Maternal and Child Health Services Title V Block Grant

2024 Application/2022 Annual Report

New Jersey

APRIL 6, 2023

NEW JERSEY DEPARTMENT OF HEALTH

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I.A. Letter of Transmittal

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PHILIP D. MURPHY
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Commissioner

[Insert Date]

Shirley Payne, PhD, MPH
Director, Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Payne:

In accordance with the amendments made to Title V of the Social Security Act by the Omnibus Reconciliation Act of 1989, the State of New Jersey hereby applies for the Maternal and Child Health Service Block Grant for the Federal Fiscal Year 2024. This letter serves as a formal notification that the New Jersey Title V Program at the New Jersey Department of Health would like to continue spearheading all Title V Maternal and Child Health Services Block Grant activities in the federal Fiscal Year 2024.

New Jersey's 2022 Annual Report and 2024 Application Year have been submitted electronically via the Health Resources and Services Administration's Electronic Handbook (EHB). Through this submission, our team has demonstrated our continuous commitment to providing comprehensive and high-quality services to New Jersey's maternal and child health population.

Sincerely,

_____
Nancy Scotto-Rosato, PhD
Assistant Commissioner
Division of Family Health Services
New Jersey Department of Health

Abstract

Background: New Jersey (NJ) is one of the nation's most urbanized, densely populated, racially, and ethnically diverse states. NJ's diversity highlights the importance of addressing disparities in health outcomes and the need to ensure a culturally competent workforce and service delivery system. NJ's disparities in maternal health outcomes are known to be among the highest in the United States. The Division of Family Health Services (FHS) within the New Jersey Department of Health (NJDOH) houses the Title V Program (TVP) and is charged with working to promote and protect the health of mothers, children, and adolescents, including those with special health care needs, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. The Maternal and Child Health Block Grant Application and Annual Report that TVP submits each year to the Maternal Child Health Bureau (MCHB) provides an overview of initiatives, state-supported programs, and other state-based responses. These initiatives and programs are strategically designed to address the maternal and child health needs in NJ as identified through our continuous needs assessment process and in concert with the NJDOH's strategic plan, the State's Health Improvement Plan, Healthy NJ 2030, and the collaborative process with other maternal child health partners.

Methodology: Through partnerships and collaborations with other state agencies, family organizations, public and private entities, and other MCH partners, FHS is working to improve health outcomes for mothers, children including children, and youth with special health care needs, and families as well as working to eliminate disparities. Initiatives and programs are developed and fine-tuned to strategically address MCH needs identified through continual needs assessment, public input, and in concert with Nurture NJ, the NJDOH strategic plan, the State's Health Improvement Plan, Healthy NJ 2030 and other MCH needs assessments and findings.

Results: Findings included the need to have trusted support persons in the community who can advocate for birthing people and families and who can provide education, resources, and help in navigating the complex healthcare system. NJ has developed and expanded a perinatal workforce, including community health workers, doulas, home visitors, and others to address both healthcare needs and social determinants of health issues. Families with children and youth with special health care needs continue to need coordinated, family-centered, community-based, and culturally competent services.

Conclusions: NJ's TVP continues to support the work and mission of Title V and actively works on developing innovative ways to improve the health and well-being of NJ women and children, including those with special health care needs and families.

III.A. Executive Summary

III.A.1 Program Overview

New Jersey (NJ) is one of the nation's most urbanized, densely populated, racially, and ethnically diverse states. The New Jersey Department of Health (NJDOH) must develop and implement culturally responsive public health interventions to optimize health for the 9 million NJ residents, including the yearly 100,000 newborns the State welcomes. NJ's diversity highlights the importance of addressing disparities in health outcomes and the need to ensure a culturally competent workforce and service delivery system.

The Division of Family Health Services (FHS) within NJDOH works to promote and protect the health of mothers, children, adolescents, and at-risk populations and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. The Maternal and Child Health Block Grant (MCHBG) Application and Annual Report that FHS submits annually to the Maternal Child Health Bureau (MCHB) provides an overview of initiatives, state-supported programs, and other state-based responses. These initiatives and programs are strategically designed to address the maternal and child health (MCH) needs in NJ. The needs assessment that we regularly conduct in concert with the NJDOH's strategic plan, the State's Health Improvement Plan, Healthy NJ 2030, and the collaborative process with other MCH partners inform all the activities we implement.

To ensure access to enabling services and population-based preventive services, consistent with the findings of the Five-Year Needs Assessment, the goals, and State Priority Needs (SPNs) selected by FHS are built upon the work of prior MCH Block Grant Applications/Annual Reports and in alignment with NJDOH's and FHS' goals and objectives. The State Priority Needs (SPNs) are:

SPN 1-Increasing Equity in Healthy Births,
SPN 2-Reducing Black Maternal and Infant Mortality,
SPN 3-Improving Nutrition & Physical Activity,
SPN 4-Promoting Youth Development Programs,
SPN 5-Improving Access to Quality Care for CYSHCN,
SPN 6-Reducing Teen Pregnancy,
SPN 7-Improving & Integrating Information Systems, and
SPN8- Smoking Prevention.

NJ has selected the following nine of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period:

NPM 1-Well Woman Care,
NPM 4-Breastfeeding,
NPM 5-Safe Sleep,
NPM 6-Developmental Screening,
NPM 9-Bullying,
NPM 11-Medical Home,
NPM 12-Transitioning to Adulthood,
NPM 13-Oral Health, and
NPM 14- Household Smoking

This past year, Title V staff (TVS) has collaborated with sister agencies, insurance companies, and community-based organizations to implement culturally responsive public health interventions to reduce disparities in health outcomes in NJ. These interventions are presented and discussed below.

Maternal/Women's/Reproductive Health & Perinatal/Infant's Health

According to America's Health Rankings, NJ's disparities in maternal health outcomes are known to be among the highest in the US. In 2018, in response to NJ's maternal and infant health crisis, the NJ Title V Program (TVP) funded diverse community-based organizations to support the Healthy Women, Healthy Families initiative (HWHF). Through the HWHF initiative, the NJ TVP has taken a targeted approach to reduce Black infant mortality (BIM) rates. As a result, partners from the Departments of Labor and Workforce Development, Education, Transportation, Children and Families, Human Services, and Community Affairs, as well as community partners, regularly collaborate with NJDOH to address the high BIM rates. One of the most salient aspects of the HWHF initiative is the implementation of specific BIM reduction activities. To better address potential adverse health outcomes post-delivery, American College of Obstetricians and Gynecologists (ACOG) recently updated the postpartum guideline; instead of a routine checkup that is done 4 to 6 weeks after giving birth, they recommend that the postpartum visit should be ongoing. Considering this novel change to holistically serve the MCH population, in FY24, TVP has drafted a HWHF 2.0 request for proposal that places an emphasis on the 4th trimester (i.e., postpartum). HWHF 2.0 will focus on implementing breastfeeding support, and postpartum doula services.

To date, approximately 250 individuals were trained to become community doulas, and as of March 2023, 653 births have been attended by doulas. To ensure the sustainability of community doula services, NJ TVP partnered with the NJ Department of Human Services (DHS) to offer doula services to women through Medicaid Benefits. NJ Medicaid benefits have been expanded to cover doula services. Presently, birthing people whom Medicaid covers can receive services from a Medicaid-enrolled community doula.

NJ TVP has also established and expanded a Community Health Worker (CHW) workforce. Through a partnership with the Colette Lamothe-Galette Community Health Worker Institute (CLG-CHWI), multiple state colleges deliver courses and training that equip Community Health Workers (CHWs) with skills to provide equitable care to their clients. Concurrently, TVP is working with key officials to expand Medicaid benefits to cover CHWs' services. Thus far, the CLG-CHWI has successfully trained and integrated over 300 CHWs into NJ health systems. Of those, 4 have attended the new American Sign Language (ASL) class initiated in 2023. About 32% of our trainees identified as bilingual. They are also trained to respond to diverse public health challenges, including COVID-19 response, mental health, and others. Upon course completion, CHWs receive 9 college credits toward an associate degree.

In 2023, the Reproductive and Perinatal Services (RPHS) Team within NJ TVP announced a competitive request for proposals (RFP) to establish the NJ Community Health Worker Hub (CHW Hub). Although NJ TVP will not use MCHBG funding to fund the CHW Hub, TVP staff were involved in designing the RFP and will play an instrumental role in implementing the hub. Once established, the CHW Hub will ensure NJ has a strong CHW workforce by working with organizations across the State to manage training, deploying, and engaging CHWs. The CHW Hub will also actively support and advocate for the integration of CHWs into standard healthcare practice.

Moreover, the TVP will strengthen existing partnerships with state colleges and enhance the current curriculum for CHWs to include additional emerging public health issues (e.g., Long-COVID). NJ TVP will continue working with key officials to explore expanding Medicaid benefits to cover CHWs' services through the 1115 Waiver. In FY2022, NJ TVP, in collaboration with the Division of Mental Health and Addiction Services (DMHAS), launched a pilot program to facilitate reimbursement for services provided to clients covered by Medicaid. Simultaneously, TVS will solidify a novel partnership with Horizon's Neighbors in Health to give trained CHWs access to numerous employers throughout the State across large health systems.

The NJ Maternal, Infant, and Early Childhood Home Visiting (MIECHV) continues to provide parents with community-based education and in-home support, including evidence-based safe sleep strategies. Additionally, the NJ MIECHV continues to utilize the Connecting NJ (CNJ) referral system to connect New Jerseyans to programs such as HWHF, MIECHV, community resources, medical care, doula programs, social support agencies, and more. Through CNJ, families are connected to care and personalized support.

NJ TVP Epidemiology Team conducted a formative evaluation of the HWHF initiative. The Team synthesized the results into a set of recommendations. These recommendations informed the development of new objectives and the decision to expand evidence-based activities (e.g., lactation education and postpartum doula care) across the State. Moreover, NJ TVP Epidemiology Team conducted a formative evaluation of Fetal Alcohol Syndrome Prevention (FASD) and Postpartum Depression and Mood Disorders (PPD-MD) initiatives. The Team evaluation project informed necessary culturally sensitive programmatic changes and the development of new objectives that seek to improve health outcomes related to FAS and PPD-MD.

Shortages in mental health and addiction specialists are evident for the general population, especially MCH populations with limited resources. In FY 23, TVP announced a competitive RFP to pilot an Alma Program Expansion Project, which aims to support pregnant persons who may be experiencing mental health issues and/or substance misuse. Alma is an evidence-based peer specialist program developed by the University of Colorado and expanded in NJ to include substance misuse. It supports new and expectant parents experiencing depression, anxiety, and stress. Developed by a collaborative team of researchers, mental health providers, community members, and parents, Alma gives parents the support and skills they need to navigate this important chapter in their lives.

Racial and ethnic disparities persist in preterm birth rates, necessitating the need to address these disparities and reduce preterm birth rates. TVP has partnered with the Maternal Health Innovation (MHI) Team to implement the Preterm Birth Prevention Program. In FY23, the team undertook multiple activities. One of the key activities is the creation of statewide clinical service best practices standards (one for 17P, one for cerclage, and one for vaginal progesterone cream). While piloting these resources, the team was able to expand the distribution of services to home-visiting residents, Federally Qualified Health Centers (FQHCs), patients in identified healthcare systems, and select providers.

Child Health

One in six children aged 3–17 has a developmental disability. Unfortunately, children with developmental delays are usually not identified until after entering school. Access to adequate coordinated service is paramount. Through the NJ Early Childhood Comprehensive System (ECCS) Health Integration: Prenatal to Three (ECCS P-3) Initiative, the NJ Department of Children and Families (DCF), in partnership with NJ TVP, was able to maintain integrated developmental health promotion and screening as a service of the statewide Connecting NJ system effective in FY19. Through FY20 – FY22, CNJ's central hubs maintained their outreach through the pandemic and post-pandemic which enabled thousands of children to receive parent-led developmental screenings. In FY23, we anticipate a sustained reach with a slight increase, with the ability to continue outreach to families in the community during outside community events with the lifting of COVID mandates. DCF, in partnership with TVP, plans to strengthen relationships with pediatric providers in utilizing and referring families to the CNJ system, which can link families to services and programs that support the overall child and family well-being.

Adolescent Health

Adolescents and young adults (AYA) in NJ have continued to experience disruptions to learning and other mental and physical health issues due to COVID-19. AYAs experience school absences due to COVID-19 and increased mental health challenges and bullying rates, which have hit an all-time high with the return to in-person learning. Schools are still experiencing a spike in physical fights with a virtual twist as student witnesses share videos online which exacerbates the impact of the incidents. Currently, one in five students are victims of bullying, with higher rates for adolescents with disabilities and those who identify as lesbian, gay, bisexual, transgender, non-binary, Black, Indigenous, and People of Color (BIPOC). This information, in addition to the Youth Risk Behavioral Surveillance (YRBS), which provides additional insight into youth sexual behavior fueling the rise of STI, has provided significant insight into the needs of adolescents in NJ.

The CAHP plan for the upcoming year includes a strong focus on bullying prevention, mental health/suicide prevention, sexual health, and school health. The MCHBG specifically supports adolescent mental health, suicide prevention, and school health, implementing evidence-based models that help reduce bullying and stigma and improve school climate. All CAH programs work together to support adolescents and their health needs holistically. Mental health and suicide prevention activities include training on screening and assessment using the Ask Suicide-Screening Questions (ASQ), Columbia Suicide Severity Rating Scale (CSSRS), SafeSide™ Training for primary care settings, Safety Planning, Adolescent Care and Treatment of Suicide (ACTS Training), and interventions for suicidal teens (Collaborative Assessment Management of Suicide and Attachment-Based Family Therapy). The Garrett Lee Smith Suicide Prevention Project (GLS) and MCHBG support a new learning and resource portal for professionals, parents, caregivers, and a youth named Prevent Suicide NJ (PSNJ) https://preventsuicidenj.org/. PSNJ launched in September of 2022 after the national launch of hotline #988, which will replace the National Suicide Prevention Lifeline number. Since the launch, PSNJ has had over 10,000 hits to the website and has a mailing list of 1,600 people who receive regular updates on trainings, resources, and community events. In addition, NJDOH is implementing Lifelines Trilogy, an evidence-based competent community suicide prevention model for school districts. Other initiatives contributing toward positive outcomes in addressing the State's priority areas of reducing teen pregnancy, promoting youth development, and improving physical activity and nutrition are the Whole School, Whole Community, Whole Child School Health NJ Project, the NJ Personal Responsibility Education Program (PREP), and the NJ Sexual Risk Avoidance Education (SRAE) Program. All CAH programs support evidence-based models rooted in Social and Emotional Learning (SEL) and Positive Youth Development (PYD), proven frameworks to reduce bullying by increasing empathy and self-awareness. In addition to Lifelines Trilogy, these programs include the Teen Outreach Program (TOP®), Love Notes, and Teen PEP.

Professional development for the year will include Mental Health First Aid Training, Mentor/ Advisor Training, Mindfulness/Mental Health for Youth-Serving Professionals, Practical Applications of the Attuned School Approach™ and a week-long Sexual Health Educator Training conducted by ANSWER. Other professional development will be added as needed.

Children and Youth with Special Health Care Needs (CYSHCN)

In NJ, families of CYSHCN have access to a myriad of services to ensure that children in need of specific services get access to necessary services to help them thrive. These services are provided through the following interventions:

(1) Newborn Screening and Genetic Services (NSGS) ensure that all newborns and families affected by an out-of-range screening result receive timely and appropriate follow-up services. NJ remains among the leading states offering the most screenings, with 60 disorders on the current screening panel. NJ's newborns are also screened with pulse oximetry through the Critical Congenital Heart Defects (CCHD) screening program
(2) Birth Defects and Autism Registry (BDAR) ensures that all children 0 through five years old who have a congenital disability and all children 0 through 21 years old who have an Autism Spectrum Disorder (ASD) are registered. In 2020, staff took on the monitoring of COVID pregnancies and infant outcomes through a CDC-funded project to review maternal charts for all births to COVID positive persons in 2020 and 2021.
(3) Early Hearing Detection and Intervention (EHDI) program ensures that children who did not pass their initial screening receive timely and appropriate follow-up remains an area for continued efforts.
(4) Family-Centered Care Services (FCCS) addresses families' medical and social conditions by providing, in addition to quality health care, referrals to support accessible services within state departments, divisions, and county and municipal agencies. Our FCCS case managers also refer children to NJ Early Intervention Services (NJEIS) to ensure eligible children receive important services on time. As children age out of NJEIS and continue to need case management, these children move back to our county-based Case Management Units (CMUs).
(5) Specialized Pediatric Services (SPS) consist of eight Child Evaluation Centers (CECs), of which four house Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder Centers and three provide newborn hearing screening follow-up, three Pediatric Tertiary Centers, five Cleft Lip/Palate Craniofacial Anomalies Centers. The SPS program aims to provide access to comprehensive, coordinated, culturally competent pediatric specialty and sub-specialty services to families with CYSHCN that are 21 years old or younger. With support from the State and Title V funds, health service grants are distributed to multiple agencies throughout NJ.
(6) The NJ Early Intervention Services provides services to children from birth to three years of age who are experiencing developmental delays. Approximately 18,000 children receive services at any given time, including Occupational Therapy, Speech Therapy, Physical Therapy, and Developmental Intervention.

NJ's Title V CYSHCN program collaborates with intergovernmental and community-based partners to ensure that care through these multiple systems is coordinated, family-centered, community-based, and culturally competent. Communication across State agencies and timely training for State staff, community-based organizations, and families with CYSHCN remain a priority to ensure that families are adequately supported. Therefore, through the Title V CYSHCN program, staff provide access to comprehensive, coordinated, culturally competent pediatric specialty and sub-specialty services to families with CYSHCN that are 21 years old or younger.

Cross-Cutting/Systems Building

The Oral Health Services Unit (OHSU) continues to educate the public about the importance of preventive oral health services and good oral health, with programs predominately targeted to school-aged children and pregnant women. Other preventative services include dental screening, nutrition counseling, and placement of sealants and fluoride varnish for underserved, uninsured and underinsured children across New Jersey. During 2021 – 2022, OHSU is proud to report the completion of the first NJ third-grade oral health Basic Screening Survey (BSS), a national standard for establishing key oral health baseline data. The survey results will be reported to the Centers for Disease Control and Prevention by Mid-2023.

In 2022-2023, OHSU will initiate the next phase of the Oral Health Basic Screening survey, concentrating on children enrolled in Head Start and Early Head Start. Additionally, leveraging on our experience, collaborations, and close partnerships with other agencies, OHSU aims to continue expanding our oral health outreach services to cover more children at schools and pregnant women across New Jersey.

COVID-19

The impact of COVID-19 on all areas of maternal, child, and adolescent health has been and continues to be significant. Published studies confirm the pre-pandemic persistent racial/ethnic health disparities and their exacerbation during the COVID-19 pandemic. These results illuminated the deep racial inequities and gaps in US public health and healthcare systems. Per the literature, the discontinuation and/or scaling back of lifeline services during the pandemic is believed to have exacerbated preexisting socioeconomic, health, and emotional challenges.

NJ TVS continues to support the work and mission of Title V and actively works on developing innovative ways to improve the health and well-being of NJ women, children, and families. For instance, TVP partnered with Rutgers Project ECHO to develop a CHW COVID-19-specific curriculum to raise awareness, identify the impact of COVID-19

in high-risk populations and combat the ill effects of COVID-19 in NJ. As the COVID-19 pandemic continues to evolve rapidly, TVP continues to collaborate with partners and families to deliver services and support

III.A.2. How Federal Title V Funds Complement State-Supported Efforts

Title V Funds are essential in supporting NJ's MCH efforts. FHS uses Title V MCH funding as the primary source for multiple public health interventions to address health disparities and inequities for NJ's birthing people. The current initiatives are impactful in the realm of maternal and child health as they relate to health outcomes, risk factors, chronic diseases, mental health, and the COVID-19 response. A few examples of key programs funded by Title V funding:

1. Healthy Women, Healthy Families initiative – to fund grantees that provide services and support birthing individuals in the communities and potentially improve maternal and infant health and reduce both Black Infant and Black Maternal mortality
2. ConnectingNJ – to fund grantees to operate and maintain a single point of entry for families to access needed resources such as home visiting, community health worker support, doula care, etc.
3. NJ Fetal Infant Mortality Review (FIMR)- to fund grantees to conduct FIMR-related activities (e.g., Chart review, family interview); these activities that seek to identify ways to strengthen the systems of care and resources available to families to prevent future deaths.

Title V funding serves as the main funding source used by the NJ TVP to support MCH populations in accordance with Title V and other federal and state guidelines to protect and promote the health and well-being of women, children, and families. Please see the Table in the Expenditures Section. It depicts the federal / state partnership and how State MCH funds support Federal Title V funds.

Title V funds are used to support NJ's state priority MCH efforts, including increasing equity in healthy births, reducing BIM, improving nutrition and physical activity, promoting youth development, improving access to quality care for children and youth with special health care needs, reducing teen pregnancy, improving, and integrating health information systems and smoking prevention. Therefore, Title V funds are necessary to equitably better the health of birthing people and their families in NJ.

III.A.3. Maternal and Child Health Success Story

Special Child Health Services—A Parent's Leadership Journey

The leadership of parents representing the voice of families in meaningful roles within disability programs and communities is crucial to positive outcomes and accountability. One NJ mom started her leadership journey just wanting to make positive changes for the benefit of other families. This mom expected to live an anonymous life, to work in her chosen profession as a Special Education Teacher, and to experience the challenges and rewards of daily life, but that path changed while raising two sons with Usher syndrome. She had to learn to navigate her reality and make adjustments that eventually put her on the path to being a parent leader.

She began in a parent-to-parent compacity by sharing her story to help other families with a child diagnosed with hearing loss avoid some of the frustrations. This led to being on panels at Education Days, seminars, and conferences to address a larger audience of parents and professionals. Her progression then moved to involvement in advocacy and awareness groups, even working briefly for a company that makes cochlear implants to help families who were deciding about cochlear implants for their children.

Her leadership journey continued to serve on boards and advisory groups of organizations that were meaningful to her family. She presented with her family on 'Advocating as a Family' and has written several articles for Exceptional Parent magazine. This Mom's volunteer efforts for families in the Usher syndrome community culminated in creating the first sleep-away summer camp for youth with Usher syndrome that has been held in the US and the UK. Eventually, she became a Project Director for an EHDI grantee and even won the National EHDI Parent Leadership Award in 2020. As of January 9th, 2023, this mom, Pam Aasen, joined our SCHS team as the new NJ EHDI Coordinator, where she will continue to help families by adding the parent voice to the NJ EHDI Program.

Special Child Health Services—Case Management Holistic Support

Case Management (CM) has been working with a family for 9.5 years since the child was diagnosed with a neurogenerative disorder at age 15 and referred by his pediatric psychiatrist for a need to move into a handicapped-accessible apartment. Mom is Spanish-only speaking and a single mother. The Family was successfully moved to their first-floor apartment; then CM helped with the transition to high school from in-district to out-of-district as his condition worsened in his later teenage years. CM regularly contacted the Child Study Team (CST) case manager and the family. CM also assisted Mom with the Division of Developmental Disabilities (DDD) referral, PerformCare, Medicaid, and securing a new pediatric psychiatrist when he moved out of state. Just last year, in 2022, CM helped Mom connect with a Spanish-speaking employee at a company in Minnesota who specially designed a handicap-accessible van that was delivered to NJ. CM worked with Mom to work out a loan with the company and assisted Mom with Catastrophic Illness in Children Relief Fund (CICRF) application to get reimbursed for van costs. The van has improved the child's and mom's quality of life.

Special Child Health Services—Case Management Holistic Support (Continued)

Special Child Health Services Case Manager (SCHSCM) worked with a single mother who had recently moved her family from Central America to NJ. She spoke only Spanish and was not able to read. At the time, the family had few resources, and the child was not enrolled in school. With the case manager's assistance and the collaboration of additional community partners such as the local public health nurse and the local hospital finance department, the family was successfully linked to a medical home, obtained dental care, and gained access to immunizations. The CM also supported the family through the process of school enrollment and successfully connected the family to the local Family Success Center and Connecting NJ who provided financial assistance and helped with essential needs and linkage to a home visiting program and Early Intervention for a younger child in the home.

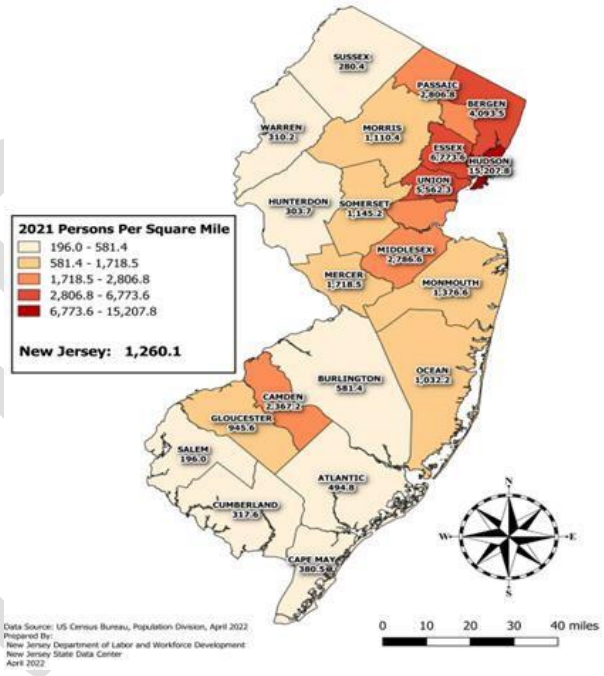
III.B. Overview of the State

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

The mission of FHS is to improve the health, safety, and well-being of families and communities in NJ. The Division promotes and protects the health of mothers, children, adolescents, and at-risk populations and reduces disparities in health outcomes by ensuring access to quality comprehensive care. The Division's ultimate goals are to enhance the quality of life for each person, family, and community and to invest in future generations' health.

In 2021, the population density (persons per square mile) in NJ was 1,260 to 1 compared with 93 to 7 nationally. There are 564 municipalities and 21 counties in NJ. The most populated counties in NJ are in the northern part of the state; these are Bergen and Essex counties, each with a population of 955,732 and 863,728, respectively. While Bergen is one of the most populated counties, it is also one of the top 5 most densely populated counties (Figure 1).

Figure 1. 2021 Population Density: New Jersey Counties



Data Source: https://www.nj.gov/labor/lpa/content/maps/Popden.pdf

According to the 2022 NJ Population Estimates of race, 53.5% of the population were white, non-Hispanic; 15.3% were Black; 10.3% were Asian; 0.1% were American Indian and Alaska Native; and 2.4% reported two or more races. In terms of ethnicity, 20.9% of the population was Hispanic. The 2020 American Community Survey (ACS) identified that 31.6% of New Jersey residents speak a language other than English in the home compared to 21.5% nationally.

The racial and ethnic mix for NJ mothers, infants, and children is more diverse than the overall population composition. According to 2021 birth certificate preliminary data, 27.9% of mothers delivering infants in NJ were

Hispanic, 47.3 % were white non-Hispanic, 12.6% were Black non-Hispanic, and 9.9 % were Asian non-Hispanic. The growing diversity of NJ's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

MCH priorities continue to be a focus for the NJDOH. FHS, the Title V agency in NJ, has identified 1) improving access to health services thru partnerships and collaboration, 2) reducing disparities in health outcomes across the lifespan, and 3) increasing cultural competency of services as three priority goals for the MCH population. These goals are consistent with the Life Course Perspective (LCP), which proposes that an interrelated web of social, economic, environmental, and physiological factors contribute, to varying degrees through the course of a person's life and across generations, to good health and well-being. Social Determinants of Health (SDOH), the conditions in which people live, learn, work, play, worship, and age significantly affect health, functioning, and quality of life. Healthy People 2030 identifies five key areas of SDOH: economic stability, education, social and community context, health and health care, and neighborhood and built environment. In consideration of SDOH, there is a heightened need for integrating both health and non-health partners, as well as state, and external partners, in addressing infant, and maternal mortality, the opioid crisis, and other public health issues facing NJ.

The selection of NJ's eight State Priority Needs is a product of FHS's continuous needs assessment. Influenced by the MCH Block Grant needs assessment process, the NJDOH budget process, the NJ State Health Improvement Plan, Healthy NJ 2030, Community Health Improvement Plans, and the collaborative process with other MCH partners. FHS has selected the following State Priority Needs:
SPN #1) Increasing Equity in Healthy Births,
SPN #2) Reducing Black Maternal and Infant Mortality,
SPN #3) Improving Nutrition & Physical Activity,
SPN #4) Promoting Youth Development Programs,
SPN #5) Improving Access to Quality Care for CYSHCN,
SPN #6) Reducing Teen Pregnancy
SPN #7) Improving & Integrating Information Systems, and
SPN # 8) Smoking Prevention.

These goals and State Priority Needs (SPNs) are consistent with the findings of the Five-Year Needs Assessment and are built upon the work of prior MCH Block Grant Applications/Annual reports. Consistent with federal guidelines from the MCHB, Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure services to meet the health of all NJ families. During a period of economic hardship and federal funding uncertainty, health emergency challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of healthcare providers and culturally appropriate services. Based on NJ's eight selected SPNs as identified in the Five-Year Needs Assessment, NJ has selected the following eight of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period:
NPM #1 Well Woman Care,
NPM #4 Breastfeeding,
NPM #5 Safe Sleep,
NPM #6 Developmental Screening,
NPM #9 Bullying,
NPM #11 Medical Home,
NPM #12 Transitioning to Adulthood
NPM #13 Oral Health, and
NPM #14 Household Smoking.

State Performance Measures (SPMs) have been reassessed through the needs assessment process. The existing SPMs which will be continued are:
SPM #1 Black Non-Hispanic Preterm Infants in NJ,
SPM #2 The percentage of children (≤6 years of age) with elevated blood lead levels (≥10 ug/dL) [Deactivated].
SPM #3 Hearing Screening Follow-up,
SPM #4 Referral from BDARS to Case Management Unit,
SPM #5 Age of Initial Autism Diagnosis, and
SPM #6 -Teen Outreach Program (TOP), Reducing the Risk, and Teen Prevention Education Program (PEP) completion.
SPM #7 Black Infant Mortality in NJ

Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model summarizes the selected eight NPMs and aligns the impact of Evidence-Based Informed Strategy Measures (ESMs) on NPMs and National

Outcome Measures (NOMs). The purpose of the ESMs is to identify NJ TVP efforts that can contribute to improved performance relative to the selected NPMs. The Logic Model is organized with one NPM per row. The Logic Model is the key representation that summarizes the Five-Year Needs Assessment process and includes the three-tiered performance measurement system with ESMs, NPMs, and NOMs. The Logic Model represents a more integrated system created by the three-tiered performance measure framework, which ties the ESMs to the NPMs, which in turn influences the NOMs.

Considering the high rate of adverse birth and pregnancy outcomes in NJ, NJ TVP has been collaborating with community-based organizations to strategically address these adverse birth outcomes on persisting racial and ethnic disparities as they relate to pregnancy and birth outcomes.

Maternal/Women /Reproductive Health & Perinatal/Infant Health

1) HWHF grants have been awarded in state fiscal year 2019 (start date of July 1, 2018) through a request for proposals process and will be re-bided for state fiscal year 2024. This initiative aims to improve maternal and infant health outcomes for women of childbearing age (defined by CDC as 15-44 years of age) and their families, especially Black families, through a collaborative and coordinated community-driven approach. This is being done using a two-pronged approach:
    a. County-level activities focus on providing high-risk families and/or women of childbearing age access to resource information and referrals to local community services that promote child and family wellness
    b. BIM municipality-level activities focus on Black NH women of childbearing age by facilitating community linkages and supports, implementing specific BIM programs, and providing education and outreach to health providers, social service providers, and other community-level stakeholders. BIM activities include breastfeeding support groups, fatherhood support groups, Centering pregnancy (group prenatal care), Centering parenting (group pediatric care), and Doulas. From July 2018 to February 22, 2023, the percentage of clients who mainly benefited from services offered through HWHF was 43.9%, 35.0%, 15.4%, 2.0%, and 3.4% for Hispanic, NH Black, NH White, and Asian, respectively.
    c. In June 2023, the HWHF grant cycle will end. Based on a comprehensive list of recommendations that were made by the NJ TVP evaluation team that evaluated the program, the RPHS Team within TVP is revising the RFP to better address the need of the MCH population that the HWHF focuses on (Black, NH, and Hispanic). Informed by current birth, infant mortality rates, and population density at each NJ county, the team created 4 statewide regions that will implement key maternal and child health programs (e.g., breastfeeding education to non-traditional audiences, and doula postpartum support) starting in FY24 for 5 years until the expiration of the new grant cycle (Figure 2).
2) Connecting NJ (formerly called Central Intake) hubs have been established; these are single points of entry for screening and referral of women of reproductive age and their families to home visiting programs and necessary medical and social services. The CHW model continues to perform outreach and client recruitment within the targeted community to identify and enroll women and their families in appropriate programs and services and provide case management. NJ TVP has established a CNJ committee and convenes representatives from the CNJ, DCF, and NJ TVP to eliminate duplication of effort and services, ensure alignment with emerging needs, and improve the overall flow of the standardized screening tools. These tools are used for referrals to programs and services through a centralized web-based system (SPECT – Single Point of Entry and Client Tracking), where all clients' contacts are documented from referral to enrollment.
    a. The purpose is to: (a) to ensure critical information is collected from all enrolled participants to guide service referrals, education, and case management planning; and (b) to collect data necessary to demonstrate the impact of the program on the well-being of women and families and birth outcomes. Additionally, information about the services specifically targeted to women in cities with high rates of Black Infant Mortality (BIM) is also collected in a data system called NJCHART. BIM activities include participation in centering groups, doula services, services for fathers, and breastfeeding support services. The top 5 Service Referrals Categories provided by CNJ from July 2018 to March 2022 included**:** Family Support (28.68%), Nutrition (25.11%), Healthcare (12.26%), and Public Benefits (9.52%). For the period, the percentage of clients who mainly benefited from services offered through CNJ were 45%, 25%, 22%, 5%, and 2% for Hispanic, White- NH, Black- NH, other, and Asian, respectively.

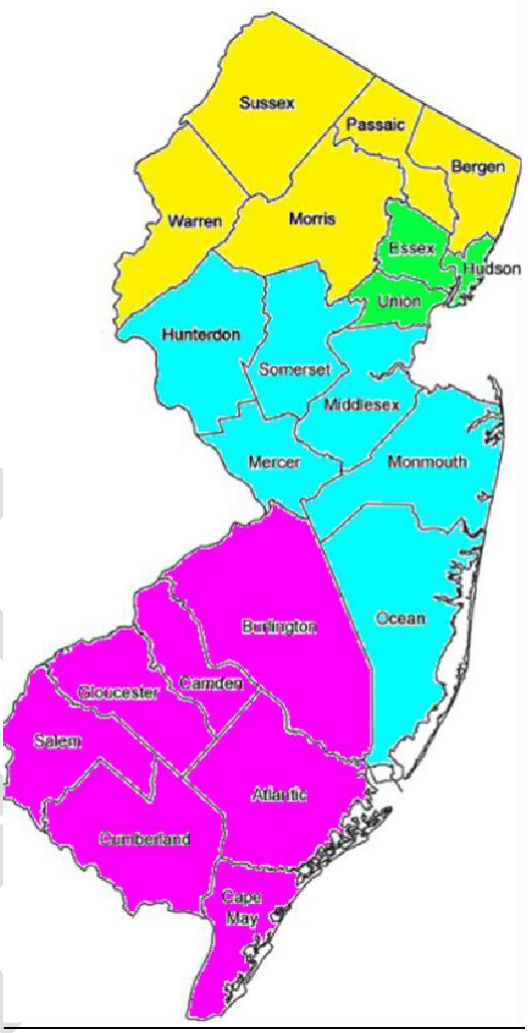
Figure 2. Healthy Women Healthy Families Regions for Fiscal Year 24

Region 1: Bergen, Morris, Passaic, Sussex, and Warren

Region 2: Hudson, Essex, Union

Region 3: Ocean, Monmouth, Mercer, Middlesex, Somerset, Hunterdon

Region 4: Atlantic, Burlington, Cape May, Cumberland, Salem, Gloucester, and Camden

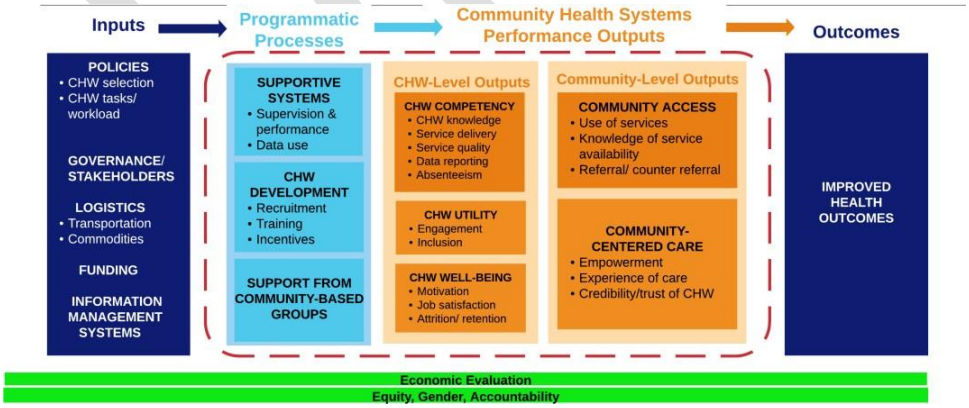


3) The creation of the NJ Doula Learning Collaborative (DLC) aligns with the First Lady Tammy Murphy's Nurture NJ initiative to improve birth outcomes and achieve equity in maternal and infant health. The goal of the DLC is to reduce maternal and infant mortality and eliminate racial disparities in health outcomes by providing training, workforce development, supervision support, mentoring, technical assistance, direct billing, and sustainability planning to community doulas and doula organizations throughout the State of NJ. Thus far, the DLC has developed and supported the doula workforce that delivers doula care to NJ's Medicaid and CHIP members as enrolled NJ FamilyCare providers.
4) In response to the NJ stillbirth rate that is higher than the national rate, in February 2023, NJ TVP released a Request for Application (RFA) that seeks to increase awareness of stillbirth prevention measures and decrease New Jersey's high stillborn rate. The selected grantees received $100,000 to create and implement a State-wide Evidence-based Stillbirth Awareness Campaign that focuses on awareness and prevention measures to reduce New Jersey's high stillborn rate by targeting providers and birthing individuals. In conjunction with New Jersey's Autumn Joy Stillbirth Research and Dignity Act, and the selected grantee, NJ TVP will establish hospital protocols for the care of grieving families. The Stillbirth Awareness Campaign aligns with the Nurture NJ Strategic Plan and includes recommendations to reduce NJ's maternal mortality, eliminate racial disparities in birth outcomes, and make New Jersey the safest and most equitable place in the nation to give birth and raise a baby.
5) The Postpartum Depression and Mood Disorder (PPMD) grant was awarded in 2006 through a law that was passed to screen women after birth. The program has since continued to provide postpartum care for women. The focus of the program is to provide postpartum screening in women across NJ to decrease postpartum depression in women after birth. This is being achieved through a streamlined process so that moms can connect with providers within their counties to receive the care they need. Currently, NJ TVP is looking to

improve the process by which the calls go through a warmline to provide more efficient care for moms in need of mental health attention after birth.

6) The Fetal Alcohol Spectrum Disorder (FASD)/Perinatal Addictions Prevention Project grant program serves to increase education and awareness of the risk for FASD, and the risks associated with other prenatal substance exposure. The grant program's main activities are to train and educate private and public prenatal care providers throughout the state of NJ to use the 4p's Plus, or the PRA, to screen women for substance abuse. The three regional Maternal Child Health Consortia, under the supervision of TVP, are tasked with providing training and awareness to providers, and pregnant persons, as well as their families. Training and education are delivered via presentations, workshops, and seminars. Social media is also utilized as appropriate to provide consumer education and awareness. To ensure the program's effectiveness, NJ TVP is looking to improve the process by which training is being offered and educational materials are being disseminated.
7) The Alma Program Expansion Project aims to establish a new Alma program in NJ that will provide new and expectant parents with evidence-based knowledge, skills, and support from peer mentors. The Project seeks to improve maternal mental health and substance misuse and eliminate racial disparities in health outcomes by providing workforce development (training and supervision), program delivery support, expanded focus on substance use as a program target, and technical assistance. The program offers a creative solution to offer care that many communities want as well as expand the mental health workforce by providing tools that can be locally adapted to meet needs and elevate expertise within communities.
8) Another program promoting the Life Course Perspective is the Maternal Infant and Early Childhood Home Visiting (MIECHV) Program, which expanded home visiting across all 21 NJ counties. The NJ MIECHV Program aims to expand NJ's existing home visiting service system, which provides evidence-based family support services to improve family functioning, prevent child abuse and neglect; and promote child health, safety, development, and school readiness. Full implementation of the NJ MIECHV Program is being carried out in collaboration with the Department of Children and Families (DCF). It promotes a system of care for early childhood.
9) The establishment of NJDOH's Colette Lamothe-Galette – Community Health Worker Institute (CLG-CHWI) provides training to educate CHWs on 12 core CHW competencies necessary to work effectively with vulnerable populations. Through the CLG-CHWI, CHWs attend 144 hours of relevant classroom instruction over 17 weeks and complete 1000 to 2000 hours of on-the-job training with reflective supervision. CLG-CHWI partners with community colleges across the States in Essex, Camden, Mercer, and Ocean Counties to offer classroom instruction. Through the Rutgers Project ECHO, CHWs will be provided with additional training aimed at raising awareness and knowledge on specific health topics, including basics of COVID-19 transmission and prevention, and identifying the impact of COVID-19 in communities where individuals work and live to maintain personal and community safety. Moreover, in late 2023, in collaboration with key stakeholders and CHW instructors who have designed the CHW core curriculum NJ TVP is adding a case management competency to equip CHWs with the skill needed to better case manage their clients. Figure 3 displays an overview of the CHW workforce and the expected outcomes.

Figure 3. Overview of NJ Community Health Worker Workforce and Expected Outcomes



Therefore, NJ TVP is taking a targeted approach to improving pregnancy and birth outcomes in the state by enhancing existing programs and creating new programs with an emphasis on this priority population through the CHW Workforce. TVP recognizes the importance of a statewide collaboration of existing traditional and non-traditional partners to address the social determinants of health (SDOH), which will be instrumental in moving the needle on pregnancy and birth outcomes.

Figure 4. Stakeholder Map

As a result, partners from the Department of Labor and Workforce Development, Division of Community Affairs, Department of Education, Department of Transportation, Department of Children and Families, Department of Human Services, Department of Community Affairs, and the Community are strategically collaborating and using MCH block grant funds to implement culturally responsive public health interventions in NJ (Figure 4).

