Maternal, Infant and Early Childhood Home Visiting Program

Supplemental Information Request for the Submission of the Statewide Needs Assessment

Section 1 – Introduction

The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) provides a tremendous opportunity for collaboration and partnership at the Federal, State, and community levels to improve health and development outcomes for at risk children through evidence-based home visiting programs. Through MIECVH, New Jersey can strengthen its evidence-based Home Visiting services which are a critical component in a statewide, comprehensive, high-quality statewide childhood system targeting the State's highest risk families and communities.

NJ has strong statewide support and committed stakeholders invested in strengthening evidence-based home visiting (EBHV) services as a core strategy to improve maternal, child and family health and well-being, and to eliminate disparities. The Division of Family Health Services (FHS) in the NJ Department of Health (DOH) is the lead administrative agency for MIECHV. In partnership with FHS for implementation of the New Jersey Home Visiting Program (NJ-HV) is the Department of Children and Families (DCF), Division of Family and Community Partnerships (FCP). DOH and DCF work collaboratively with a strong network of state and local stakeholders to improve home visiting services and to strengthen programs and activities carried out under Title V of the Social Security Act while enhancing a comprehensive, high quality early childhood system. Over the past eight years, the NJ-HV leadership team has successfully implemented a comprehensive NJ-HV State Plan, developed a strong Home Visiting Continuous Quality Improvement (CQI) Plan, and worked closely with colleagues across other state departments and across other sectors to fully integrate HV services within NJ's larger Early Childhood System of Care.

Key Needs Assessment partners include DCF, Johns Hopkins University, and the CQI Workgroup. Ongoing collaboration and efforts to engage families in at-risk communities to gain their perspectives and input is constant. Community needs are continually assessed at county levels and coordinated by Central Intake hubs and the County Councils for Young Children. This Needs Assessment was completed with review and input from many other state and local partners as well as other needs assessment documents including, but not limited to, the Preschool Development Grant (PDG); the Title V Maternal and Child Health Block Grant (MCHBG); the Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant; the Pritzker Children's Initiative Planning Grant implemented through Advocates for Children of New Jersey; Head Start, the Child Abuse, Prevention and Treatment Act (CAPTA) Planning Grants and reports; Nurture NJ Strategic Plan documents, the State Health Improvement Plan, and Healthy NJ 2030 planning documents.

In addition to DOH and DCF as the central NJ MIECHV partners, efforts and activities to support MIECHV also include other state agencies, especially those in the Interdepartmental Planning Group (IPG). The IPG is comprised of representatives of five state departments – Department of Education (DOE-Division of Early Childhood Education, Offices of Special Education and Title One, Homeless and Migrant Education), Department of Human Services (DHS- Division of Family Development), Department of Health (DOH-Office of Early Intervention), Department of Labor and Workforce Development (DOL-Strategic Planning and Outreach), and Department of Children and Families (DCF-Offices of Licensing, Child Protection and Permanency, Family and Community Partnerships).

The purpose for completing this Needs Assessment Update Narrative is to identify at-risk communities, understand the needs of families, and assess services in their early childhood systems. The needs assessment process will help identify target populations and select home visiting service delivery models that best meet the State and local needs. Through this statewide needs assessment update, the NJ MIECHV Program has identified at-risk communities as those counties with concentrations of the following indicators: premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school drop-outs; substance abuse; unemployment; or child maltreatment. The identification of at-risk communities through this needs assessment update has enabled the NJ MIECHV Program to respond to the diverse needs of children and families in New Jersey.

By mandate of federal law, the needs assessment update must identify communities with concentrations of defined risk factors, assess the quality and capacity of home visiting services in the state, and assess the state's capacity for providing substance abuse treatment and counseling services. The purpose of updating the statewide needs assessments is to gather more recent information on community needs and ensure that NJ MIECHV Program is being implemented in areas of high need.

To meet the federal statutory requirements for a statewide needs assessment update, the NJ MIECHV Program has:

1. Identified communities with concentrations of risk, including: premature birth, low-birth-weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school drop-outs; substance abuse; unemployment; or child maltreatment.
2. Identified the quality and capacity of existing programs or initiatives for early childhood home visiting in NJ and included: a) the number and types of programs and the numbers of individuals and families who are receiving services under such programs or initiatives; b) the gaps in early childhood home visitation in the State; and c) the extent to which such programs are meeting the needs of eligible families.
3. Discussed the State's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.
4. Coordinated with and take into account requirements in: a) the Title V MCH Block Grant program needs assessment; b) the communitywide strategic planning and needs assessments conducted in accordance with section 640(g)(1)(C) of the Head Start Act; and c) the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect, and other family resource

services operating in the State required under section 205(3) of Title II of Child Abuse. Prevention and Treatment Act (CAPTA).

This current Needs Assessment is the first statutory mandate to complete a statewide needs assessment since 2010, when the first Needs Assessment was performed in NJ. Through the Needs Assessment process, a more current understanding of the needs for home visiting services can be gained; this update will identify communities with concentrations of defined risk factors, assess the quality and capacity of home vising services in the state, and assess NJ's capacity for providing substance abuse and counseling services. For NJ, it is anticipated that the Needs Assessment update will enable NJ-HV to understand the current needs of families and children, and at-risk communities; target home visiting services to at-risk communities with evidence-based home visiting models that meet community needs; support statewide planning to develop and implement a continuum of home visiting services for eligible families and children prenatally through kindergarten entry; inform public and private stakeholders about the unmet need for home visiting and other services in the state; identify opportunities for collaboration with state and local partners to establish appropriate linkages and referral networks to other community resources and supports and strengthen strong early childhood systems; and direct technical assistance resources to enhance home visiting service delivery and improve coordination of services in at-risk communities.

Section 2 of this needs assessment show the identification of all 21 counties in NJ as at-risk given that all 21 counites contain geographic areas at the sub-county (municipal) level or pockets that demonstrate indicators of risk. Section 3 of this needs assessment identifies the quality and capacity of existing programs for early childhood home visiting in the New Jersey, including the number and types of programs and the numbers of individuals and families who are receiving services; the gaps in early childhood home visiting, including descriptions of underserved communities; and the extent to which such Home Visiting (HV) programs are meeting the needs of eligible families. Section 4 of this needs assessment discusses New Jersey's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services. Section 5 of this needs assessment provides a narrative summary of the coordination with Title V Maternal and Child Health Block Grant, Head Start and CAPTA Needs Assessments and includes a discussion of how the NJ-HV will address unmet needs.

The impact of COVID-19 on all areas of maternal and child health continues to evolve and be significant. On March 9, 2020, Governor Murphy issued Executive Order 103, declaring the existence of a public health emergency. COVID-19 necessitated a rapid transition from in-person programs and services to those being administered remotely whenever possible. Home visitors are continuing to serve pregnant women and their families in New Jersey through telephone and video communication. These communications can continue to be maintained as available and appropriate. Local service providers may need to assess the best decision on which visit format (virtual or in-person) to utilize given community conditions, family needs and staff and safety issues. Decisions to resume in-person home visits must be done cautiously with the goal of minimizing public health risks and prioritizing the health and safety of staff and the families which they serve. As the situation with COVID19 continues, it will be even more critical to maintain partnerships with in-need families and continue to collaborate and work

closely with colleagues across other state departments, such as through the IPG, in assessing and meeting needs of at-risk families.

Section 2 – Identifying At-Risk Communities (Counties) with Concentrations of Risk

New Jersey has utilized the simplified method and data provided by HRSA to identify at-risk counties. The simplified method is based on indices of risk in five domains: low socioeconomic status, adverse perinatal outcomes, child maltreatment, crime, and substance use disorder, based on nationally available county-level data. Indicators within each domain align with the characteristics described in statute to identify communities with concentrations of risk. The simplified method identifies a county as at-risk if at least half of the indicators within at least two domains had z-scores greater than or equal to one standard deviation higher than the mean of all counties in the state.

NJ counties identified by the simplified method include Atlantic County, Bergen County, Burlington County, Camden County, Cape May County, Cumberland County, and Essex County based on having at least two domains with z-scores greater than or equal to one standard deviation higher than the mean of all counites in the state. The counties which have at least one domain with z-scores greater than or equal to one standard deviation higher than the mean of all counties in the state are Hudson County, Passaic County, and Salem County.

The NJ HV Program has included all NJ counties in its at-risk list because it recognizes that all NJ counties contain small geographic pockets of impoverished and at-risk communities that do not appear in a strictly county level assessment. Through prior needs assessments and the last 10 years of experience in running a statewide system, the needs in all 21 NJ counties have been documented.

The list of at-risk counties appears in Table 7 of the Needs Assessment Data Summary. The list includes all 21 NJ counties given that all 21 counties contain geographic areas at the sub-county level (municipal) or pockets that demonstrate increased indicators of risk. For the purposes of this needs assessment update, HRSA has interpreted the term “community” as a county or county equivalent. This is a change from the original MIECHV needs assessment, which allowed awardees to determine how to operationalize “community.” NJ had identified all 21 counties as at-risk communities in its prior needs assessment of 2010.

Through the Pritzker Children’s Health Initiative and the Advocates for Children of New Jersey, a series of meetings held between July and December 2019 were held by a team of public and private sector leaders, including leaders in NJ-HV, to develop and action plan to ensure that an additional 25% of low income infants and toddlers in NJ – approximately 27,000 young children have access to high quality services by 2023, including evidence based home visiting. According to their report “Unlocking Potential – A Roadmap to Making New Jersey the Safest, Healthiest and Most Supportive Place to Give Birth and Raise a Family,” “while New Jersey already has a number of early childhood foundational programs in place, more could be done to expand and strengthen these vital supports and services in order to reach more low-income

families." Additional findings in "Unlocking Potential" cite that Evidence-based, voluntary home visiting, provided by well-trained professionals during pregnancy and throughout a child's first few years, can yield profound results for parents and babies, but in New Jersey:

- Less than 2% of New Jersey's 310,000 children ages 0-3 currently benefit from home visiting supports.
- Although all parents could benefit from home visiting services when welcoming a new baby into their family, home visiting services in New Jersey are not universal and access is limited to only those families with the greatest needs.
- The primary funding source for the state's home visiting system, the federal Maternal, Infant and Early Childhood Home Visiting program (MIECHV) grant, has not been increased since its inception 10 years ago, creating funding deficits for programs.

