care for the child and adolescent is centralized, coordinated and monitored. A team approach to medical home improvement includes engaged staff members and parents as key improvement partners.

NJAAP has identified the medical home as one of 8 key issues to address to improve pediatric care in NJ. Since 2009, NJAAP, NJ DOH and other partners have been working to increase primary care team education and awareness about the medical home to promote prevention, wellness and chronic care management. With the opportunity for NCQA Recognition as a patient centered medical home, NJAAP's support has enabled participating practices to assess their current level of "medical homeness" using the Medical Home Index, and additionally has engaged their participation in various QI activities.

The plan for the applicant year for NPM #10 is to continue the Medical Home Technical Assistance Program for 2015-2016 "Improving Population Health Management" which proposes that the NJAAP, in partnership with the Statewide Parent Advocacy Network (SPAN) and the NJDOH, implemented HRSA's Integrated Systems Grant (ISG) to improve access to quality, culturally competent, family centered systems of service for children, especially children with special health care needs. This support for the Medical Home Initiative enabled NJAAP to work with over 30 practices in 13 counties across NJ in the development of practice teams and utilization of the model for improvement to strengthen patient centered medical homes.

New Jersey's competitive application, to the National Resource Center (NRC) and AMCHP for the 2nd cohort of the Adolescent and Young Adult Health (AYAH) Collaborative Improvement and Innovation Network (CollIN), was approved. Data from a NJ FQHC report identified a greater than 50% disparity for adolescent preventive medical visits at FQHCs (averaging about 45% during the years of 2013-2015) as compared to private physician offices (averaging about 97%). The goal of the NJ AYAH CollIN is to increase the FQHC adolescent visit rate to achieve the Healthy People 2020 goal of 75.6%. The State Team is scheduled to attend a two-day Summit on May 9-10th. Assistance will be provided for the Team

to develop an 18-month collaborative workplan for implementing evidence-based strategies. Before this Summit, on April 11th, Southern New Jersey Perinatal Cooperative will convene a youth panel to present their ideas on adolescent-friendly services.

The Medical Home Technical Assistance Program for 2015-2016 “Improving Population Health Management” which is grant funded by FHS will provide in-depth Technical Assistance for 5 Pediatric Practice teams, raise awareness for patient centered medical home including "Triple Aim", and address the needs identified through a recent survey.

The number of health care professionals in practices participating last year in the Medical Home Technical Assistance Program has been selected as ESM 10.1 which should increase NPM #10 (percentage of adolescents with a preventive service visit in the last year).

Table NPM 10

	2003	2007	2011-2012	2016
Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year	84.11	94.54	93.27	NA

Source – National Survey of Children’s Health (NSCH)

Plan for the Application Year - NPM #11: Percent of children with and without special health care needs having a medical home

Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Providing comprehensive care to children in a medical home is the standard of pediatric practice that should be delivered within the context of a trusting and collaborative relationship between the child’s family and a competent health professional familiar with the child and family and the child’s health history. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child’s family and a competent health professional familiar with the child and family and the child’s health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. State staff continues to develop refined techniques within the electronic reporting system (i.e., CMRS) that will include all seven qualities essential to medical home care.

CSHCN with a medical home has been a priority for the SCHEIS program which has been supported by several partnerships and collaboratives. Having a primary care physician service identified in a child’s Individual Service Plan (ISP) developed with an SCHS CM served as a medical home proxy beginning 2014 reporting. It is acknowledged that a medical home is more comprehensive than just having a

primary care physician. In part, it is also imperative for a child to have consistent health insurance to increase access to said provider. Of the 21,220 children age 0 to 18 years served in FFY 2016, 6,276 (approximately 30%) had a primary care physician documented, and of those children approximately 60% had insurance identified in their ISP. The percent of CYSHCN ages 0-18 years served by SCHS CMUs with a primary care physician has been selected as ESM 11.1, which should increase NPM #11 (Children with and without special health care needs having a medical home).

2014 SCHS CM data obtained through CMRS informed a quality improvement initiative targeting medical home charting within CYSCHN's ISP's. FCCS staffs identified baseline SFY 14 data on key proxies used to note documentation of those outcomes in CMRS by the SCH CMUs and compared those findings to NJ State and national findings reported in the 2009/2010 National Survey of CSHCN (NS-CSHCN). Baseline 2014 and follow-up 2015 findings were shared with the SCHS CMUs at quarterly SCHS CM meetings. These presentations are part of FCCS staff's ongoing quality improvement project, for further discussion about ensuring access to a medical home for CYSCHN and CMRS documentation of this work. Although the estimated percent remained steady from FFY 2015 to FFY2016, there was a 4.2% increase in CMRS documentation of the numerator and a 6.5% increase in documentation of the denominator.

During SFY17, all Programmatic, Narrative and Chart Review Site Visit Forms for Child Evaluation Centers (CECs), Cleft Lip/Palate Craniofacial Centers (CLCP) and Pediatric Tertiary Centers (PTCs) were revised to include questions regarding the presence and/or establishment of a Medical Home. Questions include: "1) Does the team provide each family with education regarding the concept of a Medical Home and its role in coordination of care for CYSHCN? 2) Does the team assist/facilitate the establishment of a Medical Home for the patient and patient family if no Medical Home is Present? 3) How are patients assessed for the Presence of a Medical Home? 4) Do Multidisciplinary Evaluation Reports and ISPs include document regarding Medical Home? "

Table NPM 11 - Percent of children with and without special health care needs having a medical home

	2007	2011_2012	2016
Percent of children with special health care needs having a medical home	51.8	42.2	NA
Percent of children without special health care needs having a medical home	57.8	55.4	NA

Data Source: National Survey of Children's Health (NSCH)

A total of seven pediatric/family medicine practices across NJ, representing 126,500 children were recruited to participate in the AAP's Patient Centered Medical Home Technical Assistance program. The goal of the project was to expand and build NJ's capacity by having the NJAAP/Medical Home Quality Improvement Team become NCQA Recognized Experts and by staffing an "NCQA Recognition Warm Line" available to Pediatricians across the State. In September 2015, FCCS was awarded a 2 year ISG to increase the percentage of CYSHCN with a medical home by 20%. FCCS is partnering with NJAAP, SPAN, and a subset of SCHS CMUs for this project. As part of the current ISG, FCCS and its partners have: developed a Shared Plan of Care tool that will be piloted in spring/summer 2017 by three SCHS CMUs to increase cross-system care coordination; developed five (5) presentations that are being delivered to seven partnering primary care practices in 25 locations to increase knowledge, partnerships, and integration; developed linkage agreements between partnering practices and both SPAN and SCHS CMUs to increase integration across partners; and connected partnering practices with SCHS CM to increase awareness of SCHS CMUs as a shared resource for CYSHCN, including those who are within the transition to adulthood age range.

Health Service grants funded by RPHS will continue to require agencies to outreach and facilitate enrollment of potentially eligible children into health insurance. The Improving Pregnancy Outcomes

Initiative will increase health insurance enrollment by assessing health insurance status and referring uninsured families with adolescents.

State SCHEIS staff will continue to refine tracking of Performance Measures in CMRS and provide documentation training to Special Child Health Services Case Management Units to ensure activities related to these Measures are accurately counted. Changes to CMRS are proposed and in process to modify reporting, data collection, and tracking of medical home components. ISG funding of \$15,000 in 2016 and \$10,000 in 2017 is proposed to implement these changes to CMRS.

State staffs will continue to share resources and training updates with SPSPs on the reorganization of State programs and services that can influence access to primary and specialty care, including the Comprehensive Waiver, Managed Long Term Services and Supports, and changes in access to care through implementation of the Affordable Care Act. Likewise, continuing to promote linkages between the Medicaid managed care agencies will remain important in supporting families with CYSCHN seeking in-State specialty care.

Title V will continue to support a safety net of specialty providers and case management units. Trends in the use of specialty care across the provider network will continue to be monitored by State staffs via onsite monitoring and programmatic reports. Likewise, continued collaboration with network agencies, State agency and community-based partners through the COCC, and consumers, will continue to promote linkage for CYSHCN with a medical home.

Plan for the Application Year - NPM #12 (transition to adulthood)

The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90% of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions.

Table NPM #12: *The percentage of adolescents (12-17) with (and without) special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

	2010	2011	2012	2013	2014	2015	2016*
Annual NPM #12 Indicator	37.9	41.8	41.8	N/A	12.2	25.3	41.3
Numerator					352	1,101	2,073
Denominator					2,892	4,385	5,017
Is the Data Provisional or Final?	Final	Final	Final		Final	Final	Provisional

Notes - Indicator data for 2010-2012 comes from the National Survey of CYSHCN, a numerator and denominator are not available (N/A). Beginning 2014, the denominator represents all children age 12-17 years served in FFY by Special Child Health Services Case Management Units (SCHS CMU). The numerator reflects the number of children who had at least one of four transition-type services identified in their Individual Service Plan (ISP).

- For 2014 and 2015, four possible types of transition to adulthood services were identified as proxies:
1. identification of an adult-level primary care physician (i.e., pediatrician excluded in the current definition),
 2. transition-specific services including Division of Developmental Disabilities (DDD),
 3. employment, and
 4. health insurance.

*Beginning 2016, a fifth type of service was added following SCHS CMU feedback during a quality improvement presentation in September 2016: supplemental security income (SSI).

SCHSC CMUs serve children with special health care needs up to their 22nd birthday. When the age criterion is relaxed to include youth age 12 to 21 years, 5,846 youth were served in FFY 2016. Of those youth, 2,425 (approximately 42%) received at least one service to aid in transition to adulthood.

Identification and monitoring of transition to adulthood needs for CYSHCN and their families served through the SCHS CMUs statewide is ongoing. Transition packets continue to be updated and shared with families and linkage with community-based supports is provided. State staffs monitor the SCHS CMUs efforts to in reach and outreach to CYSHCN regarding transition, and documentation of goals related to transition on adolescents' ISPs. Likewise, efforts to capture the discussion of transition to adulthood between families of CYSHCN and SPSP providers are in process.

The SCHS CMUs continue to facilitate transition to adulthood with youth by ensuring a transition to adulthood goal on the ISP. Likewise, exploring youth and their parents' needs to facilitate transition with insurance, education, employment, and housing, and linking them to community-based partners will continue. The quality improvement project that started in 2014 includes transition to adulthood CMRS documentation and NPM #12 proxies described above. FCCS staff presented additional CMRS documentation training on transition to adulthood in December 2016 as part of the current ISG.

The ongoing QI presentations to the SCHS CMUs stimulated an active discussion about how SCHS CM documentation produces system wide data that is used for QI and MCHBG reporting. These presentations also inform FCCS and SCHS CMU staffs on areas for training to more effectively unlearn and relearn documentation methods, to move from a lengthy narrative charting style to the use of drop down menus supported by brief entries that use shorter more consistent terminology. The State Health Data Specialist staff collaborate with the Quality Assurance Specialist Nurse and Program Officers to review and analyze CMRS data, and to provide additional QI presentations highlighting progress and additional areas of improvement in documentation on the Core Outcomes at SCHS CMU quarterly meetings.

During SFY17, all Programmatic, Narrative and Chart Review Site Visit Forms for Child Evaluation Centers (CECs), Cleft Lip/Palate Craniofacial Centers (CLCP) and Pediatric Tertiary Centers (PTCs) were revised to include questions regarding Transition to Adulthood. Questions include: "1) does the team provide each family with education regarding the concept of Transition of Care (from pediatric to adult care) and its role in the coordination of care for CYSHCN? 2) Does the team assist/facilitate a Transition Plan of Care for the patient and patient family if no Transition Plan of Care is Present? 3) How is Transition to Adulthood addressed by this agency? 4) Do Multidisciplinary Evaluation Reports and ISP include documentation regarding Transition to Adulthood?"

SCHS CMUs and pediatric specialty providers will refer youth and/or their parents to NJ Council for Developmental Disabilities (NJ CDD) for participation in Partners in Policymaking (PIP) self-advocacy training as well as continue to assist youth and their families to advocate for transitional supports through their individualized education plans and community-based supports. Title V will continue to participate in PIP mock trials to facilitate the development of clients' self-advocacy skills.

Under health care reform, NJ Medicaid eligibility for single adults has expanded in 2014 to up to 133% FPL. As this population is intended to include a significant percentage of childless adults with incomes below 133% of FPL, it is anticipated that CYSHCN transitioning to adulthood will have expanded opportunity to access health coverage through Medicaid, the insurance exchange, and coverage through their parents' insurance through age 26 (or in certain circumstance till age 31). In addition, it is also possible that some youth/young adults with special needs on Medicaid may experience a shift in eligibility to an insurance exchange. 20.4% of the 12-17 year old youth who were served by SCHS CMUs in FFY2016 had an insurance service documented. Of those with insurance documented, 54.2% had Medicaid/NJ Family Care specifically.

The Arc of NJ's annual Mainstreaming Medical Care Conference has been planned for May 30, 2015. Title V participates on its Advisory Board, and the overarching theme of last year's conference was promoting medical care for persons with developmental disabilities. The integration of behavioral and medical care, work incentives for persons on SSI or SSDI benefits, and Managed Long Term Services and Supports for persons with developmental disabilities are common themes. These key concepts are vital in developing transition planning for many of NJ's CYSHCN and/or their families and SCHS CMU and SPSP providers are encouraged to attend these trainings.

The percent of CYSHCN ages 12-17 years served by SCHS CMUs with at least one transition to adulthood service has been selected as ESM 12.1, which should increase NPM #12 (Transition to Adulthood).

Annual Report - NPM #10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

From July 2009 through August 2014, NJAAP, in partnership with the SPAN and the NJDOH, implemented HRSA's Integrated Systems Grant (ISG) to improve access to quality, culturally competent, family centered systems of service for children, especially children with special health care needs. This support for the Medical Home initiative enabled NJAAP to work with over 30 practices in 13 counties across NJ in the development of practice teams and utilization of the model for improvement to strengthen patient centered medical homes. The ISG program success was measured utilizing practice pre/post responses on the Medical Home Index (a nationally validated self-assessment tool for measuring "Medical Homeness") Results for participating practices showed an overall increase from pre to post, representing an increase in their overall "Medical Homeness". Receiving recognition for their degree or "Level" of Medical Homeness, was for many practices, the next step after participating in NJAAP's Medical Home Initiative.

In 2015, NJAAP implemented the Patient Centered Medical Home Technical Assistance program to support practices taking the next step toward NCQA Recognition as a Patient Centered Medical Home. The National Center for Quality Assurance (NCQA) recognition as a Patient Centered Medical Home involves a detailed and lengthy process with many standards and elements, including "Must Pass" elements, that busy Pediatric practices find difficult to navigate independently. Attainment of NCQA Recognition as a PCMH provides practices with payment incentives that will support and sustain financing their Medical Homes. Research demonstrates that PCMHs achieve powerful results. The Patient-Centered Primary Care Collaborative recently summarized PCMH demonstration findings that show success in increasing quality while reducing costs (<http://www.pcpcc.net/content/pcmh-outcome-evidence-quality>).

To build NJ in-house capacity to best support pediatric practices in the NCQA-PCMH process, the NJAAP/Medical Home Quality Improvement Team members attended the 3-day NCQA Content Expert training sessions (1 attended in 2014; 2 attended in 2015) with a goal of becoming NCQA Recognized Content Experts (currently 1 team member is at Certified status). Knowledge gained from attending these classes has allowed team members to better support the NJAAP NCQA Recognition Warm Line" – available (Fall 2014) at (609) 842-0014 for technical assistance with PCMH Recognition.

In addition to expanding in house capacity, through the Patient Centered Medical Home Technical Assistance Program, NJAAP worked with 7 practices across NJ, (representing 126,500 children) utilizing the knowledge gained through the Model for Quality Improvement and by overseeing the policies, processes and procedural changes that many of the practices implemented throughout their participation in the Medical Home Initiative. NJAAP provided technical assistance as several of the participating practices moved toward applying for formal National (NCQA) recognition as a Patient-Centered Medical Home. Given the time commitment required by practices to successfully document and submit their application to NCQA, 4 of the 7 participating practices engaged the use of a PCMH Recognition Consultant, to aid in the process of NCQA application submission, while also engaging our Medical Home team as a resource regarding suggestions for QI projects, review of tools they were using to aid in NCQA

submission, selection of Chronic Diseases for population management, MOC credit information, and as an overall medical home information source.

In an effort to assess level of interest and need as to how best our team could support practices along the PCMH continuum, the NJAAP Medical Home team created and distributed a Medical Home Program Survey to the participating practices. Responses point to the need for Care Planning and Care Management within practices that have or will undergo NCQA Recognition.

Pending attendance at the AYAH CoIIN Summit on May 9-10, 2017, the State Team will convene to develop a feasible 18 month workplan with measurable objectives, evidence-based strategies and collaborative activities to improve the rate of the adolescent well visit at FQHCs.

Annual Report - NPM #11: Percent of children with and without special health care needs having a medical home

All (100%) of CYSHCN referred into NJ Title V's SPSP providers and SCHS CMUs are screened for status of primary care provider and their families are provided with information on how to link with a primary care provider/medical home. The Title V SCHS CMUs and pediatric specialty providers will continue to provide a safety net for families of CYSCHN. The number of CYHSCN served across SPSP remained consistent; 61,153 (SFY15) verse 61,976 (SFY16).

Demand remains particularly high for comprehensive team evaluation, and some agencies report a 3- to 6-month wait to schedule new clients. To reverse the wait time to schedule a new comprehensive team evaluation, State staffs provide consultation to SPSP agencies. In an attempt to reduce wait time, one CEC recently implemented a pre-appointment call to families of CYSCHN that screened for presenting needs. In some instances, this technique allowed for targeted appointments with specialists rather than a full evaluation, streamlined scheduling, reduced appointment wait time to less than 6 weeks, and opened up appointments that necessitated full team evaluations in a more timely manner. Anecdotally, the agency reported that although their efforts required a slight increase in staffing time it yielded a reduced wait time, and all CYSCHN as well as their referring physicians were provided with service plans. The results of this effort were shared with other CECs, and they are exploring the possibility of replicating it. State programmatic monitoring to ensure that clients have and/or are referred to community-based providers will remain ongoing; chart audits and visits to assess clinic days and provide consultation as well as follow-up telephone support will continue.

Likewise, family input to assess their experience with receiving specialty care through the SPSP providers was sought through a patient satisfaction survey. The survey was developed with parent and provider input, translated into Spanish, tested for cultural competency, and administered at SPSP clinic visits during December 2014 and December 2015. It included questions related to clinic setting/staff as well as medical care; quality of physical evaluations, receipt of clear directions on follow-up care, coordination of services and ratings on services received. Over 1,700 parents of CYSCHN opted to complete the anonymous self-administered survey each year, with 16% of responses completed in Spanish in 2015. Although some medically complex CYSCHN regularly seek treatment at SPSP clinics; i.e., Tertiary Care providers, many remain under the care of a community-based provider and seek consultation at the SPSP clinics. This collaborative treatment model requires coordination with CYSCHN's medical home. Survey findings for both years were analyzed and reviewed by Title V staff and used in program evaluation and planning. Findings were then shared with all SPSP providers in fall 2016 for use in self-evaluation. Title V anticipates that these family satisfaction findings will support future efforts to improve coordinated care and linkage with medical home.