Child and Adolescent Health Program

In addition to Title V funds, the Child, and Adolescent Health Program (CAHP) currently holds two federal grants to prevent teen pregnancy and promote youth development- (1) the Personal Responsibility Education Program (PREP) and (2) the Sexual Risk Avoidance Education (SRAE) Project. Through PREP, SRAE, and the Whole School, Whole Community, Whole Child School Health Program, CAHP funds a State Adolescent Health Coordinator to direct statewide youth engagement consisting of 10 Youth Advisory Boards and the NJDOH Voice of Youth Planning Committee.

SRAE is a school and community-based program focused on building protective factors for youth aged 12-14 to help delay sexual activity and reduce pregnancy and Sexually Transmitted Infections (STIs). SRAE uses a Social and Emotional Learning (SEL) curriculum to provide engagement opportunities, including community service learning, mentoring, and youth leadership. SRAE also utilizes a parent education program employing motivational interviewing techniques to improve parent/teen communication when talking with teens about risks. SRAE is a developmentally appropriate public health approach to sexual health education complementary to the PREP program, which provides extensive education on Sexual Risk Reduction in addition to avoidance. PREP is a school- and community-based comprehensive sexual health education program that replicates evidence-based, medically accurate programs proven effective in reducing initial and repeat pregnancies among teens aged 14-19. NJ PREP also seeks to help teens avoid and reduce high-risk sexual behaviors through the promotion of delay, abstinence, refusal skills, use of condoms and other forms of birth control, and reducing the number of sexual partners. NJ PREP provides education on the following adult preparation topics: Healthy Relationships, Life Skills, and Adolescent Development. All SRAE and PREP programming is complete, medically accurate, and Lesbian, Gay, Bisexual, Transgender, Intersex, Asexual, and Questioning (LGBTIAQ)-inclusive and trauma-informed.

The Leadership Exchange for Adolescent Health Promotion (LEAHP), a national learning collaborative supporting adolescent health, was established by the National Coalition of STD Directors (NCSD) and Child Trends in partnership with the National Association of State Boards of Education (NASBE). The NJ LEAHP team was formed in January 2020 and will continue through June of 2023 due to delays from the COVID-19 pandemic. NJ TVP has established a multi-sector, state-level leadership team with the goal of developing state-specific action plans in

support of policy assessment, development, implementation, monitoring, and evaluation to address adolescent health in three priority areas: sexual health education (SHE), sexual health services (SHS), and safe and supportive environments (SSE). In May of 2022, LEAHP, in coordination with the PREP program, is launching an STI working group which, through LEAHP, will develop action steps to address both SHE and SHS regarding recent increases in STI rates amongst adolescents. The NJ team is led by Jessica Shields (NJ TVP), with colleagues from the NJ Department of Education (DOE), NJDOH Division of HIV, STD, and TB services, DCF, and the NJ State Board of Education.

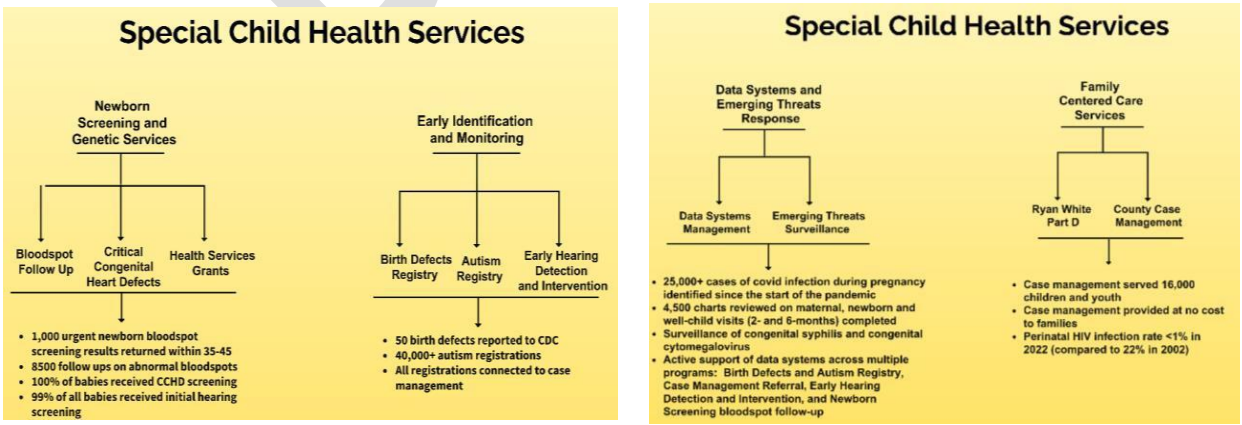
The CAHP is in the 5th and final year of a Health Resources Service Administration (HRSA) grant for Pediatric Mental Health Care Access (PMHCA) which enhances the existing Department of Children and Families (DCF) administered Pediatric Psychiatry Care Collaboratives, with telehealth technology. PMHCA aims to improve access to pediatric mental and behavioral health services, which became essential during the COVID-19 pandemic. Key partners include Hackensack Meridian Health, the American Academy of Pediatrics-NJ Chapter, and Rutgers University Behavioral Health Care. To date, over 15,032 youth less than 21 years of age have been screened, and 23,178 mental health consultations/ referrals were completed. As of April 2022, 27 pediatric practices, representing approximately 86 providers, have been equipped with telehealth technology through this HRSA grant.

The CAHP is in year three of a five-year Garrett Lee Smith State/Tribal Youth Suicide Prevention from the Department of Health and Human Services (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA). The project period ends on 11/29/25, and the award is for $736,000 per year. Readiness to Stand United Against Youth Suicide: A NJ Public Health Community Initiative Readiness to Stand (NJ R2S Challenge) is a collaborative grant with NJ DCF, the Office of the Secretary of Higher Education (OSHE), and multiple community-based organizations. In its second year, the New Jersey R2S Challenge has had significant accomplishments, including the launch of Prevent Suicide NJ, gatekeeper trainings for youth-serving professionals, education and resources for NJ's County Colleges, the second cohort of Lifelines Trilogy in 5 school districts, and the 2022 Adolescent Health Symposium: Challenges Today Solutions for Tomorrow with over 600 professionals (pediatricians, nurse practitioners, social workers, guidance counselors, school nurses, and other youth-serving professionals) in attendance. Plans for the coming year include the launch of the training center on the Prevent Suicide NJ Learning Portal, Cohort three of Lifelines Trilogy in 3-5 additional school districts, Attachment-Based Family Therapy (ABFT) training for DCF Intensive in Community Providers within the Children's System of Care; the Stanley Brown Safety Plan Training Collaborative Assessment and Management of Suicide Care (CAMS-Care) and the SafeSide® Training for Pediatricians.

Children and Youth with Special Health Care Needs (CYSHCN)

New Jersey's CYSHCN program is known as Special Child Health Services (SCHS). It includes four programs coordinated: Newborn Screening Follow-up and Genetic Services (NSGS), Early Identification and Monitoring (EIM), Data Systems and Emerging Threat Response (DSET), and Family-Centered Care Services (FCCS). Located within these programs are the Birth Defects and Autism Registry (BDAR), the Early Hearing Detection and Intervention (EHDI) Program, Specialized Pediatric Services Program (SPSP), and the Ryan White Part D (RWPD) program. These programs work as an integrated continuum of care. The diagrams below highlight some of our 2022 successes (Figure 5).

Figure 5. 2023 Special Child Health Services

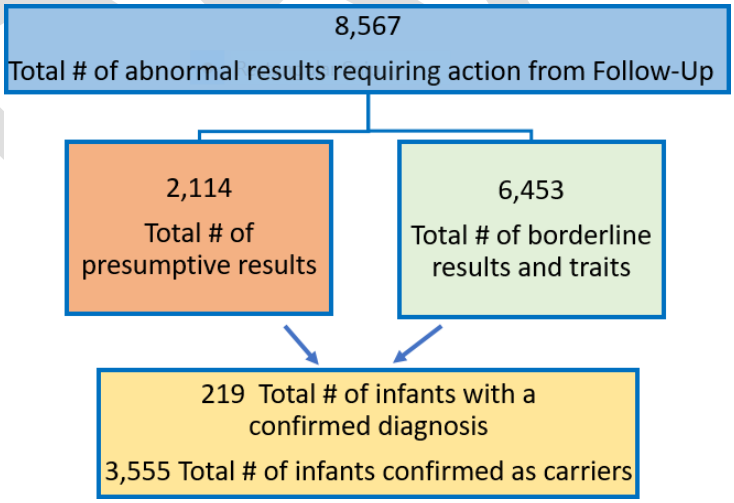


Newborn Screening and Genetic Services

The NSGS Program ensures that all newborns and families affected by an out-of-range screening result receive timely and appropriate follow-up services. On December 5, 2022, X-linked adrenoleukodystrophy (X-ALD) was added to the NJ newborn screening panel bringing the total number of biochemical/bloodspot screenings to 61 disorders. Due to the critical nature of many of the disorders for which NJ newborns are screened, follow-up staff act on presumptive positive results identified by the Newborn Biochemical Screening (NBS) Laboratory for these disorders during regular business hours, Saturdays, and certain State holidays to maximize timely referral to the appropriate specialists. To ensure NJ's program is up to-date and effective in terms of screening technologies and operations and is responsive to any current concerns regarding newborn screening, the NSGS program staff meets and communicates regularly with several advisory panels composed of parents, physicians, specialists, and other stakeholders. The overarching group is the Newborn Screening Advisory Review Committee (NSARC) and the five established subcommittees of NSARC. The sale of newborn biochemical bloodspot filter cards funds the NSGS program.

The Newborn Screening Follow-Up staff contacts primary care providers, specialty care providers, and parents to ensure timely evaluation, and confirmatory testing, and to obtain a final diagnosis. Results received from the NBS Laboratory range from low risk to presumptive positive. Low-risk follow-ups involve sending letters to parents, making telephone calls to physicians and hospitals, and utilizing multiple resources to locate babies for repeat testing. Time for follow-up on low-risk results ranges from two to eight weeks until cases are closed. In 2022, over 99,000 babies were screened, and 8,567 results were sent for follow-up. Approximately 2,114 of those results were presumptive positive; 1,031 were time-critical presumptive results, and the other 1,083 were non-time-critical results (Figure 6). Time-critical presumptive results require expedient actions to ensure that those babies receive prompt medical intervention and treatment. As per protocol, presumptive cases must be reported to physicians and specialists within three hours of receipt of the result from the NBS Laboratory. However, the NSGS team has averaged approximately 30 minutes to report. Time for follow-up on presumptive results ranges from one week to twelve months until cases are closed. These cases can remain open longer if the complexity of a disorder requires multiple office visits/diagnostic tests to confirm a diagnosis accurately. The NSGS team confirmed diagnoses for 219 babies (Figure 6).

Figure 6. 2022 Flow Chart of Newborn Screening Follow-up Results



Since 2011, NJ has mandated newborn pulse oximetry screening to detect Critical Congenital Heart Defects (CCHD). Pulse Oximetry results are captured by NJ's Birth Certificate system and used to identify children at risk for CCHD. NJ is the first state in the nation to integrate the CCHD screening with their Birth Defects Registry. The Newborn Screening and BDAR staff educate hospitals about the screening protocol and ensure compliance with the

mandate and reporting confirmed diagnoses. All infants with failed screens are reported to the BDAR, and staff follow up to ensure that the congenital cardiac conditions are also reported. Since pulse oximetry screening was mandated, 45 babies were identified as “saves,” with one identified in 2022. Saves are defined as babies who were not diagnosed with or suspected to have a CCHD prior to the pulse oximetry screening.

In May 2021, the CCHD program began collaborating more closely with the BDAR to meet the goals and objectives laid out in Component C of a Cooperative Agreement with the Centers for Disease Control and Prevention’s (CDC) (Advancing Population-Based Surveillance of Birth Defects; CDC-RFA-DD21-2101). Component C focuses on the timing and method of CCHD detection. This project continues and fits well with our already established quality assurance activity of matching BDAR data to the pulse oximetry screening results in the birth certificate file to ensure that all babies who failed the screening are registered. As part of this project and to improve data quality BDAR and pulse oximetry screening staff collaborated to have new fields added to the BDAR pulse oximetry/CCHD module. BDAR user trainings were held, and the new fields went live in mid-January 2023.

Early Hearing Detection and Intervention (EHDI)

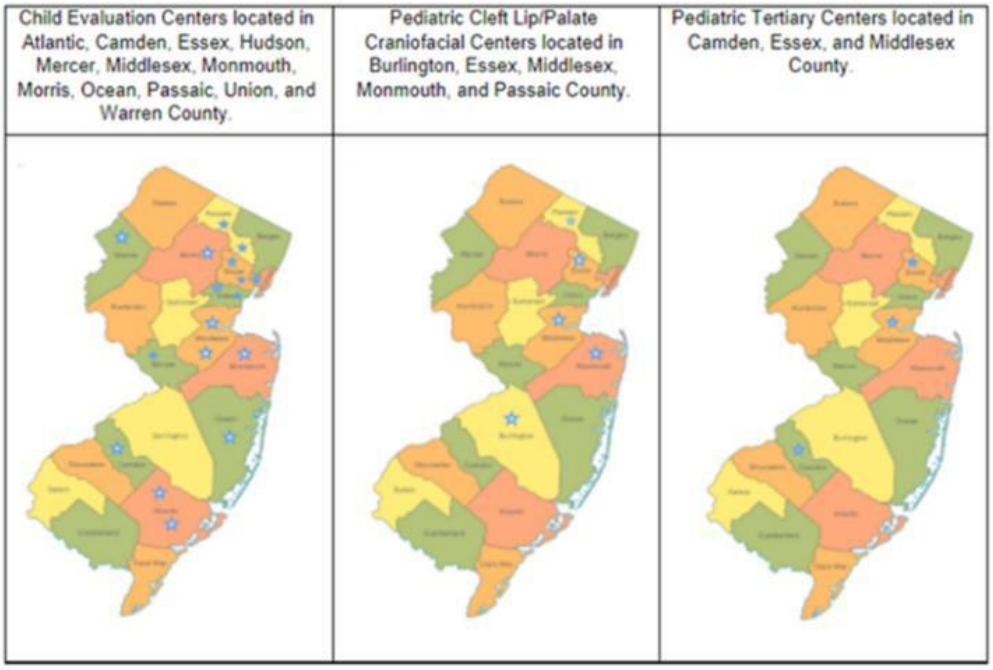
The NJ EHDI Program abides by the national public health initiative “'1-3-6' Guidelines.” These guidelines seek to ensure that all babies born in New Jersey receive a newborn hearing screening before one month of age, complete diagnostic audiologic evaluation prior to three months of age for infants who do not pass their hearing screening and enroll in early intervention by no later than six months of age for children diagnosed with hearing loss. The EHDI program offers technical support to hospitals on their newborn hearing screening and follow-up programs.

New Jersey hospitals are very successful in ensuring newborns hearing screening; however, receiving timely and appropriate follow-up remains an area needing improvement. New Jersey EHDI works with health care providers, local and state agencies that serve children with hearing loss, and families to ensure that infants and toddlers receive timely hearing screening and diagnostic testing, appropriate habilitation services, and enrollment in intervention programs designed to meet the needs of children with newly identified hearing loss.

Specialized Pediatric Services Program (SPSP)

The goal of the SPSP is to provide access to comprehensive, coordinated, culturally competent pediatric specialty and sub-specialty services to families with CYSHCN that are 21 years old or younger (Figure 7). With support from the State and Title V funds, health service grants are distributed to multiple agencies throughout NJ. The SPSP consists of eight Child Evaluation Centers (CECs), of which four CECs house Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder (FAS/FASD) Centers, and three CECs provide Newborn Hearing Screening (NBHS) Follow-up. Additionally, there are three Pediatric Tertiary Care (PTC) Centers and five Cleft Lip Cleft Palate-Craniofacial (CLCPC) Centers. All centers provide services statewide across the 21 counties in New Jersey. In SFY22, there were a total of 117,551 patients served across all centers within the Specialized Pediatric Services Program. Of these, 61% (71,182) of children were served at the CECs, 1% (1,389) at the CLCPCs, and 38% (44,341) at the PTCs. Approximately 58% of the children served are uninsured or are covered via Medicaid/Medicare programs.

Figure 7. Location of Funded Specialized Pediatric Centers

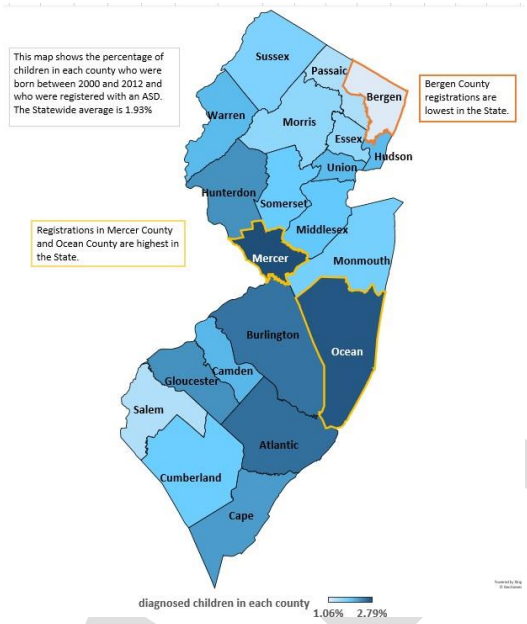


Birth Defects and Autism Registries (BDAR)

Dating back to 1928, New Jersey is proud to have the oldest requirement in the nation for reporting birth defects. Over the years, our BDAR has become a robust population-based registry for children with birth defects and Autism Spectrum Disorder (ASD) and provides invaluable surveillance and needs assessment data for service planning and research. All 47 birthing hospitals and hundreds of non-hospital-based practices report to the BDAR through our online registry. Annually, we receive an average of 4,700 birth defect registrations and 3,600 autism registrations. In 2021, we began our efforts to allow non-New Jersey hospitals to register New Jersey-resident babies. The Birth Defects and Autism Reporting System (BDARS) has been redesigned to include a statewide pre-registration search feature to reduce duplication of records, reduction of questions, and easier to use checkoff lists for common comorbidities, symptoms, and behaviors. As NJ has the statutory authority to capture fetal deaths due to birth defects at 15+ weeks of gestation, a new module has been implemented to capture and report these fetal deaths to the CDC. The EIM staff continues to educate providers about the BDAR, how to register, and the rules regarding the Registry. Staff creates reports and resources for both providers and families. These continuous efforts and changes will improve our data's accuracy and overall surveillance efforts.

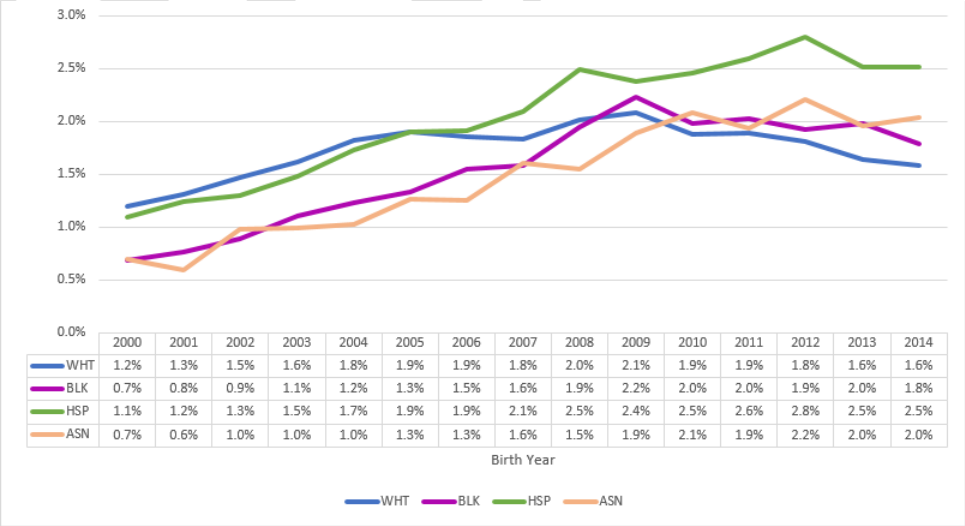
Beginning in 2009, the Autism Registry is the largest mandated autism registry in the country. We are the only registry in the country that includes children up to the age of 22 and refers them to their local county case management services. We serve as a model registry and continue to provide technical assistance to other states considering a registry. The Autism Registry provides quality prevalence information for the entire state (Figure 8), and information about racial and ethnic disparities. It examines known perinatal risk factors and how they influence the New Jersey prevalence rates (Figure 8).

Figure 8. Prevalence of Autism Across New Jersey



The Autism Registry data has also provided useful information about the prevalence of autism across time and across different populations. The Registry rates compare to the CDC's rates and can provide rates across all counties and additional information about perinatal risk factors and comorbidities. As seen in the figure below, not only is there an increase in the prevalence of autism over time, but we see that the race/ethnicity differences are reducing for the most recent birth cohorts. This narrowing of autism rates by race and ethnicity is potentially due to expanded services, more multilingual professionals, and a strong family education program such as the CDC's Learn the Signs, Act Early program.

Figure 9. Autism Spectrum Disorder (ASD) Prevalence Over Time



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
WHT	1.2%	1.3%	1.5%	1.6%	1.8%	1.9%	1.9%	1.8%	2.0%	2.1%	1.9%	1.9%	1.8%	1.6%	1.6%
BLK	0.7%	0.8%	0.9%	1.1%	1.2%	1.3%	1.5%	1.6%	1.9%	2.2%	2.0%	2.0%	1.9%	2.0%	1.8%
HSP	1.1%	1.2%	1.3%	1.5%	1.7%	1.9%	1.9%	2.1%	2.5%	2.4%	2.5%	2.6%	2.8%	2.5%	2.5%
ASN	0.7%	0.6%	1.0%	1.0%	1.0%	1.3%	1.3%	1.6%	1.5%	1.9%	2.1%	1.9%	2.2%	2.0%	2.0%

Data Systems and Emerging Threat (DSET) Response

One of our most important functions is to participate in public health surveillance efforts. Special Child Health Services recently began collecting data on COVID-19-positive pregnant persons and their infants. For 2020 infection dates and a sample of 2021 infection dates, staff abstract maternal and newborn hospital charts and well-child visit

charts for infants up to 6 months. Title V funding supplements project funding in addition to CDC funding received under the Enhancing Laboratory Capacity grant. As of October 2022, there were almost 25,906 COVID positive pregnant persons; however, this equates to approximately 1% of the total positive COVID cases and between 6 and 10% of the birthing population, depending on the county (Figure 10). To date, we have completed the medical abstractions of 71% of 2020 maternal cases, 71% of 2020 infant cases,13% of 2021 maternal cases, and 30% of 2021 infant cases.

Family-Centered Care Services (FCCS)

FCCS oversees and provides approximately four million dollars in funding to 21 county-based CMUs. These funds include federal and state MCH Block grants, Casino-revenue, and Catastrophic Illness in Children Relief funds (CICRF). CMUs also receive funds from their county governments. These units provide resources and referrals to families of children from birth up to their 22nd birthday. Annually, over 16,300 families receive services from SCHS-CM. The diversity of NJ is seen in the children and families served by the CMUs. The race/ethnicity breakdown for children served in SFY22 is 33.18% Hispanic or Latino, 37.05% White, 13.89% Black or African American, 6.7% Asian, and 9.63% other Races.

FCCS plays a central role in ensuring that all counties provide robust services and collect key information to establish quality and equity across New Jersey. FCCS staff also educates all CMUs about important federal, state, and community partners. FCCS's ongoing intergovernmental and interagency collaborations include, but are not limited to, the Social Security Administration, NJ Department of Children and Families, Department of Banking and Insurance (DOBI), the Boggs Center/Association of University Centers on Disabilities, NJ Council on Developmental Disabilities, and community-based organizations such as Autism NJ, New Jersey Chapter, American Academy of Pediatrics (NJAAP), NJ Hospital Association, and the disability-specific organizations such as the Arc of NJ, Statewide Parent Advocacy Network (SPAN), and the Statewide Community of Care Consortium (COCC). Consultation and collaboration with NJDOH's other DOH programs such as EIS, RWPD, MCH, Women, Infants, and Children (WIC), Federally Qualified Health Centers (FQHCs), HIV/AIDS, Sexually Transmitted Diseases (STD) and Tuberculosis, as well as Public Health Infrastructure Laboratories, and Emergency Preparedness affords FCCS with opportunities to communicate and partner in supporting CYSHCN and their families.

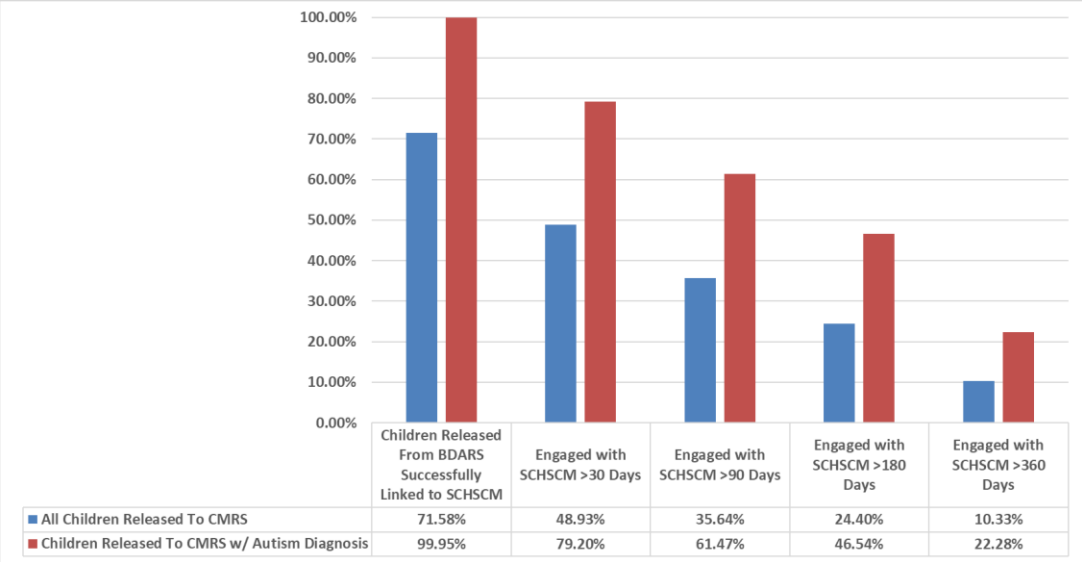
Through FCCS, CMUs remain successful in linking children to important services. Below is an excerpt from an email showcasing the role of CMUs working with Title V-CYSHCNs.

Reflective Quote:

"You may remember that I'm a parent of two boys who have complex medical needs and that my older son, passed away a few years ago. At that time, many supports weren't accessible to us, but during the struggle to find appropriate services for him, Special Child Health Services was my one saving grace. My case manager at SCHS understood our needs better than anyone, and all the helpful supports he ever received came from her suggestions and/or direct help."

One key factor that FCCS focuses on for SCHSCM is the level of engagement with children referred to CMRS from the BDARS. The figure below illustrates the level of family engagement within SCHSCM. The special needs population at large has a diverse level of need. For example, comparing a child born with hypospadias, which can be surgically corrected and require no further assistance from a CMU to a child with a diagnosis of autism spectrum disorder, which may have a greater and prolonged level of need, results in a greater level of engagement. Examples such as this, as well as families who we are unsuccessful in contacting, explain why CMUs only successfully link with 71.58% of all children and families released to them from BDARS. However, children with more complex or comprehensive conditions, such as Autism, successfully link and remain engaged for a greater amount of time after their initial linkage to SCHSCM. By comparison, children with an Autism diagnosis released from BDARS to SCHSCM successfully link 99.95% of the time. Of those children with Autism, 22.28% remain engaged for more than 360 days from their initial linkage compared to 10.33% of all children (Figure 10).

Figure 10. Level of Engagement for Children Linked to Special Child Health Services Case Management After Release From BDARS



FCCS staff focus on continuous quality improvement (CQI) initiatives. One major endeavor is the redesign of the Case Management Referral System (CMRS) which will greatly improve the data gathering capability and enhance consistency in documentation within Individual Service Plans (ISPs) across the CMUs. All 21 CMUs use CMRS to track and monitor services. CMRS provides the ability for CMs to create and modify an ISP, track services, referrals, and linkages to care, document each contact with the child and child's family, and register previously unregistered children. It provides the State Title V program with the opportunity for desktop audits, the ability to track access to care, and ensures more measurable and readily tracked outcomes.

Additionally, FCCS runs a Fee-for-Service program that assists eligible New Jersey families to purchase hearing aids, orthotics, or prostheses through a State approved vendor system. Family cost participation is calculated using a sliding scale based off family size and income, and the case managers support families in completing the application process. Since Grace's Law was passed in 2008 requiring NJ insurance companies to cover medically necessary expenses incurred in the purchase of hearing aids for children under the age of fifteen (15), most children served by this program are NJ children who do not have NJ-based health insurance plans or any health insurance coverage at all.

SCHS also refers children from birth to three to NJEIS which serves the developmental and health-related needs of children. NJEIS provides quality services in a child's natural environment by enhancing the capacity of families to support their child using a parent model and creating a partnership between practitioners and families. The purpose of early intervention is to promote the child and family's ability to meet developmental outcomes chosen by the family and outlined in the Individualized Family Service Plan (IFSP). The system serves approximately 30,000 families annually and provides approximately 40,000 service hours per month. NJEIS provides several services, some of which are: occupational, physical, and speech therapy as well as developmental intervention. NJEIS is a fee-for-service program and operates with Family Cost Participation (FCP) based on a sliding scale.

III. C. Needs Assessment

For the interim needs assessment update, NJ TVP compiled and synthesized statistics seeking to inform the current maternal and child health interventions that MCHBG is funding. The Team has compiled data from multiple sources, including but not limited to American Community Survey (ACS), New Jersey Pregnancy Risk Assessment Monitoring System (PRAMS), World Health Organization (WHO), Centers for Disease Control (CDC), and more.

Maternal/Women's/Reproductive Health & Perinatal/Infant's Health

Maternal Mortality

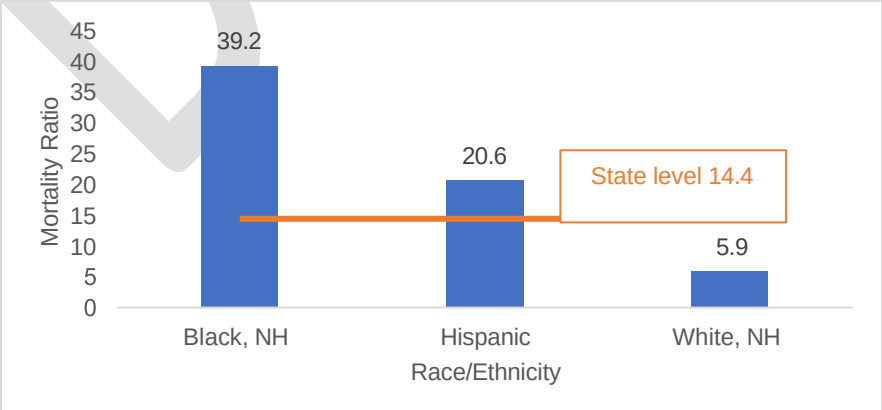
According to the World Health Organization (WHO), approximately 295,000 women died of a pregnancy-related cause, 86% of whom were women from Sub-Saharan Africa and Southern Asia. Nearly 3 out of every four maternal deaths in 2017 were due to complications such as hemorrhage, post-delivery infection, pre-eclampsia/eclampsia, unsafe abortions, and delivery complications. The remainder was due to chronic conditions such as cardiac disease and diabetes.

According to Pregnancy Monitoring and Surveillance System (PMSS), the 2018 pregnancy-related mortality ratio (PRMR) in the US was 17.3 deaths per 100,000 live births in the US. When stratified by race/ethnicity, evident disparities persist. Black, NH women had a PRMR of 41.4 deaths per 100,000 live births from 2016-2018, more than three times the rate for White, NH women (13.7 deaths per 100,000 live births, Figure 5). Additionally, Hispanic women had the lowest PRMR among all races/ethnicities nationally, with a rate of 11.2 deaths per 100,000 live births.

NJ's maternal health outcomes and disparities are among the highest in the US. Approximately 50 women die from pregnancy-related (PR) complications in NJ every three years. According to America's Health Rankings, NJ's maternal health outcomes and disparities are known to be among the highest in the U.S. Black women experience seven times the rate of death from pregnancy-related causes compared to their white counterparts.

The NJ Maternal Mortality Review Committee (NJMMRC) reviews all pregnancy-related and pregnancy-associated deaths during pregnancy or within one year postpartum. Statistics shared in the recently released New Jersey Maternal Mortality Report 2016-2018 for 2016-2018 confirm persistent racial and ethnic disparities with regard to maternal mortality. The NJMMRC identified 44 pregnancy-related deaths, of which 39/43 (91%) were determined to be preventable. The state-level pregnancy-related mortality ratio (PRMR) for 2016-2018 was 14.4 deaths per 100,000 live births; however, similarly to national PMSS data, disparities are evident among race/ethnicity. The PRMR for Black, NH women was 39.2 deaths per 100,000 live births, which was 6.6 times higher than the PRMR for White, NH women, which was 5.9 deaths per 100,000 live births (Figure 11). Hispanic women had a PRMR (20.6 deaths per 100,000 live births) 3.5 times higher than White, NH women (Figure 11).

Figure 11. Pregnancy-Related Mortality Ratio by Race/Ethnicity, New Jersey, 2016-2019



Source: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, NJDOH; New Jersey Maternal Mortality Review Committee

Based on the analysis conducted by the MMRC, the leading contributing factors for pregnancy-related deaths were

1) lack of provider/patient knowledge,
2) lack of continuity of care/care coordination,
3) lack of standardized policies and procedures, substandard clinical skill/quality of care, and lack of assessment.

While the leading contributing factors for pregnancy-associated but not related cases were

1) lack of continuity of care/care coordination,
2) complications of substance use disorder,
3) complications of mental health conditions,
4) lack of provider/patient knowledge and lack of standardized policies and procedures.

The MMRC made an array of recommendations that they categorize into five themes by classes of maternal mortality, emphasizing actions that providers and facilities could take to identify and potentially address maternal mortality disparities.

1) Pregnancy-related deaths
    a. Ensure high-quality care,
    b. Build patient knowledge,
    c. Address barriers to care,
    d. Implement a holistic approach to care and
    e. Share patient records and information about care provided.

2) Pregnancy-associated but not related deaths
    a. Implement a holistic approach to care,
    b. Ensure high-quality care,
    c. Address barriers to care, and
    d. Share patient records and information about care provided

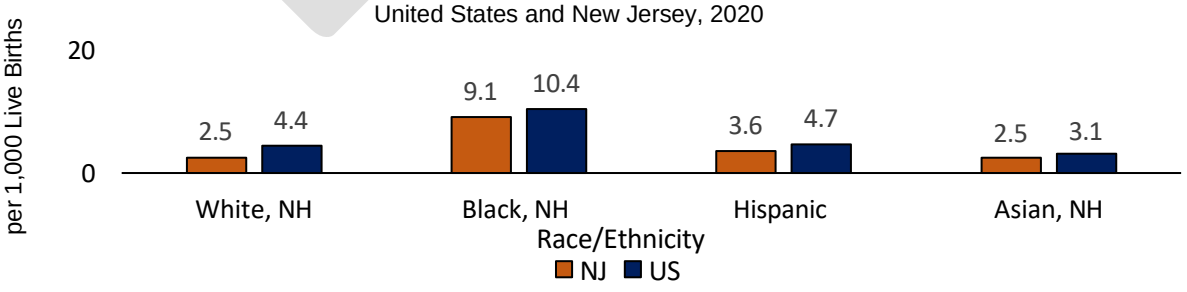
Infant Mortality

According to America's Health Rankings, as of 2021, New Jersey (NJ) has the 3rd State with the lowest overall infant mortality rate among the 50 states; however, similarly to the racial and ethnic disparities observed nationally, these disparities persist.

Despite the overall decline in IMR, in 2020, racial and ethnic disparities continued to persist in the US among Black, NH women, who had the highest IMR (10.38) per 1,000 live births, followed by American Indian or Alaska Native, NH (7.68), Native Hawaiian or Other Pacific Islander, NH (7.17), Hispanic (4.69), White, NH (4.40), and Asian, NH (3.14)

In 2020, the Black, non-Hispanic (NH) infant mortality rate (IMR) in NJ was 9.1 per 1,000 live births, while the IMR for White, NH infants was 2.5 per 1,000 live births. Additionally, the Hispanic IMR was 3.6 per 1,000 live births (Figure 12). The Black, NH IMR was about four times higher than the IMR for White, NH infants, and the Hispanic IMR was about two times higher than the rate among White, NH infants in NJ. Findings from the most recent 5-year needs assessment include the need to address NJ's maternal mortality crisis, especially with regard to disparities. These statistics warrant the need to continue implementing public health interventions that seek to address these racial and ethnic disparities and improve maternal and child health outcomes in NJ.

Figure 12. Infant Mortality Rate by Race/Ethnicity, United States and New Jersey, 2020



Source: 2020 Infant Mortality Rate Data: New Jersey State Health Assessment Data

Birth Outcome: Preterm Birth

Preterm live births are defined as the birth of an infant before 37 weeks of gestation. Being born prematurely increases an infant's risk of morbidity and mortality. Premature infants have a greater risk of dying in the first month of life, may require intensive care at birth, and are at higher risk of developmental disabilities and chronic illnesses throughout life.

Nationally, in 2020, disorders related to preterm birth and low birth weight accounted for about 16% of infant deaths before their first birthday. Based on statistics provided by the CDC, 1 of every 10 infants in the US was born prematurely in 2021. An increase of 4% in the preterm birth rate was observed nationally from 2020 to 2021 (10.1% to 10.5%, respectively). In 2021, while an increase was observed nationally, the preterm birth rate dropped in NJ from 9.3% to 9.2%, respectively. An 8% dropped in preterm rate is observed in NJ from 2016 to 2021, while a 7 % increase is observed nationally for the same period. These statistics warrant the need to continue implementing public health interventions that seek to address these racial and ethnic disparities and improve maternal and child health outcomes in NJ.

Formative Evaluation Projects & Results

In the past few months, NJ TVP has led multiple projects to assess the needs of the MCH population in NJ.

1) Healthy Women Healthy Families- Evaluation Project

The Healthy Women Healthy Families (HWHF) initiative is a community-based funded by the MCHBG that has been implemented in NJ since 2018. HWHF initiative focuses on improving and providing quality access to women's preconception, prenatal, and interconception care and reducing health disparities in birth outcomes, including Black infant mortality (BIM). This is done using a two-pronged method: 1) county-level activities that focus on providing high-risk families and/or birthing individuals and caregivers of young children access to resource information and referrals to local community services that promote child and family wellness and 2) Black Infant Mortality (BIM) municipality level activities that focus on Black, NH birthing individuals and caregivers of young children by facilitating community linkages and supports, implementing specific BIM activities, and providing education and outreach to health providers, social service providers, and other community-level stakeholders. Six community-based organizations have been funded since 2018 to implement community activities for five years (July 1, 2018, through June 30, 2023).

In 2022, the NJ TVP team conducted a formative evaluation of the HWHF initiative. They utilized data from various sources, including PRAMS data, to examine some of the outcome measures that were selected by the Team that developed the HWHF initiative in 2018.

The evaluation project had multiple phases corresponding to key project activities.

- Phase 1 involved compiling maternal and child health-related statistics, formulating the evaluation questions, selecting the methodological approach, designing the surveys, and the initial recruitment for the project.
- Phase 2- involved administering online surveys through the Novisurvey platform and hosting a listening session with the grantees.
- Phase 3- involved data analysis of survey responses, hosting one listening session, and the write-up of results and recommendations.

NJ TVP Epidemiology Team designed three surveys administered via Novisurvey to grantee agency staff (Executives and Directors), community health workers (CHWs, staff), community doulas, and clients who have benefited from activities that HWHF funds fund. The TVP Epidemiology Team synthesized responses from the survey and the listening session to generate a set of comprehensive recommendations. NJ TVP utilized the recommendations to revise the HWHF Request for Proposal (RFP).

As a result of the formative evaluation project, NJ TVP Epidemiology Team generated a comprehensive list of culturally competent recommendations grouped into four categories:

1. System Level,
2. Programmatic Level,
3. Data-related, and
4. Material Development or Revision

Upon completion of the evaluation project in early 2023, NJ TVP Epidemiology Team shared recommendations with TVP leadership and RPHS staff. The recommendations made by the NJ TVP Epidemiology informed the development of new objectives and the decision to expand BIM-related activities across the State. Moreover, they assist with identifying the best pathways to adopt for implementing BIM activities throughout the State and ensure optimal staff-to-client ratio to adequately serve the population of focus.

TVP staff revised the RFP and released a new version that focuses on implementing breastfeeding education and postpartum support. The goal of HWHF continues to be to improve maternal and infant health outcomes for women of childbearing age (as defined by CDC as 15-44 years of age) and their families, especially Black and Hispanic women, through a collaborative and coordinated community-driven approach by implementing:

1. County-level activities that will focus on providing families and/or women of childbearing age access to resource information and referrals to local community services that promote child and family wellness, and
2. Black, NH, and Hispanic Infant Mortality (BHIM) municipality activities will focus on Black NH and Hispanic women of childbearing age by facilitating community linkages and supports, implementing specific BHIM programs, and providing education and outreach to health and social service providers and other community-level stakeholders.

Through this RFA the NJDOH seeks to increase access to comprehensive and culturally sensitive postpartum care by implementing breastfeeding education, postpartum doula care, and case management through community health workers. HWHF grantees will implement postpartum doula care and evidence-based breastfeeding education programs in all 21 NJ Counties. However, due to high Black, NH, and Hispanic mortality rates, grantees will be expected to provide additional services to support selected municipalities further. Moreover, due to the revision made, all grantees are now required to address specific county-level outcome measures on preconception care, pregnancy, and birth outcomes, interconception care, and long-term outcomes. TVP will monitor the outcome measures by race/ethnicity over time to evaluate the effectiveness of the HWHF initiative in the future.

Additionally, in response to the recommendations that surfaced through the HWHF evaluation project, NJ TVP, in collaboration with key stakeholders and CHW instructors who have designed the CHW core curriculum, will add a case management component to the CHW course curriculum. This case management component will equip CHWs with the skill needed to better case manage their clients. The added sessions will offer the following:

1. Care management and the key responsibilities of care managers
2. Identifying community resources
3. Providing effective referrals
4. Role Play: Client-Centered Referrals
5. Gender Identity
6. Case Study
7. Elements of an Effective Care Management Plan
8. Establishing Client Priorities and Developing Action Plans
9. Activity: Developing a Care Management Plan
10. Care coordination – what it is, why it is essential, and how it is done effectively.

2) Community Health Worker Evaluation

In collaboration with the Rutgers School of Public Health, NJ TVP developed an evaluation project that focuses on examining the adopted strategies used to train, deploy, and engage CHWs. The populations of focus include racial and ethnic populations, immigrants, those with limited English proficiency, the homebound, seniors, the homeless, disabled populations, migrant workers, pregnant and nursing mothers, the underinsured and uninsured, undocumented workers, and substance abusers.

