Connecting New Jersey (CNJ) Guidelines

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Introduction to the Connecting NJ (CNJ) Guidelines

The Connecting NJ (CNJ) Guidelines are a reference and living document for guidance on CNJ processes that are carried out by CNJ staff. The guidelines serve as a foundational tool for CNJ core elements, structure, operations, and best practices.

As a living document, it is updated regularly, being responsive to new information and questions that emerge that have not previously been addressed.

All CNJ staff are welcome and encouraged to suggest amendments and additions as the system evolves. This feedback may be emailed to your assigned New Jersey Department of Children and Families (DCF) or Department of Health (DOH) Project Officer, which will in turn be shared with the CNJ Workgroup, which meets as needed to review, discuss, and approve suggestions.

Recent Updates: (insert date)

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Chapter 1: Introduction and Core Elements

Section 1.1: New Jersey's Maternal, Infant, and Early Childhood (MIEC) System of Care

A maternal, infant, and early childhood system of care brings together partners from health, early care and education, child welfare, human services, and family support programs—along with community leaders, families, and other stakeholders—to achieve shared goals for the well-being of children and families.

New Jersey (NJ) understands that the early years of a child's life present an incredible opportunity to build a strong foundation as the brain rapidly develops during the first five years of life. NJ also acknowledges the family's important role and has made immense investments across state departments to provide an array of **Maternal, Infant, and Early Childhood (MIEC)** services.

All children benefit from an organized system of community resources to help them thrive, like health care, quality early learning experiences, healthy nutrition, and parent support. However, when the system is not well organized, it can be difficult for families to access resources for themselves and their children and challenging for maternal-child health and well-being service providers to connect families to critical supports. This can have long-lasting consequences on children's health and well-being. New Jersey's Connecting NJ (CNJ) system is the backbone to ensure MIEC services are organized, accessible, and is a partnership between New Jersey's Department of Health (DOH) and Department of Children and Families (DCF).

Section 1.2: Connecting NJ Program Description

Located in all 21 counties across NJ, Connecting NJ (CNJ) is a single point of entry that helps to simplify the referral process, improve care coordination, provide developmental screening, and ensure an integrated maternal, infant, and early childhood care system. The primary focus of CNJ is to assist birthing individuals, caregivers (mothers, fathers, grandparents, kinship, foster parents, legal guardians), and young children (birth to five) in efficiently accessing the most appropriate services. However, all county sites will assist families and individuals with needed connections across the lifespan.

CNJ staff remain up to date on the local array of available services and work closely with families and provider partners to ensure that referrals best match a family's needs based on program eligibility, language/culture, and other considerations. CNJ provides families and providers with easy access to resource information and referrals to a wide range of local community-based services that promote child and family wellness.

CNJ works closely with partners to eliminate duplication of efforts and services, maximize the collective impact, and appropriate utilization of available and often scarce resources. Incoming referrals to CNJ may come from the following partners: prenatal and pediatric health providers,

social services agencies, community partners, community health workers, and directly from families themselves.

CNJ Hubs were initially established in 2011, with the evolution of evidence-based home visitation being available statewide throughout NJ. CNJ Hubs expanded statewide to match those service linkage needs, as well as expanded to address the needs of all birthing individuals and families with children from birth to five years old. In November 2019, a team of multidisciplinary experts was assembled to guide the development of a science-based, comprehensive, and actionable plan focused on equity and improved outcomes for all women and infants. First Lady of New Jersey Tammy Murphy officially launched Nurture NJ in early 2019 as a statewide initiative committed to reducing maternal and infant mortality and morbidity, as well as ensuring equity in maternal and infant morbidity and mortality for Black and Brown women in the state. Nurture NJ is a multipronged, multi-agency initiative that aims to make New Jersey the safest place for women to give birth and raise a child, and to eliminate the state's racial disparities.[1]

CNJ Hubs support activities of Nurture NJ's Strategic Plan to ensure NJ is a safe place for every birthing individual to live and raise their child by supporting meaningful linkages to programs and services to support their pregnancy and overall child and family well-being.

Section 1.3: Core Program Initiatives within Connecting NJ

To ensure NJ families are connected to the resources and support they need, there are several initiatives within the CNJ Hubs to address the complex needs of families in New Jersey. Below are the key initiatives within each of the CNJ Hubs for families to access.

Healthy Women, Healthy Families (HWHF)

The goal of the Healthy Women, Healthy Families (HWHF) program is to improve maternal and infant health outcomes for women of childbearing age and their families and to reduce health disparities during preconception, interconception, and the postpartum period. This initiative includes case management services by community health workers (CHWs) to provide high-risk families and women of childbearing age access to resource information and referrals to local community services that promote child and family wellness. Maternal-child health-focused community health workers are paired with clients to provide them access to resource information and referrals to local community services based on their needs. In addition, they provide one-on-one support and important prenatal and postpartum education. Community health workers serve as an integral bridge between their clients, their communities, and the greater health system. Community health workers are available in every county in NJ and can work with clients for up to 2 years.

In addition, the Healthy Women, Healthy Families initiative consists of specific municipality level activities within each region that focus on providing community support and linkages to

[1] Page 10: https://nurturenj.nj.gov/wp-content/uploads/2021/01/20210120-Nurture-NJ-Strategic-Plan.pdf

Black non-Hispanic and Hispanic women of childbearing age. These additional initiatives include breastfeeding education sessions aimed at nontraditional groups and postpartum doula services. Nontraditional breastfeeding education sessions are informational sessions aimed not just for lactating individuals but for their greater support network, including grandparents, fathers, support persons, siblings, and adolescents. The postpartum doula program pairs clients with postpartum-trained doulas after birth to provide continuous physical and emotional support, access to resources and referrals, and postpartum education for up to 12 months after birth. These programs are available in Paterson, Elizabeth, Newark, Plainfield, Trenton, New Brunswick, Atlantic City, and Camden.

The Healthy Women, Healthy Families initiative targets all women of childbearing age (15-44 years old) at preconception, interconception, prenatal, and postpartum for enrollment into the community health worker case management with a heavy focus on prenatal and postpartum individuals, high-risk individuals, particularly those who are not yet engaged in mainstream service systems (e.g., Medicaid/NJ FamilyCare, and Social Security), and require assistance with social determinants of health needs such as employment, education, housing, transportation, food and nutrition. The case management program has three levels of service intensity as follows, with each implementing agency having specific eligibility criteria in their service areas:

Level 1 Clients

- Contact at a minimum should be at least biweekly.
- CHW should not go longer than 14 days without a contact attempt.

Level 2 Clients

- Contact at a minimum should be at least every 3-6 weeks.
- CHW should not go longer than 42 days without a contact attempt.

Level 3 Clients

- Contact at a minimum should be at least every other month.
- Contact for these clients should be on an as-needed basis.
- Level 3 clients can include individuals such as caregivers, fathers, spouses, relatives, children, and other inclusive groups that are a part of birthing individuals' journeys.

The Early Childhood Initiative

Goal: A strategic partnership between the DCF Divisions of Child Protection and Permanency (CPP) and Family and Community Partnership (FCP). The goal is to strengthen vulnerable families of infants and young children through engagement and teaming with community partners to decrease risk factors and increase Protective Factors. Early Childhood Specialists support child welfare case practice, particularly those involving substance-affected infants, and strengthen systems integration and service linkages at the local level.

Target Population: Families with children from birth to 5 years of age. This provides an opportunity for focused intervention services to prevent further system involvement.

Objectives and Expected Outcomes:

- Objective 1: Staff development

  Expected Outcomes: Child Welfare, Early Childhood, and Family Support Partners will work as a team and integrate the Strengthening Families Protective Factors Framework (SF_PFF) in their practice.

- Objective 2: Enhanced Assessment, Planning, and Service Access

  Expected Outcomes: As a team, Child Welfare, Early Childhood, and Family Support partners will conduct more thorough assessments, develop individualized plans, effectively engage families, and link them with resources, services, and supports that will decrease risk factors and increase Protective Factors.

- Objective 3: Systems Integration and Coordination

  Expected Outcomes: Parents, Child Welfare, Early Childhood, and Family Support partners will collaborate at the community level to ensure that services are accessible, appropriate, coordinated, and effective.

Evidence-Based Home Visitation (EBHV) Programs

The overall mission of the New Jersey Home Visiting Initiative is to improve the physical and emotional well-being of infants, children, and their families in New Jersey by providing community-based education and in-home support to parents. Eligibility criteria for EBHV services vary by model, but typically programs begin working with families during pregnancy and continue until the child is age two or three.

Home visitors provide pregnant women and new parents with health information, parenting education, and linkages to resources that support child and family well-being. DCF-funded EBHV models include:

- Healthy Families – TANF Initiative for Parents (HF-TIP) – pregnancy/birth to age three
- Nurse-Family Partnership (NFP) – first-time pregnancy to age two
- Parents As Teachers (PAT) – pregnancy/infancy to preschool
- Home Instruction for Parents of Preschool Youngsters (HIPPY) – ages three to five (Bergen County only)

Section 1.4: Connecting NJ Outcome Goals and Objectives

CNJ is a partnership between the NJ Department of Health (DOH) and the Department of Children and Families (DCF). We have shared outcome goals and objectives for the CNJ Hub System. Below are key county-level outcome goals and objectives for all the CNJ Hubs.

Goal: CNJ will provide pregnant women, parents, and caregivers early linkages to core programs such as evidence-based home visitation services, Healthy Women Healthy Families services (Community Health Workers/Postpartum Doulas/Breastfeeding Support), or other programs based on the family's needs. The CNJ Hub will be fully integrated into the statewide infrastructure to support at-risk families and prevent child abuse and neglect in New Jersey.

Objective 1

- Maintain a comprehensive home visiting system that targets 100% of prenatal and maternal child health providers (FQHCs, OBGYNs, pediatricians, etc.) within the target county (every year or ongoing).

Outcome

- The comprehensive home visiting referral system and database are fully developed and maintained.

Objective 2

- 75% of primary prenatal providers within a target county will regularly utilize the Perinatal Risk Assessment (PRA) for their patients (every year or ongoing).

Outcome

- Percentage of primary prenatal providers within the target county utilizing the Perinatal Risk Assessment (PRA).

Objective 3

- 75% of prenatal and maternal child health providers will actively participate in the home visiting system through outreach and referrals (ongoing).

Outcome

- Percentage of prenatal and maternal child health providers actively participating in the home visiting system.

Objective 4

- In collaboration with Family Health Initiatives (FHI) through the CNJ Links Database system, distribute data reports to participating providers, indicating the total number of 1) screens processed, 2) women and families referred to appropriate services, 3) women enrolled in services, and 4) other measures as identified by local partners (quarterly).

Outcomes

- Data collection, reporting, and distribution for participating providers' awareness on patient referrals, engagement, and outcomes (quarterly).

- Encourage collaboration across the CNJ network, including providers, Hubs, and state departments (ongoing).

Objective 5

- Collaborate with other state departments, such as but not limited to the NJ Department of Health (DOH), NJ Department of Children and Families (DCF), NJ Department of Human Services (DHS), and the NJ Department of Labor (DOL) (ongoing).

Outcome

- Increased awareness of state resources that are available to families.

Goal 2: CNJ will improve county-level perinatal health outcomes.

Objective 1

- Collaborate with FHI to promote universal screening amongst prenatal providers in the Hub's target county (ongoing).