Title V is committed to collaboration with the DHS Office of Medicaid Managed Care, the COCC, SPAN, and the NJAAP, and other community-based partners to engage in medical home initiatives to reinforce linkage of CYSCHN with comprehensive community providers. ISG projects are ongoing and have built upon one another. In July 2009 Title V, in partnership with the NJAAP and SPAN, implemented HRSA's Integrated Systems Grant (ISG) to improve access to quality, culturally competent, family-centered

systems of service for children, especially children with special health care needs. This project enabled NJAAP to work with over 30 practices in 13 counties across the State in the development of practice teams and use of the model for improvement to strengthen patient-centered medical homes. The ISG program success was measured using evaluation of the Medical Home Index (a nationally validated self-assessment tool for measuring “Medical Homeness” that each practice must complete pre- and post-program participation). Results for participating practices showed an overall increase from pre- to post, representing an increase in their overall “Medical Homeness.” Receiving recognition for their degree or “Level” of Medical Homeness, is for many practices, the next step after participating in NJ AAP’s Medical Home Initiative.

With knowledge gained through the Model for Quality Improvement and with the policies, processes and procedural changes that many of the practices implemented throughout their participation in the Initiative, many of the practices were ready to apply for formal recognition, with a goal of payment incentives that will support and sustain financing their Medical Homes. National Center for Quality Assurance (NCQA) recognition as a Patient Centered Medical Home involves a detailed and time-consuming process with many standards and elements, including “Must Pass” elements. Focus for Fiscal Year 2014 was to provide guidance and technical assistance to the practices that were ready to begin this recognition process.

SPAN, the NJAAP, and COCC members in 2012 targeted improvement in access to medical homes for immigrant CYSHCN and their families in three high need/limited English proficiency communities in northern NJ: Passaic, Hudson and Union counties. This project engaged Federally Qualified Health Centers, parents of CYSHCN, and family resource specialists linked with the SCHS CMUs in the above-mentioned counties to promote "medical homeness". Likewise, it promoted navigation skill development for immigrant underserved parents of CYSHCN, and leadership training. Referral to and coordination with in-State specialty care providers was also a component of technical assistance provided to private community-based pediatricians and family practitioners, hospital-based practices, and FQHCs through the ISG medical home project.

In 2014, Title V in collaboration with SPAN, the COCC, the NJAAP, and other community-based partners, responded to a HRSA request for applications for a State Implementation Grant for Enhancing the System of Services for CYSHCN through System Integration. Although that opportunity was approved but not funded in the first year, funding was granted in the second year. Aims set forth by HRSA in three domains, cross-system care coordination, integration, and shared resource, are being addressed in collaboration with SPAN, NJAAP, and a subset of the SCHS CMUS. Program implementation and project evaluation of the current ISG aligns with and expands NPM #11 and NPM #12 reporting.

Ongoing improvements to the Case Management Referral System (CMRS) allowed new and different opportunities to track NPM 11 and 12. Rather than definitive identifiers for these Performance Measures, “proxies” were identified and used for this year’s reporting. SCHS CMUs served 21,767 children in FFY 2016.

Annual Report - NPM #12

Efforts to improve documentation of transition to adulthood activities performed by SCHS CMs and documented in the electronic Case Management Referral System (CMRS) were implemented. State staffs provided technical assistance and guidance via site visits, desktop audits, and conference calls to improve the data collected and reported on transition to adulthood activities and client outcomes. As part of an ongoing QI initiative, State staff have presented QI findings and additional guidance on an approximately quarterly basis to SCHS CMUs.

The adolescent subset of CYSHCN served through Title V is observed to be significant. In SFY 2016, approximately 20% of CYSHCN served across the SCHS CMUs were aged 14-19 years of age. The percentage of youth age 14-19 years served by the SPSP agencies was greater, comprising nearly 26%

of those served by the Tertiary Centers, and 25% by the CEC/FAS Centers. The Cleft Lip/Palate Craniofacial Centers reported 11% CYSHCN served among that same age group. These distributions demonstrate an increase in the number CYSHCN aged 14-19 from the previous year indicating that transition planning and implementation will remain a priority for these youth, their families, NJ Title V, and providers.

Documentation of transition planning was largely noted by SCHS CMUs to occur on or about age 14. A discussion with parents/youth about transition planning, and the distribution of transition packets were noted. An anecdotal observation by the SCHS CMs noted that families reported that they preferred to receive materials incrementally rather than one very large packet filled with resources. That incremental method provided them with the opportunity to focus on one or a few transition needs at a time, such as primary care provider; access to Supplemental Security Income and/or health insurance including Medicaid, Medicaid expansion and/or private insurance or the Marketplace; education/job training supports; statewide systems of care including the Department of Human Services' Division of Developmental Disabilities and/or the Department of Children and Family's Children's System of Care Initiative, and others. Furthermore, the Fee for Service program is creating a brochure aimed at increasing programmatic knowledge and access for those who may have been terminated from the Supplemental Security Income program or have aged out of the covered benefits portion of their insurance program in efforts to support transition to adulthood. Follow-up monitoring and discussion supported family's ability to digest the material, and critically think about their needs over time.

The Specialized Pediatric Services (SPS) providers conducted evaluations and developed service plans with adolescent CYSHCN and their families. In addition, SPS providers reported providing youth with transition to adulthood resources regarding genetics, family medicine, adult providers, support groups and other medical and social related needs. The linkage of CYSHCN to multidisciplinary team members including social work and other community-based systems such as SCHS CM, SPAN, and disability-specific organizations including the Arc, Tourette's Association, and Parents' Caucus was also a strategy implemented by the SPSP agencies.

Through an agreement with SPAN, the Family WRAP (Wisdom, Resources and Parent to Parent) project provides information, resources and one-to-one family support that are directly helpful to clients. Likewise, the close working relationship with the SCHS CMUs and the SPAN Resource Parents and Parent to Parent family support offers some opportunities for cross-training on community-based resources for transition.

Linkages developed through previous ISG grants have facilitated the distribution of materials developed by SPAN, NJ AAP, NJDOH, and other community partners engaged in the COCC to medical practices. Community-based partners continued to identify resources and linkages to support transition to adulthood for CYSHCN. Likewise, training was provided to Title V providers on work incentives for persons who receive SSI or SSDI benefits, and NJ DHS' Managed Long Term Services and Supports program.

A major systems change in the redistribution of services for children and adolescents under age 16 with developmental disabilities was implemented. Access to care for those children and adolescents has been reassigned to the DCF, and they are also charged with collaboration with the Department of Education (DOE) and DHS's Division of Developmental Disabilities (DDD) to facilitate transition to adulthood services. At age 18 or high school graduation, youth/young adults' services are the responsibility of the DHS's DDD. Training on this systems change, as well as continued training on DHS' DDD and DCF's Children's System of Care Initiative affecting adolescents with developmental disabilities, is occurring with regularity among the SCHS CMUs. Collaboration with intergovernmental and community partners including DDD, DCF, NJ Council on Developmental Disabilities, Boggs Center, SPAN, the Arc, Traumatic Brain Injury Association and families is critical to appropriate access to services and supports. Identification and monitoring of transition to adulthood needs for CYSHCN and their families served through SCHS CMUs statewide is in process as well. County-specific transition packets including resources related to education, post-secondary education, vocational rehabilitation, housing, guardianship, SSI, insurance, and Medicaid/NJ FamilyCare are shared with families and linkage with community-based supports is provided. State staffs monitor the SCHS CMU's efforts to inreach and

outreach to CYSHCN regarding transition, and documentation of goals related to transition on adolescents' individualized service plans.

Aligned with the Title V CYSHCN programs and funded by Part D of the Ryan White Care Act, the NJ Statewide Family Centered HIV Care Network remains a leading force in providing care to women, infants, children, youth (WICY) and families infected and affected by HIV disease in the State. Consequently, there is ongoing collaboration across systems within the Division of Family Health Services' Maternal Child Health and CYSHCN's programs, and the Ryan White Part D program to support WICY needs in the community. NJ ranks third in the nation for pediatric cases. Of youth 13-24 years, 1,045 were living with HIV/AIDS in 2015. Through diligent efforts to treat and educate HIV-infected pregnant women, the perinatal transmission rate in NJ remains very low. Intensive case management, coupled with appropriate antiretroviral therapy, enables children with HIV to survive into and successfully transition into adulthood.

However, transition to an adult program for CYSCHN is a critical decision and one that must be planned appropriately to ensure the youth remains in care. In 2013, the Title V CYSHCN program critically reviewed transition to adulthood across its community-based services, and presented a poster depicting NJ's experience at the annual AMCHP conference. Although Title V will continue to assess youth's progress toward transition and linkage with community-based supports, the SCHS CM and SPSP programs are exploring the development of standardized needs assessment and quality indicators to better measure NJ CYSHCN's experiences.

II.F.1.e. CSHCN

The population domain of CSHCN includes NPM #11 and #12 which were covered in the previous Adolescent / Young Adult Health domain and SPMs 3, 4 and 5 which impact NOMs 13, 15, 16, 17, 18, 19, 20, 21 and 22.

Plan for the Application Year

State Performance Measure 3: Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening and who have outpatient audiological follow-up documented.

An important SPM in the domain of CSHCN is SPM #3 (Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening and who have outpatient audiological follow-up documented) which was selected during the last Five-Year Needs Assessment.

The NJ EHDI Quality Improvement (QI) Stakeholders Committee and Subcommittees met regularly in 2016 to identify tests of change for improvement of screening, diagnostic testing and early intervention enrollment. These committees have been adapted to become three separate learning communities, grouped by their focus of program objectives. Each of these committees met a minimum of four times per year. The Timely Diagnosis Learning Community, the Early Intervention Learning Community, and the Family Engagement Learning Community will be composed of stakeholders who share our common EHDI goals, concerns and commitment. The Learning Communities will include a cohort-based multidisciplinary approach to improve EI access to services, timely hearing screening, language acquisition, enlist family engagement and language, literacy and social and emotional growth for the infants and children of New Jersey. Each committee will include at least one pediatric clinician, one care coordinator and one family member of a deaf or hard of hearing child in addition to other professional and family members.

EHDI staff will continue to work with two or three hospitals each year that have lower-than-average follow-up rates to develop PDSA model quality improvement projects to identify and implement changes at their facilities when possible.

The EHDI program will continue to send hospital-level surveillance data to each hospital with maternity services. A report with their overall statistics is sent annually. In intervening quarters, hospital contacts received a reconciliation list of children who were still in need of follow-up after missed or referred inpatient hearing screening. During 2016 the program used a Plan/Do/Study/Act (PDSA) quality improvement process to determine if a monthly notification to hospitals of children in need of a follow-up improves outcomes. Following the success of this PDSA QI process, the monthly reconciliation process was adopted.

The program will continue annual distribution of audiology facility reports to highlight timeliness of follow-up and identify children with incomplete follow-up testing.

The EHDI program plans to increase efforts to work with the medical home to ensure children are receiving follow-up after referred hearing screening or inconclusive follow-up testing. An extract available in the NJ Immunization Information System (NIIS) allows the EHDI program to identify the name, address and fax number of the medical home provider that has most recently provided immunization data for a child and will use this to send fax-back forms to provider offices to remind providers to refer children for additional follow-up.

The program will continue the grant-supported activities including case management outreach to families in need of hearing follow-up and support by the EI hearing consultants. In addition, two new grant-supported activities, a Deaf and Hard of Hearing Mentoring program and the development of learning communities for parents of children identified with hearing loss are planned. These activities will continue pending continued availability of grant funds. Beginning in 2017, expanded grant-supported activities will include additional efforts to engage parents of children with hearing loss in EHDI program activities and creating a program to provide adult deaf/hard of hearing mentors to families of children that are diagnosed with hearing loss.

EHDI staff will provide educational presentations to hospital staff, pediatricians, audiologists, otolaryngologists, special child health service case managers, Early Intervention Service coordinators, and other health care professionals, focusing on the need to decrease rates of children lost to follow-up. The EHDI program frequently uses webinars to make educational outreach efforts more accessible to the target audiences, decrease staff travel time, and improve efficiency while decreasing costs.

Plan for the Application Year

State Performance Measure 4: Percent of live children registered with the Birth Defects and Autism Reporting System (BDARS) who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services.

SPM #4 was chosen to improve the timeliness and effectiveness of using the Birth Defects and Autism Reporting System (BDARS), which has been an invaluable tool for surveillance, needs assessment, service planning, research, and to link families to services. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928, and since then, linking registered children to health services. Since 1985, NJ has maintained a population-based registry of children with all defects. Starting in 2003, the Early Identification and Monitoring (EIM) Program received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ passed legislation mandating the reporting of Autism. Subsequently, with the adoption of legislative rules in 2009, the Registry added the Autism Spectrum Disorders (ASD) as reportable diagnoses, was renamed the Birth Defects & Autism Reporting System (BDARS), expanded the mandatory reporting age for children diagnosed with birth defects up to age 6, and added severe hyperbilirubinemia as a reportable condition. The system refers all living children and their families to our SCHS Case Management Units via the BDARS direct link to the Case Management Referral System (CMRS).

In 2016, CDC funding continues to assist the Program in making improvements to the Birth Defects Surveillance System. The BCSR will continue making improvements to the Birth Defects & Autism

Reporting System (BDARS), CMRS, Pulse Oximetry, and Exceptional Events Module to improve their ease of operation and efficiency.

BDR staff will continue to provide training, on an as-needed basis, to birthing facilities, autism centers, Case Management Units, and other agencies in the use of the electronic BDARS and its modules. Staff will continue to monitor the use of the electronic BDARS, and will assist reporting agencies with concerns. In addition, BDR staff will continue to review the quality of the data in the BDARS and its modules.

Site visits will continue to be conducted in each of NJ's birthing hospitals and SCHS CMUs to ensure proper usage of the BDARS and CMRS as needed. FCCS staff reviews the CMUs' performance in linking referred families to services. FCCS staff provide ongoing feedback and technical assistance to SCHS CMUs on a statewide, county-level, and individual-level basis.

BDR staff will continue to work with the agencies to ensure complete and appropriate referral to services. BDR staff also will be working with non-traditional reporting sources, e.g., FQHCs, and facilities from bordering states to register children with birth defects and/or special health care needs. Building upon information visits conducted in FFY 2013, Federally Qualified Health Centers will be encouraged to report children diagnosed in their facilities.

Surveillance activities will expand due to the increase in readily available electronic data. These will include identifying any relationships between diagnoses, geographic and temporal patterns, and other descriptive statistics.

Plan for the Application Year

State Performance Measure 5: Average age of initial diagnosis for children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder.

	2009	2010	2011	2012	2013	2014	2015
Annual Indicator SPM #5	4.4 years	4.2	4.6	4.7	4.8	5.3	5.0

Notes - Data has not yet been subject to quality assurance reviews.

SPM #5 was chosen to measure the timeliness of diagnosing autism in children. Early diagnosis is important for initiation of services, as children who receive services at an early age have better functional outcomes. Based on the most recent data available from the BDARS, the average age of initial diagnosis of an Autism Spectrum Disorder of children reported to the NJ Autism Registry is 5.0 years old. Although there is no timeline for diagnosing autism, the Registry encourages all reporting agents to quickly report children diagnosed with the Autism Spectrum Disorder so that families can be linked to SCHS Case Management.

While the causes of autism are not known, receiving intensive services early in a child's life can improve development in speech, cognitive, and motor skills. Appropriate diagnosis at an early age is an important precursor to ensuring that families gain access to early and intensive intervention. In NJ, the average age of initial diagnosis of an Autism Spectrum Disorder of children reported to the Registry increased from 4.8 in 2013 to 5.3 2014. We believe this is due to Registry reporters being more behavioral health units who typically treat children with Asperger's Disorder. The average age of a child with Asperger's is considerably higher than a child with either autistic disorder and/or pervasive developmental disorder-not otherwise specified, 8.3 years old, versus 4.6, and 4.9 respectively. Two important activities in the upcoming years that will change the reporting of age of first diagnosis in the Registry is the rewriting of the Autism Registry rules and the redesigning of the Birth Defects and Autism Reporting System (BDARS) that will capture the age of the child when he or she was first diagnosed as opposed to the date

of first diagnosis. The new rules will be tied to the new Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 criteria for autism spectrum disorders and eliminate the reporting of the specific disorders of autistic disorder, Asperger's disorder, and pervasive developmental disorder –not otherwise specified (PDD-NOS).

In order for this performance measure to be accurately determined, patients who are under the age of 22 with autism in NJ need to be reported to the Autism Registry by licensed health care providers who have either diagnosed them or are providing follow-up care and have the full information regarding the child's date of first diagnosis. BDARS staff have conducted outreach to educate and inform physicians and health facilities about the Registry, how they can register children with autism living in NJ, and the rules regarding the Registry. Registry staff have visited and trained staff from medical centers specializing in child development, developmental evaluations, and behavioral health. Additionally, they have trained staff from many private pediatric practices that follow older children with autism through annual well visits. Registry staff have also trained several psychiatric/behavioral departments located within hospitals including units within Newark Beth Israel Medical Center, University Medical Center of Princeton at Plainsboro, St. Clare's Medical Center, and Meridian Health System's which includes Jersey Shore Medical Center and Riverview Medical Center. Staff from the Registry presented information concerning the Autism Registry to state and county case managers as part of training on the case management electronic component to the BDARS and they continue to retrain new staff within health facilities as needed. Staff have also created materials for both providers and families about autism and these materials have been translated into multiple languages including Spanish, Korean, Polish, Hindi, and Arabic. There is also information about the Autism Registry on the DOH website and staff continue to make conference presentations and exhibits.

NJDOH has also addressed this performance measure by working with the NJ Chapter of the American Academy of Pediatrics and the Elizabeth M. Boggs Center on Developmental Disabilities, NJ's University Centers for Excellence in Developmental Disabilities (UCEDD), in reaching out to various health care providers and distributing information and trainings on the Learn the Signs, Act Early campaign that educates providers on childhood development, including early warning signs of autism and other developmental disorders, as well as to encourage developmental screenings and intervention. In addition, the Governor's Council for Medical Research and Treatment of Autism has funded additional clinical centers in their pursuit to create a NJ Autism Center of Excellence (NJACE).

NJDOH will continue to focus on the importance of early identification of autism. Registry outreach efforts will continue with harder-to-reach providers such as office-based pediatric offices and those not affiliated with a major hospital through mailings and collaboration with other state Departments such as the Department of Education. Providers with less timely reporting to the Registry will continue to be contacted and reminded of the mandate to report and of the importance of the linkage to SCHS Case Management Units. The case management component of the BDARS will allow for an electronic assessment of referral rates. Registry staff will be able to use these reports to monitor timeliness as well as numbers.

The NJDOH is committed to continuing efforts to reduce the age of the first diagnosis to of autism. The Governor's Council for Medical Research and Treatment of Autism will continue to fund new grantees in their efforts of early identification of autism in children. Additionally, Early Intervention Systems will

continue their efforts with such providers as speech pathologists, occupational therapists and so forth who will act as a basis for early referral of children at risk for autism.

**Annual Report (Last Year's Accomplishments)
State Performance Measure 3:**

Provisional data indicates that for 2013, 82.1% 2016, 85.4% of infants received follow-up after referring on inpatient screening. Since follow-up exams are still occurring on children born at the end of 2013/2016, we expect that the rate will increase when final data is available. We anticipate the final rate will be level with prior years.

