



**MATERNAL AND CHILD
HEALTH SERVICES TITLE V
BLOCK GRANT**

State Narrative for New Jersey
MCH Block Grant



July 7, 2022

Table of Contents

III.A. Executive Summary	2
III.A.1. Program Overview	2
III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts	7
III.A.3. MCH Success Story	8
III.B. Overview of the State	9
FY 2023 Application/FY 2021 Annual Report Update	22
III.D. Financial Narrative	25
III.D.1. Expenditures	25
III.D.2. Budget	25
III.E. Five-Year State Action Plan	26
III.E.1. Five-Year State Action Plan Table State: New Jersey	26
III.E.2. State Action Plan Narrative Overview	32
III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems	33
III.E.2.b. ii. Family Partnership.....	36
III.E.2.b.iii. MCH Data Capacity	39
III.E.2.b.iii.b. State Systems Development Initiative (SSDI).....	41
III.E.2.b.iii.c. Other MCH Data Capacity Efforts	42
III.E.2.b. iv. MCH Emergency Planning and Preparedness	43
III.E.2.b.v. Health Care Delivery System	45
III.E.2.b.v.b. Title V MCH-Title XIX Medicaid Inter-Agency Agreement (IAA)	46
III.E.2.c State Action Plan Narrative by Domain	51
Women/Maternal Health - Annual Report	52
Women/Maternal Health - Application Year	54
Perinatal/Infant Health - Annual Report	57
Perinatal/Infant Health - Application Year	65
Child Health - Annual Report	69
Child Health - Application Year	72
E.2.c.4.a. Adolescent Health - Annual Report	74
Adolescent Health - Application Year	80
Children with Special Health Care Needs - Annual Report.....	82
Children with Special Health Care Needs - Plan for the Application Year	87
Cross-Cutting/Systems Building - Annual Report	91
Cross-Cutting/Systems Building - Application Year	94
III.F. Public Input.....	96
III.G. Technical Assistance	97
Table 1a: New Jersey Five-Year Needs Assessment Framework Logic Model – Listed by NPM	98
Table 1b - Staffing for MCHS.....	102
Table 1c - Staffing for SCHS.....	103

III.A. Executive Summary

III.A.1. Program Overview

New Jersey (NJ) is one of the most urbanized, densely populated, racially and ethnically diverse states in the nation. 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 100,000 newborns that the state welcomes yearly. NJ's diversity highlights the importance of addressing disparities in health outcomes and highlights 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 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 (MCH) 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 MCH partners.

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

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 9-Bullying,
NPM 4-Breastfeeding,	NPM 11-Medical Home,
NPM 5-Safe Sleep,	NPM 12-Transitioning to Adulthood, and
NPM 6-Developmental Screening,	NPM 13-Oral Health.

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 aiming at reducing 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 U.S.¹. In 2018, in response to NJ's maternal and infant health crisis, the NJDOH FHS funded diverse community-based organizations to support the Healthy Women, Healthy Families initiative (HWHF). Through the HWHF initiative, the NJDOH has taken a targeted approach to reduce black infant mortality (BIM) rates by implementing specific BIM reduction activities include- breastfeeding support, fatherhood support, centering pregnancy, and centering parenting programs, doula services, and more. 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.

Through focus groups, birthing people in NJ echoed the need to have a trusted support person who can advocate on their behalf and help them navigate the complex health system. HWHF facilitates the establishment of a trusted perinatal workforce including Community Doulas and Community Health Workers (CHWs), who are trained to provide culturally competent care.

To date, approximately 150 women were trained to become community doulas, and as of December 2021, 547 births have been attended by doulas from the 3-year Doula Pilot Program. Preliminary results from an evaluation conducted

¹ America Health Rankings. Health of Women and Children. Accessed on April 20, 2022. [Explore Health Measures in New Jersey | 2019 Health of Women and Children Report | AHR \(americashealthrankings.org\)/education](#)

by researchers from Montclair State University in 2021 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. To ensure the sustainability of community doula services, NJ's Title V Program (TVP) partnered with the NJ Department of Human Services to offer doula services to women through Medicaid Benefits. NJ Medicaid benefits have been expanded to cover doula services. Presently, birthing people who are covered by Medicaid are enabled to receive covered services from a Medicaid enrolled community doula.

NJ's 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 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. To date, the CLG-CHWI successfully trained and integrated 180 CHWs into NJ health systems. Thirty-two percent of our trainees identified as bilingual. They are also trained to respond to diverse public health challenges in areas including COVID-19 response, mental health, and others. Upon course completion, CHWs receive 9 college credits toward an associate degree.

In July 2021, through [legislation signed by NJ's Governor](#), NJ is now the second state in the nation to establish a universal Home Visiting Program. NJ's Maternal Infant and Early Childhood Home Visiting Program (MIECHV) is a statewide program with the capacity to serve over 5,000 families of infants and young children. The overall mission of MIECHV is to improve the physical and emotional well-being of infants, children, and their families in NJ by providing community-based education and in-home support to parents, including evidence-based safe sleep strategies. The Central Intake system, which was rebranded in 2022 into a more welcoming and consumer-friendly name, [Connecting NJ \(CNJ\)](#), is a county-based single point of entry system for referrals 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.

Through these public health interventions, NJDOH is leading a pivotal shift toward a sustainable non-traditional, community-based perinatal workforce capable of helping birthing people and their families navigate the healthcare system and get access to individualized care tailored to their needs. NJ'S TVP was invited to develop a Policy Development Handout to be featured on the Association of Maternal & Child Health Programs (AMCHP) [MCH Innovations Database](#)². The handout is designed to serve as a resource to help interested teams in replicating NJ's doulas expansion through Medicaid reimbursement.

This coming year, NJ TVP will continue to reinforce the non-traditional perinatal workforce (NTPW) in NJ, and use \$500K that was appropriated from the Governor's Murphy 2022 budget to further expand the reach of the CLG-CHWI in the community to advance the mission of NJ TVP. Moreover, the team 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 to work with key officials to explore the expansion of Medicaid benefits to cover CHWs services and establish a state registry for both CHWs and community doulas. 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. In 2023, the teams will evaluate and determine the effectiveness of the training on increasing CHW competencies and improving curricula materials and instruction to address gaps in training.

Concurrently, NJ's TVP designed an evaluation project that will assess the outcome indicators and evaluate the status of current HWHF activities being implemented in the communities. Upon completion of the evaluation project, TVP will synthesize the results into a set of comments, recommendations, and suggestions to inform future programmatic and policy decisions concerning the HWHF initiative. Additionally, NJ's TVP is investigating novel methodological approaches to standardize the Fetal and Infant Mortality Review (FIRM) case identification process across NJ's three maternal and child health consortia.

Shortages in mental health and addictions specialists are evident for the general population and especially for maternal child health populations with limited resources. TVP anticipates announcing a competitive Request for Proposals (RFP) to pilot an Alma Program Expansion Project which aims to support pregnant persons who may be experiencing mental health issues and/or substance use issues.

² Association of Maternal & Child Health Programs (AMCHP). Policy Development Expansion of Community-Based Doulas Through Medicaid Reimbursement. Access on April 20, 2022. https://amchp.org/database_entry/expansion-of-community-based-doulas-through-medicaid-reimbursement/

Racial and ethnic disparities continue to persist in preterm birth rates, necessitating the need 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.

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) Impact Initiative, the NJ Department of Children and Family (DCF) in partnership with NJ TVP was able to integrate developmental health promotion and screening as a service of the statewide Connecting NJ system effective in FY19. Through FY20 and FY21, CNJ's central hubs maintained their outreach despite the pandemic. This enabled thousands of children to receive parent-led developmental screenings. In FY22, we anticipate a sustained reach with a slight increase, with the ability to 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 been greatly impacted by COVID-19. AYAs have experienced school closures, the hurdles of virtual learning, masking and social distancing from their peers, and missing important milestones and activities such as graduation, sports, and social activities. Findings from Adolescent Behaviors and Experiences Survey (ABES) included increased drug and alcohol use, significant increases in persistent feelings of sadness and hopelessness, with approximately 1/3 of students surveyed reporting that they perceived they were treated badly or unfairly because of their race³. The COVID-19 pandemic has also impacted bullying, as students shifted from in-person learning to virtual learning and then back to in-person learning. During these shifts, bullying also shifted from in-person to online with a sharp increase in physical fights at the start of the 2021-22 school year that has since quieted. Still, 1 in 5 students are victims of bullying with higher rates for adolescents with disabilities, those who identify as lesbian, gay, bisexual, transgender, and non-binary, and Black, Indigenous, 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. These findings have informed our plan for the upcoming year and will continue to aid the Child and Adolescent Health Program (CAHP) in future endeavors.

The CAHP plan for the upcoming year includes a strong focus on mental health/suicide prevention, sexual health, and school health. The MCHBG specifically supports adolescent mental health, suicide prevention, and school health, but all programs work together to holistically support adolescents and their health needs. 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 (Dialectical Behavioral Therapy, 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 youth, named Prevent Suicide NJ (PSNJ). PSNJ will launch in September of 2022 after the national launch of hotline #988 which will replace the National Suicide Prevention Lifeline number⁴. 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.

Professional Development for the year will include Mental Health First Aid training, Building Your Social and Emotional Learning (SEL) Toolkit, Sexual Health 101, Engaging Youth Across Multiple Platforms, Talking with Teens about Sexual Health with Al Vernacchio- Parent Engagement webinar, Working with Youth with Developmental and Intellectual Disabilities, Diversity, Equity and Inclusion training for adults on Race, Trauma and Mental Health and an AYA training series: Bringing Your Voice to the Table™.

NJDOH CAHP will also continue to implement our SEL Bullying Prevention activities including The Teen Outreach Program TOP® and Lifelines Trilog. TOP® an SEL-based model proven to reduce teen pregnancy will reach at least 1,500 NJ youth and Lifelines Trilog an SEL-based suicide prevention program will reach at least 4,500 NJ students aged 12-18 (5th - 12th grade).