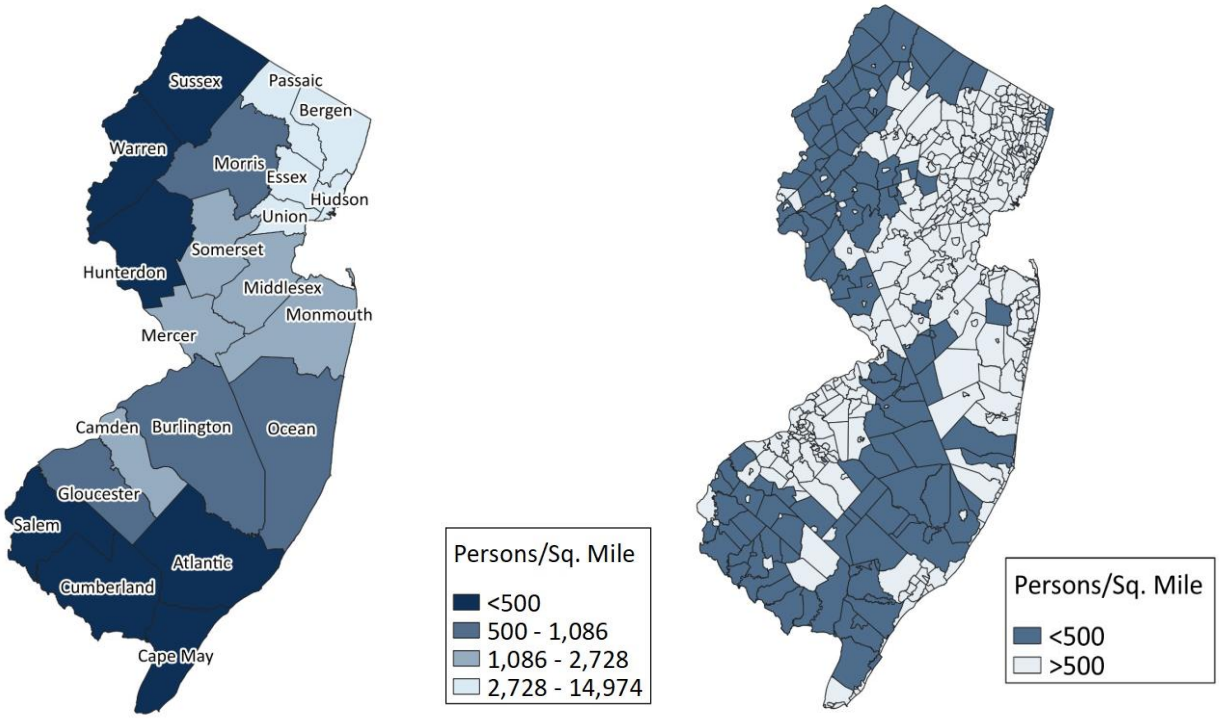
Overview of New Jersey and Support for Inclusion of All 21 Counties as At-Risk

New Jersey is the most urbanized and densely populated state in the nation with over 9.0 million residents. It is also one of the most racially and ethnically diverse states in the country with the racial and ethnic mix for NJ mothers, infants, and children being more diverse than the overall population. The most populated counties are Bergen and Middlesex, while Salem and Cape May are among the least populated. Although NJ is the most densely populated state in the country, there is considerable variability across the counties. Hudson County is the most densely populated while Salem in the least densely populated county (See Appendix A-1).

Although no communities in NJ meet the formal federal definition of a Rural area, there are extreme pockets of need in rural parts of the state. The NJ Office of Rural Health identified rural counties and communities as those having population density of fewer than 500 people per square mile. Seven counties and 123 municipalities are rural in using this definition as in Figure 1[1]:

[1] Institute for Families, School of Social Work, Rutgers University. New Jersey Rural Health Needs Assessment Executive Summary, https//www.nj.gov/health/fhs/primarycare/documents/Rural%20Health-New%20Jersey%20Rural%20Health%20Needs%20Assessment-website.pdf

Figure 1: New Jersey Population Density by County and Municipality, 2017

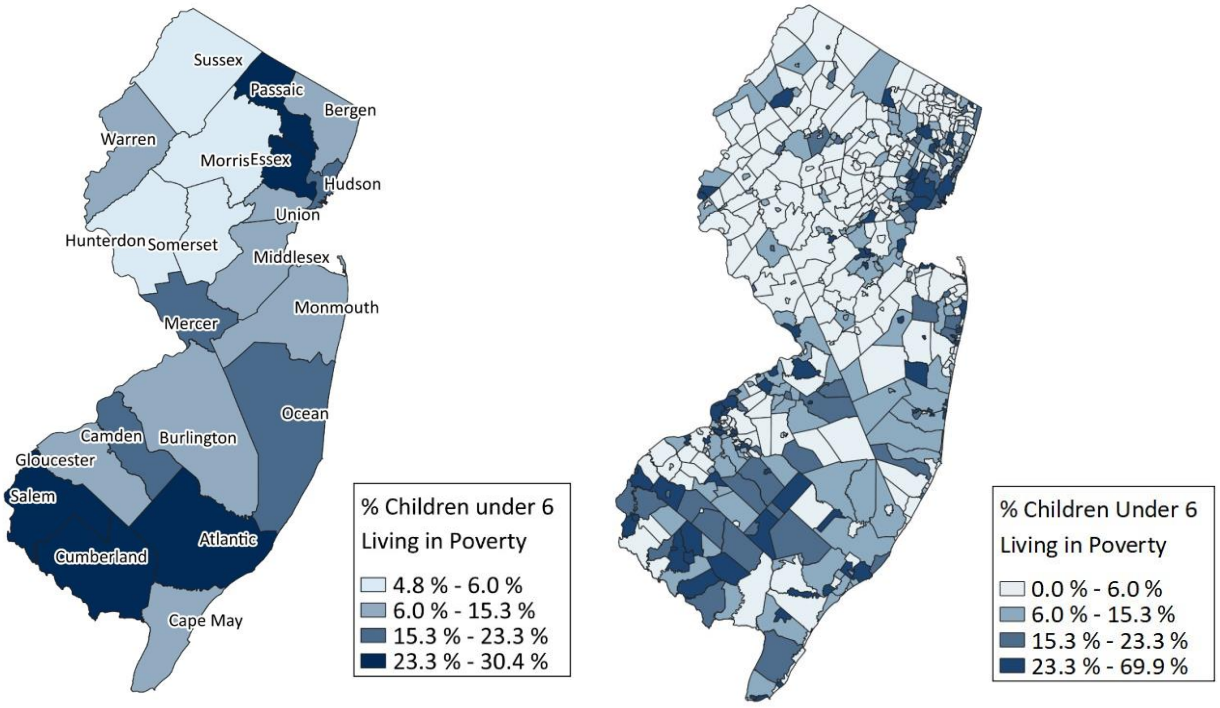


Of the estimated 626,249 children under the age of 6 in New Jersey, 17% live in poverty. Children growing up in poverty have less access to resources such as safe and affordable housing, access to education, public safety, available and affordable healthy foods, local health services, and environments free of toxins. They also experience worse health outcomes than their peers growing up in higher income households[2].

Figure 2 highlights the variability across and within counties in the percentage of children under 6 living in poverty. Even among the counties with the highest percentages of children in poverty, there are pockets of concentrated need as well as areas with less extreme poverty.

Figure 2 – Percentage of Children under 6 living in poverty by County (left) and Municipality (right), 2013-2017[3]

[2]American Community Survey 2013-2017, B17020
[3] American Community Survey 2013-2017, B17020



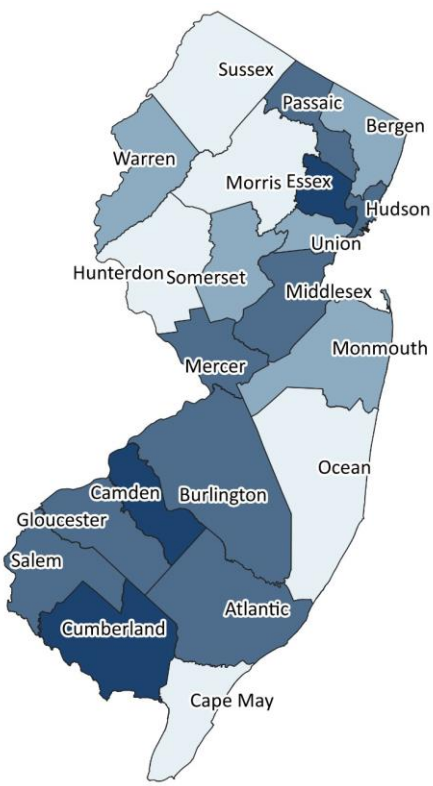
In New Jersey, the percentages of children under 6 living in poverty vary notably by race/ethnicity; the percentages are highest for children who are black (31.7%) and Hispanic (28.2%). The percentages for white, not Hispanic and Asian children under age 6 who are living in poverty are 8.5% and 5.2% respectively. (See Appendix Table A-2)

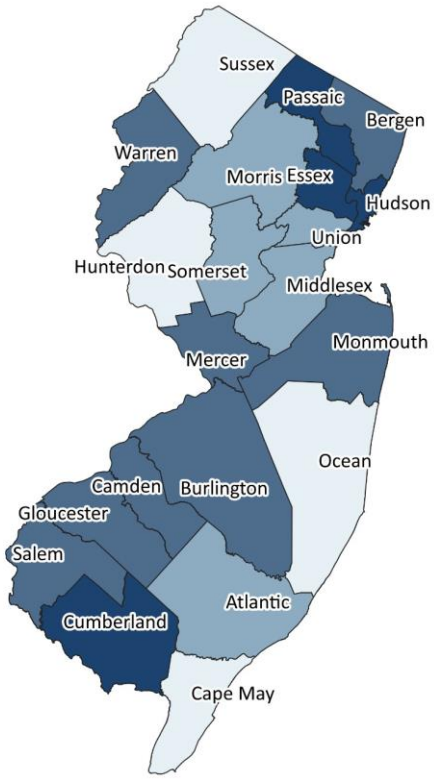
Racial disparities in birth outcomes in New Jersey are alarming in that infant mortality rates are nearly 5 times higher for black infants and child death rates are twice as high as those for white infants and children, respectively. As infant mortality is a key measure of population health that reflects the underlying well-being of mothers and families, the Healthy Women Healthy Families Initiative (HWHF) was launched by DOH effective July 2018 to improve maternal and infant health outcomes for women of childbearing age and their families, while reducing racial, ethnic, and economic disparities in those outcomes through a collaborative coordinated community driven approach through the use of Community Health Workers and Central Intake Hubs. HWHF and MIECHV partner together in collaboration through scheduled quarterly meetings and in trainings as well as conferences and other venues to improve birth outcomes and reduce disparities.

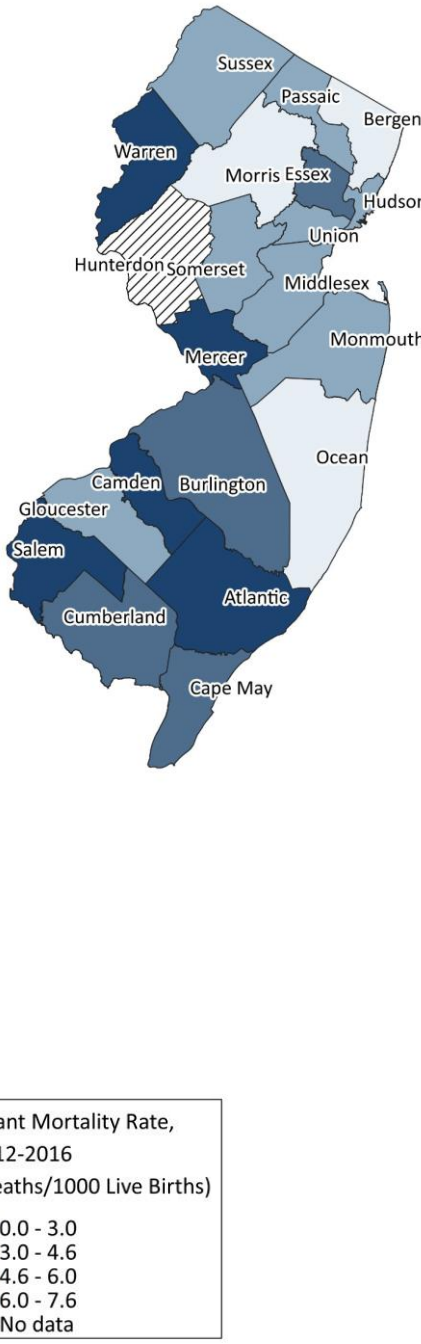
New Jersey also experiences variability in birth outcomes by place of birth as demonstrated in review of outcomes by county for low birth weight, preterm birth and infant mortality. Low birth weight rates range from a low of 5.9% in Morris and Essex to a high of 10.4% in Cumberland. Percentages of infants born preterm range from 7.4% in Cape May to 12.8% in Cumberland and the infant mortality rate varies from 2.8 deaths per 1,000 live births in Morris to 7.6% in Camden. Figure 3 maps these three health indicators by county over the past five years for which data are available. See Appendix Table A-4, New Jersey selected Birth and Death Outcomes, by County.