Table SPM #3: Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening and who have outpatient audiological follow-up documented.

	2008	2009	2010	2011	2012	2013	2014	2015	2016
Annual SPM#3 Indicator	74.2%	78.9%	86.1%	86.0%	86.4%	88.2%	85.8%	86.0%	85.4%
Numerator	2246	2364	2444	2451	2131	1945	1821	1869	1771*
Denominator	3026	2997	2837	2850	2467	2205	2122	2173	2073*

*Note – Data for 2016 is incomplete, follow-up reports are still being received for these children and the final rate is expected to exceed this rate.

The Early Hearing Detection and Intervention (EHDI) program is responsible for assuring newborn hearing screening goals are met, including assuring audiological follow-up for children that did not pass initial screening. The following activities were completed in 2016 to achieve program goals:

- Members of the multidisciplinary EHDI Quality Improvement Stakeholder Committee continued regular conference call meetings during 2016. This committee developed aim statements and four subcommittees were established (medical home, audiology, hospital refer follow-up, and early intervention) with the goal of developing and implementing small tests of change. The Plan-Do-Study-Act (PDSA) model of quality improvement is being utilized for these activities. In September 2016, this process was amended to become three separate Learning Communities, grouped by their focus of the program objectives. Each of these communities will meet a minimum of four times per year. The Timely Diagnosis Learning Community, the Early Intervention Learning Community, and the Family Engagement Learning Community will be composed of stakeholders who share our common EHDI goals, concerns and commitment. The learning communities will include a cohort-based multidisciplinary approach to improve EI access to services, timely hearing screening, language acquisition, enlist family engagement and language, literacy and social and emotional growth for the infants and children of New Jersey. Each committee will include at least one pediatric clinician, one care coordinator and one family member of a deaf or hard of hearing child in addition to other professional and family members.
- Completed the annual update to the NJ Pediatric Hearing Health Care Directory, a listing of audiologists, hearing aid dispensers, and otolaryngologists who provide services to young children. The Directory is available on the internet at www.hearinghelp4kids.nj.gov.
- Trained 6 new users on the EHDI reporting module in the NJ Immunization Information System (NJIIS) which is used by audiologists and other practitioners who are conducting hearing follow-up to report outpatient exams. The EHDI program receives approximately 89% of reports entered by providers through this Web-based application and the rest are sent to the program on paper forms.

- Continued use of HRSA EHDI grant funding for county-based special child health services case management staff to conduct follow-up phone calls to parents and physicians of children in need of hearing follow-up. During 2016 the case managers contacted approximately 800 families.
- Continued use of HRSA EHDI grant funding for one of the Early Intervention (EI) program’s Regional Early Intervention Collaborative’s (REIC) to provide two part-time consultants who specialize in working with children with hearing loss. They have an initial phone conversation with parents of children who have recently been diagnosed with hearing loss to review EI services and discuss communication options for children with hearing loss. The consultants participate in the initial early intervention family meetings via remote access, using laptops with web-cameras. The consultants served a total of 150 families during the year.
- The EHDI Monthly Reconciliation Report is distributed to individual hospitals detailing children still in need of additional audiological follow-up after not passing inpatient hearing screening. This serves as a notice to hospitals of babies still in need of reminder contact. In addition, a report including statistics comparing the individual hospital to statewide statistical averages is sent annually.
- Continued annual distribution of a report to provide audiology facilities with feedback on the timeliness of follow-up for children seen at their facility after not passing inpatient hearing screening. The report also includes statistics on the timeliness and completeness of the documentation of their results.
- Presented information in multiple formats including conference calls, webinars, and in-person presentations on a variety of EHDI-related subjects to varied audiences which included parent support staff, audiologists, Case Management and Service Coordinators and hospital birth certificate clerks. In 2016 in-person presentations included presentations at the New York Mid-Atlantic Consortium for Genetic and Newborn Screening Services Summit and at the 2016 National Early Hearing Detection and Intervention Conference in San Diego, CA.

b. Annual Report (Last Year's Accomplishments)
State Performance Measure 4:

NJ has been very successful in linking children registered with the Birth Defects Registry (BDR) (also known as the Special Child Health Services Registry) with services offered through our county-based Special Child Health Services Case Management Units (CMUs). However, the system did not track children and families to determine if and what services were offered to any of the registered children. To address this weakness, added in 2012, the Case Management Referral Systems (CMRS) is used by the CMUs to track and monitor services provided to the children and their families. It electronically notifies a CMU when a child living within their county has been registered. Also included in CMRS is the ability to create and modify an Individual Service Plan (ISP), track services, create a record of each contact with the child and child’s family, create standardized quarterly reports and other reports, and register previously unregistered children.

State Performance Measure 4: Percent of live children registered with the Birth Defects and Autism Reporting System (BDARS) who have been referred to NJ’s Special Child Health Services Case Management Unit who are receiving services.

	2012	2013	2014	2015	2015
Annual Indicator SPM #4	36	50	84.7	88.9	90.1
Numerator	1747	3508	11,089	13,696	13,6346

Denominator	4875	7047	13,096	15,404	15,135
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Note: 2012 data was based upon the time period of February – September 2012 due to implementing the CMRS in January 2012. The numerator reflects all children whose records contain an ISP objective begin date or perform date within the FFY 2013 (2674) or were referred to the Early Intervention Program (432) or whose records indicated that the child’s goals were achieved, but there was no record of any services (402). The denominator reflects the number of children referred from the BDARS (7047). There also were 471 children whose case status were active, but had no record of any services. There were 1,452 children whose families did not respond to any contact attempt by the Case Management Unit.

Beginning in 2014, definitions and inclusion criteria were expanded. The numerator reflects all children whose record has any of the five following criteria for services:

1. Case closed within FFY with a reason of “goals achieved”
2. Child referred to Early Intervention within FFY
3. Individual Services documented with a begin and/or end date within FFY
4. Individual Service Objectives documented with a perform date within FFY
5. Case Management Actions (excluding any letter correspondence that is part of an initial letter series) documented with a date performed within FFY

These children must have received any of these services within a given FFY and registered with the BDARS (registration date not restricted to FFY).

The denominator represents the number of children served by SCHS Case Management in FFY who had been registered with the BDARS regardless of registration date (i.e., the numerator) plus any additional children who were registered and released to case management within a given FFY but did not receive services as currently defined (FFY16 n=1,501).

CMRS allows CMUs to receive registrations in real time, enables faster family contact, and more rapidly assists a registered child in gaining access to appropriate health and education services.

In 2013, CDC continued to fund the BDARS through a cooperative agreement for improvements in the Birth Defects Surveillance system. Rutgers, Bloustein Center for Survey Research (BCSR) continued the deployment of CMRS for the BDARS. During and after deployment, the BCSR continued to work with staff from both the EIM Program and the SCHS county-based CMUs to identify and correct issues in the case tracking and management component of the BDARS. In 2014, within the CMRS component of BDARS, the BCSR created and implemented an Exceptional Event module in collaboration with BDAR and Family Centered Care Services (FCCS) staff. The Exceptional Event module was originally intended to track families affected by Super Storm Sandy using Social Services Block Grant (SSBG) funds. However, team collaboration suggested the expansion and adaptability of this module to track other natural disasters, interpersonal family crises, and other ‘exceptional events’ that may impact the needs of children with special health care needs and their family. In 2016, FCCS provided funds to BCSR to further expand CMRS to include additional tracking for the Medical Home for CYSHCN initiative.

The Pulse Oximetry Module continues to collect information on children who failed their newborn pulse oximetry screening test, which is used to identify children at risk for critical congenital heart defects (CCHD), which may not be apparent at birth. NJ is the first state in the nation to integrate the CCHD screening with their birth defects registry. Each month EIM Program staff review information from the Pulse Oximetry Module to determine the final diagnosis of a child who failed the screening test. This review involves determining whether the child has been diagnosed with a CCHD by reviewing BDARS registrations and contacting the hospital that performed the screening test.

BDR staff continued to provide training to birthing facilities, autism centers, and CMUs in the use of the electronic BDARS. They also continued to assist the units as they transition from the paper-based system to the electronic system.

In 2014, the SCHS Registry:

- Processed registrations for over 9,200 children with birth defects and other special health needs,
- Referred nearly 7,400 families to the SCHS CMUs, and

- Received over 2,400 new autism-related registrations, excluding anonymous registrations.

BDR staff continues to collaborate with staff from FCCS and BCSR to identify and correct issues related to the BDARS and the CMRS to improve its ease of use and efficiency. In 2015, CDC continues to fund the Program through a cooperative agreement for improvements in the Birth Defects Surveillance System. The BCSR will continue making improvements to the BDARS, CMRS, and the Pulse Oximetry and Exceptional Event Modules. The BDR staff will continue to work with the hospitals and other agencies to ensure complete reporting, especially with the birthing hospitals to ensure all children who failed their pulse oximetry screening test are reported through the BDARS.

Site visits will be conducted in each of NJ's birthing hospitals to audit their reporting through the BDARS. Facilities having the lowest levels of appropriate reporting, based upon results of the audits, will receive remedial assistance from staff of the BDR. The BDR staff will continue to identify non-traditional reporting sources, e.g., FQHC, as a means to ensure all families with special health care needs children will be identified and referred to the appropriate CMU for services.

FCCS staff revised annual site visit audits to include protocol-based review of electronic records in CMRS. In these electronic record reviews, staff assessed key functions and expectations of the CMUs and evaluated Individual Service Plans to assess linkage to services. FCCS staff continues to review electronic documentation of the six key performance indicators (e.g., medical home, transition to adulthood), with an expectation of refining how this information is collected within CMRS.

b. Annual Report (Last Year's Accomplishments) State Performance Measure 5:

The NJ Autism Registry is the largest mandated autism registry in the country with 23,000 children registered as of November 2016. We are the only registry that includes children up to the age of 22 and refers them to case management services. We serve as a model registry and continue to provide technical assistance with other states considering a Registry, such as Massachusetts. In FY 2014, over 1,800 children were newly reported to the BDARS including all children with a diagnosis of autistic disorder, Asperger's syndrome, or pervasive developmental disorder- not otherwise specified and who had information about the date of first diagnosis. Staff has stressed the importance of quickly reporting children diagnosed as having autism by continuing to provide outreach about the Autism Registry through conference presentations and focused meetings. Staff participated in several exhibits including the Annual School Health Conference sponsored by the NJ Chapter of the AAP and have presented to a number of private pediatric offices throughout NJ. Staff continues to send out mailings on a periodic basis to newly identified providers and have recently deployed a new Autism Registry webpage (http://www.state.nj.us/health/fhs/sch/autism_registry.shtml) which will include information for parents, providers, and researchers.

Providers with untimely reporting were contacted and reminded of the mandate to report and of the importance of the linkage to SCHS CMUs. The electronic reporting component of the BDARS facilitated timelier reporting by facilities and since the BDARS added the SCHS CMU component, referral of these children to services is significantly faster. A specific target for this current year was conducting our first annual audit of autism reporting facilities in conjunction with the Birth Defects quality assurance audits.

II.F.1.f. Cross-cutting or Life Course

This section concerning the domain of Life Course includes the SPN #8 Improving Integration of Information Systems and SPN #8 Smoking Prevention and the NPM #13 Oral Health and #14 Household Smoking. SPN #8 was added as a SPN recognizing the adverse impact of smoking on all population domains and many NPMs and NOMs.

Plan for the Application Year - NPM #13:

- A) Percent of women who had a dental visit during pregnancy and
- B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Oral health is an important part of general health. The second selected NPM in the domain of Child Health is NPM #13A (Percent of women who had a dental visit during pregnancy) and #13B (Percent of children, ages 1 through 17, who had a preventive dental visit in the past year). Access to oral health care, good oral hygiene, and adequate nutrition are essential components of oral health that help to ensure children, adolescents, and adults achieve and maintain oral health throughout the lifespan. People with limited access to preventive oral health services are at greater risk for oral diseases.

Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children’s health, education, and ability to learn. According to the American Dental Association and the American Academy of Pediatric Dentistry, the dental visit should occur within six months after the baby’s first tooth appears, but no later than the child’s first birthday. Having the first dental visit by age 1 teaches children and families that oral health is important. Children who receive oral health care early in life are more likely to have a positive attitude about oral health professionals and dental exams. Pregnant women who receive oral health care are more likely to take their children for regular dental check-ups.

State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting good oral health include: providing preventive interventions such as age appropriate oral health education, promoting the application of dental sealants and the use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral disease, and increasing the number of community health centers with an oral health component.

Table NPM #13

	2007	2011-2012	2016
Percent of women who had a dental visit during pregnancy	N/A	N/A	N/A
Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	78.7	79.9	N/A

Notes - Source – National Survey of Children's Health (NSCH)

Utilizing an evidence-based strategy approach in future years, the COHP plans to continue the implementation of the following program initiatives while also enhancing efforts that reach school-age children and pregnant women through oral health and hygiene education efforts supplemented with distribution of oral health personal care resources.

COHP has selected the following for ESM #13: preventive and any dental services for children enrolled in Medicaid or CHIP. The ESM was selected since all oral health education activities conducted in the school and community settings serve to improve the oral health status of school age children. The COHP provides age-appropriate oral health and hygiene education, healthy food choice selection, smoke, smoke-less and spit tobacco cessation, and oral injury prevention education along with mouth-guard distribution to prevent oral injury in areas of high need, high risk, where the water is not optimally fluoridated. In addition, numerous special initiatives take place including, “Sugar-less Day to Prevent Tooth Decay, “Projects: BRUSH, PEDs and REACH, and Project SMILE which not only educate students about the importance of preventive oral health practices but also serves to increase family and community awareness due to family and community engagement. In addition, every 2 years, the NJ Department of Health updates the Dental Clinic Directory, “Dial a Smile” that serves as a public resource to assist in identifying providers of clinical dental services. Assisting students and families to establish a dental home

helps them to receive regular dental check-ups and serves to assist in the elimination of costly emergency room dental visits. The “Be a Smart Mouth” oral health Home Visiting Initiative targets first time families and engages the family in oral health and hygiene dialogue. Through the “Be a Smart Mouth” Initiative, NJ home visiting staff are trained to assist families to establish a dental home while educating them about good oral health and hygiene practices. From inception of the “Be a Smart Mouth” oral health training in 2014 until December 2016, 142 home visiting staff from the Healthy Families Model, 97 staff from the Nurse Family Partnership Model and 93 staff from the Parents as Teachers Model or 332 home visiting staff were trained.

NJ has developed and implemented the “Be a Smart Mouth” oral health component for home visiting programs that was implemented in 2014. Through a Statewide effort, over 4,000 families participating in the MIECHV Program were reached and provided oral health education and personal care resources. Families were assisted in establishing a dental home and encouraged to have regular dental exams. In 2015, the COHP continued to develop and implement cutting edge programs such as the continuation of the “Be a Smart Mouth: Home Visiting and Oral Health Perfect Together! Initiative. The integration of oral health into the home visiting program allows trained staff to provide oral health and hygiene instruction and healthy food choices education to first time families. In addition, families were assisted to establish a dental home which helps to reduce hospital emergency room dental visits thereby reducing health care costs. As a result of the 2015 oral health trainings, over 2,600 families were reached. Program efforts continued in 2016 with over 1,400 families reached by staff from the 3 NJ Home Visiting model programs. Efforts in 2016 emphasized oral health literacy. Training included good oral health practices while educating families about the importance of health literacy by reinforcing the American Academy of Pediatrics Policy Statement promoting early literacy development. Families received an oral health care kit that included an age-appropriate story book encouraging parents to read to their children on a daily basis as part of a nightly oral health care toothbrushing routine. Given the success of “Be a Smart Mouth,” the Program will be highlighted in the upcoming NJ Best Practice Collection of the Association of State and Territorial Dental Directors. In addition, “Be a Smart Mouth” training materials were shared with our federal partners and reviewers at the NJ Block Grant Meeting in New York, August 2015. In response to a request from the National Maternal Child Health Resource Center seeking information pertaining to home visiting programs with an oral health component, NJ provided an over view of the “Be a Smart Mouth” oral health training program for review and potential replication on a national level. Program promotion efforts will continue to emphasize “Be a Smart Mouth” as a cost-effective model for replication on a national level with the goal of increasing the number of first-time families who have a dental home and receive a preventive dental visit.

As an upcoming activity through collaborative efforts, the COHP plans to work with staff from the Department of Children and Families and home visiting staff from the three NJ MIEC Home Visiting Programs to determine the following information:

1. Do you have a dentist?
2. Did you have a dental check-up in the last year? (pregnant woman)
3. Did your child have a dental check-up in the last year?

Home visiting staff report families consistently sharing “appreciation for the oral health resources.” In addition, during trainings staff shared their experiences of the on-going oral health dialogue with families that included, “use of oral health products, reminder to take the child to the dentist along with usefulness of oral health resources.”

Project REACH, (Reducing Early Childhood Caries Through Access to Care and Education) is a multidisciplinary train-the-trainer initiative that provides oral health education and resources to educate obstetrical staff about the importance of good oral health with the overarching goal of reducing early childhood caries through dissemination of oral health education and personal care resources for pregnant women and their children and referring them for dental services along with establishing a dental home. Approximately 2,274 multi-disciplinary providers were trained during 2016.

Project PEDs (Pediatricians Preventing Early Dental Disease) is a multidisciplinary train-the-trainer initiative that provides oral health education and resources to educate pediatricians about the importance

of oral health and assist them to incorporate preventive oral health education in the well child visit. Through dissemination of oral health education and personal care resources along with dental care referrals and assistance in establishing a dental home, clients will be encouraged to seek preventive dental care visits. Over 2,500 multi-disciplinary providers participated in Project PEDs trainings throughout the State during 2016.

The NJ Dental Clinic Directory, “Dial a Smile” is a public source of information on dental clinic services in NJ. The Directory has a Statewide distribution to school nurses, hospital emergency room directors and nurse managers, summer camps directors, athletic directors and home visitors from the three NJ MIECHV Programs. Staff use the Directory to refer individuals for dental care services and assist them to establish a dental home. Use of the Directory helps to reduce costly hospital emergency room care for non-traumatic dental services and increases the use of the Statewide network of Federally Qualified Health Centers. The NJ Dental Clinic Directory was updated in 2016.

In aligning with the national trend to incorporate an oral health education component into nursing curriculum, the Director, Children’s Oral Health Program explored options to include an oral health component into the maternity, pediatric and community health clinical experiences at Schools of Nursing in NJ. During 2016, the College of New Jersey, School of Nursing, Health and Exercise Science partnered with the Children’s Oral Health Program to implement an oral health and hygiene and oral health literary initiative for the community health nursing clinical component for senior level nursing students. This special initiative, “Bedtime Bytes” was funded by the Dental Trade Alliance with additional support from the NJ Department of Health. The overarching goal was to increase oral health literacy, assist in the establishment of a dental home, and improve the oral health status of high-risk children while emphasizing the integration of oral health education in School of Nursing curriculum.

National Performance Measure 14:

- A) Percent of women who smoke during pregnancy and
- B) Percent of children who live in households where someone smokes

Adverse effects of parental smoking on children have been a clinical and public health concern for decades and were documented in the 1986 U.S. Surgeon General’s Report. Unfortunately, millions (more than 60%) of children are exposed to secondhand smoke in their homes. These children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections leading to 7,500 to 15,000 hospitalizations annually in children under 18 months; and sudden infant death syndrome (SIDS).