³ Adolescent Behaviors and Experiences Survey (ABES). Access on April 20, 2022. <https://www.cdc.gov/healthyouth/data/abes.htm>

⁴ The Lifeline and 988. Access on April 20, 2022. <https://suicidepreventionlifeline.org/current-events/the-lifeline-and-988/>

Children and Youth with Special Health Care Needs (CYSHCN)

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

- (1) Newborn Screening and Genetic Services (NSGS) ensures 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 in 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 birth defect 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, and divisions as well as county and municipal agencies. Our FCCS case managers also refer children to NJ Early Intervention Services (NJEIS) to ensure that eligible children receive important services on time, and 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, and five Cleft Lip/Palate Craniofacial Anomalies Centers. The goal of the SPS program 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. With support from the State and Title V funds, health service grants are distributed to multiple agencies throughout NJ.
- (6) The NJEIS provides services to children from birth to three years of age who are experiencing developmental delays. At any given time, approximately 15,000 children receive services including Occupational Therapy, Speech Therapy, Physical Therapy, and Developmental Intervention.

NJ's Title V CYSHCN program diligently 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 remains a priority to ensure that families are adequately supported. Therefore, through the Title V CYSHCN program, staff 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.

Cross-Cutting/Systems Building

The Division of Community Health Services in collaboration with the TVP and other key stakeholders has implemented Fluoride Varnish programs, including those for school-age and HeadStart / Early HeadStart populations. To ensure that the population of focus gets the necessary education to care for their teeth, the Division of Community Health Services has implemented oral health education for doulas and home visitation staff as well as other health care professionals who work directly with families with young children and birthing people. Moreover, to increase awareness of best practices for prescribing pain medications and to combat the opioid epidemic in NJ, the team designed and implemented an opioid education program for dental professionals and dental students.

COVID-19

The impact of COVID-19 on all areas of maternal, child, and adolescent health has been and continues to be significant. COVID-19 necessitated a rapid transition from in-person programs and services to those being administered remotely whenever possible. 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 public health and health care systems in the U.S. [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 challenges⁵. TVS, as well as Title V grantees, operated remotely from home during the pandemic. The teams have transitioned from offering virtual appointments to now offering both in-person and virtual depending on the program's specifics and clients' preferences.

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 aiming at raising awareness, identifying the impact of COVID-19 in high-risk populations, and combating the ill effects of COVID-19 in NJ. The first project ECHO webinar training was held in November of 2020 and it will continue until June 2022. As the COVID-19 pandemic continues to rapidly evolve, TVP continues to collaborate with partners and families to deliver services and support.

⁵ McCloskey, L.; Amutah-Onukagha, N.; Bernstein, J.; Handler, A.; Setting the Agenda for Reproductive and Maternal Health in the Era of COVID-19: Lessons from a Cruel and Radical Teacher. *Maternal and Child Health Journal* (2021) 25:181–191. <https://doi.org/10.1007/s10995-020-03033-y>

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

Title V Funds are essential in supporting NJ's MCH efforts. FHS uses the Title V MCH funding as the primary source for multiple public health interventions aimed at addressing 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 COVID-19 response. A few examples of key programs funded by Title V funding:

1. Maternal Mortality Review Committee (MMRC)- to support staff salary to do chart abstraction, case summaries, and data entry into CDC's Maternal Mortality Review Information Application (MMRIA) system
2. Healthy Women, Healthy Families initiative – designed to improve maternal and infant health and reduce both Black Infant and Black Maternal mortality
3. NJ Fetal Infant Mortality Review (FIMR) is partially funded by Title V funds to support the Family Health Line which is the 1-800 number for referrals to a variety of programs and services.

Please see Table in Section 3.D.1. Expenditures demonstrate the federal / state partnership and how FY 2021 Federal Title V funds are supported by State MCH funds. Therefore, 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.

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. MCH Success Story

Special Child Health and Early Intervention – The NJ EHDI Program Goes International!

In March, a Morris County-based audiologist received a call from a mother of a baby who was unexpectedly delivered at home 3 weeks prior to this call. The mom reported that her physician advised her about the importance of having her infant son undergo a newborn hearing screening prior to one month of age and she, in turn, had contacted several audiology facilities in her area to set up an appointment for this service. There was a sense of urgency surrounding the scheduling of the baby's hearing screening as the family was leaving New Jersey that weekend to move to their new home in Kenya. Despite best efforts and a very limited time frame of only 2 days before the family's departure abroad, a newborn hearing screening appointment in New Jersey could not be secured. Our NJ EHDI audiologist called the parent and provided a possible solution – namely having her daughter undergo her initial hearing screening in Kenya. A search of Kenya-based pediatric audiologists located three facilities located in Nairobi. We also provided the family a copy of a NJ EHDI Newborn Hearing Follow-up Report form so that their Nairobi-based audiologist could complete the form and send it back to the NJ EHDI program. On April 5, the parents sent the following email to NJ EHDI: "You have been absolutely amazing, and yes, it's so great that the appointment was set up so quickly and the team at the facility recommended by you have been so helpful and welcoming - am so happy. (Our son) was able to complete his screening today as planned and I have hard copies of both the facility report of the test as well as the form required by the NJ Health Department, everything has gone so smoothly... thank you loads for everything you have done to make sure we had all the help we needed, my family and I are forever indebted to you."

MCH – Expanding the Perinatal Workforce

NJ's TVP continues to make great strides in developing and expanding the perinatal workforce. The CLG-CHWI, established in 2020, continues to expand and increase its graduates, who receive a standardized community health worker training and certification program. NJDOH is partnering with Rutgers Project ECHO to provide an educational webinar series to support NJ CHWs. The CHW ECHO series aims to help CHWs raise awareness and knowledge concerning COVID-19, identify the impact of COVID-19 in communities with vulnerable and high-risk populations, and combat the ill effects of COVID-19 in the NJ public health response. The session continues until May 2022. Additionally, NJDOH was successful in being awarded \$9 Million over three years from the Centers for Disease Control and Prevention to further train, deploy, and engage CHWs in addressing health disparities exacerbated due to the pandemic. NJ's TVP further anticipates the release of a request for proposals to implement the Alma model, to train CHWs and other outreach workers to approach and address mental health and substance use issues within the perinatal population.

The Doula Learning Collaborative (DLC) established in 2021, is funded 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. NJ's TVP, the DLC, and NJ's First Lady's Office are working together to help develop, support, and expand NJ's doula workforce.

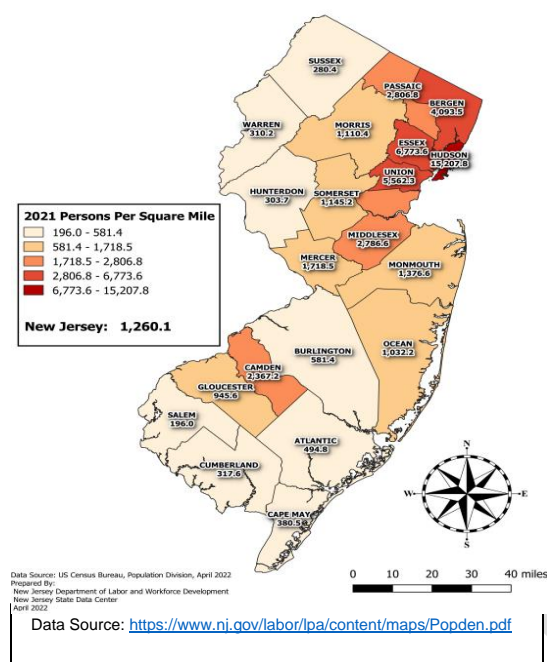
In efforts to build and expand the maternal health care workforce, Governor Murphy has also proposed \$1 million in funding to expand the midwifery workforce in NJ. The funds will be used to further develop education programs and increase clinical training placements for nurse-midwives.

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 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 Division's ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

Figure 1. 2021 Population Density: New Jersey Counties



In 2021, the [population density](#) (persons per square mile) in NJ is 1,260 to 1 compared with to 93 to 7 nationally. There are 564 municipalities and 21 counties in NJ. The most populated counties in NJ are located 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).

[According to the 2021 NJ Population Estimates](#) of race, 54.6% of the population were white, non-Hispanic; 15.1% were black, non-Hispanic; 10% were Asian; 0.6% were American Indian and Alaska Native, and 2.3% 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. Among this group, 43.2% who speak Spanish in the home also speak English less than very well. 32.1% of those who primarily speak Indo-European languages and 36.5% of those who primarily speak Asian and Pacific Island languages speak English less than very well.

The racial and ethnic mix for NJ mothers, infants, and children is more diverse than the overall population composition⁶.

According to 2021 birth certificate preliminary data, 27.95% 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-Hispanic⁷. 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 life span, and 3) increasing cultural competency of services as three priority goals for the MCH population. These goals are consistent with the Life Course Perspective (LCP) which proposes that an inter-related web of social, economic, environmental, and physiological factors contribute 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 the environments in which people live, learn, work, play, worship, and age, have a significant effect on health, functioning, and quality of life. [Healthy People 2030](#) identifies five key areas of SDOH as 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

⁶ United States Census Bureau. Quick facts New Jersey. Accessed on April 20, 2022. <https://www.census.gov/quickfacts/fact/table/NJ/PST040218>

⁷ United States Census Bureau. Quick facts New Jersey. Accessed on April 20, 2022. <https://www.census.gov/quickfacts/fact/table/NJ/PST040218>

state, and external partners in addressing infant, maternal mortality, the opioid crisis, and other public health issues facing NJ.

The selection of the NJ's eight State Priority Needs is a product of FHS's continuous needs assessment. Influenced by the MCH Block Grant needs assessment process, the NJDOH budget process, the NJ State Health Improvement Plan, Healthy NJ 2030, Community Health Improvement Plans, and the collaborative process with other MCH partners, The process of identifying NJ priority needs is further detailed in the Needs Assessment Summary Section 3.C.

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, and
- SPN #7) Improving & Integrating Information Systems.

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 magnified by the COVID-19 public health emergency, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services. Based on NJ's eight selected SPNs as identified in the Five-Year Needs Assessment, NJ has selected the following 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, and
- NPM #13 Oral Health.