Figure 3: Health Characteristics by County[4]

[4] New Jersey Department of Health, New Jersey State Health Assessment Data, https://www.doh.state.nj.us/doh-shad/topic/Births.html







Figures 1-3 as well as other findings from the Maternal Child Health Block Grant, the Healthy Women Healthy Families Initiative, the Preschool Development Grant and the Pritzker Report all demonstrate that at-risk populations are identified in all 21 counties.

For aligning service delivery with needs, municipality level data are critical. Figure 4 highlights variability in low birth weight and preterm birth by municipality and demonstrates how within

counties, there is variability by municipality for both outcomes. Selected initiative in the state focus on municipalities with the least favorable outcomes. For example, the DOH HWHF initiative addresses high black infant mortality in eight municipalities. These municipalities are identified in Figure 5.

Figure 4: Health Characteristics by Municipality, 2013-2017[5]

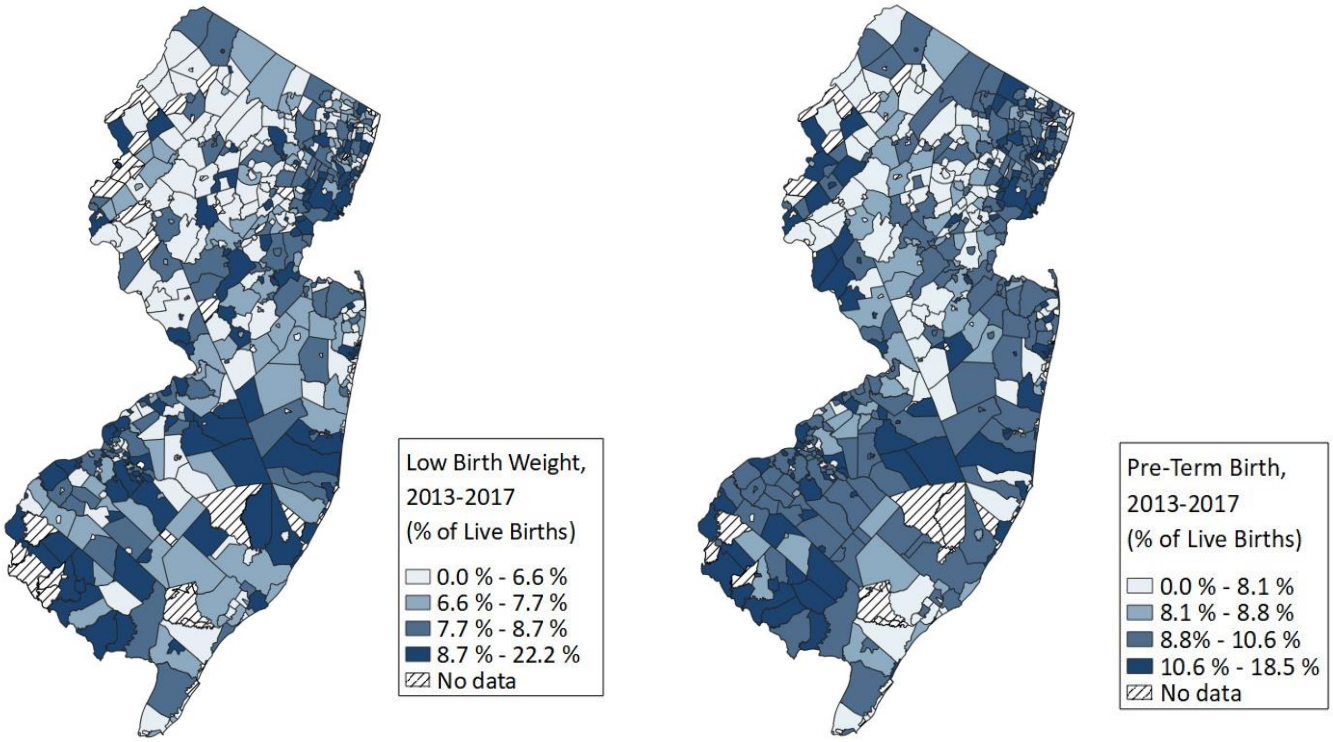
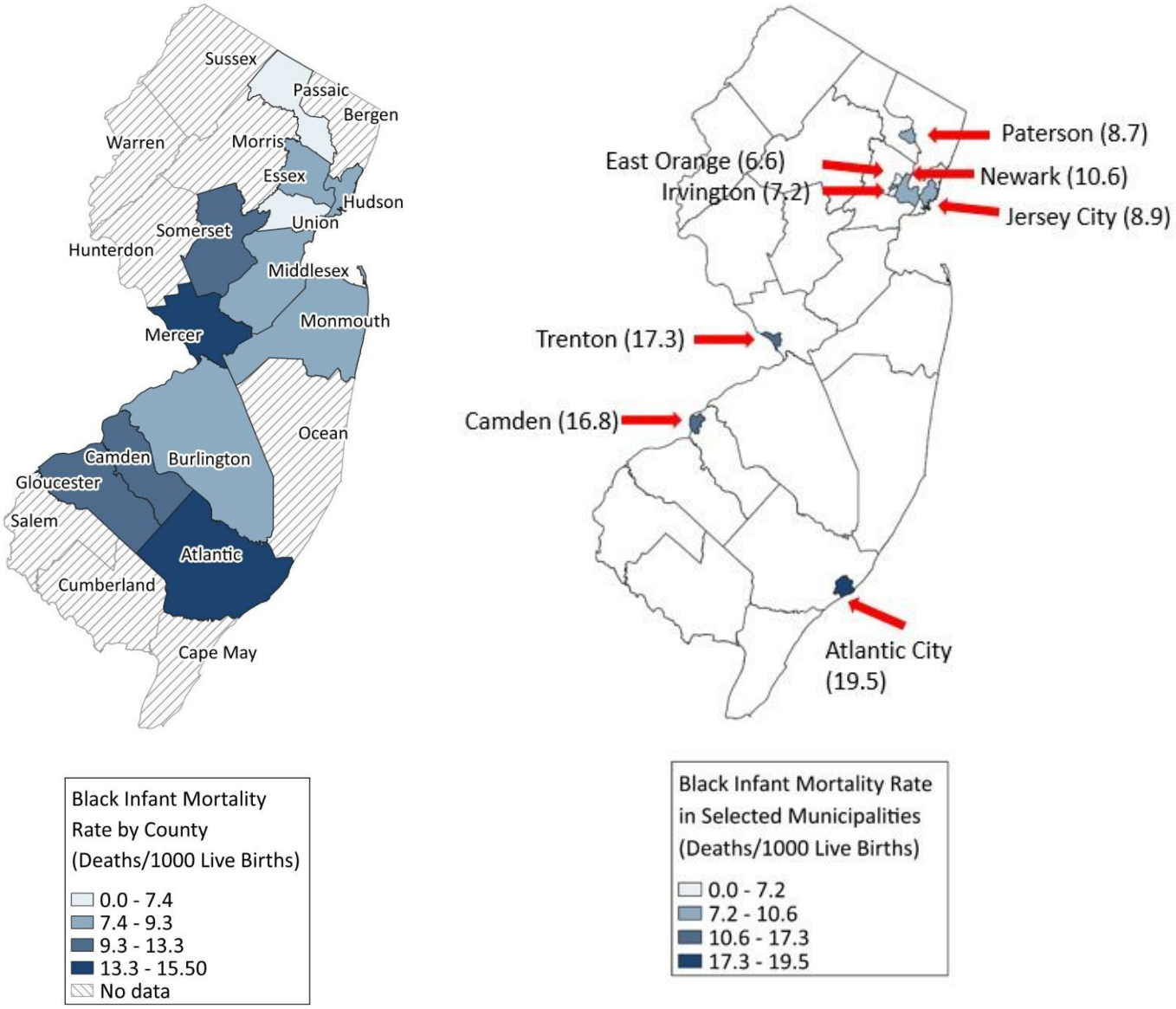


Figure 5: Black Infant Mortality Rate by County (Left) and in Municipalities Participating in Healthy Women, Healthy Families Initiative (Right), 2012-2016[6]

[5] New Jersey Department of Health, New Jersey State Health Assessment Data, 2016-2017, https://www-doh.state.nj.us/doh-shad/topic/Births.html

[6] New Jersey Department of Health, New Jersey State Health Assessment Data, 2016-2017, https://wwwdoh.state.nj.us/doh-shad/topic/Births.html



Advocates for Children of New Jersey (ACNJ) annually review the conditions for children living in each county and ranks the counties according to four domains: child and family economics, child health, safety and well-being, and education. Three indicators inform each domain for a total of twelve. Please See Appendix Table A-3 which summarizes the 2018 rankings, with 1 indicating most favorable and 21 the least favorable in each domain.

Children who are vulnerable or underserved include those with poverty/economic stressors, special education needs, special medical/health needs, and those who otherwise have special circumstances. The prevalence and distribution of NJ children from birth through five who experience poverty/economic stressors vary across and within counties. At the county level,

vulnerable children on the basis of living below poverty are identified in Figure 2. Vulnerable children are also identified on the basis of enrollment in public programs for which eligibility is determined, in part, on the basis of family income. Head Start and Early Head Start offer early learning, health and family support services for children in families at or below the federal poverty level. In 2018, 26 Head Start Programs had 12,069 slots for children ages 3-5 years, and 29 Early Head Start programs had slots for an additional 313 pregnant women and 2,960 young children, birth up to 3 years.[7] The vast majority of participants meet eligibility requirements on the basis of income, but some qualify on the basis of being in foster care, homeless, or receiving TANF or SSI.

Additional programs for which eligibility is determined, in part, on the basis of family income include Temporary Assistance to Needy Families (TANF) as well as the Supplemental Nutrition Assistance Program (SNAP) and the Supplemental Nutrition Program for Women Infants and Children (WIC). Income eligibility for SNAP and WIC (up to 185% FPL) is far more generous than that for TANF (up to 26.2% FPL). Variations in enrollment by county reflect eligibility requirements for each program, population size, and client accessibility to and interest in participating in each program.

Figure 6 identifies how economic vulnerability varies across counties by highlighting the numbers of women and children enrolled in WIC; more than 13,000 are enrolled in Essex, Hudson, Ocean, and Passaic. Passaic is also one of four counties in which more than one in five children live in households receiving SNAP. Variability in economic need at the municipality level is shown by reviewing participation in SNAP and TANF (Figure 7). While the highest need municipalities, shown in dark blue often appear comparable in the maps for SNAP and TANF, many fewer children live in households receiving TANF given more restrictive income eligibility. Figure 8 shows

[7] Office of Head Start. New Jersey Program Information Report. Enrollment Statistics Report. 2018. [29] Center on Budget and Policy Priorities, TANF Benefits Remain Low Despite Recent Increases in Some States, 2019, https://www.cbpp.org/sites/default/files/atoms/files/10-30-14tanf.pdf. Appendix Table 2. [30] Data are not available specific to children in order to calculate percent enrolled by county.