As a result of the many health consequences, the health costs from smoking in pregnancy are significant. The excess costs for prenatal care and complicated births among pregnant women who smoke exceed \$4 billion a year. It has been estimated that a 1% drop in rates of smoking among pregnant women could result in a savings to the US of \$21 million in direct medical costs in the first year. Another \$572 million in direct costs could be saved if the rates continued to drop by 1% a year over seven years. Secondhand smoke also has significant health effects on an infant. Pregnant women exposed to second handsnake have a 20% increased risk of having an infant born with low birth weight, and secondhand smoke exposure also increases the risk for infections in the infant, and even death from SIDS. Children living with smokers are also more likely to get asthma attacks, ear infections, and serious respiratory illnesses like pneumonia and bronchitis due to secondhand smoke. The cost to care for childhood illnesses resulting from exposure to secondhand smoke is estimated at \$8 billion a year. In addition to the effects during the perinatal period, health consequences for older children and adults (whether from directly smoking or from a secondhand exposure) are well documented in the literature and include respiratory infections and disease, cancer, and death.

ESM 14.1 was selected to monitor and promote preventive dental services among NJ children enrolled in Medicaid or CHIP.

Tables NPM 14A & B:

A) Percent of women who smoke during pregnancy

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
14 A. Percent of women who smoke during pregnancy	15.9	14.7	13.9	15.5	18.9	17.8	16.9	15.8	16.9	14.2

Notes - Data is from the NJ PRAMS Survey in the NJ SHAD System
<https://www26.state.nj.us/doh-shad/query/selection/prams/PRAMSSelection.html>

B) Percent of children who live in households where someone smokes

Annual Objective and Performance Data	2003	2007	2011-2012	2016
14B. Percent of children who live in households where someone smokes	28.7	19.7	20.3	NA

Data Source: National Survey of Children's Health (NSCH)

**Plan for the Application Year (Plan for the Coming Year)
National Performance Measure 14:**

Plans for the upcoming year to address NPM #14 include:

Promoting Mom's Quit Connection (MQC) to expand reach to pregnant and parenting mothers in NJ;

- Train prenatal health care providers to screen and refer smoking adolescent and adult patients (with a specific focus on pregnant/postpartum mothers).
- Train statewide prenatal providers to generate an automatic electronic referral for pregnant smokers identified during the Perinatal Risk Assessment (PRA) process. The Southern New Jersey Perinatal Cooperative is currently piloting PRA electronic referral to MQC in four pilot sites in the South. PRA is being used more and more frequently in the state and an automatic referral would increase the reach of MQC across NJ.
- Conduct an extensive public awareness campaign re availability of MQC for pregnant women who smoke. Use no-cost and low-cost television and radio advertisements, many of which are available from the Centers for Disease Control and Prevention.

Increasing Capacity for Direct Service in NJ;

- Continue to expand MQC's existing services to enable face-to-face counseling in the Northern and Central regions of the state, handle increased volume of calls and requests for face-to-face counseling resulting from outreach activities, and expand activities into the postpartum period to decrease the likelihood of relapse.
- While MQC does not currently turn away postpartum women, because of limited funding, they do not actively outreach to or offer programming specifically for postpartum women. Because of the high relapse rate in postpartum women, it is essential to expand programming to address this population's needs.

Preventing relapse after delivery;

- Develop Pregnant Smoker to Stay Quit Mom interactive online app and social networking site to connect women with cessation services, provide mechanism for registering/intake survey, offer stay quit support (e.g., online chat groups for parenting moms), and provide targeted and general cessation information.
- Develop a personalized quit plan using the newly developed online app and send personalized Text to Quit messages to pregnant women and new mothers.

Preventing young people from starting to use tobacco is the key to reducing the death and disease caused by tobacco use. Adolescent smoking and smokeless tobacco use are the first steps in a

preventable public health tragedy. Adolescent users become adult users, and few people begin to use tobacco after age 18. Current cigarette use among NJ high school students declined sharply during 1997–2003; however, rates have remained relatively stable over the past several years.

In addition to price increases, several strategies can achieve a substantial reduction in youth consumption. These include limiting youth access to tobacco, strong community-based programs concentrating on secondhand smoke, mass media campaigns combined with community-wide interventions, and evidence-based school health programs. However, initiatives to reduce youth smoking must be maintained and accompanied by changes in adult behavior. Policy makers must consider approaches that sustain delayed initiation into adulthood. Comprehensive, effective, and sustainable tobacco-control programs, as well as tobacco cessation programs, are essential to reduce tobacco-caused disease, death and disability.

Annual Report (Last Year's Accomplishments) Annual Report NPM # 13:

- A) Percent of women who had a dental visit during pregnancy and
- B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

The Children's Oral Health Program (COHP) has over a 31-year history of providing interactive, age-appropriate oral health education programs to school-age children throughout the State. During the 2015-2016 school year, approximately 80,000 students in high-risk areas where the water is not optimally fluoridated received oral health/hygiene education and oral health personal care resources. During that school year, over 13,000 students participated in the voluntary school-based fluoride mouth rinse program, "Save Our Smiles," and over 2,000 kindergarten and first-grade students participated in the Project: BRUSH initiative that engaged the school and local community with oral health messages throughout the year. Other key programs included "Sugar-Less Day to Prevent Tooth Decay" carried out in the 21 counties of the State with over 1,400 fourth-grade students participating. Efforts to target multidisciplinary obstetric, pediatric, medical, nursing and home visiting staff resulted in educating approximately 5,100 providers through train-the-trainer efforts to incorporate oral health care instruction in the patient and home visiting setting.

During 2016, the NJ Dental Clinic Directory, "Dial a Smile" was updated and distributed to over 3,500 school nurses, WIC sites, summer camps, special needs children's programs, and the NJ Home Visiting Programs in efforts to assist clients in securing a dental home and increasing access to dental care services.

A variety of publications including the "Miles of Smiles" annual school newsletter was mailed to over 3,300 schools while the "Oral Health Facts for Women, Infants, and Children" newsletter was provided for WIC Coordinators throughout the State.

While the overarching goal of the COHP is to improve the oral health status of school-age children through a variety of interactive oral health education programs, special initiatives are also conducted by the Program. During the 2015-2016 school year, Project: BRUSH an interactive oral health awareness campaign that promotes good oral health practices for children in grades K to 1 reached approximately 2,000 students and included the "Ask a Dental Hygienist" activity. "Sugar-Less Day to Prevent Tooth Decay" engaged fourth-grade students, school nurses, and art and classroom teachers in themed poster contests. This successful initiative targeted approximately 1,400 students and enjoyed press coverage in major Statewide newspapers. In an on-going effort to collaborate with other Programs in the Division, the COHP collaborated with the Adolescent Health Program and conducted "Sugar-Less Day to Prevent Tooth Decay" for 6th grade students in the southern region of the State.

Project PEDs, "Pediatricians Preventing Early Dental Disease" continued to be implemented in select FQHC sites as a train-the-trainer model reaching over 2,500 patients. The initiative highlights the importance of engaging and educating a multidisciplinary pediatric staff regarding the importance of addressing oral health care and referral for dental services during the well child visit.

Project: REACH, "Reducing Early Childhood Caries through Access to Care and Health Education," is an oral health education initiative targeting a multidisciplinary obstetric staff in federally qualified health centers throughout the State reached over 2,000 pregnant women emphasizing the oral-systemic health link and providing resources for dental care referral. Women receive "Oral Health Care Starter Kits" for personal and infant oral health care.

Project PEDs, "Pediatricians Preventing Early Dental Disease" continued to be implemented in select FQHC sites as a train-the-trainer model reaching over 3,100 patients. The initiative highlights the importance of engaging and educating a multidisciplinary pediatric staff regarding the importance of addressing oral health care and referral for dental services during the well child visit.

Project: REACH, "Reducing Early Childhood Caries through Access to Care and Health Education," is an oral health education initiative targeting a multidisciplinary obstetric staff in federally qualified health centers throughout the State reached over 2,100 pregnant women emphasizing the oral-systemic health link and providing resources for dental care referral. Women receive "Oral Health Care Starter Kits" for personal and infant oral health care.

[Medicaid's Early and Periodic Screening, Diagnostic and Treatment \(EPSDT\)](#) program offers comprehensive preventive child health services to all Medicaid-eligible children under age 21 including periodic physical exams; hearing, vision and developmental screenings; screening children for elevated blood lead levels; vaccines; health education; and dental inspections and referrals. Medicaid in NJ is administered by the Division of Medical Assistance and Health Services (DMAHS) in the NJ Department of Human Services. The performance on this indicator has improved greatly and according to the 2011 Annual EPSDT Participation Report.

Dental initiatives undertaken by DMAHS to promote utilization of dental services include:

Oral Health Stuffer – "Keeping Your Child's Smile Healthy" was updated in 2012 to indicate age referral to dentist should occur by the age of 1. Language was revised to provide information in layman's terms while educating the consumer on dental terms.

Dental Advisory Council - meets three times a year, but is also convened for special projects. The Council's activities include study of priorities, standard of care, quality measures, barriers to care and access strategies, utilization strategies, program benefits and cost of care. The council prepares specific recommendations to DMAHS and interprets goals and policies for professional and community interest groups.

Medical/Dental Directors Meetings – These meetings occur two to three times a year and are a forum to allow DMAHS to communicate directly with the medical and dental directors for the NJFC-MCOs on interpretations, expectations or revisions to policies as set forth in NJ Administrative Code (N.J.A.C.) or the HMO Contract.

Insure Kids Now Website – Information on the dental benefits available to children enrolled with NJFC/Medicaid is posted on this site along with the names and contact information for dentists seeing children by HMO and State Fee for Service.

Annual Report (Last Year's Accomplishments) National Performance Measure 14:

Initiated in 2001 with funding from the NJDOH-Comprehensive Tobacco Control Program, Mom's Quit Connection (MQC) is NJ's maternal child health smoking cessation program. There have been changes in the services provided and their capacity to be a statewide program through the years based on availability of funds. MQC's trained Tobacco Dependence Specialists utilize a proactive behavior modification model, offering face-to-face individual counseling at the referring health care facility, onsite group counseling or telephone counseling to assist clients in developing a customized quit plan. From July 1, 2013 - June 29, 2014, there were a total 504 referrals to MQC case management: 274 were fax

referrals, 32 were self-referrals, and 198 were referred through the PRA system. Of the 139 open MQC clients for this grant year, 70.5% either decreased their consumption or quit smoking. During that same time 72 face-to-face intakes were completed and 37 telephonic intakes were completed. A total of 2,440 client contacts were made through phone, email, in person or mail. During this year, 106 clients received a total of 380 sessions: 200 sessions were face-to-face and 180 were telephone sessions.

The program was expanded during FY 2015 and Mom's Quit Connection (MQC) was able to develop a multi-pronged and comprehensive statewide approach to perinatal smoking cessation activities. The new activities include:

- Promoting Mom's Quit Connection (MQC) in order to further expand its reach to pregnant and parenting mothers in NJ.
- Increasing capacity of Mom's Quit Connection with respect to direct services for pregnant and parenting mothers statewide.
- Preventing relapse after delivery.

MQC provides free onsite Ask, Advise, and Refer Brief Intervention training to maternal-child healthcare providers, hospital staff and physicians, medical and nursing schools, MCH consortia, medical associations, community and social service agencies statewide. Upon completing the training, MQC provides technical assistance to clinicians and office staff in implementing the fax to quit referral process and ongoing cessation support as a routine component of care. In FY 2014, there were a total of 40 educational programs on the dangers of smoking and the risks of exposing children to secondhand and thirdhand smoke with 1,178 participants for this grant year. Staff conducted 31 Ask, Advise, and Refer: Brief Intervention trainings to a total of 284 professionals.

II.F.1.f. Other Program Activities

During CY 2016, the Family Health Line received and assisted 10,322 calls, and made 7,726 referrals which is a 29% increase in calls from CY2015 (7,974 calls). The Reproductive and Perinatal Health Services monitors the grant with the Family Health Line that is a component of the Center for Family Services, Inc. The Reproductive and Perinatal Health Services provides the Family Health Line with consultation, technical assistance and educational material support to facilitate its participation in community events and networking. The Family Health Line employs three clinical staff members who are responsible to answer the Perinatal Mood Disorders Speak Up When You're Down calls. They screen the callers and coordinate working with Mental Health Providers.

II.F.2. MCH Workforce Development and Capacity (concise)

(<35,000 characters for II.F.2., II.F.3., II.F.4. & II.F.5.)

States should use this section to describe actions taken to improve the capacity of the MCH workforce in the state, including changes in noted strengths and needs. The state's description of the MCH workforce should identify any changes to the workforce funded by Title V, as well as the current capacity of the workforce within the state to address the needs of the MCH population. States should also describe critical workforce development and training needs of state Title V staff.

NJDOH has identified through the State Health Assessment, the State Health Improvement Plan and the Departments' Five Year Strategic Plan, the need to improve the public health workforce in the areas of access to care, quality improvement, systems integration and population health management. MCH workforce development and capacity is also a priority for the Division of Family Health Services (FHS). As such, the FHS developed and has initiated an MCH Workforce Development and Capacity Plan with the overall goal to prepare present and future maternal and child health workers with the skills and knowledge to succeed in the transformed public health system under the Affordable Care Act. Without an adequately trained MCH staff, vital Title V services and functions would not be provided to meet the

needs of the current and future MCH population. Recognizing the value of an experienced and trained staff, the FHS has taken action to improve the capacity of the MCH workforce despite a long-standing hiring freeze.

The FHS implemented the development of succession planning to assure essential functions were considered in long-term planning. During this past fiscal year, cross-training of staff was implemented to assure the ability to maintain key roles in the event of short-term staffing shortages. Changes in the workforce funded by Title V have been quite minimal, reflecting the long-standing MCH priorities and core functions of staff. A Division-wide survey was conducted to identify gaps and needs related to skills development and training. Staff identified several areas such as the need for further training and the development of metrics that are specific to the long-term outcome measurement of maternal and child health in order to maintain the momentum of quality improvement already begun by the NJDOH. Multiple needs were also identified in the areas of data measurement, collection and integration. The majority of staff concurred there was a need for training to help them effectively conduct return on investment (ROI) analyses of MCH programs. As a result of the NJDOH's paradigm shift toward results-based accountability, additional training is needed for staff to become skilled in collecting data appropriate for accountability documentation and to develop accountability metrics to better calculate the ROI for MCH programs tied to public health outcomes. FHS also recognized the need for incorporating the perspectives of families and family representatives into the MCH workforce under the broader umbrella of systems integration. Continued family involvement in health transformation is essential for effective program and policy development related to newly aligned systems.

Critical workforce developmental and training needs of state Title V staff have included extensive training in continuous quality improvement (CQI) to increase the capacity of the workforce to understand, select and use QI methods and tools but also to foster a CQI culture at FHS and eventually to the local agencies that are funded by MCH Block. We have already seen the positive results of this training through the participation of staff in the Collaborative Improvement and Innovation Network (CollIN) to Reduce Infant Mortality, and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Given the diversity of our state, cultural competency trainings continue to be provided to staff as an essential component of their continuing education activities. Other available opportunities have been pursued through trainings offered at national conferences including AMCHP, the MCH Epidemiology Conference, and the MCH Public Health Leadership Institute. Departmental trainings have been offered on Ethics, grant writing, and grants management. Opportunities to supplement staffing through student internships, special temporary assignments, fellowship programs and state assignees have also been successful.

While the NJDOH and the FHS have taken proactive steps in creating a learning organization by providing workforce development opportunities, there is still a need for specialized in-house training and educational programs specific to the identified needs of our MCH workforce. Therefore, the Division established a Memorandum of Agreement with the Rutgers School of Nursing and Rutgers School of Public Health to implement training programs that offer continuing education credits to public health, social work and nursing professionals currently employed by the Division. On February 25, 2016, FHS launched the first training session of the MCH Title V Professional Development Training. Through the course of 2016-2017, five training sessions will be offered for staff to attend. MCH Title V Learning Session II occurred June 2016. Learning Session III was held in November of 2016 and Session IV will be held in April 2017. Each learning session will equip MCH staff with the necessary tools to make informed decisions in program management. The content of the training will include the history and current structure of key Title V and Non-Title V MCH Programs serving women, children and families locally and nationally and the elements of program design, planning, and implementation. There will be a focus on program evaluation planning that will entail learning the fundamentals of program evaluation. Participants will acquire skills in how to provide direction for grantees in how to monitor and evaluate the performance and delivery of MCH programs by using performance indicators and measures the health of populations and communities. The training will incorporate the use verbal, written, and cyber skills to communicate health status disparities, analysis of policies and systems, proposals for intervention, and evaluation of performance of health systems to improve health. MCH participants will acquire knowledge about how to incorporate Family Centered Care into practice.

NJDOH continues to participate in programs to increase the Maternal Child Health workforce in collaboration with the National MCH Workforce Development Center. In 2016, NJDOH hosted graduate and undergraduate student front the former Paired Practica Program. The students were instrumental in preventing the Zika Virus through the NJDOH Zika Prevention Kit Initiative. NJDOH disseminated 13,000 Zika Prevention Kits statewide through Women Infant and Children agencies, Local Health Departments and Federally Qualified Health Centers. In June 2017, NJDOH will host a new group of students through the National MCH Workforce Development Title V MCH Internship Program. The Title V MCH Internship program will provide future MCH professionals with experience working in state Title V agencies, with mentorship and guidance from Title V agency preceptors.

The focus on workforce development will continue to be a pivotal component of FHS operations. As such, each staff person has as a requirement under their individualized Performance Assessment Report, a criterion to include a professional development plan for each yearly rating period (October 1 to September 30).

FHS recently evaluated its current and future workforce requirements for the State's MCH Services. The evaluation resulted in reclassification of titles to meet the needs of the changing roles and requirements and keeping aligned with NJDOH's strategic plan. FHS hired employees and are hiring new employees in the title series of Health Data Specialist and Analyst, Research and Evaluation to support the MCH Epidemiology and SCHEIS Programs. Additionally, we are preparing to hire additional Quality Assurance Specialists. Hiring employees in these titles will improve effectiveness and efficiency of the public health system especially in the MCH programs. The vacant positions resulted from retirements, resignations and promotions.

The workforce capacity of MCH service units and programs is described previously in section II.B.2b.ii (Agency Capacity) and Section II.B.2b.iil (MCH Workforce Development and Capacity). This section more completely describes FHS's capacity to promote and protect the health of all mothers and children, including children and youth with special health care needs (CYSHCN). The Maternal and Child Health Services (MCHS) and Special Child Health and Early Intervention Services (SCHEIS) Units ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care through collaboration with other agencies and private organizations and the coordination of health services with other services at the community level.

The mission of the [FHS](#) is to improve the health, safety, and well-being of families and communities in NJ. The FHS works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

Table 1d - Title V Program Capacity and Collaboration to Ensure a Statewide System of Services (See Supporting Document #1) summarizes according to the six MCH population health domains the collaborations with other state agencies and private organizations, the state support for communities, the coordination with community-based systems, and the coordination of health services with other services at the community level.