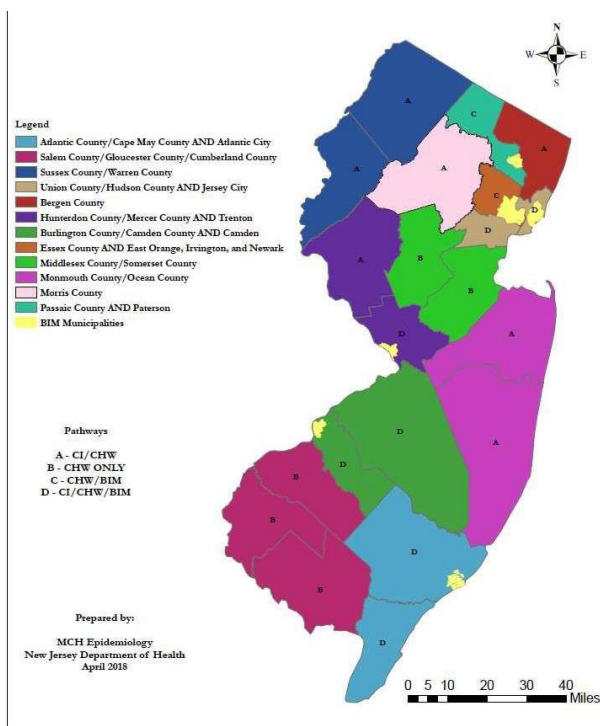
State Performance Measures (SPMs) have been reassessed through the needs assessment process. The existing SPMs which will be continued are:

- 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 (See Supporting Document #1) 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 Evidence-Based or Informed Strategy Measures (ESMs), National Performance Measures (NPMs), and National Outcome Measures (NOMs). The Logic Model represents a more integrated system created by the three-tiered performance measure framework which ties the ESMs to the NPMs which in turn 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.

Figure 2. Healthy Women Healthy Families Regions



Maternal/Women /Reproductive Health & Perinatal/Infant Health

1) HWHF grants have been awarded in fiscal year 2019 (start date of July 1, 2018) through a request for proposals process. The goal of this initiative is 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 and
- 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.

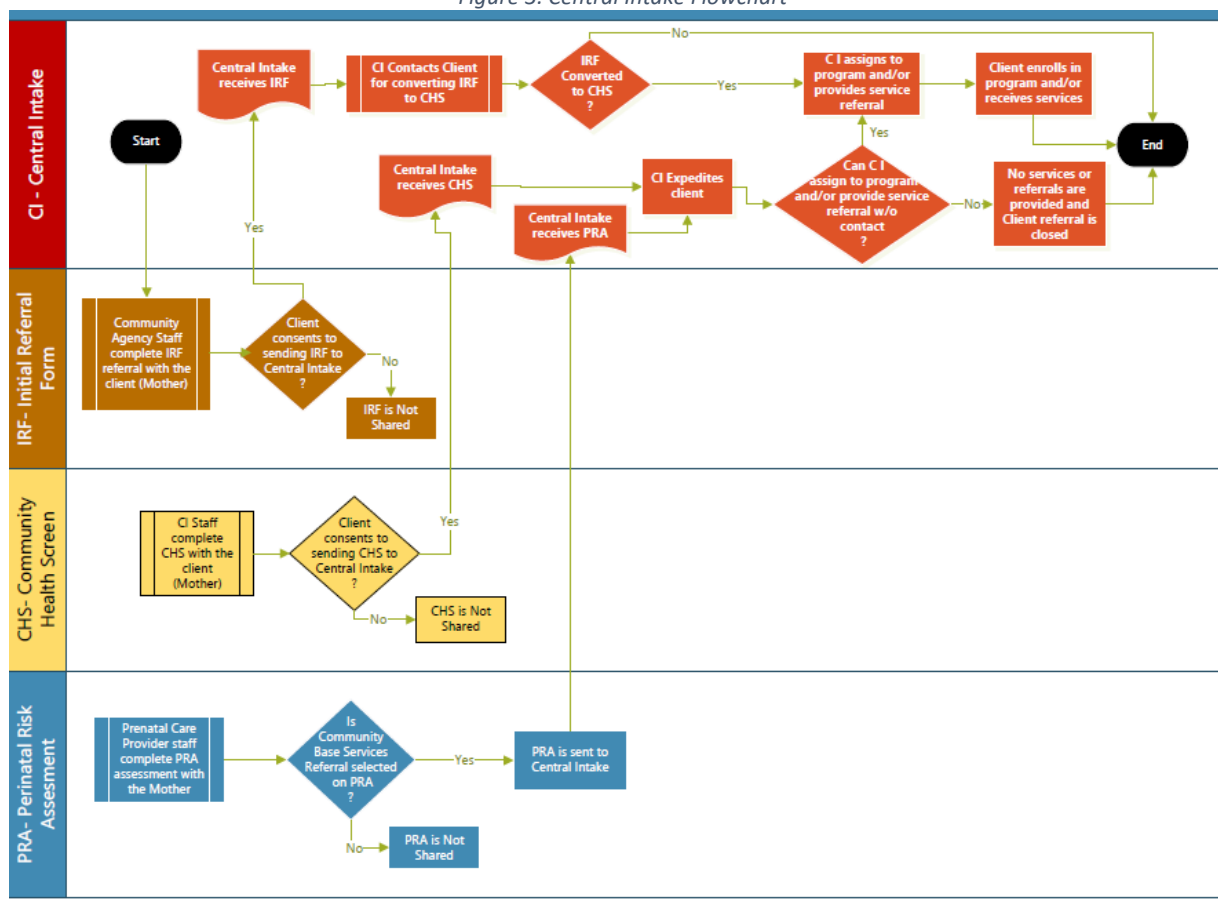
From July 2018 to March 2022, the percentage of clients who mainly benefited from services offered through HWHF were 42.9%, 36.4%, 14.9%, 3.3%, and 2.1% for

Hispanic, Black, NH, White, NH, other, and Asian, respectively. Figure 2 displays the target regions and the services offered by county. Additionally, the HWHF Fatherhood initiative was a success with a total of 207 fathers graduating from the program since its inception three years ago with alumni still staying involved.

- 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 necessary home visiting programs and necessary medical and social services (Figure 3). The CHW model performs outreach and client recruitment within the targeted community to identify and enroll women and their families in appropriate programs and services and provides case management for up to 3 years. CNJ hubs work closely with community providers and partners, including CHWs, to eliminate duplication of effort and services. Standardized screening tools are used and referrals to programs and services are tracked in a centralized web-based system (SPECT – Single Point of Entry and Client Tracking), documenting all client contacts from referral to enrollment. 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 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 (22.97%), Healthcare (13.45%), and Public Benefits (9.55%). For the aforementioned period, the percentage

of clients who mainly benefited from services offered through CNJ were 43.86%, 25.82%, and 22.56%, 5.36%, 2.38% for Hispanic, White, NH, Black, NH, other and Asian, respectively.

Figure 3. Central Intake Flowchart



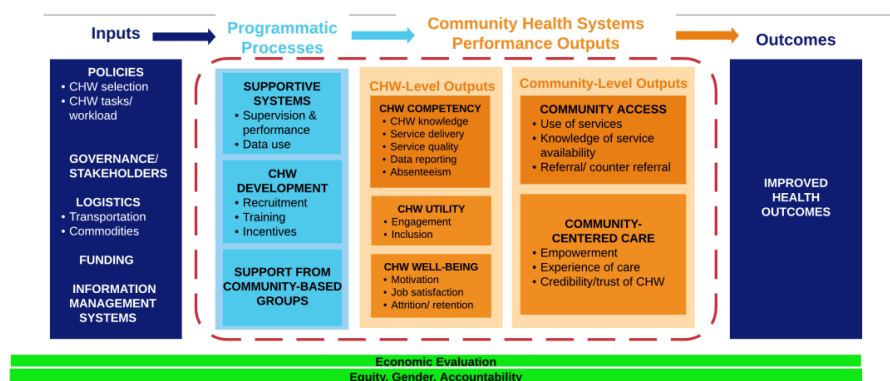
- 3) The creation of the NJ Doula Learning Collaborative (DLC) is in alignment with the Nurture NJ initiative to improve birth outcomes and achieve equity in maternal and infant health⁸. The goal of the DLC is to reduce maternal and infant mortality and eliminate racial disparities in health outcomes 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. A focus for the DLC will be to develop and support the doula workforce that delivers doula care to NJ's Medicaid and CHIP members as enrolled NJ FamilyCare providers.
- 4) 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, NJDOH 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.
- 5) 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 activity is 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 are tasked with providing training and awareness

⁸ Hogan, V. K., Lee, E., Asare, L. A., Banks, B., Benitez Delgado, L. E., Bingham, D., Brooks, P. E, Culhane, J., Lallo, M., Nieves, E., Rowley, D. L., Karimi-Taleghani, P. H., Whitaker, S., Williams, T. D. & Madden-Wilson, J. The Nurture NJ 2021 Strategic Plan. The State of New Jersey, Trenton, NJ, 2021

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.

- 6) Another program promoting the Life Course Perspective is the Maternal Infant and Early Childhood Home Visiting (MIECHV) Program which has expanded home visiting across all 21 NJ counties with over 6,500 families served annually over the prior five-year period. The goal of the NJ MIECHV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to improve family functioning; prevent child abuse and neglect; and promote child health, safety, development, and school readiness. Full implementation of the NJ MIECHV Program is being carried out in collaboration with the Department of Children and Families (DCF) and is promoting a system of care for early childhood.
- 7) 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. Moreover, CLG-CHWI partners with community colleges 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.

Figure 4. 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 through the enhancement of existing programs and creating new programs with an emphasis on this priority population through the CHW Workforce (Figure 4). TVS recognizes the importance of a statewide collaboration of existing traditional and non-traditional partners to address the SDOH which will be

instrumental in moving the needle on pregnancy and birth outcomes.

Figure 5. 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 5).