Figure 6: WIC Participation by County (Number of Women, Infants and Children Receiving Benefits), 2017[8]

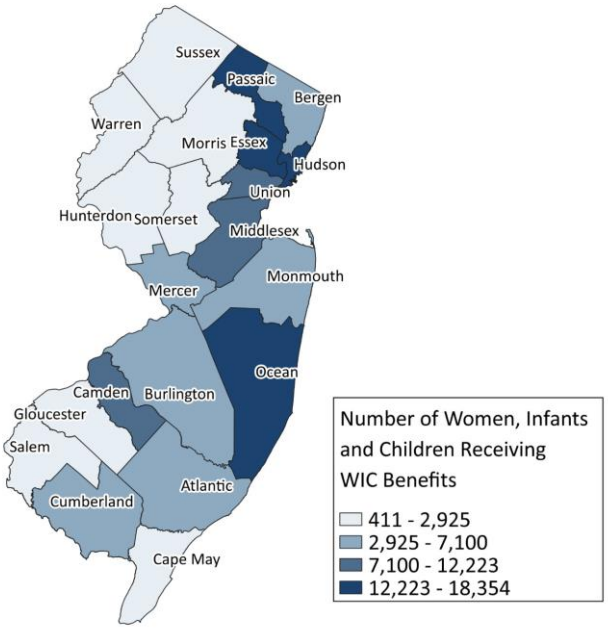
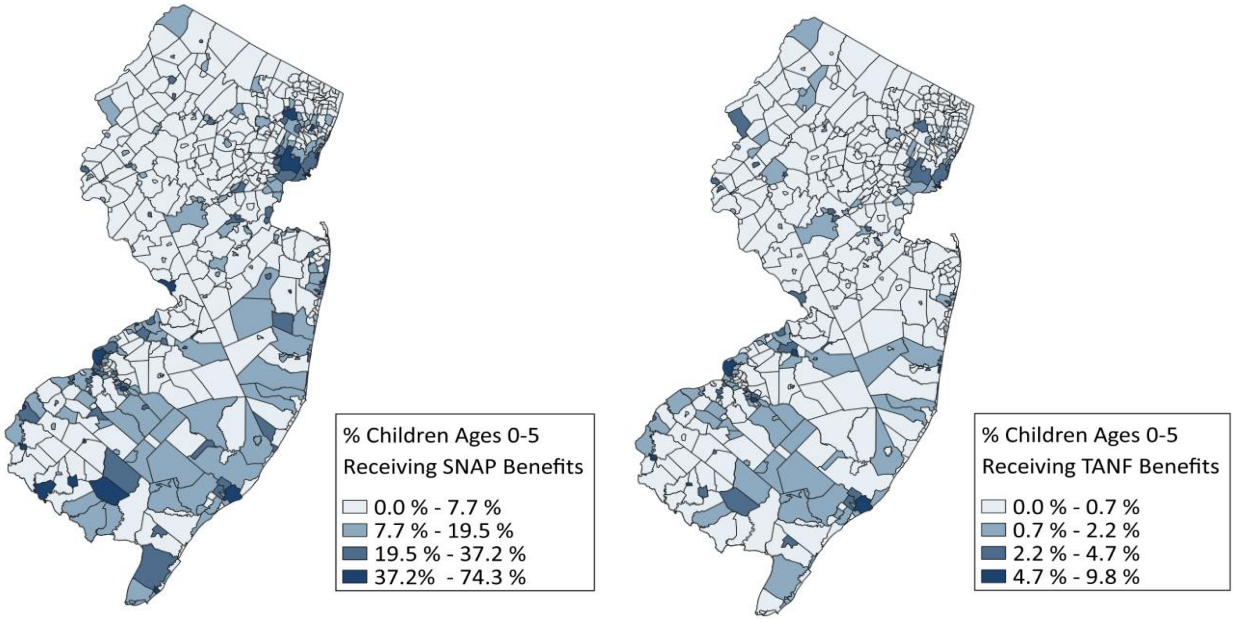


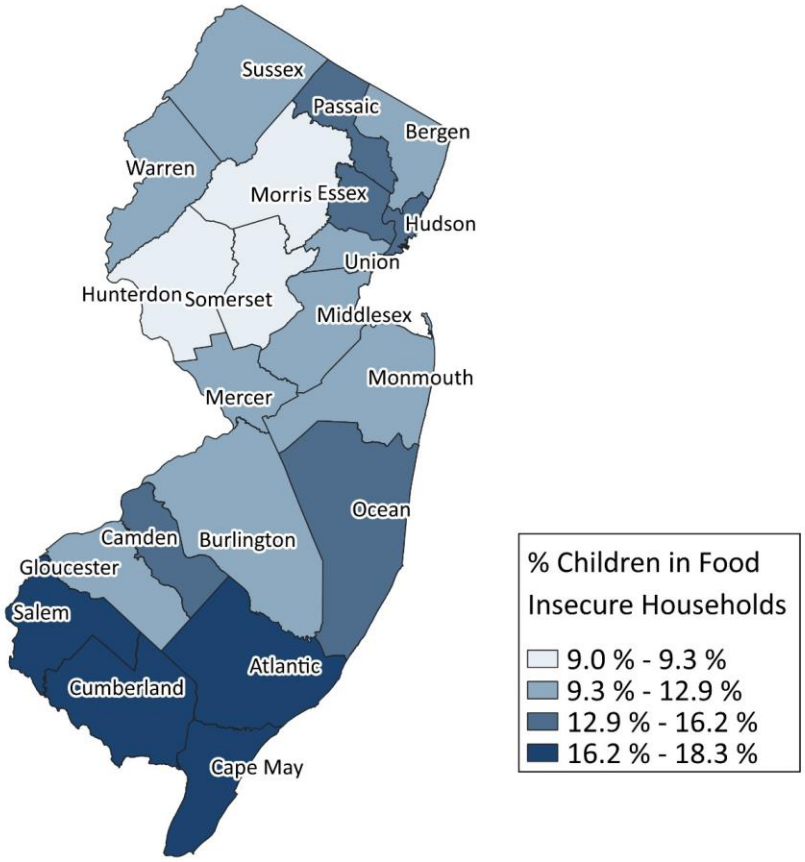
Figure 7: Children Ages 0-5, Enrolled in SNAP (Left) and TANF (Right), by Municipality, 2019[9]



[8] NJ KIDS COUNT Data Center, 2017. Women, infants and children enrolled in the WIC nutritional program in New Jersey. https://datacenter.kidscount.org/data/tables/2111-women-infants-and-children-enrolled-in-wic-nutritionprogram?loc=32&loct=5#detailed/5/4699-4720/false/871,870,573,869,36,868,867,133,38,35/any/4426 [9]

[9] 2019 County Labor Force Estimates; https://www.nj.gov/labor/lpa/employ/uirate/lfest_index.html

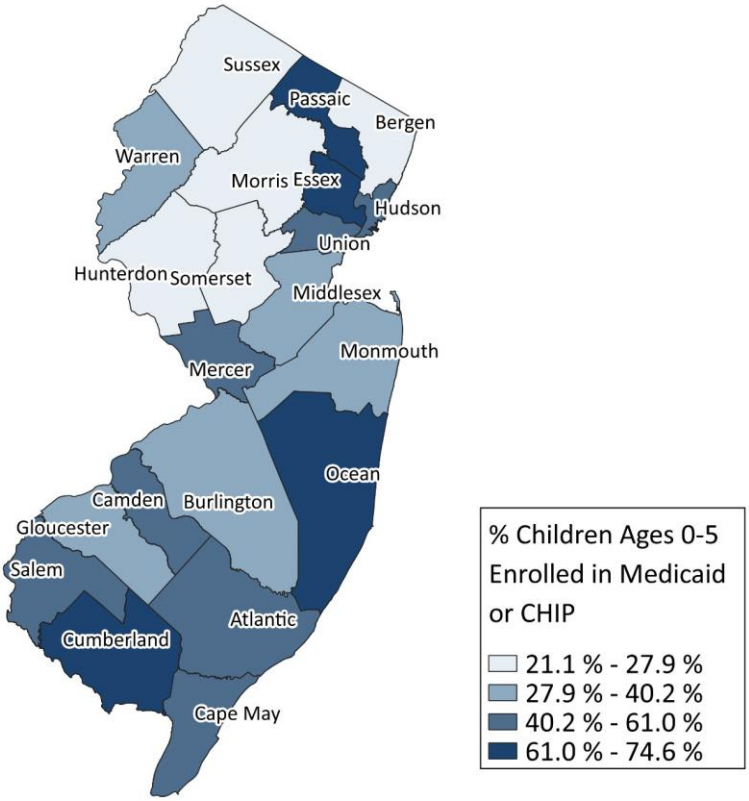
Figure 8: Food Insecure Children by County, All ages of Children, 2016[10]



Economic insecurity also can be assessed by enrollment in public insurance. As of May 2019, statewide, 224,145 children 0-5 were enrolled in Medicaid and 31,502 in the Children's Health Insurance Program. Overall, the percentage of children enrolled in Medicaid or CHIP ranges from 21.1% in Morris to 72.1% in Cumberland (Figure 9).

[10] Health Indicator Report of Food Insecurity, NJ SHAD, https://www.doh.state.nj.us/doh-shad/indicator/view/FoodInsecurity.CoChild.html

Figure 9: Children Ages 0-5 Enrolled in Medicaid or CHIP, May 2019[11]



As part of the Individuals with Disabilities Education Act (IDEA), New Jersey provides both early intervention services for children from birth up to age 3 (Part C) as well as special education services for children 3 through 5 years (Part B, Section 619). Early intervention services intend to improved outcomes that are key to educational success; services identify and meet children's needs across five areas of development (physical, cognitive, communication, social or emotional, and adaptive).[12] For children 3 through 5, New Jersey's efforts align with national efforts to provide integrated educational placements given links between inclusion and enhanced academic, social and emotional performance and positive effects on classmates without disabilities. [13] New Jersey's vision is for all general education classrooms to include and appropriately support children with disabilities. To achieve this vision, New Jersey has created a Multi-Tiered Systems of Support that includes preschool and is meant to increase inclusion

[11] Correspondence with Division of Family Development (DFD), New Jersey Department of Human Services (DHS), 6/4/19. Total Medicaid includes 112 not assigned to a county.