II.F.2. Preventive and Primary Care for Pregnant Women, Mothers and Infants

The mission of Maternal and Child Health Services (MCHS) within FHS is to improve the health status of NJ families, infants, children and adolescents in a culturally competent manner, with an emphasis on low-income and special populations. Prenatal care, reproductive health services, perinatal risk reduction services for women and their partners, postpartum depression, mortality review, child care, early childhood systems development, childhood lead poisoning prevention, immunization, oral health and hygiene, student health and wellness, nutrition and physical fitness and teen pregnancy prevention are all part of the MCHS effort. The population Domains addressed by MCHS include 1, 2, 3, 4, and 6.

Reproductive and Perinatal Health Services (RPHS), within MCHS, coordinates a regionalized system of care of mothers and children in collaboration with the [Maternal and Child Health Consortia](#) (MCHC). The MCHC were developed to promote the delivery of the highest quality of care to all pregnant women and newborns, to maximize utilization of highly trained perinatal personnel and intensive care facilities, and to promote a coordinated and cooperative prevention-oriented approach to perinatal services. Continuous quality improvement activities are coordinated on the regional level by the MCHC.

Promoting a Life Course perspective, a new request for proposals (RFP) was issued in January 2014 by RPHS and awarded last year called the Improving Pregnancy Outcomes (IPO) Initiative which targeted limited public health resources to populations and communities with the highest need to improve quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Using two models, Community Health Workers and Central Intake, the IPO Initiative will work to improve specific maternal and infant health outcomes including preconception care, prenatal care, interconceptual care, preterm birth, low birth weight, and infant mortality through implementation of evidence-based and/or best practice strategies across three key life course stages: preconception, prenatal/postpartum and interconception.

Also focused on Increasing Healthy Births and improving pregnancy outcomes is the work of NJ as a participant in the National Governors Association Improving Birth Outcomes and the Infant Mortality CoIIN. NJ was awarded the opportunity to participate in the National Governors Association (NGA) Center for Best Practices' Learning Network on Improving Birth Outcomes. This initiative enabled NJ to explore evidence-based strategies shown to be effective in addressing poor birth outcomes. Participation in this NGA Learning Network afforded the NJDOH the opportunity to hold an in-state meeting on January 13, 2014 to explore these critical issues and to set the agenda for the future. The meeting of public and private partners provided a wider awareness of NJ's prematurity rates and other related maternal and child health indicators and discussed the steps necessary to further move the needle on these important health indicators. Partnering departments included the Department of Children and Families, Human Services (Medicaid) and Education.

MCHS has embraced the Fetal Infant Mortality Review (FIMR) Program as a mechanism for quality improvement and improve the system of care to promote healthy births. FIMR is one of the original American College of Obstetricians and Gynecologists (ACOG) Partnership projects. The overall goal of NJ FIMR is to establish a statewide system of fetal-infant mortality review by implementing or expanding FIMR projects with each of the 3 regional MCH Consortia. NJ follows guidelines for planning and implementing community fetal and infant mortality review developed by the National Fetal-Infant Mortality Review Program (NFIMR). The projects use standardized data collection, entry and reporting methods to ensure consistency of the review process throughout the State. This includes using data abstraction and case review summary forms developed by NFIMR and modified by NJ FIMR. NJ is participating with NFIMR as one of the states beta testing the new database.

The NJ Maternal Mortality Review Team is part of a longstanding commitment among healthcare professionals and other concerned citizen to reduce and prevent the number of deaths related to pregnancy and childbearing among NJ residents. A multidisciplinary review team is utilized and the primary focus of the Case Review Team is to identify systems related issues. Recommendations for systems improvement are shared with healthcare professionals and the public through the Maternal Mortality Report. Team recommendations are also used for program planning at the NJDOH.

The major goals of the Perinatal Addictions Prevention Project (PAPP) include providing professional and public education, encouraging all prenatal providers to screen all of their pregnant patients for substance use/abuse and developing a network of available resources to aid pregnant substance using/abusing women. Risk-reduction coordinators working with this project provide ongoing regional professional training, individual on-site training, technical assistance and monitoring, grand rounds training, networking, and a link between regional and local services relating to prenatal substance use/abuse.

Approximately 30% of the pregnant women in NJ were screened for substance use during the past year according to the [Perinatal Risk Assessment](#) volume numbers. The majority of these patients were seen

at public clinics. Referral information is given to those women who are smoking, using drugs and/or alcohol and those who have possible domestic violence issues. Last year there were 125 education programs held for over 1,458 professionals. There were 646 programs held to educate the general public and approximately 16,290 people participated.

NJ successfully applied in 2010 for the Maternal, Infant and Early Childhood Home Visiting Program (MIEC HV) Formula and Competitive Grants to the Health Resources and Services Administration. The goal of the NJ MIEC HV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full implementation of the grant project is being carried out in collaboration with the Department of Children and Families (DCF). Currently evidence-based home visitation services are provided by 67 Local Implementing Agencies (LIAs) providing three national models (Healthy Families America, Parents As Teachers and Nurse Family Partnership) in all 21 NJ counties serving approximately 6,000 families in SFY 2014.

Through the Post-Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. Hospitals and private practitioners are receiving assistance with implementing the law that requires screening and education at specified intervals during the perinatal period. NJDOH offers a PPD helpline (1-800-328-3838) that operates 24 hours per day, seven days a week to provide resources and information to women and their families and friends. In addition, a dedicated Web site (www.njspeakup.gov) provides educational materials such as brochures, videos, books, support groups, FAQs, and other helpful Web sites on postpartum depression and other perinatal mood disorders.

The NJDOH continues to support the provision of Family Planning via a grant with the New Jersey Family Planning League to ensure that family planning services are available in all 21 counties in NJ. Family Planning agencies provide services in cooperation with other NJDOH initiatives according to [Title X national guidelines](#) including: family planning and related preventive health services, such as natural family planning methods; HIV/AIDS and sexually transmitted infections prevention and treatment; services to adolescents; cancer screening (including breast and cervical cancer); nutrition education; preconception and interconception care; infertility services; and counseling on establishing a reproductive life plan.

II.F.2. Preventive and Primary Care for Children and Adolescents

The Child and Adolescent Health Program (CHAP), within MCHS, focuses on primary prevention strategies involving the three MCH domains of Child Health, Adolescent/Young Adult Health, and the Life Course.

An emphasis in Child Health is the prevention of elevated blood lead levels among children under six years of age through collaborative, prevention-oriented outreach and education to parents, property owners, and health care providers. The Childhood Lead Poisoning Prevention (CLPP) Projects use a home visiting model to provide nurse case management and environmental investigations for children less than six years of age with confirmed elevated blood lead levels. Thirteen sites throughout the State receive funding to provide monitoring of retesting, to perform household education and conduct residential property inspections to identify and abate lead hazards. The goal of the CLPP Projects is to promote a coordinated support system for children with elevated blood lead levels and their families through the development of stronger linkages with Special Child Health Services, Medicaid Managed Care Organizations (MCOs), DCF, DOE, Department of Community Affairs, and community-based agencies that provide early childhood services.

Services include a healthy homes assessment tool so that additional health and safety issues in the home can be identified and remediated so that homes are free of disease-causing agents and sources of preventable injuries. NJDOH has established a partnership with MIEC Home Visiting programs that provide services for pregnant women, infants, young children, in addition to resource family homes that provide a safe residential environment for children who are in the foster care system.

Grants are provided to 13 local health departments, with the highest number of cases, to support the provision of nursing case management and environmental investigation services. In addition, Child Health provides grants to three agencies to administer regional coalitions, serving every county in NJ, to provide prevention-focused education and training to parents, caregivers of young children, and property owners and renters. The NJDOH co-administers the New Jersey Healthy Homes Training Center which provides training to health, social services and housing professionals. In partnership with the American Academy of Pediatrics/NJ Chapter, Child Health promotes a nationally-recognized medical home model.

Public outreach and professional education on childhood lead poisoning prevention is conducted by three Regional Lead and Healthy Homes Coalitions.

Since July 2010, Adolescent Health has been implementing School Health NJ, which utilizes the CDC Whole School, Whole Community, Whole Child ([WSCC](#)) model as its framework. This project was introduced earlier in: Preventive and Primary Care for Children and Adolescents.

Three processes are integral for successful implementation of the CSH/WSCC model: 1) establish a School Health Team; 2) assess the school's health policies, programs and practices using CDC's School Health Index (SHI) assessment tool; and, 3) develop, implement and evaluate an action plan based on the results of the assessment. Coordination of these ten components identifies gaps, avoids duplication of activities and improves the efficiency and effectiveness of health programs and services available in the school system.

The current CSH regional grantee agencies, selected through a competitive application process, are responsible for the administrative oversight, training, technical assistance and resource support needed by funded or interested public schools, grades six and above in their respective northern, central or southern region. The goal of this project is to improve the health (physical, mental, emotional and social) well-being of students and school staff and strengthen the health and safety of the school environment. Currently, these regional grantee agencies fund schools to implement evidence-based or best practice school health actions.

Sustainability of healthy school practices and programs can be ensured through community involvement, parent and youth engagement and policy. The Statewide Parent Advocacy Network (SPAN) is funded to implement "Parents as Champions (PAC) for Healthy Schools." This training empowers parents as "agents of change" to facilitate parental action in promoting healthier schools. This project also partners with various state, local and statewide professional organizations to collaborate on improving school and student health to improve their learning and consequently, their life success.

On October 1, 2013, Community Health and Wellness Services was awarded the CDC cooperative agreement DP1305 for the basic and enhanced components of "State Public Actions to Prevent Chronic Disease and Promote School Health." A staff person was recently hired and assigned to work on the school health strategy and coordination between the two service units is planned.

The CAHP successfully applied for and was awarded two new federal grants to prevent teen pregnancy in 2010. The NJ Personal Responsibility Education Program (NJ PREP) and the NJ Abstinence Education Program (NJ AEP) were described in the section on State Priority Need #6: Reducing Teen.

The website - "NJ Parent Link, New Jersey's Early Childhood, Parenting and Professional Resource Center" <http://www.njparentlink.nj.gov> was launched in June 2010 as a web-based resource for consumers and professionals. The website is designed to function as the IT gateway for all State-based services and resources for expectant parents, families with children and NJ children's health, education and welfare professionals. NJ Parent Link includes direct linkages to 15 NJ State executive departments, the Governor's office, the legislative and judicial branches, as well as federal and community resources.

Community-building features include: county contacts & local links listings; tailored subscription services; continuing education/professional development announcements; a children's art gallery; an easy-to-

navigate En Espanol feature and a translation service for over 50 languages. Numerous data collection and quality assurance markers are woven throughout the website's features to maximize assessment capabilities and real time opportunities for collaboration and coordination of shared goals and resources within the early childhood community. Total number of NJ Parent Link website hits from 1/1/2013 to 4/1/2015 was 725,837. In March 2015, 7,625 unique visitors accessed information from the NJ Parent Link website.

II.F.2. Preventive and Primary Care for Children with Special Health Care Needs

NJ maintains a comprehensive system to promote and support access to preventive and primary care for CYSHCN through early identification, linkage to care, and family support. Title V partially supports this safety net which is comprised of pediatric specialty and sub-specialty, case management, and family support agencies that provide in-state regionalized and/or county-based services. It is designed to provide family-centered, culturally competent, community-based services for CYSHCN age birth to 21 years of age, as well as to enhance access to medical home, facilitate transition to adult systems, and health insurance coverage. The Specialized Pediatric Services Programs (SPSP) agencies are a significant resource of pediatric specialty and subspecialty care in NJ, and are used widely by CYSHCN including Medicaid recipients. Although clients are screened for their ability to pay for clinical services, the support provided by Title V enables all CYSHCN to be served regardless of their ability to pay. There is no charge for SCHS CM and family support.

Administratively housed in the Family Centered Care Services (FCCS) Unit these services include 21 county-based Special Child Health Services Case Management Units (SCHS CMUs), one Family Support project, and multiple Specialized Pediatric Services Programs (SPSP); 9 Child Evaluation Centers (CECs) of which 5 house Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder Centers, and 3 provide newborn hearing screening follow-up, and 5 Cleft Lip/Palate Craniofacial Anomalies Centers and a small State operated Fee-for-Service program. Likewise, State and federal collaborations among the FCCS programs and non-Title V funded programs such as the Ryan White Part D Family Centered HIV Care Network (RWPD), Early Intervention System (EIS), Federally Qualified Health Centers (FQHC), medical home initiatives, Supplemental Security Income (SSI), Catastrophic Illness in Children Relief Fund (CICRF) and other community-based initiatives extend the safety net through which Title V links CYSHCN with preventive and primary care.

CYSHCN are referred into NJ's preventive and primary system of care through mandatory and/or informal pathways. Mandatory reporting by medical providers is required for infants/children that rule in for reportable conditions identified via the Newborn Biochemical Screening and the Birth Defects and Autism Registry programs, and in NJ reporting is linked to access to care. The expansion of newborn biochemical screenings to 55 reportable disorders reinforces the continued need to maintain an in-state body of providers to treat children with these conditions, as well as a potential increase in number of referrals to the SPSP agencies, subsequent reporting to the BDARS, follow-up by SCHS CM and the provision of family support. Receipt of referral by the BDARS results in outreach by the SCHS CMUs, whereby families are offered follow-up and linkage to services. Follow-up is recorded in the electronic Case Management Referral System (CMRS), which provides a system for Title V to review and analyze follow-up. Likewise, the SCHS CMUs and SPSP agencies submit registrations of CYSHCN with reportable conditions to the BDARS. Additional formal referral mechanisms that result in linkage to the SCHS CMUs includes the State Data Exchange of SSI applicants under age 16 years and CICRF applicants. Informal linkages to SCHS CM and/or SPSP include self-referral by families, and referral by community-based family support and providers for pediatric specialty/subspecialty outpatient care.

Through Title V support, each of NJ's 21 counties maintains an SCHS CMU partially funded by its Board of Chosen Freeholders to promote access to preventive and primary care for CYSHCN. With parental consent, SCHS CMUs work with the child's parents, physician and/or specialists to evaluate an affected child's strengths and needs; and collaborates with the family and community-based partners to develop an individual service plan (ISP) for the child and family. Medical, educational, rehabilitative, developmental, social, emotional and economic needs of the child and family are targeted. Statewide

SFY 2016 data indicate that 16,365 CYSHCN were served, 11,234 ISPs developed, 5,495 SSI referrals received and 4,431 CYSHCN were on SSI. The age distribution indicates that most CYSHCN served are age 5-13 years (46%), age 1-4 years (20%), birth to 364 days (16%), age 14-19 years (14%), and those over age 20 (2%). Nearly 99% served are documented to have insurance, of which 63% are enrolled in a Medicaid managed care organization. Approximately 25% self-identify as Hispanic, and race data indicates 43% white, 13% black, 4% Asian, 6% more than one race, 5% other, and 28% unknown. Quality assurance is underway to reduce the number reported as unknown. All SCHS CMUs are required to assess the health care needs and insurance status of CYSHCN served.

State Title V staffs, SCHS CMUs and SPSP providers, and SPAN Family Resource Specialists receive training from State agencies such as the NJ Department of Human Services, and the Department of Children and Families to become Informal Application Assistors for Medicaid/NJ FamilyCare programs as well as to learn about Managed Long Term Services and Supports, how to obtain care through the Marketplace, and behavioral services through PerformCare. These trainings build capacity among Title V agency providers to enhance access to primary and preventive care for CYSCHN. For example, an SCHS CM reported being able to assist a parent to problem solve a denial of home health aide services for a 12-year-old with autism and significant developmental delays by advocating on Mom's behalf with PerformCare, her child's school district, and her Family Support Organization. Repeated phone calls, home visits, and written appeals by the SCHS CM supported Mom's efforts to clarify the missing information and resolve her child's needs.

Recognizing that SCHS CM and family support are valuable in assisting families of CYSHCN to access care, Title V works collaboratively with the SCHS CMUs and family support organizations, including Family WRAP. Specific Family WRAP programs include Project Care, Parent-to-Parent and Family Voices New Jersey. SPAN and SCHEIS have continued to identify/develop resources to expand the number of Family Resources Specialists (FRS) trained as support specialists to work on site at the SCHS CMUs or regionally. In addition, Title V, Early Intervention Systems, SPAN, and other community-based partners are collaborating on an AMCHP sponsored "Learn the Signs. Act Early." initiative.

Through collaboration with SPAN, the NJ Chapter, Academy of Pediatrics (NJAAP), SCHS CMUs, SPSP providers, and the Community of Care Consortium efforts are ongoing to improve access to coordinated preventive and primary care through medical home.

Preventive and primary care services are in demand and most recent data indicate that in the number CYSHCN served across SPSP services has remained consistent over the past 2 years; 61,153 (SFY2015) vs. 61,976 (SFY2016). Comprehensive multidisciplinary team evaluation is provided through the CECs to assess the needs of children with congenital or acquired neurodevelopmental disorders including communication, learning, and behavioral disorders. A copy of the team-based plan of care is provided to the family of the CYSCHN and/or their primary care physician of record. In SFY16, 3,286 CYSHCN were seen at the CECs for multidisciplinary evaluations including FAS, and the most frequently diagnosed conditions include Attention Deficit Hyperactivity Disorder (ADHD) (27%), Autism (15%), Developmental Delays (12%), Speech Disorders (11%), and Psychiatric Disorders (10%). Furthermore, more than 51,646 visits were reported. Of note, 50% CYSHCN served were enrolled in one of the Medicaid programs and less than 1% were uninsured.

Access to in-state pediatric specialty and subspecialty care is further provided through NJ's Cleft Lip/Palate Craniofacial Anomalies Centers and Tertiary Care Centers. Multidisciplinary teams ensure that patients receive necessary medical, nutritional, and developmental care, and that there is coordination of care with primary care providers, sub-specialists, hospitalists, and other community-based providers such as FQHCs. A total of 28,608 CYSHCN received evaluations and services through the five Craniofacial Centers and three Tertiary Centers in sfy16. SFY 2016, data indicate that 1,874 CYSHCN were served through the Cleft Centers, of which 59% were insured through State Medicaid program; 30% had some form of private insurance, and 1% of children's insurance status was reported as uninsured/unknown. Approximately 39% were under the age of 1 and nearly 27% were age 5-13 years, reinforcing the need for continuation of coordinated care through school age. Coordination with community-based dental providers including orthodontia remains a challenge, and collaboration with patients' care management

organizations is helpful to resolve access. The Tertiary Centers reported over 26,734 clients served in SFY 2016, with the majority (39%) reported as age 5-13 years. Again, these Centers of Excellence as noted in the NJ Medicaid Managed Care Contract fill a need for specialty care providers that accept Medicaid with nearly 65% served reported being enrolled in a NJ Medicaid/NJ FamilyCare program, and only 1% were uninsured, and less than 1% paying for care on a sliding scale. Specialty services in greatest demand during that same time period include; Cardiology (13%), Gastroenterology (10%), Oncology (10%), Endocrinology (8%), Neurology (7%) and Radiology (7%).

This complement of Centers fills a critical in-State need for access to pediatric specialty and subspecialty care, and the providers are vested in providing family centered care. A family satisfaction survey was launched in 2014 through 2015, to gather family input on their experiences with services and access to care. Findings were made available to all 17 SPSP Centers during fall 2016.