The evaluation project aid NJ TVP in assessing the effectiveness of the CLG and Rutgers Project ECHO training on increasing CHW competencies and improving curricula materials and instruction to address gaps in training. Based on the evaluation project results, NJ TVP is working on further updating the curricula and assessment materials to better equip CHWs with the skill needed to serve their clients adequately. NJ TVP and evaluation partners are also using results to assess progress and improve strategies for recruitment and deployment to optimize CHW integration into community organizations and to address and support the integration of CHWs within diverse organizations.

3) Fetal Alcohol Syndrome Prevention and Postpartum Depression and Mood Disorders- *Evaluation Project*

In 2001 the Fetal Alcohol Syndrome (FAS) Taskforce comprised representatives from the NJ Department of Health and Senior Services (DHSS) recommended steps to expand prevention programs and strengthen systems to alleviate the effects of prenatal alcohol exposure in NJ. The NJ DOH funded multiple grantees to implement FAS-related activities that seek to reduce the impact of prenatal exposure to substances in NJ communities.

The NJ Postpartum Depression and Mood Disorders (PPD-MD) Initiative was established by Governor Codey in July 2005 to raise awareness about postpartum depression and to increase access to appropriate clinical services. Through this initiative, NJ TVP, through the grantees it funds, seeks to provide information about symptoms, screening, diagnosis, and treatment of postpartum depression to healthcare providers and New Jerseyans. PPD- MD Grantees outreach to women and their families via a toll-free hotline, brochures, online resources, and State-

In 2023, over 20 years after the implementation of the FAS program and over 15 years after the implementation of the PPD-MD program NJ TVP Epidemiology Team designed and conducted an informative evaluation project to inform future programmatic and policy decisions of the program. The evaluation projects had multiple phases corresponding to key project activities.

- Phase 1 involved compiling maternal and child health-related statistics, formulating the evaluation questions, selecting the methodological approach, designing the surveys, and the initial recruitment for the project.
- Phase 2- involved administering online surveys through the Novisurvey platform and hosting a listening session with the grantees.
- Phase 3- involved data analysis of survey responses, hosting one listening session, and the write-up of results and recommendations

As a result of the formative evaluation project, NJ TVP Epidemiology Team generated a comprehensive list of culturally competent recommendations grouped into four categories:

1. System Level,
2. Programmatic Level,
3. Data-related, and
4. Material Development or Revision

Based on the recommendations, TVP staff revised the FAS and PPD-MD RFPs and released a new version in FY24. The goals and objectives of the upcoming FAS and PPD-MD RFPs will be informed by the evaluation results and recommendations.

Adolescent Health

The CAHP collects pre- and post-survey data for all students who participate in our programs (with parental consent). The following is data collected in the prior program year related to social-emotional learning and bullying prevention.

After completing a Personal Responsibility Education Program (PREP) EBM, students reported the following:

- 74% indicated they were more or much more able to manage their emotions in healthy ways
- 73% indicated they were more or much more able to resist or say no to peer pressure
- 76% indicated they were more or much more likely to talk with a parent or caregiver about things going on in their life

After completing a Sexual Risk Avoidance Education (SRAE) EBM, students reported the following:

- 66% indicated they were more or much more able to manage their emotions in healthy ways
- 70% indicated they were more or much more able to resist or say no to peer pressure
- 69% indicated they were more or much more likely to work together to find a solution to a conflict
- 67% indicated they were more or much more likely to speak up or ask for help if they were being bullied

After completing the Teen Outreach Program (TOP) (specifically), students reported the following:

- 93% indicated they were able to make decisions to keep themselves healthy and safe (4% increase)
- 86% indicated they were able to come up with ways to solve problems (9% increase)
- 89% indicated they were able to understand how other people feel (4% increase)
- 81% indicated they were able to help make their community a better place (11% increase)

- 88% indicated they could handle the challenges that came their way (6% increase)

Students receive a pre- and post-survey provided by the funder (Family Youth Services Bureau) that covers all EBMs implemented. Students who participate in TOP specifically receive an additional pre- and post-survey developed by the model developer. The above data shows how students who participated in our programs had increased skills and protective factors related to social-emotional learning and bullying prevention.

After reviewing pre- and post-assessment survey data (referenced above), CAHP noted a difference in the response rate between middle and high school youth on the FYSB survey. This may be in part due to the wording of the questions on the FYSB survey versus the wording of the TOP survey. It is important to note that 80% of the youth who completed TOP were part of the SRAE program, and therefore the gap between the rate of responses is concerning. CAHP staff will investigate this and reach out to FYSB for support regarding the wording of the middle school survey questions that may be causing this differentiation in response. Due to the statistically significant change rate for protective factors on the TOP survey, CAHP is confident that the program is being administered successfully and that any issue would be specific to the FYSB survey. Unfortunately, CAHP is not able to change the wording of either of the surveys administered. CAHP can advocate for changes in question wording annually and will address questions at that time.

Children and Youth with Special Health Care Needs (CYSHCN)

During the calendar year 2022, the Specialized Pediatric Services Program collaborated with Family Centered Care Services staff to analyze how many children utilizing grant-funded Child Evaluation Center services are known to Case Management. Results showed that approximately 15% of children were known to Case Management. Given the results, the SPSP will educate the grant-funded Child Evaluation Center grantees on available case management services, provide the contact information for each county case management unit, and encourage the grantees to work directly with SCHSCM and share the information with the families they serve. \

In 2022, FCCS conducted a pilot satisfaction survey of families registered with SCHSCM for continuous quality improvement. The results showed that 79% of responders felt their SCHS case manager supports their family, and 77% said their CM meets the needs of their family. Additionally, over 65% of responders ranked the overall value of SCHSCM services as either excellent or very good. The pilot response rate was lower than expected, but through the redesign of the electronic data system (CMRS), FCCS will be able to enhance communication with the families served by SCHSCM and conduct annual and exit satisfaction surveys. The data will help to continuously identify areas of improvement and guide policy and implementation of SCHSCM services across the State.

FCCS utilizes the Case Management Reporting System as its primary hub to document all case management activities. These include communication with affected families, individual service plans, case management actions, service delivery, deactivations, and more. Currently, CMRS is undergoing a major redesign that will enable the capturing of data to monitor and evaluate the services provided to CYSCHN populations. The redesign encompasses several modules of the system, including Individual Service Plan, Exceptional Events, Child Information, custom reports at the CMU level, the ability to conduct family surveys, and features that will better facilitate communication with families.

III.D. Financial Narrative

III.D.1. Expenditures

III.D.2. Budget

[Content for this section will be added later]

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

New Jersey		State Action Plan Table			2024 Application/2022 Annual Report
Priority Needs	**Strategies**	**Objectives**	**National and State Performance Measures**	**Evidence-Based or –Informed Strategy Measures**	**National and State Outcome Measures**
Women/ Maternal Health					
Increasing Healthy Births & Reducing Black Maternal and Infant Mortality	Promote evidence-based strategies to increase preventive medical visits for women (ages 18 – 44 yrs.) such as the Community Health Worker model through the Healthy Women, Healthy Families Initiative, and the Maternal, Infant, and Early Childhood Home Visiting Program.	Increase the percentage of women, ages 18 to 44, with a preventive medical visit in the past year by 1% by 2024 (Baseline 2020 BRFSS: 78.7%).	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	ESM 1.1: Percentage of women aged 18-44 who report receiving preventive medical visit in the past year	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low-birth-weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births

					NOM 10: The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy NOM 11: The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth
Smoking Prevention	Increase smoking screening and referrals of pregnant women to Mom's Quit Connection.	Reduce the percentage of women who smoke during pregnancy by 2% per year by 2024 (Baseline 2020 NJ PRAMS 2.7%). Reduce the percentage of children who live in households where someone smoke by 2% by 2024 (Baseline 2018-2019 National Survey of Children's Health 9.7%).	NPM 14.1 Percent of women who smoke during pregnancy	ESM 14.1.1 – Number of pregnant women referred to Mom's Quit Connection	NOM 2 – Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3 – Maternal mortality rate per 100,000 live births NOM 4 – Percent of low-birth-weight deliveries (<2,500 grams) NOM 5 – Percent of preterm births (<37 weeks) NOM 6 – Percent of early term births (37, 38 weeks) NOM 8 – Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1 – Infant mortality rate per 1,000 live births NOM 9.2 – Neonatal mortality rate per 1,000 live births

					NOM 9.3 – Post neonatal mortality rate per 1,000 live births NOM 9.4 – Preterm-related mortality rate per 100,000 live births NOM 9.5 – Sudden Unexpected Infant Death (SUID) rate per 100,000 live births NOM 19 – Percent of children, ages 0 through 17, in excellent or very good health
Perinatal/Infant Health					
Reducing Black Maternal and Infant Mortality	Increase infant safe sleep practices as reported by the PRAMS survey (on the back, no co-sleeping, no soft bedding). Continue to implement through the Healthy Women Healthy Families initiative, Black Infant Mortality programs that are evidence-based interventions to reduce Black infant mortality and other disparities. These programs include Group	Increase infant safe sleep by 1 percentage point by 2024 (Baseline PRAMS 2020: 73.7%). Decrease Black non-Hispanic preterm births by 1 percentage point by 2024 (Baseline Birth	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding. SPM # 1: The percentage of Black non-Hispanic preterm births in NJ.	ESM 5.1: Percentage of women reporting in PRAMS that they practice Infant Safe Sleep Environment (no co-sleeping, on back, and no soft bedding). ESM 5.2: Rate of Black, NH preterm birth in NJ per 1,000 live births	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

	prenatal care, the Doula program, Fatherhood initiatives, and Breastfeeding support, groups. They are available to all birthing persons (BP) with an emphasis on Black, NH BP.	Certificate 2021: 13.1 per 1,000 Live Births). Decrease Black Infant Mortality rate by 1 percentage point by 2025 (Baseline Death Certificate data 2020: 9.1 per 1,000 Live Births).	SPM #7: Decrease the rate of Black infant mortality in NJ per 1,000 live births.	ESM 5.3: Rate of Black, NH infant mortality in NJ per 1,000 live births.	

Improving Nutrition & Physical Activity	Increase births in Baby-Friendly hospitals by promoting certification of hospitals and sharing breastfeeding data (birth certificate data and mPINC). The Doula Learning Collaborative (DLC) provides training, workforce development, supervision support, mentorship, technical assistance (TA), direct billing, and sustainability planning to community doulas and doula organizations throughout the State of NJ. Community doulas have the inherent local knowledge and understanding that enables them to provide equitable and culturally responsive care to pregnant people during pregnancy, birth, and postpartum which can potentially lower rates of adverse birth outcomes.	Increase births in Baby-Friendly hospitals by 2% by 2024 (Baseline current number in 2023 of Baby-Friendly hospitals: 13) Increase the percentage of women trained to become community doulas by 5% in 2025	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	ESM 4.1: Percentage of Births in Baby-Friendly Hospitals ESM 4.2: rained to become community doulas enrolled as NJ FamilyCare (Medicaid) Providers.	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Child Health					
Promoting Youth Development	Increase completed ASQ developmental screens online as part of ECCS Impact Program	Increase developmental screening among children, ages 9 – 35 months, by 2 percentage points by 2024 (Baseline National Survey of Children's Health 2020-2021: 34.8%).	NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.	ESM 6.1: Promote parent-completed early childhood developmental screening using an online ASQ screening tool.	NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 19: Percent of children, ages 0 through 17, in excellent or very good health

Adolescent Health					
Promoting Youth Development & Reducing Teen Pregnancy	Number of bullying/suicide prevention presentations delivered by or supported by NJDOH Title V Build youth's capacity for self-awareness, social awareness, self-management, relationships, and decision-making helps build the core skills that teens need to refrain from bullying others and bounce back when they are bullied. Implement evidence-based Teen Pregnancy Prevention models in high-need areas with African American and Hispanic teens aged 15-19.	Increase the number of adolescents participating in a bullying awareness and prevention program Increase the percentage of students completing at least 75% of an evidence-based pregnancy	NPM 9: Percent of 9-12th graders who reported being bullied on school property or electronically bullied. SPM 6 – Increase the percentage of students completing the TOP program,	ESM 9.1 – Percentage of high school students who are electronically bullied (counting being bullied through texting, Instagram, Facebook, or other social media). ESM 9.2 – Percentage of high school students who are bullied on school property. ESM 9.3: Number of students (male and female) who completed at least 75% of an evidence-based Teen Pregnancy Prevention Model (Teen Outreach Program, Reducing the Risk or Teen PEP)	NOM 16.1; Adolescent Mortality Rate Ages 10-19 per 100,000 NOM 16.3: Adolescent Suicide Rate Ages 15-19 per 100,000

	Adopt evidence-based youth engagement strategies aimed at increasing the percentage of students completing at least 75% of an evidence-based teen pregnancy prevention program (TOP program, Love Notes, Reducing the Risk, and Teen PEP) in counties/municipalities that are high risk.	prevention program (TOP program, Love Notes, Reducing the Risk, and Teen PEP) per year, by 5% by 2024 (Baseline 2021 Birth Certificate data: births to teens 19 and under 2,287).	Reducing the Risk, and Teen PEP per year.		
Children with Special Health Care Needs					
Improving Access to Quality Care for CYSHCN	Identify and monitor transition to adulthood needs for CYSHCN and their families served through the Case Management Units (CMUs). Explore youth and their parents' needs to facilitate transition with insurance, education, employment, and housing, and link them to community-based partners.	Increase the percentage of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service by 3 percentage points by 2025 (Baseline New Jersey Special Child Health Services, Family Care Center Services 2021: 45.0%).	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.	ESM 12.1: Percent of CYSHCN ages 12-17 years served by SCHS CMUs with at least one transition to adulthood service	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
Improving Access to Quality Care for CYSHCN	Provide comprehensive care with physicians and allied health professionals, by partnering with patients and their families.	Increase the percentage of children and children with special health care needs, aged 0 – 17	NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical	ESM 11.1: Percent of CYSHCN ages 0-18 years served by SCHS CMUs with a primary care physician and/or Shared Plan of Care	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

	Provide a baseline for programmatic needs to increase the percentage of CYSHCN with a primary care physician and identify the 'next steps' needed to establish medical homes for CYSHCN.	years old, who have a medical home by 4 percentage points by 2025 (Baseline The New Jersey Special Child Health Services, Family Care Center Services 2021: 40.1%)	home.	(SpoC).	NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 25: Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year
Improving & Integrating Information Systems	Universal newborn hearing screening began largely due to evidence that clearly demonstrated improved language and developmental outcomes in Deaf/hard of hearing children that receive Early Intervention services as soon as possible and ideally before six months of age.	By the end of the funding period at least 70% of children that are identified as having a permanent hearing loss as a result of newborn hearing screening will be enrolled in Early Intervention services within two months of the diagnosis.	SPM 3: Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening and who have outpatient audiological follow-up documented.		
Improving Access to Quality Care for CYSHCN	Special Child Health Services Unit Coordinators are expected to assign new BDARS referrals to a case manager for initial outreach within fourteen (14) days of referral. Adopt methods that facilitate an increase in the percentage of BDARS referrals that are assigned to a case manager within 14 days.	Increase the percent of live children registered with the Birth Defects and Autism Reporting System (BDARS) who have been referred to NJ's SCHS CMUs who are receiving services by 0.5% by 2025 (Baseline The New Jersey Special Child Health	SPM 4: Percent of live children registered with the BDARS who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services.		

		Services, Family Care Center Services 2021: 95.9%).			
Improving Access to Quality Care for CYSHCN	Improve BDARS to reduce the time from referral to autism diagnosis.	Decrease the age of autism diagnosis by 1 year by 2025 (Baseline NJ Autism Registry 2021: 4.8 years old).	SPM 5: Age of Autism Diagnosis		
Cross-Cutting/Systems Building					
Improving & Integrating Information Systems	Monitor and guide service delivery to assure that all children have access to preventive oral health services. Provide preventive interventions such as age-appropriate oral health education. Promote the application of dental sealants and the use of fluoride, increasing the capacity of state oral health programs to provide preventive services.	Increase the percentage of children, ages 1 – 17, who had a preventive dental visit in the past year by 2% by 2022.	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.	ESM 13.2.1: Percent of children enrolled in Medicaid or CHIP who receive preventive and any dental services (CMS-416).	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 19: Percent of children, ages 0 through 17, in excellent or very good health

III.E.2. State Action Plan Narrative Overview

NJDOH has identified, through the State Health Assessment, the State Health Improvement Plan, and the Department's Five-Year Strategic Plan, the need to improve the public health workforce in the areas of access to care, quality improvement, systems integration, and population health management. MCH workforce development and capacity are also a priority for the Division of Family Health Services (FHS). Without an adequately trained MCH staff, vital Title V services and functions would not be provided to meet the needs of the current and future MCH population. Recognizing the value of experienced and trained staff, the FHS has taken action to improve the capacity of the MCH workforce despite a long-standing hiring freeze.

NJ TVP provides comprehensive services to the maternal and child health (MCH) population through multiple community-level public health interventions. TVP constantly assesses and reassesses the need of the NJ MCH population. In response to the substance use crisis in NJ. TVP applied to secure technical assistance support from the National Center on Substance Abuse and Child Welfare to develop a State Action Plan. This project, led by the NJ TVP staff, seeks to develop a State Action Plan to increase awareness of and capacity to address substance use disorders (SUD) during and after pregnancy for birthing individuals in NJ. In partnership with cross-system partners, the team led by TVP staff is composed of representatives from the Governor's Office, the Office of the First Lady, the Department of Children and Families (DCF), the Department of Human Services (DHS), and the Department of Health (DOH). Through the academy, the team has learned about the key resources (e.g., evidence-based approaches) that can inform the development of an effective action plan. The team is expected to release the plan in Fall 2023.

To provide additional support to NJ Birthing People who are currently experiencing a long wait time due to the current mental health provider shortage in NJ, the Alma program will be piloted in NJ. In state FY24, TVP will collaborate with, and fund selected grantees to pilot the Alma program in NJ communities. The Alma program will train and educate peer mentors on how to support new and expectant mothers who are facing depression, anxiety, or other mental health and substance use issues. The Alma program is in alignment with the "task-shifting" concept. One of the key foundations of the Alma program is Behavioral Activation, which is a type of psychotherapy that many studies have demonstrated to be effective in supporting recovery from depression.

Additional interventions include the deployment of a non-traditional perinatal workforce (e.g., CHWs, doulas) in NJ communities through the Healthy Women Healthy Families initiative. The doulas and CHWs have the inherent local knowledge and understanding that enables them to provide equitable and culturally responsive care to pregnant people during pregnancy, birth, and postpartum, which can potentially lower rates of maternal and infant health complications.

Preventive and Primary Care for Children with Special Health Care Needs

NJ maintains a comprehensive system to promote and support access to preventive and primary care for CYSHCN through early identification, linkage to care, and family support. Title V partially supports this safety net that is comprised of pediatric specialty and subspecialty providers, case management, and family support agencies that provide in-state regionalized and/or county-based services. It is designed to provide family-centered, culturally competent, community-based services for CYSHCN from birth to their twenty-second (22nd) birthday, enhance access to medical home services, facilitate transition to adult systems, and ensure health insurance coverage.

At no cost to families, Special Child Health Services Case Management (SCHSCM) operates 21 county-based CMUs, supports one Family Support project, one Autism Spectrum Disorder Support Service project, multiple SPSP health service grants, and a small State-operated Fee-for-Service program. State and federal collaborations among the FCCS programs and non-Title V funded programs such as the RWPD Family-Centered HIV Care Network, EIS, FQHC, medical home initiatives, Supplemental Security Income (SSI), CICRF and other community-based initiatives extend the safety net through which Title V links CYSHCN with preventive and primary care.

The SPSP agencies are a significant resource for pediatric specialty and subspecialty care in NJ and are used widely by CYSHCN, including Medicaid recipients. Although clients are screened for their ability to pay for clinical services, the support provided by Title V enables all CYSHCN to be served regardless of their ability to pay.

State TVS, CMUs, and SPSP providers receive training from state agencies such as the NJ Department of Human Services, and the Department of Children and Families to become Informal Application Assistors for Medicaid/NJ

FamilyCare programs. Additionally, staff learns about Managed Long-Term Services and Supports (MLTSS), how to obtain care through the Marketplace, and behavioral services through PerformCare. These trainings build capacity among Title V agency providers to enhance access to primary and preventive care for CYSCHN.

III. E.2.a. State Title V Program Purpose and Design

NJ Title V Program (TVP) is uniquely positioned through its leadership and many partnerships with families, professionals, healthcare organizations, local, state, and federal agencies, and stakeholders to address healthcare needs of mothers, children, and adolescents, including those with special health care needs, at-risk populations, and families and to reduce disparities in health outcomes. In concert with the NJ Department of Health State Health Assessment, State Health Improvement Plan, the Nurture NJ Strategic Plan, and Healthy NJ2030 planning documents, the NJ TVP includes Maternal and Child Health and Special Child Health Services. Works to address selected state priority needs through strategies as noted in the State Action Plan Table.

NJ TVP serves as a leader and convener. TVS facilitates collaboration and partnership with many agencies and organizations, including the SPAN Parent Advocacy Network, the NJ Chapter, the American Academy of Pediatrics, the NJ Hospital Association, and state Maternal and Child Health Consortia. TVP continually undergoes an evaluation of individual program success, ongoing challenges, and emerging issues. NJ TVP is committed to providing a foundation for family and community health across the state and works to assure access to the delivery of quality health services for mothers, infants, and children, including children with special health care needs.

Alarming disparities have persisted despite programs designed to improve maternal outcomes. NJ TVP convenes, collaborates, and partners with other public and private agencies, families, and stakeholders to perform a comprehensive maternal morbidity and mortality environmental scan to develop a needs assessment to address NJ's maternal health crisis. The NJ TVP developed initiatives to determine and address the root causes of adverse health outcomes. One of the initiatives is the Healthy Women, Healthy Families (HWHF) Initiative works toward improving 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. This coordinated approach uses CHWs (to complete clinical and social needs assessments) and Connecting NJ Hubs, or county-specific "points of entry," for clinical assessments. Referrals and tracking occur through a central data management platform. Through this Initiative, NJ TVP serves as a convener, collaborator, and partner to traditional health partners and non-traditional, community-based partners such as faith-based organizations that specifically address social determinants of health that lie outside the scope of health. These partnerships are essential in improving pregnancy outcomes, especially among high-risk populations, addressing health disparities and structural racism, and reducing Black infant mortality (BIM). Utilizing innovative and evidence-based approaches to address cross-cutting issues that impact the health status of the most vulnerable populations is a critical piece of the developed HWHF.

Additionally, NJ TVP partners with the NJ Maternal Health Innovation (MHI) Team at NJDOH and implemented the Preterm Birth Prevention Program in NJ Communities. TVP engages with healthcare leaders at diverse organizations, for example, NJ sections of the American College of Obstetricians (ACOG), the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), and the American College of Nurse-Midwives (ACNM); the NJ Perinatal Quality Collaborative (NJPQC); the NJ Health Care Quality Institute (NJHCQI); Federally Qualified Health Centers; hospital associations; regional New Jersey maternal child health consortia; foundations; and birthing hospital facility Chief Executive Officers, maternal health, and quality improvement experts.

As a leader NJ TVP facilitates collaboration and partnership with many agencies and organizations, including Statewide Parent Advocacy Network (SPAN), the New Jersey Chapter American Academy of Pediatrics, the New Jersey Hospital Association, and state Maternal and Child Health Consortia. TVP continually undergoes an evaluation of individual program success, ongoing challenges, and emerging issues. NJ TVP is committed to providing a foundation for family and community health across the state and works to assure access to the delivery of quality health services for mothers, infants, and children, including children with special health care needs.

Moreover, in response to the substance use crisis in NJ. TVP applied to secure technical assistance support from National Center on Substance Abuse and Child Welfare to develop a State Action Plan. In September 2022, NJ was selected by the National Center on Substance Abuse and Child Welfare (NCSACW) to participate in the 2023 Policy Academy: Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. The Policy Academy is supported by Children's Bureau (CB), Administration on Children, Youth and Families (ACYF), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Health Resources and Services Administration (HRSA).

This project, led by NJ TVP staff, seeks to develop a State Action Plan to increase awareness of and capacity to address substance use disorders (SUD) during and after pregnancy for birthing individuals in NJ. In partnership with cross-system partners, the team led by TVP staff is composed of representatives from the Governor's Office (GOV), the Office of the First Lady, the Department of Children and Families (DCF), the Department of Human Services (DHS), and the Department of Health (DOH). The NJ team is dedicated and will devote adequate time to ensure the successful implementation of the State Action Plan starting in the summer of 2023.

III. E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III. E.2.b.i. MCH Workforce Development

NJDOH has identified, through the State Health Assessment, the State Health Improvement Plan, and the Department's Five-Year Strategic Plan, the need to improve the public health workforce in the areas of access to care, quality improvement, systems integration, and population health management. MCH workforce development and capacity are also a priority for the Division of Family Health Services (FHS). Without an adequately trained MCH staff, vital Title V services and functions would not be provided to meet the needs of the current and future MCH population. Recognizing the value of experienced and trained staff, the FHS has taken action to improve the capacity of the MCH workforce despite a long-standing hiring freeze.

Most FHS staff concurred that training was needed to help them effectively conduct return on investment (ROI) analyses of MCH programs. FHS also recognized the need for incorporating the perspectives of families and family representatives into the MCH workforce under the broader umbrella of systems integration. Continued family involvement in health transformation is essential for effective program and policy development related to newly aligned systems. As a result, the NJDOH provided additional training to staff and equipped them with the skills needed to collect data appropriate for accountability documentation and to develop accountability metrics to calculate better the ROI for MCH programs tied to public health outcomes. Moreover, NJDOH collaborated with community partners through advisory boards, steering committees, and more. FHS also recognized the need for incorporating the perspectives of families and family representatives into the MCH workforce under the broader umbrella of systems integration. Continued family involvement in health transformation is essential for effective program and policy development related to newly aligned systems.

The FHS implemented the development of succession planning to ensure essential functions were considered in long-term planning. During this past fiscal year, cross-training of staff was implemented to provide the ability to maintain key roles in the event of short-term staffing shortages. Changes in the workforce funded by Title V reflect staff's long-standing MCH priorities and core functions.

Given the diversity of our state, cultural competency trainings continue to be provided to staff as an essential component of their continuing education activities. TVS also pursue other training opportunities through trainings offered at national conferences, including AMCHP, the MCH Epidemiology Conference, and the MCH Public Health Leadership Institute. Departmental trainings have been offered on ethics, grant writing, and grants management. Opportunities to supplement staffing through student internships, special temporary assignments, fellowship programs, and state assignees have also been successful. Recruitment and Retention of qualified TVP staff are ongoing goals of NJ TVP.

In collaboration with TVP, FHS implemented succession planning to ensure essential staff roles were part of the long-term planning. During this past fiscal year, TVP continued to cross-train staff to ensure the ability to maintain key roles in the event of short-term staffing shortages. Changes in the workforce funded by Title V reflect the staff's long-standing MCH priorities and core functions. A focus on filling key positions and building the public health infrastructure is a key focus of NJDOH. NJDOH was recently awarded a CDC grant (CDC-OE22-2203) which will create an Office of Workforce and Professional Development whose main goal is to holistically forecast, plan, assess gaps, and determine ways to improve retention and invest in a diverse future talent pipeline.

Maternal/Women's/Reproductive Health & Perinatal/Infant's Health

MCH Workforce & Training

Below is a list of the new staff who recently joined the Reproductive and Perinatal Health Team RPHS team to advance maternal and child health outcomes in NJ.

1) RPHS recently welcomed a new Project Coordinator, Karen Farrior. She oversees the Fetal Alcohol Syndrome, Postpartum Depression and Mood Disorders, Family Planning, and Colette Lamothe-Galette Institute. Ms. Farrior is a Certified Public Manager (CPM) with a Master's Degree in Business Management, a concentration in Organizational Leadership, and a Bachelor's Degree in Sociology.

2) Cynthia Armand serves as a Program Management Officer (PMO) for the RPHS Team. Cynthia manages multiple state and federal grants, including Fetal Alcohol Syndrome, Postpartum Depression, and Mood Disorders. Ms. Armand. holds a master's degree from Rutgers University in Public Health and is a Certified Health Education Specialist (CHES).
3) Ngozi Okafor serves as a Program Specialist. She is a 2021 graduate of Rutgers University on the New Brunswick campus. She holds a Bachelor of Science in Public Health, a Certificate in Health Disparities, and minored in French. She has been involved in several professional activities within the New Jersey Department of Health, Division of Family Health Services, and has experienced an increased involvement with the Maternal Child Health team following a shift in responsibilities
4) Noelle Abbott serves as a PMO. She assists with implementing and managing the Healthy Women Healthy Families grant. Noelle also serves as a TVS co-lead overseeing the Connecting NJ Initiative in 14 counties and partnering with the Department of Children and Families to support this centralized intake referral system in every county. Noelle is also a member of the NJ Breastfeeding Strategic Plan Steering Committee since its inception this past fall. It aims to provide a roadmap to foster systemic changes to increase breastfeeding amongst NJ birthing individuals. Noelle graduated from the Edward J. Bloustein School of Planning and Public Policy at Rutgers University in 2021, earning her Bachelor's in Public Health.
5) Sumantha Banerjee, MPH, CHES, serves as a Public Health Consultant 2. She graduated with my MPH at the University at Albany's School of Public Health with a concentration in Community Health and Behavioral Health Sciences. She has extensive expertise in managing public health preparedness grants. Before joining RPHS, she also served as grant coordinator for a regional hospital preparedness grant and, most recently, managed homeland security grants for county and state agencies. As the newest RPHS team member, Sumantha supports MCH-related projects as needed until a project is assigned to her in the coming months.

TVP continues to utilize the vulnerable populations plan created at the COVID-19 pandemic's peak. The team has revised the plan to adapt it to the current needs. It encompasses epidemiology in high-need areas, areas where individuals are more susceptible to contracting COVID-19. Additionally, the NJ COVID-19 vulnerable populations plan includes a list of populations deemed vulnerable to COVID-19, that includes racial and ethnic populations, immigrants, limited English proficiency, homebound, seniors, homeless, disabled populations, migrant workers, pregnant and nursing mothers, underinsured and uninsured, undocumented workers and substance abusers.

Many of these vulnerable populations face an increased risk of exposure to COVID-19 as many experiences higher rates of unemployment. They are more likely to work in essential, low-income jobs that do not allow telework; and do not have health insurance or paid sick leave through employers. Racial and ethnic minority groups, seniors, people with low socioeconomic status, the homeless, those with SUD, pregnant women, and/or those with certain underlying medical conditions such as heart disease, diabetes, obesity, and smoking are also at increased risk of contracting COVID-19 and/or experiencing severe illness from COVID-19. Other populations such as immigrants, migrant workers, undocumented workers, limited English proficiency, homebound and disabled populations traditionally do not access health care on a routine basis, thereby increasing their risk for severe disease. In addition, distrust of medical and governmental entities, anti-vaccination sentiments, and disparities in vaccine coverage may impact the achievement of high COVID-19 vaccination rates in these population groups. Knowing the value of CHWs along with their long-term use in NJ TVP programming, their limited training, lack of a standardized curriculum, and difficulty recruiting, retaining, and advancing in their careers, NJ TVP decided to invest, establish and build the NJDOH Colette Lamothe-Galette Community Health Worker Institute, https://www.nj.gov/health/fhs/clgi/

In May 2020, NJDOH created the Colette Lamothe-Galette Community Health Worker Institute (CLG-CHWI), a program to train and certify CHWs. NJDPH secured a grant from the NJ Department of Labor's Growing Apprenticeship in Non-Traditional Sectors (GAINS) Program, the Institute's primary funder. The Institute is named in honor of Colette Lamothe-Galette, the former NJDOH's 1st Population Health Director, who went on to the Nicholson Foundation, where she served as a Senior Program Officer and led The Nicholson Foundation's CHW efforts until she passed away from COVID-19 on April 4, 2020.

Often, CHWs are frontline public health workers who are trusted by the people they serve because of their intimate understanding of the cultures, languages, and challenges of their neighborhoods. NJ TVP has made the expansion of CHWs in NJ a strategy to address inequities in our healthcare system. One of the ways the NJ TVP has worked over the past several years to improve the health of vulnerable populations within the state is to support and help sustain initiatives that involve CHWs. This work has included efforts to establish standardized training, build CHW capacity, and expand the number of CHWs statewide.

Through the CLG-CHWI, CHWs are hired as apprentices, allowing them to experience both classroom and on-the-job training. Training includes 144 hours of related classroom technical instruction covering 13 core competencies supplemented by 1000 to 2000 on-the-job hours, with reflective supervision. This CHW apprentice occupation is registered with the US Department of Labor (USDOL).

Considering the SUD crisis in NJ, NJ TVP has been working on expanding CHW core competencies to include SUD training that offers specialized tracks in the form of additional training on primary actions of state and/or local public health-led efforts to address underlying conditions of SUD. Moreover, additional training will be included to focus on the integration of CHWs in novel settings that include prisoner re-entry programs, mental health, and substance use disorders, Certified Community Behavioral Health Clinics (CCBHCs), and FQHCs who have never utilized CHWs. These novel settings have been selected due to the challenges facing these vulnerable populations. These novel settings will be a part of innovative demonstration projects where we test the Return on Investment (ROI) of CHWs and explore sustainable funding strategies with Medicaid.

Adolescent Health

Adolescents are best served by providers and professionals with an understanding of adolescent development and trending health issues. For those working with adolescents, like other special populations, skills matter. Therefore, CAHP is dedicated to assisting the NJ adolescent workforce in being prepared to address the complex needs of this age group. Education of the adolescent workforce is essential to the provision of high-quality health education and services for adolescents that are accessible, developmentally appropriate, effective, inclusive, and equitable. At all levels of professional education, providers in all disciplines serving adolescents need to be equipped to work effectively with this age group. They must be attuned to the nature of adolescents' health problems and have a range of effective strategies for risk assessment, disease prevention, care coordination, treatment, and health promotion in their clinical repertoire.

Currently, CAHP is staffed by four master's level professionals, one master's candidate, and an administrative assistant. Staff expertise consists of sexual health, counseling, public health, health science administration, education, and social work with a range of backgrounds, including direct service provision, program management, public school education, and community-based services. Over the past two years, we have recruited 3 of the 4 professionals working in the program. Training is an essential part of CAHP. In addition to training in the EBMs implemented through programs, staff also received training in subject matter including but not limited to youth mental health, social and emotional learning, positive youth development and mentoring, and parent/caregiver engagement.

Current assessments of the adolescent workforce participating in NJDOH programs suggest the knowledge and skills of some providers/professionals working with adolescents lack essential skills and knowledge needed to serve this vulnerable population effectively. As an example, self-reported data on perceptions of professional competencies related to youth mental health collected via surveys of staff at 8 school districts prior to the implementation of Lifelines Trilogy suggested that members of the crisis team were unaware of or had misinterpretations of school policies regarding mental health including which tools to use for screenings, where to refer for services and when to include parents/caregivers. In addition, self-reported data from pre- and post-survey trainings provided to NJDOH grantees indicated a similar lack of knowledge and skills related to subjects such as birth control and other contraceptives, STIs, and social and emotional learning, prior to training. In our survey of adolescents, over 85% indicated they do not feel understood or supported by the adults in their lives (professionals, parents, and caregivers. Given the current landscape of adolescent health education, support, and service needs, continued training and education of adolescent health professionals and providers is an important goal for the Child and Adolescent Health Program and the professionals/providers who work with the adolescent population.

Children with Special Health Care Needs

Within the SCHS unit, we have been focusing on workforce development in several ways. We envision what our organizational chart needs to look like in the future and build the positions to get to that vision. This year, we developed a group of staff known as the Data Systems and Emerging Threat Response program. Within this program are data staff, who sit within our other programs but report to a single data coordinator who ensures that the data work across the programs is met. By cross-training, and having staff work on multiple data systems, they can ensure that we can meet our data demands even when staff is out, leaving, or retiring. Additionally, the Coordinator

runs a monthly data group across the division to bring staff from MCH, WIC, EIS, and SCHS together. These training meetings expose staff to new ideas and information.

Meeting the needs of emerging threats such as COVID, ZIKA, and natural disasters has often happened in an ad hoc manner. This team is designed to look at ways more prospectively to address developing issues. The focus has been on bringing in different types of staff that are able to write and execute funding opportunities, work with medical records, and organize and manage projects with quick turnaround times. Having the staff means we can be more strategic and timelier in collecting data and producing results and recommendations for changes. Along with bringing in new staff, we are looking for more opportunities to capitalize on existing staff expertise. We conducted a survey asking staff about needs for training, desired areas they want to expand, and hidden "talents." One staff person let us know that she had learned SAS in her Master's program and would be interested in more data work. We were able to reallocate data tasks to her and paired her with a colleague who was struggling with her data tasks.

Another area of workforce development is hiring more early-career staff and exposing them to meetings, stakeholders, and project management. As in medicine's "see one, do one, teach one" philosophy, we have started a grant group that exposes junior staff to the grant writing process including having staff conduct "Grant 101" training, linking staff with mentors, and allowing staff to take the lead on grants with the more experienced staff acting as mentors and reviewers. Our philosophy is "see a few, be work on some, write one." Additionally, we are bringing junior staff to board meetings, workgroups, and stakeholder meetings and letting them take on these roles over time.

III. E.2.b. ii. Family Partnership

This section summarizes the relevant family/consumer and organizational relationships which serve the MCH populations and expand the capacity and reach of the state Title V MCH and CYSHCN programs.

Maternal/Women's /Reproductive Health & Perinatal/Infant's Health

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

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

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

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

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

Recognizing the importance of parent/consumer involvement through focus groups in designing and implementing a program to address preterm births and infant mortality issues, the MCH Program incorporated focus groups into several programs under the HWHF initiative, including those for doulas, breastfeeding, and addressing disparities. The HWHF grantees have also established Community Advisory Boards with an emphasis on recruiting new and nontraditional partners. Similarly, the MIECHV also requires funded grantees to implement County Advisory Boards.

Adolescent Health

Jennie Blakney, the Children, and Adolescent Health Program (CAHP) Program Manager, is the NJDOH representative on the NJ Youth Suicide Prevention Advisory Council, an advisory council to the Governor's office with membership from state departments, youth-serving professionals, and families. Most parents/caregivers that attend the committee have lost a child/teen/young adult to suicide. Their insight and input are/were essential to grant applications, services, and advocacy of youth/young adults struggling with suicidal ideation.

The CAHP currently implements Teen Speak, interactive training for parents and caregivers to help them improve communication with teens. Teen Speak offers a variety of educational and interactive options to help you find the format that works best for you. Pick one or try them all! Together the Teen Speak Series offers a comprehensive and supportive program for everyone supporting or parenting a teen. Teen Speak provides realistic scenarios and a detailed roadmap on how to tackle even the toughest conversations with ease. CAHP's skilled facilitators, trained in Teen Speak deliver virtual and in-person learning sessions for parents and caregivers to help them enjoy the teen

years, which can be challenging and exciting. In 2024, CAHP will release a new RFA for Statewide Parent and Professional Engagement Program (S-PEP).

Children with Special Health Care Needs

The NJ Title V CYSHCN Program, SCHS, partners, collaborates, and coordinates with various governmental and non-governmental entities on federal, state, and local levels. CMUs also work closely with parents, families and caregivers, primary care physicians, specialists, other health care providers, hospitals, advocacy organizations, and many others to facilitate access to coordinated, comprehensive, culturally competent care for CYSHCN. CMUs work with programs within the NJ Departments of Human Services (DHS) and Children and Families (DCF) in addressing many needs facing CYSHCN, including medical, dental, developmental, rehabilitative, mental health, and social services. DHS administers Title XIX and Title XX services and provides critical support for ensuring access to early periodic screening detection and treatment for CYSHCN. The State DHS Medicaid, Children's Health Insurance Program Reauthorization Act (CHIPRA) NJ FamilyCare Program, and the Division of Disability Services afford eligible children comprehensive health insurance coverage to access primary, specialty, and home health care that CYSHCN and their families need. CMUs utilize patient satisfaction surveys to improve and refine their referral and linkage practice. Many trainings provided to grantees are also opened to parents/consumers as either participants or speakers. Educational materials and informational brochures for the CYSHCN population are reviewed by parents/consumers allowing for input for health literacy and cultural competence.

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

Both the EHDI and the NSGS Programs within the SCHS also recognize the pivotal role that consumers and parents play in the effective administration of their programs. EHDI has an Advisory Council composed of parents of Deaf and hard of hearing children and consumers who themselves are Deaf or hard of hearing. Participants on the council take part in literature reviews, advise the NJDOH regarding innovations in the programmatic area and assist in the review of operations of the program. NSGS meets and communicates regularly with several advisory panels composed of parents of special needs children, physicians, specialists, and others to ensure NJ's program is state-of-the-art in terms of screening technologies, operations, and responsive to any current concerns regarding newborn screening.

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

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

As evidenced by the multitude of advisory councils, consumer groups, coalitions, interdepartmental workgroups, and committees, the NJDOH greatly emphasizes the active and meaningful participation of parents and consumers in the development, design, implementation, and evaluation of Title V programs. This is a core strength of the NJDOH Title V programs.

III. E.2.b.iii. MCH Data Capacity

III. E.2.b.iii.a. MCH Epidemiology Workforce

The MCH Epidemiology program is housed within the Maternal Child Health Services (MCHS) Unit of the NJDOH, FHS. Currently, it falls under the supervision of the Research Scientist I, who serves as the Project Director for the NJ Pregnancy Risk Assessment Monitoring System (PRAMS), and the State Systems Development Initiative (SSDI) and oversees all MCH Epidemiology activities. Presently the team encompasses a lead full-time MCH epidemiologist and two full-time Research Scientists II responsible for managing/analyzing MCH data and one FTE vacancy. Title V, MCH Block Grant, and the SSDI grant fund MCH Epidemiology positions.

In state fiscal year 2022, the MCH Epidemiology program recruited a Research Scientist I. She is responsible for the research, design, coordination, and implementation of all programs and activities within the MCH Epidemiology program. She serves as the Maternal and Child Health Epidemiologist Lead and the PRAMS Project Director. She integrates her clinical expertise with public health practice to focus on improving maternal and child health outcomes. Moreover, she designs and conducts complex statistical analyses to identify underlying factors associated with maternal and child morbidities at the state level. She has been instrumental in developing health data systems designed to improve maternal and child health outcomes in NJ. Her additional duties include designing and developing research protocols and conducting evaluation projects of maternal and child health initiatives implemented in NJ communities funded through the Title V grant. Moreover, she is responsible for preparing technical reports and needs assessments for programs; developing, reviewing, and analyzing publications and other documents pertaining to current MCH research developments; disseminating information to internal and external professional staff and serving as the SSDI Project Director.