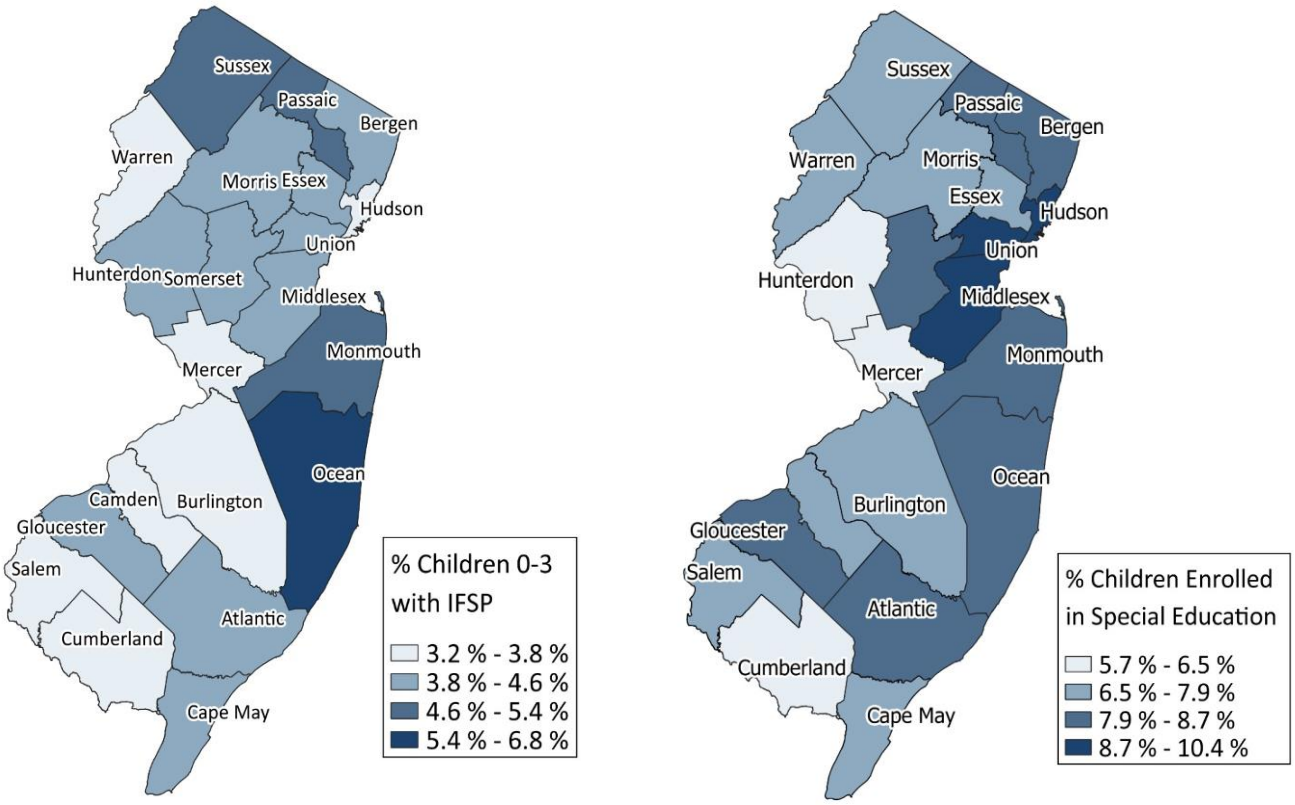
[12] U.S. Department of Education, 40th Annual Report to Congress on the Implementation of the *Individuals with Disabilities Education Act, 2018.* https://www2.ed.gov/about/reports/annual/osep/2018/parts-b-c/40th-arc-foridea.pdf

[13] National Council on Disability, IDEA Series. https://ncd.gov/sites/default/files/NCD_Segregation-SWD_508.pdf

[38] U.S. Department of Health and Human Services, U.S. Department of Education, Policy Statement on Inclusion of Children with Disabilities in Early Childhood Programs. https://www2.ed.gov/policy/speced/guid/earlylearning/joint-statement-full-text.pdf

through the implementation of Positive Behavior Supports (Pyramid Model in Early Childhood) and academic interventions.

Figure 10: Children 0-3 Years with Individualized Family Service Plan (IFSP) by County, 2017 (Left) and Children 3-5 Years Enrolled in Special Education, 2016 (Right)



The percentage of children 0 up to 3 years participating in special education with individualized family service plans (IFSP) through Part C of IDEA ranges from 3.39% in Middlesex to a high of 6.76% in Ocean counties. The numbers in each county increase as children get older with a total of 793 infants < 12 months, 3818 infants greater than 12 and less than 24 months, and 9033 toddlers greater than 24 and less than 36 months. While the age differences are expected as children are more likely to be screened and referred for services as they get older, there also are differences by race/ethnicity. Among children with an IFSP, 41.7% are white not Hispanic, 36.6% Hispanic, 9.8% black, 7.5% Asian, and 4.3% multiracial (See Appendix C-11; Figure 10). Overall, nearly 95% of children receive all services on the IFSP in a timely manner with two counties at less than 85% --Atlantic and Cumberland.[14]

[14] New Jersey Department of Health, Division of Family Health Services, New Jersey Early Intervention System County Performance and Determination Report, FY 2017-2018, https://nj.gov/health/fhs/eis/documents/County_Performance_Report%20(002).pdf

As of 10/15/17, across the state, 19,763 children ages 3 through 5 participated in special education through Part B IDEA.[15] Of these, 45.9% receive the majority of services in a regular early childhood program, 14.2% receive the majority of services outside of the regular early children program, and 39.8% attend a special education program entirely.[16]

Geographic variability also is noted in the percentages of children enrolled in Part B; in 2016, enrollment varied from 5.7% in Cumberland to a high of 10.4 % in Middlesex. (See Figure 11). Overall percentages for children receiving services in Part B are higher than for those receiving Part C, in part, due to the increased likelihood of older children being enrolled in preschool programs and referred by their teachers. Younger children 0-3 are likely to be referred only if in child care settings and referred by the provider. Parents may not be familiar with early intervention services nor recognize behaviors or symptoms meriting referral.

Statewide, an estimated 10.4% of NJ children, ages 0-5 years, have special health care needs, comparable to what is reported for all children in the US.[17] Data are not available at county levels to identify children with special health care needs from the National Survey of Children's Health. However, county-level data are available specific to birth defects and autism.

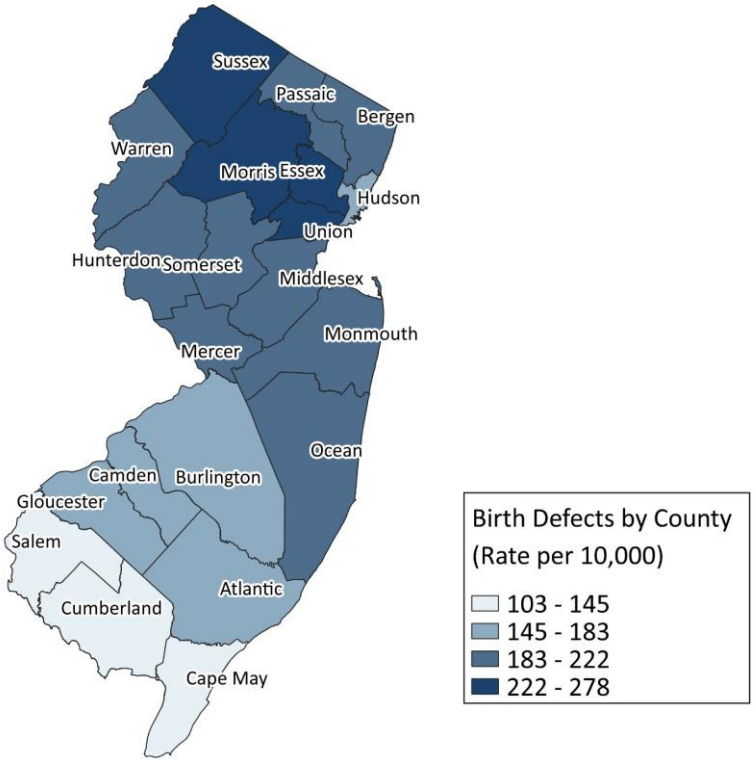
The New Jersey Birth Defects Registry mandates reporting by health care facilities, providers, and medical examiners, the birth defects for children 5 years and younger. Across all categories, the rate of birth defects is 213/10,000 children with cardiovascular being the most common. Counties with the highest reported levels of birth defects include Sussex, Essex, Union and Morris, where rates exceed 260/10,000 (Figure 11).

[15] New Jersey Department of Education, Office of Special Education Programs, Children Receiving Free and Appropriate Education (Ages 3-5), 2017. https://nj.gov/education/specialed/data/2017/3_5_FAPE.pdf

[16] New Jersey Department of Education, Office of Special Education Programs, Children Participating in Separate Settings. 2017. https://nj.gov/education/specialed/data/2017/3-5_Placement.pdf

[17] Child and Adolescent Health Measurement Initiative. 2016-2017 National Survey of Children's Health (NSCH) data query.

Figure 11: Birth Defects/Congenital Anomalies by County[18]



New Jersey has the highest autism rates among states in the Autism and Developmental Disabilities Monitoring (ADDM) Network. ADDM is a surveillance system that provides 2014 estimates of the prevalence of ASD among eight year old children in 11 ADDM sites.[19] An estimated 1 in 34 8-year old children are diagnosed with autism in NJ relative to the ADDM average of 1 in 59 8-year old children.[48] The ADDM network also examined prevalence among children 4 years of age in 7 of the original sites and, again, found NJ to have the highest rates (28.4/1000 children).[20] The high rates are attributed, in part, to excellent clinical and educational services and high rates of detection, researcher access to both educational and health records, and increases in perinatal risk factors associated with autism (e.g., multiple order births, advanced maternal age).[21] New Jersey's mandated autism registry tracks prevalence by county; Mercer and

[18] New Jersey Birth Defects Registry, https://www.nj.gov/health/fhs/bdr/

[19] Christensen DL, et al. Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 8 Years – Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2012. *MMWR Surveill Summ*, 65(13):1-23. 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6237390/ New Jersey data based on data from four counties (Union, Hudson, Essex, and Ocean) [48] New Jersey Department of Health, New Jersey Autism Registry, https://nj.gov/health/fhs/autism/documents/NJAC_11_24C%20managed%20care.pdf

[20] Christensen DL, et al. Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 4 Years – Early Autism and Developmental Disabilities Monitoring Network, Seven Sites, United States, 2010, 2012, and 2014. *Surveillance Summaries,* 68(2): 1-19. 2019. https://www.cdc.gov/mmwr/volumes/68/ss/ss6802a1.htm?s_cid=ss6802a1_w

[21] New Jersey Department of Health, New Jersey Autism Registry, https://nj.gov/health/fhs/autism/documents/NJAC_11_24C%20managed%20care.pdf

Ocean counties have higher rates than other counties, while Bergen has lower rates, perhaps due to deliveries, by some women from Bergen, outside the state in New York.[22]

Data from the Pregnancy Risk Assessment Monitoring System (PRAMS) yields statewide estimates of the special needs of mothers who recently gave birth. Among PRAMS participants in 2017, in the 3 months prior to becoming pregnant, 50.7% had alcoholic drinks, 11.6% smoked, 8.3% had depression, and 14.9% experienced anxiety. In the last 12 months preceding pregnancy, 1.3% experienced intimate partner violence. During the last 3 months of pregnancy, 3.5% smoked and 10.6% drank; 1.3% reported IPV during pregnancy. Postpartum, a larger percentage of women reported smoking (7.0%), and 13.2% experienced post-partum depression.[23]

Central Intake data also inform about the special needs of mothers. Central Intake reports economic, social and health risks using screens conducted by community health workers (community health screen or CHS) and medical providers (perinatal risk assessment or PRA). These screens are conducted both prenatally and postnatally making direct comparisons to PRAMS challenging. As reviewed at a 2018 NJ Continuous Quality Improvement Committee Meeting, 64% of mothers screened had at least one of the DCF prioritized risks for referral to home visiting. Among mothers who were screened with the CHS, 11% reported tobacco use, 4% alcohol, and 2% drug use with an overall 9% screening positive on the 4Ps Plus (depression, tobacco use, substance use, domestic violence). Percentages of mothers reporting domestic violence ranged from 1% among those screened with a PRA to 4% of those screened with a CHS. Using both screens, 3% reported perinatal depression. Among mothers enrolled in home visiting, 42% reported having inadequate social support.

Across the state, the rate of children 0 through 5 years referred to Child Protection and Permanency (CP & P) is 26.7/1000 with a range from a low of 11.3/1000 in Bergen to a high of 71.7/1000 in Cumberland (Figure 12, Appendix A-12).