To ensure family participation and address cultural competency, the Centers provide written informed consent guidelines for all aspects of the evaluation, diagnostic and/or treatment services. The confidentiality of records is protected, written procedures regarding access to records is made available to all staff, and the sharing of records is determined by the parents of CYSHCN. Each Center maintains written procedures for parental consent for release of records. The Centers must comply with the Americans with Disability Act (ADA) requirements. Limited English proficiency needs are addressed through access to foreign language interpreters and/or interpreters for the deaf. Of note, the SFY15 family satisfaction survey administered to families of children who received services through an SPSP provider indicated a significant number of English as second language respondents. Of the nearly 1,800 surveys administered, 16% were completed in Spanish. This small but significant finding reinforces the value of language and cultural support. The Centers cannot discriminate through admission policies, hiring practices, or promotional opportunities on the basis of race, religion, ethnic origin, sex or handicapping conditions. CYSHCN with ongoing needs that warrant care coordination are linked with the SCHS CMU located in their county of residence.

Through the Fee-For Service (FFS) program State Title V staffs and SCHS CMUs process requests for assistance with uncovered expenses for medically necessary services such as hearing aids, braces, orthotics, prostheses, and medications to treat asthma and cystic fibrosis. In SFY 2017, 23 CYSHCN received benefits through FFS. 100% of FFS applications are screened for NJ Medicaid, NJ FamilyCare, and/or accurate interpretation of their commercial health coverage and are referred to their county SCHS CMU for supports. The demand for assistance to purchase hearing aids for youth age 18-21 has gradually increased. NJ's Grace's Law and the Affordable Care Act (ACA) have improved coverage, an example being that hearing aid coverage is now considered an essential health benefit. Some families continue to experience gaps in coverage and require assistance through FFS, for example, those with grandfathered plans, certain employer-sponsored plans, and those ineligible for State programs due to residency have found that some challenges remain. Likewise, challenges continue for CYSHCN, families, and providers, in understanding insurance benefits and how to use them, particularly for families with limited English proficiency. Title V staffs, the SCHS CMUs, and SPAN Family Resource Specialists are instrumental in assisting CYSHCN to understand and use their coverage. For example, with the implementation of Grace's Law in 2008, certain health benefit plans were mandated to provide limited coverage of \$1,000 per hearing aid for children 15 years and younger every 24 months. Subsequently, the ACA prohibited annual or lifetime benefit limits on essential health benefits. Consequently, the inclusion of hearing aids as an essential health benefit is a strength for families of CYSHCN; however, the NJ specific \$1,000 benefit limit no longer applies. This change presents the potential for an increase in out-of-pocket expenses for some CYSHCN, and challenges for hearing aid dispensers to renegotiate reimbursement with insurance carriers. To that end, State Title V staffs, the Early Hearing Detection and Intervention Audiologist, and SCHS CM's provide technical assistance to applicants, providers, insurance providers, and Human Resource departments as needed. Furthermore, SCHS is developing a Hearing Aid Vendor Survey as a Continuing Quality Improvement project aimed to structure an educational webinar for vendors.

A priority for SCHEIS is ensuring rehabilitative services for blind and disabled individuals less than 16 years old receiving services under Title XIX. Historically, SCHEIS has addressed the early identification,

outreach to and the support of that special needs population through follow-up of CYSHCN by the SCHS CMUs. Typically, CYSHCN age birth to 21 years of age are identified to the SCHS CMUs in the county in which the CYSHCN resides through the BDARS and the CICRF; by community, family and self-referrals; and through the Department of Human Services transmittal of Social Security Administration's Supplemental Security Income (SSI) data provided via the State Data Exchange.

The SSI transmittal is electronic and enables the NJDOH to conduct monthly uploads of county-specific reports which are then viewable by the SCHS CMUs through the NJDOH's secured web access. The SCHS CMUs outreach to all CYSHCN referred by SSI to screen CYSHCN for need and/or eligibility for the services through the Fee for Service program; offer information and referral; development of an ISP; case management services as needed; linkage with community-based primary and pediatric specialty care, transition to adulthood, family support and social service supports across local, State, and federal programs. With electronic access to their county-specific reports, the SCHS CMUs manage their workflow. In addition, receiving the data electronically has enabled SCHEIS to more accurately track the numbers of CYSHCN referred and served. State FCCS staffs monitor the transmittal and follow-up of SSI referrals by the SCHS CMUs, and status of follow-up has been included as an indicator on the SCHS CMU evaluation tool.

II.F.3. Family/Consumer Partnership

Building the capacity of women, children and youth, including those with special health care needs, and families to partner in decision making with Title V programs at the federal, state and community levels is a critical strategy in helping NJ to achieve its MCH outcomes. FHS has several initiatives to build and strengthen family/consumer partnerships for all MCH populations, to assure cultural and linguistic competence and to promote health equity in the work of NJ's Title V program.

Efforts to support Family/Consumer Partnerships, including family/consumer engagement, are in the following strategies and activities:

- Advisory Committees;
- Strategic and Program Planning;
- Quality Improvement;
- Workforce Development;
- Block Grant Development and Review;
- Materials Development; and
- Advocacy.

This section summarizes the relevant family/consumer and organizational relationships which serve the MCH populations and expand the capacity and reach of the state Title V MCH and CYSHCN programs. **Table 1f** - MCH Organizational Relationships with Partnerships, Collaboration, and Cross-Program Coordination (See Supporting Document #1) summarizes the partnerships, collaborations, and cross-program coordination established by the state Title V program with public and private sector entities; federal, state and local government programs; families/consumers; primary care associations; tertiary care facilities; academia; and other primary and public health organizations across the state that address the priority needs of the MCH population but are not funded by the state Title V program.

The public health issues affecting MCH outcomes generally affect low-income and minority populations disproportionately and is influenced by the physical, social and economic environments in which people live. To address these complex health issues effectively, FHS/Title V program recognizes that a spectrum of strategies to build community capacity and promote community health must include parents and consumers representing the affected populations as integral partners in all activities in order to have full community engagement and successful programs. In order to carry out these functions and address the public health disparities affecting NJ's maternal child health population, FHS/Title V program has incorporated consumer/family involvement in as many programs and activities as appropriate.

NJ has prided itself on its regional MCH services and programs, which have been provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. Partially funded by FHS, the MCHC are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs. The three MCHC are located in the northern, central and southern regions of the state. It is a requirement of the statute governing the MCHC that 50% of their Board of Directors be comprised of consumers representing the diverse population groups being serviced by their organizations.

Recognizing the importance that parent/consumer involvement has in the design and implementation of a program to address issues related to preterm births and infant mortality, the MCH Program incorporated parent/consumer involvement into an FHS major initiative, the Improving Pregnancy Outcomes Project (IPO), which requires grantees to have a Consumer Advisory Council to help guide the program, assist with the evaluation and quality improvement initiatives as well as the design and development of all educational/information materials. Similarly, the Home Visitation Program (MIEC-HV) also requires funded grantees to implement Consumer Advisory Work Groups.

The NJ Title V CYSHCN Program, also referred to as Special Child Health and Early Intervention Services (SCHEIS), partners, collaborates, and coordinates with many different governmental and nongovernmental entities, on federal, state, and local levels, as well as parents, families and caregivers, primary care physicians, specialists, other health care providers, hospitals, advocacy organizations, and many others to facilitate access to coordinated, comprehensive, culturally competent care for CYSHCN. SCHEIS works with programs within the NJ Departments of Human Services (DHS) and Children and Families (DCF) in addressing many needs facing CYSHCN including medical, dental, developmental, rehabilitative, mental health, and social services. DHS administers Title XIX and Title XX services and provides critical supports for ensuring access to early periodic screening detection and treatment for CYSHCN. The State DHS Medicaid, Children's Health Insurance Program Reauthorization Act (CHIPRA) NJ FamilyCare Program, and the Division of Disability Services afford eligible children comprehensive health insurance coverage to access primary, specialty, and home health care that CYSHCN and their families need. SCHEIS utilizes patient satisfaction survey as a means to improve and refine. All trainings provided to grantees are also open to parents/consumers as either participants or speakers. All CYSHCNs educational materials and informational brochures receive input and are reviewed by parents/consumers for health literacy and cultural competence.

SCHEIS collaborates with many offices and programs in DHS to develop and implement policy that will ensure that children referred into the SCHS CMUs and their families are screened appropriately for healthcare service entitlements and waived services. SCHEIS programs including case management, specialized pediatrics, and Ryan White Part D, screen all referrals for insurance and potential eligibility for Medicaid programs, counsel referrals on how to access Medicaid, NJ FamilyCare, Advantage, and waiver programs, and link families with their county-based Boards of Social Services and Medicaid Assistance Customer Care Centers. Program data including insurance status is collected put into a report which is compared with Medicaid data in determining CYSHCN need. Referrals are made to Boards of Social Services, NJ Family Care, Advantage, Charity Care, Department of Banking and Insurance, and Disability Rights NJ for support and advocacy.

The Early Hearing Detection and Identification (EHDI) program within the SCHEIS also recognizes the pivotal role that consumers and parents play in the effective administration of the program. EHDI has an Advisory Council composed of parents of deaf and hard of hearing children and consumers who themselves are deaf or hard of hearing. Participants on the council take part in literature reviews, advise the NJDOH regarding innovations in the programmatic area and assist in the review of operations of the program.

Collaboration between SCHEIS staff, SCHS CMUs and SPSP and the DHS, Division of Family Development (DFD) is essential in coordinating access to care and social services for many of NJ's most vulnerable CYSHCN and their families. The primary tasks of DFD include directing NJ's welfare program, Workfirst NJ (WFNJ), and providing funding, information management services, and administrative

support to the county and/or municipal welfare departments that implement the federally funded Food Stamps food assistance program. The DFD also oversees child care licensing, Kinship supports for families, and child support. The federal SSI benefit program for aged, blind or disabled individuals is also supplemented by DFD. WFNJ recipients who may be eligible for federal SSI benefits can now get free legal help. The DFD has established an agreement with Legal Services of NJ (LSNJ) to assist recipients in either filing for SSI benefits or appealing a denial of benefits.

The DHS Division of Disabilities Services (DDS) and SCHEIS collaborate to promote and facilitate independence and participation for people with disabilities in all aspects of community life. Through its system of Information and Referral (I&R), the DDS supports active information exchange regarding community services and fosters coordination and cooperation among government and community-based agencies. The I&R Specialists commonly refer families of CYSHCN to the SCHEIS CECs, Tertiary Care Centers and Cleft Lip/Palate and Craniofacial Anomalies Centers; SCHS CMUs and family supports. In addition, SCHEIS refers families to the Traumatic Brain Injury (TBI) Fund, TBI Waiver and Personal Preference: NJ Cash and Counseling Program; and the Medicaid Personal Care Assistant (PCA) services. The SCHEIS regularly uses these DDS resources to assist families of CYSHCN to find health and transition to adulthood supports.

In operation for over 20 years, the Catastrophic Illness in Children Relief Fund (CICRF) Commission administers a financial assistance program for NJ families whose children have an illness or condition otherwise not fully covered by insurance, State or Federal programs, or other source. By legislative mandate, SCHEIS participates on the CICRF Commission.

The NJ Council on Developmental Disabilities (NJ CDD) functions in accordance with the federal Developmental Disabilities Assistance and Bill of Rights Act, and in NJ State government by N.J.S.A. 30:1AA 1.2 and is codified in Title 10 of the State Administrative Codes. According to State statute the Title V agency has a seat on the NJ CDD. The purpose of the NJ CDD is to engage in advocacy, capacity building, and systemic change that contribute to a coordinated, consumer and family-centered, consumer and family-directed comprehensive system that includes needed community services, individualized supports, and other forms of assistance that promote self-determination for individuals with developmental disabilities and their families.

In accordance with the 1993 Family Support Act the NJ CDD established the Regional Family Support Planning Councils (RFSPCs) to provide a way for parents and family members of people with developmental disabilities to come together to exchange knowledge and information about family support services and to advocate for families and individuals with developmental disabilities at the local and state level on issues that directly impact their lives. They also collaborate with the state Division of Developmental Disabilities (DDD) on how to better serve individuals and their families.

The Medical Assistance Advisory Committee (MAAC) operates pursuant to 42 CFR 446.10 of the Social Security Act. The 15-member Committee is comprised of governmental, advocacy, and family representatives and is responsible for analyzing and developing programs of medical care and coordination. State SCHEIS staffs participate at MAAC meetings and share information on access to care through Medicaid managed care with Committee members as well as with SCHEIS programs. Likewise, information shared by the MAAC is incorporated into SCHEIS program planning to better assure coordination of resources, services, and supports for CYSHCN across systems. The quarterly MAAC meetings continue to provide a public forum for the discussion of systems changes in DHS's Medicaid program as well as invite collaboration across State programs. Updates keep stakeholders including the public and providers informed of NJ's progress in implementation of MLTSS, and the restructuring of services to children and youth with the developmental disabilities through DDD, DCF, DOE and DOL, Vocational Rehabilitation.

The Statewide Parent Advocacy Network (SPAN) and the NJAP are key partners with the Title V Program in NJ in many initiatives and projects to better serve CYSHCN and empower families. The Statewide Community of Care Consortium (COCC), a leadership group of SPAN, dedicated to improving NJ's performance on the six core outcomes for CYSHCN and their families, includes three co-conveners from

Title V, SPAN and NJAAP. This group also includes DHS, DCF, the NJ Primary Care Association, and over 60 statewide participating stakeholder organizations. The COCC partners are continuing to work to improve the access of children with mental health challenges to needed care, and to improve the capacity of primary care providers to address mental health issues within their practice. A Family Guide to Integrating Mental Health and Pediatric Primary Care has been developed and shared with families. COCC co-conveners continue to meet with NJ's child protection agency, DCF Division of Protection and Child Permanency, about addressing challenges for children with mental health needs under their care. As an organization consisting of parents or families of CYSHCN, SPAN's guides, publications and presentations are consistently developed, by design, with family and consumer involvement.

Collaboration with the Department of Labor and Workforce Development ensures access to programs such as Vocational Rehabilitation, Social Security Disability Determination, Temporary Disability Insurance, and Workers Compensation. The Division of Vocational Rehabilitation (DVR) Services is responsible for training and placement of persons of employable age with disabilities. As SCHEIS counsels families on transition to adulthood planning options, programs regularly refer to DVR. Likewise, DVR staffs collaborate with SCHEIS programs on family and provider training, individual service plan, and individualized education plan development.

Childcare is a need for CYSHCN, and SCHEIS collaborates with MAPS to Inclusive Child Care Training and Technical Assistance Project, Healthy Start programs (all have Parent/Consumer Advisory Boards), as well as the MCH Adolescent Health unit. The goals of the project are to increase the quality of early care and education for children with special needs; increase the number of child care providers that offer inclusive child care; increase awareness among parents, child care providers, and child care resource and referral agencies of the services available for children with special needs; and improve the delivery of services for children with special needs through collaboration among providers of child care services and special needs services. Its focus remains planning to develop strategies that facilitate and enhance the inclusion of CYSHCN in child care settings.

Title V works with many different partners to help ensure NJ is on the cutting edge with newborn screening policies and operations in NJ. The Newborn Screening Advisory Review Committee (NSARC), established by Executive Order from the Commissioner includes parents, primary care physicians, specialists, nurses, health care organization representatives, including those from Medicaid and private health plans, advocacy organizations, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the Centers for Disease Control.

SCHEIS works with many federal partners and other state/territory colleagues to share and gain information on services and initiatives for CYSHCN. In March and May of 2015, SCHEIS participated in technical assistance calls arranged through HRSA's MCHB to share information on NJ's critical congenital heart defects screening program and the Autism Registry respectively. In May 2012, NJ was one of six states to receive a 3-year HRSA-funded demonstration grant for pulse oximetry screening to detect critical congenital heart disease (CCHD). NJ was the first state in the nation to implement mandatory screening, and a number of infants have been detected through this screening that might otherwise have been discharged from the hospital without detection. Implementation of screening has been a collaborative effort with representation from the NJ Chapter, AAP (NJAAP), the NJ NICU Collaborative and SPAN on the NJDOH CCHD Screening Working Group. In addition, the grant has enabled us to continue extensive educational and training efforts throughout the state with a sub-grant to NJAAP.

School health coordination and collaboration is accomplished statewide through funding to three regional CSH grantee agencies, each with a seven-county service area. Through a mini-grant opportunity developed in SFY2014 and implemented in SFY2015, the CSH regional grantees and Adolescent Health State staff worked with various advisory "experts" from state government or professional statewide organizations to develop (SFY 2014) and implement (SFY2015) a mini-grant application in each of the Coordinated School Health model components. Parental involvement is a key element of the CSH program. Parent led Councils provide input to the program and participate in the implementation.

The NJ Statewide Network for Cultural Competence began in 2002 as an initiative of the NJ DOH FHS Title V program to improve culturally competent policies, procedures and practices through participation in a technical assistance project developed by the National Center for Cultural Competence at Georgetown University. Upon completion of the project, participants decided to work together to develop a broad-based network to advance culturally competent practices in NJ. Early milestones included the development of a listserv and resource directory in 2003, and the launch of a website in 2005. The NJSNCC has held four (4) statewide annual conferences in 2010, 2012, 2014 and 2015, and is in the process of planning for another one in the Fall of 2016. The Network initiated the first of its webinars last year, and plans to hold webinars on a quarterly basis.

The agencies and organizations involved in the Network include more than 130 public/non-profit State, community and private sector agencies engaged in or promoting culturally and linguistically competent service delivery, education, policies and practices. The goals are to: identify existing resources in NJ; i.e. agencies and individuals who have knowledge and skills working with people from diverse needs, cultures, languages or population groups; foster professional development and education; stimulate, promote and celebrate the development and dissemination of best and promising practices in culturally and linguistically competent service delivery. Objectives are to promote knowledge, dissemination, exchange and application of culturally and linguistically competent practices; demonstrate that such practices increase access; improve quality of care, services, and outcomes; reduce disparities and foster health equity; share policy and practice guidelines in culturally and linguistically competent service delivery; collect, compile and share resource information on programs and services that are culturally and linguistically competent; provide a statewide resource tool/guide for accessing culturally and linguistically competent services to individuals and families with diverse needs; and, identify key stakeholders and constituencies and opportunities for affiliations and future collaborative activities.

As evidenced by the multitude of advisory council, consumer groups, coalitions, interdepartmental work groups, and committees, the NJDOH places a great emphasis on the active and meaningful participation of parents and consumers in the development, design and implementation and evaluation of Title V programs. This is a core strength of the NJDOH Title V programs

II.F.4. Health Reform

National health care reform has been one of many changes impacting the role of FHS as NJ's Title V agency. FHS has positioned itself to play an important role in health systems development and transformation. FHS had long ago shifted from a direct service delivery orientation to a preventive, population-based assurance role that could be responsive to new national programs and policies and the changing economic climate.

While there is no way to identify the exact number of residents who the MCH Block Grant serves that have gained insurance coverage as a result of the Affordable Care Act and Medicaid expansion, it is clear that the collective work of MCH grantees, stakeholders and partners has yielded great returns when we examine NJ's overall insurance and Medicaid enrollment estimates since the implementation of the Affordable Care Act. MCH grantees, stakeholders and partners typically refer uninsured pregnant women, women of childbearing age, children and adolescents to resources to access primary, preventive and reproductive health care services.