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 complimentary 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 formed in January 2020 and will continue through June of 2023 due to delays from the COVID-19 pandemic. NJ TVP has a multi-sector, state-level leadership team with the goal to develop 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, (NJDOH), 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 4th year of a five-year HRSA grant PMH enhances the existing DCF administered statewide network of nine regional Pediatric Psychiatry Care Collaboratives, with telehealth technology. Pediatric Mental Health (PMH) 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 182,662 youth less than 21 years of age have been screened and 17,651 mental health consultations/ referrals were completed. As of April 2022, 54 pediatric practices, representing approximately 112 providers, have been equipped with telehealth technology through this HRSA grant.

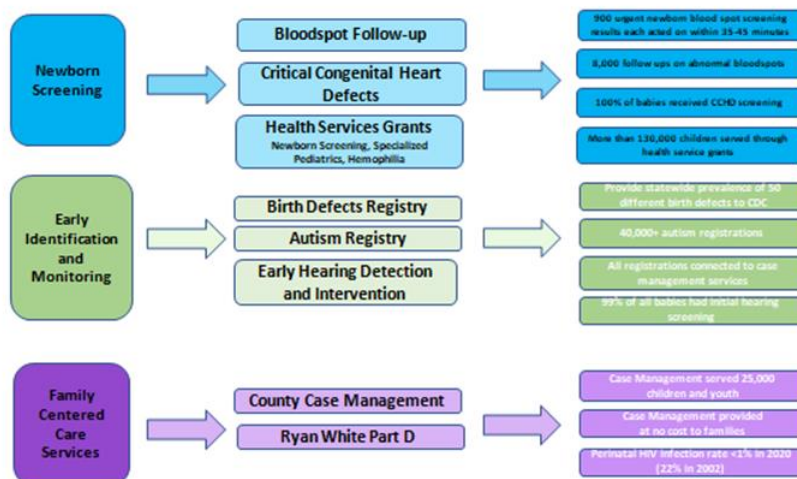
The CAHP is in year two of a five-year Garrett Lee Smith State/Tribal Youth Suicide Prevention from the DHHS Substance Abuse and Mental Health Services Administration (SAMHSA). The project period ends 11/29/25 and the award is for \$736,000 per year. Readiness to Stand United Against Youth Suicide: A NJ Public Health Community Initiative (NJ R2S Challenge) is a collaborative grant with NJ DCF, the Office of the Secretary of Higher Education, and multiple community-based organizations. In its first year, Readiness to Stand United Against Youth Suicide: A New Jersey Public Health Community Initiative (New Jersey R2S Challenge) has accomplished much including the development of a Prevent Suicide NJ Learning Portal, gatekeeper training for youth-serving professionals, education and resources for NJ's County Colleges, the first cohort of Lifelines Trilogy training in 3 survivor school districts, and a kickoff event with over 1,300 professionals (pediatricians, nurse practitioners, social workers, guidance counselors, school nurses and other youth-serving professionals) in attendance.-In May of 2022, GLS will support its second large professional education conference: Adolescent Health Symposium 2022: Challenges Today Solutions for

Tomorrow, featuring a multitude of topics that will assist youth-serving professionals in their care of adolescents. Plans for the coming year include the launch of Prevent Suicide NJ Learning Portal in July of 2022, along with the launch of 988; a statewide youth led suicide prevention and awareness campaign, Cohort two of Lifelines Trilogy in 3-5 additional school districts; clinical training for all NJ County College Counselors; Attachment-Based Family Therapy (ABFT) training for DCF Intensive In Community Providers within the Children's System of Care; and multiple other educational and clinical training for youth-serving professionals including (Understanding and detecting suicide, screening and assessment of suicide, Adolescent Clinical Treatment of Suicide, ABFT, Dialectical Behavioral Therapy (DBT), Collaborative Assessment and Management of Suicide Care (CAMS-Care) and more.

Children and Youth with Special Health Care Needs (CYSHCN)

New Jersey's CYSHCN program is known as Special Child Health Services (SCHS) and includes three programs coordinated (Figure 6): Newborn Screening Follow-up and Genetic Services (NSGS), Early Identification and Monitoring (EIM), 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 three programs work as an integrated continuum of care. The diagram below highlights some of our 2021 successes.

Figure 6. 2021 Special Child Health Services



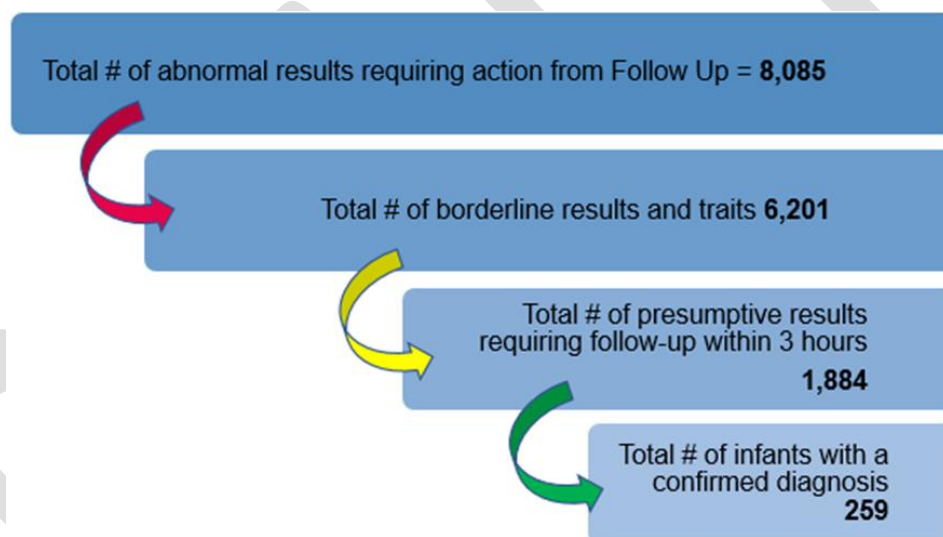
Newborn Screening and Genetic Services

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 January 31, 2022, SMA was added to the NJ newborn screening panel bringing the total number of biochemical/bloodspot screenings to 60 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 state-of-the-art in terms of screening technologies, 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 NSGS program is funded by the sale of newborn biochemical bloodspot filter cards.

The Newborn Screening Follow-Up staff contact primary care providers, specialty care providers, and parents to ensure timely evaluation, confirmatory testing, and to obtain a final diagnosis. Results received from the NBS Laboratory range from low risk to presumptive. Low risk follow-ups involve sending letters to parents, making telephone calls to physicians and hospitals, and utilizing multiple resources to locate babies for further testing. Time for follow-up on low-risk results ranges from two to eight weeks until cases are closed. In 2021, over 98,000 babies were screened, and 8,085 results were sent to follow-up. Approximately 1,884 results required aggressive actions to ensure that those babies received prompt medical intervention and treatment (Figure 7). As per protocol, presumptive cases must be reported to physicians and specialists within three hours from receipt of 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 the disorders require multiple office visits/diagnostic tests to accurately confirm diagnoses. The NSGS team confirmed diagnoses for 259 babies.

Figure 7. 2021 Flow Chart of Newborn Screening Follow-up Results



Since 2011, New Jersey has mandated newborn pulse oximetry screening to detect Critical Congenital Heart Defects (CCHD). Pulse Oximetry results are captured by New Jersey's Birth Certificate system and used to identify children at risk for CCHD. New Jersey 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, 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 44 babies were identified as "saves" with three identified in 2021. Saves are defined as babies who were not indicate with 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 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.

Early Hearing Detection and Intervention

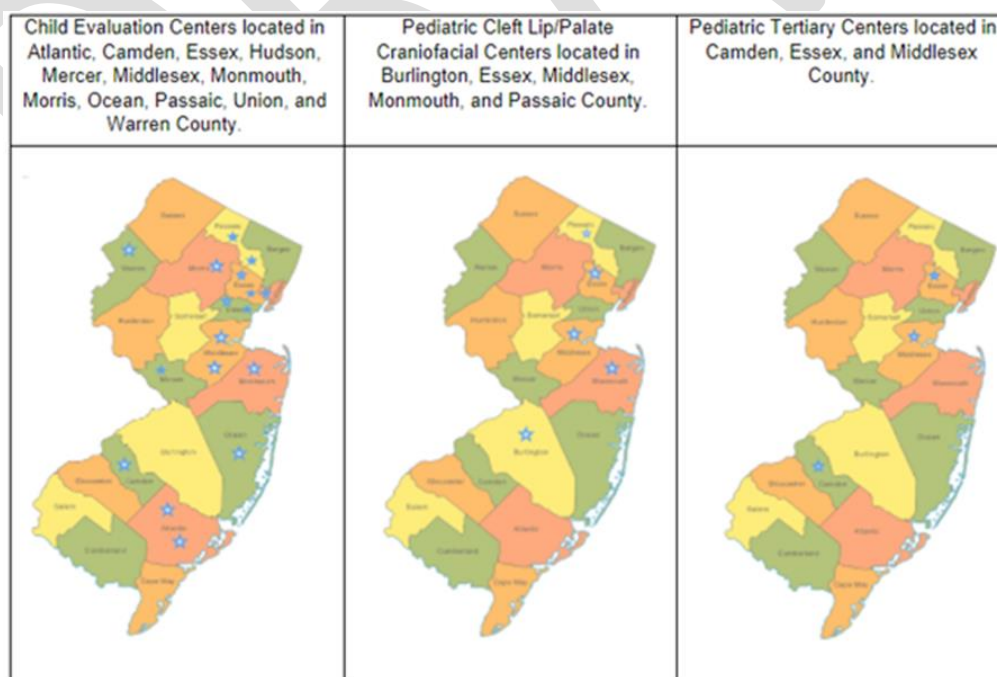
The New Jersey EHDI Program abides by the national public health initiative “1-3-6’ Guidelines.” These guidelines seek to ensure that all babies born in New Jersey receive a newborn hearing screening before the age of one-month, complete diagnostic audiologic evaluation prior to three months of age for 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

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. With support from the State and Title V funds, health service grants are distributed to multiple agencies throughout NJ (Figure 8). 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 SFY21, there were a total of 121,260 patients served across all centers within the Specialized Pediatric Services Program, of these 57% (69,150) of children were served at the CECs, 1% (1,131) at the CLCPCs, and 42% (50,979) at the PTCs. Approximately 58% of the children served are uninsured or are covered via Medicaid/Medicare programs.