A 2018 needs assessment conducted by the Department of Children and Families documented high levels of need among families who are involved with CP & P.[15] Commonly reported needs related to substance use, family poverty, and caregiver mental health with many families experience multiple needs. Surveyed staff indicated that for most services, such as substance use, services were well aligned with levels of family need. The report also identified that shortages of services related to housing and family poverty required broad, cross-system solutions in order for families to provide safe, stable homes for their children. The report also concluded that future efforts should examine how needs and services relate to child welfare outcomes, including child safety, permanency, and well-being.

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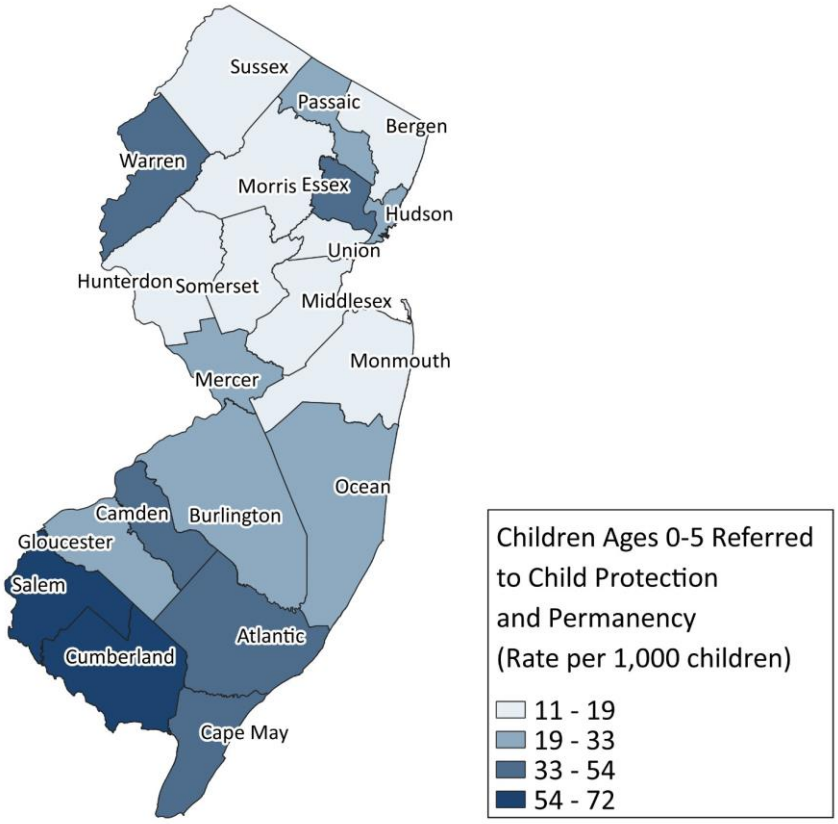
[22] The Birth Defects and Autism Reporting System (BDARS) is a tool for surveillance, needs assessment, service planning, research, and linking families to services. The BDARS refers children and families to the Special Child Health Services Case Management Units which are within the Family Centered Care Services Program.

[23] New Jersey PRAMS. https://www-doh.state.nj.us/doh-shad/query/selection/prams/PRAMSSelection.html

[15] NJ Department of Children and Families, DCF Needs Assessment 2018, Executive Summary: Phase IV Survey Findings and Synthesis.
https://www.nj.gov/dcf/childdata/protection/DCF.Needs.Assessment.Phase.IV.Executive.SummaryMarch2018.pdf

Figure 12: Children Ages 0-5 Years Referred to Child Protection and Permanency (Rate per 1,000 Children), 2017



Children also may be vulnerable on the basis of special circumstances such as living in military families or living in households in which English is a second language or family members experience other communication barriers. In addition, children may be at high risk due to having an incarcerated parent or experiencing transportation barriers or social isolation with limited family/community supports. Limited data are available at the county level or specific to children ages 0-5 for these characteristics.

Section 3 – Identify Quality and Capacity of Existing Programs

This section of the NJ MIECHV Program needs assessment identifies the quality and capacity of existing programs for early childhood home visiting in NJ including: 1) the number and types of individuals and families who are receiving NJ MIECHV Program services, 2) the gaps in early childhood home visiting in NJ, and 3) the extent to which the NJ MIECHV Program is meeting the needs of eligible families.

The NJ MIECHV Program prioritizes delivering services to eligible families who reside in communities in need, as identified in this statewide needs assessment, taking into account staffing and community resources. NJ currently provides 3 evidence-based models in all 21 counties. The NJ MIECHV programs are intended to provide an array of long-term intensive early childhood services that reach at-risk families beginning in pregnancy and continuing through early childhood to kindergarten entry. All three models include outreach, education and support to fathers, as available; and/or to grandparents and other key primary caregivers. A brief description of key elements of each of the three DCF-funded models and the intended recipients follow:

Nurse-Family Partnership (NFP) is specifically intended for pregnant women with a first pregnancy or a first-time live birth that enroll in services by the second trimester of pregnancy (no later than 28 weeks gestation). Participation in NFP is voluntary. Nurse home visitors (RNs) provide pregnancy and parenting education, family support and community linkages for parents/families. Home visits are weekly and become less frequent over time according to the family's needs. NFP services continue until the child is two years old to improve the health, well-being and self-sufficiency of first-time mothers, fathers and their children. Nurse home visitors carry a small caseload of 25 families. They follow a standard set of written guidelines issued by the NFP National Service Office for pregnancy, infancy and toddlerhood, and use the *Partners in Parenting Education* curriculum to develop protective factors in six domains:

- Personal Health–nutrition, exercise, tobacco, alcohol/other drug use, and mental health
- Environmental Health–health and safety in the home, work, school, and neighborhood
- Life Course Development–child spacing, completing education, and finding employment
- Maternal Role–parental roles to promote health and development of infants/toddlers
- Family and Friends–relationship skills and support for personal goals and childcare needs
- Health and Human Services–links with other community resources to meet family needs

Healthy Families Program (HF) is a voluntary EBHV model that promotes healthy pregnancy, positive parenting, parent-child interaction, and the healthy growth and development of infants and children. HF links parents/families to need social service and health care resources. HF works with mothers, fathers and other caregivers and participation in the program is voluntary. While every effort is made to identify women prenatally, HF can accept referrals for families with newborns or infants (up to 12 months of age) for TANF recipients. Since 2007, NJ has placed a greater emphasis in HF on enrolling families earlier, during pregnancy. In addition, to maximize the use of limited resources, and enable programs to serve more families, NJ decreased the

recommended length of participation from age five to age three, with the understanding that by age three, parents will be encouraged to enroll their children into a preschool program.

All DCF-funded HF sites use the Parents As Teachers *Born to Learn* curriculum as a standard guide for parent education in their work with families. Home visitors (Family Support Workers) have varying levels of education (high school to college educated), but all are uniformly trained in the essential concepts of the model. HF emphasizes the need for program staff that can successfully build trust with families and demonstrate cultural respect and competence, often reflecting the race/ethnicity and languages of the target population.

Parents as Teachers (PAT) is an early childhood parent education, family support and school readiness program. The program is voluntary, and any interested families may participate (universal eligibility) in the program. Enrollment in PAT may occur at any point in time. In New Jersey, home visitors (Parent Educators) conduct a minimum of bi-weekly home visits and quarterly group education sessions. Families are encouraged to complete 39 personal home visits and 20 group meetings. Parent Educators have a minimum of a bachelor's degree. PAT sites follow a set of national standards and 12 guiding principles issued by the PAT National Center to promote model fidelity and accountability. PAT uses a core parent education curriculum, *Born to Learn*®, to guide visit content. Parent Educators conduct regular home visits and include small group meetings to address early childhood development and parenting. Participation may continue from enrollment up to age five.

The primary program focus of PAT is on: a) strengthening parenting skills; b) increasing parent knowledge of early childhood development; c) screening and early detection of developmental delays; d) improving child health and wellness (primary care, immunizations); e) reducing parent social isolation and building the family resource networks; f) preventing child abuse and neglect and g) increasing children's school readiness. In New Jersey, DCF-funded programs also provide education and support to women enrolled during pregnancy and include a focus on a core set of perinatal and child health measures.

County-based Central Intake Hubs coordinate the outreach and assignment of families in need to the most appropriate HV model. As shown in Appendix A Table 13, each county offers each of these three models; each of the three models is comprehensive and long-term. Together these three model programs provide a total of 4801 slots. Local programs served 5700 unique children in FY2018.

Table 1: Home Visiting Slots and Number of Unique Children Served by Home Visiting in FY18 by County and Model

County	Total # Home Visiting Slots - HFA	# Unique Children Served - HFA	Total # Home Visiting Slots - NFP	# Unique Children Served - NFP	Total # Home Visiting Slots - PAT	# Unique Children Served - PAT	Total # of EHS-HV Slots
Atlantic	95	121	50	44	70	77	See Cape May[24]
Bergen	78	122	50	54	20	21	98
Burlington	76	88	50	55	60	95	31
Camden	143	213	150	142	80	92	0
Cape May	113	149	50	45	60	83	166
Cumberland	100	127	100	85	88	114	See Cape May
Essex	224	352	150	148	60	77	0
Gloucester	80	101	50	50	50	68	See Cape May
Hudson	95	143	65	63	60	73	36
Hunterdon	30	101	10	17	10	14	161
Mercer	103	102	125	117	60	51	100
Middlesex	132	215	153	157	60	67	0
Monmouth	145	233	112	128	60	67	0
Morris	66	72	50	76	40	52	0
Ocean	70	72	50	52	40	49	60
Passaic	203	245	150	144	60	65	0
Salem	80	93	25	10	60	35	See Cape May
Somerset	17	See Middlesex[25]	10	15	60	66	See Hudson[26]
Sussex	69	116	50	33	40	65	0
Union	139	153	65	60	60	89	0
Warren	40	See Hunterdon[27]	40	31	50	36	0
New Jersey	**2098**	**2818**	**1555**	**1526**	**1148**	**1356**	**658**

Improving the quality and capacity of existing HV programs has been a priority for the NJ HV Program and the focus of its Evaluation and CQI Workgroup, the NJ MIECHV CQI Plan, the NJ

[24] This agency operates HV in Cape May, Cumberland, Gloucester, Atlantic and Salem counties and data are combined as a single program site.
[25] This agency operates HV in both Middlesex and Somerset counties and data are combined in the MIS as a single program site.
[26] This agency operates HV in Hudson and Somerset counties and data are combined as a single program site.
[27] This agency operates HV in both Hunterdon and Warren counties and data are combined as a single program site.

MIECHV Evaluation Plan, and CQI activities conducted at the LIA level. The focus on quality and capacity improvement of existing home visiting services supports the assessment of gaps in home visiting service delivery and unmet need among MIECHV-eligible families. Evaluation of staffing, community resources, and other requirements for implementation of evidence-based home visiting services has supported the assessment of the readiness of communities to provide HV services effectively and planning statewide strategies to strengthen the delivery of home visiting services that additionally support at-risk communities in building their readiness.

For purposes of this needs assessment, "home visiting programs" are programs that use home visiting as a primary intervention strategy for providing services to pregnant women and/or children from birth to kindergarten entry. The 3 evidence-based models funded by HRSA and included in this NJ MIECHV needs assessment are NFP, HFA and PAT as described earlier.

The (quality and) capacity of the existing NJ MIECHV Program is summarized in Table 7 (At-Risk Counties) of the Needs Assessment Data Summary and includes the following data for each listed at-risk county.