NJ's uninsured rate was reduced from 14.9% in 2013 to 11.7% in 2014. Over 250,000 residents signed up for commercial coverage through the Health Insurance Marketplace. More than one-third of those individuals were under the age of 35, which covers the age range for most childbearing women and children. As for Medicaid expansion, NJ has increased Medicaid enrollment by over 35% (458,489 more enrollees) as compared to averages from July - September of 2013. This is higher than the national average of 21% for the same timeframe.

Although the Affordable Care Act has clearly made a difference relative to access to care for a large number of residents of NJ, there are populations that have not directly benefitted from the law. Most notable among this population is undocumented residents. However, NJ does have programs that meet the needs of this at-risk population. Through the State funded Uncompensated Care Fund, NJ reimburses 20 licensed federally qualified health centers with over 110 sites throughout the State (covering all 21 counties) for medical and dental care services provided to the uninsured. Among this population are women who would otherwise receive coverage for prenatal care services through a Medicaid Waiver program for pregnant undocumented women. The Medicaid waiver program has limited funds and once its funds have been exhausted, the population is automatically referred to the federally qualified health centers for necessary services. Through these collective efforts, MCH grantees, stakeholders, partners and other State Executive Branch agencies have had an impact on meeting the ongoing needs of MCH populations that remain uninsured despite the implementation of the Affordable Care Act.

As evidence of NJ's strong partnership with HRSA and the MCH Bureau, the State has consistently provided funding for the Uncompensated Care Fund. In SFY 2017, the State appropriated more than \$28 million for this program. This allowed the federally qualified health centers to provide medical and dental services to over 96,000 uninsured women in 2015. The centers provided over 45,500 visits for reproductive health services to uninsured women that year. It also allowed the Centers to serve over 20,600 uninsured children ages 0-18, providing these children with needed medical and dental services.

In NJ, health care is beginning the transition to move out of hospitals and into outpatient settings through the Accountable Care Organizations and the new Delivery System Reform Incentive Payment Program. The NJ DOH has allocated \$166.6 million in hospital funding, approved by the Centers for Medicare and Medicaid Services, to the Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP Program is one component of the NJ's Comprehensive Medicaid Waiver as approved by the Centers for Medicare & Medicaid Services (CMS). DSRIP is a demonstration program designed to result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower costs by transitioning hospital funding to a model where payment is contingent on achieving health improvement goals. Hospitals may qualify to receive incentive payments for implementing quality initiatives within their community and achieving measurable, incremental clinical outcome results demonstrating the initiatives' impact on improving the NJ health care system.

The DSRIP program supports the Healthy NJ 2020 vision: "For New Jersey to be a state in which all people live long, healthy lives." This innovative program will reward hospitals with funding to improve quality of care by facilitating and providing home bound services, improved hospital services and reducing the number of re-hospitalizations for the conditions the participating hospitals have chosen to address. These conditions include obesity, diabetes, asthma, cardiac care, chemical addiction and behavioral health. FHS/Title V staffs have been collaborating with the NJDOH/DSRIP staffs and Department of Human Services /Division of Medical Assistance and Health Services (Medicaid) in the design and implementation of the program to assure that MCH population needs are addressed.

FHS staffs and grantees also have been working in collaboration with the NJ Department of Human Services /Division of Medical Assistance and Health Services as they reviewed and certified three Accountable Care Organizations (ACOs) for the cities of Newark, Trenton and Camden.

The Healthy Greater Newark ACO will serve three zip codes within the city of Newark where the need for health care services is high. These zip code areas have been found to have a significant number of people who experience higher rates of emergency room visits and a greater rate of hospital admissions than those living in other parts of the city. Not only will the ACO improve access to care, it will provide supportive services to people in their homes and in the community. This will have a significant impact in reducing unnecessary hospitalizations and emergency room visits that place enormous burdens on the patients themselves and the area hospitals.

The Healthy Greater Newark ACO as part of their needs assessment findings will focus on improving care for chronically ill children, as well as enhancing perinatal and maternal health services. FHS is utilizing this opportunity to help strengthen availability and access to primary care for the families and children we serve by joining in a coordinated effort to provide quality care primarily in high need areas such as the city of Newark.

Trenton Health Team (THT) and the Camden Coalition of Health Care Providers were also approved by the State to form a Medicaid Accountable Care Organization (ACO) to serve the Trenton and Camden community as part of a three-year demonstration project utilizing a three-part goal of improving health outcomes, lowering healthcare cost and improving the patient's experience of receiving care. THT's and the Camden Coalition Medicaid ACO will achieve those goals through continuing and expanding upon collaborating with the community at large, health and social services organization and the Departments of Health, Human Services and Children and Families. FHS will continue to collaborate with these three ACOs to ensure that our MCH population needs are being addressed.

II.F.5. Emerging Issues

Emerging MCH Issues have been included in the State Action Plan narrative and include Obesity, Nutrition, Autism and Improving and Integrating Information Systems. These issues have been considered emerging issues for several years and their importance recognized by State Priority Needs (#2 Improving Nutrition & Physical Activity and #7 Improving & Integrating Information Systems) and State Performance Measures (#5 Age of Initial Autism Diagnosis).

Zika virus infections and related birth defects is a recent emerging issue that will require expanded partnerships and collaboration across Departments to be adequately addressed. The NJ DOH has formed a Department-wide work group which meets twice a month to coordinate a statewide response. In response the Zika Virus, Family Health Services, NJ MCH Title V programs have initiated an extensive campaign to prepare and respond to the public health risks posed by the Zika virus in collaboration with NJDOH Communicable Disease Services. Standard of Procedure protocols have been created and implemented to navigate pregnant women and infants through care linkage and follow up, and systems have been created to supply data collection for surveillance as set forth by the CDC Zika Pregnancy Registry.

Current FHS MCH Zika Virus activities include:

1. Distribution of Zika Prevention Kits through multiple points of service,
2. Development of a video for women infected with Zika available in multiple languages,
3. Sponsoring Regional Zika Prevention Conferences with the MCH Consortia and the Zika Regional Education Coordinators, and
4. Implementation of the US Zika Pregnancy Registry Enhanced Data Collection using a module in the statewide SPECT system.

II.F.6. Public Input

An integral part of the NJDOH's efforts to secure public input into the annual development of the MCH Block Grant Application and Annual Report, a public hearing is scheduled each year. A draft of the application narrative is posted on the NJDOH's website four weeks prior to the public hearing. Notification of the public hearing and availability of the draft application is posted on the NJDOH's website and is e-mailed to over 300 individuals on the Division of Family Health Services e-mail distribution lists.

Family input is centric to development and evaluation of FCCS programs. In addition to the Press Ganey surveys administered by SPSP provider agencies, in 2014 and 2015, the Title V program distributed 2 family satisfaction surveys in English and Spanish. Over 1,700 responses were received each year. Data was cleaned and analyzed, shared with provider agencies, and used in review and planning for services during fall 2016. An example of preliminary data that will be helpful in planning services includes: 71% of parents whose children received services through the Child Evaluation Centers said that their coordination of services was excellent. Findings from the family satisfaction surveys continue to inform areas for further investigation and quality improvement, such as the need for additional analysis of factors contributing to wait time and identification of successful strategies for overcoming this barrier to care. Additionally, family and youth input on multi-system access to care is obtained through the COCC, a community coalition led by SPAN and comprised of parents of CYSHCN and youth, State agency representatives, and community-based organizations. COCC members and visitors meet quarterly and collaborate to improve access to share updates on federal, State, and community-based programs and services that address access to care for CYSHCN.

The Maternal Child Health (MCH) Block Grant and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) State Plan Public Hearing was held on May 27, 2016 from 9:00AM to 12:00PM at the New Jersey State House Annex Committee Room 1. Ms. Lisa Asare, Assistant Commissioner, Division of Family Health Services, Ms. Electra Moses, WIC Director, Dr. Marilyn Gorney-

Daley, Director of Special Child Health and Early Intervention Services, Ms. Pauline Lisciotta, Program Manager for Family Centered Care Services, Ms. Joy Rende, Program Manager Early Identification and Monitoring Program, Ms. Maggie Gray, Coordinator, Primary and Preventive Health Services, Dr. Nancy Scotto Rosato, Research Scientist, NJ Autism Registry, and Ms. Zenaida Steinhauer, Quality Assurance Specialist, NJ Birth Defects Registry presided over the hearing as Panel Members. There were 12 scheduled presenters which included two providing video testimony. One scheduled presenter was absent. Three additional persons, including two children, also presented testimony. In total, three persons provided specific testimony for WIC, the remainder provided testimony primarily for MCH. Please see attached agenda.

All testimonies given were in strong support of WIC services and MCH/Title V resources and services. Many emphasized the need for continued collaboration to address challenges including encouraging breast feeding, improving birth outcomes, and decreasing birth defects. The importance of peer to peer relationships to increase support and community health workers in reaching populations in need, was emphasized. Some testimonies gave evidence that issues affecting health outcomes including much more than health issues; social issues including schools and housing for example, could also greatly impact health. Concerns about health equity and the need to address health disparities were also voiced. The importance of having a system that was connected with supports such as the birth defect registry being connected with county case management services was also praised. The message of “it taking a village” to address the needs of children, parents, and families was stressed. Two teenaged sons of one parent spoke about the need for more opportunities and training for young adults to be peer leaders. One son, who had met with the Secretary of the USDA, spoke about the need for better nutrition in schools and the need to include physical activities for students of all abilities.

Ms. Asare expressed sincere appreciation to the attendees and presenters for their testimony and input on behalf of the Department and panel members. She shared common themes heard with the audience and advised that written testimonies would still be welcome for MCH and WIC through June 15th. All attendees expressed appreciation for the opportunity to speak on issues affecting their populations and communities and to offer recommendations. Overall, the testimonies provided were positive and in strong support of the need to continue efforts and work of WIC and MCH/Title V toward improved outcomes for NJ’s children and families. The hearing concluded around approximately 11:45AM.

II.F.7. Technical Assistance

FHS has identified the need for technical assistance in the area of Zika Virus Prevention Planning for the MCH population and MCH workforce professional development and will complete and submit a Technical Assistance Request Form.

Table 1a: New Jersey Five-Year Needs Assessment Framework Logic Model – Listed by NPM

Domains <i>(set by HRSA)</i>	State Priority Needs based on Needs Assessment	Strategies <i>(to be developed into Evidence-Based Informed Strategy Measures (ESMs) for 2017)</i>	National Outcome Measures (NOMs) <i>(states select from list)</i>	National Performance Measures (NPMs) & State Performance Measures (SPMs)	Evidence-Based Informed Strategy Measures (ESMs)
1) Women's/ Maternal Health	#1 Increasing Healthy Births	Improving Pregnancy Outcomes (IPO) Initiative; Central Intake (CI) & Community Health Workers (CHW) IM CoIIN; MIEC Home Visiting Program (MIECHV); Office of Women's Health; Perinatal Designation Level regulations, Development of the NJ VON Collaborative, MCH Consortia TQI Activities	1 Prenatal Care; 2 Maternal Morbidity; 3 Maternal Mortality; 4 Low Birth Weight; 5 & 6 Preterm Births 8 Perinatal Mortality; 9 Infant Mortality; 10 FAS; 11 NAS	NPM #1 Well Women Care (Percent of women with a past year preventive medical visit)	ESM 1.1: Increase first trimester prenatal care (EBC) from birth certificate records.
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	Improving Pregnancy Outcomes (IPO) Initiative; IM CoIIN; MIEC Home Visiting Program; NJ SIDS Center activities; Healthy Start; HBWW, SUID-CR; DOSE; Tote Bags Surveillance (PRAMS, EBC) NJ Baby Box Safe Sleep Education Program	1, 2, 3, 4, 5, 8, 9 9.5 Sleep Related SUID; 15 Child Mortality; 19 Child Health Status	NPM #5 Infant Safe Sleep (Percent of infants placed to sleep on their backs). SPM #1 Black preterm births	ESM 5.1: Increase infant safe sleep (PRAMS – on back, no co-sleeping, no soft bedding).
2) Perinatal/ Infant Health	#2 Improve Nutrition & PA #3 Reducing Black Infant Mortality	Improving Pregnancy Outcomes (IPO) Initiative; IM CoIIN; MIEC Home Visiting Program; Healthy Start; HBWW, Loving Support© Through Peer Counseling Breastfeeding Program Baby Friendly Hospitals, BF Surveillance (PRAMS, EBC) Breastfeeding and NJ Maternity Hospitals: A Comparative Report	1, 4, 5, 8, 9, 9.5, 10, 11, 15, 19	NPM #4 Breastfeeding (A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months). SPM #1 Black preterm births	ESM 4.1: Increase births in Baby Friendly hospitals (EBC/mPINC).

Domains <i>(set by HRSA)</i>	State Priority Needs based on Needs Assessment	Strategies <i>(to be developed into Evidence-Based Informed Strategy Measures (ESMs) for 2017)</i>	National Outcome Measures (NOMs) <i>(states select from list)</i>	National Performance Measures (NPMs) & State Performance Measures (SPMs)	Evidence-Based Informed Strategy Measures (ESMs)
3) Child Health	#2 Improving Nutrition & Physical Activity	Sustainable Jersey for Schools certification; ShapingNJ; Whole School, Whole Community, Whole Child (WSCC); NJ AHPERD; Healthy Community grants; Obesity efforts in Nemours Foundation collaboratives; Early care and education NPA YMCA State Alliance	14 Cavities; 19 Child Health Status; 20 Overweight	NPM #8 Physical activity (Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day). SPM #2 Children with Elevated Blood Levels	ESM 8.1: Number of schools participating in an activity (training, professional development, policy development, technical assistance) to improve physical activity among children (6-17).
3) Child Health	#4 Promoting Youth Development	ECCS Impact with DCF Project LAUNCH and Help Me Grow with DCF Early Intervention System MIECHV Project LAUNCH and Help Me Grow with DCF NJ AAP/PCORE Medical Home Project Learn the Signs, Act Early Campaign	13 School Readiness; 17 CSHCN; 18 Mental/Behavioral 19 Child Health Status;	NPM #6 Developmental Screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool).	ESM 6.1: Increase completed ASQ developmental screens online as part of ECCS Impact Program.
4) Adolescent/ Young Adult Health	#4 Promoting Youth Development	NJ AAP/PCORE Medical Home Project; Outreach to providers; Case Management Services;	16.1 Adolescent Mortality; 16.2 MVA; 16.3 Suicide; 17, 18, 19, 20, 21,22	NPM #10 Adolescent Medical Visit (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year).	ESM 10.1: Number of pediatric patients served in practices participating in the Medical Home Technical Assistance Program in the last year.
4) Adolescent/ Young Adult Health and 5) CYSHCN	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	NJ AAP/PCORE Medical Home Project; D70 Integrated Systems-Medical Home; Transition to adulthood needs assessment; SPAN/ISG 1; ARC of NJ	16.1 Adolescent Mortality; 16.2 MVA; 16.3 Suicide; 19 Child Health Status 17, 18, 19, 20, 21,22	NPM #11 Medical Home (Percent of children with and without special health care needs having a medical home).	ESM 11.1: Percent of CYSHCN ages 0-18 years served by Special Child Health Services Case Management Units (SCHS CMUs) with a primary care physician.

<i>Domains</i> <i>(set by HRSA)</i>	<i>State Priority Needs based on Needs Assessment</i>	<i>Strategies</i> <i>(to be developed into Evidence-Based Informed Strategy Measures (ESMs) for 2017)</i>	<i>National Outcome Measures (NOMs)</i> <i>(states select from list)</i>	<i>National Performance Measures (NPMs) & State Performance Measures (SPMs)</i>	<i>Evidence-Based Informed Strategy Measures (ESMs)</i>
5) CYSHCN and 4) Adolescent/Young Adult Health	#5 Improving Access to Quality Care for CYSHCN	Case Management Services; Redesign BDARS; D70 Integrated Systems-Medical Home; NJ AAP/PCORE Medical Home Project; Outreach to providers; Hospital level reports; Audits; Provider education CM level reports; Medicaid Managed Care Alliances, Subsidized Direct Specialty and Subspecialty Services, Participation in Medical Assistance Advisory Council, Arc of NJ SPSP Services	19 Child Health Status 16, 17, 18, 19, 20, 21,22	NPM #12 Transitioning to Adulthood (Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care). SPM #3 Hearing screening F/U; SPM #4 Referred from BDARS to Case Management Unit; SPM #5 Age Initial Autism Diagnosis;	ESM 12.1: Percent of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service.
6) Life Course		Project REACH, Project PEDS ShapingNJ; MIEC Home Visiting; Dial a Smile Dental Clinic Directory; Miles of Smiles; WIC Newsletter; Special Needs Newsletter;	14 Kids 1-6 with cavities; 19 Child Health Status;	NPM #13 Oral health (A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year).	ESM 13.1: Preventive and any dental services for children enrolled in Medicaid or CHIP (CMS-416).
6) Life Course	#7 Improving & Integrating Information Systems	IPO, Central Intake / PRA / SPECT MIEC Home Visiting SSDI, ECCS; VIP; SHAD; EPHT Master Client Index Project	Most NOMs	Most NPMs	
6) Life Course	#8 Smoking Prevention	Mom's Quit Connection; Perinatal Addiction Prevention Project; IPO, Central Intake / PRA; MIEC Home Visiting; SSDI, ECCS	Most NOMs	#14 Household Smoking (A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes).	ESM 14.1: Increase referrals of pregnant women to Mom's Quit Connection.