Figure 8. Location of Funded Specialized Pediatric Centers

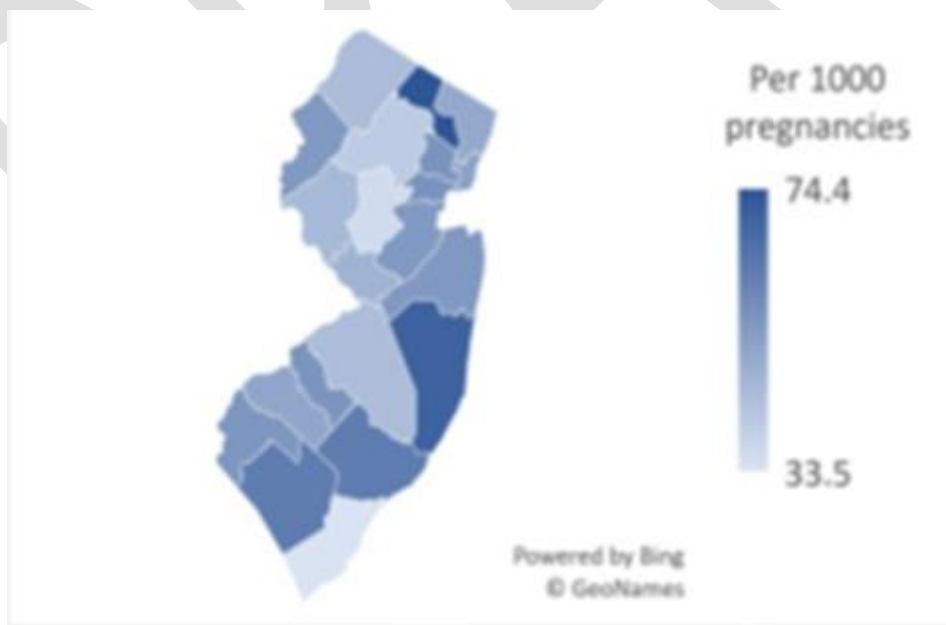


Early Identification and Monitoring

Dating back to 1928, New Jersey is proud to have the oldest requirement in the nation for the reporting of birth defects. Over the years, our BDAR has become a robust population-based registry for children with birth defects and Autism Spectrum Disorders (ASD) and provides invaluable surveillance and needs assessment data for service planning and research. All 49 birthing hospitals and hundreds of non-hospital-based practices report to the BDAR through our online registry. Annually, we receive an average of 4,600 BDR and 3,200 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 search to reduce duplication, reduction of questions, and more 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 continue to educate providers about the BDAR, how to register, and the rules regarding the Registry. Staff create reports and resources for both providers and families. These continuous efforts and changes will improve the accuracy of our data and improve our overall surveillance efforts.

One of our most important functions is to participate in public health surveillance efforts. In 2020, EIM staff began to collect data on COVID-19 positive pregnant persons and their infants. Starting with 2020 births, we have abstracted maternal charts and worked with NJ Chapter of the American Academy of Pediatricians (NJAAP) to collect infant outcome data. These data are provided to the CDC and currently comprise 25% of the maternal data that is used in the CDC reporting. New Jersey was able to capitalize on its prior ZIKA experience, collaboration with Communicable Disease Services and Population Health, our relationships with hospitals, and our strong clinical and data staff to accomplish this project. Leveraging MCH funding to cover staff time and effort, EIM successfully monitored and reported monthly COVID-19 maternal and infant outcomes until CDC funding was allocated. As of April 2022, there were almost 18,500 COVID pregnant women. This equates to approximately 1% of the total positive COVID cases and between 3 and 7% of the birthing population depending on county. We have successfully completed the medical abstractions of 32% of 2020 maternal cases and 50% of 2020 infant cases. We are continuing our efforts by abstracting maternal and infant charts for a sample of 2021 births, and the 2021 COVID case abstractions are scheduled to begin in late Spring 2022.

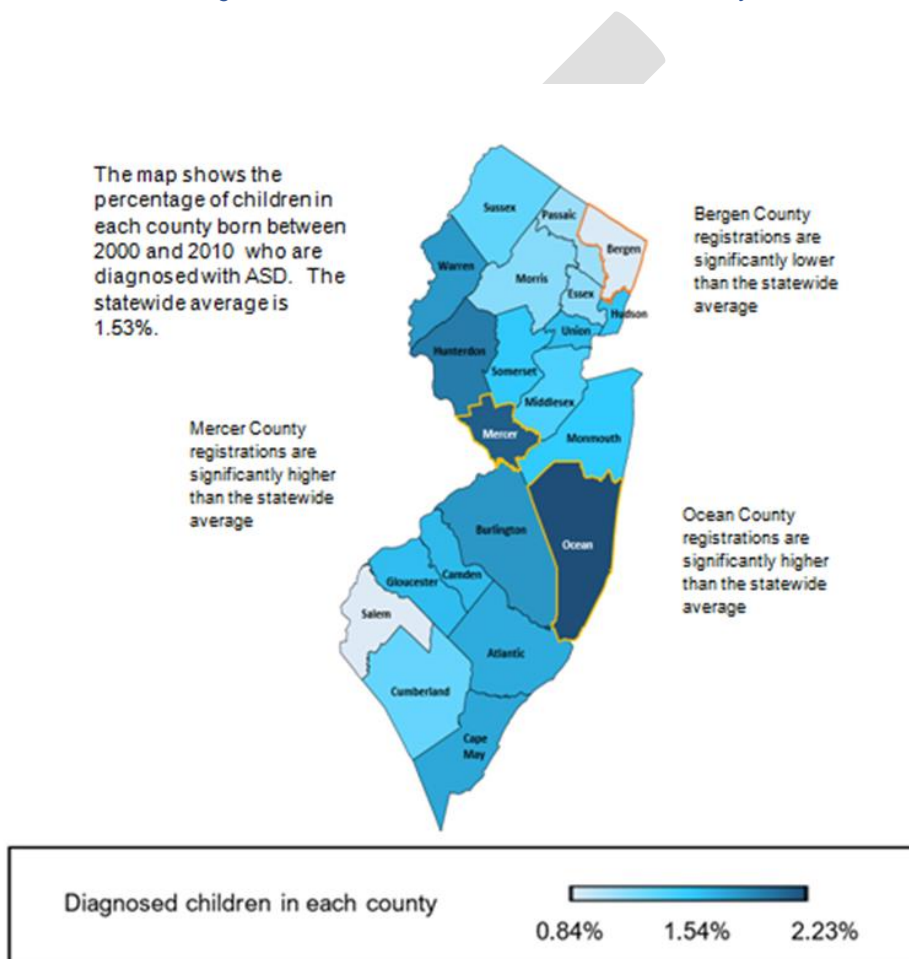
Figure 9. COVID-19 Cases per 1,000 Expected Pregnancies



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 case management services. We serve as a model registry and continue to provide technical assistance to other states considering a registry. The

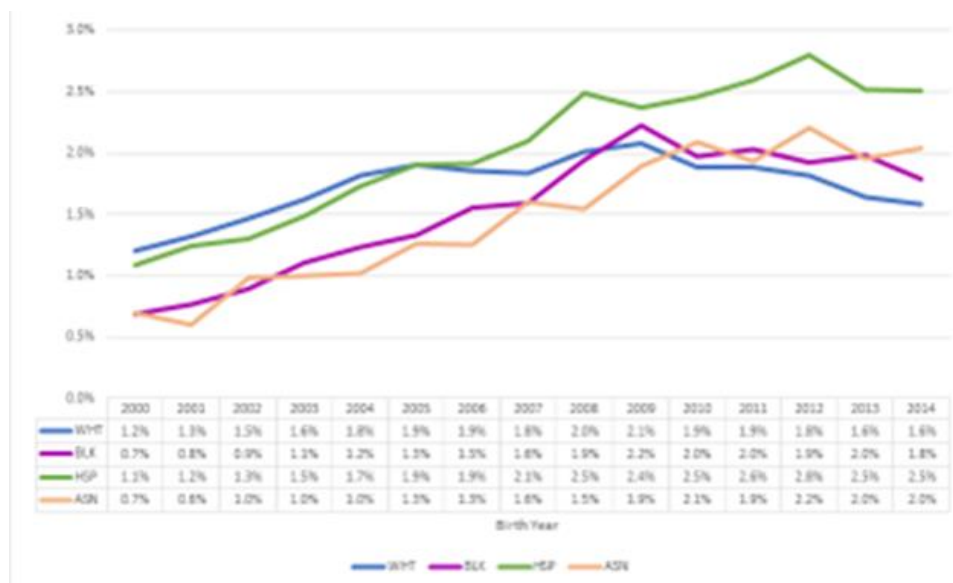
Autism Registry provides quality prevalence information for the entire state, information about racial and ethnic disparities, and examines known perinatal risk factors and how they influence the New Jersey prevalence rates (Figure 10).

Figure 10. 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 (Figure 11). The Registry rates compare to the CDC's rates when only diagnosed children are included and can provide rates across all counties and additional information about perinatal risk factors, comorbidities, and Early Intervention participation. 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.