Outcomes

- PRA will be utilized by 100% of hospitals and FQHCs in the target county.
- PRA utilization by private prenatal providers in the target will increase by 5% annually.

Objective 2

- Collaborate with Healthy Women, Healthy Families program partners for referrals within the target county (ongoing).

Outcome

- Families will be linked to long-term maternal-child health services, such as community health workers and postpartum doulas.

Section 1.5: Target Population

Connecting NJ (CNJ) has a community focus of universal reach of birthing individuals, caregivers (mothers, fathers, grandparents, kinship, foster parents, legal guardians), and children from birth to five years of age. CNJ should make a priority to support individuals who are:

- low-income or uninsured
- racial, ethnic, and linguistic minorities
- with chronic health conditions
- with multiple social and economic stressors
- underserved immigrants and migrants
- victims of domestic violence
- individuals impacted by mental health issues, and/or alcohol and substance use disorder

- involved with the Division of Child Protection and Permanency

Section 1.6: Utilizing the Strengthening Families Protective Factors Framework

CNJ Hubs utilize the Strengthening Families™ Framework[2] as a philosophy and approach to assessing and addressing the needs of the families they serve. Strengthening Families™ is a research-informed approach to increase family strengths, enhance child development, and reduce the likelihood of child abuse and neglect. It is based on engaging families, programs, and communities in building five protective factors:

- **Parental resilience**: Managing stress and functioning well when faced with challenges, adversity, and trauma
- **Social connections:** Positive relationships that provide emotional, informational, instrumental, and spiritual support
- **Knowledge of parenting and child development:** Understanding child development and parenting strategies that support physical, cognitive, language, social, and emotional development
- **Concrete support in times of need:** Access to concrete support and services that address a family's needs and help minimize stress caused by challenges
- **Social and emotional competence of children:** Family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships

The five protective factors at the foundation of Strengthening Families™ are characteristics that have been shown to make positive outcomes more likely for young children and their families, and to reduce the likelihood of child abuse and neglect.[3]

Section 1.7: Developmental Health Promotion and Screening

Connecting NJ (CNJ) may provide anticipatory guidance and promote developmental health (physical, cognitive, and social-emotional). Successful health promotion efforts should consider the current developmental reality of the child, as well as the developmental expectations for the next months and the developmental potential for growth over time.

CNJ may offer each family the opportunity to complete a developmental screen. Screening young children is an effective and efficient way for professionals to check a child's development, help parents celebrate their child's milestones, know what to look for next (anticipatory guidance), and determine whether follow-up steps are needed. It's also an essential first step toward identifying children with delays or disorders in the critical early years.

CNJ may utilize the Ages and Stages Questionnaire and Ages and Stages Questionnaire: Social Emotional, Second Edition (ASQ-3 and ASQ SE-2), are reliable, accurate developmental and

[2] https://cssp.org/wp-content/uploads/2018/11/About-Strengthening-Families.pdf
[3] http://cfsslo.org/five-protective-factors/

social-emotional screenings for children between one month to 5 ½ years. The ASQ-3 screens five skill areas: communication, gross motor, fine motor, problem-solving, and personal-social. The ASQ SE-2 helps to track a child's social and emotional development. Brookes Publishing Family Access Portal (ASQ Online) is a web-based management system for the Ages and Stages Questionnaires and makes it easier for CNJ to manage and track child data.

CNJ may offer a connection to other programs (such as EBHV, community partners, etc.) and/or health providers that also provide developmental screening and support if the family is not interested in receiving the developmental screening from CNJ.

See Appendix D: *Connecting NJ (CNJ) Developmental Screening Operating Policy and Procedures* for further details.

Section 1.8: Case Management

The primary function of the Connecting NJ (CNJ) Case Manager is to work in collaboration with the Connecting NJ Hub. Case Managers provide short-term case management, three months up to six months, if needed, to high-risk families, families not seeking a core program at the time, and families needing advocacy and follow-up with resources and referrals. The Case Manager is responsible for coordinating and providing care that is safe, timely, effective, efficient, equitable, and client centered. The Case Manager will link families to existing resources in the community, provide personalized care coordination to ensure they are connected to appropriate resources, receive timely information, and are provided continued supports, advocacy, and follow-up as needed.

Upon providing a referral for a family that is not moving on to a Hub program, CNJ shall ask whether the caregiver would like CNJ to follow up. Based on a family's needs, case management may be applicable. Those families requesting short-term support and case management will receive follow-up. CNJ staff should discuss an agreeable time frame for follow-up. If a caregiver prefers not to be followed up with, the service referral is immediately closed as "not interested in follow-up".

Strong consideration for follow-up with families should be given for these presenting needs:

- prenatal care
- children's medical home
- early intervention
- domestic violence
- housing/food insecurity
- crisis intervention

Case Managers will have a minimum caseload of 15 monthly individuals/families and will provide a weekly touch base for one hour. Key goals:

- Identifying the client's key problems to be addressed, as well as individual needs and interests.
- Determining the expected care goals and target outcomes with the family.

- Developing a comprehensive case management plan of care that addresses these problems and needs while supporting the achievement of their care goals.

Section 1.9: Easy Access

Each CNJ Hub shall have a local and/or toll-free telephone number for public and provider access, with after-hours messaging capability. In addition, the CNJ Hub shall utilize a confidential fax and/or email address.

Section 1.10: Local Service Linkages

The CNJ staff shall be familiar with the broad range of services available to individuals and families within the county that include prenatal care, infant/child health, family planning, WIC, Evidence Based Home Visiting, Head Start/Early Head Start, childcare services, preschool programs, Family Success Centers, Early Intervention, special child health services, behavioral health, domestic violence support, financial needs/public assistance services, substance use/addiction treatment, developmental screening, and more.

All CNJ Hubs shall develop Business Rules to guide the local referral process. The criteria for referral linkages shall be developed in collaboration with all core program partners.

Section 1.11: Hub Map of Services and Programs

CNJ Hubs are responsible for managing tools and charts to organize their partnerships, connections, programs, and service linkages. CNJ Hubs are also asked to keep abreast of gaps and barriers in their community and may identify these during their quarterly reports to the state. The following items are recommended to ensure each local CNJ Hub has the necessary resources in their community to support families.

- **System of Care Diagram** that represents the local services and stakeholders for the target county.
- **Resource Directory,** a list of organizations that provide services in the community. These organizations, along with details about the services offered and any operational notes (hours of operation, location, eligibility requirements, language capacities), must be registered with FindHelp in CNJ Link and updated on an ongoing basis as identified or needed, with a formal review and updated quarterly ***at a minimum***. Information about new service providers and updates to existing service providers should be submitted to FindHelp.
- **Decision Trees**, which are a visual that depicts the process for linking families to programs and services. This decision tree shall be used by CNJ to triage incoming referrals to programs based on identified criteria and family needs. Families may also be referred to supportive services. The decision tree shall be a fluid document, reviewed ***at least annually in the first quarter of the fiscal year*****,** and modified as new core programs are added or removed from the Hub and shared with the DCF or DOH Project Officer.

- **CNJ Hub Business Rules,** which guide the referral process for core programs, as depicted in the county-specific Decision Tree. The business rules shall be a fluid document, reviewed ***at least annually in the first quarter of the fiscal year***, modified to reflect the current decision tree, and shared with the DCF or DOH Project Officer.

Section 1.12: Recommended Content for CNJ Hub Business Rules

Business rules guide the flow of decisions and connections to core programs and services through the Hub. The following items provide best practice guidance on content, steps, and communication necessary to support a succinct flow of referrals through the CNJ Hub to core programs. It is recommended that CNJ Hubs include these items at a minimum when developing and/or revising their CNJ Hub business rules. Below is information to help you assess if these components are included in your business rules.

- Communication between the Program and CNJ before any referrals are made
    - If a family is interested in services, what is the process for connecting the family to the service?
    - Work with the program to develop a process to inform CNJ about changes in program capacity.

- How screens (Perinatal Risk Assessment, Community Health Screen, and Initial Referral Form) are processed by CNJ
    - Which staff member handles the screen when it is received in the CNJ Hub?
    - If the Hub is expediting referrals, how is that handled?
    - How are screens being tracked in CNJ Link, or is it happening in another way?
    - What are the initial steps taken in the Hub when first receiving a screen?
    - What is the order in which families should be assigned to programs in your Hub? (For example, if one referral goes to one core program, the next family ideally would be assigned to another core program unless the family is not interested in that core program.)
    - The process that is in place if a family is interested in a program that is currently at capacity.

- Outreach to the family
    - What timeframe does your CNJ Hub follow to make its initial attempt to contact the family? (e.g., first contact attempt should be within 24-48 hours of receiving the screen)
        - Please refer to Outreach and Engagement of Incoming Referrals (Section 3.1) for additional guidance.
    - How many contact attempts does CNJ staff make, and over what period do they reach out to a family?
    - Once a participant has been contacted, how long does the CNJ Hub support that participant?
        - CNJ Specialist, Early Childhood Specialist, or Case Manager
    - Is CNJ staff expected to document contact attempts in CNJ Link?
    - If a family is not interested in a program, how does CNJ serve the family?

    - If the family is interested in home visiting, but the home visiting program is full, how does CNJ serve the family?
    - When does the CNJ Hub close a family in CNJ Link?
- Program outreach to the family
    - What types of outreach methods are acceptable?
    - How soon should the program start outreach attempts to the family?
    - How many attempts should be made and over what period of time?
    - When does a program close a family in CNJ Link, and when should a family be returned to the Hub?

Section 1.13: Community Advisory Board (CAB)

CNJ Hubs are required to convene a Community Advisory Board (CAB) consisting of individuals and partner agencies, which must also be 25% diverse consumers. It is required that consumers of services be active participants in decision-making. The CAB must meet ***at least quarterly*** to discuss significant issues in attaining services for participants, including barriers to care identified by the participants and Connecting NJ (CNJ). Community Alignment Specialists (CAS) will lead or co-lead the planning and facilitation of the Community Advisory Boards with CNJ staff and other CAB members. They will develop agendas, write meeting summaries and recommendations, and have them accessible during site visits. The CAS will assess the CAB's composition for gaps and strengths and work to fill any gaps for the CAB ongoing.

Section 1.14: Hub Partners Meeting

CNJ Hub staff and staff from core programs are required to meet regularly, as determined by the local group, but should occur ***at least quarterly***. These meetings serve as an opportunity for CNJ and core program staff to discuss core program capacity, barriers to engagement, community outreach and engagement strategies, community trends, service needs of families, continuous quality improvement strategies for engagement and retention, and other issues that impact program operation of the CNJ Hub and/or core programs.

Section 1.15: Connecting NJ Hub Screening Tools

Perinatal Risk Assessment (PRA)
The PRA is a standard screening tool that determines demographic, medical, and psychosocial risk factors during pregnancy. The PRA includes the 4Ps Plus to screen for tobacco, alcohol, and other drug use, perinatal depression, and domestic violence. The PRA shall be completed by health care providers during prenatal appointments on the PRA Connect website praconnect.org. PRA consent is covered by the patient's consent for treatment by the provider and covers their insurance provider receiving information related to their care. The completed PRAs, if referred to CNJ, are then sent to the CNJ Link system for CNJ staff to follow up on the individual.

CNJ Online Self-Referral Form
The CNJ Online Self-Referral Form is a web-based informational gathering tool used by birthing and parenting individuals and caregivers requesting support through CNJ. CNJ staff will utilize this information to engage those who requested support and complete comprehensive screening to facilitate appropriate program connection and service linkage.