The Research Scientist II serves as the NJ PRAMS Coordinator. She has been the NJ PRAMS coordinator for the past nine years. Duties include: completing all SSDI required progress reports and continuation applications; responding to internal and external data requests; providing overall PRAMS project coordination; organizing PRAMS Steering Committee meetings; assuring compliance with the PRAMS protocol; completing all PRAMS progress reports and continuation applications. She plays a key role in coordinating PRAMS data dissemination and the development of PRAMS data briefs, topic reports, and the NJ State Health Assessment Data (NJSHAD) system PRAMS data query.

In May 2022, a second Research Scientist II joined the MCH Epi Team. Her role primarily involves expanding access to data across the state to improve mortality reviews and supporting data initiatives within the MCH Epidemiology unit. She promotes the health of pregnant women, infants, and children through the analysis of MCH data trends and facilitates efforts to develop strategies to improve MCH outcomes. Duties include: standardizing the methodological approach used by NJ Fetal Infant Mortality Review (FIMR) grantees, linking, and analyzing data, conducting applied research projects to provide information about improving health outcomes;, participating in the routine reporting of MCH indicators and birth outcomes research by demographic indicators, geography, and hospital; conducting data linkages and analysis for SSDI; and responding to internal and external data requests.

The MCH Epidemiology program is currently in the process of hiring a Health Data Specialist. The prospective candidate will support all MCH Epi data-related projects. Duties include: linking and analyzing data and conducting applied research projects to provide information about improving health outcomes; linking PRAMS data to birth certificates and/or other data sources and conducting analysis, creating and updating PRAMS-related data for briefs and other reports annually; participating in the routine reporting of MCH indicators and birth outcomes research by demographic indicators, geography and hospital; conducting data linkages and analysis for SSDI; and responding to internal and external data requests.

To better identify the needs of the NJ MCH population, it is paramount for TVP to have access to quality data capable of informing MCH policies, need assessment activities, and program evaluation. Therefore, the MCH Epidemiology unit is working arduously to build and expand the NJ MCH data capacity to support TVP public health interventions and activities while contributing to data-driven decisions making in MCH interventions.

The MCH Epi unit has initiated several efforts to increase data capacity and advance the development and utilization of linked information systems between available datasets (WIC and Vital statistic data) to improve access to

electronic MCH health data. Tile V Epidemiologists within the MCH unit use Statistical Analysis System (SAS) and LinkPlus software to perform deterministic and probabilistic data linkage. The data linkage projects are as follows:

1. Periodically, PRAMS Data is linked to NJ Birth Data, Universal Billing Data, and WIC Data, allowing for the development of statewide PRAMS queries posted on NJSHAD and updated yearly. Researchers and NJ TVS use the data query to track various programmatic activities, including infant sleep positioning and breastfeeding practices. This data query gives Title V staff more direct and timely access to NJ PRAMS indicators.
2. Epidemiologists within the MCH Epi unit periodically analyze the linked dataset and draft and post data briefs on the MCH Epidemiology webpage. The data presented in briefs derived from the Pregnancy Risk Assessment Monitoring System weighted survey responses.

III. E.2.b.iii.b. State Systems Development Initiative (SSDI)

The Maternal and Child Health Epidemiology (MCH Epi) TVP promotes the health of pregnant women, infants, and children through the analysis of trends in maternal and child health data and facilitates efforts aimed at developing strategies to improve MCH outcomes through the provision of data and execution of applied research projects. Moreover, the MCH Epi TVP program provides MCH surveillance and evaluation support to Maternal and Child Health Services (MCHS).

Evaluating services for NJ mothers, infants, and children is important in improving access to health services and reducing disparities in health outcomes. The lack of comprehensive and timely data can limit the ability to make decisions supported by data. Reliance on official data that is sometimes three years old does not support an MCH system of care that is responsive to the changing needs of women and their families. The State Systems Development Initiative (SSDI) project, which resides in the MCH Epidemiology TVP, focuses on enhancing and expanding the NJ TVP data capacity by improving data exchange for linkages within the department and between other agencies. The NJ SSDI project is responsive to all NJ priorities. It focuses on integrating information systems that are deemed necessary to ensure the availability of timely information for decision-making in all priority areas.

The NJ SSDI project seeks to build, strengthen, and expand New Jersey's MCH data capacity to support Title V MCHBG program activities and contribute to data-driven decision-making in MCH programs, including assessment, planning, implementation, and evaluation. To ensure the continued effectiveness and readiness of data to inform Title V needs assessment, NJ SSDI staff within TVP established a robust data structure that includes data linkages using 'provisional' real-time data. By improving the MCH data structure, NJ is better able to support informed decision-making, provide effective and efficient resource allocation and improve the quality of programming for NJ's MCH population.

The NJ SSDI project plays a key role in advancing the development and utilization of linked information systems between key MCH datasets in the state. Data exchanges currently occur between MCH Epi, Vital Statistics, and Pregnancy Risk Assessment and Monitoring System (PRAMS), also housed in the MCH Epi TVP and Centers for Health Statistics. Using birth data retrieved monthly and death data and hospital discharge data retrieved when the latest files are available, the NJ SSDI project has expanded the use of recent provisional data for analysis, decision-making, resource allocation, and evaluation of NJ's MCH Title V activities. Partial funding of PRAMS is supported through the SSDI grant to ensure the availability of PRAMS data for linkage.

NJ TVP staff utilized the linked datasets to conduct analyses and produce reports (e.g., data briefs and topic reports). These reports are available on the MCHEpi webpage and the New Jersey Department of Health's State Health Assessment Data (NJSHAD). Thus far, TVP has demonstrated success in accessing and linking data across several data sources. The goals and objectives that the MCH Epi TVP will utilize the SSDI funds for the 2022-2027 SSDI grant period are depicted in the table below.

GOAL 1 - Build and expand New Jersey's MCH data capacity to support Title V MCH Block Grant program activities and contribute to data-driven decision-making in MCH programs, including assessment, planning, implementation, and evaluation.
Objective 1.1 - MCH Epi will provide data support to State Title V MCH Needs Assessment.
Objective 1.2 - MCH Epi will improve linked birth and infant death certificates annually.
Objective 1.3 - MCH Epi will link Perinatal files for the latest months available to provide current data for annual reporting and analysis.
GOAL 2 - Advance the development, access, and utilization of linked information systems between key MCH datasets in the state.
Objective 2.1 – MCH Epi will implement the annual PRAMS survey, link data for Title V reporting, and other collaborative activities.
Objective 2.2 - MCH Epi will obtain access to hospital discharge data annually.
Objective 2.3 - MCH Epi will obtain National Immunization Survey data annually from their official website.
Objective 2.4 – MCH Epi will advance the utilization of the minimum/core indicators data sets for Title V MCH programs.
GOAL 3 – Assist and provide program evaluation and data supports to inform New Jersey Department of Health's public interventions/ initiatives that align with the Nurture NJ Strategic Plan, which focuses on reducing maternal mortality and eliminating racial disparities in birth outcomes
Objective 3.1 – MCH Epi will design and conduct as-needed informative evaluation projects to inform the design and implementation of maternal and child health programs in NJ.
GOAL 4- Improve data collection, analysis, and visualization to inform public health policies related to emerging issues.
Objective 4.1- MCH Epi will work on standardizing the NJ Fetal Infant Mortality Review (FIMR) case identification process.
Objective 4.2 – MCH Epi will support FIMR committees in the process of uploading data to the National Fatality Review Case Reporting System (NFR-CRS)
Objective 4.3- MCH Epi will develop MCH Indicator reports for data visualization and utilization.

III. E.2.b.iii.c. Other MCH Data Capacity Efforts

Maternal/Women's /Reproductive Health & Perinatal/Infant's Health

Title V data capacity efforts that are funded by sources other than SSDI include updating the annual MCH Block Grant performance measures, providing data for the Five-Year Needs Assessment, and providing customized data to internal and external partners for program planning and evaluation. In addition, the CDC provides funding to NJDOH to implement the NJ Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is housed within the MCH Epi program and is a crucial surveillance tool necessary to improve the health of NJ mothers and infants.

To inform program planning and evaluation, MCH Epi staff conduct PRAMS data analysis and develop PRAMS data briefs and topic reports. Additionally, the MCH Epi program, in collaboration with the Center for Health Statistics, developed a custom dataset query for NJ PRAMS data which is posted on the NJSHAD system on the NJDOH website. MCH Epi staff update the PRAMS data query annually.

Moreover, to increase the NJ data capacity, MCH Epi staff entered multiple other agreements not funded by the SSDI or Title V grants. The table below depicts two of MCH Epi's agreements in this grant cycle.

Agreement(s) and Contract(s)				
Type of Agreement	**Project(s)**	**Between**		**Description**
Data Use Agreement	Fetal and Infant Mortality Review	New Jersey Department of Health-MCH Epi	Michigan Public Health Institute (MPHI)	The purpose of this agreement is to establish the terms and conditions for the collection, storage, and use of data obtained from the fatality case reviews submitted by Fatality Review (FR) teams in the State of New Jersey and entrusted to the National Fatality Review Case Reporting System (NFR-CRS).
Data Use Agreement	Postpartum Assessment of Health Survey (PAHS) study formerly known as Postpartum Assessment of Women Study (PAWS).		Columbia University in the City of New York	This agreement aims to enable researchers at Columbia to use 2020 NJ PRAMS survey data to conduct the PAWS observational cross-sectional study and to return the link dataset to MCH Epi TVP for analysis.

Several CDC survey supplements have been included in the NJ PRAMS survey to collect data on emerging MCH issues. For example, in response to the COVID-19 pandemic, a COVID-19 supplement was added to NJ PRAMS in October 2020, and a COVID-19 vaccine supplement was added in April 2021. Both supplements will be included in PRAMS through March 2023.

Adolescent Health

CAHP uses 3 separate databases/dashboards to collect program performance measures and program fidelity information for the PREP and SRAE Programs. In addition to these databases, the New Jersey Readiness to Stand (R2S) challenge actively evaluates all aspects of program delivery. The NJ School Health recently completed and released a comprehensive evaluation report from the last 5 years of implementation of the CDC WSCC model.

Children and Youth with Special Health Care Needs

All Special Child Health Services programs work routinely with real-time files from the Vital Events Registration Information (VERI) system containing all birth and fetal death certificates. The NSGS Program data capacity is

centered on the PerkinElmer Laboratory Information System (LIMS), Specimen Gate, and Patient Care modules. This is a shared data system used by the Newborn Screening Laboratory and the Newborn Screening Follow-Up program. Additionally, the NSGS program has a Memorandum of Understanding with the Association of Public Health Laboratories, Inc. regarding the NewSTEPs data repository.

The Early Hearing Detection and Intervention program received inpatient hearing screening data via VERI, and outpatient hearing evaluations are reported in a module in the New Jersey Immunization Information System (NJIIS). Data from those sources are merged in an EHDI database and used to generate multiple reports to meet program needs. These include a monthly data reconciliation report and annual reports to hospitals, midwives, and audiologists.

The Birth Defects and Autism Registry System (BDARS) and the Case Management Referral System (CMRS) are developed and maintained via funding through a Memorandum of Agreement with Rutgers University. The CMRS system is undergoing a major overhaul to improve the system's ability to be flexible in responding to new situations, such as future pandemics and natural disasters that will impact the service needs of children with Special Health Care needs. Furthermore, the system redesign helps improve the quality of data reporting, improve the user experience, and implement an acuity measurement. The acuity measurement will be developed through a weighted scale that utilizes pivotal information from CMRS, such as diagnosis, linkage to services, insurance information, medical home, transition to adulthood, and other key data to determine each child's level of acuity in a format that is easily understood and utilized by stakeholders. These data elements allow Family Care Centered Care Services (FCCS) staff to evaluate staffing of Case Management Units at County level to respond to communities of greater need and determine each child's real-time level of need at-a-glance.

As part of a cooperative agreement, SCHS programs provide de-identified hearing screening, follow-up data on all NJ occurrent births, case data for certain congenital disabilities, critical congenital heart defect screening results, and both maternal and newborn data, including infant outcomes up to six months of age for cases with pregnancy complicated by COVID-19 infection.

SCHS is working with New Jersey Innovation Institute (NJII) staff, a New Jersey Institute of Technology corporation, on a Master-Person Index (MPI) project. NJII has worked with other DOH programs to use data algorithms to establish a MPI to link individuals across data systems. NJII is receiving hospital admission data and VERI and NJIIS records to create MPIs for millions of individuals. SCHS has created a charter to put the BDARS records through a process to assign MPIs to the BDARS records to facilitate matching data with birth certificates and other data systems. The program expects to complete the initial BDARS data match in early 2023 and then will explore assigning MPI to other SCHS data systems, such as the NSGS program data.

Another effort to improve data capacity and quality is the recent implementation of batch-processing upload option for BDARS records. Initially, the program uses this process to create BDARS records for children with confirmed disorders identified by the NSGS program. This functionality will later be rolled out to hospitals to allow them to create data files to be uploaded to create new cases to replace having staff manually complete the BDARS form for each new case.

III.E.2.b. iv. MCH Emergency Planning and Preparedness

In January 2023, the New Jersey Department of Health (NJDOH) released the Continuity of Operations Plan (COOP) that will be reviewed and updated annually. This COOP plan presents a framework that establishes the operational processes/procedures to sustain essential functions when normal operations are not feasible and provides the necessary guidance for restoring the Department's full functions following a disruptive event. This plan was adapted from the U.S. Department of Homeland Security, Homeland Security Preparedness Technical Assistance Program's COOP Sample Plan Template document.

The NJDOH officials have prepared this comprehensive COOP to ensure that essential operations can be continued or carried out during an emergency that disrupts normal operations. In collaboration with other DOH leaders, the Assistant Commissioner of Family Health Services, who also serves as the Title V Director, partook in developing the COOP. Moreover, all divisions, including the Division of Family Health Services, where Title V primarily resides, are part of the COOP's development and maintenance. Title V leadership is involved in developing and implementing the COOP and is also part of the Rapid Mobile Response Team (RMRT) that the Division of Emergency Preparedness leads.

This COOP plan enables the Department to identify the essential functions that need to be preserved and to develop the requisite strategies that may be required to maintain these essential functions in the event of any disaster or emergency that could potentially disrupt governmental operations and services. The team developed a COOP decision process. The table below depicts the different levels of emergency and the potential impact on the agency.

Class/Level of Emergency	**Impact on Agency**
I	Disruption of up to 12 hours, with little effect on services or impact to essential functions or critical systems. • No COOP activation required, depending on individual agency requirements.
II	Disruption of 12 to 72 hours, with minor impact on essential functions. • Limited COOP activation, depending on individual agency requirements.
III	Disruption to one or two essential functions or to a vital system for no more than three days. • May require movement of some personnel and equipment to an alternate facility/work site or location in the primary facility for less than a week.
IV	Disruption to one or two essential functions or to the entire agency with potential of lasting for more than three days but less than fourteen days. • May require activation of orders of succession for some key personnel.

Historically, the NJDOH has prepared for the unforeseen by looking outward to the communities it pledged to protect. The NJDOH has also partnered with public health partners who will assist in implementing emergency operations efforts when needed. Through these efforts, the Department has become increasingly aware of the extent to which disasters and emergencies can weaken and damage our capabilities to deliver essential governmental and programmatic functions and services to the people and public health partners.

The Family-Centered Care Program in Special Child Health and Early Intervention Services is upgrading the current case management system to enable us to quickly reach out to all our families with children with special health care needs. This system includes an "exceptional events" module that was developed in response to Superstorm Sandy. This module was redesigned to allow more flexibility in collecting the family's needs and how they can be utilized and better serve the community in case of an emergency event.

The COVID Pandemic highlighted key gaps in data and surveillance that were quickly rectified with an emergency response dashboard that highlighted COVID positive rates and vaccination rates among NJ residents. Since this, the

NJDOH has been committed to continuing surveillance and data management by creating a centralized data hub and a maternal data center that specifically focuses on NJ families' health indicators.

Pregnant women, infants, and children have unique risks with public health emergencies. Gaps in emergency preparedness and response planning can leave MCH populations especially vulnerable. For instance, the COVID-19 pandemic necessitated an immediate response to address the needs of MCH populations. Services and resources were quickly transitioned into remote access when possible. TVP grantees continue to offer a hybrid option to the population being served by our programs.

Published studies confirm the pre-pandemic persistent racial/ethnic health disparities and their exacerbation during the COVID-19 pandemic. These results illuminated the deep racial inequities and gaps in the US public health and healthcare systems. Per the literature, the discontinuation and/or scaling back of lifeline services during the pandemic is believed to have exacerbated preexisting socioeconomic and emotional challenges. Some of the key lessons that TVP learned through the pandemic is the need to be flexible on how resources and services are delivered to the MCH population in NJ. For example, many healthy centers transitioned to offering telehealth/telemedicine during the pandemic to accommodate patients and be compliant with CDC and hospital guidelines. Additionally, during the COVID-19 pandemic's peak, NJ WIC shoppers were provided the option to purchase a wider variety and sizes of WIC foods, including contracted (Mead Johnson, maker of Enfamil) infant formula products. The team also updated the WIC WOW MIS system WIC Shopper app, UPC codes, and grocery systems to make them more accessible to clients and easier to use.

III.E.2.b.v. Healthcare Delivery System

III.E.2.b.v.a. Public and Private Partnership

The NJDOH collaborates with many other federal, state, and non-governmental partners to complement Title V program efforts to provide a systems approach to ensure access to quality care and needed services for the MCH population. Through the First Lady's Nurture NJ, a statewide awareness campaign committed to reducing maternal and infant mortality and ensuring equitable care among women and children of all races and ethnicities, the NJDOH has partnered with other state departments and agencies. These partners include the health systems, physicians, doulas, community organizations, and most importantly, mothers and their families to make a transformational change in a system that has historically failed mothers and babies.

The Nurture NJ Strategic Plan was released in January 2021. It requires all sectors, including health and Title V, as well as education, housing, business, government, justice, and others, to join forces. This Strategic Plan was developed to reduce NJ's maternal mortality by 50% over five years and eliminate racial disparities in birth outcomes. This plan culminates over a year of in-person and virtual meetings with over 100 critical stakeholders, including national public health experts, NJ state departments and agencies, health systems, physicians, doulas, community organizations, and mothers and families. The plan seeks to reduce maternal mortality and eliminate racial disparities by: ensuring all women are healthy and have access to care before pregnancy, building a safe, high-quality, equitable system of care for all women prenatally through postpartum care; and ensuring supportive community environments during every other part of a woman's life so that conditions and opportunities for health are always available.

Nine action areas for the Nurture NJ strategic plan are as follows:

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

In June 2021, NJDOH launched the NJMCQC, a 34-member of legislated State Maternal Health Task Force. Assistant Commissioner Nancy Scotto-Rosato, also the Title V Director, engages in multiple MCQC-related activities and supervises the Team that conducts MCQC-related activities within FHS. The NJ MCQC is part of the HRSA-funded State Maternal Health Innovation Program (SMHIP), a selective innovation program to complement ongoing Title V programs nationwide. The NJMCQC coordinates efforts and strategies to reduce maternal mortality, morbidity, and racial and ethnic disparities within the state. The NJMCQC works collaboratively with TVP and other organizations, such as the Perinatal Quality Collaborative, involved in developing and implementing maternal mortality and morbidity reduction strategies within the state. The NJMCQC convenes quarterly to: Promote buy-in, Implement the Nurture NJ Strategic Plan, translate data into action, strategize on future activities, and solicit funding opportunities. The vision to make NJ the safest and most equitable place in the nation to give birth and raise a baby is at the forefront of the work of the NJMCQC and is supported by TVP.

Moreover, in FY23, in partnership with the Governor's Office (GOV), the Office of the First Lady, the Department of Children and Families (DCF), the Department of Human Services (DHS), and the Department of Health (DOH) a Team lead by TVS developed a State Action Plan to promote healthy development and family recovery for infants, children, parents, and caregivers affected by prenatal substance exposure. In FY24, the Team will start implementing the Action Plan. The appointed Team Lead across each department are well-versed in program coordination and community capacity building. Moreover, they have solid partnerships with key stakeholders and state leaders to successfully enact the State Action Plan.

III.E.2.b.v.b. Title XIX Medicaid Inter-Agency Agreement (IAA)

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Interagency Letter of Agreement Between the State of New Jersey Department of Health
and
Department of Human Services,
Division of Medical Assistance and Health Services

This letter of agreement between the State of New Jersey Department of Health (DOH) and Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) is intended to promote the coordination of DOH's Maternal and Child Health Services Title V Block Grant with the Title XIX Medicaid Medical Assistance Program (Medical Assistance Program) in New Jersey.

Title V programs have great expertise in providing an infrastructure and access to services related to maternal and child health that Medicaid in turn can build upon. Title V programs have knowledge in developing model programs and materials that can be used by the Medical Assistance Program. Title V personnel are also skilled in providing outreach services to Medicaid beneficiaries thus enabling access on behalf of the Medical Assistance Program.

The purpose of this letter of agreement is to describe the respective roles and responsibilities of each agency in their coordination work to avoid duplication of services and effort.

The Maternal and Child Health (MCH) Services Block Grant and the Medical Assistance Program, authorized by Title V and Title XIX of the Social Security Act (SSA), serve complimentary purposes and goals. Coordination and partnerships between the two programs greatly enhance their respective abilities, increase their effectiveness, and guard against duplication of effort. Such coordination is the result of a long series of legislative decisions that mandate the two programs to work together. Interagency Agreements (IAAs), required by both Title V and Title XIX legislation, can serve as a key factor in ensuring coordination and mutual support between the two agencies (or divisions within an agency) that administer the two programs.

DOH, Division of Family Health Services (FHS), is responsible for administering a program of maternal and child health services (administered under the Maternal and Child Health Block Grant under Title V of the Social Security Act), pursuant to N.J.S.A. 26:1A·37.

DHS, DMAHS, is responsible for administering the Medical Assistance Program, pursuant to N.J.S.A 30:40-5; and As the State-designated Agency to administer the Maternal and Child Health Services Title V Block Grant program, the DOH acknowledges its responsibility to coordinate with DMAHS in administration of Title V programs.

As the State-designated Agency to administer the Medical Assistance Program in New Jersey, DMAHS acknowledges its responsibility to coordinate with DOH in administration of the Medical Assistance program.

This letter of agreement represents the continued commitment of each agency to coordinate with the other agency to avoid duplication of services and effort.

Therefore, to carry out their assigned duties to further the public good, the parties agree to the following:

Responsibilities of Both DOH and DMAHS shall:

1. Coordinate policies and procedures that impact health care services or the delivery of health care services to maternal and child health populations, including children with special health needs.

2. Share information regarding case management services, as permitted by applicable laws and separate data sharing agreements, and coordinate case management services, when appropriate, with all interested parties including Medicaid Managed Care Organization case managers.

3. Notify each other of any changes in criteria or standards relating to the provision of services pursuant to the Maternal Child Health Title V Block Grant or Medical Assistance Program for pregnant women, mothers, and children prior to such changes.

4. Notify each other of any known changes in federal or State statutes, regulations, or policies that would impact programs that are administered under the Maternal and Child Health Title V Block Grant or Medical Assistance.

5. Identify how the DOH and DMAHS can work together to identify individuals within the maternal and child health population, including children with special health care needs, in need of medical and remedial services.

6. Share appropriate and relevant aggregate data affecting health status or delivery of health care services to the maternal and child health population, including children with special health care needs.

7. Meet at least annually to review any proposed revisions regarding case management services.

8. Agree that the use or disclosure of any individually identifiable health information concerning either program's participants shall be limited to purposes directly connected with the administration of each agency's programs or provision of supports and services and prevent any unauthorized use or disclosure of protected health information in accordance with applicable federal, State, and local laws. Any exchange of confidential information between the Departments will be documented and authorized through a memorandum of agreement for data sharing.

9. Establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the information resulting from the administration of Maternal and Child Health Programs and Medical Assistance.

Responsibilities of DOH:

1. Special Child Health and Early Intervention Services (SCHEIS)

DOH shall:

i. Provide support and collaborate with OHS on education, training, and program development relating to diagnosis and reporting requirements for birth defects including critical congenital heart defects, hearing loss, and autism.
ii. Meet at least annual with DMAHS to improve access to services for children with reportable birth defects, hearing loss and autism.
iii. Ensure that the Special Child Health Services case management network is available for the provision of case management services for children with special health care needs from birth to twenty-one (21) years of age.
iv. Establish quality measurements for appropriate outcomes.
v. Act as the primary contact for the vendor responsible for the Medicaid fund recovery.
vi. Ensure that early intervention services agencies comply with New Jersey Early Intervention Services (NJEIS) criteria.
vii. Provide assistance and input to DMAHS for the development of Medicaid manuals and regulations relating to the Early Intervention Medicaid Initiative (EIMI).
viii. Develop procedures for the monitoring of EIMI.
ix. Assure that State matching funds are available through NJEIS.
x. Report to DMAHS, the costs of DOH's administrative activities that are reasonable and necessary to support the requirements of EIMI.

2. Child Health:

DOH shall:

i. Provide support and collaborate with DMAHS on education, training, and program development relating to lead poisoning prevention.
ii. Promote and facilitate enrollment of children into Medicaid and/or NJ FamilyCare.

3. Childhood Lead Poisoning Prevention Surveillance System (CLPPSS):

DOH shall:

i. Ensure quality monitoring of lead information, inspections, and abatements.
ii. Meet at least annually with DMAHS to improve lead screening efforts and case manage children with elevated blood lead levels.

Responsibilities of DMAHS:

1. Special Child Health and Early Intervention Services (SCHEIS)

DMAHS shall:

i. Meet at least annually with DOH to ensure timely and accurate program operation.
ii. Provide DOH with individual Medicaid participant claims data when the Medicaid participant requests DMAHS to provide their claim data to the DOH, and provide aggregate data to DOH, as needed, regarding children with birth defects, hearing loss and autism.
iii. Provide NJEIS with updates and changes to Medicaid regulations.
iv. Provide technical assistance, as needed, regarding requirements and specification for claims submission, processing, and data reporting for Early Intervention Medicaid Initiative (EIMI).
v. Submit claims to the federal government to draw down federal Medicaid funding for services provided under EIMI.
vi. Assist DOH in maximizing federal reimbursement for the costs of allowable administrative activities.

2. Child Health:

DMAHS shall:

i. Provide support to and collaborate with DOH on education, training, and program development relating to lead poisoning prevention.
ii. Use the DMAHS website and DMAHS staff presentations at interdepartmental meetings to get information out about NJ FamilyCare, lead screening, and issues relating to children with special health care needs.

3. Childhood Lead Poisoning Prevention Surveillance System (CCLPPSS):

DMAHS shall:

i. Coordinate with DOH to improve lead screening efforts and case management of children with elevated blood lead levels.

This letter agreement shall become effective upon signing. This agreement may be reviewed and considered for expansion, modification, or amendment at any time upon agreement of both parties. Data sharing needs set forth in this agreement will be detailed and governed by separate data sharing agreements.

DOH Signature

Lisa A. Asare, MPH
Assistant Commissioner, FHS, DOH

DHS Signature

Jennifer Jacobs
Director, DHMAS, DHS

III.E.2.C State Action Plan Narrative by Domain

Women/ Maternal Health

Annual Report

Improving the domain of Women's/Maternal Health is crucial to the State Priority Need of Increasing Equity in Healthy Births (SPN #1) and the National Outcomes Measures (NOMs) 2, 3, 4, 5, 6, 8,9.1, 9.2, 9.3, 9.4, 10, 11,23 and 24. The selection of NPM #1 (Well Women Visits) during the Five-Year Needs Assessment process recognizes the impact the life course approach will have on increasing healthy births and improving women's health across their life span. The Life Course Perspective to conceptualizing health care needs and services evolved from research documenting early life events' important role in shaping an individual's health trajectory. The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, influence health throughout one's lifetime. NJ has prioritized improving women's health and has utilized several evidence-based strategies to increase preventive medical visits (NPM #1) including the HWHF, MIECHV, FIMR, and Maternal Mortality Review. The Governor and the First Lady have placed additional emphasis on reducing maternal mortality and morbidity through the Nurture NJ Initiative.

3.e.2.c.2.a - Annual Report - NPM #1 (Percent of women with a past year preventive medical visit)

Table NPM # 1	2012	2013	2014	2015	2016	2017	2018	2019	2020
Percent of women with a past year preventive medical visit, All	77.7	77.3	78.8	79.8	80.5	77.0	82.4	**	78.7

Data Source: Behavioral Risk Factor Surveillance System (BRFSS) in NJSHAD. Visited a Doctor for a Routine Checkup in the past year (Age-adjusted).
** Data not available on NJSHAD

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

In 2022, the overall percentage of adequate prenatal care based on the Kotelchuck Prenatal Care was 71.2%. However, racial/ ethnic disparities are observed. Specific race/ethnicity-related rates for adequate prenatal care for 2021 were 77.6%, 60.7%, and 64.6% for White, NH, Black, NH, and Hispanic, respectively. These existing disparities align with the need for TVP to improve NPM #1 by focusing on preconception care and early prenatal care. Improving access to prenatal care is essential to promoting the health of NJ mothers, infants, and families. Early and adequate prenatal care is an important component of a healthy pregnancy and birth outcome because it offers the best opportunity for risk assessment, health education, and the management of pregnancy-related complications and conditions. Prenatal care is also an opportunity to establish contacts with the health care system and to provide general preventive visits.

Moreover, preconception care is a critical component of prenatal and health care for all women of reproductive age. NJ has a targeted focus on preconception care through the family planning program. The NJ family planning grant delivers essential primary and preventative health care to patients. NJ's family planning providers provide a full range of reproductive health and family planning services, including contraceptive counseling and provision; education, testing, and treatment for sexually transmitted infections; screenings for breast and cervical cancers; and other sex education. In the fiscal year 2023, additional funding was appropriated to go towards abortion services and support to cover uncompensated costs, practical support, and a statewide needs assessment.

The main goal of preconception care is to provide health promotion, screening, and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies. Given the relationship between pregnancy intention and early initiation of prenatal care, assisting women in having a healthy and planned pregnancy can reduce the incidence of late prenatal care and promote NPM #1 (Well Women Visits).

Through the HWHF initiative, TVP uses CHWs and Connecting NJ to focus on improving maternal and infant health outcomes, including women's health with preventive medical visits, preconception care, prenatal care, inter-conception care, preterm birth, and low birth weight, and infant mortality. The primary focus of Connecting NJ is to assist pregnant people, caregivers (mothers, fathers, grandparents, kinship, foster parents, legal guardians), and young children (birth-five) in efficiently accessing the most appropriate services. On the Connecting NJ portal, reported data includes but is not limited to health status, diagnosis, socio-demographic characteristics, and more.

TVS on the project team have access to data collected on this secure system. Connecting NJ is designed to simplify the referral process, improve care coordination, provide developmental screening, and ensure an integrated maternal, infant, and early childhood care system. From July 1, 2018, to February 22, 2023, more than 92,964 pregnant women have been screened since July 2018, and over 31,020 received a service referral.

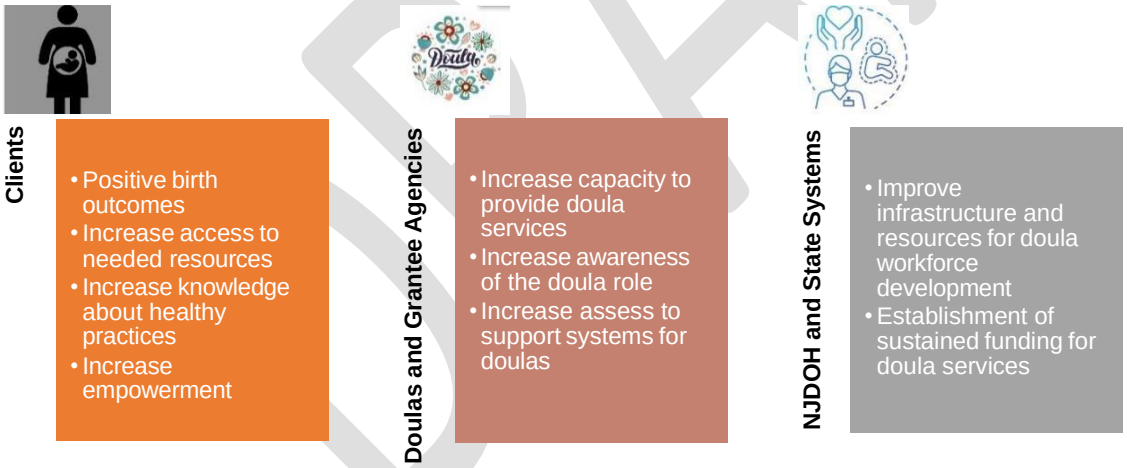
To better align the ESM with our current initiatives, ESM 1.2 (Number of individuals trained to become community-based doulas). Number of individuals trained to become community-based doulas) was selected for its positive impact on National Performance Measure (NPM) #1 (Well Women Care) and State Performance Measure (SPM) #1 (Increasing Healthy Births).

A Request for Application (RFA) was issued to create a Doula Learning Collaborative (DLC), which was awarded to Health Connect One. The DLC focuses on reducing maternal and infant mortality and eliminating racial disparities in health outcomes by providing training, workforce development, supervision support, mentoring, technical assistance, direct billing, and sustainability planning to grow the community doula workforce.

To date, approximately 250 individuals have been trained to become community doulas, and as of March 2023, 653 births have been attended by doulas from the pilot sites. Preliminary results from an evaluation conducted by researchers from Montclair State University in 2021 for the 3-year Doula Pilot Program indicate that positive birth and/or pregnancy outcomes (e.g., lower rate of cesarean deliveries, increase in breastfeeding rate) are linked to community doula services.

A mixed-methods outcome evaluation was conducted to examine the outcomes and benefits of the Doula Pilot Program as measured by quantitative data (i.e., program data from the Maternity Neighborhood database) and qualitative data (i.e., interviews with program stakeholders). Program outcomes and benefits were observed at three stakeholder levels: 1) client, 2) doula and grantee agency, and 3) NJDOH and state system levels (Figure 13).

Figure 13. Program Outcomes Across Clients, Doula and Grantees Agencies, NJDOH, and State Systems



Several actionable recommendations have emerged from the evaluation project on how to improve the implementation and outcomes of ongoing efforts related to the Doula Pilot Program. Overarching recommendations are provided, and specific actions that multiple stakeholder groups may take are offered to provide targeted guidelines for program improvement. The recommendations emphasize collaboration across stakeholder groups and are mutually reinforcing.

To ensure the sustainability of community doula services in NJ, TVS worked collaboratively with Medicaid to offer doula services to women through Medicaid Benefits. NJ Medicaid benefits have been expanded to cover doula services. Presently, a doula can now serve birthing people whom Medicaid covers as a covered benefit.

Moreover, TVP established the CLG-CHWI through a NJ Department of Labor Apprenticeship to infuse additional services in the communities. TVP collaborate with universities to create a standardized community health worker

training and certification program, resulting in a robust CHW workforce. This apprenticeship opportunity has allowed the state to educate an emerging and critical component of its workforce – creating a needed infrastructure to support CHWs, enhance CHW skill sets, and lead sustainable efforts to support this indispensable workforce. Graduation of the initial cohorts has already begun, with new cohorts continuously being enrolled.

Moreover, CHWs and their supervisors, through Title V grantees, have received and continue to receive breastfeeding education. This unique training focused on women of color and was developed to address health disparities related to reproductive justice. Breastfeeding support is also being provided by International Board-Certified Lactation Consultants (IBCLC) either in groups or in one-to-one sessions.

The programs being implemented in the communities through the HWHF initiative allow TVP to implement specific activities to support communities with limited public health resources and the highest need where impacts will be greatest to improve population health outcomes and reduce health disparities. The HWHF Initiative addresses the disparities in birth outcomes through case management and assures that appropriate referrals are made and tracked including medical care referrals to promote NPM #1 (Well Women Visits).

To ensure that the HWHF initiative is successful, NJ TVP collaborates with the NJDOH Office of Population Health and the Population Health in Action Teams. Through this collaboration, TVP established linkages with sister agencies (Department of Labor, Department of Education, Department of Transportation, etc.) and sought to address some of the barriers that exist in the scope of SDOH. Additionally, efforts to reduce maternal mortality and morbidity have been and continue to be developed under First Lady Tammy Murphy's Nurture NJ Initiative, whose goal is to "make NJ the safest place to give birth in the country."

Annual Report - NPM #14:
A) Percent of women who smoke during pregnancy and
B) Percent of children who live in households where someone smokes

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

As a result of the many health consequences, the health costs of smoking during pregnancy are significant. Excess prenatal care costs and complicated births among pregnant women who smoke exceed $4 billion a year. (See NJ Pregnancy smoking rates in table A below) It has been estimated that a 1% drop-in rate of smoking among pregnant women could result in savings to the US of $21 million in direct medical costs in the first year. Another $572 million in direct costs could be saved if the rates continued to drop by 1% annually over seven years. Secondhand smoke also has significant health effects on an infant.

Pregnant women exposed to secondhand smoke have a 20% increased risk of having an infant born with low birth weight, and secondhand smoke exposure also increases the risk of infections in the infant, and even death from SUID. Children living with smokers are also more likely to have more frequent and acute asthma attacks, ear infections, and serious respiratory illnesses like pneumonia and bronchitis due to second and third-hand smoke exposure (See NJ exposure in table B below). The cost to care for childhood illnesses resulting from exposure to second and third-hand smoke is estimated at $8 billion annually. In addition to the effects during the perinatal period, health consequences for older children and adults (whether from direct smoking or second and third-hand exposure) are well documented in the literature and include respiratory infections and disease, cancer, and death.

Perinatal Risk Assessment Data
*Majority of assessments completed by Medicaid recipients and not representative of the state overall

Year	Smoking in the month before you knew you were pregnant (4Ps Q8)	Pregnant Woman 2nd or 3rd Hand Smoke Exposure (PsychSoc Q)
2017	8.8%	7.3%
2018	7.8%	5.6%
2019	7.7%	6.0%

2020	6.0%	3.4%
2021	4.7%	2.1%
2022	4.1%	2.2%

Initiated in 2001 with funding from the NJDOH-Comprehensive Tobacco Control Program, Mom's Quit Connection (MQC) is NJ's maternal child health smoking cessation and education program. There have been changes in the services provided and their capacity to be a statewide program through the years based on the availability of funds. MQC utilizes a proactive behavior modification model, offering face-to-face individual cessation counseling, telephone counseling, and texting support to assist clients in developing a customized quit plan. Through these direct services, both for consumers and professionals, MQC focuses on reaching the women and family members who need help to quit. They educate them about tobacco use's dangers and offer judgment-free, evidenced-based treatment methods by Nationally Certified Tobacco Treatment Practitioners and NJ Certified Tobacco Treatment Specialists.

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

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

In January 2018, the MQC database software program was redesigned and upgraded to a web-based system using the Salesforce platform to support more detailed reporting and integration of planned mobile technology. Given the declining rate of maternal smoking and the stagnant and, in some cases increasing numbers of postpartum women returning to smoking after delivery, MQC chose to rebrand to MQC for Families. According to PRAMS Briefs published by the NJDOH, living with other smokers represented the most prevalent indicator for postpartum relapse. Expanding the program to MQC for Families has enhanced its cessation population parameters to include parents and caregivers of children under 8 years old along with the pregnant woman to address not only the individual smoker but all smokers in the home environment. By helping the clients quit smoking, there is significant harm reduction for their children. Multi-level interventions are standard, including mailing self-help materials, phone calls, texting, and direct individual cessation services. Relapse prevention interventions are an important part of the program to address the high relapse rates post-partum.

From July 1, 2022, through February 28, 2023, there were 306 referrals to the program, 26% from the Central region, 24% from the Northern Region, and 50% from the Southern region. About 275 of these referrals came from the automated Perinatal Risk Assessment (PRA) system: 9 referrals were faxed from providers, and 22 were self-referrals from the MQC website and Facebook page online registration option. All 306 referred clients were sent self-help cessation information and texted the option of enrolling in MQC's cessation counseling program. Twenty clients received a Level 1 cessation counseling session, and 13 clients went on to enroll in intensive cessation counseling. There was a total of 189 counseling sessions with 31 clients enrolled in case management, and 226 client status reports were received by providers on newly enrolled and existing clients. Of the enrolled pregnant clients, 80% quit or significantly reduced their consumption and 50% quit completely (the national average maternal quit rate is 24%). Among non-pregnant clients enrolled in cessation counseling, 95% quit or significantly reduced consumption, of which 48% completely quit. Throughout this year, 285 MQCF referred clients and their family members/caregivers were referred to the NJ Quitline.

Due to COVID 19, all work between July 1, 2020, and June 30, 2021, by MQCF was completed through the Zoom or Teams platforms. MQCF provides statewide training to clinicians, medical professionals, social service agencies, and educators on the Ask Advise and Refer: Brief tobacco Intervention Model (AAR), to improve assessing of tobacco use and refer pregnant women, mothers, fathers, and caregivers who use tobacco to MQCF. AAR as a CDC Best Practice intervention, teaches the trainees how to successfully talk to their clients/patients about smoking, how to advise them to quit, and where to make a referral that will facilitate quitting. Brief tobacco dependence treatment is effective as stated in the Treating Tobacco Use and Dependence: Clinical Practice Guidelines. From July 2022 through February 2023, 211 professionals received AAR training through the Zoom and Teams platforms. Professional outreach and networking are vital for reaching new providers, offering MQCF Program Orientations, and enhancing their services with professional and consumer education, tobacco resources, and a system for direct referral for cessation counseling. From July 2022 thru February 2023, an additional 271 professionals received

orientation and information sessions about MQCF and NJ Quitline. MQCF participates in conferences to increase professional awareness of the available services. Nine hundred and twelve professionals received information through conference tabling, toolkits, resource requests, and networking opportunities. Approximately 102 pregnant women and families received information about the dangers of maternal smoking and MQCF and NJ Quitline services through formal education sessions via the Zoom platform. Both virtual and in-person community outreach and partner events reached an additional 1,168 mothers and families. MQCF staff continue to follow up with every new prenatal provider trained on using the PRA to schedule a MQCF program orientation session and promote ASK ADVISE REFER training. From July 2022 through February 2023, 184 follow-up letters were sent to trained providers. A vast amount of tobacco resource information has been made available online by MQCF for anyone interested, removing any barriers to access.

Collaboration with the FHI Prematurity Prevention Initiative (PPI) facilitated the Quit for Kids (QFK) texting support Program launch in May 2020. QFK is offered to stand alone as texting support to quit or to coexist with the individual MQCF cessation services. Texts are personalized for each participant to target the difficulties of quitting smoking and are geared toward their triggers, cravings, and problems. If the participant would like to talk to an MQCF quit coach, they can connect through QFK. From July 2022 to February 2023, 24 clients opted to talk to a quit coach by CHAT or to escalate. PRA clients with a current or past history of smoking are automatically enrolled to QFK, with an opt-out option. Clients working with MQCF can be enrolled through the client database. The texting program uses the GOMO platform to provide smoking cessation and child development messages to pregnant and postpartum women, as well as dads and family members of children up to eight years old. The goal of the texting program is to engage a broader range of clients, including a demographic naturally drawn to online services and clients who may not initially be comfortable with one-on-one counseling. Enrolling with an MQCF cessation specialist is encouraged but not required. This type of customized perinatal texting program is relatively new; therefore, extensive analytics and evaluation have been built into the program to help determine its effectiveness in engaging clients and helping them to quit. From July 2022 to February 2023, 289 clients enrolled in QFK.