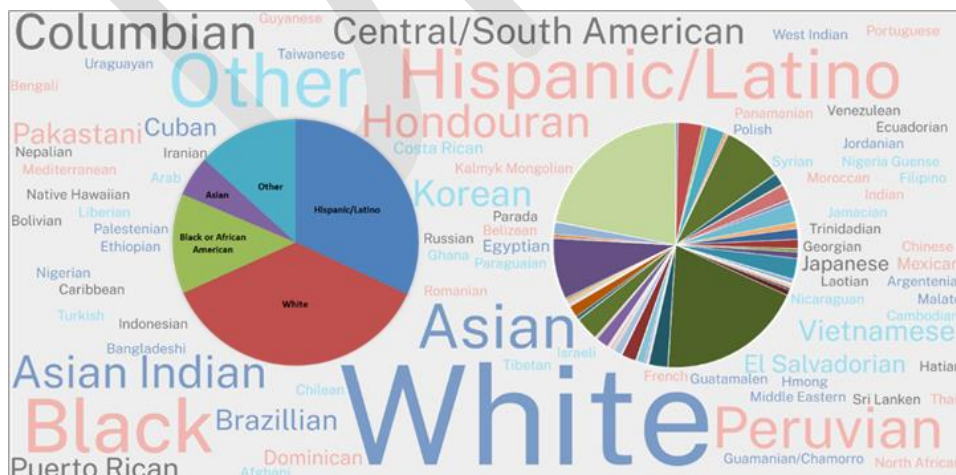
Figure 11. Autism Spectrum Disorder (ASD) Prevalence Over Time



Family-Centered Care Services (FCSS)

FCSS oversees and provides approximately 3.4 million dollars in funding to 21 county-based CMUs. These funds include federal and state MCH Block grants, Casino-revenue, and Catastrophic Illness Child 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 15,000 families receive services with the majority. The diversity of NJ is seen in the children and families that the CMUs serve. In figure 12, the pie chart on the left side shows the way Race/Ethnicity data are usually presented to allow for data comparisons across states and the nation, the pie chart on the right side and the surrounding word cloud shows the ways that individuals reported their own identity. This chart demonstrates the true diversity of New Jersey's CYSHCN population and the range of cultures and languages that our CMUs are serving.

Figure 12. Special Services Race and Ethnic Representation



FCCS plays a central role in ensuring that all counties provide a robust set of services and collects key information to establish quality and equity across New Jersey. We also educate all CMUs about important federal, state, and community partners. FCCS's ongoing intergovernmental and interagency collaborations include, but are not limited to, Social Security Administration, NJ DCF, DOBI, the Boggs Center/Association of University Centers on Disabilities, NJ Council on Developmental Disabilities, and community-based organizations such as Autism NJ, 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 DIH 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 we received that showcases the role of CMUs working with Title V-CYSHCNs.

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.

To enhance consistency in documentation within individual service plans across the CMUs, 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. All 21 CMUs use CMRS to track and monitor services. CMRS provides the ability for CMs to create and modify an Individual Service Plan (ISP), track services, referrals, 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 review, and provides the ability to track access to care and ensures more measurable and readily tracked outcomes.

SCHS also refers children from birth to three to NJ EIS. EIS serves the developmental and health-related needs of children by providing quality services in a child's natural environment by enhancing the capacity of families to support their child using a coaching model and creating a partnership between practitioners and families. The system serves approximately 30,000 families annually, and provides approximately 40,000 service hours per month, EIS provides occupational, physical, and speech therapy as well as developmental intervention. NJEIS is fee-for-service and operates with Family Cost Participation (FCP) based on a sliding scale.

III.C. Needs Assessment

FY 2023 Application/FY 2021 Annual Report Update Needs Assessment Updates

NJ's maternal health outcomes and disparities are among the highest in the U.S. 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.S⁹. As of 2019, NJ ranks 4th in worst maternal mortality rates compared to other states using data from [CDC WONDER](#)¹⁰. Approximately 14 women die from PR complications in NJ every year (Figure 14.). Black women experience seven times the rate of death from pregnancy-related causes compared to their white counterparts (Figure. 13). Moreover, severe maternal morbidity (SMM) rates are among the highest in the U.S. In 2019, SMM rates among black, Non-Hispanic (NH) women were nearly three times greater than those of white, NH women. [Child health outcomes](#) are equally concerning. While NJ has the 5th best overall infant mortality rate among the 50 states, the non-Hispanic black infant mortality rate in NJ is 3.5 times higher than the infant mortality rate for white, NH infants. The Hispanic infant mortality rate is 1.4 times higher than the rate among white, NH infants¹¹. Findings from the most recent 5 year needs assessment include the need to address NJ's maternal mortality crisis, especially with regard to disparities.

Figure 13. Pregnancy-Related Mortality Ratios by Race/Ethnicity, New Jersey, 2013-2018 | **Figure 14. Pregnancy-Associated and Pregnancy-Related Mortality Ratios, New Jersey 2011-2018**

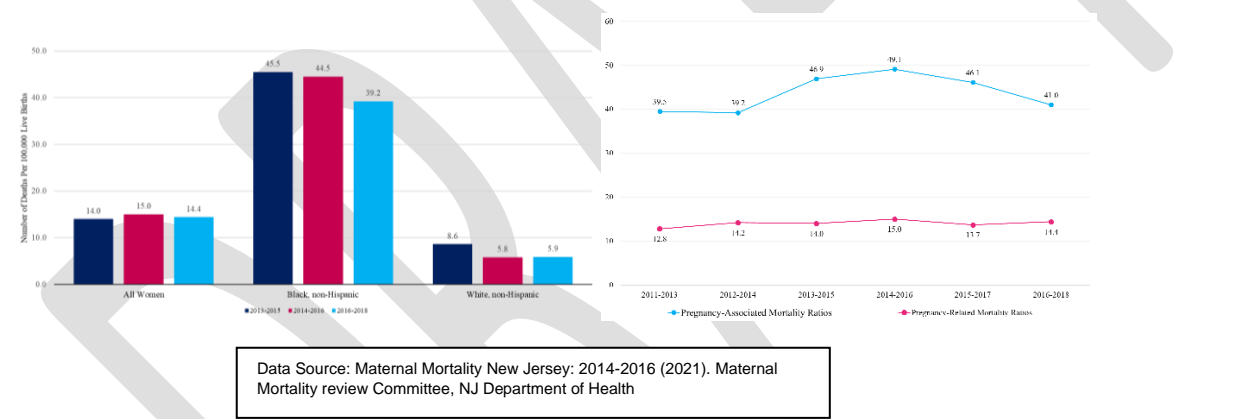
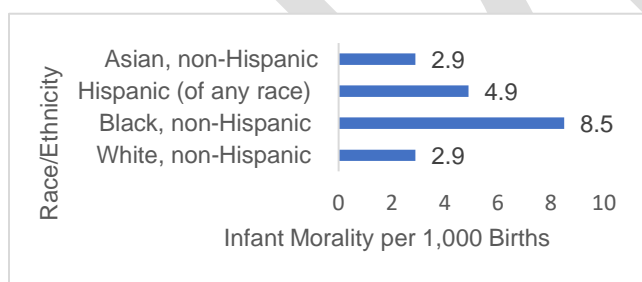


Figure 15. Infant Mortality by Race/Ethnicity per 1,000 Births



Child health outcomes are equally concerning. While NJ has the 5th best overall infant mortality rate among the 50 states, the non-Hispanic black infant mortality rate in NJ is 3.5 times higher than the infant mortality rate for non-Hispanic white infants (Figure 15.). The Hispanic infant mortality rate is 1.4 times higher than the rate among White babies.

Several efforts to address the needs of the MCH

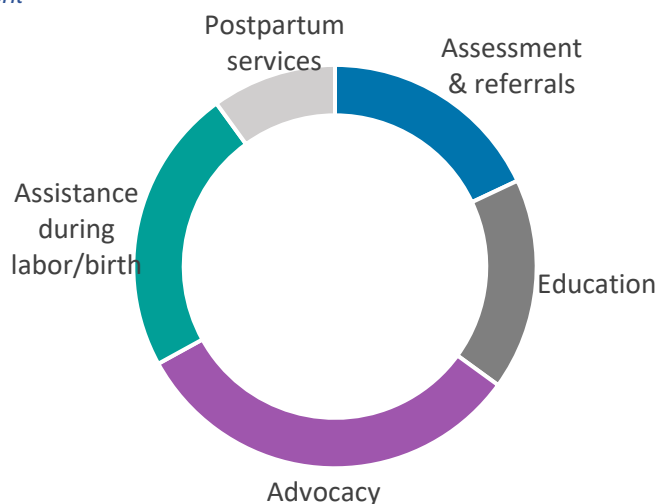
Data Source: [New Jersey State Health Assessment Data](#) (NJSHAD)

population in NJ have continued and further been developed since last year's 5 year needs assessment. In 2021, in

⁹ America Health Rankings. Health of Women and Children. Accessed on April 20, 2022. [Explore Health Measures in New Jersey | 2019 Health of Women and Children Report | AHR \(americashealthrankings.org\)](#)
¹⁰ America Health Rankings. Thematic Map: maternal Mortality. Accessed on April 20, 2022. https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_a/state/ALL?edition-year=2019
¹¹ New Jersey State Health Assessment Data. "Health Indicator Report on Infant Mortality Rate". Accessed on April 20, 2022 at NJSHAD - [Health Indicator Report - Infant Mortality Rate \(state.nj.us\)](#).

partnership with Montclair State University, TVS evaluated the 3-year doula pilot program. The team examined the five types of services doulas provide to clients during pregnancy, labor, and postpartum periods. As well, the proportion of effort spent providing these services is estimated based on stakeholder interviews (Figure 16). Several actionable recommendations have emerged from the data for improving the implementation and outcomes of ongoing efforts related to the Doula Pilot Program. These recommendations are based on evaluation data collected and compiled from May through November 2021:

Figure 16. Service Provided by Doula by Estimated Portion of time Spent



1. Continue to link doulas with Community Health Workers to help meet the needs of clients.
2. Continue and potentially enhance statewide training and certification opportunities for doulas to help expand the doula workforce in NJ.
3. Create a formalized support system for doulas to institutionalize mentoring and access to counseling or psychological support for doulas.
4. Develop and maintain a central information hub for doulas practicing in NJ to share common information.
5. Explore opportunities to increase doula compensation and expand the number of doula services that qualify for reimbursement in Medicaid.
6. Provide and share information about additional supports to increase the

number of Medicaid provider applications among doulas.