Initial Referral Form (IRF)
The IRF is the one-page standardized form that shall be used by community partners to refer clients to CNJ. This form can also be completed by CNJ staff at community events or the like for quick connection and engagement with CNJ services.

Community Health Screen (CHS)
The CHS is a standardized tool utilized by CNJ staff to complete a comprehensive screening of birthing individuals and caregivers to facilitate appropriate program connection and service linkage.

Section 1.16: Connecting NJ Data System: CNJ Link

Formerly known as SPECT (Single Point of Entry and Client Tracking), CNJ Link (cnjlink.org) is the single point of entry and client tracking system that serves as the universal data system for Connecting NJ. Owned and operated by Family Health Initiatives (FHI), CNJ Link affords secure transmission of protected health information to a central data repository and triages referrals from providers and community agencies to respective CNJ Hubs. CNJ Link is designed to integrate users from community organizations statewide that rely on the Perinatal Risk Assessment (PRA), Initial Referral Form (IRF), and/or Community Health Screen (CHS), and Connecting NJ Self-Referral Form to assess needs and provide comprehensive care to pregnant and parenting families referred to CNJ for assistance and support.

The CNJ Link system shall be used to identify community needs and facilitate making and tracking referrals. In addition, data collection and reporting, in collaboration with FHI, shall be conducted through the CNJ Link System.

Incoming referrals to CNJ may come from several sources, such as prenatal care providers, health and social service providers, community health workers, and directly from families. Incoming PRA referrals are entered into the PRA Connect system and, if referred to Connecting NJ, are sent to the CNJ Link system. IRFs and CHSs are entered directly into the CNJ Link system. Self-referrals are entered online through New Jersey's Connecting NJ website. CNJ staff shall review CNJ Link daily to monitor for new referrals received.

CNJ Link Partner System: PRA Connect

PRA Connect is the partner data system for prenatal providers to complete PRAs for pregnant individuals. If the PRA includes a referral to Connecting NJ, the completed PRA is then sent to the CNJ Link system for CNJ staff to reach out to the individual.

Information from the CNJ Link system is then sent back to an interactive report in the PRA Connect system to make providers aware of the services their patients have received and provide them with CNJ contact information should they wish to reach out. The interactive report includes information on which CNJ Hub the client was assigned to and what the client received from CNJ (i.e., whether the client was contacted, given service referrals, and/or assigned to a program).

Section 1.17: Health Insurance Portability and Accountability Act (HIPAA) Requirements

The CNJ Hubs will comply with HIPAA requirements by having fully executed Business Affiliation and Data Sharing Agreements in place with FHI. Copies of the agreement shall be kept on file.

Section 1.18: CNJ Link Accounts and User Support

FHI is responsible for the onboarding/registration of users into the CNJ Link system. Depending on their role in CNJ, FHI will assign associated training specific to the user's role. All users are required to have a verified work email address on file and sign the annual End User License Agreement (EULA)/Confidentiality Agreement.

Refer to the CNJ Link introduction video: vimeo.com/962377607/120859150e

Please visit CNJ Link directly for system user guidelines and training materials.

All user requests regarding CNJ Link must be made through the CNJ Link User Support Form, which can also be found on the CNJ Link website under Contact Us → Get Support.

To submit a request:

1. Click Contact Us > Click Get Support > the support page will open in a new window
2. Enter the required fields
3. Click Submit, and our support team will be in touch shortly

Although the user support platform is HIPAA compliant, if the request is regarding a specific participant, FHI recommends communicating with the participant's initials, referral date, and county Hub/program. This information is essential to include in a user request so FHI can locate the participant.

Examples of things within **FHI jurisdiction** to support, including but not limited to:

- Account Setup & Login Issues
- Adding Referring Agencies
- Participant Reopens
- Locating Participants
- Updating Referrals
- System Bugs/Errors/Glitches
- System Training
- Hub Partner Program Onboarding
- Reports/Data Requests

Examples of things within **CNJ Staff jurisdiction** to support, including but not limited to:

- Transferring Participants (Users with admin level access only)
- Assigning Participants to Programs
- Establishing/Using Hub Business Rules
- Warm handoff of participants between Hubs/programs
- Updating participant status and assigned staff person
- Hub/Program-specific procedures outside of CNJ Link

FHI may consult with or defer to CNJ state partners in cases beyond basic user and system support, including but not limited to other guidelines topics.

Hub Partner Program Onboarding

FHI will work with CNJ Hubs in onboarding new Hub Partner Programs. FHI will inform CNJ state partners of any prospective Hub Partner Programs for involvement, awareness, and strategizing statewide if there is more than one local program. FHI will meet with the prospective Hub Partner Program with corresponding CNJ Hub Supervisor(s) and state partners (as desired) to go over expectations, legal agreements, and program setup requirements.

If a prospective program inquiries FHI directly for partnership or a CNJ staff (not supervisor) inquires FHI directly about a prospective partner, FHI will refer them to the corresponding CNJ Hub Supervisor(s) for initial outreach and engagement.

The Hub Partner Programs will comply with HIPAA requirements by having fully executed Business Affiliation and Data Sharing Agreements in place with FHI. Copies of the agreement shall be kept on file. FHI is responsible for program setup, account creation, and program access.

Chapter 2: Key Staffing

Section 2.1: General Guidelines

If a key personnel position is vacated, the state-designated DCF or DOH Project Officer and FHI must be notified in writing within seven (7) days. Please include the plans for coverage of the position until the position is filled. Updates are required monthly to your Project Officer until the position is filled.

Section 2.2 Connecting NJ Staff Roles and Responsibilities

Key staffing shall comprise at a minimum:

Section 2.3 Connecting NJ Program Manager/Coordinator/Supervisor

The Program Manager/Coordinator/Supervisor shall be accountable for administrative duties and overall functioning of the local CNJ program to ensure successful implementation.

Key Responsibilities include:

- Planning, directing, monitoring, and oversight of the CNJ Hub(s)
- Onboarding, training, and direct supervision of the CNJ Specialist, Community Alignment Specialist, CNJ Case Manager, and Early Childhood Specialist (utilizing a reflective supervision/consultation approach)
- Reporting/evaluating operational activities using CNJ Link reports
- Implementing Continuous Quality Improvement (CQI) activities and tracking
- Participation in site visits and state-level meetings, as needed
- Ensure service coordination, and integration/alignment with other local MCH and early childhood initiatives to support and strengthen the collective impact process

CNJ Program Manager/Coordinator/Supervisor Requirements

- BA, BS, or MS Degree in Social Work, Counseling, Psychology, Nursing, or related field
- Two years of program management and supervisory experience (if fulfilling manager/coordinator role)
- Excellent written and verbal communication skills required, and computer literacy preferred
- A high level of familiarity with county health and social services is required

Section 2.4 Supervisory Training: Reflective Supervision/Consultation (RS/C)

CNJ Managers/Coordinators/Supervisors are strongly encouraged to utilize a reflective supervision/consultation (RS/C) approach to support CNJ Specialists, Community Alignment Specialists, CNJ Case Managers, and Early Childhood Specialists.

Reflective supervision is a supervisor-supervisee relationship that pays attention to the influence of relationships on other relationships, the parallel process, and empowers the supervisee to discover solutions/concepts through consciously using strategies that include active listening and waiting. The goal of reflective supervision is to support staff who then support families and create a more effective working relationship.[4]

The Diversity-Informed Tenets for Work with Infants, Children and Families state, "Self-awareness leads to better services for families: working with infants, children, and families requires all individuals, organizations, and systems of care to reflect on our own culture, values and beliefs, and on the impact that racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression have had on our lives in order to provide diversity-informed, culturally attuned services."[5] RS/C attends to the emotional responses to work with birthing individuals, infants, young children, and families, and how reactions to the content shared by families affect this work within one's discipline. In this way, RS/C offers opportunities for professionals to increase self-awareness by identifying and addressing personal biases in the context of a safe "relationship for learning." This increased self-awareness is critical to the provision of culturally responsive services.[6]

Section 2.5: Community Alignment Specialist

The Community Alignment Specialist shall be responsible for developing and maintaining relationships with agencies that serve pregnant people, children from birth to five, and their families for the purposes of establishing reciprocal referral networks and generating representation on the Community Advisory Board. They should attend all required and suggested training from Family Connects International to maintain program fidelity and all meetings and trainings deemed necessary by DCF.

Key Responsibilities include:

- Establish and maintain relationships, partnerships, and coalitions with community resources and services that provide support to families in a timely and appropriate manner, as referred by Family Connects International nurses and that participate in the community system of care for young children and their families. Identify key contacts within local partner agencies (may need to travel out of county).
- Identify resources, establish relationships with providers, maintain an updated list of resources (in Family Connects NJ Salesforce Health Cloud), and identify gaps in needed

[4] https://www.zerotothree.org/resource/reflective-practice-and-reflective-supervision/
[5] https://imhdivtenets.org
[6] https://www.allianceaimh.org/reflective-supervisionconsultation

community resources so that the broader community can be induced to grow these resources over time.

- Maintain ongoing relationships with the prenatal care providers serving residents in the county and out of county and educate prenatal providers to check off the PRA box for linkage to community-based services and share the pathways to make an FCNJ referral.
- Conduct routine follow-up meetings and/or conference calls with prenatal, pediatric, and community providers (at a minimum on a quarterly basis) to meet any new staff, review the referral process, address questions or concerns, and ensure data quality of incoming referrals.
- Attend nurse case conference meetings to provide individual case consultation about community resources to support nurse home visitors as they connect families with community resources, as needed. Communicate regularly, and as needed, to ensure access to needed information and services for CNJ referrals.
- Marketing Family Connects NJ by communicating with referral sources (e.g., obstetric-gynecologic practitioners, hospitals, pediatricians), communicating with groups that interact with families (e.g., employers, newspapers, churches, childcare agencies, the public), and soliciting support from community leaders.
- Implement and utilize community education sessions and larger events focused on prenatal, birthing, early parenting topics, and/or community resources, to provide a service to and engage the FCNJ target population in their communities. Participate in relevant local and/or regional committees and task forces to communicate and collaborate regarding community early childhood and perinatal needs. Train collaborating healthcare providers or community agencies to promote universal home visiting.
- Lead or co-lead the community advisory board (CAB) for Family Connects New Jersey as it coordinates services with others in the early childhood system of care. (Align with Connecting NJ Community Advisory Board).
- Assist in facilitating CQI processes for the local Hub to improve the referral process and alignment of resources.
- Participate in quality improvement and evaluation activities.
- Compile and maintain records, reports, and documentation of program activities regarding community relations for use in program evaluation.
- Bilingual Skills preferred.

Community Alignment Specialist Requirements:

- Master's degree in a related field (e.g., public health, psychology, social work, nursing, communications, marketing), or bachelor's degree with additional related experience. Work requires progressive experience in human services in the public sector, including skill in interacting with human service providers and agency leaders and an understanding of the role of evaluation in social services. A combined five years of experience in a related field is desired.
- Excellent written and verbal communication skills required, and computer literacy preferred. Ability to communicate clearly and professionally with a range of community stakeholders.