Based on the data in Table 7 (At-Risk Counties) from the NJ Needs Assessment Data Summary and other available data, gaps in the early childhood home visiting system in NJ have been identified. Unmet need is estimated at approximately 55% with unmet need in every county and LIAs. Additional funding and resources are needed to meet the unmet needs and support the Central Intake Hub system. In particular, there is an increased need for additional central intake staff, especially in light of the COVID19 pandemic.

Home visiting programs need to be able to meet the needs of changing demographics and characteristics of families as well as the cultural and language needs for families are increasing. HV programs need to be mindful of both family and staff attrition rates. Barriers faced by home visiting programs in at-risk counties include geographic barriers and gaps in availability and accessibility of health and social services and family supports. The need for continued and strengthened early childhood systems coordination along with public support and community buy-in for evidence-based home visiting services will continue.

Findings from the 2020 NJ Preschool Development Grant Birth to 5 (PDG B-5) grant which included leadership input from across five state departments (DOH, DCF, DHS, DOL, and DOE) and collaboration with early childhood partners of the NJ Council for Young Children, include the following gaps that are essential to fill to support collaboration between programs and services for families with children birth to age 5:

1. Identification, Programming and Supports for Children in Special Circumstances,
2. Unmet Need for Affordable Childcare and Preschool,
3. Central Intake Infrastructure to Support Coordination, and
4. Sustained Funding for an integrated data system

As programs adapt to ongoing challenges presented through the COVID19 pandemic, challenges exist in utilization and outcome data of home visiting program as utilization and outcome data may change rapidly.

According to the NJ HV State Plan of May 31, 2011, an estimated statewide need of Home Visiting slots was 13,385. Over the years, the number of funded slots and the number of estimated families in need of HV has slightly varied. Most recently, there is an estimated unmet need of 45% based on the 4800 funded slots and a need of 10,500 HV slots. The need for HV slots has most likely increased due to COVID19.

Along with the need for HV slots for families, there are continued needs to maintain adequate and enhance staffing. Vacancies and understaffing continue to be issues in Central Intake Hub staffing, which will only increase with the COVID19 Pandemic.

Regarding EBHV Needs Assessment Data and Analysis: Historically, DCF has relied on several key sources for determining service needs and priorities-- CAPTA (Title II) child welfare data, Maternal-Child Health (Title V) data and Human Services Temporary Assistance to Needy Families (TANF) data to help guide funding priorities. All current EBHV grantees are required to complete a basic needs assessment that includes socio-demographic, and health and community resource information for their target counties and major municipalities. Since DCF funds at least one program in every county, these local needs assessments have been conducted for all of New Jersey's 21 counties.

The EBHV Needs Assessment shows that every county in New Jersey has a demonstrated need for an expansion of EBHV prevention services. In NJ's rural counties in the southern or northwestern part of the state, the community is defined as an entire county, or adjacent counties. In a densely populated urban area, a community may comprise a large city or adjacent municipalities. The need for EBHV services to reach eligible at-risk families far out-weighs current program capacity.

Section 4 – Capacity for Providing Substance Use Disorder Treatment and Counseling Services

This section of the needs assessment update identifies New Jersey's capacity for providing substance use disorder counseling and treatment services to individuals and families in need of such services. Assessment of the State's capacity to meet the needs of pregnant women and families with young children impacted by substance use disorder supports the NJ MIECHV Program in identifying the system of care that is available for MIECHV-eligible families and ensuring links to care for MIECHV families.

For the purposes of this needs assessment, HRSA adopts the Surgeon General's definition of the phrase "substance use disorder treatment and counseling services" to mean "a service or set of services that may include medication, counseling, and other supportive services designed to enable an individual to reduce or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability.

The Division of Mental Health and Addictions Services (DMHAS) within the Department of Human Services DMHAS manages initiatives for substance abuse treatment for pregnant and parenting women. Women's services programs offer specialized addiction treatment, including

gender specific services, individual and group counseling, prenatal and post-partum services, community-based outreach and linkages, case management, parenting, children's services - either directly or by referral, transportation, and recovery supports. Approximately 1% (1,264) were identified as pregnant women. Please see Appendix B for the Substance Abuse Overview Statewide Table.

According to the National Institute on Drug Abuse, maternal opioid use and neonatal abstinence syndrome (NAS) are on the rise nationally. NAS occurs in newborns exposed to alcohol and/or other drugs while in the mother's womb. As per research (add foot note – JAMA and Journal of Perinatology), an estimated 21,732 babies were born with NAS in the United States in 2012, representing a five-fold increase since 2000[28]. In 2018, DOH launched an awareness campaign to reduce infant exposure to opioids. DOH partnered with DMHAS, the New Jersey Hospital Association, the New Jersey Primary Care Association, the Maternal and Child Health Consortia and others to share prevention messages through social media by displaying posters and referring individuals to resources. Data from the New Jersey Substance Abuse Monitoring System (NJSAMS) 2015 report reflects the most common substances used by New Jersey's pregnant women: heroin (59.8%) other opiates (9.7%); marijuana (13.5%); and alcohol (9.3%).

DOH maintains a Fetal Alcohol Spectrum Disorders (FASD)/Perinatal Addiction Prevention Program within the Maternal and Child Health Unit in the Division of Family Health Services. FASD is the umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with lifelong implications. According to the CDC and the U.S. Surgeon General, "There is no known safe amount of alcohol to drink while pregnant. FASD are the leading known preventable cause of mental retardation and other birth defects.

The American Academy of Pediatrics, 2017, reports that prenatal substance use continues to be a major problem in the United States and leads to serious health problems for the developing fetus. They estimate the use of illicit drug use by pregnant women is 4.4%. Illicit drug use in pregnancy can contribute to a variety of birth defects, low birth weight, small head size, premature birth, spontaneous abortion, SIDS, developmental delays and difficulties with learning, memory, and emotional control (National Institute on Drug Abuse, 2017). According to the CDC, substance use during pregnancy can result in stillbirths. With tobacco use, the risk is 1.8 to 2.8 times greater risk, marijuana use causes 2.3 times greater risk and any stimulant or pain reliever results in 2.2 times greater risk than nonusers. Exposure to passive second hand or third hand smoke causes 2.1 times greater risk of stillbirth. It is essential to educate women on the potential negative effects of using substances during pregnancy to reduce fetal demise and improve birth outcomes.

ACOG and the US Prevention Services Task Force both recommend regular, routine screening of pregnant women for their risk of substance use along with brief intervention (CDC Vital Signs, Feb 2016). Therefore, the maternal child health consortia in New Jersey, which include Southern New Jersey Perinatal Cooperative, Central Jersey Family Health Center, and

[28] Patrick et Al., JAMA 2012, Patrick et Al. Journal of Perinatology 2015, An Estimated 21, 732 babies were born with NAS in the US in 2012, representing a five-fold increase since 2000.

the Partnership for Maternal & Child Health of Northern New Jersey, receives grants from the Department of Health to provide addiction prevention education as it relates to FASD. The project staff of these agencies assists providers to locate appropriate help for their pregnant women who are determined to be at risk of continued alcohol consumption or drug use/abuse. Additionally, Family Health Initiatives receives a grant from the Department of Health to provide services to assist pregnant women to quit smoking.

Due to continued stay at home and social distance orders, FASD/Perinatal Addiction Prevention and Treatment face-to-face education has been minimized. Virtual education and seminars continue to be the main avenue for FASD/Perinatal Addiction Prevention and Treatment education.

Gaps with treatment and counseling service are multiple. Pregnant women with addiction issues face both internal and external barriers that can keep them from seeking and engaging in treatment. Barriers include challenges with transportation, childcare, and health insurance. Barriers also include lack of support and advocacy from healthcare providers who may have their own biases in treating this population as well as limitations in training and experience in treating persons with addiction issues. Additionally, the stigma of addiction and fear of being criminalized or losing custody face pregnant women with addiction issues.

Gaps, especially in this time of the COVID19 pandemic, are anticipated to be exacerbated in meeting the needs of pregnant women and families with young children who may be eligible for MIECHV services. It is evident from reports such as the 2020 Pritzker Report "Unlocking Potential," that many who are eligible for MIECHV are not receiving them; some of those who are eligible but not in receipt of services may be affected by substance abuse.

DMHAS partners with DOH, DCF, and other state partners in many initiatives for substance use disorder treatment for pregnant and parenting women. Availability of services and treatment is shared through webinars and meetings for New Jersey outreach workers including home visitors and others including community health care workers. Meetings include quarterly Partnership for Families meetings co-sponsored by DOH and DCF as well as the newly launched DOH Community Health Workers COVID-19 Project ECHO which provides online mentoring and discussion sessions with other community peers. DOH is also actively engages in the development and execution of implicit bias training for the maternal health workforce. In addition to dissemination of information on substance abuse services and treatment, there are several targeted programs in New Jersey for women and children affected by substance use.

In 2014, New Jersey was awarded a technical assistance opportunity through the federal Substance Abuse and Mental Health Services Administration (SAMHSA)-supported National Center on Substance Abuse and Child Welfare (NCSACW) to address the multi-faceted problems of NAS. In-Depth Technical Assistance (IDTA) for Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS) aims to develop practices/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. New Jersey's IDTA is providing assistance to strengthen collaboration across child welfare, addiction treatment, medical providers, and other stakeholders to improve the safety, health, and well-being of SEI, and the recovery of pregnant and parenting women and their families. New Jersey was awarded regionalized contracts for the Maternal Wrap Around Program (M-WRAP) Program, which combines intensive case management and recovery support services for opioid dependent pregnant

women. Pregnant women with an opioid use disorder are eligible for M-WRAP services through pregnancy and up to one year after the birth of the child.

Pregnant Women/Women with Dependent Children Initiative

This initiative provides a coordinated network of specialized substance abuse treatment services targeted to pregnant women and women with dependent children (PW/WDC). Services include methadone maintenance, residential, halfway house, and outpatient level of care services. Programs are required to provide gender specific services that is family centered and addresses the full range of women's needs that include clinical treatment, clinical support and community support services. Specialized services includes primary medical care for women, referrals for prenatal care; primary pediatric care i.e., immunizations for their children; trauma informed and trauma specific substance abuse treatment using the "Seeking Safety" program, and other therapeutic interventions for women to address issues of relationships, sexual and physical abuse and parenting; therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, their issues of sexual and physical abuse, and neglect; case management, transportation and child care to ensure that women and their children have access to these services. Additional services include aftercare, linkages, assistance with housing, and recovery management.

Maternal Wrap Around Program (MWRAP)

The Maternal Wrap Around Program provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent women are eligible for services during pregnancy and up to one year after the birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers work as liaisons to all relevant entities involved with each woman. The Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. The overall goal of the MWRAP is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure. MWRAP is provided statewide.

DOH and DCF leaders work with DMHAS in many collaborative efforts to address substance abuse disorder. For example, DMHAS is collaborating with DOH on its Opioid Reduction Options (ORO) project. The ORO program is aimed at reducing opioid prescribing to treat chronic pain in hospital emergency departments. DOH has developed a learning collaborative for this project where the program will provide training and education to health systems on other pain relief options in place of opioids. The initiative builds on efforts by the Office of the

Attorney General to regulate opioid prescribing, educate prescribers about the risks associated with opioids, and target enforcement efforts against reckless and criminal over-prescribers. As over half of substance use disorders still start with a prescription, this project will help to prevent an addiction that starts with a visit to the emergency room. Nationally, emergency departments prescribe opioids at a rate about 17 percent. New Jersey is home to best practices that reduce opioid prescribing— St. Joseph's Health reduced opioid prescribing down to 2 percent. The hospital has been recognized nationally.