7. Create a pipeline to bring private doulas into future program efforts to better link the doula workforce.
8. Develop and implement an awareness campaign for medical staff to improve awareness and acceptance of doulas.
9. Clarify and share information about the specific roles, responsibilities, and expectations of stakeholders involved in the program to facilitate planning and program implementation.

The services provided through the Doula Pilot Program were reported to be meaningful and had critical value to the doulas and clients. There is a mutual appreciation of the commitment and efforts made by NJ TVP and grantee agencies. Moving forward, the Doula Learning Collaborative will build on the successes and improve the challenges of the pilot program and recommendation to establish a culturally responsive platform for current and prospective community doulas. Improving and providing quality access to maternal and infant care with an emphasis on NH black families in NJ.

Moreover, NJDOH, under the direction of and in collaboration with Governor Phil Murphy and First Lady Tammy Murphy, is working to ensure that NJ becomes the safest place in the United States to give birth. To this end, First Lady Tammy Murphy launched a statewide, public-private initiative, Nurture NJ, in 2019 to help eradicate maternal mortality and morbidity health disparities for black and Latinx birthing people, especially women, in NJ. Nurture NJ staff and DOH, including Title V, along with other state agencies, the state legislature, health systems, other clinical stakeholders, and communities are tasked with identifying additional strategies to turn the tide in maternal health outcomes and build upon work already being done to address these health disparities in NJ. By creating new public-private relationships and leveraging new resources supported by legislation and federal funding Nurture NJ aims to be a thought partner and culture shifter.

The New Jersey Maternal Care Quality Collaborative (NJ MCQC) is a multidisciplinary team of stakeholders who will oversee the transformation of maternal healthcare in NJ. The collaborative will establish a shared vision and statewide goals for key health services focused on decreasing maternal deaths, injuries, and racial and ethnic disparities under the umbrella of Nurture NJ. Nurture NJ, First Lady Tammy Murphy's statewide awareness campaign is committed to reducing infant and maternal mortality and morbidity and ensuring equitable maternal and infant care among women and children of all races and ethnicities. The campaign, which is devoted to serving every mother, every baby, and every family, includes a multi-pronged, multi-agency approach to improve maternal and infant health among NJ women and children.

The FHS Assistant Commissioner has been appointed as a member of the NJ MCQC. Through engagement with the Maternal Health Innovations Team in the Office of Population Health, TVS has been actively involved, meeting with stakeholders across the state: the Maternal Child Health Consortia, Professional Societies, NJ Hospital organizations, Regional Health Hubs, the New Jersey Health Care Quality Institute, Medical Societies, Planned Parenthood, the NJ Primary Care Association, NJ Federally Qualified Health Centers, the NJ Family Planning League, and the New Jersey Perinatal Quality Collaborative. Through these meetings, teams were able to identify areas of synergy for collaboration. Moreover, key barriers to maternal health in NJ were identified, which include funding, workforce (training and diversity) needs, working in silos, and data use, access, and connectivity needs. Stakeholders shared a focus on health equity to eliminate bias in care, increase access to equitable care, collect and share data that illustrates disparities, and advocate for underserved and minority patients and families.

Ongoing data collection and research initiatives to better assess MCH population needs have also continued. Data review from several innovative programs including Doula and Centering is underway. NJ's Perinatal Risk Assessment Monitoring System (PRAMS) samples one out of every 50 mothers each month when newborns are 2-6 months old. Survey questions address the feelings and experiences before, during, and after pregnancy. The PRAMS sample design oversamples smokers and minorities. Data are weighted to give representative estimates of proportions in specific categories and actual persons. More than 26,500 NJ mothers were included between 2002 and 2019 with an average response rate of 70%. Additional questions have been incorporated into the PRAMS survey to include COVID-19 and also most recently, questions concerning the COVID-19 vaccine have been added. Information from PRAMS is used to improve health programs for NJ mothers and infants, such as improving access to high-quality prenatal care, reduction of smoking during pregnancy, and encouraging breastfeeding.

NJ is voluntarily participating in the Centers for Disease Control and Prevention (CDC) Surveillance of Emerging Threats to Mothers and Babies Network, also known in NJ as "Project W." Tracking of maternal and infant outcomes is ongoing. What is known about COVID-19 is rapidly evolving and documented outcome rates are likely to shift as the rate and distribution of infection change. Thus far, most pregnancies do not have adverse outcomes, however, continued monitoring is needed.

TVS has also been assessing workforce development needs as the workforce of Community Health Workers, Doula, and most recently Perinatal Community Health Workers and Certified Nurse Assistants are developed and expanded. TVS met with workers in these areas to determine training needs and employment tracks and opportunities. TVS is also working with Medicaid concerning reimbursement for these services. Together, TVS and Rutgers University Project Echo offered an educational series designed for doula, so that they could meet a portion of the Medicaid Certification requirements. These sessions provided information, peer-to-peer discussions, and resources for doula serving Medicaid-enrolled pregnant women.

Title V seeks public input on the Maternal Child Health Block grant (MCHBG) throughout the year at the quarterly Community of Care Consortium meetings spearheaded by the Statewide Parent Advocacy Network, the NJ Chapter of the American Academy of Pediatrics, and the NJDOH TVP. Every year, public input on the MCHBG is officially requested with the posting of the draft MCHBG on the NJDOH's website. Written testimonies are being accepted through July for inclusion in the public input section of this year's MCHBG.

NJ TVP continues to address and develop innovative ways to meet the needs of the MCH population as the COVID-19 pandemic continues to evolve. Many programs are currently in transition in terms of returning to offering in-person services and resources. We remain intentional in our approach to promoting health equity and reducing disparities. NJ remains one of the most racially and ethnically diverse states, as well as one of the most densely populated states. Many pre-COVID-19 challenges for MCH populations, such as food insecurity, mental health, and substance use issues, employment, and childcare concerns, as well as access to comprehensive culturally competent community-based health care services, have been exacerbated during the COVID-19 pandemic, especially for the most vulnerable populations, such as birthing people and families with young children. COVID-19 and vaccine confusion and myths have continued to develop since the submission of last year's 5-year Needs Assessment.

III.D. Financial Narrative

III.D.1. Expenditures

IIID Financial Narrative Expenditures

III.D.2. Budget

IIID2. Financial Budget Update needed

DRAFT

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table State: New Jersey

New Jersey					
State Action Plan Table					
Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	2023 Application/2021 Annual Report
National and State Outcome Measures					
Women/ Maternal Health					
Increasing Healthy Births & Reducing Black Maternal and Infant Mortality	<p>Promote evidence-based strategies to increase preventive medical visits for women (ages 18 - 44 yrs) such as the Community Health Worker model in the Healthy Women, Healthy Families Initiative and the Maternal, Infant, and Early Childhood Home Visiting Program.</p> <p>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.</p>	<p>Increase the percent of women, ages 18 to 44, with a preventive medical visit in the past year by 1% per year by 2023.</p> <p>Increase the percent of women trained to become community doulas to serve black birthing people by 5% in 2023.</p>	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	<p>ESM 1.1: Increase first trimester prenatal care rate</p> <p>ESM 1.2: Number of individuals trained to become community-based doulas</p>	<p>NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>NOM 3: Maternal mortality rate per 100,000 live births</p> <p>NOM 4: Percent of low-birth-weight deliveries (<2,500 grams)</p> <p>NOM 5: Percent of preterm births (<37 weeks)</p> <p>NOM 6: Percent of early term births (37, 38 weeks)</p> <p>NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <p>NOM 9.1: Infant mortality rate per 1,000 live births</p> <p>NOM 9.2: Neonatal mortality rate per 1,000 live births</p> <p>NOM 9.3: Post neonatal mortality rate per 1,000 live births</p> <p>NOM 9.4: Preterm-related mortality rate per 100,000 live births</p>

					<p>NOM 10: The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy</p> <p>NOM 11: The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births</p> <p>NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females</p> <p>NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth</p>
Perinatal/Infant Health					
Reducing Black Maternal and Infant Mortality	<p>Increase infant safe sleep practices as reported by the PRAMS survey (on back, no co-sleeping, no soft bedding).</p> <p>Continue to implement through the Healthy Women Healthy family initiative, Black Infant Mortality programs that are evidence-based interventions to reduce black infant mortality and other disparities. These programs include Group prenatal care, the Doula program, Fatherhood initiatives, and</p>	<p>Increase infant safe sleep by 1% per year by 2023.</p> <p>Decrease Black non-Hispanic preterm births by 1 percentage point by 2023.</p> <p>Decrease Black Infant Mortality rate by 1 percentage point</p>	<p>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.</p> <p>SPM # 1: The percentage of Black non-Hispanic preterm births in NJ.</p> <p>SPM #7: Decrease the rate of black</p>	<p>ESM 5.1: Promote the complete Infant Safe Sleep Environment (no co-sleeping, on back, and no soft bedding).</p> <p>ESM 5.2: Decrease the rate of black infant mortality in NJ per 1,000 live births.</p>	<p>NOM 9.1: Infant mortality rate per 1,000 live births</p> <p>NOM 9.3: Post neonatal mortality rate per 1,000 live births</p> <p>NOM 9.5: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p>

	Breastfeeding support groups for Black NH women.	by 2023.	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).	Increase births in Baby-Friendly hospitals by 2 percentage points by 2023.	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	ESM 4.1: Increase the Percentage of Births in Baby-Friendly Hospitals	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 - 3 months, by 2 percentage points by 2023.	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	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. Adopt evidence-based youth engagement strategies aimed at increasing the percentage of students completing at least 75%	Increase the number of adolescents participating in a bullying awareness and prevention program Increase the	NPM 9: Percent of 9-12th graders who reported being bullied on school property or electronically bullied. SPM 6 - Increase the percentage of	ESM 9.1 - Reduce the percentage of high school students who are electronically bullied (counting being bullied through texting, Instagram, Facebook, or other social media). ESM 9.2 - Reduce the percentage of high school students who are bullied on school property. ESM 9.3: Number of females aged 10-19	NOM 16.1; Adolescent Mortality Rate Ages 10-19 per 100,000 NOM 16.3: Adolescent Suicide Rate Ages 15-19 per 100,000