Tables NPM 14A & B:

A) Percent of women who smoke during pregnancy (last 3 months)

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
14 A. Percent of women who smoke during pregnancy	6.4	6.5	5.7	5.5	5.6	4.8	4.4	4.4	3.5	3.1	2.9	2.7

Notes - Data is from the NJ PRAMS Survey

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

Annual Objective and Performance Data	2003	2007	2011-2012	2016	2017	2018-2019	2020-2021
14B. Percent of children who live in households where someone smokes	28.7	19.7	20.3	n/a	n/a	9.7	9.7

Data Source: National Survey of Children's Health (NSCH)- NSCH 2018 19: Children who live in households where someone smokes, Nationwide vs. New Jersey (nschdata.org)

Application Year

Plans for the coming year to promote NPM 1 (Well Women Care) will include the implementation of HWHF 2.0 and collaboration with families, partners, and stakeholders in the newly implemented State Maternal Health Innovation Program. In 2022, TVS conducted an informative evaluation of the HWHF initiative. Based on the formative evaluation project results, NJ TVP Epidemiology Team generated a comprehensive list of culturally competent recommendations grouped into four categories: system level, programmatic level, data-related, and material development or revision.

HWHF 2.0 will focus on implementing breastfeeding education and postpartum support. The goal of HWHF 2.0 continues to be to improve maternal and infant health outcomes for women of childbearing age (as defined by CDC as 15-44 years of age) and their families, especially Black and Hispanic women, through a collaborative and coordinated community-driven approach. The HWHF Initiative will continue to develop partnerships with community-based maternal and child health providers/agencies with proven capabilities in implementing activities/interventions within a targeted community and the capability to focus on reproductive-age women and their families. Support programs for breastfeeding will include 1:1 and group sessions by IBCLCs and the establishment of a support group. To support the continued increase in breastfeeding initiation at birth, a statewide Breastfeeding Strategic plan was launched in 2022 and is currently underway in its implementation.

Simultaneously, county-based consumer-driven advisory boards will continue to contribute to the direction and progress of the HWHF initiative, and the Connecting NJ Hubs will meet quarterly to build partnerships and local referral systems. The MIECHV Programs and Healthy Start Programs will continue to case manage mothers and assure preventive medical visits through the monitoring of benchmarks, including a reproductive life plan, medical home, and well-women visits.

The Doula Learning Collaborative (DLC) will continue to provide training, workforce development, mentoring, technical assistance, direct billing, and sustainability planning to community doulas and doula organizations throughout the State of NJ. To date, approximately 250 individuals were trained to become community doulas, and as of March 2023, 653 births have been attended by doulas. The DLC created a comprehensive, unique training curriculum for NJ doulas. It provides cultural competency training and education in NJ-specific community-based resources for doulas. It is working with Medicaid to ensure that the NJ doula training curriculum is approved for doulas to register for Medicaid and receive Medicaid reimbursement.

The CLG-CHWI will continue to enhance the professional development of CHWs and allow for a stronger workforce. Over 300 CHWs have completed their training. The CLG-CHWI will continue to expand its programs through state funding and now will include apprenticeships for perinatal CHWs, an initiative that will assist in improving maternal-child health outcomes, and Certified Nurse Assistants (CNAs). The ELC will continue to collaborate with the CLG-CHWI, focusing on the prevention of disease and vulnerable populations.

Moreover, TVS released an RFA to establish a Community Health Worker Hub (CHW Hub). The CHW Hub is intended to build a Community Health Worker (CHW) workforce to be trained, deployed, and engaged in efforts to combat the effects of COVID-19 on the most impacted populations throughout NJ. In partnership with the NJ Department of Health, the CHW Hub will create additional trainings, deployment plans and engagement strategies to increase the CHW workforce and address health disparities. The CHW Hub will lead deployment strategies in integrating CHWs into health and care teams to assist in addressing mental health, substance use disorder, and other chronic conditions found in the community. The CHW Hub will give trained CHWs access to numerous employment opportunities throughout the state.

NJDOH relaunched its second Rutgers ECHO series in January 2022, which ended in June of 2022. NJDOH ECHO sessions included information to address social needs that COVID-19 exacerbated within vulnerable communities. This information gives doulas and CHW the training needed to aid the MCH population in service navigation in the midst of the COVID-19 pandemic. This partnership has launched its fourth CHW ECHO, which commenced in February 2023 and will continue until June 2023.

The NJ TVP and the Office of Population Health will continue to focus on improving women's and maternal health by developing and implementing a maternal mortality and morbidity strategic plan. The Department is joining efforts with First Lady Tammy Murphy's Nurture NJ Initiative and the legislature, which has proposed a package of maternal health-related bills. NJ Governor Murphy has directed the implementation of many legislative mandates to promote maternal health. These mandates include the development of an annual hospital report card of maternal care, the

establishment of the NJ Maternal Data Center, the NJ MMRC, and the NJ MCQC; Medicaid coverage for doula care, a perinatal episode of care pilot program in Medicaid, and a shared decision-making pilot program.

Millions of pregnant and parenting people are diagnosed with mood disorders, anxiety, depression, post-traumatic stress disorder, substance misuse, or other maternal mental health issues yearly. These issues are much more likely to affect women of color. TVP announces a competitive request for proposals (RFP) to expand the Alma Program in New Jersey. Alma is an evidence-based peer mentoring program created with and for new and expectant mothers experiencing depression, anxiety, and stress. Developed by a collaborative team of researchers, mental health providers, community members, and moms, Alma gives new and expectant moms the support and skills they need to navigate this important chapter in their lives.

The Alma Program Expansion Project aims to establish a new Alma program in NJ that will provide new and expectant parents with evidence-based knowledge, skills, and support from peer mentors who have faced similar challenges. The Project seeks to improve maternal mental health and eliminate racial disparities in health outcomes by providing workforce development (training and supervision), program delivery support, expanded focus on substance use as a program target, technical assistance, and a focus on advocacy and sustainability to launch and offer an Alma Program for new and expectant mothers in the State of New Jersey.

Additionally, informed by the recommendations made through the Fetal Alcohol Syndrome (FAS) Prevention and Postpartum Depression and Mood Disorders (PPD-MD) evaluation projects, TVP is drafting a new RFP for the aforementioned programs. These RFPs will be released in FY24 and will focus on increasing education, awareness, and access to services for women diagnosed with FAS and/or PPD-MD.

Through HWHF Initiative and all the aforementioned interventions and activities, TVP will continue to develop partnerships with community-based maternal and child health providers/agencies with proven capabilities in implementing activities/interventions within a targeted community and the capability to focus on reproductive-age women and their families.

Moreover, through the New Jersey Family Planning League (NJFPL), which is a direct grantee for Title X (CDC federal funding), NJ TVP will continue to provide access to quality family planning and related health services for all New Jerseyans who need them, regardless of identity, income, or insurance status.

Plan for the Application Year NPM # 14:
National Performance Measure 14:

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

Promoting Mom's Quit Connection for Families (MQCF) to expand reach to pregnant people, parents, and caregivers of young children in NJ.

Increasing Capacity for Direct Service in NJ.

- Maintain MQCF's existing services statewide
- Promote onsite trainings, orientations, and webinars to maternal and child health professionals in Central and Northern NJ.

Preventing relapse after delivery;

- Continue the development of the smoking cessation interactive app using Quit for Kids texting support program that provides customized messaging and interactive activities from first trimester through postpartum period. QFK uses a "concierge" concept that tailors messaging to personal, emotional, social, and environmental issues happening in the client's life throughout and beyond her pregnancy.
- Continue to offer Relapse Prevention counseling to all clients.

Perinatal/ Infant Health

Application Year

The domain of Perinatal/Infant Health sets the trajectory of the health of a child throughout the Life Course. NJDOH has identified the following State Priority Needs (SPN) of Reducing Black Infant Mortality and Improving Nutrition & Physical Activity and selected the related NPMs 4 (Breastfeeding) and 5 (Infant Safe Sleep) as a result of the Five-Year Needs Assessment process. N.J. has implemented several evidence-based strategies related to NPM 4 & 5 which impacts several NOMs (4, 5, 6, 8, 9.1, 9.5).

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

Promoting breastfeeding has been a long-standing priority for FHS. Breastfeeding is universally accepted as the optimal way to nourish and nurture infants, and it is recommended that infants be exclusively breastfed for the first six months. Breastfeeding is a cost-effective preventive intervention with far-reaching effects for mothers and babies and significant cost savings for families, health providers, employers, and the government. Breastfeeding provides biologically normal, appropriate nutrition and encourages normal infant development; lack of breastfeeding increases the risk of disease and obesity. FHS has developed many strong partnerships to strengthen breastfeeding-related hospital regulations, promoting breastfeeding education, training, and community support.

In 2022, in collaboration with TVP, the Women, Infants, and Children (WIC) office within the NJDOH released the Breastfeeding Strategic Plan (BSP). Presently, TVP staff sit on the committee that partakes in the implementation of the BSP that was released in September 2022. NJ TVP in partnership with WIC staff, formed an Internal Committee that has met multiple times. Thus far the preliminary focus of the group has been on a budget, prioritizing the objectives laid in the BSP. Moreover, the committee has started compiling contact information for stakeholders and started working on action steps for 2022-2023 objectives. Additionally, the NJ DOH Assistant Commissioner of Family Health Services also the Title V Director is focusing on securing resources to hire a NJ BSP Coordinator and other staff to implement the strategic plan. Funding for staffing has been added to FY24 Governor's budget and will hopefully be approved by legislators prior to July 1st.

ESM 4.1 (Increase the Percentage of Births in Baby-Friendly Hospitals) was selected for its positive impact on NPM #4 and N.J.'s ongoing efforts to promote the Baby-Friendly Hospital Initiative and its ability to monitor breastfeeding rates from birth certificate data and the mPINC Survey.

According to the Centers for Disease Control and Prevention (CDC) 2021, National Immunization Survey Breastfeeding Rate Report Card, NJ rates for newborns ever breastfed in 2019 was 82.5% (NPM 4A). Breastfeeding rates in four categories of interest from 2018 to 2019 are depicted in the table below.

Categories	2018	2019
Infants who were exclusively breastfed through 3 months	36.8%	41.2%
Infants who were breastfed at 6 months	59.8%	55.4%
Infants who were exclusively breastfed through 6 months	22.5%	23.4%
Infants who were breastfed at 12 months	34.5%	33.8%

While the percentage of infants who were exclusively breastfed through 3 months increased, the percentage of infants who were breastfed at 6 months decreased, the percentage of infants who were exclusively breastfed through 6 months increased, and the percentage of infants who were breastfed at 12 months decreased.

Table NPM #4	Born in 2011	Born in 2012	Born in 2013	Born in 2014	Born in 2015	Born in 2016	Born in 2017	Born in 2018	Born 2019
Percent of infants who ever breastfed	81.6	82.0	82.0	83.9	82.8	88.8	88.7	81.7	82.5
Percent of infants breastfed exclusively through 6 months	22.3	16.7	23.1	24.8	24.4	22.8	27.7	22.6	23.4

Notes - Source – the CDC's National Immunization Survey.
http://www.cdc.gov/breastfeeding/data/NIS_data/
DNPAO Data, Trends and Maps: Explore by Location | CDC

FHS has supported Baby-Friendly™ designation through training, technical assistance, and mini-grants. The Baby-Friendly Hospital Initiative (BFHI) is a global program launched by the World Health Organization and the United Nations Children's Fund to encourage and recognize hospitals and birthing centers that offer optimal care for infant feeding and mother/baby bonding. BFHI recognizes and awards birthing facilities that implement the Ten Steps to Successful Breastfeeding (i) and follow the International Code of Marketing of Breast-milk Substitutes (ii). Thirteen NJ hospitals have earned the "Baby-Friendly" designation. About 27% of N.J. Birthing Facilities achieved Baby-Friendly status

N.J. hospitals participate in the Maternity Practices in Infant Nutrition and Care (mPINC) Survey, a national survey of maternity care practices and policies conducted by the CDC every two years, beginning in 2007. In 2020, 40 of 49 (82%) eligible hospitals participated in the mPINC Survey, and the total score was 82 (above the national score of 81).

Exclusive breastfeeding rates at discharge varied with the racial and ethnic composition of mothers. Based on 2021 Birth, the overall exclusive breastfeeding rate at discharge for the State was 31.7%, while the rate for Black, NH, and Hispanic was 25.7% and 24.3%, respectively. Further examination of the disparity in these rates will require State leadership to reinforce breastfeeding regulations and provide support for information on locally available breastfeeding promotional activities, protocols, and the cultural appropriateness of those services, which will potentially be achieved through the implementation of the BSP. Though the team that is currently working on the implementation of the BSP is behind on a few objectives, while designing the BSP, they took into consideration the persistent racial and ethnic disparities as they relate to breastfeeding support. The table below displays one of the goals that focus on addressing persistent racial and ethnic disparities.

Goal	Strategy	Objectives	State Agencies Involved
Provide families with the support they need to breastfeed their babies.	Eliminate systemic barriers in lactation support to provide all families the support they need in a statewide environment where breastfeeding is normalized and racial and ethnic disparities in lactation are eliminated.	By 2022, allocate funding within NJDOH for at least 1 FTE to provide oversight for the Breastfeeding Strategic Plan.	New Jersey Department of Health (NJDOH)
		By 2022, increase the number of lactation support staff in WIC Services to 2.	NJDOH (WIC)
	Increase support for community organizations that provide lactation education and peer-to-peer support	By 2022, expand the role of the statewide WIC Breastfeeding Coordinator to include increased outreach to state healthcare provider organizations, nutrition programs, and other maternal child health partners.	NJDOH Department of Human Services (DHS) Department of Children and Families (DCF)

Existing Breastfeeding-related Programs

Presently, WIC Services provide breastfeeding promotion and support services for WIC participants through grants to all 16 local WIC agencies. International Board-Certified Lactation Consultants (IBCLC) and breastfeeding peer counselors provide direct education counseling and support services, literature, and breastfeeding aids, which include breast pumps, breast shells, and other breastfeeding aids. WIC staff conducts the *Loving Support*© through the Peer Counseling Breastfeeding Program. Moreover, WIC breastfeeding staff conducts professional outreach in their communities and education to healthcare providers who serve WIC participants. Close collaboration between Maternal and Child Health Services (MCHS), WIC Services (WIC), and the Office of Community Health and Wellness is ongoing. All three programs, in addition to the Office of Minority and Multicultural Health, have an interest in breastfeeding protection, promotion, and support and have similar constituencies.

Through the HWHF initiative, TVP implements community-level programs that promote breastfeeding and potentially address persistent racial and ethnic disparities. For instance, one of the target outcomes of HWHF is, increasing exclusive breastfeeding. Additionally, to address the racial/ethnic disparity in breastfeeding rates, implementing

breastfeeding support and education to non-traditional audiences as a mechanism to increase support for Black NH women is one of the interventions/strategies of HWHF. Moreover, CHWs and their supervisors receive breastfeeding education through an initiative. The" Breastfeeding in Color" training focused on women of color and was developed to address disparities, focusing on reproductive justice, and addressing inequities in human lactation. Considering that breastfeeding is a “family affair,” fathers’ and other family members’ involvement in the process is a puzzle piece that is supported by the HWHF initiative through its focus on non-traditional audiences.

Annual Report NPM #5 (infant safe sleep)

NJ TVP utilizes block grant funding to fund the Sudden Infant Death Syndrome Center of New Jersey (SCNJ). SCNJ implements activities that seek to reduce Sudden Unexpected Infant Deaths (SUID) and Sudden Infant Death Syndrome (SIDS) rates in NJ. The SCNJ develops and provides educational programs, tools, and methodologies that assist the public, health care, social service, childcare, and public health institutions, programs and providers, faith-based communities, home visiting programs, doulas, community organizations, and other initiatives that interface with caregivers. Thus, SCNJ has the access and trust needed to raise knowledge and practice of safe infant sleep and other risk-reducing behaviors and unknown causes. TVP plays a key role in monitoring the activities and ensuring they respond to New Jerseyans’ needs.

Promoting infant safe sleep was selected as NPM #5 during the Five-Year Needs Assessment process for its importance in reducing often preventable infant deaths and its potential impact on improving NPMs 1, 2, 3, 4, 5, and 6. Sleep-related infant deaths, also called SUID, including SIDS, are the leading cause of infant death after the first month of life and the third leading cause of death overall. In addition to SIDS, sleep-related SUID includes accidental suffocation, strangulation in bed, and ill-defi

Due to the heightened risk of SUID when infants are placed to sleep on side or stomach sleep positions, health experts and the American Academy of Pediatrics (AAP) have long recommended the back sleep position. The back sleep position has been called one of the seven leading research findings in pediatrics in the last 40 years (Goodstein & Ostfeld, Pediatrics, 2017). Although, by definition, SIDS and ill-defined and unknown causes refer to deaths whose etiology has not been identified, the conditions that elevate risk are known. In 2011, 2016, and in 2022, the AAP updated its recommendations to help reduce the risk of SIDS and other sleep-related deaths. The AAP recommends a safe sleep environment that consists of placing infants to sleep on their backs, having the infant share a parent's room but in his/her own sleep space (e.g., crib, bassinet, portable crib, or play yard) that meets current Consumer Product Safety Commission standards. AAP recommends that the sleep space contains a firm flat mattress of the type intended and that the sleeping space should be free of soft and loose bedding such as bumpers, pillows, and blankets.

Additional recommendations include breastfeeding or the provision of human milk and avoiding overheating and tobacco smoke exposure, by any means, during pregnancy, and after birth. These expanded, evidence-based recommendations for the first twelve months of life underlie the National Institute of Child Health and Development (NICHD) Safe to Sleep Campaign and that of the SIDS Center of New Jersey, whose research contributed to the safe sleep policies of the AAP. Adverse social and health determinants, including poverty and preterm birth, also increase vulnerability and are thus incorporated into strategies to reduce risk.

The selection of ESM 5.1 (Promote Infant Safe Sleep Environments) monitors and focuses on the safe sleep environment (Healthy Sleep), including back to sleep, no co-sleeping, and no soft bedding. Over 10 years, there has been an upward trend in the use of back-to-sleep placement.

Table NPM #5	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Percent of infants placed to sleep on their backs	65.7	67.4	68.9	70.1	69.5	70.8	70.5	69.4	75	73.4	73.0	73.7

In 2003, 58% of infants were placed to sleep on their backs. In 2017 the percentage of infants placed on their backs increased to 75%, surpassing the Healthy New Jersey 2020 NJ target of 74.1%. For 2018-20, the target fell within the

95% confidence interval of each year's achieved percentage. For 2017-2020, the percentage of Black NH, and White NH infants placed on their backs surpassed the individual target goals for each group established by Healthy New Jersey 2020. However, as in other states, there are enduring racial disparities in the reported use of back-to-sleep. In 2003, 37.8% of Black NH infants were placed to sleep on their backs. By 2020, this practice increased to 56.2%, surpassing the goal of 53.7%. In 2003, 69.2% of White NH infants were placed to sleep on their backs. In 2020, this practice increased to 84.0%, surpassing the goal of 83.7%.
Notes - Source – NJ PRAMS.
https://www-doh.state.nj.us/doh-shad/indicator/view/SafeSleep.Trend.html

To promote infant safe sleep (NPM #5), NJDOH has supported the evidence-based strategies of the American Academy of Pediatrics, the NICHD's Safe to Sleep Campaign, the activities of the SIDS Center of New Jersey (SCNJ), www.facebook.com/sidscenternj/, and www.rwjms.rutgers.edu/sids, and the work of the Sudden Unexpected Infant Death Case Review Workgroup which includes representation from the SCNJ. To improve the surveillance of infant safe sleep practices, TVP conducts the PRAMS survey, which includes questions on infant safe sleep, and participates in the SUID-CR Workgroup.

The SCNJ is a program funded by the TVP program to Robert Wood Johnson Medical School (RWJMS), a part of Rutgers, The State University of New Jersey, New Brunswick, and is based both at RWJMS and the Joseph M. Sanzari Children's Hospital at Hackensack University Medical Center, Hackensack. SCNJ was established in 1988 through the SIDS Assistance Act. The SCNJ's missions are to: 1) provide public health education to reduce the risk of sudden infant death, 2) offer emotional support to bereaved families, and 3) participate in efforts to learn about possible causes of and risk factors associated with sudden unexpected infant deaths, best practices for providing safe sleep education and other risk-reducing messages and identifying systemic challenges and barriers. Research by SCNJ faculty has contributed to the identification of risk factors and risk-reducing strategies (i.e., Ostfeld et al. Pediatrics 2006; Ostfeld et al. Pediatrics 2010; Ostfeld et al. Pediatrics 2017).

The SCNJ develops novel safe sleep interventions and tools to educate providers and the public including parents, grandparents, physicians, nurses, the childcare community, hospitals, clinics, first responders, schools, social service agencies, home visiting programs, doulas, and faith-based communities. It works with state, federal, and national organizations to reduce infant mortality, the racial and ethnic disparities associated with SUID, and the adverse antecedent social and health determinants that increase vulnerability to unsafe sleep environments. These factors include poverty, smoke exposure, preterm birth, the absence of breastfeeding or human milk, preconception health challenges, inadequate or absent prenatal care, diminished access to pre-conceptional healthcare, implicit bias, and systemic racism. Disparities in these factors greatly contribute to disparities in rates independent of or in concert with non-supine sleep. For example, preterm birth increases the risk of SUID, rising to a five-fold greater risk for those born between 24 and 27 weeks of gestation (Ostfeld et al., Pediatrics, 2017). According to the March of Dimes Report Card, in NJ, the 2017-2019 preterm birth rate among Black women is 51% higher than the rate among all other women. Additionally, in NJ in 2020, 40% of Black NH compared to 20% of White NJ women did not receive adequate prenatal care, as determined by the Kotelchuck Methods (NJSHAD). The SCNJ's newly updated Infant's Bill of Rights promotes increased collaboration among the many public health programs that address these issues with the shared goal of reducing infant mortality. SCNJ follows the guidelines of the AAP when providing risk reduction education to help families reduce the situational risks that are associated with SUID.

Despite there being a high level of knowledge across population groups about safe sleep practices, racial disparities in placing an infant supine continue to exist in the U.S. and have been the subject of extensive study. Changing knowledge to action, therefore, is also the focus of the SCNJ and includes developing effective methodologies and identifying and resolving barriers to the dissemination of information. Community focus groups and discussions help facilitate these initiatives. Interventions are also designed to be respectful of generational, cultural, and community concerns in New Jersey's diverse population. In 2020, only 54.9% of families with postpartum Medicaid coverage usually placed their infant's supine to sleep, in contrast to 85.2% of those with private insurance. These disparities also were found for both non-Hispanic White and Black infants. Moreover, for those with Medicaid, the percentage of supine sleep in 2020 represented a decline in the already low compliance level of 63.2% found in 2019. The SCNJ works with provider systems to support the development and auditing of policies and procedures to promote effective education of parents, including continuing education of provider staff, and the review of education methods.

NJ SUID rates are among the lowest in the U.S. The NJ SUID rate declined from 1.13 per 1000 live births in 1990-1992 to 0.50 in 2018, the year prior to the COVID-19 pandemic. In 2019 the SUID rate was 0.53. However, in 2020, the first full year of the pandemic, the rate rose to 0.66. The U.S. rate and the majority of state rates with data that meet statistical reliability also experienced rising rates (NCHS and NJSHAD). However, even with this increase, the

NJ SUID rate in 2020 continues to fall well below the national rate of 0.92 and remains among the lowest in the US. NJ SUID rates for both Black NH and White NH infants also fall below their national counterparts. However, there are racial disparities in rates in NJ and the U.S. Similarly, although NJ's Black, NH, and White NH infants surpassed the NPM#5 goal from 2017-to 2020, racial and ethnic disparities in NPM#5 persist throughout the US and are addressed in NJ through targeted professional and community education projects by the SCNJ and by the home visitor staff in DCF and the MIEC Home Visiting Program whose staff receives training from the SCNJ. All initiatives address racial disparity in the application of safe sleep practices and the adverse antecedent social and health risk factors that affect SUID and contribute to the disparity. In 2020 and 2021, the SCNJ gave 141 presentations to over 17,000 attendees with recorded on-demand sessions adding additional views and developed and disseminated educational tools to enhance the transfer of knowledge.

NJ has participated in the Sudden Unexpected Infant Death Case Review (SUID-CR) Registry grant funded by the CDC since 2006. SUID-CR activities have standardized, and improved data collected at infant death scenes and promoted consistent case review, classification, and reporting of SUID cases. NJ TVP and SCNJ are represented on the multi-disciplinary SUID-CR Review Board, which meets monthly as a subcommittee of the Child Fatality and Near Fatality Review Board (CFNFRB). The SUID-CR is staffed by the DCF and is an important statewide surveillance system for unexpected infant deaths. The SUID-CR makes recommendations to the statewide CFNFRB concerning infant safe sleep and promotes SUID prevention activities which are included in the CFNFRB annual report.

Efforts by the SCNJ to further improvements in diagnostic coding are achieved through collaboration between the SCNJ and the Medical Examiner system. These include addressing potential coding concerns and working to make updates in a timely manner to meet deadlines for the inclusion of corrections by the NJSHAD or NCVS systems.

In 2018, the SIDS Center of New Jersey developed a unique and free app, SIDS Info, for iOS and Android devices to enhance the education of parents and providers about safe infant sleep and enable parents and others to have direct access to this information. This novel and interactive tool contains graphics, English and Spanish text, voiceovers to eliminate language and literacy challenges, and additional resources. It gives nurses, physicians, childcare specialists, caseworkers, home visitors, and other providers a new and standardized way of reviewing the information with parents. Providers also help families download the app to their phone, ubiquitous in all population groups, to serve as an enduring resource for a generation of parents familiar with accessing information in this manner. The app can reduce the need for print material, be efficiently updated, and be more accessible and enduring than print material. It also can be shared remotely with others caring for an infant. Under a "Keep It Up!" strategy, pediatricians are encouraged to review the app with families at well-baby visits to compensate for a decline in compliance over time. Rural communities and others with limited access to health resources and parents concerned about visiting healthcare providers during the COVID-19 pandemic can access this tool directly. SIDS Info, which received a Public Health Innovation Award from the NJDOH, has been accepted as a resource by the NICHD Safe to Sleep Campaign® and as an Emerging Practice in the Innovation Hub of the Association of Maternal and Child Health Programs. The app has been newly revised to include the 2022 AAP updates to the risk reduction guidelines. In 2019, the faculty of the SCNJ announced the release of a second app, Baby Be Well®, developed in collaboration with Rutgers University and volunteers of Microsoft. It is intended to extend interest in accessing the information throughout the first year through multiple design strategies, providing an additional resource to compensate for reductions in compliance over time. Other educational strategies used by the SCNJ include: webinars in English and Spanish for the public, provider groups, and community organizations, grandparent education through faith-based community programs, hospital-based staff education through its "Nurses LEAD the Way!" initiative and tool kit, a high-school education program with established efficacy to create trusted student ambassadors who inform their community, bespoke programs developed by data analytics to target local challenges, a baby onesie distribution program designed with safe sleep messaging for newborns, participation in the community-based outreach programs including Nurture NJ, and collaboration with hospitals in the development of novel education programs that can then be shared with other hospitals once efficacy is established. To make its flyers, other resources, and live and on-demand webinars directly accessible to the public, particularly in light of the in-person restrictions during the pandemic, the SCNJ posts them on its social media platform: https://www.facebook.com/SIDSCenterNJ/ and its website: www.rwjms.rutgers.edu/sids.

Annual Report – SPM #1 (The percentage of Black non-Hispanic preterm births in NJ)

The selection of SPM #1 (The percentage of Black non-Hispanic preterm births in NJ) during the Five-Year Needs Assessment process recognizes the persisting racial/ethnic disparities in healthy birth outcomes in NJ Infants born

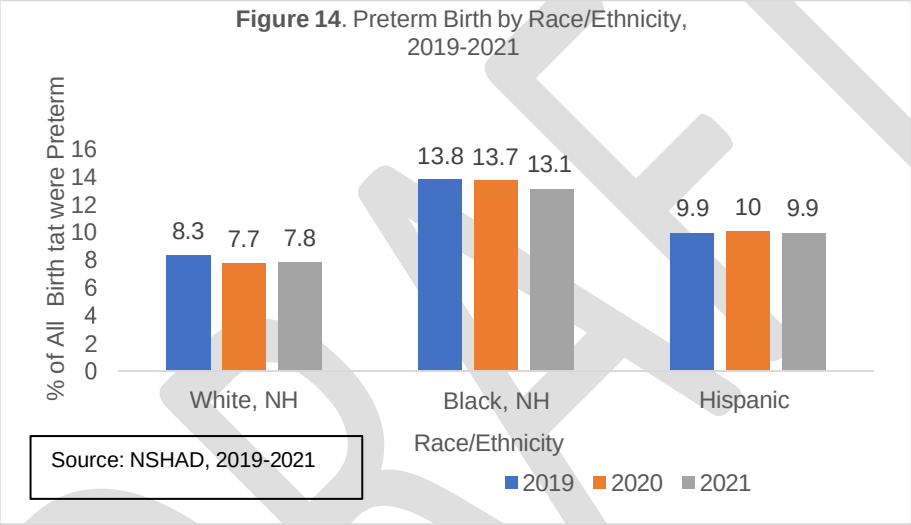
prematurely. Premature infants are at the highest risk for infant mortality and morbidity. The percentage of Black preterm births was selected to potentially address the underlying causes of Black infant mortality and the racial disparity between preterm birth rates.

The selection of ESM 5.2 (Promote referrals to evidence-based interventions aiming at reducing Black infant mortality) was selected for both SPM # 1 and 7.

Table SPM1 Percentage of Black, NH preterm births in NJ from 2009-2019

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Annual Indicator	12.7	12.8	13.3	13.3	13.6	13.1	13.5	13.8	13.7	13.1
Numerator	1,986	1,930	1,983	1,879	1,852	1,774	1,835	1,803	1,721	1,666
Denominator	15,692	15,064	14,864	14,169	13,634	13,530	13,643	13,043	12,587	12,743

Notes - Source - Birth Certificate data from the SHAD system
https://www-doh.state.nj.us/doh-shad/



Improving maternal and infant health and reducing Black, NH infant mortality is a priority within the NJDOH/FHS. Key maternal and child health indicators (including low birth weight, preterm births, and infant and maternal mortality) have not improved significantly over the last decade in New Jersey, and significant racial and ethnic disparities persist.

In 2021, preterm birth affected about 1 of every 10 infants born in the US. The preterm birth rate rose 4% in 2021, from 10.1% in 2020 to 10.5% in 2021. In 2021, NJ's preterm birth rate was 9.2%. However, racial, and ethnic disparities persist. In 2021, the preterm birth rates for White, NH, Black, NH, and Hispanic were 7.8%, 13.1%, and 9.9%, respectively (Figure 14). To address these disparities and reduce the preterm birth rates, TVP has partnered with the Maternal Health Innovation (MHI) Team to implement the Preterm Birth Prevention Program (PBPP). In collaboration with TVP staff, during SFY23, the PBPP accomplished the following:

1. Designed and launched a doula-focused survey to identify potential information barriers and opportunities for partnership.
2. Created new markers in the Perinatal Risk Assessment (PRA) to identify patients at risk for preterm delivery and began working on a self-service tool based on data pre-populated sections of the PRA.
3. Distributed 539 To-Go Kits with health monitoring tools (e.g., blood pressure cuffs, odometers), self-care resources, and health information referral pamphlets to patients with specific chronic conditions who have been identified as being at risk for preterm delivery.
4. Distributed over 3,330 flyers about clinical services to prevent preterm birth to providers, administrative staff, and birthing people across the State.
5. Between late September and December 2022, over 11 community events and one clinical leadership meeting focused on health risks for preterm delivery were delivered in NJ Communities. Additional events (including quarterly Clinical Leadership meetings) are currently being planned by staff for Spring 2023.

6. Began designing new educational workshops and whole-health events for birthing people with complex care needs (e.g., cardiovascular diseases, diabetes, hypertension, and chronic behavioral health needs) at risk for preterm delivery

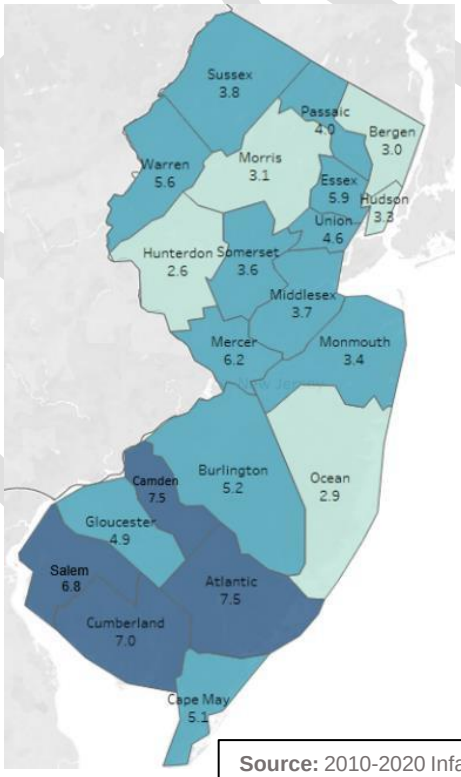
Annual Report – SPM #7 (The rate of Black Infant Mortality in NJ per 1,000 Live Births)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Annual Indicator	11.4	10.8	8.7	10.6	8.7	9.7	10.0	9.4	8.8	8.5	9.1
Numerator	182	168	136	159	129	137	136	127	120	111	114

Notes - Source - Birth Certificate data from the SHAD system
https://www-doh.state.nj.us/doh-shad/

In 2020, the Black, NH infant mortality rate in NJ was 9.1 compared to 2.5 per 1,000 Live Births for White, NH infants. The Hispanic infant mortality rate was 3.6 per 1,000 Live Births. Disparities exist between N.J. counties and municipalities in terms of Black Infant Mortality rates and other health outcomes. Counties such as Atlantic, Camden, Cumberland, Essex, and Warren have high Black Infant Mortality rates (Figure 15). Further investigation within these counties showed that certain municipalities were driving these high county rates, and therefore efforts within these municipalities are the focus of the HWHF initiative. To tackle these disparities, TVP implemented the HWHF in the communities.

Figure 15. infant Mortality by NJ Counties, 2010-2020



Source: 2010-2020 Infant Mortality Rate
Data: New Jersey State Health

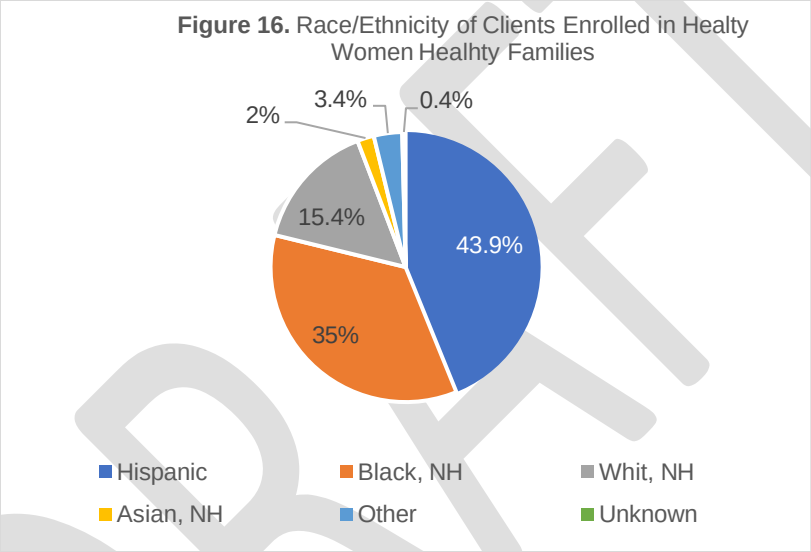
There are many potential causes of these disparities, but recent research has highlighted the effects of social determinants of health such as economic disadvantages (i.e., underemployment, or unemployment), limited education (e.g., low educational attainment), environmental barriers (e.g., housing instability, structural racism), and

social/behavioral factors (e.g., nutrition and exercise) as major contributors to health outcomes. Addressing these social determinants of health requires a comprehensive, system-level transformation that begins at the community level.

Since 2018, HWHF grantees have been implementing evidence-based activities that seek to reduce Black infant mortality and other disparities. These programs include:

1. Group prenatal care such as "Centering" provides women with a supportive forum and a longer visit with their health provider and/or their staff.
2. Doula program
3. Fatherhood initiative involves fathers during prenatal and interconception care and promotes family engagement.
4. Breastfeeding support groups for Black NH women.

From July 1, 2018, to – February 22, 2023, 2,123 BIM City Residents enrolled in the program to receive the services provided by TVP grantees. The HWHF mainly serves clients of Hispanic and Black, NH descent (Figure 16).



To better align the ESM with our current initiatives, ESM 5.4 (Number of individuals trained to become community-based doula) was selected. Through the New Jersey Doula Learning Collaborative (NJDLC), the professional home for community doulas in NJ, TVP seeks to reduce maternal and infant mortality and eliminate racial disparities in health outcomes. The NJ DLC provides training, workforce development, supervision support, mentoring, technical assistance, direct billing, and sustainability planning to community doulas and doula organizations throughout the State of NJ. The NJDLC focuses on developing and supporting the doula workforce that delivers doula care to NJ's Medicaid and CHIP members as enrolled NJ FamilyCare providers. The DLC recruited, trained, and certified first cohort of 18 Perinatal Community Health Workers (PCHW) to further support birthing individuals and potentially decrease the infant mortality rate. These PCHWs, also known as doulas, focused on helping birthing individuals navigate the healthcare system, accessing needed services, and improving adverse birth outcomes. The trained doulas provide equitable and culturally responsive care to pregnant people during pregnancy, birth, and postpartum, potentially lowering maternal and infant health complications rates. Multiple studies have shown that doula care can improve maternal and infant health outcomes; reduce preterm births and low birthweight infants; lower rates of cesarean sections; and increase rates of breastfeeding by amplifying pregnant people's voices and listening to their needs.

Application Year

Plan for the Application Year - NPM 4:
A) Percent of infants who are ever breastfed and
B) Percent of infants breastfed exclusively through 6 months

Efforts to promote Baby-Friendly Hospital Initiative (BFHI) designation through training, technical assistance, and mini-grants will continue to promote NPM 4. Surveillance through the Birth Certificate file and the mPINC survey will continue to identify areas of potential improvement.

The selection of ESM 4.1 (Increase Births in Baby-Friendly Hospitals) will monitor progress in promoting breastfeeding policies and practices in hospitals which should lead to an increase in NPM #4 (Breastfeeding). Many hospitals employ IBCLC and provide early support and information to breastfeeding mothers. However, it requires a commitment from the entire organization to implement supportive breastfeeding policies and practices.

The Breastfeeding Strategic Plan's primary purpose is to provide a roadmap to identify and foster policy, environmental, and system changes to increase breastfeeding initiation, duration, and exclusivity in NJ. Since the release, TVP staff has been actively involved in the committee and worked on materials to support the implementation of the strategic plan. TVP staff will remain involved in the implementation process of the strategic plan. WIC will continue to provide breastfeeding promotion and support services to pregnant and breastfeeding women who participate in the program.

Through HWHF, TVP will continue to fund multiple community-level organizations to implement breastfeeding education and training, primarily focusing on non-traditional audiences such as fathers, grandmothers, teens, etc. These breastfeeding education and training programs are given to increase the focus and support for breastfeeding success. The initiative aims to increase breastfeeding rates throughout the State with a high focus on Black mortality rates. Breastfeeding is known to have numerous protective factors for newborns and birthing parents. Increasing the rate of breastfeeding in marginalized and underrepresented groups will increase the likelihood of infants reaching their first birthday. CHWs are key stakeholders in educating birthing and new parents on breastfeeding.

CHW CLGI is monitored and evaluated by TVP staff. TVP staff will continue to implement breastfeeding training in partnership with the Perinatal Foundation. The breastfeeding education training for CHWs is a course designed to increase the basic knowledge of breastfeeding and cultural nuances as it pertains to breastfeeding in the Black community. The curriculum is taught using a reproductive justice and trauma-informed framework. Learners will acquire skills in the anatomy and physiology of lactation, counseling, troubleshooting common breastfeeding challenges and solutions, approaching the subject of breastfeeding, and more. Additionally, attendees will be educated on how to support breastfeeding in unique populations, including preterm birth and parents with special needs. The training consists of five modules that cover the Black Breastfeeding Experience, Global Health, the Influence of Formula, the Lactation Landscape, and Feeding Choice.

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

The public health interventions and activities depicted in the section pertaining to safe sleep through the SCNJ are supported through grant funding from TVP. TVP plays a key role in monitoring these activities and ensuring they play a key role in bettering infant health outcomes in NJ.

Compounding this challenge, during the pandemic, access to education about safe sleep, a critical compensatory behavior, also has faced barriers such as altered hospital lengths of stay, reduced home visits during and after pregnancy to uninsured families, and less access to health care. As an example of change driven by COVID, there was an increase in the percentage of preterm infants born at home, likely due to delays in affirming labor and/or concerns about potentially unnecessary trips to hospitals while COVID admissions were rising. The increase in SUID rates in 2020, both nationally and in most states with data that met statistical criteria for reliability, affirms that concerns had been warranted. In New Jersey, however, despite an increase in rates in 2020, the SCNJ's interventions delineated in this document in the PRAMS Data to Action Report contributed to keeping our State's overall and racial and ethnic-specific SUID rates among the lowest in the US. NJ's 2019 rate of 0.53 per 1000 live births (NJSHAD) or 0.51 (CDC WONDER) rose to 0.66 (NJSHAD) or 0.61 (CDC Wonder) but still fell well below the rising national level of 0.92 for 2020. Further, although the NJ non-Hispanic Black rate rose, in contrast to the rates for White NH and Hispanic infants, all continued to fall below the US rate for each group and were among the lowest rates compared to all states, with data meeting statistical reliability. However, although New Jersey's population

group rates compared favorably to national data and relative to other states, the concern remains that within the State, in the first full year of the pandemic, racial disparity in a measure of infant mortality grew.