- A high level of familiarity with county health and social services is required.
- Understanding of and experience in communication, marketing, and public relations, as well as professional oral and written experience (e.g., public speaking, grant writing).
- Leadership skills and a willingness to take initiative and be proactive.
- Ability to work independently, as well as in teams.
- Ability to accept personal differences, establish trusting relationships, and work with culturally diverse populations.
- Experience with Microsoft Office software (e.g., Word, Excel, PowerPoint, Outlook) and social media platforms (e.g., Facebook, Twitter) required.

Section 2.6: Connecting NJ Specialist

The primary function of the CNJ Specialist is to implement a county-wide system of reciprocal referrals, following the life course model, to coordinate perinatal health care and other early childhood services and supports.

Key Responsibilities include:

- Promote universal screening of birthing individuals using the Perinatal Risk Assessment (PRA).
- Promote universal screening of caregivers and their children utilizing the Community Health Screen (CHS) and the Child Profile Presenting Needs.
- Assess family's needs through screening and make appropriate referrals to programs and/or services as determined with the family and/or due to specified needs by the health care provider.
- Provide information and follow-up to referred birthing individuals, caregivers (mothers, fathers, grandparents, kinship, foster parents, legal guardians), and children from birth to five years of age.
- Provide feedback to referring agencies with data-sharing agreements on the status of referrals.
- Ensure accurate/current data entry and data tracking in CNJ Link; complete all required state forms with attention to quality assurance.
- Attend designated state meetings and participate in the state evaluation process.

Connecting NJ (CNJ) Specialist Requirements

- Minimum requirement shall be a high school degree, with two years of experience in MCH or a health-related field preferred**.** An associate's degree, BA, or BS degree in Psychology, Counseling, Nursing, or a related field is preferred, with experience in MCH or a health-related field preferred.
- Excellent written and verbal communication skills, strong engagement skills, and meticulous attention to detail required. Computer literacy required.
- High level of familiarity with county health, social service, and community resources.

Section 2.7: Early Childhood Specialist

The primary function of the Early Childhood Specialist is to work as part of the Connecting NJ Hub to address all child welfare referrals and those needing infant mental health support. They attend DCPP Early Childhood/Plans of Safe Care case conference and other relevant community-based meetings. Promote developmental health by engaging families in community spaces regarding early childhood social, emotional, and physical developmental screening. Manage the county Hub family access portals (ASQ developmental screening).

Key Responsibilities include:

- Work closely with Early Childhood Systems of Care programs to help link families to the most appropriate and available services.
- Promote universal screening of caregivers and their children utilizing the Community Health Screen (CHS), and inclusive of the Child Profile.
- Provide information and follow-up to referred women/families to facilitate service linkages.
- Provide developmental guidance and promote developmental screening for families, and make referrals as needed.
- Strengthen and align the local-level infrastructure to ensure coordination and collaboration in delivering effective community-based services for the infants, children, parents, and families identified through intake.
- Support DCF's Early Childhood Initiative by providing infant and early childhood mental health consultation to the Division of Child Protection and Permanency's local office. Provide linkages and referrals to services, with special emphasis given to families requiring a plan of safe care.
- Complete required documentation. Submit monthly/quarterly progress reports addressing process and outcome indicators that will help determine strengths and areas needing improvement.
- Participate in quality improvement and evaluation activities.

Early Childhood Specialist Requirements

- Minimum requirement shall be a bachelor's degree; master's degree preferred in Psychology, Social Work, Mental Health Counseling, Early Childhood Education
- Experience in maternal-child health (MCH), infant/early childhood mental health, parent/family support, and/or related fields and settings.
- Strong interpersonal skills with the ability to develop trusting relationships with families and partners.
- Ability to translate complex MCH and early childhood concepts into parent-friendly language.
- Awareness of cultural diversity and its impact on planning and provision of services.
- Excellence in written and oral communication.
- Strong organizational skills and ability to problem-solve.
- Full understanding of the roles of core MCH and early childhood partners.
- Infant Mental Health Endorsed (IMH-E) or pursuing is a plus.

Section 2.8: Case Manager

The primary function of the Case Manager is to work in collaboration with the Connecting NJ Hub. The Connecting NJ Case Manager is responsible for coordinating and providing care that is safe, timely, effective, efficient, equitable, and client centered. The CNJ Case Manager will link families to existing resources in the community, provide personalized care coordination to ensure they are connected to appropriate resources, receive timely information, and are provided with continued support, advocacy, and follow up as needed.

Key Responsibilities include:

- Attend all required meetings and trainings deemed necessary by DCF.
- CNJ has a community focus on pregnant people, caregivers (mothers, fathers, grandparents, kinship, foster parents, legal guardians), and children from birth to five years of age. CNJ Case Managers should make a priority to support individuals who are:
    - Low-income or uninsured, with chronic health conditions, with multiple social and economic stressors, underserved immigrants, victims of domestic violence, individuals impacted by mental health issues, alcohol and/or substance use disorder, and involved with the Division of Child Protection and Permanency.
- Provide information and follow-up to referred women/families to facilitate service linkages.
- Complete required documentation, complete accurately all necessary forms, and produce statistical reports. Submit monthly/quarterly progress reports addressing process and outcome indicators that will help determine strengths and areas needing improvement.
- Work closely with Early Childhood Systems of Care programs to help link families to the most appropriate and available services. CNJ Case Managers provide care coordination for families, research the most appropriate resources, and provide advocacy and follow-up as needed.
- Adhere to professional standards as outlined by protocols, rules, and regulations of the local Hub.
- Ensure timely response when following up with families, new enrollments, work with families, CNJ Hub, and community stakeholders to ensure viable resource options for families in general. Critical thinking and problem-solving are used to determine the best care plan for each client after assessing the client. Flexibility to change care plans in partnership with families if they are not getting the best results.
- Strong verbal and written communication skills to explain to clients, family members, and professionals the case and care plan. Compassionate and able to relate to different clients with various needs.
- Organized and can manage several different cases at once.
- Assists in identifying gaps and barriers to services and system issues that families experience in utilizing services.
- Computer literacy to maintain and manage case records is necessary and must utilize the CNJ Link data system in the local Hub.
- The CNJ Case Manager will participate in CNJ Hub activities as required by their immediate supervisor.

Case Manager (CM) Requirements

- Minimum requirement shall be a bachelor's degree; master's degree preferred in Psychology, Social Work, Mental Health Counseling, Early Childhood Education
- Experience in maternal-child health (MCH), infant/early childhood mental health, parent/family support, and/or related fields and settings.
- Strong interpersonal skills with the ability to develop trusting relationships with families and partners.
- Ability to translate complex MCH and early childhood concepts into parent-friendly language.
- Awareness of cultural diversity and its impact on planning and provision of services. Experience in working with culturally and ethnically diverse families, staff, and community stakeholders.
- Excellence in written and oral communication.
- Strong organizational skills and ability to problem-solve with a strong ability to manage different priorities.
- Full understanding of the roles of core MCH and early childhood partners.
- Proven work experience as a Care Coordinator/Case Manager or similar role.
- Apply good judgment to fast-changing situations.
- Strong customer service skills.
- Bilingual Skills preferred.
- Proficient in Microsoft Word, Excel, and basic database functions.
- Ability to maintain professional boundaries and confidentiality.
- Ability to work independently and as part of a team.
- Participate in quality improvement and evaluation activities.

Chapter 3: Operations

Connecting NJ Specialists interact and engage with families and provide appropriate screening and referrals. These sections outline expectations of policies and procedures of engagement with families.

Section 3.1: Outreach and Engagement of Incoming Referrals

Contact method is defined as a phone call, mail, text message, e-mail, in-person meeting, or virtual meeting.

Each county CNJ Hub should maintain procedures, rules, and guidance on how to best contact incoming referrals for the specific counties and communities they serve, utilizing the above-mentioned contact methods.

Once referrals are received, initial contact attempts shall be made to engage participants for services ***within two business days***.

- Connecting NJ (CNJ) may implement automatic assignments to core partner programs (if the participant is eligible) based on business rules and current CNJ program capacity.

If CNJ was ***able to contact*** the participant during initial contact, see Section 3.2 (Screening Process).

If CNJ was ***unable to contact*** the participant during initial contact, Connecting NJ (CNJ) should make ***an additional three contacts for two weeks at different times and days of the week.*** Referrals from the Division of Child Protection and Permanency should be provided with an ***additional two weeks of outreach efforts, once per week***.

- If CNJ is still ***unable to contact*** the participant ***after two weeks***, based on the Business Rules, the participant shall be assigned to a Hub program (if eligible) for outreach or closed.

All outreach attempts, resources, referrals, and appointments shall be documented in CNJ Link.

Section 3.2: Screening Process

Connecting NJ (CNJ) uses standardized screening tools (PRA or CHS, inclusive of the Child Profile) to assess the needs of the caregiver and child(ren) and determine eligibility for maternal, infant, and early childhood services. CNJ also receives the Initial Referral Form (IRF) that requires further conversation with the family to complete the CHS to assess needs and make appropriate referrals.

Section 3.3: CNJ Hub Screening Tools

Refer to Section 1.15 CNJ Hub Screening Tools

Section 3.4: Screening for Community-based Programs

CNJ works collaboratively with local partners to determine which core services (known as "Programs" in CNJ Link) will be routinely offered. These are typically programs that provide long-term support and may include.

- Evidence-Based Home Visiting – specified as Healthy Families, Parents as Teachers, Nurse-Family Partnership, or other established local EBHV Programs (e.g., HIPPY in Bergen County, or Parent-Child Home in Middlesex County)
    - A discussion and offering of EBHV programs shall take place with all families, especially for: women with minimal family and social support, first-time mothers, and women who have several "Psychosocial Risk Factors" (as specified on the CHS and PRA)
- Healthy Women, Healthy Families
- Healthy Start Case Management (Camden, Essex, Mercer)
- Early Head Start (where applicable)

Section 3.5: Screening for Healthcare Needs

Participants who fall under the categories below shall be provided with information on medical care providers and other services in their area.

- Birthing individuals who are not currently receiving prenatal care or who are unsure where to go for prenatal care
- Individuals who do not have a primary care physician for themselves or their children
- Referrals where "Emergency Room" or "Nowhere" is indicated under Primary Care on the Community Health Screening form
- Referrals where "Dentist" and "Primary Care" are indicated as areas of need in the CHS form
- Behavioral Health
- Health Insurance
- High-risk women within the target population

Section 3.6: Screening for a Child's Needs and Development

Connecting NJ will utilize the Child Profile to assess the presenting needs of each child under the age of five. In addition, CNJ will provide each caregiver the opportunity to screen their child's development utilizing the Ages and Stages Questionnaires.

See Appendix D: *Connecting NJ (CNJ) Developmental Screening Operating Policy and Procedures* for further details.

Section 3.7: Initial Areas to Discuss

Families have an array of needs and possess varied knowledge about community-based resources and child development. Connecting NJ Hubs' opportunity to engage caregivers in a conversation may be limited. Therefore, these are some recommended areas to explore with a caregiver upon initial engagement.

- If pregnant, are they currently receiving prenatal care
- Caregiver and child(ren) have a medical home
- Caregiver and child(ren) have health insurance
- Emergency needs (access to food, GA/TANF, emergency housing/shelter, domestic violence assistance)
- WIC
- Caregiver's understanding of their child's development and any concerns
- Quality childcare

Section 3.8: Screening of Families Referred from the Division of Child Protection and Permanency (DCPP)

Science points to the prevalence of individuals in child welfare systems who are experiencing toxic stress, which impacts a child's brain development, behavior, and attachments. Connecting NJ can help both children and their caregivers build resilience and promote protective factors.