Table 1b: Findings of the Five-Year State Needs Assessment (from Appendix B, Guidance page 9)

<i>Domains</i>	<i>State Priority Needs</i>	<i>Title V Capacity (strengths/needs) (adequacy/limitations)</i>	<i>Title V Partnerships Family/consumer engagement, Leadership, Coordination</i>	<i>Health Status on Pertinent NPMs and NOMs</i>
1) Maternal/ Women’s Health	#1 Increasing Healthy Births	Improving Pregnancy Outcomes Initiative; Central Intake; CHW IM CoIIN; MIECHV; MCHCs; <i>InterDepartmental collaboration; Systems development; Involvement of health care providers, insurers and payors;</i>	IPO County Advisory Groups, Central Intake (PA/CHA), Community Health Workers MCH Consortia, IM CoIIN Workgroups, MIEC Home Visiting Advisory Groups, Infant Child Health Committee	#1 Well Women Care ↑ <u>Legend</u> ↑ improving ↔ unchanged ↓ worsening
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	Improving Pregnancy Outcomes Initiative; Central Intake; CHW IM CoIIN; MIECHV; MCHCs; <i>InterDepartmental collaboration; Systems development; Involvement of health care providers, insurers and payors;</i>	IPO County Advisory Groups, Infant Child Health Committee, IM CoIIN Workgroups, MIEC Home Visiting Advisory Groups, NJ Breastfeeding Coalition, SUID Review Team	#4 A & B Breastfeeding ↑ #5 Safe Sleep ↑
3) Child Health	#2 Improving Nutrition & Physical Activity	ShapingNJ Coordinated School Health/Whole School, Whole Community, Whole Child (CSH/WSCC)	ECCS Impact, Project Launch, Help Me Grow, CSH/WSCC Partnerships, ShapingNJ Partnership, YMCA State Alliance, Sustainable Jersey for Schools	#6 Dev Screening ↑ #8 Physical activity ↔
4) Adolescent/ Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	Transition to adulthood needs assessment; SPAN/ISG 1; ARC of NJ NJAHIVSTDPPCC	NJ Adolescent HIV STD & Pregnancy Prevention, Collaborating Coalition (NJAHIVSTDPPCC), Practice Parent Advisory Council, NJ AAP/PCORE, SHCS Case Management	#10 Adol Prev Visit ↑ #11A & B Medical Home ↔ #12 Transition to Adulthood ↑
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	21 SCHS Case Management Units SPSP Services (9 CECs with 5 FAS, 5 Cleft Lip/Palate, 3 Tertiary Care); regionalized NJ Family WRAP (family support); 7 RWPD Family Centered HIV Network; NJ AAP/PCORE Medical Home Project; Superstorm Sandy Block Grant enhanced capacity for SCHS Case Management, Family WRAP, Medical Home but funding ends 6/30/15 and families and medical home initiatives need to transition	Family Satisfaction Surveys Intergovernmental collaboration with SSA & State agencies; DHS Medicaid /NJ FamilyCare, Division of Disability Services, Division of Developmental Disabilities; DCF’s Children’s System of Care Initiative, Perform Care, DOBI Division of Insurance; DOL Disability Determinations Unit; DOE Part B Community of Care Consortium & Special Education Advisory Taskforce; PHLEP; Catastrophic Illness in Children Relief Fund, NJ Council on Developmental Disabilities, Special Education Advisory Council; SPAN, Community of Care Consortium (COCC); Map to Inclusive Childcare Team; NJ Inclusive Childcare Project	#11A & B Medical Home ↔ #12 Transition to Adulthood ↑
6) Life Course	#7 Improving & Integrating Information Systems, #8 Smoking Prevention	Mom’s Quit Connection; Perinatal Addiction Prevention Project; Central Intake / PRA; <i>Involvement of health care providers, insurers and payors;</i>	MIEC Home Visiting, COHEP, IPO Initiative (CI & CHW), MCH Consortia; NJ Medical Society; NJ-AAP	#13A & B Oral Health ↔ #14 Household Smoking ↑

Table 1c - Summary of MCH Population Needs

Domains	State Priority Needs	Pertinent NPMs (trend - ↑ improving, ↔ unchanged, ↓ worsening)	+ Strengths / - Needs	Successes, challenges, gaps, disparities (major health issues)
1) Maternal/ Women’s Health	#1 Increasing Healthy Births	#1 Well Women Care ↑	+Low uninsured rates, -Low preventive care use, -Late prenatal care, -Unintended pregnancy	Multiple initiatives, <i>Lack of preventive care, Late/inadequate prenatal care, Unintended pregnancy</i>
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	#4 Breastfeeding ↑ #5 Safe Sleep↑	+Baby Friendly Initiative +Revised Hospital regulations, +Strong coalitions, +SUID-CR	Baby Friendly Initiative <i>Formula supplementation, Unsafe sleep practices</i>
3) Child Health	#2 Improving Nutrition & Physical Activity	#8 Physical Activity ↔ #6 Developmental Screening ↑	+ShapingNJ partnerships, +CSH/WSCC regional partnerships, -funding	ShapingNJ partnerships <i>Built environment caloric dense foods lack of PA opportunities</i>
4) Adolescent/Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	#11 Medical Home↔, #12 Transitioning to Adulthood↑	+Advocacy groups - SPAN +HIV/STD/TPP Coalition, -funding	<i>Lack of preventive care, barriers to sharing medical information</i>
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	#11 Medical Home↔, #12 Transitioning to Adulthood↑ #10 Adolescent Well Visit↑	+Advocacy groups, -funding -TA	<i>Health insurance reimbursement</i>
6) Life Course	#7 Improving & Integrating Information Systems, #8 Smoking Prevention	#13 Oral Health↔ #14 Household Smoking↑	+Cessation options -Lack of provider participation	<i>Health insurance reimbursement, Smoking relapse</i>

Table 1d – Title V Program Capacity and Collaboration to Ensure a Statewide System of Services

Domain	State Priority Needs (SPNs)	Collaborations with other state agencies and private organizations	State Support for Communities	Coordination with Community-Based Systems	Coordination of Health Services with other Services at the Community Level
1) Maternal/ Women’s Health	#1 Increasing Healthy Births	IPO with DCF, MIECHV with DCF/DHS, MCHC, IM CoIIN with DHS, ICHC	IPO Advisory Groups & CI Hubs,	IPO with Central Intake and CHWs, MCHC	Central Intake with DCF, MIECHV, Healthy Start, Strong Start, WIC
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	MCHC, Home Visiting with DCF & DHS, NJHA Perinatal Collaborative, IM CoIIN with DHS, ICHC	IPO Advisory Groups & CI Hubs,	IPO with Central Intake and CHWs, MCHC	Central Intake with DCF, MIECHV, Healthy Start, Strong Start, WIC
3) Child Health	#2 Improving Nutrition & Physical Activity	ShapingNJ, CSH/WSCC AHPERD, NJPHK, SOPHE, NJDA, DEP, JJC, DoT, ICHC	CSH/WSCC grantees, NJ Council on Physical Fitness & Sports; OLHD; Chronic Disease Coalition,	FQHCs CSH/WSCC	School Health, Early Care & Education, County Councils for Young Children , Sustainable NJ for Schools
4) Adolescent/Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	School Health with DOE, DCF PREP AEP NJAHIVSTDPPCC	PREP & AEP grantees; CSH/WSCC grantees	Adolescent Advisory Group; CSH/WSCC	School Based Youth Services
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	NJ AAP/PCORE Medical Home, County Base Management	SCHS Case Management Units	County-based Case Management, SPAN	EIS, SCHS Case Management
6) Life Course	#7 Improving & Integrating Information Systems, #8 Smoking Prevention	IPO with DCF; HV with DCF & DHS; NJ Medical Society NJ-AAP; NJ OB/GYN Society MCHC, ICHC	IPO Advisory Groups & CI Hubs	IPO with Central Intake and Community Health Workers	Central Intake with DCF, NJ 211 , Family Health Line

Table 1e - Staffing for MCHS

Staff Person	Title	Function	Related NPM	Tenure in MCH
Lisa Asare	Assistant Commissioner	Director FHS	1-15	11
Nashon Hornsby	Chief of Operations	Oversees FHS	1-15	12
Marilyn Gorney-Daley	MCHS Director	Director of MCHS Services Unit	1-15	20
Lakota Kruse	Medical Director	HV Program Director	1-15	24
Nancy Mimm	RPHS Program Manager	Oversees RPHS	1-15	4
Cynthia Collins	CAHS Program Manager	Oversees CAHS	7-12	24
Maggie Gray	Coordinator Primary & Preventive Health Services	Coordinator RPHS programs	1-6	20
Anna Preiss	Research Scientist 2	Coordinator MIECHV and RPHS programs	1-6	22
Renee Booze-Westcott	Program Specialist 3	Coordinator RPHS programs	1-6	23
Elizabeth Dahms	Public Health Consultant 1 Nursing	Coordinator RPHS programs	1-6	17
Loletha Johnson	Public Health Consultant 1 Nursing	Coordinator RPHS programs	1-6	17
Crystal Owensby	Coordinator Primary & Preventive Health Services	Child Health (childhood lead poisoning prevention) Coordinator	7-12	24
Jaydeep Nanavaty	Research Scientist 1	Child Health Surveillance Coordinator	7-12	17
Pat Hyland	Public Health Consultant 1 Nursing	Child Health nurse case manager	7-12	24
Siobhan Pappas	Health Data Specialist 2	Environmental Consultant/Epidemiologist	7-12	1
Beverly Kupiec-Sce	COHP Director	Directs COPH activities	13	31
Ingrid Morton	MCH Epi Program Manager	Manages MCH Epi programs	1-15	23
Sharon Smith	Research Scientist 2	PRAMS Coordinator	1-15	14

Table 1e - Staffing for SCHEIS

Staff Person	Title	Function	Related Priority NPM	Tenure in MCH
Marilyn Gorney-Daley, DO, MPH	Director SCHEIS	Service Unit Director, Director for CSHCN	11, 12	20 yrs
Diane DiGiovacchino	Administrative Assistant 3	Administrative support	11,12	29 yrs
Rita Belfiore	Secretarial Assistant 3	Secretarial support	11,12	29 yrs
Joy Rende, MSA, RNC-MN, NE-BC	Program Manager, Early Identification and Monitoring	Supervises activities of Early Identification and Monitoring Program (EIM)	11,12	2 yr
Joseph Sweatlock, PhD, DABT	Research Scientist I	Responsible for data management for EIM	11,12	13 yrs
Kathryn Aveni, RNC, MPH	Research Scientist I	Supervises activities of Early Hearing and Detection Intervention	11,12	15 yrs
Mary Knapp, MSN, RN,	Coordinator Primary and Preventive Health Services	Coordinator NJ Birth Defects Registry	11,12	32 yrs
Linda Biando, MSN, RN	Public Health Consultant 1, Nursing	Provides follow up with medical professionals	11,12	27 yrs.
Nancy Schneider, MA, CCC-A, FAAA	Research Scientist 2	Audiologist, liaison to the audiology community	11,12	15 yrs
Zenaida Steinhauer, RN, BSN,MPA	Quality Assurance Specialist, Health Services, Nursing	Ensures that the information on each BDR registration is accurate and complete	11,12	16 yrs
Anthony Mosco, AA	Software Development Specialist Assistant	Technical assistance related to the Birth Defects and Autism Registry	11,12	9 yrs
Sandy Howell, PhD	Research Scientist 1	Coordinates the Autism Registry	11,12	9 yrs
Nancy Scotto Rosato, PhD	Research Scientist 2	Assists in the coordination of the Autism Registry	11,12	9 yrs
Nicole Moore	Principal Clerk Typist	Provides clerical support for Birth Defects and Autism Registry	11,12	17 yrs
Donna Williams	Head Clerk	Provides supervision of clerical staff for Birth Defects and Autism Registry	11,12	12 yrs
Tracey Justice	Principal Clerk Typist	Provides clerical support for Early Hearing Detection and Intervention	11,12	12 yrs
Mary Lou Colon	Secretarial Assistant 3	Provides clerical support for Program Manager of EIM	11,12	9 yrs
Raymia Geddes	Principal Clerk Typist	Provides clerical support for Birth Defects and Autism Registry	11,12	5 yrs
Pauline Lisciotto, MSN, RN	Program Manager	Administer FCCS Unit; SCHS Case Management & Family Support, Fee for Service, Specialized Pediatric Services program (SPSP), Ryan White Part D activities	11,12	24 yrs
Linda Barron	Public Health Consultant 2, Nursing Specialized Pediatric Services Program (SPSP)	Public health nurse consultation re: SPSP programs and services, program officer for SPSP health services grants	11,12	2 yrs
Felicia Walton, BA	Program Specialist 3	Public health consultation re: SCHS CM programs, family support, and Fee for Service program, program officer for SCHS CM health services grants	11,12	7 yrs
Stephanie Kneeshaw-Price, MS, PhD	Health Data Specialist 1	Lead SCHS CM and Superstorm Sandy data collection and analysis,	11,12	2.5 yrs

		administers SCHS CM electronic case management referral system		
Ellen Dufficy, M.Ed., RN	Public Health Consultant 1, Nursing Ryan White Part D	Public health nurse consultation re: Women, Infants, Children, and Youth (WICY) infected and/or affected by HIV/AIDS. Liaison between Title V MCH & CYSCHN programs and WIC population, providers, and systems development	11,12	22 yrs
Dawn Mergen, RN	Quality Assurance Specialist Health Services Nursing		11,12	1.5 yrs
Deborah Verbos, MSN, RN	Public Health Consultant 2, Nursing	Public health nurse consultation across SCHS CMU agencies and Medicaid managed care expertise	11,12	1 yr
Susan Agugliaro	Secretarial Assistant 3	Clerical support to Program Manager and maintains Fee for Service Letters of Agreement	11,12	30 yrs
Claudia Pollet, MD, MPH	Health Science Specialist	Supervises and directs activities of Newborn Screening & Genetic Services	11,12	3 yrs
Suzanne Canuso, MSN, RN	Public Health Consultant 1, Nursing	Oversees and evaluates programmatic activities of Newborn Screening and Hemophilia health service grants.	11,12	7 yrs
Diane Driver, MSN, RN	Public Health Consultant 2, Nursing	Manages health services grants for Newborn Screening Follow-up Services	11,12	3 yrs
Suzanne Karabin, MS	Research Scientist 2	Prepares data reports, meeting agendas and minutes, updates protocols/checklists for follow up on abnormal screening results, works with software vendor, initiates and follows cases.	11,12	15 yrs
Yvonne Miller Watkins, RNC, BSN, MAS	Quality Assurance Specialist, Health Services, Nursing	Prepares and provides training and quality improvement visits to NJ birthing hospitals, ensures quality of program charts, initiates and follows cases as needed.	11,12	15 yrs
Jon Watkins, MPA, CHES	Public Health Representative 1	Provides follow-up of all newborns with abnormal screening results	11,12	10 yrs
Karyn Dynak	Supervising Public Health Representative	Provides follow-up of all newborns with abnormal screening results	11,12	9 yrs
Felicidad Santos, MD, MPH	Public Health Representative 1	Provides follow-up of all newborns with abnormal screening results	11,12	8 yrs
Tariq Ahmad, MBBS, MPH	Public Health Representative 1	Provides follow-up of all newborns with abnormal screening results	11,12	9 yrs
Kathy Melnicki	Public Health Representative 1	Provides follow-up of all newborns with abnormal screening results	11,12	3 yrs
Alvina Randolph	Head Clerk	Provides clerical support for Newborn Screening Follow-up	11,12	25 yrs
Paula Jumper	Principal Clerk Typist	Provides clerical support for Newborn Screening Follow-up	11,12	5 yrs
Betty Durham	Principal Clerk Typist	Provides clerical support for Newborn Screening Follow-up	11,12	16 yrs
Parents/Family members				
Statewide Parent Advocacy Network Diana Autin (grantee)	Executive Director	Parent Partner	11,12	22+

Table 1f - MCH Organizational Relationships with Partnerships, Collaboration, and Cross-Program Coordination

Domain	State Priority Needs	MCHB Investment Grant	Other Investments	Other DOH	Other State Departments	Local Agencies	Performance Measures/ Goals	Family Consumer Partnerships
1) Maternal/ Women's Health	#1 Increasing Healthy Births	MIECHV,	FQHC, Family Planning	HIV/AIDS; WIC; CH&W	DCF, DHS, DOE	IPO grantees, MCHC, MIECHV grantees	IPO objectives; HV Benchmarks; NPM 1,2,3; NOM 1-8,21,22	HV Advisory WG, IPO County Advisory Groups, MCHC, CCYC
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	MIECHV, Healthy Start, SSDI	FQHC, WIC; SUID-CR	NJIS; WIC	DCF, DHS, DOE	IPO grantees, MCHC, MIECHV grantees	IPO objectives; HV Benchmarks; NPM 5; NOM 1-9	HV Advisory WG, MCHC, IPO County Advisory Groups, CCYC
3) Child Health	#2 Improving Nutrition & Physical Activity		FQHC, CSH/WSCC; SDYR; EIS	CH&W	DCF, DOE, DOT	WSCC grantees	WSCC objectives; NPM 8; NOM 9,11	CSH/WSCC Partners; CCYC; SPAN
4) Adolescent/ Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	PREP, AEP	FQHC, CSH/WSCC; SDYR	HIV/AIDs; CH&W	DCF, DOE	PREP & AEP grantees	WSCC objectives; PREP & AEP objectives; NPM 11,12; NOM 10,11,13,15-17	CSH/WSCC Partners
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	CSHCN SIG	SCHS CMUs, SPSP grantees	EIS,WIC, FQHC, Div of HIV/AIDS, STI,TB; Div of PHILEP	DCF, DHS, DOE, DOBI, CICRF, NJ Council on DD	Local health depts., hospitals, special services school districts, disability specific/ charitable agencies	NPM 11,12; NOM 18,19,20,23	SPAN/Family WRAP, COCC
6) Life Course	#7 Improving & Integrating Information Systems #8 Smoking Prevention	SSDI, MIECHV		CH&W	DCF, DHS, DOE, NJMS, NJ-AAP, NJOGS, MCHC	LHD, IPO grantees, MIECHV	NPM 13,14	HV Advisory WG, IPO County Advisory Groups, MCHC, CCYC

Table 1g - Family/Consumer Partnerships

Domain	Priority	Advisory Committees	Strategic and Program Planning	Quality Improvement	Workforce Development	Block Grant Development and Review	Materials Development	Advocacy
1) Maternal/ Women's Health	#1 Increasing Healthy Births,	IPO Advisory Committees, Central Intake Advisory Committees	IM CoIIN, NGA	IPO Evaluation; MIECHV Evaluation	IPO Training & Technical Assistance; MCH Title V Professional Development Training	Annual public input & public comment		IPO Advisory Committees, Central Intake Advisory Committees
2) Perinatal/ Infant Health	#2 Reducing Black Infant Mortality,	IPO Advisory Committees, Central Intake Advisory Committees	IM CoIIN, NGA	IPO Evaluation; MIECHV Evaluation	MCH Title V Professional Development Training	Annual public input & public comment		Infant Child Health Committee, County Councils for Young Children
3) Child Health	#3 Improving Nutrition & Physical Activity	Infant Child Health Committee, County Councils for Young Children			MCH Title V Professional Development Training	Annual public input & public comment		Infant Child Health Committee, County Councils for Young Children
4) Adolescent/ Young Adult Health	#4 Promoting Youth Development; #6 Reducing Teen Pregnancy	NJAHIVSTDP PCC	PREP State Plan	PREP performance measures; PREP & AEP Surveys	PREP & AEP Quarterly TA; MCH Title V Professional Development Training	Annual public input & public comment	surveys, brochures	
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	FAS Taskforce Cleft Lip/Palate Federation CEC Federation COCC SCHS CM Association	Annual planning in preparation for MCHB Public and/or provider input through family satisfaction surveys	Quarterly and annual programmatic & fiscal monitoring Annual review &/or revision of health service grant Attachment C	AMCHP scholars programs, Quarterly SCHS CM meetings/trainings on statewide systems and programs with parents and providers across FCCS invited, SPAN trainings on local, state, and national topics related to family support, transition, etc. for CYSHCN,	Annual public and/or provider input; hardcopy &/or public testimony	All surveys, brochures, &/or educational materials developed with family input and tested for cultural competency	Parents educated on self-advocacy through SPAN-Family Voices, NJ AAP, and/or mailings of materials from State, federal, and or disease specific organizations, Title V participation in NJ CDD Partners

					NJ AAP medical home trainings, DOH-Human Resources Development Institute trainings on HIPAA, cultural competency, etc., CityMatch webinars			in Policy Making mock hearings for parents and guardians of CYSHCN & self advocates
6) Life Course	#7 Improving & Integrating Information Systems; #8 Smoking Prevention	IPO Advisory Committees, Central Intake Advisory Committees		IPO Evaluation; MIECHV Evaluation	MCH Title V Professional Development Training	Annual public input & public comment	Website; Stakeholder survey	IPO Advisory Committees, Central Intake Advisory Committees