Systemic, Institutional, and Cultural Challenges

Three factors are relevant in examining the next steps for intervention: 1) the need to better address the systemic challenges that disproportionately and disadvantageously affect well-documented health and social risk factors for SUID within the non-Hispanic Black population; 2) the need to correct through more committed policy and legislation the institutional loopholes that diminish the provision of comprehensive and consistent safe sleep education despite enduring efforts by public health programs charged with reducing the risk of SUID; 3) the need to further assess and address root causes in the well-documented disparities throughout the US in the adoption of back to sleep and other guidelines despite also well-documented awareness of these guidelines.

With respect to the first step, while it is beyond the SCNJ's scope of work to address larger social challenges, it does and will continue to participate in forums such as the Perinatal Quality Collaborative Health Disparities Work Group to bring attention to the role of these issues in elevating the risk of SUID and of disparities in rates. Structural racism, implicit bias, neighborhoods with higher crime, and greater food insecurity also affect outcomes. With respect to the second step, from 2020-2021, the SCNJ, funded by TVP, gave 141 presentations, reaching a provider and community audience of over 17,000. Many more were reached by the availability of post-presentation on-demand programming and through extensive multi-modal outreach and interventions developed by the SCNJ. However, to better understand possible barriers to succeeding, the SCNJ identified the populations at greatest risk and agencies that are critical to the risk reduction education of those populations. SCNJ issued data-based reports to identified groups and gave state, regional, and national presentations on these challenges. Moreover, they increased efforts to raise awareness and accountability within relevant systems as well as efforts to increase their collaboration in adopting solutions.

Families insured by Medicaid and families located in low-income, rural NJ communities are at the highest risk for many health and survival challenges, including SUID. In 2020, only 54.9% of families with postpartum Medicaid coverage usually placed their infant's supine to sleep, compared to 85.2% of those with private insurance. These disparities also were found for both non-Hispanic White and Black infants. Of even more concern for those with Medicaid is the percentage of supine sleep. The SCNJ has recommended and is working toward improving managed care policies and practices for safe sleep education and accountability regarding compliance with such policies and procedures. It also recommends improved compliance with providing continuing education for managed care medical and nursing staff. COVID has placed great demands on clinical staff in all healthcare systems, but these goals can help achieve necessary improvements in provider education of families and resulting improvements in infant care practices in the home.

In addition, the SCNJ will continue working with individual hospitals in higher-risk areas to develop staff and parent education programs. When efficacy is demonstrated, the SCNJ will provide the hospital with a platform for sharing the project, including in its annual SIDS Awareness Month programming. The SCNJ will continue to provide its education materials, including a small supply of back-to-sleep baby onesies, available in English and Spanish that families with limited resources particularly welcome. Efforts to underwrite additional onesies are being explored, as these items are reported to help engage the parent and nurse in a dialogue about safe sleep.

With respect to the third step, knowledge of risk factors does not automatically lead to changes in behavior or even to sustaining compliance over time. A large body of research has confirmed the enduring disparity in accepting some safe sleep guidelines and provided insights into the historical, cultural, and systemic bases for many of these decisions. The SCNJ will continue to apply this knowledge in its outreach programs and work with parents and communities to improve the acceptance of recommendations. Grandmothers and great-grandmothers often care for the family's newborn and carry influence in many populations. They come from a generation whose safe sleep guidance and cultural practices about infant care contradicted today's evidence-based information. Previous generations were advised to place infants prone to avoid choking, a concern not supported by evidence. Without the opportunity to learn about the latest information, well-intentioned grandparents may not support what their adult children are doing regarding using safe infant sleep practices. "I put all of my babies to sleep on their tummies, and they were just fine." is an often-repeated comment that underscores the challenge in public health education. Non-compliance with evidence-based recommendations, such as dietary advice, exercise, seatbelt wearing, and back to sleep, does not automatically elicit the worst-case outcome. Thus, behaviors that are not recommended appear benign in the absence of consequences. Reaching grandparents thus becomes an essential part of the educational

mission. The SCNJ will continue to attempt to educate grandparents through presentations to faith-based communities and emerging collaboration with healthcare providers who serve them.

Interventions and Tools

The work of the SCNJ is supported through grant funding from TVP. In addition to the systemic approaches described, plans for the coming year to promote safe infant sleep include continued education through the SCNJ, MIEC Home Visiting Program, and the Sudden Unexpected Infant Death Case Review Workgroup, including representation by the SCNJ. Staff from the MIEC Home Visiting Program have all been trained by the SCNJ and will promote the infant safe sleep message during their visits to over 7,000 families annually in NJ. The SCNJ is now planning a new cycle of staff education. The SCNJ's baby onesies with back-to-sleep messaging will be provided to a portion of home visitors and hospitals, and resources are being sought for more. The SCNJ is also working with the NJ's new Universal Nurse Home Visiting Program to ensure that safe sleep education is supported in their curriculum. Doulas and Midwives will also continue to receive safe sleep education. Outreach education to the Division of Child Protection and Permanency, Licensed Child Care, the Federally Qualified Health Centers, and the many providers' groups, institutions, and organizations that work to improve outcomes and partner with the SCNJ will also continue. During the pandemic, the rise in clinical needs created a challenge for setting up education programs within clinical settings. The expectation is that access will improve, and the pandemic will abate.

The SCNJ will continue to identify and address community-level risk factors and barriers to compliance. Results from focus groups and survey findings from a broad spectrum of parents will continue to support these efforts. The SCNJ education programs address provider knowledge of safe sleep practices, skills for educating families and identifying barriers, and an understanding of the impact of adverse social and health determinants and implicit bias in elevating the risk of SUID and racial disparity. When addressing such adverse social and health risk factors as smoking and preterm birth, the SCNJ conducts research to assess impact and opportunity. It works closely with relevant public health, social service, and healthcare systems and programs such as the NJ Perinatal Quality Collaborative Health Disparities Work Group and Mom's Quit Connection- a program meeting the needs of families who want to stop smoking to develop additional strategies.

New initiatives are being planned around newly published national research by the SCNJ (Ostfeld BM et al. Journal of Perinatology, 2022), which determined that smoking through all 3 trimesters of pregnancy elevates the risk of SUID fivefold. That continuation of smoking throughout pregnancy among those who smoke is by far the most common pattern for both White, NH, and Black, NH populations. The SCNJ also continues to develop direct public education methods, such as through SIDS Info, its free mobile phone app, and social media platforms, and work with community groups to ensure relevance.

During the pandemic, families' direct access to this information was essential. SCNJ will continue to disseminate educational tools via free mobile phone apps, on-demand and live webinars and baby clothing adorned with safe sleep messaging. The material dissemination will be done in multiple languages.

The SCNJ has updated SIDS Info to include the new 2022 American Academy of Pediatrics inclusions to its risk reduction guidelines. It will continue to be available in English and Spanish with voice-over to overcome literacy challenges. A new awareness campaign accompanies this tool's relaunch that providers have found valuable in discussing safe sleep and that families have found helpful in retaining and sharing the information. Intended for NJ, it is in use in other states, as well. Funding for the SIDS Info app was derived from health services grant from the TVP to the SCNJ. In 2019, a second free educational app, Baby Be Well®, was developed by SCNJ faculty via a collaboration between Rutgers University and volunteers of Microsoft Corporation and designed to stimulate return visits throughout the first year of life to compensate for a decline in the use of safe sleep over time. Both apps were accepted into the Emerging Practice section of the Association of MCH programs.

The SCNJ also identifies risk factors more likely to be associated with specific age clusters in the first year of life, such as Sudden Unexpected Postnatal Collapse in the first days after birth and creates programs to highlight and address these. In this case, the initiative will reinforce the importance of hospital policies for supervised skin-to-skin care during this period. SCNJ programs are directed to institutions (i.e., schools, hospitals, clinics, hospital grand rounds programs, public health programs), organizations (i.e., WIC, HWHF grantees, NJAAP, Maternal, and Child Health Consortia, Nurture NJ), providers (i.e., pediatricians, obstetricians, nurses, social service providers, home visitors, clergy, community workers, doulas, first responders), and the public (i.e., baby fairs, community programs). The SCNJ will continue to work closely with the Medical Examiner system to address issues related to coding. An emphasis will be placed on those recently identified in a national study wherein SUID codes were used for extremely

preterm infants dying proximate to their birth (Ostfeld & Hegyi, Society for Pediatric Research 2022). When needed, timely updates must meet the inclusion deadlines of NJSHAD and NCVS to maintain accuracy on SUID rates.

The SCNJ will continue to work with and survey local communities to identify barriers to families receiving education. In higher-risk communities, a high-school student ambassador for a safe sleep program developed by the SCNJ was found effective, thus supporting plans for broader adoption. While this initiative was delayed during the pandemic due to the challenges faced by public schools, it is being considered a new project. SCNJ activities also include participation in implicit bias initiatives and inclusion of this topic in its education programs. The SCNJ has updated its Infant's Bill of Rights to serve as a framework that can potentially address the risk factors in addition to safe sleep that both the AAP guidelines and a large body of research support as contributory.

Receiving education from a trusted provider, such as a physician or nurse, increases parents' retention and application of the information. The SCNJ will continue working closely with provider groups and their relevant organizations and training programs. The SCNJ educates hospital nurses, who play a key role in modeling and teaching about safe sleep. The SCNJ provides a hospital-based program, Nurses LEAD the Way, by presenting at hospital-level and regional nursing conferences and meetings and communicating through other venues such as listservs, live and on-demand webinars, and e-blasts. A return to on-site rather than virtual presentations is now possible. The SCNJ works with all three maternal and child health consortia to reinforce safe sleep messaging within their member hospitals. In addition to providing education, the SCNJ makes educational scripts, videos, and hospital safe sleep audit protocols to aid in identifying and addressing potential barriers to compliance. Moreover, SCNJ developed electronic and hard copy educational materials that are translated into English, Spanish, Haitian-Creole, Farsi, Arabic, and Portuguese. Dari has been added to serve Afghan refugees. Many of the SCNJ resources, including live and on-demand webinars, Frequently Asked Questions, a short video, information about its free safe sleep apps, and flyers in multiple languages, are tools that can be accessed from the SCNJ social media site: https://www.facebook.com/SIDSCenterNJ/ and website: www.rwjms.rutgers.edu/sids. Information about these resources will continue to be widely disseminated.

The SCNJ's resources are also disseminated through collaboration with its many partners. The SCNJ will continue to form partnerships with community-level programs. The SCNJ will continue to study SUID and report findings in academic venues and community settings as warranted. These findings will inform interventions.

Outreach to providers continues to grow and now includes education for obstetricians and pediatricians. Obstetricians and gynecologists serve a critical early window of opportunity for risk reduction by educating families about safe pregnancy practices for lowering the risk of SUID, such as avoidance of household smoke around the pregnant woman and growing concerns about vaping. Gynecologists also can serve as a conduit of information on risk reduction practices for grandmothers.

In all its outreach, racial and ethnic disparities in adverse antecedent social and health determinants that contribute to disparities in rates shall continue to be addressed by the SCNJ. Such determinants include preterm births, diminished access to care, poverty, high neighborhood crime, exposure to second-hand smoke, a significant contributing factor rising to the level of causality, and other unsafe environmental conditions. Individually and collectively, they create an infant more vulnerable to unsafe sleep practices. In addition, implicit bias and structural racism contribute to disparities, raising stress levels and reducing participation in health care. A survey conducted by the Robert Wood Johnson Foundation and others determined that 22% of African Americans avoid healthcare in anticipation of racism. The SCNJ will continue focusing on these broader issues and working toward best practices for increasing the provision of and compliance with safe sleep practices.

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

In partnership with the Maternal Health Innovation (MHI) team and the NJ MCQC, TVP will continue to co-lead multiple activities aiming at reducing preterm birth rates of untimely death for non-Hispanic Black and Hispanic infants. Through the Preterm Birth Prevention Program (PBPP), TVP staff, in collaboration with key stakeholders, will create, disseminate, and evaluate provider-specific resources on preterm birth prevention for identified patients. They will convene multidisciplinary meetings with stakeholders to assess the challenges, opportunities, and overall impact of identified preterm birth prevention services and resources. They will use data from varying sources and improve timely information sharing to support and identify patients in need of preterm birth prevention services. They will distribute and provide information about preterm birth prevention

services and resources. Lastly, they will compile data from activities for recommendations, reports, and presentations to NJDOH leadership and partners. Moreover, TVP, in collaboration with MHI, will continue to support the design of new educational workshops and whole-health events for birthing people with complex care needs (e.g., cardiovascular diseases, diabetes, hypertension, and chronic behavioral health needs) at risk for preterm delivery.

Plan for the Application Year SPM 7 (The rate of Black Infant Mortality in NJ)

The HWHF Initiative will continue to develop partnerships with community-based maternal and child health providers/agencies with proven capabilities in implementing activities/interventions within a targeted community and the ability to focus on reproductive-age women and their families. As support for BIM reduction programs in targeted BIM regions continues to evolve, in the state fiscal year 2024, the HWHF initiative will also focus on postpartum care through the novel postpartum doula care. Moreover, through the HWHF initiative, TVP will provide evidence-based lactation education to birthing individuals and their social network (e.g., fathers, grandparents, siblings, etc.). The DLC will continue to train community doulas and educate them on how to enroll in NJ FamilyCare Medicaid fee-for-service and the Managed Care Organization's process to become Medicaid providers. The DLC will continue to provide training, workforce development, supervision support, mentoring, technical assistance, direct billing, and sustainability planning to community doulas and doula organizations throughout the State of NJ.

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Child Health

Annual Report

The domain of Child Health includes the State Priority Needs of #3 Improving Nutrition and Physical Activity and the selected National Performance Measures of #6 Developmental Screening. NPMs #6 was selected during the Five-Year Needs Assessment process for their impact on overall child health and wellness and the evidence-based strategies that NJDOH and its partners implemented.

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

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

	2011-2012	2016	2017-2018	2018-2019	2019-2020	2020-2021
NPM 6: Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool	25.02	32.9	36.1	36.4	36.9	34.8

Source – National Survey of Children's Health (NSCH)
https://www.childhealthdata.org/browse/survey/results?q=9597&r=1

Developmental screening is a required benchmark performance measure for the NJ MIECHV Program. Improving developmental screening practices and policies is an ongoing focus of Home Visiting's continuous quality improvement activities. The NJ MIECHV Program promotes and monitors parents who have completed the child development screening tools (ASQ and ASQ: SE). In SFY 2022, 5,628 NJ MIEC Home Visiting families with young children participated in a parent-led developmental screening across all 21 NJ counties.

The NJDOH, through TVP, is an active interdepartmental partner with the NJ Council for Young Children (NJCYC), the Preschool Development Grant: Birth to Five (PDG B-5), the CDC's NJ "Learn the Signs. Act Early." (LTSAE) Ambassador (housed at the SPAN Parent Advocacy Network and is also NJ's AMCHP Family Delegate), and the NJCYC Infant Child Health Committee (ICHC) that has established a priority of improving system connections for children and families with health care providers, community services, early intervention, child care, home visiting, and early care & education settings.

Improvements in early childhood systems continued through the NJ Early Childhood Comprehensive System (ECCS) and Collaborative Improvement and Innovation Network (CoIIN). The focus remains to create universal access to evidence-based developmental screening through the early childhood Connecting NJ (formerly known as Central Intake) system (Help Me Grow Central Access point). Connecting NJ supports linkages and access to programs and services for families within their community. The NJ LTSAE Ambassador activities focus on promoting family-engaged developmental monitoring and screening and referral and connection to services through trainings, presentations, and materials distributed across the state. As the State Parent Lead for the ECCS Impact CoIIN and MIEC Home Visiting programs, the LTSAE Ambassador activities also focus on the priorities of the NJCYC ICHC and support the teams with accessing LTSAE materials as well as with family-engagement activities. NJ's Child Developmental Passport, created in collaboration between the NJ LTSAE Ambassador at SPAN and the ECCS CoIIN team (available in English & Spanish), includes a developmental tracker to empower parents to track their child's developmental screening information.

The NJ LTSAE Ambassador also led the LTSAE COVID Response Project activities (July 2020- September 2022) that focused on supporting developmental health promotion and resilience-building activities for families impacted by the pandemic. Through this work, trainings, and support were provided to families, the statewide networks of Family Success Centers, pediatric practices participating in the NJ Reach Out and Read program, Community Health Workers participating in the CLG-CHW Institute as part of their CHW ECHO sessions,

Federally Qualified Health Centers, and Family Engagement Specialists at County Resource & Referral Agencies (CCR&Rs), among others. Presentations were provided at various statewide meetings - Community of Care Consortium, Infant Child Health Committee Meeting, NJDOH/NJDCF Partnership for Families Grantee Meeting, Governor's Council on the Prevention of Developmental Disabilities, etc. Additionally, a Developmental/Resilience toolkit was developed to provide resources for supporting the developmental health and resiliency of children ages 3-5 and their families. The toolkit aims to build resilience in children by strengthening the knowledge of parents/caregivers about the following:

- Parenting
- Child development
- Social connections and networks of support
- Social and emotional competence of children

The toolkit also includes children's books (from the CDC and recommended by NJ Reach Out and Read program) and a hands-on craft activity. Many resources in the Developmental/Resilience toolkit are available in English and Spanish, and some are also available in Brazilian Portuguese, Simplified Chinese, and Haitian Creole: https://spanadvocacy.org/act-early-resilience-toolkit/

In addition, the CDC's Milestone Tracker App and the Milestones Matter Learning module are embedded in the NJ WIC Shopper App and available for families receiving WIC services to support the developmental monitoring of their young children. Through a technical assistance grant from the CDC and the Association of State Public Health Nutritionists (ASPHN), and in collaboration with the LTSAE Ambassador at SPAN, NJ WIC is piloting the Milestone Checklist program at 3 WIC clinics in Ocean County. Before implementation, the NJ LTSAE Ambassador provided an overview of the resources and information WIC staff can share with families who complete the milestone checklist during their WIC clinic visits. Act Early materials, including NJ's Child Developmental Passport, VROOM/Milestones Matter posters, the Developmental/Resilience Toolkits, and customized versions of the CDC's Children's Books in English and Spanish, were also made available for dissemination to families.

Additionally, SPAN Parent Advocacy Network, in collaboration with the NJ Chapter of the American Academy of Pediatrics on the Early Identification and Referral for Autism (EIRA), developed an ECHO project. The ECHO project provided education to pediatric practices on early identification, referral, and care coordination of children with ASD. SPAN is also collaborating on a project with the NJ site for the Autism & Developmental Disabilities Monitoring (ADDM) Network to promote awareness about the importance of parent-engaged developmental monitoring and the early identification of ASD using a validated screening tool in the Newark area.

The selected ESM 6.1 will monitor progress on increasing parent-completed early childhood developmental screening using an online ASQ tool. It will also monitor how well early childhood developmental screening is promoted across the Departments of Health, Children and Families, Human Services, and Education, which will drive improvement in NPM #6 (Developmental Screening). NJ DCF, in collaboration with TVP at NJDOH, implements Early Childhood Comprehensive Systems Prenatal through Three grant that focuses on enhancing the early childhood system. This iteration has focused on health integration and promotion of the coordinating system of care of families of young children and creating greater awareness with health providers as they support families with young children. The previous iteration of ECCS (Impact) focused on 5 communities to test and scale up developmental health promotion and parent-completed early childhood developmental screenings in children under 3 years old.

The ASQ Enterprise software (Brookes Publishing) is being utilized to add a parent/family portal for easy access to developmental screening and links screening to Connecting NJ hubs. NJ's expanded data system links developmental screenings with all 21 Connecting NJ hubs to enhance the engagement of families not connected to early childhood services/programs. This expansion of the data system could potentially be engaged and linked for additional services and supports as identified, including developmental needs as determined by the completed ASQ. Families receive support and referrals to an array of services, for instance, pediatric primary care and/or other systems partners, including home Visiting, Healthy Women Healthy Families Community Health Workers, and/or other service providers as determined by the family and their needs/interests. The referrals and connections provided through the extend to quality Child Care, Early Head Start/Head Start, and Preschool programs. In FY22, the Connecting NJ hubs maintained developmental health promotion, screening, and linkage. There were 1,382 screens completed through the Connecting NJ hubs via the Brookes Publishing Family Access Portal for children 2 months to 60 months. Below is a chart outlining the percentage of children reached by age domain for FY20, 21, and 22.

ASQ- Family Access Portal Screens completed	FY 20	FY 21	FY 22
Total # of screens	1689	1107	1382
Age of Child	**%**	**%**	**%**
2-12MO	35%	35%	25.9
13-24MO	18%	22%	26.9
25-38MO	16%	19%	21.8
39-50MO	20%	13%	14.9
51-66MO	11%	11%	10.5

Application Year

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

The NJDOH will continue to participate as an active interdepartmental partner with the NJ Council for Young Children (NJCYC), the Preschool Development Grant Birth to Five (PDG B-5), CDC's NJ "Learn the Signs Act Early (LTSAE)." LTSAE Team and the NJ CYC Infant Child Health Committee (ICHC). The ICHC has prioritized improving system connections for children and families with health care providers, community services, early intervention, childcare, home visiting health care, and early care and education settings to support overall child development and well-being. The NJ ECCS Impact CoIIN work informs potential improvements in early childhood systems, focusing on creating universal access to evidence-based developmental screening. The Connecting NJ system (Help Me Grow Central Access Point) supports linkages and access to programs and services for families within their community.

The Early Childhood Comprehensive System (ECCS) Impact grant ended in July 2021. Through the newly awarded ECCS Health Integration Prenatal to Three grant, NJ DCF, in partnership with TVP at NJ DOH, will continue to maintain and improve upon the Connecting NJ System. NJ DCF and TVP at NJ DOH will continue to partner with the NJ's LTSAE Ambassador program, which has activities focusing on promoting parent-engaged developmental monitoring and screening and referral and connection to services through trainings, presentations, and materials distribution across the state. The State Parent Lead for the ECCS and MIEC Home Visiting programs is the LTSAE Ambassador and supports the teams with accessing LTSAE materials and with family-engagement activities.

In FY24, plans to update LTSAE materials with NJ's information on the updated CDC milestone format are being explored. Funding to support these activities is being sought. In the meantime, the general LTSAE tools will continue to be utilized. In addition, the CDC's Milestone Tracker App is embedded in the NJ WIC Shopper App to support the monitoring of children receiving WIC services. The Boggs Center on Developmental Disabilities, NJ's federally designated University Center of Excellence on Developmental Disabilities, the Statewide Parent Advocacy Network (SPAN), the state's federally-designated Parent Training and Information Center (PTI), and Family to Family Health Information Center (F2F) and the Boggs Center on Developmental Disabilities, NJ's federally-designated University Center of Excellence on Developmental Disabilities collaborated on the Act Early State Systems Grant with the shared goal of LTSAE COVID Response Project with the goals to:

a. Bolster the 4 steps of early identification of developmental delays and disabilities: 1) Parent-engaged Developmental Monitoring 2) General developmental and autism screening 3) Referral for early intervention services 4) Receipt of early intervention services for children birth to 5
b. Advance the promotion and distribution of existing, relevant tools, materials, and programs to improve resiliency among families with young children during COVID-19 response and mitigation efforts.

Through the new iteration of ECCS P-3, the intentional focus is being given to the pediatric provider community to promote developmental health and monitoring utilizing the LTSAE tools. The ECCS P-3 Team will continue these plans through the Physician provider outreach and engagement group to work on protocols to strengthen connections with the pediatric provider network to Connecting NJ. The different engagements and protocol development will support the needs of their pediatric patients for services and promote developmental well-being (such as Home Visiting, HWHF, CHWs, Early Education, etc.). The NJ ECCS P-3 team will support the Connecting NJ system in sustaining developmental health promotion and screening activities.

SPAN will continue to collaborate with the NJ Chapter of the American Academy of Pediatrics on the Early Identification and Referral for Autism (EIRA) ECHO project to educate pediatric practices on the early identification, referral, and care coordination of children with ASD. SPAN is also collaborating on a project with the NJ site for the Autism & Developmental Disabilities Monitoring (ADDM) Network to promote awareness about the importance of parent-engaged developmental monitoring and the early identification of ASD using a validated screening tool in the Newark area.

Grow NJ Kids (GNJK), a Quality Improvement Rating System (QRIS) developed for early learning programs, requires the use of a "state-approved" developmental screening at Level 2 of a 5-level rating. The Implementation of a parent/family portal for easy access to parent-completed early childhood developmental screenings in children < 3 years old through the ECCS P-3 grant is ongoing. The parent/family portal will permit monitoring of ESM 6.1 (Promote parent-completed early childhood developmental screening) and promote improvement in NPM #6.

NJ has completed significant work to create an aligned early childhood data system through the NJ Enterprise Analysis System for Early Learning (NJ-EASEL). The NJ-EASEL project currently links DOE Statewide Longitudinal Data System (NJ SMART), County/District/State (CDS) reference data, and DHS childcare subsidy data (CARES). NJ-EASEL is in the process of integrating DOH birth record data (EBF/VIP) and data from two DCF Home Visiting systems, Healthy Families (FAMSys) and Parents as Teachers (PATSys).

In future phases, NJ-EASEL plans to integrate DCF childcare licensing information (LIS), DHS Workforce Registry (NJ Registry for Childhood Professionals, a component of the Grow NJ Kids data system), DHS Grow NJ Kids data, DOE staff/workforce data (NJ SMART), DOH Early Intervention System (NJEIS), DOE assessment data (Title 1), DHS cash and food stamp assistance data (FAMIS) and DCF foster care system, and other states early learning and development data collections within the parameters of state and federal privacy laws.

The NJ-EASEL project measures outcome objectives initiated through the Race to the Top Early Learning Challenge RTTT-ELC grant. The NJ-EASEL project shows that early developmental screening directly impacts identifying children and referring them to needed services resulting in positive outcomes for children. The NJ-EASEL integrated data warehouse will serve as the repository through which collected data informs the quality improvement and outreach activities "managed" by GNJK. Overall, NJ-EASEL enables program administrators to provide increased access to high-quality early care and education programs and professionals for NJ's children and families. NJ-EASEL will continue to provide visibility of the collaboration and coordination among Early Childhood Care and Education programs across agencies through the linkages and crossover reports of these programs for participating children.

Adolescent Health

Annual Report

The domain of Adolescent/Young Adult Health includes focuses on NPM #9: Bullying (Percent of 9-12th graders who reported being bullied on school property or electronically bullied), NPM #11 (Percent of children with and without special health care needs having a medical home) and NPM #12 (Percent of children with and without special health care needs who received services necessary to make transitions to adult health care). Considering that the reporting on NPM #11 and #12 overlap the two domains of Adolescent/Young Adult Health and SCHCN, the narrative for NPM #11 and #12 will be presented in this Adolescent/Young Adult Health section and not repeated in the CYSHCN Section. This section serves as the State's narrative plan for the Annual Report and the Application year. Planned activities for the Application year are described, and programmatic efforts have been summarized for the Annual Report year, with primary emphasis placed on the performance impacts achieved. The strategies and activities to address the identified priorities from the Needs Assessment Summary are further described.

Annual Report - NPM #9 (Bullying)

Improving NPM #9 (Bullying) is an important measure in the domain of Adolescent/Young Adult Health (AYAH) and is related to SPN #4, Promoting Youth Development, and SPN #5, Preventing Teen Pregnancy. Bullying can impact both short and long-term physical and emotional health in adolescents and young adults. Bullying can lead to physical injury, social problems, emotional problems, increased risk-taking behaviors, and death. Bullied teens are at increased risk for mental health problems, have problems adjusting to school, and are connected to absenteeism. Bullying also can cause long-term damage to self-esteem.

The selection of ESM 9.1 (Reduce the percentage of high school students who are electronically bullied) and ESM 9.2 (Reduce the percentage of high school students who are bullied on school property) monitor progress in reducing bullying that takes place on social media and in-person at school which should lead to a decreased the percentage of 9-12th graders who reported being bullied on school property or electronically bullied NPM #9.

Through the CAHP, multiple efforts are made to decrease bullying in schools and build the social-emotional learning (SEL) competencies of both bullies and bullied youths. Building youth's capacity for self-awareness, social awareness, self-management, relationships, and decision-making helps build the core skills teens need to refrain from bullying others and bounce back when they are bullied.

According to Collaborative for Academic Social and Emotional Learning (CASEL), these skills allow children to calm themselves when angry, initiate friendships, resolve relationship conflicts respectfully, and make ethical and safe choices. To develop these capacities, children need to experience safe, nurturing, and well-managed environments where they feel valued and respected; and have meaningful interactions with others who are socially and emotionally competent; and receive positive and specific guidance.

Bullying is a learned behavior that often starts at home. It is learned from older siblings, extended family, and parents and then transferred to school behaviors. Youth who are bullies are at increased risk for substance use, academic problems, and violence to others later in life. Teens who are both bullies and victims of bullying suffer the most serious effects of bullying and are at greater risk for mental and behavioral problems than those who are only bullied or bullies. To tackle the bullying problem, CAHP implements multiple parent engagement programs that help parents better understand and support their teens. Connection to a supportive adult has been associated with decreased drug use, delayed initiation of sex, and fewer suicide attempts in teens. Key risk factors for teen decision-making include family-related protective factors such as positive values and norms expressed and modeled by family members and other trusted adults and feelings of connection to groups that encourage responsible behaviors. Teen Speak, one of the parent engagement programs implemented via CAHP, offers skill-building workshops for parents and other supportive adults to help foster critical intergenerational connections and build protective factors in the home and community. Through short, multimedia workshops focused on improving adult-teen communication and in-person facilitated sessions where parents and caregivers can practice new techniques to engage their teens; Teen Speak seeks to reduce harmful behaviors and build strong family relationships. Teen Speak also collects data from participants via pre-surveys, polls during lessons, and a post-retrospective survey. Since 10/01/22, CAHP grantees have offered 5 cohorts of Teen Speak, engaging over 100 parents and caregivers with plans to offer another 6-10 cohorts through the Spring and Summer. In 2023, CAHP will release an RFA for Statewide Parent and Professional Engagement (S-PEP) to create a centralized space for parents, caregivers, and professionals to access Teen Speak and MITEY Change (for professionals). Ideally, this will expand and streamline access to parent/caregiver and professional education to better care for adolescents in NJ.

In addition to engaging teens and parents directly, youth-serving professional capacity must be improved at the school and community-based level. There is a strong connection between bullying and mental health, and the National Institute of Health and Human Development (NICHD) research studies show that anyone involved with bullying—those who bully others, those who are bullied, and those who bully and are bullied—are at increased risk for depression. NICHD-funded research studies also found that, unlike traditional forms of bullying, youth who are bullied electronically—such as by computer or cell phone—are at higher risk for depression than those who bully them. Even more surprising, the same studies found that cyber victims were at higher risk for depression than were cyberbullies or bully victims (i.e., those who both bully others and are bullied themselves), which was not found in any other form of bullying. These findings are in the NICHD news release: Depression High Among Youth Victims of School Cyberbullying, NIH Researchers Report.

CAHP and CAHP grantee staff have been trained in multiple approaches to working with our most vulnerable youth. They attended: comprehensive training in suicide prevention and safe messaging, mindfulness, youth mentoring, youth-adult partnering, cyber-bullying, effective use of social media, LGBTIAQ inclusivity training, and an intensive Transgender 101 train the trainer, social and emotional learning (SEL) and trauma-informed care (TIC). Training and technical assistance (TA) occur quarterly. They are required for all PREP, SRAE, and School Health program grantees but are open to all CAH Programs and Program Partners, including schools and community-based organizations where CAH programs operate.

In November 2020, NJDOH was awarded a Garrett Lee Smith (GLS) Tribal/State Youth Suicide Prevention Grant. In addition to providing training and education for suicide prevention, screening, and treatment to youth-serving professionals, the GLS grant will launch a statewide implementation of Lifelines Trilogy, comprehensive suicide prevention, intervention, and postvention program. GLS is a 5-year grant that will fund at least 3 school districts annually to implement Lifelines Trilogy, reaching at least 7,500 school faculty and staff, 30,000 students, and 15,000 parents and caregivers by 2025. As stated above, in 2023, the CAHP will add MITEY change as a program offered to youth-serving professionals in NJ.

Through a comprehensive approach aimed at building skills, competencies, and capacity of teens, parents/caregivers, and youth-serving professionals, the CAHP seeks to decrease bullying and increase resilient responses to bullying in our schools and communities. The most recent program added to the CAHP roster is Lifelines Trilogy, a comprehensive suicide prevention program with a 5th through 12th-grade curriculum. The curriculum is grounded in SEL and focuses on the importance of asking for help. Three schools have completed training and begun the student curriculum. Thus far, 452 5th and 6th, 188 7th and 8^{th,} and 158 11th and 12th graders have received the curriculum. Pre and post-test data is being analyzed and will be available in next year's annual report.

SPN # 6 (Reducing Teen Pregnancy)
Annual Report SPM 6 (TOP program, Reducing the Risk, and Teen PEP completion)

Simultaneously, to satisfy SPN # 6-Reducing Teen Pregnancy, TVS has selected ESM 9.1 (ESM 9.3: Number of females aged 10-19 who give birth), which monitors progress in reducing teen pregnancy in NJ. The CAHP has adopted the Teen Outreach Program (TOP®), Love Notes, Reducing the Risk, and Teen PEP, all evidence-based models (EBM) proven to reduce teen pregnancy. From 10/1/22 - 3/1/23, 1,889 students have been actively engaged in the EBM's indicated (This represents an incomplete program year which ends 9/30/23). The CAH Programs link teens from diverse backgrounds and groupings within schools and facilitate dialogues that encourage teens to be introspective, connect with their peers, partner with adults, and participate in bettering their communities. Data is collected for all EBMs implemented via pre- and post-surveys delivered to participants that measure sexual health behaviors such as using birth control, barrier contraceptives, and delaying/abstaining from sexual activities. In addition, SEL questions regarding bullying behaviors, teen connectedness, and resiliency are also measured. Improved SEL is also linked to improved decision-making and healthy relationships and contributes to reducing teen pregnancy.

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

Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventative care and immunizations. They are also less likely to be hospitalized for preventable conditions and are more likely to be diagnosed early for chronic or disabling conditions. The American Academy of Pediatrics (AAP) specifies seven

qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Ideally, medical home care is delivered within a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child, the family, and the child's health history. The Maternal Child Health Bureau (MCHB) uses the AAP definition of medical home. CMUs continue to link families to medical homes and document within the Case Management Referral System (CMRS) all seven qualities essential to medical home care.

CYSHCN, with a medical home, has been a priority for the FCCS program and has been supported by several partnerships and collaboratives. Having a primary care physician service identified in a child's ISP developed with a case manager served as a medical home proxy beginning with 2014 reporting. As part of the Medical Home grant, FCCS and its partners developed a Shared Plan of Care (SPoC), a document meant to increase care coordination for CYSHCN. This additional component was added to the medical home proxy with 2017 reporting continued today for ESM 11.1. While a medical home is more comprehensive than just having a primary care physician, it is also imperative for a child to have consistent health insurance to increase access to the provider. Of the 15,619 children aged 0 to 18 years served in SFY 2022, 42.5 % had a primary care physician and/or SPoC documented. Of those children, approximately 54% had insurance identified in their ISP, which remains similar to the prior year. The percent of CYSHCN ages 0-18 years served by CMUs with a primary care physician and/or SPoC has been selected as ESM 11.1. The annual state performance indicator below has consistently exceeded the annual objective since 2019: (37.9% vs. 37% in 2019, 40.8% vs. 38% in 2020 and 40.1% vs. 39% in 2021, and 40% vs. 40.6% in 2022).

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

	2017	2018	2019	2020	2021	2022
Annual NPM #11 Indicator	34.7%	34.7%	37.9%	40.8%	40.1%	40.6%
Numerator	7,616	7,039	6,654	6,503	5,783	6,347
Denominator	21,944	20,276	17,542	15,919	14,407	15,619
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional	Provisional

*****Note: Data above reflects CYSHCN ages 0-18 years served by Special Child Health Services Case Management Units with a primary care physician and/or Shared Plan of Care.
Data Source - The New Jersey Special Child Health Services, Family Care Center Services

While SCHS data only include children with special health care needs who live in NJ and participate in our case management system, our findings are not different from those of the National Survey of Children's Health (NSCH). NSCH estimates the percent of children with and without special health care needs having a medical home (NPM 11). For the combined years of 2019-2020, 40.8% (n=296) of children with special health care needs are estimated to have a medical home. Although New Jersey does not collect data on children without special health care needs, the National study does estimate that 47.5% (n=1078) have a medical home.

For many CYSHCNs, a specialty provider often serves as the child's usual source of care, where care coordination becomes vital to ensure primary care services are not overlooked. Past chart reviews have shown that greater than 90% of CYSHCN receiving services through SPSP grant-funded programs have a primary care physician listed. In SFY20, the program included evaluating every child seen in a Specialized Pediatric Services Program (SPSP) grant-funded program for the designation of a primary care provider as part of the grantee's goals and objectives. The Title V CMUs and pediatric specialty providers will continue to provide a safety net for families of CYSHCN.

Annual Report - NPM #12 (Transition to adulthood)

The transition of youth to adulthood has become a priority nationwide, as evidenced by the clinical report and algorithm developed jointly by the AAP and the American College of Physicians to improve healthcare transitions for all youth and families. Over 90% of children with special health care needs now live to adulthood but are less likely than their non-disabled peers to complete high school, attend college, or be employed. Health and health care are cited as two of the major barriers to making successful transitions. Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease.

The New Jersey Special Child Health Services Case Management Units provide children with special health care needs with transition to adulthood services up to their 22nd birthday. Data for transition services provided by SFY is presented below. The annual state performance indicator consistently exceeded the annual objective for all reported years included in the table below; (45.2% vs. 34% in 2019, 43.6% vs. 37% in 2020, 45.0% vs. 40% in 2021, and 47.4 vs. 43% in 2022). The National Children's Heath Survey estimates that 14.4% of adolescents with special health care needs, ages 12 through 17, received services necessary to make transitions to adult health care in NJ. This estimate is based on a sample count of 30. While CMUs provide free resources and referral services, many children may receive these services through their school; therefore, these two measures are not equivalent.

Table: Provision of Transition Service in New Jersey for children with special health care needs ages 12 to 17 years.

	2017	2018	2019	2020	2021	2022
Annual NPM #12 Indicator	43.8%	41.6%	45.0%	43.6%	45.0%	47.4%
Numerator	2,246	1,960	1,642	1,102	955	962
Denominator	5,127	4,717	3,635	2,530	2,125	2030
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional	Provisional

Data Source - The New Jersey Special Child Health Services, Family Care Center Services
Note: CMUs serve children with special health care needs until their 22nd birthday.

Children aged 12 – 21 are offered and/or provided with transition services. These data are not shown in the table above. Seven possible types of transition to adulthood services were identified as proxies; the identification of an adult-level primary care physician; transition-specific services; employment; health insurance; SSI; SPoC; Exceptional Events documented in the youth's record tied to transition.

The SCHS has been providing transition to adulthood services through its Case Management Units. These services include Healthcare PCP Services, Education, Rehabilitative Service (Vocational Training) Transition, and Social/Emotional/Economic Services. The service delivery has exceeded the annual objectives set by the program. In 2022, 962 children received transition services out of the total 2,030 children eligible for the services. This performance (47.4%) exceeds the annual objective of 46%.

Identification and monitoring of transition to adulthood for CYSHCN and their families served through the CMUs statewide is ongoing. Transition packets continue to be updated and shared with families, and linkage with community-based support is provided. State staff monitors the CMUs efforts to outreach to CYSHCN regarding transition, including documentation of goals related to transition on the ISP.

The CMUs continue to facilitate transition to adulthood with youth by ensuring a transition to adulthood goal on the ISP. Likewise, exploring youth and their parents' needs to ease the transition with insurance, education, employment, and housing and linking them to community-based partners will continue.

Ongoing CMRS presentations to the CMUs stimulate active discussions about how SCHSCM documentation produces system-wide data used for CQI and MCH Title V Block Grant reporting. These presentations also inform FCCS and CMUs on areas for training to more effectively unlearn and relearn documentation methods to move from a lengthy narrative charting style to drop-down menus supported by brief entries that use shorter and more consistent terminology. The State data/analytical staff collaborates with the Program Officers to review and analyze CMRS data. Monthly meetings are held jointly with FCCS state staff and all 21 CMUs to provide additional CQI presentations highlighting progress and additional areas of improvement in documentation on the Core Outcomes.

The FCCS team is implementing a comprehensive redesign of CMRS that will greatly expand the ability to track transition services. A current limitation of the data system is that transition exists as a single service to be recorded on an ISP, but the redesign will make transition its service domain, allowing for a greater depth of detailed transition data to be easily recorded by CMUs and readily obtainable for data analysis.

CMUs and pediatric specialty providers will refer youth and/or their parents to NJ Council for Developmental Disabilities (NJCDD) for participation in Partners in Policymaking (PIP) self-advocacy training as well as continue to assist youth and their families in advocating for transitional supports through their individualized education plans and

community-based supports. TVP will continue to participate in PIP mock trials to facilitate the development of clients' self-advocacy skills.

CMUs largely noted documentation of transition planning to occur on or about age 14. A discussion with parents/youth about transition planning and the distribution of transition packets were noted. An anecdotal observation by the case managers noted that families preferred receiving materials incrementally rather than in one large packet filled with resources. That incremental method provided them with the opportunity to focus on one, or a few transition needs at a time, such as primary care provider, access to Supplemental Security Income, and/or health insurance, including Medicaid, Medicaid expansion, and/or private insurance or the Marketplace; education/job training supports; statewide systems of care including the Department of Human Services Division of Developmental Disabilities and/or the DCF's Children's System of Care (CSOC) Initiative, and others.

Through an agreement with SPAN, the Family WRAP (Wisdom, Resources, and Parent to Parent) project provides information, resources, and one-to-one family support that are directly helpful to clients active in SCHSCM and case managers.

Due to the rising percentage of children in NJ diagnosed with ASD, FCCS partnered with Autism New Jersey to provide support to case managers for children active in SCHSCM who have been diagnosed with ASD as well as other learning disabilities. This agreement enables case managers to provide the necessary support to children and their families active in SCHSCM.

Linkages developed through current and previous ISG grants have facilitated the distribution of materials developed by SPAN, NJ AAP, Autism NJ, NJDOH, and other community partners engaged in the Community of Care Consortium (COCC) to medical practices. Community-based partners continue to identify resources and linkages to support transition to adulthood for CYSHCN.

Within DCF is Children's System of Care (CSOC), which works collaboratively with the Department of Education (DOE) Offices of Special Education, the DDD, and the DVRS to help facilitate transition to adulthood services. After age of 21, developmental disability services are provided by the DDD. Training on these systems for adolescents with developmental disabilities is occurring regularly among the CMUs. Collaboration with intergovernmental and community partners, including Autism NJ, DDD, DCF, NJ Council on Developmental Disabilities, Boggs Center, SPAN, the Arc, Traumatic Brain Injury Association, and families, is critical to appropriate access to services and supports. Identification and monitoring of transition to adulthood needs for CYSHCN and their families served through CMUs statewide are also in process. County-specific transition packets, including resources related to education, post-secondary education, vocational rehabilitation, housing, guardianship, SSI, insurance, and Medicaid/NJ Family Care, are shared with families, and linkage with community-based supports is provided. State staff monitors the CMU's efforts to outreach to CYSHCN regarding transition, and documentation of goals related to transition on adolescents' service plans.