Connecting NJ connects with the DCPP worker within 48 hours of receiving a referral and engages in a conversation to:

- Understand the status of the investigation/case and identify what other referrals have been made by DCPP.
- Identify risk and protective factors: explore the family's trauma history and resiliency, family and social connections, child/ren's development and attachment to the primary caregiver(s), caregiver and child/ren's daily routine, and knowledge of parenting and child development.
- Brainstorm with the DCPP worker about appropriate/best-fit community-based services based on the family's wishes and identified risk factors.
- If the caregiver is already enrolled in a Hub program, inform the worker of their status and provide the program supervisor's contact information.
- If the caregiver requires a Plan of Safe Care, discuss delaying outreach until the case conference to align with the strategies identified. If the DCPP worker prefers for CNJ to conduct outreach prior, CNJ will reach out to the family.

Section 3.9: Participant Follow-Up

Allowing the caregiver the choice to have CNJ follow-up regarding a specific service referral empowers them to plan for themselves and their family. Upon providing a referral for a family that is not moving on to a Hub program, CNJ shall ask whether the caregiver would like CNJ to follow up. Based on the family's needs, case management may be applicable. Those families requesting short-term support and case management will receive follow-up. CNJ staff should discuss an agreeable timeframe for follow-up. If a caregiver prefers not to be followed up with, the service referral is immediately closed as "not interested in follow-up."

Strong consideration for follow-up with families should be given for these presenting needs:

a. prenatal care
b. children's medical home
c. early intervention
d. domestic violence
e. housing/food insecurity
f. crisis intervention

Section 3.10: Case Closures and Return to Hub

A case may be closed within CNJ Link when:

- Completion of goals and referrals, and when participants' identified needs have been met.
- When a participant is not interested in any programs or services.
- Unable to contact participant at specified outreach timeframes as outlined in Outreach and Engagement and Participant Follow-Up Sections (Sections 3.1).

CNJ Hubs shall monitor CNJ Link daily for referrals that core programs have returned. Hub programs shall communicate the needs of the returned family in the notes section. Based upon the return disposition, Business Rules, and CNJ program capacity, referrals shall be reassessed and assigned to other core programs as appropriate.

Chapter 4: Performance Assessment, Feedback, and Reporting

Section 4.1: Continuous Quality Improvement (CQI)

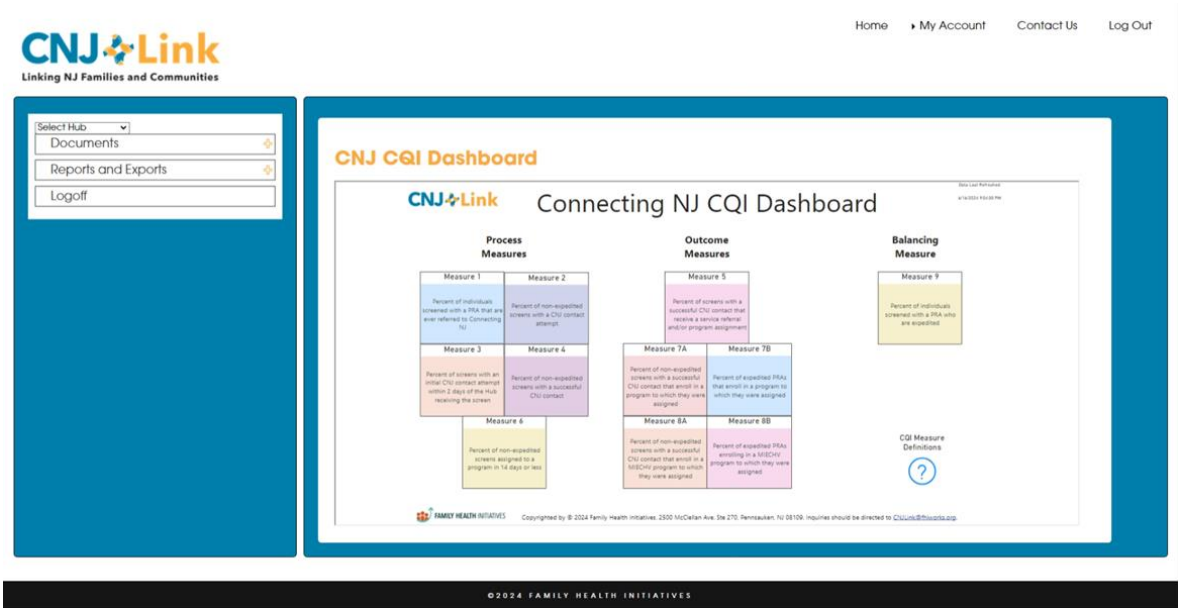
As part of the Maternal and Infant Early Childhood Home Visiting (MIECHV) initiative, NJ state leadership established a Home Visiting/Connecting NJ CQI Evaluation Committee to inform and guide CQI and evaluation efforts in the state's Connecting NJ Hubs and home visiting programs. The Committee includes state leaders from the Department of Health (DOH), the Department of Children and Families (DCF), home visiting model technical assistance providers, home visiting program leadership, Connecting NJ state leadership, parent leaders, and the Johns Hopkins University (JHU) evaluation team. The Committee meets quarterly and is co-facilitated by a representative from DCF and JHU. Over time, the Committee has developed a strong culture of continuous quality improvement (CQI) and has become a model for this work in NJ's early childhood system of care more broadly.

The CNJ CQI measures track the activity of the CNJ Hubs and CNJ network, including both process measures and outcome measures. This includes measures like time to contact, successful contacts, and measures around service referrals and program assignments. These measures are reviewed by the CQI Committee, including the Hubs, and should inform CNJ Hub-recommended CQI activities.

Recommended CQI Activities

To work on continually improving practice, it is recommended that CNJ Hubs conduct at least one Plan-Do-Study-Act (PDSA) cycle per quarter. These PDSAs should be planned and implemented by the CQI team at each CNJ Hub. It is recommended that each PDSA be logged using a PDSA form that captures all aspects of each of the steps of the PDSA cycle.

The CNJ CQI Dashboard was created by the Home Visiting/Connecting NJ CQI Evaluation Committee



Section 4.2: Interagency and Prenatal Care Provider Feedback

The CNJ Grantees shall keep a record in CNJ Link of all referrals made by providers or community agencies and shall generate a report indicating whether the referrals were completed or not. A copy of the report shall be submitted to each provider or agency making participant referrals, via email or hard copy, whichever is preferred.

The interagency feedback shall be generated quarterly and shall include the following:

- Number of referrals submitted by the agency
- Names of participants referred
- Resource or program each participant was referred to

Prenatal Care Provider Feedback:

The Provider CNJ Report is a dashboard in the PRA Connect system that allows prenatal providers to see which PRA patients were referred to CNJ and what CNJ services they received.

The report includes the following:

- Number of First Visit PRAs submitted
- Number of patients referred to CNJ
- Name, date of birth, and estimated due date of patients

If the patient is referred to CNJ, the report includes:

- Which CNJ Hub was the patient sent to

- Hub contact information
- What CNJ services the patient received, including contacts, service referrals, and program assignments

Data Sharing Agreements must be in place between the provider and FHI to share detailed participant data. Also, see HIPAA requirements under *Chapter 1, Section 1.17.*

To assist with Health Provider Outreach and Engagement, refer to *Appendix E: Connecting NJ Health Provider Outreach and Engagement Guidance*

Section 4.3: Reporting

DCF Grantees: Quarterly Reports are submitted electronically to the designated DCF Project Officer and the Contract Administrator on a quarterly basis by the ***15th of the month*** for the previous quarter. The Year-to-Date report is due on July 31st after the fiscal year is complete.

DOH Grantees: Quarterly Reports are submitted to the DOH Project Management Officer for review and approval before being electronically uploaded by the grantee to the DOH System for Administering Grants Electronically (SAGE) on a quarterly basis, ***10 business days*** after the end of the quarter. The CNJ Year-to-Date report is due at the same time as the last quarter report.

Appendix

Appendix A: NJ's Maternal, Infant, and Early Childhood System of Care (MIEC) Across State Departments

Education (DOE)	Human Services (DHS)	Children & Families (DCF)	Health (DOH)	Labor (DOL)
State-Funded Preschool	Subsidized Child Care	Child Care Licensing	Title V MCH Block Grant	NJ Family Leave
Early Head Start/Head Start Collaboration	Child Care Development Block Grant (CCDBG)	Family Childcare Registration	Perinatal Risk Assessment (PRA)–	Temporary Disability Insurance (TDI)
Teacher Credential & Licensing	Wraparound Care	NJ Evidence-Based Home Visiting Programs	Perinatal Addiction	Family Leave Insurance (FLI)
Preschool Special Education (IDEA Part B)	NJ First Steps-- Infant/Toddler	Strengthening Families (SF) Protective Factors Framework	ALMA – Peer Mentor Programs	Unemployment Insurance (UI)
School Support Services (for teen parents)	Family Outreach Workers	Help Me Grow-NJ / Connecting NJ (CNJ)	NJ Postpartum Resources and Support Network	Earned Sick Leave
Federal Title I Services for low-income families	Family Childcare Providers	Parent-Linking/School-Based	Access to Prenatal Care	Work-Force NJ (WFNJ)
Other Federal Education Programs & Services	Child Care Resource & Referral Agencies (CCR&R)	Project TEACH-Teen Parents	Maternal Infant and Early Childhood Home Visiting (MIECHV)	One-Stop Career Centers (OSCC)
Regional Achievement Centers (RAC)	Childcare Workforce Registry	Family Success Centers	Healthy Women, Healthy Families	CHW apprenticeship w/ Rutgers
NJ Council Young Children	WorkFirst NJ-TANF/GA SNAP	DV & Women's Services	Doulas	Smart Steps Career Advancement Voucher Program (CAVP)
	Emergency Services-Addiction & Mental Health	NJ Children's Trust Fund	CLG-CHWI	WFNJ-OJT
	Disability Services (parents)	Federal CBCAP Funds (Child Abuse Prevention)	FQHCs / Primary Care	YTTW-Youth Transition to Work
	Medicaid/NJ FamilyCare	Children's Behavioral Health & Developmental Disabilities	Maternal Care Quality Collaborative	Youth Corps Literacy-Title II
		Child Protection & Permanency	WIC Services / Breastfeeding	Federal Bonding
			Child Health / Immunizations	YouthBuild
			Childhood Lead Program	
			Adolescent Health	

			Personal Responsibility Education Program (PREP) Sexual Risk Avoidance Education (SRAE) Pregnancy Prevention School Health NJ Pediatric Mental Health GLS Suicide Prevention Early Intervention (IDEA Part C) Special Child Health Services Safe Sleep	