DMHAS' Opioid Overdose Recovery Program (OORP) responds to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. OORP utilizes Recovery Specialists and Patient Navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The Recovery Specialists and Patient Navigators maintain follow-up with these individuals for a minimum of 8 weeks after the initial contact. OORP includes linking individuals to appropriate and culturally specific services and provides support and resources throughout the process. OORP providers are required to have protocols and procedures in place for priority populations that include pregnant women and parents who have custody of their children and are at risk of child welfare involvement. For pregnant women, OORP provider policies must indicate how they will collaborate with the hospital social worker and/or hospital staff to ensure coordination and access of MAT services. This program was initially implemented in five counties as of January 2015 and is now currently operational in all 21 counties in New Jersey.

Section 5 – Coordinating with Title V MCH Block Grant, Head Start and CAPTA Needs Assessment

The completion of this NJ MIECHV needs assessment has been coordinated with the needs assessments of the Title V MCH Block Grant, Head Start and CAPTA and have taken into account requirements in: (1) the Title V MCH Block Grant program needs assessment; (2) the communitywide strategic planning and needs assessments conducted in accordance with section 640(g)(1)(C) of the Head Start Act; (3) the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect, and other family resource services operating in the state required under section 205(3) of Title II of CAPTA.

The completion of this NJ MIECHV needs assessment has also benefitted from the needs assessment conducted for the Preschool Development Grant Birth to 3 conducted by NJ DCF and Johns Hopkins University. Many of the findings in the PDG NA have been included in this needs assessment, particularly Sections 2 and 3.

The effective coordination of the NJ MIECHV needs assessments with the needs assessments required by Title V MCH Block Grant, Head Start, and CAPTA has leveraged other available data sources; strengthened coordination with other early childhood system partners to assess and identify risk, unmet need, and gaps in care; and ensured that home visiting is well coordinated with the NJ early childhood system of care.

The NJ MIECHV NA has shared drafts of its needs assessment and county data summaries with the other agencies (DCF, DOH/MCH, DOE). The NJ MIECHV Program has received and discussed drafts of the other agencies needs assessments. This coordination and sharing of needs assessments and their findings has informed the MIECHV Program of risk, unmet need, and gaps in care for families with young children.

Title V Maternal and Child Health Block Grant (MCHBG)

The findings in the MCHBG Needs Assessment include the need for expanded partnerships, collaborations, and coordination of MCH programs continue especially involving the Healthy Women Healthy Families Initiative. FHS is working very closely with the NJDOH newly created Office of Population Health, where the Maternal Mortality Review Commission and the State Maternal Health Innovation Program are both housed. Together FHS and the Office of Population Health work collaboratively to improve birth outcomes and reduce disparities.

This year the COVID-19 public health emergency has added a heightened examination of the needs for the MCH population. COVID-19 is an unprecedented public health threat that continues to rapidly evolve. In the effort to transition many in-person programs and services to remote and virtual operations in order to limit exposures to COVID19, additional needs have been identified. Food insecurity, domestic violence issues, unemployment issues, confusion and fear concerning labor and delivery issues, as well as many other health concerns have all been and continue to be identified.

Head Start

The New Jersey Head Start State Collaboration Office (NJHSSCO) is located in the New Jersey Department of Education, Division of Early Childhood Education (DECE). The New Jersey State Board of Education's (SBOE) vision states that students will be exceptionally prepared to the global economy and socially ready to contribute to local, national, and international communities. Their mission is to provide leadership to achieve excellence in New Jersey public education. SBOE works to engage legislators, school administrators, teachers, students, parents, and other stakeholders in formulating policies that enhance education, empower families, and broaden opportunities for students.

The focus of the DECE is to enhance social, emotional, physical, and academic development of New Jersey children—preschool through third grade—by providing leadership, resources, and professional development in support of high-quality early childhood programs within a comprehensive, collaborative program.

NJHSSCO's purpose is to promote partnerships between Head Start agencies, state and local governments, and the private sector to help ensure that children and their families from low-income households have access to high-quality education services. They provide leadership to empower families and broaden collaboration opportunities at the state and local levels.

DOH is a major partner with the New Jersey State Advisory Council, called the New Jersey Council for Young Children (NJCYC) of which NJ HV and Head Start leadership are members. As per the 2020 Unlocking Potential report of the Pritzker Children's initiative, one of the goals is to have more low-income infants and toddlers having access to high-quality subsidized childcare. A major strategy to achieve this goal is to full utilize opportunities to expand Early Head Start to reach more infants and toddlers. Another strategy offered to enable more low income families with infants and toddlers to be connected to critical services to ensure healthy growth and development is through supporting the NJ Council for Young Children as the coordinating entity to align services, assist families and inform the system of needs, gaps, and opportunities.

Child Abuse Prevention and Treatment Act (CAPTA)

The New Jersey Task Force on Child Abuse and Neglect (NJTFCAN) is a statutorily established, multidisciplinary citizen review panel in support of New Jersey's child welfare system. NJ HV Leadership from both DOH and DCF is represented on NJTFCAN. The NJTFCAN also serves as New Jersey's Children's Justice Act (CJA) designated entity that entitles it to receive and administer CJA funds. The purpose of the NJTFCAN, in accordance with the statute, is to study and develop recommendations regarding the most effective means of improving the quality and scope of child protective services and child maltreatment prevention initiatives provided or supported by State government. This includes a review of the practices and policies used by the Division of Child Protection and Permanency (CP&P) and the Division of Family and Community Partnerships (FCP) in the Department of Children and Families (DCF), in order to: optimize coordination of child abuse related services and investigations; promote the safety of children at risk of abuse or neglect; ensure a timely determination with regard to reports of alleged child abuse; educate the public about the problems of, and coordinate activities relating to, child abuse and neglect; develop a statewide plan to prevent child abuse and neglect and

mechanisms to facilitate child abuse and neglect prevention strategies in coordination with the FCP; mobilize citizens and community agencies in a proactive effort to prevent and treat child abuse and neglect; foster cooperative working relationships between state and local agencies responsible for providing services to victims of child abuse and neglect and their families; and serve as one of DCF's federally mandated Citizen Review Panels.

The Child Abuse Prevention and Treatment Act (CAPTA) provides Children's Justice Act (CJA) grants that are used to develop programs to reform state systems and improve states' responses to cases of child abuse and neglect, particularly child sexual abuse and suspected cases of child abuse and neglect fatalities. The NJTFCAN is one of New Jersey's required Citizen Review Panels and provides feedback to DCF to enhance the Department's application for federal CAPTA grant dollars. In New Jersey, CJA funds are also used to establish and support programs to improve New Jersey's child protection system in a manner that limits additional trauma to child victims of abuse and neglect. In accordance with the NJTFCAN's Three-Year Assessment for 2018 to 2021, model programs and innovative approaches were implemented to improve the identification, investigation, and prosecution of child abuse and neglect, as well as enhance the effectiveness of the judicial process.

Current work of NJTFCAN includes understanding and addressing Adverse Childhood Experiences (ACEs). Research on the subject of ACEs has shown that individuals who experience high levels of adversity early in life are more likely to see a lasting impact from that adversity, including long-term health issues, substance abuse issues, mental health challenges, financial instability, homelessness, and more. The lasting impact from ACEs can erode protective factors in an individual's adult relationships, thus perpetuating the cyclical nature of adversity and maltreatment. The NJTFCAN has recommended that DCF continues its efforts to implement a trauma-informed lens over the work that they do. Recognizing and addressing the root cause of trauma rather than simply remedying the outward projections of trauma are more effective in creating a stable environment in which to facilitate healing and relief. Ultimately, by shifting DCF's work to a trauma-informed, healing-centered approach, New Jersey can minimize the impact from ACEs on its population and improve outcomes for families.

Section 6 – Conclusion

MIECHV remains a sustained investment in New Jersey with joint support by state and community leadership. As with the 2010 Needs Assessment, and as with supportive findings from many other prior needs assessments and documents including but not limited to the Preschool Development Grant (PDG); the Maternal and Child Health Block Grant (MCHBG); the Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant; the Pritzker Children's Initiative Planning Grant implemented through Advocates for Children of New Jersey; Head Start, the Child Abuse, Prevention and Treatment Act (CAPTA) Planning Grants and reports; Nurture NJ Strategic Plan documents, the State Health Improvement Plan, and Healthy NJ 2030 planning documents, all 21 counties contain at-risk communities and therefore NJ HV is a statewide program offering 3 evidence-based models in each county.

As per many documents including the 2020 Unlocking Potential Report through the Pritzker Children's Initiative, evidence-based, voluntary home visiting, provided by well-trained professionals during pregnancy and throughout a child's first few years, can yield profound results for parents and babies. In New Jersey however, less than 2% of New Jersey's 310,000 children ages 0-3 currently benefit from home visiting supports. Although all parents could benefit from home visiting services when welcoming a new baby into their family, home visiting services in New Jersey are not universal and access is limited to only those families with the greatest needs. Additionally, the primary funding source for the state's home visiting system, the federal MIECHV grant, has not been increased since its inception 10 years ago, creating funding deficits for programs.

Partnerships and continued collaboration are essential to move the work of MIECHV forward. Engaging families in at-risk communities continues to be a need to prioritize. Strengthening partnerships with DOH, DCF, JHU, the CQI workgroup, IPG, and other state agencies, as well as partnerships with the Central Intake Hubs and CCYCs is essential to be able to respond to the diverse needs of children and families in New Jersey.

Findings in this needs assessment as well as others such as the PDG Needs Assessment are in alignment with regard for the need to support collaboration between programs and services for families with children birth to age 5, which include addressing: Identification, Programming and Supports for Children in Special Circumstances; Unmet Need for Affordable Childcare and Preschool; Central Intake Infrastructure to Support Coordination; and Sustained Funding for an integrated data system.

System integration is needed for improved coordination among early childhood organizations and alignment with maternal and infant health initiatives to ensure a seamless array of services. Supporting the NJ Council for Young Children is an essential strategy to help align services, assist families and inform the system of needs, gaps, and opportunities.

The county-based Central Intake Hubs are an essential resource and gateway for pregnant women and families with young children to access services and supports. Adequate staffing and retention are needed to strengthen these hubs in their connection between families and critical maternal and child health and early childhood services. As the number of HV slots increase to meet the increased number of families in need, EBHV staffing, including CI Hub staffing will need to increase.

Needs will need to continue to be assessed and evaluated especially regarding the unprecedented, rapidly evolving situation with the COVID19 pandemic. A rapid response and/or shift in delivery of services may need to be made in response to the evolving COVID19 pandemic. As data becomes available concerning the impact of COVID 19, NJ HV will need to be vigilant in monitoring needs of families.

NJ HV looks forward to continuing its partnership with other state and community agencies, as well as families, to learn together on changes that are needed to sustain and improve efforts to address at-risk communities in New Jersey.

Plans for disseminating findings from this update will include the following: use of existing communication structures – DOH's routine weekly communications with DCF, as well as quarterly CQI meetings and quarterly meetings with supervisors of programs statewide – to share results and discuss strategies to improve local home visiting program performance to improve staff retention and efficiency in filling vacated positions. We will continue work with our evaluator Johns Hopkins University to share information to explore opportunities for research involving shared data and to participate in developing peer-reviewed literature as a strategy to advance work in home visiting.