Transition planning and implementation will remain a priority throughout SFY23. The adolescent subset of CYSHCN served through TVP remained relatively the same between SFY2019 and SFY2020.d In SFY2020, 17% of patients at CECs and 16% of patients at FASD Centers were of youth 14-19 years of age, while 9% of CYSHCN of the same age group were served at Cleft Lip Cleft Palate-Craniofacial (CLCPC) Centers. In addition, youth between the ages of 14 and 19 comprised 30% of those served at PTC Centers. The SPSP providers engage with adolescents and their families to facilitate transition to adult services. Transition services primarily include discussions about the importance of adult care, options for adult care (providers/locations), sharing resources regarding genetics, family medicine, adult providers, support groups, and other medical and social-related needs. The linkage of CYSHCN to multidisciplinary team members, including social work and other community-based systems such as SCHSCM, SPAN, and disability-specific organizations, including the Arc, Tourette's Association, and Parents' Caucus, are strategies implemented by the SPSP agencies. As shown in past reviews and surveys, plans of care and documentation on transition to adult care vary amongst the three SPSP categories: CEC, CLCPC, and PTC Centers. The SPSP collaborates with each grantee to ensure that a definition of transition to adult care is established at each site and that practice policies regarding transition to adult health care are created and implemented.

Aligned with the TVP programs and funded by Part D of the Ryan White Care Act, the NJ Statewide Family Centered HIV Care Network remains a leading force in providing care to Women, Infants, Children, Youth (WICY) and families infected and affected by HIV disease in the State. Consequently, there is ongoing collaboration across systems within the Division of Family Health Services' Maternal Child Health and CYSHCN's programs and the Ryan White Part D program to support WICY needs in the community. NJ ranks third in the nation for pediatric cases. Of youth 13-24 years, 432 were living with HIV/AIDS, & of youth 0-12 years, 26 were living with HIV/AIDS in 2020. Through diligent efforts to treat and educate HIV-infected pregnant women, the perinatal transmission rate in NJ remains very low.

Intensive case management and appropriate antiretroviral therapy enable children with HIV to survive and successfully transition into adulthood.

Application Year

Plan for the Application Year - NPM #9 (Bullying), SPN # 6 (Reducing Teen Pregnancy)

The CAHP will continue to implement Social and Emotional Learning (SEL) and parent engagement programs along with virtual activities that provide youth with opportunities to lead and educate their peers. The CAHP will continue to promote the adoption of Evidence-based SEL programs including TOP®, LifeLines Trilogy, Love Notes, Teen PEP and the WSCC model in NJ schools. NJDOH will be sunsetting Reducing the Risk (RTR) and including Get Real in its place starting October 1, 2023. In addition, the CAHP will be expanding the reach of Teen Speak statewide through a new RFA S-PEP (Statewide Parent and Professional Engagement Program. Teen Speak currently serves approximately 500 parents statewide and with the new RFA will serve increasing numbers of parents over a 4-year grant cycle. CAHP will continue to host the NJDOH Voice of Youth Planning Committee (VYPC) as they plan and implement youth-led virtual programs for their peers. The VYPC has not yet chosen a focus for 2023, they are gearing up to host the annual YAB meeting and share takeaways from the 2022 3-part webinar series Bringing Youth Voice to the Table™. Finally, NJDOH will continue to provide training and technical assistance to our grantees and partner organizations that will help youth-serving professionals build their competencies to help provide youth opportunities to avoid bullying as a perpetrator or victim. In 2023, S-PEP will launch a youth professional development training called MITEY Change. Motivational Interviewing Training for Empowering Youth towards Change provides education and resources to enhance professional's knowledge, skill, and confidence in providing effective and efficient youth risk coaching. This is an online course developed by Dr. Jennifer Selerno, the developer of Teen Speak.

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

State SCHS staff will continue to refine tracking of Performance Measures in CMRS and provide documentation training to CMUs to ensure activities related to these measures are accurately counted. CMRS is being redesigned to improve performance on the Six Core Outcomes for CYSHCN and promote targeted improvement to the documentation for access to a medical home (NPM #11) and transition to adulthood (NPM #12). With CDC Surveillance and Expanded Laboratory Capacity (ELC) grant funding, the redesigned system will support tracking of CYSHCN referred to SCHSCM and monitoring of services offered and/or provided to determine family/child outcomes.
Updates are being made to CMRS to accommodate reporting, data collection, and tracking of medical home components. Having a primary care physician is the 'first step' in building the infrastructure of a medical home for CYSHCN. ESM #11.1 provides a baseline for programmatic needs to increase the percentage of CYSHCN with a primary care physician and identify the 'next steps' needed to establish medical homes for CYSHCN, a medical home webpage on the Department's website, includes a Shared Plan of Care (SPoC, a medical home tool for families).

Plan for the Applicant Year - NPM #12 (Transition to adulthood)

Efforts to improve documentation of transition to adulthood activities performed by CMUs and documented in CMRS will continue. State staff provide ongoing technical assistance and guidance via site visits, desktop audits, and conference calls to improve the data collected and reported on transition to adulthood activities and client outcomes.

Transitioning to an adult program for CYSCHN is a critical decision that must be planned appropriately to ensure continuity of care. Although TVP will continue to assess youth's progress toward transition and linkage with community-based supports, the SCHSCM and SPSP programs are exploring the development of standardized needs assessment and quality indicators to better measure NJ CYSHCN's experiences. An example of a quality indicator is the acuity tool that is being built into the electronic database; this will assist case managers to highlight children on the cusp of adolescence and adulthood. For NPM 12, needing to address the transition to adulthood is imperative for the child's subsequent success in adulthood. The CMRS redesign will also categorize transition services as its standalone category to improve both the success of the child coming to adulthood and federal reporting.
Although reconfiguring data, reporting tracking systems, and generating reports, are challenges, our biggest challenge remains the state staff vacancies for critical positions. Beginning in 2021, FCCS increased to a total of nine staff members as we filled several vacancies with temporary staff. Nevertheless, the goal remains to seat staff members into permanent roles as the program continues to utilize temporary staffing for most of these positions.

Children with Special Health Care Needs

Annual Report

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

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

Provisional data indicates that for 2022, 81.7% of infants not passing initial newborn hearing screening at birthing hospitals had a documented outpatient audiological follow-up visit. Since follow-up exams are still occurring on children born at the end of 2022, we expect the rate to increase when final data is available. We anticipate that the final rate will be level with prior years and exceed the target. The program also monitors the follow-up rates by race/ethnicity for disparities in outcomes.

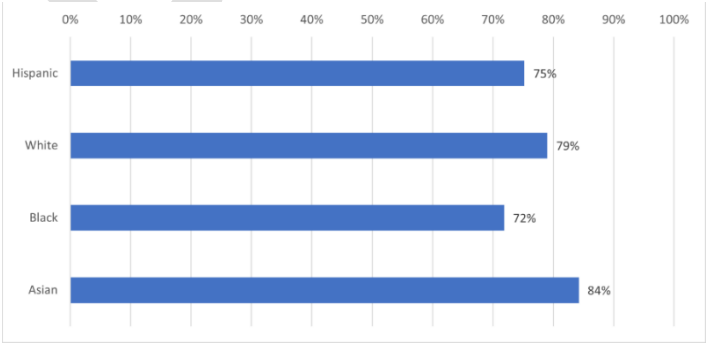
Table SPM #3: Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening and who have outpatient audiological follow-up documented.

		2014	2015	2016	2017	2018	2019	2020	2021*	2022*
Annual SPM#3 Indicator		85.8%	86.0%	89.0%	87.5%	86.1%	82.6%	79.7%	81.0%	81.7%
Numerator		1821	1869	1833	1570	1571	1362	1439*	1397	1612
Denominator		2122	2173	2059	1798	1824	1648	1804*	1724	1970

*Note – In July 2021 a new birth registry system was implemented Vital Events Registration and Information (VERI) Follow-up reports are still being received for children born at the end of 2022, and the final rate is expected to exceed this rate.

In addition to the overall Follow-up Rates, the data are provided by race/ethnicity. While we strive for 100% follow-up and to eliminate racial and ethnic disparities, we cannot always track and document the follow-up visits (Figure 17). Birthing facilities are required to make at least one contact with families of children that did not pass the initial screening to remind them of the need for follow-up. Additional contact efforts are made by case managers funded by the EHDI program. Sometimes families are unable to be contacted with documented phone numbers disconnected and/or mail returned undeliverable. Other families are unresponsive to contacts, with attempts resulting in unanswered voicemail messages. Other families do not have follow-up testing completed despite contacts made by the hospital or case manager. Barriers can include lack of insurance, transportation or childcare issues preventing travel to an outpatient audiology appointment, or parents not feeling follow-up testing is important because the child appears to respond to sounds around the home.

Figure 17. Total Outpatient Follow-up of Babies Referred



The EHDI program is responsible for assuring newborn hearing screening goals are met, including ensuring timely and ear-specific audiological follow-up for children that did not pass the initial screening. All outpatient audiologic

reporting to the EHDI program continues to be submitted via an EHDI module in the New Jersey Immunization Information System (NJIIS) registry. The NJIIS program had a complete system rebuild and the EHDI module was also modified to improve the information collected about follow-up contacts to parents.

During 2022,

- EHDI trained 18 new users in 2022 on the EHDI reporting module in the NJIIS, which is used by audiologists and other practitioners conducting hearing follow-ups to report outpatient exams. The EHDI program receives approximately 89% of reports entered by providers through this Web-based application, and the rest are sent to the program on paper forms.
- Nancy Schneider, M.A., CCC-A, FAAA, the audiologist for the NJ DOH trained 10 audiologists and audiology graduate students on how to use the NJ Early Hearing Detection and Intervention Program's online reporting module within the NJ Immunization Information System.
- NJ DOH continued using HRSA EHDI grant funding for county-based special child health services case management staff to conduct follow-up phone calls to parents and physicians of children needing hearing follow-up.
- NJ DOH continued to use HRSA EHDI grant funding for one of the Early Intervention (EI) program's Regional Early Intervention Collaborative's (REIC) to provide two part-time consultants who specialize in working with Deaf and Hard of Hearing children. The process includes an initial phone conversation with parents of children recently diagnosed with hearing loss to review Early Intervention (EI) services and discuss communication options for these children. The consultants participate in the initial EI family meetings via remote access, using laptops with web-cameras. The consultants served a total of 88 families during this year.
- The EHDI Monthly Reconciliation Report is distributed to individual hospitals detailing children still in need of additional audiological follow-up after not passing inpatient hearing screening. This serves as a notice to hospitals of babies still in need of reminder contact. In addition, a report including statistics comparing the individual hospital to statewide statistical averages is sent annually.
- Annual distribution of a report to provide audiology facilities with feedback on the timeliness of follow-up for children seen at their facility after not passing inpatient hearing screening continued. The report also includes statistics on the timeliness and completeness of the documentation of their results.
- The Hearing Evaluation Council (HEC), a Commissioner-Appointed advisory board to the NJ EHDI program, held three meetings this year. The HEC is made up of physicians (a pediatrician and otolaryngologist), an audiologist, a child of Deaf or Hard of Hearing adults, a member of the Deaf community, a Hard of Hearing individual, and NJ residents interested in the welfare of Deaf and Hard of Hearing Children (including a parent of Deaf and Hard of Hearing children and a teacher of the Deaf and Hard of Hearing).
- The NJ Stakeholders (NJSH) group, a new HRSA grant initiative, held four meetings this year. The NJSH group is made up of providers who work in the EHDI system and parents of Deaf/Hard of Hearing children, including audiologists, Early Intervention providers, the NJ Part C Coordinator liaison, Teachers for the Deaf/Hard of Hearing, a cochlear implant provider, case managers, and DOH EHDI staff.
- NJ EHDI has completed a three-year Memorandum of Understanding with the NJ Department of Human Services' Leveling the Playing Field (LTPF) initiative enhancing the NJ EHDI Deaf Mentor Program. Funding for this initiative provided access to appropriate language role models for Deaf and Hard of Hearing children (from birth to age 5) whose families have selected American Sign Language (ASL) as a primary mode of communication. LTPF sought to enhance EI and early childhood education by having ASL fluent paraprofessionals interact with Deaf and Hard of Hearing children in the same way hearing childcare workers are interacting with hearing children in their center. The goal was to provide full access to language throughout the child's day.

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

NJ TVP has successfully linked children registered with the BDAR with services offered through our county-based Special Child Health Services CMUs. The CMUs use the CMRS to track and monitor services provided to the children and their families. It electronically notifies a CMU when a child living within their county has been registered and released for follow-up. Also included in CMRS is the ability to create and modify an ISP, track services, create a record of each contact with the child and the child's family, create standardized quarterly reports and register previously unregistered children.

The annual state performance indicator below has consistently exceeded the annual objective for all the reported years included the table below; (96.1% vs 92.2% in 2019, 95.1% vs 92.4% in 2020, 95.9% vs 92.6% in 2021, and 95.0% vs 92.8% in 2022).

Table SPM # 4: Percent of live children registered with the Birth Defects and Autism Reporting System who have been referred to NJ's Special Child Health Services Case Management Unit and who are receiving services

	2017	2018	2019	2020	2021	2022
Annual Indicator SPM #4	90.7%	94.4%	96.1%	95.1%	95.9%	95.0%
Numerator	13,737	13,224	12,018	13,473	12,753	14,249
Denominator	15,136	14,007	12,501	14,178	13,302	14,999

*Data Source- The New jersey Special Child Health Services, Family Care Center Services
Note: The numerator reflects all children whose record has any of the five following criteria for services:
1. Case closed within SFY with a reason of "goals achieved,"
2. Child referred to Early Intervention within SFY,
3. Individual Services documented with a begin and/or end date within SFY,
4. Individual Service Objectives documented with a perform date within SFY, and
5. Case Management Actions (excluding any letter correspondence that is part of an initial letter series) documented with a date performed within SFY.

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

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

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

BDAR and FCCS staff collaborate to improve functionality, ease of use, and efficiency of the system.

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

Annual Report- SPM # 5 Average age of initial diagnosis for children reported to the NJ Birth Defects & Autism Reporting System with an Autism Spectrum Disorder.

SPM #5 was chosen to measure the timeliness of diagnosing autism in children. Early diagnosis is important for initiation of services, as children who receive services at an early age have better functional outcomes. While the causes of autism are not known, receiving intensive services early in a child's life can improve development in speech, cognitive, and motor skills. Appropriate diagnosis at an early age is an important precursor to ensuring that families gain access to early and intensive intervention.

Table SPM # 5: Average age (in years) of initial diagnosis for children reported to the NJ Birth Defects & Autism Reporting System with an Autism Spectrum Disorder.

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Annual Indicator SPM #5	4.6	5.0	5.6	5.2	5.3	5.3	4.8	4.8	4.8	4.6

In FY 2022, over 3,400 children diagnosed with autism were newly reported to the BDARS. The average age of initial autism diagnosis is 4.6 years old. The current average age of 4.6 indicates a significant decline from the previous five years (SFY2017-2021) when the average ages were approximately 5.0 years. While this indicator considers the age when the child is first diagnosed, it includes all children reported during that year. Since the Registry mandates reporting all children through their 22nd birthday, previously diagnosed older children are sometimes registered for the first time. Since the Registry began in 2009, previously diagnosed children are continually being registered by their primary care providers and newly seen specialists such as behavioral and mental health providers. Therefore, we also calculated the average age of diagnosis for children born between 2007 and 2013. The average age of diagnosis for this group is 4.6. More recent birth cohorts may get diagnosed earlier as enhanced screening efforts and public awareness increase.

For the pooled birth cohorts of 2007-2013, the average age at initial diagnosis is significantly different by race and ethnicity. The average age at initial diagnosis for white non-Hispanic children was 4.9 years, significantly greater than Black (4.6 years), Hispanic (4.4 years), and Asian (4.2 years) children The average age of initial diagnosis for female children was 4.8 years, significantly greater than for male children (4.6 years). Also, autism is more prevalent among males, with a male-to-female ratio of 4:1.

While the average age is useful for comparison to other states, age at diagnosis is not normally distributed. The distribution is skewed with 52.5% of the children diagnosed before the age of 4 years of age, 23.7% of children are diagnosed between ages 4 and six years of age, and 23.8% of the children were diagnosed after the age of six years of age. The youngest age group is often identified through developmental screening with a major indicator being lack of language acquisition. The second age group is probably identified as children enter kindergarten and are noticeably different than their peers. The older group is characterized by children who perhaps had some delays but difficulties engaging in social communication with peers in primary school become more apparent, or they were originally diagnosed with other learning or behavioral disorders.
To ensure the quality of the data, BDARS staff have conducted outreach to educate and inform physicians and health facilities about the Registry, how they can register children with autism living in NJ, and the rules regarding the Registry. Registry staff has visited and trained staff from medical centers specializing in child development, developmental evaluations, and behavioral health. Additionally, they have trained staff from many private pediatric practices that follow older children with autism through annual well visits. Registry staff has also trained several psychiatric/behavioral departments located within hospitals. Staff from the Registry presented information concerning the Autism Registry to state and county case managers as part of training on the case management electronic component of the BDARS. They continue to retrain new staff within health facilities as needed. Staff has also created materials for both providers and families about autism, and these materials have been translated into multiple languages, including Spanish, Korean, Polish, Hindi, and Arabic. There is also information about the Autism Registry on the DOH website, and staff continue to make conference presentations and exhibits.

TVP will continue to address this performance measure by working with the NJ Chapter of the American Academy of Pediatrics and the Elizabeth M. Boggs Center on Developmental Disabilities, NJ's University Centers for Excellence in Developmental Disabilities (UCEDD), in reaching out to various health care providers and distributing information and trainings on the Learn the Signs, Act Early campaign that educates providers on childhood development, including early warning signs of autism and other developmental disorders, as well as to encourage developmental screenings and intervention.

One of the most important BDARS changes this year allows providers to verify if a child had already been registered for another provider. This change significantly reduced the burden on our reporting agencies and improved the system's efficiency; this is significant as our mandate requires all children 0-22 with ASD to be registered. Children see many healthcare providers; each needing to verify registration or register the child. With the new system, healthcare providers can simply search the system for a child, thus, significantly reducing the number of duplicate registrations. Moreover, if a child had been registered with non-autism diagnoses, their providers can now add the new autism diagnosis and review and update the child's contact information. Additionally, the autism data collection pages have been redesigned to provide more check-off options rather than asking providers to use text fields to provide information about comorbidities, symptoms, and other pertinent information.

Application Year

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

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

The EHDI program will continue using HRSA EDHI funding for county-based special health services case managers to conduct follow-up phone calls to parents and physicians of children needing hearing follow-ups. The EHDI Program also sends hospital-level surveillance data to NJ birthing hospitals. Monthly hospital contacts continue to receive a reconciliation list of children that are still in need of follow-up after missed or referred inpatient hearing screening, as this has been shown to improve successful follow-up rates. A report with each birthing hospital's overall statistics is sent annually. The program will continue to distribute the audiology facility reports to highlight the timeliness of follow-up and identify children with incomplete follow-up testing.

The EHDI program plans to continue working with medical homes to ensure that children receive timely and appropriate follow-up after a referred hearing screening or inconclusive follow-up testing. An extract available in the NJIIS allows the EHDI program to identify the name, address and fax number of the medical home provider that has most recently provided immunization data for a child and will use this information to send fax-back forms to provider offices to remind them to refer children for additional follow-up as needed.

The program will continue the grant-supported activities including case management outreach to families in need of hearing follow-up and support by the EI Hearing Consultants. In addition, the HRSA EHDI grant-supported Deaf and Hard of Hearing Mentoring and Role Model program for families of children identified with hearing loss has been operational since 2018. The Deaf Mentor program has been enhanced by funding from the NJ Department of Human Services Leveling the Playing Field initiative.

EHDI staff will continue educational presentations to hospital staff, pediatricians, audiologists, Special Child Health Service Case Managers, Early Intervention Service Coordinators, and other healthcare professionals, focusing on decreasing the number of lost children to follow-up. The EHDI program frequently uses webinars to make educational outreach efforts more accessible to the target audiences, reduce staff travel time, and improve efficiency while decreasing costs.

NJ EHDI staff will continue to collaborate with the EI Hearing Consultants to coordinate outreach meetings with pediatric audiologists regarding timely referral of children with hearing loss to Early Intervention.

As per the suggestion of the NJ EHDI advisory board, The Hearing Evaluation Council, regarding CMV/pediatric hearing loss awareness/prevention, NJ EHDI has updated its website with public service information in multiple languages geared toward women of childbearing age.

A newly passed law (1/18/22, P.L.2021, c.413) requires all infants born in our state to be screened for congenital Cytomegalovirus (CMV). This legislation also requires the establishment of a public awareness campaign to educate New Jerseyans on the value of early detection, intervention, and treatment options for children diagnosed with this condition. cCMV is the most common congenital infection in the United States, with approximately 1 in 200 children born with this condition or approximately 30,000 children born yearly. According to the CDC, 10–20% of children born with cCMV will go on to have neurodevelopmental disabilities, including sensorineural hearing loss. Every year, as many as 400 infants die because of this virus.

An Ad Hoc Committee that includes a diverse group of healthcare professionals and NJ DOH staff who share an interest in this topic has been meeting regularly to investigate evidence-based universal cCMV screening protocols and formulate follow-up guidelines for those children in New Jersey who have tested positive for this diagnosis. Committee members include representatives from two primary advisory groups that serve the NJ DOH: The Newborn Screening Advisory Review Committee (NSARC) and the Hearing Evaluation Council for the New Jersey Early Hearing Detection and Intervention Program. Currently, the Committee is developing condition readiness criteria for New Jersey's Newborn Screening Panel to be presented at the May meeting of NSARC. In addition to surveying State birthing facilities regarding cCMV screening practices, the NJ DOH is also participating in a national survey from the CDC regarding cCMV surveillance activities in our state.

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

SPM #4 was chosen to improve the timeliness and effectiveness of the BDARS, which has been an invaluable tool for surveillance, needs assessment, service planning, research, and linking families to services. Through CDC funding, the BDARS continues to be upgraded and improved. In the past, these upgrades have included creating the Pulse Oximetry and Exceptional Events modules and improving functionally to decrease the burden on providers and state staff from unnecessary duplications.

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

On-site visits will be conducted in each CMU to ensure proper usage of the CMRS as needed and to strengthen the relations with state FCCS staff; this will allow more consistent use of the system linking referred families to services. FCCS staff provide ongoing feedback and technical assistance to CMUs on a statewide, county-level, and individual-level basis.

We will continue to enhance the CMRS system by adding new measures to capture needs, improving case definition across our case management units, and enhancing our exceptional events module so that communication with families can be streamlined and improved in times of emergencies. The way in which cases are defined as "active" or "inactive" impacts our ability to appropriately measure such things as length of services and number of children being serviced. Our FCCS program staff have been working intensively to standardize the CMUs definitions and will be working with our programmers to ensure the system is accurately capturing data; this will allow the CMUs the flexibility they need to better provide services to their families and yield accurate quarterly and annual reports.

SCHS/FCCS has been provided CDC-Enhancing Laboratory Capacity funding to redesign the CMRS system. The improvements will allow for an integrated documentation model to incorporate not only service provisions, but changes in need resulting from exceptional events that are cataloged appropriately and chronologically. In the wake of the COVID-19 pandemic, the increased need to gather details surrounding exceptional events was apparent. An exceptional event creates and documents the unique needs of the CYSHCN population that the CMUs serve. This redesign will allow for documented emergency preparedness and anticipation of unique needs for this vulnerable population during these extraordinary events. Examples of other exceptional events outside of natural disasters and statewide emergencies are more personalized family-centered issues such as the change of family structure/health (e.g., death of an immediate family member, divorce, unforeseen illness/injury), housing issues (e.g., loss of housing), economic factors, changes in insurance status, or new diagnoses. With improved data capture regarding exceptional events, the program will be able to develop emergency preparedness plans and directed assessments to serve the child's/family's needs more effectively. In addition to the exceptional events module, the CMRS redesign will provide additional insights, improve functionality, and increase data capture in the ISP module.

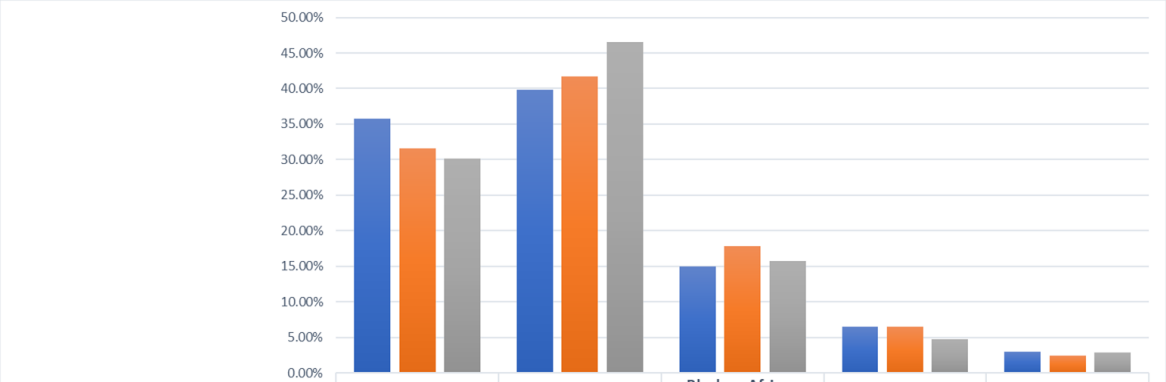
FCCS staff will further examine the population they serve and how they can establish quality improvement and quality assurance measures for maintaining an improved and uniform practice of case management, developing policies and procedures, and monitoring equitable services across the population. The main priorities of this redesign are to improve the quality of data reporting, improve the user experience, and implement an acuity measurement. The redesign will allow for enhanced reporting regarding medical homes for the CYSHCN population and improved data quality surrounding the transition to adulthood process for the adolescent population served by SCHSCM. FCCS will use a weighted scale that utilizes pivotal information in CMRS, such as diagnosis, linkage to services, insurance information, medical home, transition to adulthood, and other key data points, to determine each child's acuity level in a format that the end users easily understand. These data will also allow FCCS staff to evaluate staffing of CMUs, identify communities of greater need, and determine each child's real-time level of need at-a-glance.

Early stages of this redesign included exploration of data systems used by Title V CYSHCN case management programs in other states. Direct communications with some of these programs provided useful feedback in developing a framework for NJ to build upon for developing the requirements for this redesign. The FCCS team continues to collaborate with our system developer to ensure that the system requirements are met to help us achieve the goals noted above.

In concurrence with the CMRS redesign, FCCS will continue creating and revising policies and procedures to create a more uniform standard of practice for case management services and consistent documentation in a child's record across the state. These innovations will enhance statewide monitoring and aid the CMUs in providing comprehensive and equitable care in every county.

To monitor equitable services, FCCS staff has begun exploring Race/Ethnicity data on the population served in SCHSCM to ensure the program reaches all communities within New Jersey. Below is a graphic comparing the SCHSCM population served in SFY'22 by Race/Ethnicity Compared to the Race/Ethnicity of all children registered in CMRS and the NJ DOE Special Education population (Figure 18). The table below indicates that SCHSCM is reaching diverse communities throughout New Jersey. In the coming year, FCCS staff will be working to disaggregate categories to examine better who utilizes CMUs and where there is a need for more outreach to ensure that all children with special health care needs and families may benefit from SCHSCM services.

Figure 18. Race/Ethnicity Data for SCHSCM Served Population SFY'22 vs. CYSCHN Population Registered in CMRS vs. New Jersey Department of Education, Office of Special Education



	Hispanic or Latino	White	Black or African American	Asian	Other
SCHS-CM Served Populatoin SFY'22	35.71%	39.87%	14.94%	6.53%	2.95%
CYSHCN Population Registered in CMRS	31.58%	41.69%	17.82%	6.50%	2.41%
NJDOE Special Education Population	30.13%	46.58%	15.69%	4.74%	2.86%

Data Source: NJ Department of Education, Office of Special Education Programs, 2021 (Ages 3-21 Only)
Data Note: "Other" category is defined as the combination of "Two or More Races," "American Indian or Alaskan Native," "Native Hawaiian or Pacific Islander," and "Other Race."

SPM # 5 (Average age of initial diagnosis for children reported to the NJ Birth Defects & Autism Reporting System with an autism spectrum disorder.)

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

In the upcoming year, Autism Registry staff will continue to perform in-depth analyses of the registry data and merge with other data sets to better understand the needs of those with autism. As indicated above, the average of initial diagnosis is 4.8 years. The criteria for a diagnosis of autism are deficits in a person's social communication and interaction, restrictive or repetitive behaviors, interests or actions that become apparent in early childhood and create functional limitations or impairment in everyday life. The severity is further classified from levels 1 to 3, indicating the support the person needs (requiring some support - level 1, substantial support – level 2, and very substantial support – level 3). Because the registry collects the individual's symptoms at the time of diagnosis, and doesn't track changes over time, younger children may go on to exhibit additional symptoms that were not observed or not recorded in the child's registration. Of particular concern are behavior that put the child at risk for injuries, inability to remain safely in the home, or even death. Using hospital Uniform Billing (UB) data, the registry will compare the number of hospitalizations of people with autism associated with events such as crises due to comorbid mental health

conditions, self-injury, and accidents, including those that occurred due to the person eloping (for example, leaving the home and wandering, near-drowning incidents, and darting into traffic).

In addition, ascertaining racial and ethnic diversity beyond currently used categories is of interest to the registry and important in understanding differences in the average age of autism diagnosis by race/ethnicity. Cultural norms may impact what is considered typical childhood behavior and provide insight into the differences in age of diagnosis or even whether a child is evaluated for autism at all. A planned paper should help us signal that one's culture may be a social determinant to seek medical care among families with children with an autism spectrum disorder. The registry will utilize UB data to expand beyond current racial categories and provide more information about the diversity of population.

Cross-Cutting/ Systems Building

Annual Report

This section concerning the domain of Life Course includes the SPN #8 Improving Integration of Information Systems and the NPM #13 Oral Health. ESM 13.1 for oral Preventive and any dental services for children enrolled in Medicaid or CHIP (CMS-416).

Annual Report - NPM #13:

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

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

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

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

New Jersey has selected the following for ESM #13: preventive and any dental services for children enrolled in Medicaid or CHIP. The ESM was selected since all oral health education activities conducted in the school, and community settings serve to improve the oral health status of school-age children.

There are 24 Federally Qualified Health Centers with 136 locations in all 21 state counties. Fifty-eight locations provide dental services, eight centers have mobile dental units, and there are 7 school-based locations in Newark and one in New Brunswick.

In SFY22 (2021 – 2022), FQHC dental providers provided 115,700 uninsured patients with dental services under the Uncompensated Care Fund.

	2011-2012	2016	2017	2018	2019	2020	2021
Percent of women who had a dental visit during Pregnancy*	N/A	N/A	N/A	46.3*	N/A	40.0	TBD^
Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**	79.9+	82.1+	81.9+	54.5**	51.8**	41.5**	TBD^

Notes: *Sources: +National Survey of Children's Health (NSCH): 2007-2017*

**New Jersey Pregnancy Risk Assessment Monitoring System (PRAMS), Maternal and Child Health Epidemiology, New Jersey Department of Health, NJ SHAD: https://www-doh.state.nj.us/doh-shad/query/result/prams/PRAMS/Teeth.html.*
***Annual EPSDT Participation Report, CMS-416, State Fiscal Year 2020: (12b. Total Eligible (1-18-year-olds) receiving preventative dental services/1a. Total individuals (1–18-year-olds) eligible for EPSDT. Total eligibility count used does not consider length of eligibility for EPSDT services.), NJ FamilyCare, Bureau of Dental Services, Department of Human Services, Division of Medical Assistance and Health Services, 2022.*
^Claims total for FFY 2022 will not be available until April 2023.

Since the 1980s, the Children's Oral Health Program (COHP) has provided age-appropriate and developmentally targeted oral health education programs to school-age children covering all 21 counties in New Jersey. In addition, COHP provides oral health education programs for parenting and community groups and at WIC sites. During the 2021-2022 school year, over 17,500 students received oral health and /or hygiene education and oral health personal care items including toothbrushes and floss. School and community presentations are conducted in areas of high risk for dental disease and high need of oral health services by registered dental professionals, who provide evidence-based oral health and hygiene information, including the oral disease process, tooth anatomy, healthy food choices, reducing the use of sugary foods and beverages, tobacco cessation and the dangers of vape and e-cigarette products, positive lifestyle choices to increase health and reduce systemic disease, and oral injury prevention education. At the present time, schools and community groups have the option of in-person, virtual recorded, and virtual live oral health education increasing flexibility and access.

COHP is dedicated to advancing oral health access through other initiatives, such as continuing the Fluoride Varnish pilot program. Several Fluoride Varnish events were held during the 2021-2022 school year, providing education and fluoride varnish to 485 students, more than double during the last reporting period. Other special school initiatives include the "Sugar-less Day to Prevent Tooth Decay" poster contest for 4th, 5th, and 6th grades, "Project BRUSH" for grades K and 1, and "Project Smile" for grades 2 and 3. Special initiatives are designed to engage the whole school community with positive oral health messages. Additionally, over 620 students participated on a statewide anti-vaping presentation titled "Don't Get Vaped In."

COHP's interprofessional oral health training programs include "Project PEDs (Pediatricians Eradicating Dental Disease), an introduction to Caries Risk Assessment and the application of fluoride in the pediatric medical setting for physicians, nurses, and physician assistants, and Project REACH (Reducing Early Childhood Caries Through Access to Care and Health Education), for physicians and obstetric nurses to provide information on the importance of oral health care for pregnant women. The COHP newsletter, "Miles of Smiles" for school nurses is distributed each Fall annually to school nurses throughout the state. In the 2021-2022 school year, 2,981 newsletters were distributed.

The New Jersey Department of Health is also pleased to report the completion of NJ's first-ever State Oral Health Plan (2023-28) and finalized the first ever Third Grade Basic Screening survey (a measure recognized nationally as important to assess and gather data about oral health). The data collected on the Oral Health Status of NJ Third Grade students has been analyzed, and the final report will be submitted to the Centers for Disease Control and Prevention in Mid- 2023.

The COHP program continues to educate the public about the importance of preventive oral health services and good oral health, with programs predominately targeted to school-aged children and pregnant women. Last year, with ongoing funding from the Health Resources and Services Administration (HRSA), the New Jersey Department of Health continued to direct the activities of two programs to address two public health priorities: 1) Providing, through Federally Qualified Health Centers (FQHCs), nutrition counseling at dental visits to Medicaid-eligible or uninsured caregivers, and their children ages 6-11, aimed at improving oral health and reducing obesity and overweight status; and 2) Reducing opioid addiction and reducing the number of opioids prescribed in New Jersey by dental professionals, by providing training to dentists and dental school students to educate them on opioid prescribing best practices in alignment with Centers for Disease Control and Prevention (CDC) recommendations.

Every 2 years, the NJ Department of Health directs the COHP to survey all State Health Officers and Dental Directors to update the Dental Clinic Directory, "Dial a Smile". This directory, available online on the Department of Health website, serves as a public resource to identify providers of sliding scale, low-cost, and no-cost clinical dental services, increase access to care, and assist the public to establish dental homes and decrease Emergency Room visits for dental emergencies. Information about the "Dial A Smile" directory and how to find it online is regularly given to community stakeholders and included in COHP special initiatives, programs, and newsletters. The directory is edited periodically upon request and will be updated during the Summer and Fall of 2023 for an

updated release in 2024. The 2022 Dial A Smile Directory is available online at: https://www.nj.gov/health/fhs/oral/documents/dental_directory.pdf .

The new State Dental Hygienist, Becky Parnian, joined the OHSU in January 2023 and supports the dental director in the application for and implementation of new grant activities that advance Maternal and Child Health through improved oral health outcomes.

Application Year

Plan for the Application Year NPM # 13:

A. Percent of women who had a dental visit during pregnancy and

B. Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

The Children's Oral Health Education program, since the 1980s, has educated the public about the importance of preventive oral health services and good oral health, with programs predominately targeted to school-aged children and pregnant women. With ongoing funding from the Health Resources and Services Administration (HRSA), the New Jersey Department of Health will continue to direct the activities of several programs to address two public health priorities: 1) Providing funding for nutrition, education, and counseling at dental visits to Medicaid-eligible or uninsured children ages 5-18, aimed at preventing dental decay through discussion about healthy food choices, and 2) Providing preventive dental services such as application of sealants and Fluoride varnish to reduce the risk of dental caries and assist families in establishing dental homes.

The Oral Health Services Unit (OHSU) will continue to oversee the deliverables and activities of the Children's Oral Health Program (COHP), now in its 40th year. During the new fiscal year, our two federally qualified health center (FQHC) grantees with locations in the north, central, and southern parts of the state will continue to receive funding. They will continue to introduce and implement evidence-based interventions to improve oral health for vulnerable residents, with the primary focus on vulnerable children, their mothers, and pregnant women. Through multiple education and preventive activities, such as Oral Health training at schools, "Don't Get Vaped In," an anti-tobacco education program, and "Sugar-less Day "activities, our grantees will continue to narrow the oral health disparity gap in New Jersey children. Additionally, COHP will continue "The Project REACH," an initiative to reduce early childhood caries by educating pregnant women through oral health trainings provided to Obstetricians.

To adhere to the Centers for Disease Control and Prevention (CDC) recommendation and establish key oral health baseline data for New Jersey students in 3rd grade, OHSU successfully completed the first Basic Screening Survey in New Jersey during the 2022-2023 school year (December 2022). In the next grant cycle, we aim to expand the Basic Screening Survey activity to children in Head Start and Early Head Start programs.

In 2022, the OHSU was awarded a four-year grant by HRSA. The overarching goal of this new grant, "Caries Prevention: Risk Assessment, Dental Sealants, and Nutrition Education/Counseling," is threefold: 1- Increase access to lower-cost, preventive oral health to stave off more costly restorative treatment in the subsequent future; 2- Improve overall the oral health of at-risk populations (children and adolescents) through: i) the reduction of dental caries, the #1 chronic disease in children and ii) the reduction of factors causing "medium to high-risk" caries status; and 3- Increase patient/caregiver awareness and understanding of the use of dental sealants and the various nutrition-related (food and beverages) linkages that can be harmful and those that can be complementary to achieving ideal oral health. The OHSU will continue these grant activities during the next MCH grant cycle.

In February 2023, the OHSU submitted an application for a five-year partnership and funding opportunity with the CDC. If awarded, the OHSU seeks to implement an innovative approach using a Demonstration Model Project that focuses on the integration of oral health within and across all ten Whole School, Whole Community, Whole Child (an evidence-based approach created by CDC) components to ensure healthy outcomes, the highest levels of student academic achievement, and the completion of improvement plans using the CDC School Health Index to alleviate health disparities in school districts with the highest needs including those disproportionately affected by chronic diseases. Additionally, children and their families will be referred to oral health services to establish a dental home.

The State Dental Director, Dr. Darwin Hayes, will continue to provide technical assistance to and serve on multiple committees as a subject matter expert and to advocate for the oral health of all NJ residents. The new State Dental Hygienist, Becky Parnian, will assist the dental director in applying for and implementing new grant activities that advance Maternal and Child Health through improved oral health outcomes.