Appendix B: Strengthening Families™ Protective Factors

CORE MEANINGS OF THE STRENGTHENING FAMILIES PROTECTIVE FACTORS

Protective Factor	Core Meaning
Parental Resilience: Managing stress and functioning well when faced with challenges, adversity and trauma.	Resilience Related to General Life Stressors a. managing the stressors of daily life b. calling forth the inner strength to proactively meet personal challenges, manage adversities and heal the effects of one's own traumas c. having self-confidence d. believing that one can make and achieve goals e. having faith; feeling hopeful f. solving general life problems g. having a positive attitude about life in general h. managing anger, anxiety, sadness, feelings of loneliness and other negative feelings i. seeking help for self when needed Resilience Related to Parenting Stressors a. calling forth the inner strength to proactively meet challenges related to one's child b. not allowing stressors to keep one from providing nurturing attention to one's child c. solving parenting problems d. having a positive attitude about one's parenting role and responsibilities e. seeking help for one's child when needed
Social Connections: Positive relationships that provide emotional, informational, instrumental and spiritual support.	a. Building trusting relationships; feeling respected and appreciated b. Having friends, family members, neighbors and others who: • provide emotional support (e.g., affirming parenting skills) • provide instrumental support/concrete assistance (e.g., providing transportation) • provide informational support/serve as a resource for parenting information • provide spiritual support (e.g., providing hope and encouragement) • provide an opportunity to engage with others in a positive manner • help solve problems • help buffer parents from stressors • reduce feelings of isolation • promote meaningful interactions in a context of mutual trust and respect c. Having a sense of connectedness that enables parents to feel secure, confident and empowered to "give back" to others

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CORE MEANINGS OF THE STRENGTHENING FAMILIES PROTECTIVE FACTORS

Protective Factor	Core Meaning
Knowledge of Parenting and Child Development: Understanding child development and parenting strategies that support physical, cognitive, language, social and emotional development.	Seeking, acquiring and using accurate and age/stage-related information about: a. parental behaviors that lead to early secure attachments b. the importance of • being attuned and emotionally available to one's child • being nurturing, responsive and reliable • regular, predictable and consistent routines • interactive language experiences • providing a physically and emotionally safe environment for one's child • providing opportunities for one's child to explore and to learn by doing c. appropriate developmental expectations d. positive discipline techniques e. recognizing and attending to the special needs of a child
Concrete Support in Times of Need: Access to concrete support and services that address a family's needs and help minimize stress caused by challenges.	a. being resourceful b. being able to identify, find and receive the basic necessities everyone deserves in order to grow (e.g., healthy food, a safe environment), as well as specialized medical, mental health, social, educational or legal services c. understanding one's rights in accessing eligible services d. gaining knowledge of relevant services e. navigating through service systems f. seeking help when needed g. having financial security to cover basic needs and unexpected costs
Social and Emotional Competence of Children: Family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions and establish and maintain relationships.	<u>Regarding the parent:</u> a. having a positive parental mood b. having positive perceptions of and responsiveness to one's child c. responding warmly and consistently to a child's needs d. being satisfied in one's parental role e. fostering a strong and secure parent-child relationship f. creating an environment in which children feel safe to express their emotions g. being emotionally responsive to children and modeling empathy h. talking with one's child to promote vocabulary development and language learning i. setting clear expectations and limits j. separating emotions from actions k. encouraging and reinforcing social skills such as greeting others and taking turns l. creating opportunities for children to solve problems <u>Regarding the child:</u> a. developing and engaging in self-regulating behaviors b. interacting positively with others c. using words and language skills d. communicating emotions effectively

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Appendix C: Case Closure Definitions

Client Refused Service

Participant refused *this SPECIFIC* HV program but is interested in a different program (i.e., may be interested in PAT or CHW, but not NFP)

Not able to accommodate participant's schedule

Program staff have been unable to accommodate participants' education or work schedule, however, another program might be able to.

Not Eligible

Participant does not meet program criteria but may be eligible for a different program (HV, CHW, etc.)

Outreach Time Expired

The program is unable to enroll participants within the specified outreach period, OR clients' gestational age has exceeded program limitations prior to enrolling. CNJ or another program is likely to enroll the participant.

Outreach Unsuccessful

Unable to reach the client, however, *there is a strong likelihood* that another program may be able to reach them.

Program at Capacity

No available openings for a client in this specific program.

Referred in Error

CNJ or ECS mistakenly referred to the incorrect program and needs the referral back for reassignment.

Returned for Assignment

For use by ECS and CHW. Client's immediate needs have been met, and the participant desires participation in a program or CHW case management.

Services not available in the Client language

Even with available translation assistance, no program staff is able to provide services in the participant's primary language. However, another program may be able to meet participant needs.

Other Reason

"Other" should *only* be used in rare circumstances and must be clearly documented in notes.

Client Close/Discharge Options: The client is not returned to HUB for reassignment. The client is removed from the system.

Additional Services Not Needed

Connecting NJ (CNJ)/Family feels they have received the services and benefits of the program but is no longer interested in participating. An example is a pregnant person who has participated throughout the pregnancy but feels that any services after the birth are no longer needed.

Already Receiving Services

Client is currently receiving services from *another* Home Visiting or CHW program.

Case Completed

Client has successfully completed all of the objectives or requirements of the program.

Client Noncompliant

Program staff are in contact with the participant; however, the client has missed several consecutive scheduled appointments.

Duplicate

The program is already working with or outreaching the client.

Infant/Maternal death**

Neonatal, infant, or maternal death

Lost To Follow-Up

Staff are no longer able to contact the client after *some* program participation.

No longer Pregnant**

Client is no longer pregnant due to EAB or loss.

Outreach Time has **Expired**

Unable to enroll the client within the program-specified outreach period. Unlikely that another program will be able to enroll a participant.

Patient Moved

Client has moved out of the area serviced by the current program.

Patient Refused Service

Client actively refuses new participation in a program OR refuses any further visits from program staff with whom they may have been working.

Referrals Completed

Client's needs have been successfully met via service referrals, and no additional services are needed. Generally used by ECS and CHW programs for a client who only requests one or two specific services ***AND*** a 2-page CHS ***IS*** completed.

Services not avail in Pt lang

Even with available translation assistance, no program staff can provide services in the participant's primary language.

Unable to accommodate participant schedule*

Program staff is unable to accommodate the participant's education or work schedule, despite attempts to visit virtually, evenings, and weekends.

Unable to Contact

Unable to contact the client by any means within–specific outreach period. Unlikely that CNJ or another program will be able to make successful contact.

Other

Please discuss this with CNJ HUB. "***OTHER***" should only be used in rare circumstances and must be clearly documented in notes.

***Unavailable during the day** was removed and amended to **Unable to accommodate participant schedule**

Previous close reason of **No longer Pregnant/Infant Loss was split into **No longer Pregnant** and an additional discharge reason, **Infant/Maternal death**

Appendix D: Connecting NJ Developmental Screening Operating Policy and Procedures

Connecting NJ Developmental Screening

Operating Policy and Procedures

Table of Contents

Background

As part of the Early Childhood Comprehensive Systems Collaborative Improvement and Innovation Network (ECCS CoIIN), developmental screening was first tested and piloted in Essex, Camden, Cumberland, Middlesex, and Passaic Central Intakes in 2018. In July of 2019, with funding from the Preschool Development Grand Birth-Five for the Early Childhood Specialist Initiative, developmental screening was expanded statewide. Families of young children now have universal access to developmental screening through the Brookes Publishing Family Access Portal.

1. The Importance of Early Childhood Development and Developmental Screening

Children come into the world eager to learn. The first five years of life are a time of enormous growth of linguistic, conceptual, social, emotional, and motor competence. Right from birth, a healthy child is an active participant in that growth, exploring the environment, learning to communicate, and, in relatively short order, beginning to construct ideas and theories about how things work in the surrounding world. The pace of learning, however, will depend on whether and to what extent the child's inclinations to learn encounter and engage supporting environments. There can be no question that the environment in which a child grows up has a powerful impact on how the child develops and what the child learns.

Screening young children is an effective, efficient way for professionals to check a child's development, help parents celebrate their child's milestones and know what to look for next, and determine whether follow-up steps are needed. It's also an essential first step toward identifying children with delays or disorders in the critical early years, *before* they start school.

- Because social-emotional and developmental delays in children can be subtle, most children who would benefit from early intervention aren't identified until after they start

school. In fact, this happens 70% of the time when busy pediatricians and specialists rely on clinical judgment alone.[7]

- Developmental delays, learning disorders, and behavioral and social-emotional problems are estimated to affect 1 in every 6 children.[8] Only 20% to 30% of these children are identified as needing help before school begins.[9]

- Intervention before kindergarten has huge academic, social, and economic benefits. Studies have shown that children who receive early treatment for developmental delays are more likely to graduate from high school, hold jobs, live independently, and avoid teen pregnancy, delinquency, and violent crime, which results in savings to society of about $30,000 to $100,000 per child.[10]

- If social-emotional problems are identified and addressed early, children are less likely to be placed in special education programs, and later in life, they're also less likely to experience school failure and unemployment.

Here are some points you can make to parents during conversation or in printed materials that you distribute before screening[11]:

- Your answers will show your child's strengths and highlight any areas in which your child may need more help or practice. **And if additional practice is needed, I can share some <u>fun and easy activities</u> that you and your child can do at home.**

- Your answers will help me get to know your child better and how I can support them in the classroom. **This may include modifying certain classroom activities.**

- Your answers will be helpful in determining whether your child needs further support or assessment. **It's best to share concerns early when your child can reap the benefits of early intervention, rather than waiting until your child starts school. And even if a concern is a typical variation in development, it's better to raise concerns with a professional so you can be sure.**

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[8] Glascoe, F.P. (2000). Early detection of developmental and behavioral problems. Pediatrics in Review, 21(8), 272–280.

[8]*Dunkle, M. (Fall 2004). High Quality Developmental Screening.* Developmental & Behavioral News, 13(2).
[9] Component Seven: Surveillance and Screening Facilitator Manual, Medical Home Initiatives for Children with Special Needs. http://www.medicalhomeinfo.org/training/materials/April2004Curriculum/SS/Screening Facilitator.pdf
[10] Glascoe, F.P., Shapiro, H.L. (2004, May 27). Introduction to Developmental and Behavioral Screening developmental behavioral pediatrics online. Retrieved December 16, 2005, from http://www.dbpeds.org/articles/detail.cfm?id=5

[11] Helping Parents Understand the Benefits of Developmental Screening. https://agesandstages.com/wp-content/uploads/2017/11/Helping-parents-understand-the-benefits-of-developmental-screening.pdf

2. The Ages and Stages Questionnaire (ASQ-3) and Brookes Publishing Family Access Portal

a. The Ages and Stages Questionnaire and Ages and Stages Questionnaire: Social Emotional, Second Edition (ASQ-3 and ASQ SE-2) provides reliable, accurate developmental and social-emotional screening for children between 1 month and age 5 ½ years old. The ASQ-3 screens five skill areas: communication, gross motor, fine motor, problem solving, and personal-social. The ASQ SE-2 helps track a child's social and emotional development.

b. Adjusting for Prematurity: A child's age is adjusted if he or she is 3 or more weeks premature and is under 2 years of chronological age. Once a child is 2 years and older, adjusted ages no longer need to be calculated. Both the ASQ-3 and the ASQ: SE-2 require you to adjust a child's age for prematurity.

c. The Brookes Publishing Family Access Portal (ASQ Online) is a web-based management system for the Ages and Stages Questionnaires that makes it easier for ASQ users to manage and track child data. ASQ Online has all the integrity of ASQ-3 and ASQ SE-2 plus the convenience of automated scoring, and a powerful functionality that transforms ASQ findings into child screening reports.

3. Roles and Responsibilities of Staff

a. Program Administrator: Oversees the ASQ Family Access portal within the Program (Connecting NJ). The program administrator also conducts the technical support, set-up, and monitoring of the portal. (Early Child Specialist/Supervisor or CNJ Supervisor)

b. Provider: Is assigned a completed screen within the ASQ Family Access portal and is responsible for follow-up, including sharing the results of the screen; and providing resources and referrals to supportive services. (Early Childhood Specialist and Connecting NJ Specialist)

c. Reviewer: Only has access to data and reports within the Family Access Portal.

4. Procedures for Assigning and Reviewing a Developmental Screen

a. Program Administrator or designee logs in daily to the ASQ Family Access portal to check for *New Family Access Screenings* to approve and assign to a provider. (When a screen is outside of the county, follow the transfer policy)
   - Results of the screen should be taken into consideration when assigning to a provider.

b. Within 1 business day of receiving an assignment, the Provider sends (via email or text) a confirmation/thank you message and general info (about CNJ, development, etc.) to the parent/caregiver.

c. Within 5 business days of CNJ receiving the completed screen, the Provider reviews the screen, compiles relevant materials, and attempts to provide feedback to the parent/caregiver.

- If scores are **above the monitoring zone ('on track')** and there is no parent concerns noted in the unscored section, the Provider outreaches the parent/caregiver to schedule a discussion. If unable to reach the parent/caregiver during the initial follow-up effort, 3 more attempts shall be made at three different times and days of the week for a period of 2 weeks. If still unable after 2 weeks, the Provider sends the parent/caregiver (via mail or email) a letter, a copy of the screen and summary, general development learning activities, and additional information about community programs and CNJ.

- If scores are near the **cut-off ('in the monitoring zone'),** the Provider outreaches the parent/caregiver to schedule a discussion. If unable to reach the parent/caregiver during the initial follow-up effort, 3 more attempts shall be made at three different times and days of the week for a period of 2 weeks. If still unable after 2 weeks, Provider sends parent/caregiver (via mail or email) a letter, copy of the screen and summary, general development learning activities, intervention activities targeted to domains of possible concern, information about IDEA Part C (Early Intervention) or Part B (Early Childhood Special Education) services and additional information about community programs and CNJ. The letter should invite the parent/caregiver to contact CNJ to discuss and to rescreen the child in 2 months.

- If **scores are below the cut-off ('further assessment needed'),** in any domain OR if there are parent concerns noted in the unscored section, the Provider outreaches the parent/caregiver to schedule a discussion. If unable to reach the parent/caregiver during the initial follow-up effort, 3 more attempts shall be made at three different times and days of the week for a period of 2 weeks. If still unable after 2 weeks, the Provider sends the parent/caregiver (via mail or email) a letter, a copy of the screen and summary, intervention activities targeted to the domains of concern, information about IDEA Part C or B services, and additional information about community programs and CNJ. The letter should invite the parent/caregiver to contact CNJ to discuss and to rescreen the child in 2 months.

5. Discussing Results with Caregivers[12]:

a. Use consistent talking points from "Home Visitors Guidance on Talking with Parents Regarding Developmental Screening, Administration, Referral and Follow-Up" (derived from the Birth to Five: Watch Me Thrive Home Visitor's Guidance).

b. Thank the parent/caregiver for completing the screen.

c. Consider cultural or language issues

[12] ASQ-3™ and ASQ:SE™ Tips for Discussing Screening Results with Families

- What is the family's home language? Do you need an interpreter? What family members should be included in this discussion
- Consider adjusted procedures or timelines for situations where the parent/caregiver speaks a language other than CNJ staff and/or available ASQ-3 questionnaires.

d. Begin the conversation by celebrating the child's strengths

e. Address any missing items or issues with completion of screen.

f. Address any concerns the parent/caregiver noted on screen or stated during correspondence.

g. Ask if child's medical home or childcare center has ever noted concerns or developmental delays.

h. Encourage parent/caregiver to share the screening and summary sheet with their child's medical home and/or childcare provider.

i. Remember, it is not your job to convince parent/caregiver to make a referral, but to guide and support
   - Be ready for big feelings, or no feelings. Stay calm. Support parents when they are ready. Your role is to support, guide and inform parents about resources. If parent/caregiver is not ready to make a referral, that is their choice.

j. Referrals to Part B Services: Provide parent/caregiver with contact information for the school district's Early Childhood Special Education services.

k. Referrals to Part C Services: Offer parent/caregiver option of receiving toll-free #, assisting them in calling (3-way), or having Early Intervention contact them with their permission.

l. Handouts for clients can include but are not limited to:
   - CDC LTSAE materials
   - SPAN/Boggs "What to Do When There Are Developmental Concerns"
   - Zero To Three's Age-Based Tips from Birth to 36 Months

6. Transferring and Managing Screens Outside of County and State

a. If screen is from a different county than designated CNJ, the Program Administrator will accept and assign the screen to the Provider. After the screen is assigned, email Rynesha Williams, Family and Community Engagement Coordinator, the Child ID, child's initials, and which county to transfer the screen too. She will email once the ASQ screen is transferred to the correct county.

b. If screen is from outside of the state the program administrator accepts the screen and outreaches to the family with the results via phone, email, mail or text. The provider will recommend the results be shared with their medical home and give them additional resources, such as Help Me Grow information in particular state, CDC's Milestone Tracker App or other standard national resources.

Recommended language for letter to parent/caregiver:

Dear [parent]:

Thank you for submitting the recent online questionnaire form for your child, [name]. Although we provide screening services to New Jersey residents only, we would like to review the results of your screening with you and recommend that you share them with your child's pediatrician. Your state may offer similar screening programs that you can follow up with in the future or you can visit cdc.gov/ncbddd/actearly/milestones-app.html to download the Milestone Tracker App. Here are some additional resources that may be beneficial.

(include Help Me Grow information in their particular state and other standard national resources)

Sincerely,
[CNJ Hub]

7. Documenting Follow-up in CNJ Link

The Family Access Portal allows Connecting NJ not only to provide a service for families but also as an outreach tool to engage families who otherwise may not come into contact with Connecting NJ. If a developmental screen is completed, and the family is not already found open in CNJ Link, an Initial Referral Form should be completed (referral source should be Family Access Portal). All notes and service referrals should be documented.

Appendix I: Family Access Portal Website Addresses

Help Me Grow New Jersey
Free Developmental Screening

To complete a free developmental screen
use the links below for your designated County.

County	English ASQ - 3 Link
Atlantic	http://bit.ly/ASQAtlanticCoEnglish
Bergen	www.asqbergen.org
Burlington	http://bit.ly/ASQBurlingtonEng
Camden	http://bit.ly/ASQeng
Cape May	http://bit.ly/ASQCapeMayEnglish
Cumberland	www.asq.2.vu/cumberland
Essex	http://ASQEssex.2.vu/English
Gloucester	www.asqonline.com/family/203f6b
Hudson	www.asqhudson.org
Hunterdon	www.asqhunterdon.org
Mercer	www.asqmercer.org
Middlesex	www.asqmiddlesex.org
Monmouth	https://www.asqonline.com/family/f50e39
Morris	www.asqmorris.org
Ocean	https://www.asqonline.com/family/53e08e
Passaic	www.asqpassaic.org
Salem	www.asqonline.com/family/50e796
Somerset	www.asqsomerset.org
Sussex	https://www.asqonline.com/family/74ef7a
Union	www.asqunion.org
Warren	https://www.asqonline.com/family/e977b8

Help Me Grow
New Jersey

Help Me Grow New Jersey
Free Developmental Screening

Para completar una pantalla de desarrollo gratuita, use los enlaces a continuación para su condado designado.

Condado	Español ASQ- 3 Link
Atlantic	http://bit.ly/ASQAtlanticCoSpanish
Bergen	www.asqbergenfamilias.org
Burlington	http://bit.ly/ASQBurlingtonSpanish
Camden	http://bit.ly/ASQspan
Cape May	http://bit.ly/ASQCapeMaySpanish
Cumberland	www.asq.2.vu/cumberlandspan
Essex	http://ASQEssex.2.vu/Spanish
Gloucester	www.asqonline.com/family/22675c
Hudson	www.asqhudsonfamilias.org
Hunterdon	www.asqhunterdonfamilias.org
Mercer	www.asqmercerfamilias.org
Middlesex	www.asqmiddlesexfamilias.org
Monmouth	https://www.asqonline.com/family/5b057b
Morris	www.asqmorrisfamilias.org
Ocean	https://www.asqonline.com/family/3091c8
Passaic	www.asqpassaicfamilias.org
Salem	www.asqonline.com/family/4e3207
Somerset	www.asqsomersetfamilias.org
Sussex	https://www.asqonline.com/family/c1567c
Union	www.asqunionfamilias.org
Warren	https://www.asqonline.com/family/052b8c

Help Me Grow
New Jersey

Appendix E: Connecting NJ Health Provider Outreach and Engagement Guidance

Connecting NJ Health Provider Outreach and Engagement Guidance

A. Rationale

- Strategic, ongoing outreach is critical for developing and maintaining relationships with providers to increase the number of families referred to Connecting NJ.
- Regular outreach increases referrals to Connecting NJ, helps families connect to services more efficiently, and creates provider buy-in to the Connecting NJ system.
- A standardized, shared set of language and outreach practices across the Connecting NJ system will ensure that a consistent baseline of outreach is delivered to providers throughout New Jersey.
- Standardized outreach practices will allow the Connecting NJ system to uplift best practices, to better assess barriers to referrals from providers, and inform ongoing Continuous Quality Improvement activities.

B. Contents. This document is structured with the goal of providing standardized guidance for each of the typical stages of outreaching and establishing a relationship with a provider. These stages include: 1.) Setting up the initial meeting; 2.) Conducting the initial meeting; and 3.) Maintaining and expanding the relationship once it has been established. The last section of this document offers special considerations when conducting outreach to health providers and additional tips and ideas.

C. Definitions and Roles. This guidance utilizes the following terms, defined as follows:

- **Connecting NJ:** New Jersey's network of partners and agencies dedicated to helping New Jersey families thrive. Connecting NJ utilizes a county-based, single point-of-entry system that simplifies and streamlines the referral process for obstetrical, prenatal, and medical care providers, community agencies, and families.
- **Provider:** For the purposes of this document, the "Provider" is any medical practice that provides prenatal, obstetric, postpartum, or pediatric/family care.
- **Outreach:** Activities conducted to establish, develop, and maintain collaborative relationships with providers to increase referrals to Connecting NJ.
- **CNJ Link:** The Connecting NJ statewide referral database serves as a secure portal to link families to services. This system is utilized by referring providers, Connecting NJ Hubs, and other community-based programs.
- **CNJ Hub:** County-specific receiver of incoming referrals from providers and other sources to CNJ. Each Hub triages referrals to appropriate programming for further outreach.
- **PRA:** The Perinatal Risk Assessment (PRA) is the mechanism used by providers to refer a patient to Connecting NJ for community-based services directly through

CNJ Link. It is structured as a health questionnaire and provides an introductory view of a patient's presenting health and social service needs.

- **Outreach Roles:**
  - **Community Alignment Specialist (CAS):** The Community Alignment Specialist develops and maintains relationships with providers (and other entities) that serve pregnant people, children birth to five, and their families for the purposes of establishing reciprocal referral networks and generating representation on the Community Advisory Board.
  - **Early Childhood Specialist (ECS):** The Early Childhood Specialist develops and maintains relationships with providers (and other entities) that serve pregnant people, children birth to five, and their families for the purposes of promoting child developmental screening and referrals to the Connecting NJ system.