III.F. Public Input

[Will add content after public hearing]

V. Supporting Documents

Selected of Acronyms

Table 1: General Acronyms- Throughout the Application	
Acronym	**Full Name**
ACS	American Community Survey
ACYF	Administration on Children, Youth and Families
AMCHP	Association of Maternal & Child Health Programs
CB	Children's Bureau
CHW	Community Health Workers
DCF	Department of Children and Families
DCF	Department of Children and Families
DHS	Department of Human Services
ESM	Evidence-Based or Informed Strategy Measures
FHS	Family Health Services
FQHC	Federally Qualified Health Center
HRSA	Health Resources and Services Administration
MCHC	Maternal Child Health Consortia
MCH	Maternal and Child Health
MHI	Maternal Health Innovation
MIECHV	Maternal Infant and Early Childhood Home Visiting
NCSACW	National Center on Substance Abuse and Child Welfare
NH	Non-Hispanic
NJ	New Jersey
NJ DLC	New Jersey Doula Learning Collaborative
NJDOH	New Jersey Department of Health
NJSHAD	New Jersey State Health Assessment Data
NOM	National Outcome Measures
NPM	National Performance Measures
PRA	Perinatal Risk Assessment
RFA	Request for Application
RFP	Request for Proposal
ROI	Return on Investment
RPHS	Reproductive and Perinatal Health Services
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	social determinant of health
SPM	State Performance Measures
SPN	State Priority Needs
SUD	substance use disorders

TVP	Title V Program
TVS	Title V Staff
VERI	Vital Events Registration Information
WHO	World Health Organization

Table 2: Women Health	
Acronym	**Full Name**
CNJ	Connecting NJ
FASD	Fetal Alcohol Spectrum Disorder
HWHF	Healthy Women, Healthy Families
NJMMRC	New Jersey Maternal Mortality Review Committee
PMSS	Pregnancy Monitoring and Surveillance System
PMSS	Pregnancy Monitoring and Surveillance System
PPMD	Postpartum Depression and Mood Disorder
PRAMS	Pregnancy Risk Assessment Monitoring System
PRMR	Pregnancy-related Mortality Ratio
PRMR	Pregnancy-related Mortality Ratio
SSDI	State System Development Initiative

Table 3: Perinatal and Infant Health	
Acronym	**Full Name**
NICHD	National Institute of Child Health and Development
AAP	American Academy of Pediatrics
BFHI	Baby-Friendly Hospital Initiative
BSP	Breastfeeding Strategic Plan
IBCLC	International Board-Certified Lactation Consultant
PCHW	Perinatal Community Health Workers
PRA	Perinatal Risk Assessment
SCNJ	SIDS Center of New Jersey
SIDS	Sudden Infant Death Syndrome
SUID	Sudden Unexpected Infant Death
WIC	Women, Infants, and Children

Table 4: Child Health	
Acronym	**Full Name**
LTSAE	Learn the Signs. Act Early
ASQ	Ages and Stages Questionnaires
CoIIN	Collaborative Improvement and Innovation Network
ECCS	Early Childhood Comprehensive System
EIRA	Early Identification and Referral for Autism
F2F	Family to Family Health Information Center
ICHC	CYC Infant Child Health Committee
LRRC	Lakewood Resource and Referral Center
NJCYC	NJ Council for Young Children
PTI	Parent Training and Information Center
SPAN	Statewide Parent Advocacy Network

Table 5: Adolescent Health	
Acronym	**Full Name**
CASEL	Collaborative for Academic Social and Emotional Learning
TOP	The Teen Outreach Program
RTR	Reducing the Risk
Teen PEP	Teen Prevention Education Program
CAHP	Child and Adolescent Health Program
S-PEP	Statewide Parent and Professional Engagement Project
NICHD	National Institute of Health and Human Development
GLS	Garrett Lee Smith (GLS) Tribal/State Youth Suicide Prevention Grant
PREP	Personal Responsibility Education Program
SRAE	Sexual Risk Avoidance Education
MITEY Change	Motivational Interviewing Training for Empowering Youth towards Change
AYA	Adolescents and Youth Adults
BIPOC	Black, Indigenous, People of Color
NICHD	National Institute of Health and Human Development
S-PEP	Statewide Parent and Professional Engagement Program
VYPC	Voice of Youth Planning Committee
YAB	Youth Advisory Board
R2S	Readiness to Stand
FYSB	Family Youth Services Bureau

Table 6: Children with Special Health Care Needs	
Acronym	**Full Name**
AAP	American Academy of Pediatrics
ADDM	Autism and Developmental Disability Study
ASD	Autism Spectrum Disorders
ASL	American Sign Language
BDAR	Birth Defects and Autism Registry
BDARS	Birth Defects and Autism Reporting System
CCHD	Critical Congenital Heart Defects
cCMV	congenital Cytomegalovirus
CDC	Centers for Disease Control and Prevention's
CECs	Child Evaluation Centers
CHIPRA	Children's Health Insurance Program Reauthorization Act
CHOP	Children's Hospital of Philadelphia
CICRF	Catastrophic Illness in Children Relief Fund
CLCPC	Cleft Lip Cleft Palate Craniofacial
CMRS	Case Management Referral System
CMUs	Case Management Units
COCC	Statewide Community of Care Consortium
CQI	continuous quality improvement/initiatives
CSOC	Children's System of Care
CYSHCN	Children and Youth with Special Health Care Needs
DCF	Children and Families
DDD	Division of Developmental Disabilities
DHS	Department of Human Services
DOBI	Department of Banking and Insurance
DOE	Department of Education
DSET	Data Systems and Emerging Threat Response
DVRS	Division of Vocational Rehabilitation
EHDI	Early Hearing Detection and Intervention

EIM	Early Identification and Monitoring
EIS	Early Intervention Services
ELC	Expanded Laboratory Capacity
FAS/FASD	Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder
FCCS	Family Centered Care Services
FQHCs	Federally Qualified Health Centers
HEC	Hearing Evaluation Council
ISP	Individual Service Plan
LTPF	Leveling the Playing Field
MAAC	Medical Assistance Advisory Committee
MCHB	Maternal Child Health Bureau
MLTSS	Managed Long-Term Services and Supports
MPI	Master-Person Index
NBHS	Newborn Hearing Screening
NBS	Newborn Biochemical Screening
NJAAP	New Jersey Chapter of the American Academy of Pediatricians
NJACE	NJ Autism Center of Excellence
NJCDD	NJ Council for Developmental Disabilities
NJEIS	New Jersey Early Intervention Services
NJIIS	New Jersey Immunization Information System
NSARC	The Newborn Screening Advisory Review Committee
NSCH	National Survey of Children's Health
NSGS	Newborn Screening Follow-up and Genetic Services
PCP	Primary care provider
PIP	Partners in Policymaking
PTC	Pediatric Tertiary Care
REIC	Regional Early Intervention Collaborative
RWPD	Ryan White Part D
SCHS	Special Child Health Services
SCHSCM	Special Child Health Services Case Management
SMA	spinal muscular atrophy
SPAN	Statewide Parent Advocacy Network
SPoC	Shared Plan of Care

SPSP	Specialized Pediatric Services Program
SSI	Supplemental Security Income
STD	Sexually Transmitted Diseases
UB	Uniform Billing
UCEDD	University Centers for Excellence in Developmental Disabilities
WIC	Women Infants and Children
WICY	Women Infants Children Youth

Table 7: Cross-Cutting Systems Building

Acronym	**Full Name**
ASTDD	Association of State and Territorial Dental Directors
BMI	Body Mass Index
BSS	Basic Screening Survey
COHP	Children's Oral Health Program
DOE	Department of Education
FMR	Fluoride Mouth Rinse
OHS	Oral Health Services
OHSU	Oral Health Services Unit

Staffing List

Staffing for Maternal, Child and Adolescent Health

Staff Person	Title	Function	Related NPM	Tenure in MCH in Year
Nancy Scotto-Rosato, PhD	Assistant Commissioner	Title V Director	1-15	20+
Child and Adolescent Health				
Vacant	CAHP Coordinator	Oversees CAHP	7-12	
Jennie Blankie, MEd	Child and Adolescent Health Program Manager	Oversees CAHP/ GLS Youth Suicide Prevention	1-6	6
Jessica Shields, BS	Program Specialist 1	Oversees PREP	1-6	1.5
Gaspar Clacer, MS	Public Health Representative 2, Health Education	Oversees School Health Grant	1-6	<1
Amy Smuro, MAT	Pediatric Mental Health Program Coordinator	Oversees Pediatric Mental Health Access Grant	1-6	<1
Tiffany Charles	Program Specialist Trainee	Oversees SRAE	1-6	
Reproductive and Perinatal Health				
Felicia L. Harris, MSHS	RPHS Program Manager	Oversees RPHS	1-15	2
Karen Farrior	RPHS Program Coordinator	Coordinate activities within RPHS	1-15	2
Sarah Torres, BS	Program Specialist 3	Coordinator RPHS programs	1-15	1
Lisa D'Amico, RNC-MSN-APNC	Public Health Consultant 2 Nursing	Coordinator RPHS programs	1-15	5
Pamela Taylor, MPH	Public Health Consultant 2	Collette Lamothe-Galette Community Health Worker Institute-Statewide Coordinator	1-15	3
Dorothy Reed, MA	Program Management Officer.	ELC and DLC grants and support MIECHV	1-15	2
Cynthia Armand, MPH	Public Health Consultant 2		1-15	<1
Noelle Abbott	Program Specialist Trainee		1-15	<1
Sumantha Banerjee, MPH, CHES	Public Health Consultant 2		1-15	<1
Maternal and Child Health Epidemiology				
Genevieve Lalanne-Raymond, MPH, BSN, RN	MCH Epi – Research Scientist 1	Manages MCH Epi programs PRAMS Project Director	1-15	1
Sharon Cooley, MPH	MCH Epi – Research Scientist 2	PRAMS Coordinator	1-15	8+
Adwoa Nantwi	Research Scientist 2	MCH Epidemiologist who assists the Research Scientist I	1-15	<1
Vacant	Health Data Specialist 2	MCH Epidemiologist who assists the Research Scientist I	1-15	

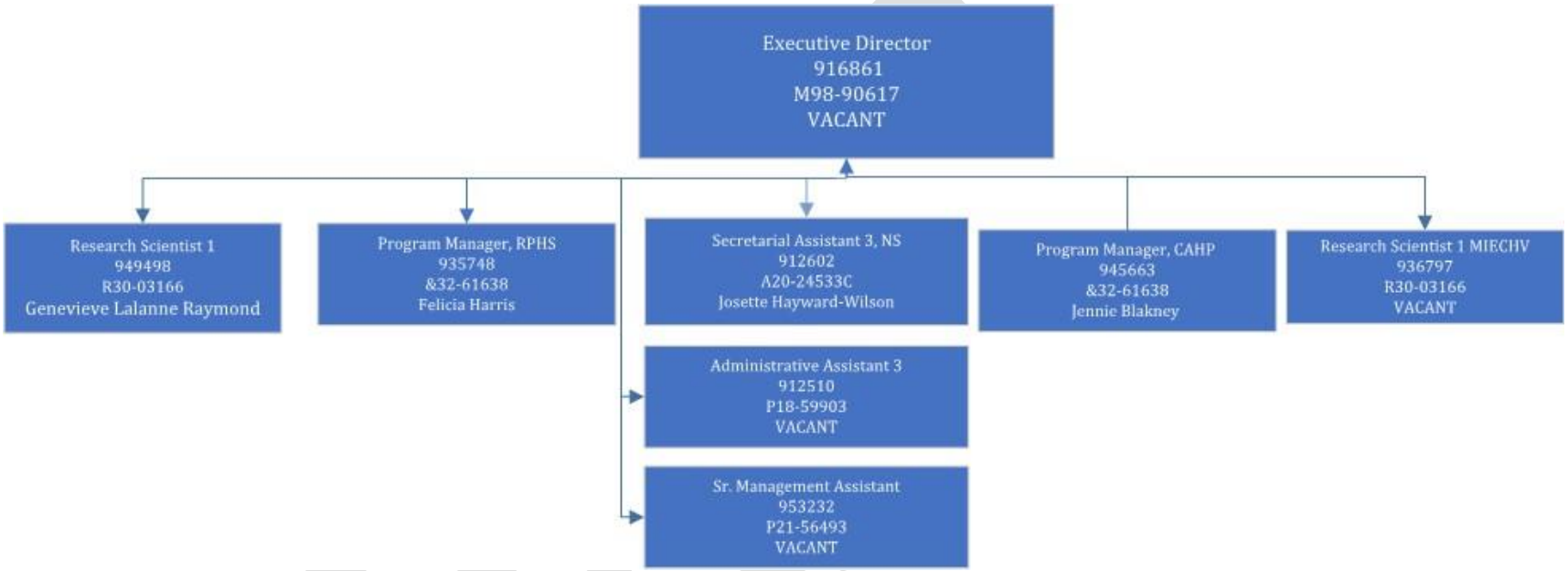
Staffing for SCHS

Staff Person	Title	Function	Related Priority NPM	Tenure in MCH
Sandra Howell, PhD	Executive Director	Service Unit Director, Director for CYSHCN	11,12	15 yrs.
Pam Aasen (Temp)	Analyst 1, Research and Evaluation	EHDI Coordinator		<1 yr.
Stephanie Agugliaro	Public Health Representative 3	Provides support to the autism registry.		3 yr.
Kathryn Aveni, RNC, MPH	Research Scientist 1	DSET	11,12	18 yrs.
Julia Bixler	Public Health Representative Trainee	SCHS Case Management & Family Support and Ryan White Part D activities		
Courtnie Brown	Sr. Management Assistant	HR Liaison		2 yrs.
Nicole Dennis	Administrative Analyst 1	Provides data analysis work and support for EHDI		4 yrs.
Diane Driver	Nursing Consultant	Works on the CCHD project.		8 yrs.
Vanessa Gray (Temp)	Program Specialist 2	Public health consultation re: SCHSCM programs, family support, and Fee for Service program, program officer for SCHSCM health services grants	11,12	
Tracey Hayes	Principal Clerk Typist	Provides clerical support for EHDI		19 yrs.
Daniel Heitner	Research Scientist 2	Supports FCCS Unit; SCHS Case Management & Family Support, Fee for Service, Ryan White Part D activities	12,12	1 yr.
Jennifer Hopkins	Program Specialist 1	Program Management Officer for health service grants in NSGS and HEM		2 yrs.
Suzanne Karabin	Research Scientist 2	Coordinator for the Autism Registry		21 yrs.
Dawn Mergen	Program Specialist 4	Program Manager for FCCS Unit; SCHS Case Management & Family Support, Fee for Service, Ryan White Part D activities	11,12	9 yrs.
Kidanemariam Meshesha	Research Scientist 2	Provides data services for BDRS & FCCS	11,12	1 yr.
Nicole Moore	Agency Services Representative 3	Provides clerical support for BDAR		24 yrs.
Anthony Mosco	Software Development Specialist Assistant	Technical assistance related to the BDAR		15 yrs.

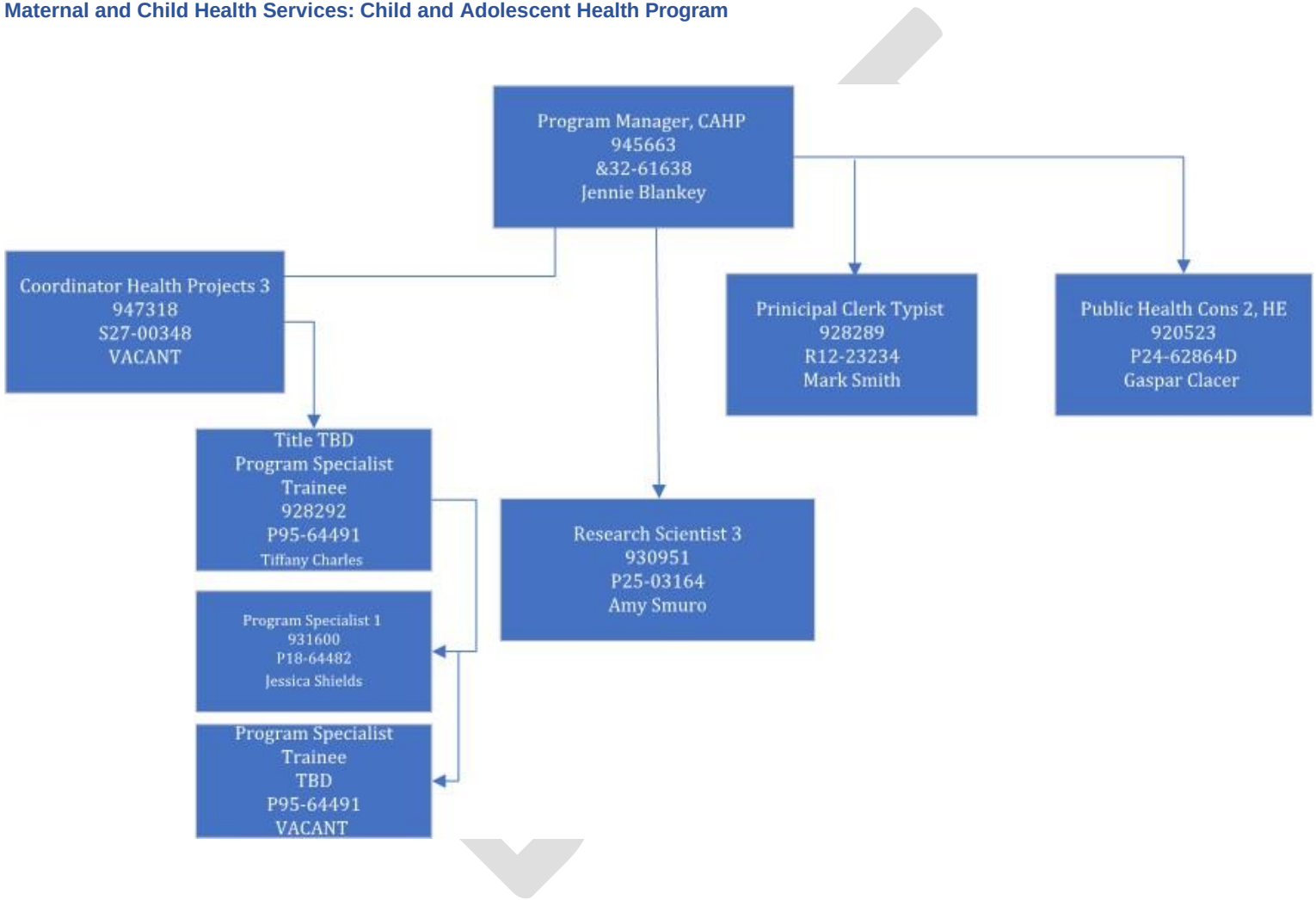
Elena Napravnik	Research Scientist 2	Supervises activities of EIM (interim)		4 yrs.
Nancy Schneider, MA, CCC-A, FAAA	Research Scientist 2	Audiologist, liaison to the audiology community		21 yrs.
Hanna Sea	Research Analyst I	Program Management Officer: manages health services grants for SPSP		5 yrs.
Jing Shi, MS	Research Scientist 2	Responsible for data management for EIM	11,12	5 yrs.
Dorothy Snyder	Secretarial Assistant 3	Secretarial support	11,12	7 yrs.
Morgan Spanier	Public Health Representative Trainee	SCHS Case Management & Family Support and Ryan White Part D activities		
Lisa Stout, BSN, RN	Nurse Consultant	Ensures that the information on each BDAR registration is accurate and complete		4 yrs.
Hui Xing	Research Scientist 2	Provides data services for BDRS & FCCS	11, 12	4 yrs.
Vacant	Research Scientist 1 (EIM)	Works with the Autism Registry, analyzes data, writes grants		
Vacant	QA Specialist (EIM)	Ensures BDAR registrations are accurate and complete by QA review and perform facility audits		
Vacant	Nursing Consultant	Responsible for CCHD and Quality Assurance education regarding NSGS		
Vacant	Research Scientist 2 (EIM)	Works with the Birth Defects Registry, analyzes data, writes grants		
Vacant	Health Data Specialist App	Supports data coordination for EIM and EHDI		
Vacant	Nursing Consultant (EIM)	Ensures that the information on each BDAR registration is accurate and complete		
Vacant	Program Specialist 2	Public health consultation re: SCHSCM programs, family support, and Fee for Service program, program officer for SCHSCM health services grants	11,12	
Vacant	Nursing Consultant	Public health nurse consultation across CMU agencies and Medicaid managed care expertise		
Vacant	Public Health Representative Trainee	Provides support to and onsite training with Public Health Representatives who follow-up on all newborns with abnormal newborn screening results		

VII. Organizational Chart

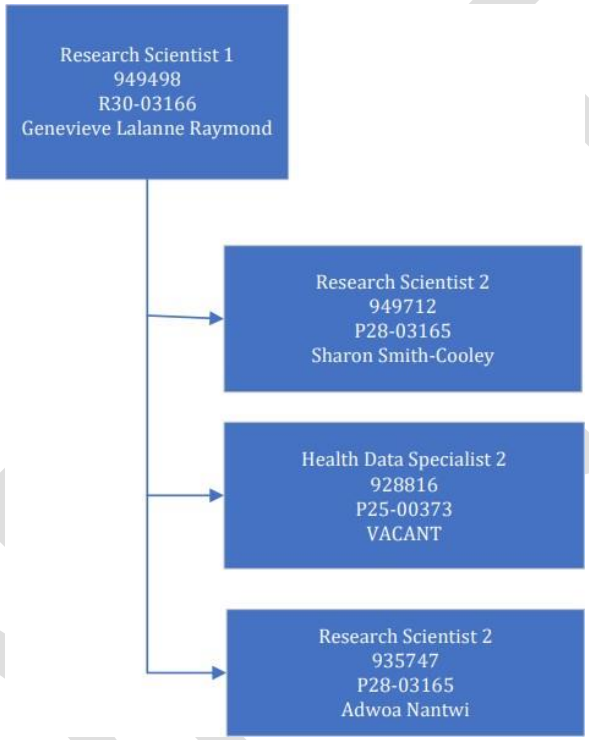
Maternal and Child Health Services Office of the Director



Maternal and Child Health Services: Child and Adolescent Health Program



Maternal and Child Health Services: Maternal and Child Health Epidemiology



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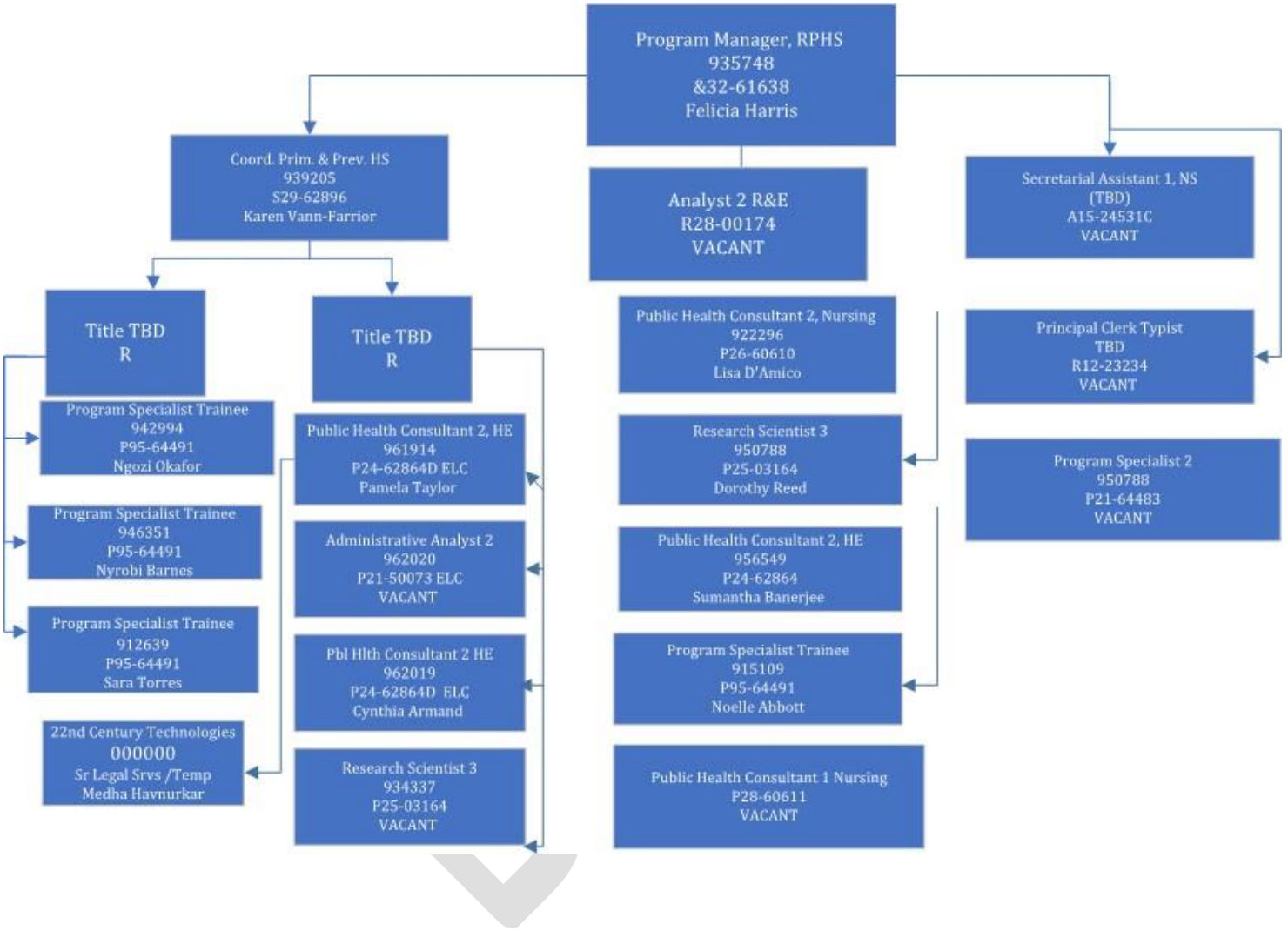
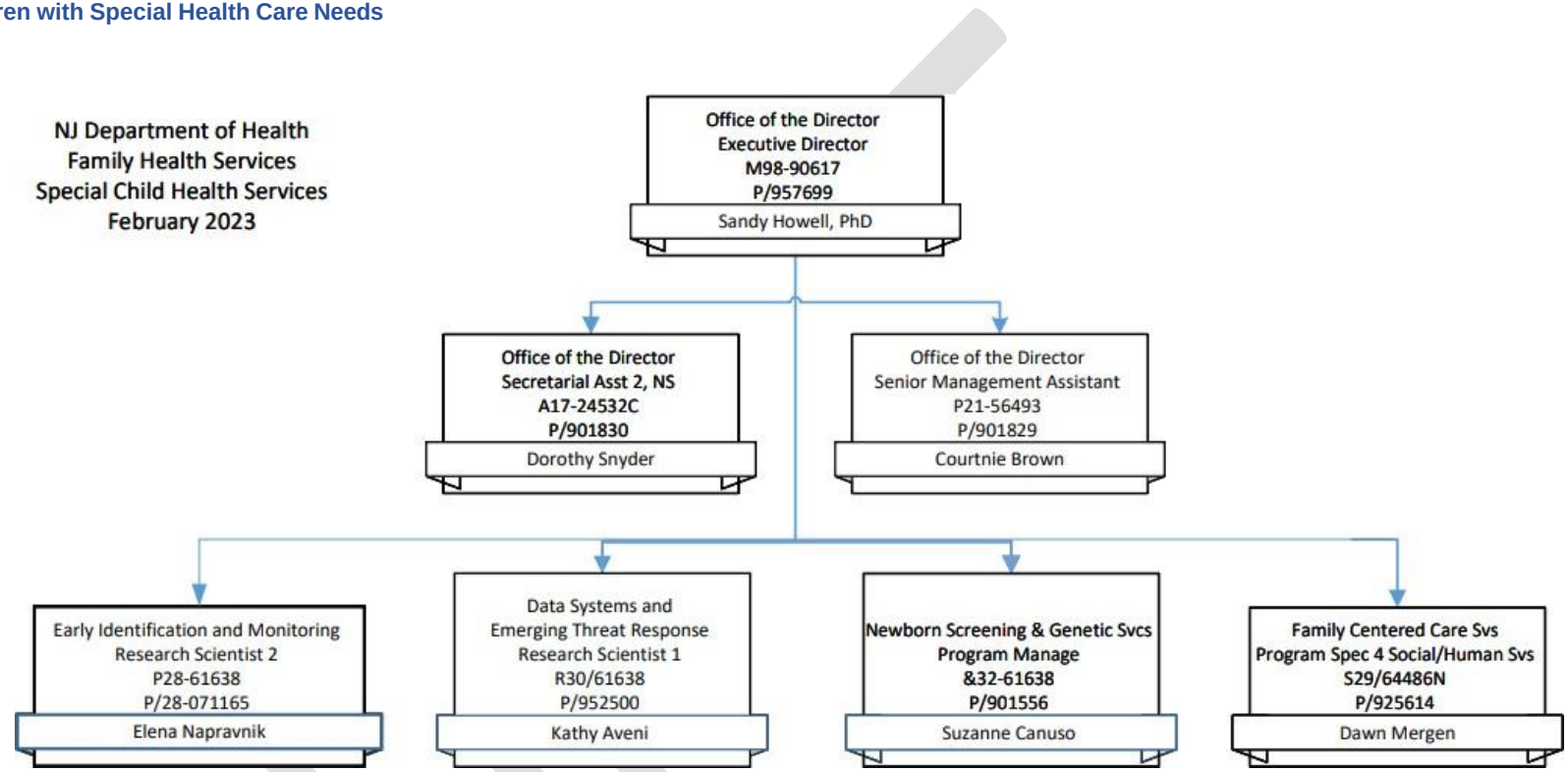
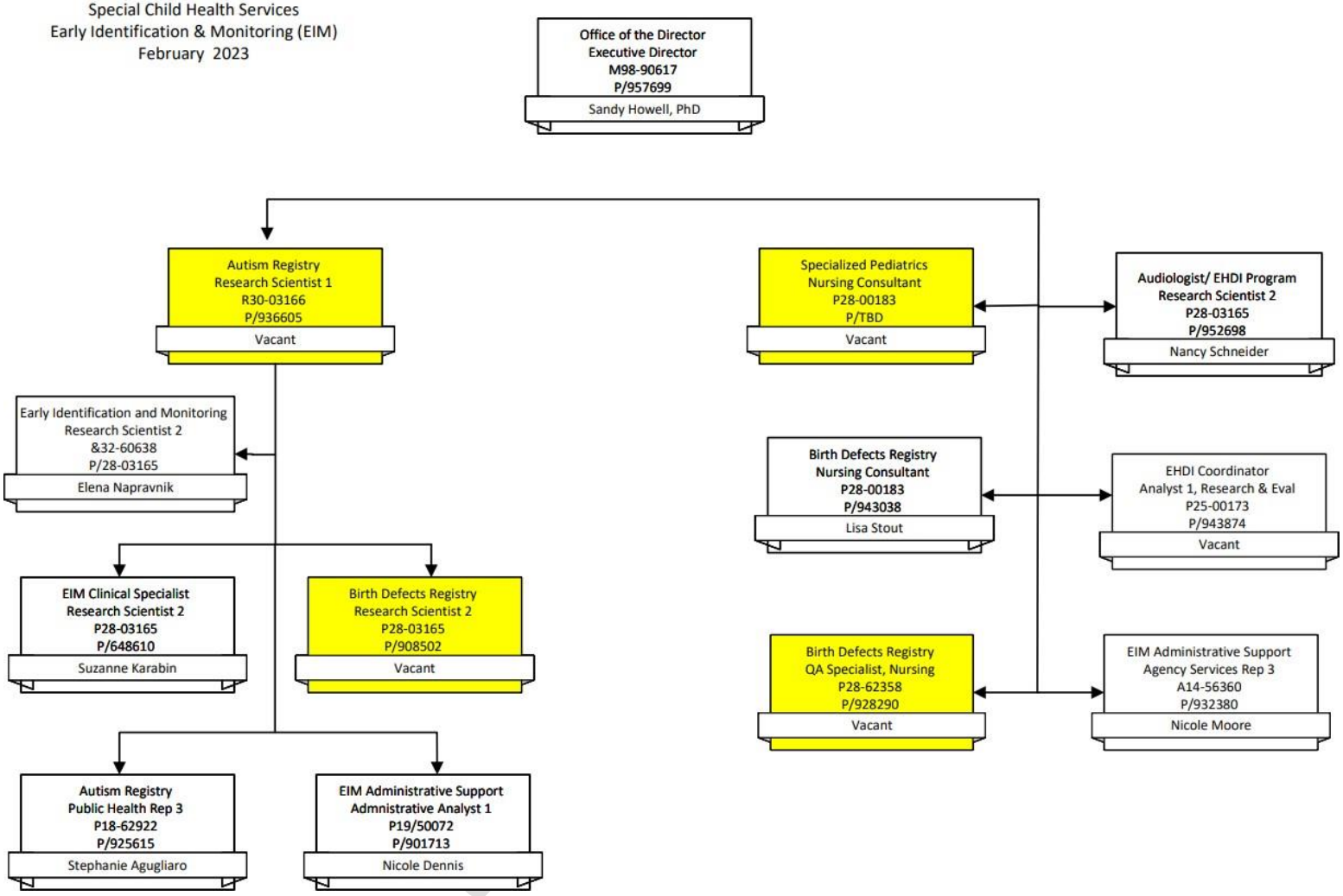


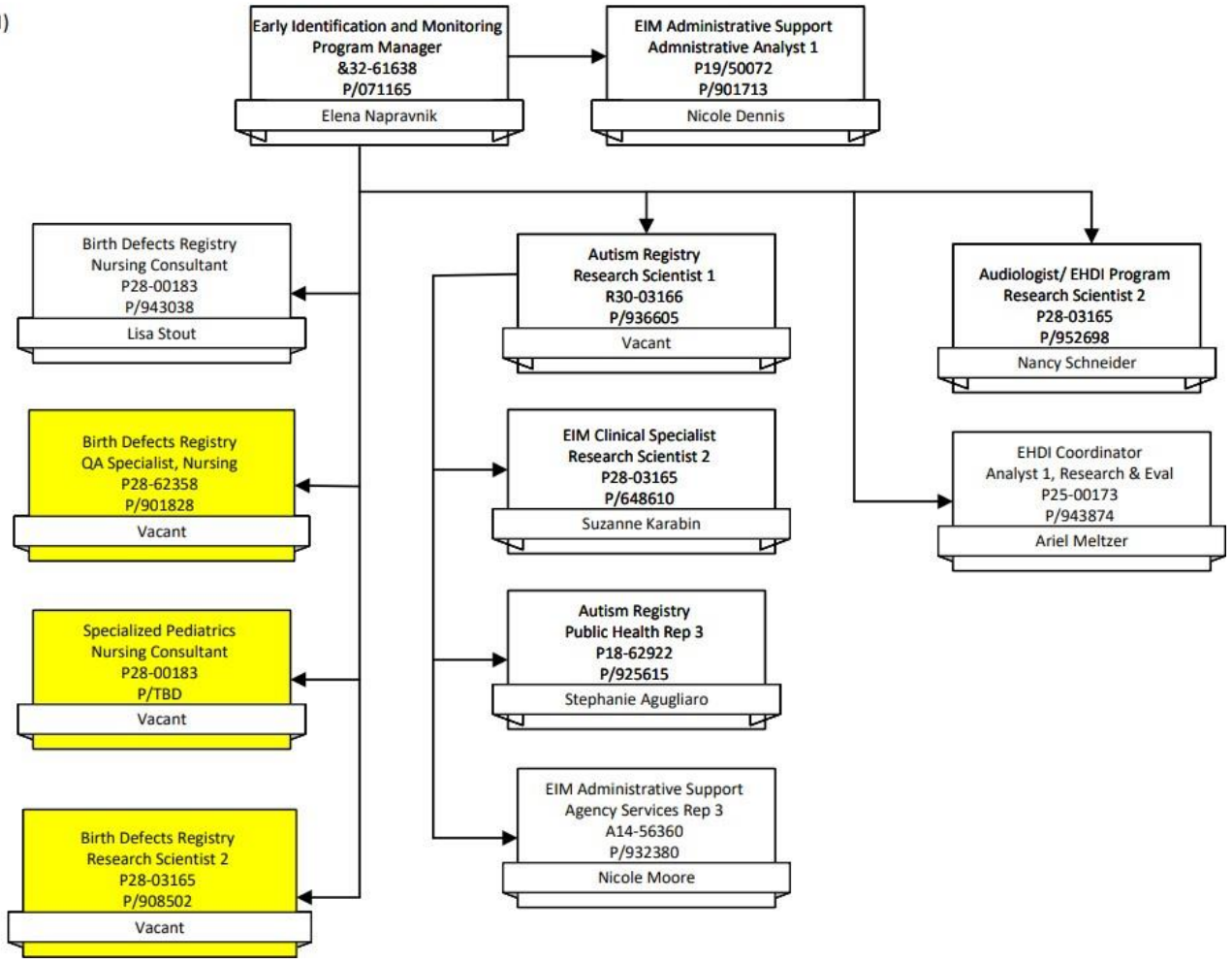
Children with Special Health Care Needs



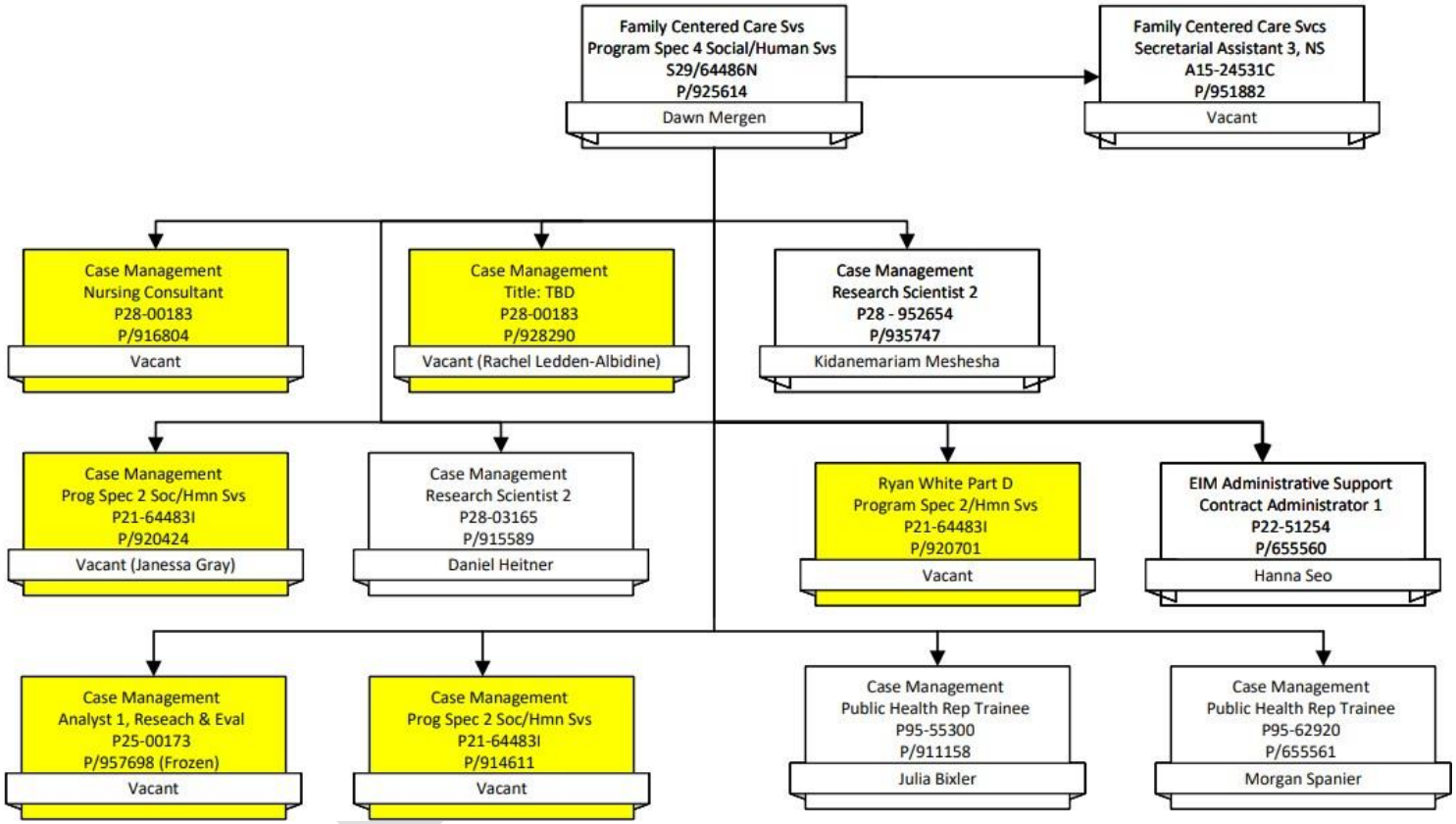
NJ Department of Health/Family Health Services
Special Child Health Services
Early Identification & Monitoring (EIM)
February 2023

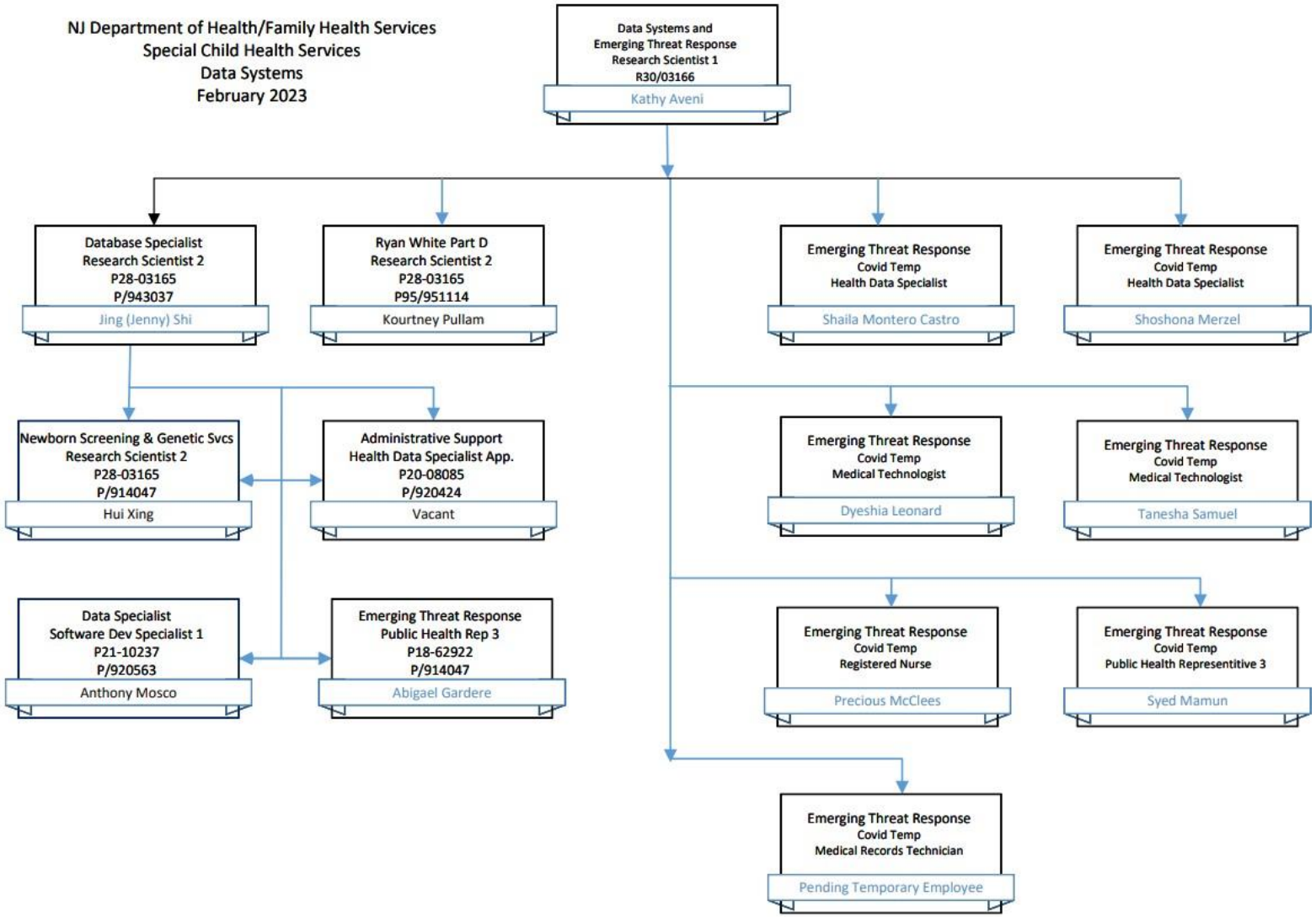


NJ Department of Health/Family Health Services
Special Child Health Services
Early Identification & Monitoring (EIM)
January 2023



NJ Department of Health/Family Health Services
Special Child Health Services
Family Centered Care Services
February 2023




NJ Department of Health/Family Health Services
Special Child Health Services
Data Systems
February 2023
Data Systems and
Emerging Threat Response
Research Scientist 1
R30/03166
Kathy Aveni
Database Specialist
Research Scientist 2
P28-03165
P/943037
Jing (Jenny) Shi
Ryan White Part D
Research Scientist 2
P28-03165
P95/951114
Kourtney Pullam
Emerging Threat Response
Covid Temp
Health Data Specialist
Shaila Montero Castro
Emerging Threat Response
Covid Temp
Health Data Specialist
Shoshona Merzel
Newborn Screening & Genetic Svcs
Research Scientist 2
P28-03165
P/914047
Hui Xing
Administrative Support
Health Data Specialist App.
P20-08085
P/920424
Vacant
Emerging Threat Response
Covid Temp
Medical Technologist
Dyeshia Leonard
Emerging Threat Response
Covid Temp
Medical Technologist
Tanesha Samuel
Data Specialist
Software Dev Specialist 1
P21-10237
P/920563
Anthony Mosco
Emerging Threat Response
Public Health Rep 3
P18-62922
P/914047
Abigael Gardere
Emerging Threat Response
Covid Temp
Registered Nurse
Precious McClees
Emerging Threat Response
Covid Temp
Public Health Representitive 3
Syed Mamun
Emerging Threat Response
Covid Temp
Medical Records Technician
Pending Temporary Employee