Establishing the Provider Relationship: Setting up the Initial Meeting

A. Who to Outreach

- Connecting NJ interfaces with a broad range of traditional and non-traditional providers to promote Connecting NJ services and encourage referrals to the Connecting NJ system. Identifying who these providers are in your catchment area is the first step to conducting outreach.
- These providers can include (but are not limited to) the following roles: obstetricians, gynecologists, doulas, midwives, pediatricians, and primary care physicians; and can include (but are not limited to) the following practices: Federally Qualified Health Centers, prenatal clinics, OBGYN offices/groups, pediatrician offices/groups, and family practices.
- After identifying a provider of interest, a subsequent step is to identify an effective person of contact for that provider or practice. This contact may be the doctor/doula/midwife etc. but is also very likely to be an office manager or another staff member in a management role at that practice. Identifying this contact person or persons can be the most significant challenge to initiating a relationship with a new provider, and often requires creativity, persistence, relational communication and sales skills, and a customized strategy for each provider.

B. How to Outreach

- When pursuing a new provider, a primary goal is to generate interest in setting up an initial meeting with them to discuss Connecting NJ services.
- Stop-byes with promotional materials and a quick elevator pitch are particularly effective, and especially effective if you are able to obtain contact information for a person to follow up with afterwards.

- Cold calls and emails may also work but are often less effective.
- If a provider is unavailable or closed, leaving promotional materials with a receptionist, in a mailbox, or under or around the door may generate interest, but is unlikely and should not be relied upon.
- Networking and friendly communication is often the key to opening the doors to a successful relationship with the provider. Does the receptionist know who is best to reach out to? Is there a preferred time to call? Is email more convenient? Professionalism, confidence, gratitude, and a warm attitude of curiosity and service can also go a long way.

C. When to Outreach.

- Providers operate differently and on different schedules. Knowing what days and times the office is open is important; identifying less busy days and times to reach out or stop by is helpful.
- Stop-byes during lunch hours are often successful.
- Trial-and-error is often how the initial contact is first made. Persistence and frequent attempts are necessary.
- Timely follow-up after an initial contact with a provider is important. If you stopped by and the provider is interested in setting up a meeting, calling or emailing the provider by the next day or at minimum within the business week can increase the likelihood of that meeting actually happening. Waiting too long in between contacts will decrease this.

Conducting the Initial Meeting

A. What to Talk About in the Initial Meeting:

- **Understand the Provider's Needs, Roles, and Processes**

  - Show interest in getting to know the Provider and the patients they serve, and express curiosity by asking open-ended questions about how the Provider operates and the needs of their patients. Thoughtful, knowledgeable questions can be helpful and generate trust. Good questions may include:

    - *How many patients do you serve?*
    - *What kinds of needs do they typically have?*
    - *Are there specific resources that your patients tend to ask for?*
    - *Do you accept Medicaid?*
    - *How are uninsured patients handled?*
    - *Where do your moms deliver?*

- *Where do moms go for their ultrasounds?*
- *How are high-needs pregnancies handled?*
- *Do you offer Centering prenatal care?*
- *Do you accept non-English speaking patients/offer translation services?*

- Develop a deeper understanding of the Provider's internal referral process and key staff involved in referring their patients to community-based services. Questions may include:

    - *Who in your office has conversations with patients about their needs?*
    - *If the office is a PRA provider, who is completing the PRAs?*
    - *How are the PRAs completed? When?*
    - *Are all PRA families referred to Connecting NJ? If not, what situations/needs designate a referral to Connecting NJ?*
    - *How is the referral process communicated to the patient?*
    - *How are non-PRA families referred to services?*
    - *If the office is a prenatal provider and not yet a PRA provider, would they be interested in learning more about accessing the CNJ Link system.*

- **Discuss How Collaboration Can Benefit the Provider and their Patients.** Explore and explain how Connecting NJ can be a support to the Provider. Benefits of collaborating with Connecting NJ include:

    - Connecting NJ can help the Provider meet their patient's social service needs by identifying resources for their families and working to connect them to these resources. In practices where needs are high and social workers are limited, this can be a big draw for the Provider. Discuss the role of social determinants of health and the variety of community-based resources that Connecting NJ offers for all their patients across the lifespan.
    - Connecting NJ can establish in-home support for the patient via a registered nurse or family support worker to promote improved health outcomes for the patient and their families. Emphasize the high level of child developmental screening as well as mental health, domestic violence, substance use, and other health screenings that these home visitation programs provide, and that these cumulative services can support the family for up to five years after the child's birth.
    - Highlight how easy the Connecting NJ experience is for the patient. Connecting NJ is streamlined, convenient, personalized, relational,

effective, and provides quick access to comprehensive services and continuity of care.

- Highlight how easy the Connecting NJ experience is for the Provider. Connecting NJ can provide a closed feedback loop for referrals, and report back to the Provider the supportive services their referred patient received. If the office is a PRA provider, let them know that the online PRA "PRA Connect" portal allows them (and their patients) direct access to this feedback.

- **Identify your main Points of Contact for the Provider.** Be sure to leave the meeting with a clear understanding of who are your point(s) of contact moving forward. Is it the OB, the nurse manager, the office manager, the staff member who completes the PRA? Be sure to ask what the best way is to contact that person, when the best time to reach out is, and to record that contact information for follow-up.

- **Discuss What Happens When the Provider Refers.**

  - Make sure the Provider understands how to refer their patients to Connecting NJ (via the PRA "Community-Based Services" Referral Box, or an emailed or faxed IRF), and to answer any questions they may have about Connecting NJ, the PRA, IRF, PRA Portal, etc.
  - Explain what happens when the Provider refers their patient: the patient will receive a friendly call (and/or text/email/mail depending on how your local Connecting NJ Hub operates) from a Connecting NJ staff member who will then work with the patient to further assess their needs and connect them to available resources.
  - If possible, share the phone number the patient will be called or texted from so the patient can expect the call/text and be more likely to pick up.
  - Emphasize the importance of how the Provider explains this referral process to their patients. The more prepared their patients are to be contacted by Connecting NJ, the more likely they are to connect with services.

B. Share Materials with the Provider. Be sure to support your discussion with relevant literature and materials. These materials include:

- **Your Contact Information:** Business Cards, or other means of sharing your contact information, as well as contact information for any other Connecting NJ system member you recommend the Provider be in contact with.

- **Referral Information:**
  - PRA Provider Video
  - PRA Connect Portal
  - PRA Patient Video and Portal: yourhealthyourstory.org
  - Connecting NJ Flyer
  - "Check the Box" Flyer (prenatal PRA Providers)
  - Initial Referral Form (all other Providers)
  - Your slideshow presentation (if prepared/provided)

- **Resource Information:**
  - Family Connects NJ Flyer and website
  - NFP, HF, PAT Home Visiting Flyers
  - Any other information on resources the Provider may be interested in

C. Concluding the Meeting and Setting Up Next Steps:

Explore next steps with the Provider:

- Offer to provide a CNJ presentation at an upcoming staff or department meeting.
- Are there further contacts or partners the Provider would like to put you in touch with?
- Are there further resources the Provider would like more information on?
- Invite the Provider to your next Community Advisory Board Meeting.

Conclude the Meeting:

- Thank the Provider for taking time out of their busy schedule to meet with you, and for referring their patients.
- Make sure to communicate how important the Provider is to the Connecting NJ and Family Connects NJ systems. How significant their role is at the statewide level in improving health outcomes for New Jersey mothers. How much you and the State of New Jersey appreciate their partnership. Without their participation, we would not be able to continue to keep resources such as home visiting in our community. We truly rely on their partnership to keep these free programs filled and going and there for the next family who needs them, and we are deeply grateful for their interest, compassion, and time.

Post-Meeting: Be sure to follow up with an email thanking the Provider for their time, highlighting important reminders and including any important attachments.

After The Initial Meeting – Maintaining and Expanding the Relationship

A. Creating and Maintaining the Referral Feedback Loop

- A "referral feedback loop" is a mechanism that tells the Provider what the referral status/disposition is of the patients they have referred to Connecting NJ. This information can tell the Provider if the patient was successfully contacted by Connecting NJ, if there were barriers to contact, if the client enrolled in a program, if a client declined a program, etc.
- Establishing a referral feedback loop can be very helpful in maintaining and strengthening the relationship with the Provider. It demonstrates Connecting NJ's investment in their patients and partnership in their care, and many Providers appreciate this follow-up information that allows them to "close the loop".
- Ask the Provider what their preferred referral feedback loop mechanism is. The easiest mechanism for them to use is the PRA Connect online portal, which was developed for Providers for this very purpose. Other mechanisms can include a manually created report (typically an Excel or Word document), or an in-person discussion or call-in in which updates are verbally discussed.
- Keep in mind that knowing the Provider's referrals (knowing their referred patient's names and situations, risks, and needs) goes a long way in assuring the Provider that you care. In other words, study up before you close the loop with them.
- The referral feedback loop provides an excellent reason and opportunity to connect regularly with the Provider to provide them with this updated information. Would the Provider be open to a monthly or quarterly meeting with you to discuss this report with them? Such meetings can also be a good time to discuss their higher-needs patients (how can Connecting NJ help?), patients you have been unable to reach (does the Provider have a better or updated phone number?), and any new updates/resources that may be helpful to them.

B. When to Follow Up

- Regular, planned follow-up communication (meetings, calls, emails, mailings, stop-byes to drop off flyers/materials, thank-you' s, etc.) is critical to maintaining and expanding your relationship with the Provider and ensuring continued referrals to Connecting NJ. Frequent and repeated engagement is often needed to stay at the forefront of the Provider's attention. Stay organized around when the last time you were in communication with the Provider, what was discussed, and what next steps were promised, and add reach-out reminders to your calendar.
- The frequency and timing of your regular follow-up with the Provider will be individualized to the Provider, based on their needs and availability. Ask them what

works best for them – is it a monthly or quarterly meeting to discuss your feedback loop? Is it a weekly email to check in on their needs? If regular follow-up is not possible, be sure to connect well with your contact so they remember you and aim for an annual meeting at minimum to review Connecting NJ services and processes.

- There may be times when setting up a meeting or call becomes more urgent and necessary. Reach out if you notice a recent decrease in referrals (why is this happening – has there been a change in the Provider's staffing or policies?), if there is a change in the Provider's leadership, staffing, or your point of contact (especially among staff who process PRAs, frontline staff who offer community-based services to their patients, or newer staff who may not yet be familiar with Connecting NJ), or if there is a change in your staffing in terms of who the Provider's Connecting NJ point of contact is.

C. Pursuing Further Opportunities for Collaboration

Once the Provider relationship has been well-established, don't be afraid to pursue further opportunities for collaboration. Such opportunities can go a long way in strengthening provider buy-in to the Connecting NJ system and can open significant outreach channels later down the line. Examples of opportunities can include:

- On-site Connecting NJ representation – would the Provider be willing to allow a Connecting NJ staff member on-site to meet with their patients after their appointments to offer Connecting NJ services, or to hold on-site Connecting NJ office hours?
- Bringing in other Connecting NJ outreach and education-related activities – would the Provider be interested in collaborating on outreach events (like Books, Balls, and Blocks), programs (like Reach Out and Read), or other prenatal/early parenting education sessions?
- Further chances to meet and connect with the community – would the Provider be interested in attending Community Advisory Board Meetings, or participating in a prenatal/early parenting-focused workgroup?