	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.	percentage of students completing at least 75% of an evidence-based pregnancy prevention program (TOP program, Love Notes, Reducing the Risk, and Teen PEP) per year, 5% by 2023	students completing the TOP program, Reducing the Risk, and Teen PEP per year.	who give birth.	
Children with Special Health Care Needs					
Improving Access to Quality Care for CYSHCN	<p>Identify and monitor transition to adulthood needs for CYSHCN and their families served through the Case Management Units (CMUs).</p> <p>Explore youth and their parents' needs to facilitate transition with insurance, education, employment, and housing, and link them to community-based partners.</p>	Percent of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service	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	<p>Provide comprehensive care with physicians and allied health professionals, by partnering with patients and their families.</p> <p>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.</p>	Increase the percentage of children and children with special health care needs, age 0 - 17 years old, who have a medical home by 4 percentage points by 2023.	NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.	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 (SPoC).	<p>NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system</p> <p>NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling</p> <p>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health</p>

					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. In a random sample of 969 Case Management Referral System (CMRS) records, approximately 57.1% were assigned within the 14-day timeline. To increase the percent of children registered with BDARS who have been referred to SCHS CMUs and subsequently receive services, a second goal has been set to increase the % of BDARS referrals that are assigned to a case manager	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 2023.	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.		

	within 14 days to 60% by 2020.				
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 2023.	SPM 5: Average age of initial diagnosis for children reported to the NJ Birth Defects & Autism Reporting System with an Autism Spectrum Disorder		
Cross-Cutting/Systems Building					
Improving & Integrating Information Systems	<p>Monitor and guide service delivery to assure that all children have access to preventive oral health services.</p> <p>Provide preventive interventions such as age-appropriate oral health education.</p> <p>Promote the application of dental sealants and the use of fluoride, increasing the capacity of state oral health programs to provide preventive services.</p>	Increase the percentage of children, ages 1 - 17, who had a preventive dental visit in the past year by 2% by 2023.	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.	ESM 13.2.1: Preventive and any dental services for children enrolled in Medicaid or CHIP (CMS-416).	<p>NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year</p> <p>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health</p>

III.E.2. State Action Plan Narrative Overview

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

NJ TVP is uniquely positioned through its leadership and many partnerships with families, professionals, health care organizations, local, state, and federal agencies, and stakeholders to address health care 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 which includes Maternal and Child Health and Special Child Health and Early Intervention Services, works to address selected state priority needs through strategies as noted in the State Action Plan Table.

NJ Title V, as a leader, 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. Title V programs continually undergo evaluation of individual program success, ongoing challenges, and emerging issues. NJ Title V 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.

Coordinated, comprehensive, culturally, and linguistically competent, family-centered systems of care are available in Title V's Special Child Health Case Management System, which includes the implementation of AMCHP's National Consensus Standards for Systems of Care for Children and Youth 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. Through the NJ TVP, initiatives were developed to determine and address the root causes of adverse health outcomes. One of the initiatives currently underway is the Healthy Women, Healthy Families (HWHF) Initiative. The 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 Central Intake Hubs, or county-specific "points of entry" for clinical assessments. Referrals and tracking occur through a central data management platform called "NJCHART." Through this Initiative, NJ TVP serves as a convener, collaborator, and partner to not only traditional health partners but also to 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 BMI. 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 Title V partners with the NJ Maternal Health Innovation Team, also at NJDOH, to address maternal health. Health care leaders also engaged include the NJ MMRC. 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.

New Jersey Title V, as a leader, facilitates collaboration and partnership with many agencies and organizations including SPAN, the New Jersey Chapter American Academy of Pediatrics, the New Jersey Hospital Association, and state Maternal and Child Health Consortia. Title V programs continually undergo evaluation of individual program success, ongoing challenges, and emerging issues. New Jersey Title V 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.

Coordinated, comprehensive, culturally and linguistically competent, family-centered systems of care are available in Title V's Special Child Health Case Management System, which includes the implementation of AMCHP's National Consensus Standards for Systems of Care for Children and Youth with Special Health Care Needs.

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

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

3.E.2.b.1 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.

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

The majority of FHS staff concurred there was a need for training to help them effectively conduct return on investment (ROI) analyses of MCH programs. As a result of the NJDOH's paradigm shift toward results-based accountability, additional training is needed for staff to become skilled in collecting data appropriate for accountability documentation and to develop accountability metrics to better calculate the ROI for MCH programs tied to public health outcomes. FHS also recognized the need for incorporating the perspectives of families and family representatives into the MCH workforce under the broader umbrella of systems integration. Continued family involvement in health transformation is essential for effective program and policy development related to newly aligned systems.

Given the diversity of our state, cultural competency trainings continue to be provided to staff as an essential component of their continuing education activities. Other available opportunities have been pursued through trainings offered at national conferences including AMCHP, the MCH Epidemiology Conference, and the MCH Public Health Leadership Institute. Departmental trainings have been offered on ethics, grant writing, and grants management. Opportunities to supplement staffing through student internships, special temporary assignments, fellowship programs, and state assignees have also been successful. Recruitment and Retention of qualified TVP staff are ongoing goals of NJ TVP. NJ remains in a hiring freeze with exemptions made for critically needed positions, including those within Title V.

Moreover, TVS expresses interest in participating in Phase Two of the National MCH Workforce Development Center's newly redesigned 2022 Learning Journey which will be hosted by the University of North Carolina at Chapel Hill (UNC). TVS seeks to learn new evidence-based tools and get equipped with new sets of skills, needed to increase TVP workforce capacity in leadership, team management, data mining, and dissemination. Moreover, TVS will take the opportunity to learn novel techniques in drafting strong grant proposals that create equity and diversity in state partnerships. TVS is dedicated to improving NJ's current health systems by implementing cross-cutting activities aimed at improving the health of our children, youth, women, families, and communities. TVS is coordinating with UNC to plan the 2022 Learning journey, this opportunity will further enhance staff skills in health equity and continue to promote an environment of continuous learning.

In January 2022 the Division of Family Health Services added a Diversity, Equity, and Inclusion Manager to the team. Ms. Rajneet Goomer holds this title as well as the NJEIS Operations Manager. Ms. Goomer leads with a DEIB lens and is reviewing all aspects of NJEIS to assure we are equitably meeting the needs of all families and children in the system as well as building capacity regarding cultural competence and DEIB within the workforce at all levels. She will begin to work within the division to build capacity amongst programs and again assure a DEIB lens with all decisions and actions taken.

In the summer of 2022, NJ TVP will host two Title V summer interns and one Graduate Student Epidemiology Program (GSEP) intern.

The Title V interns will work together on 2 projects:

- 1) Project 1: The interns will assist in identifying organizational partners and recruiting stakeholders for an STI workgroup. The interns will design the data collection instruments to be used with the STI workgroup members who will include community members, key stakeholders, and service providers, then collect and analyze the data from them to assist in developing a statewide strategic plan to address the increase in STI rates among adolescents.
- 2) Project 2: Interns will be offered the opportunity to partake in standardizing the NJ FIMR case identification process. The interns will work closely with maternal and child health epidemiologists within the department to conduct a comprehensive literature review aiming at identifying techniques to support the standardization of the case identification process and communicate findings and recommendations for action to maternal and child health epidemiologists, DOH Leadership and other stakeholders (e.g., Maternal and Child Health Consortia).

The GSEP intern will work closely with maternal and child health epidemiologists within FHS to evaluate the NJ Health Women Healthy Family Initiative (HWHF). More specifically, the intern will collaborate with the assigned mentor to evaluate specific measurable outcomes related to preconception, pregnancy, and birth outcomes and their alignment with the overarching goals of the HWHF initiative. The intern will gain ample experience in program evaluation.

MCH Workforce Training and COVID-19

The NJDOH has created a vulnerable populations plan, which 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, Orthodox Jewish populations, 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; 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 substance use disorders, 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 (particularly in Orthodox Jewish populations), and disparities in vaccine coverage may impact achievement of high COVID-19 vaccination rates in these population groups.

Often, members of the communities they serve, CHWs are frontline public health workers who because of their intimate understanding of the cultures, languages, and challenges of their neighborhoods are trusted by the people they serve. NJDOH in recent years has made the expansion of CHWs in NJ a strategy to address inequities in our healthcare system. One of the ways The NJDOH 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. We plan to use this same strategy of training, deploying, and engaging CHWs to respond to COVID-19 in vulnerable populations. We will expand outreach within the NJDOH and in the field to include other social service providers, community-based organizations (CBOs), and faith-based organizations (FBOs) partners, using a regional field team structure.

CHWs reach out to vulnerable populations, educate them on services available and make critical linkages to additional social supports, activities that will be implemented as part of the COVID-19 response. Many CHWs are involved in case management as well. Knowing the value of CHWs along with their long-term use in NJDOH programming, their limited training, lack of a standardized curriculum, and difficulty recruiting, retaining, and advancing in their careers, NJDOH decided to invest, establish and build the NJDOH Colette Lamothe-Galette Community Health Worker Institute, <https://www.nj.gov/health/fhs/clgi/>

Colette Lamothe Galette Community Health Worker Institute

In May 2020, NJDOH created the Colette Lamothe-Galette Community Health Worker Institute (CLG-CHWI), a program to train and certify CHWs. The NJDOH secured a grant from the NJ Department of Labor's Growing Apprenticeship in Non-Traditional Sectors (GAINS) Program, which is 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.

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).

Community Problem and Response

COVID-19 is disproportionately impacting some communities. These vulnerable populations often have underlying medical conditions, comorbidities, and living and work conditions that make them more susceptible to COVID-19 exposure and death. CHWs often come from the communities they serve and can educate individuals on how to protect themselves, mitigate the risks of COVID-19 exposure, and access the many social supports available to these vulnerable populations. To address these social needs, CHWs will be trained in COVID-19-related competencies and social supports.

We propose building on the CLG-CHWI to train, deploy and engage more CHWs. We will do this by expanding CHW core competencies to include mental health & substance use disorder (SUD), adding new CHW specialized tracks in the form of additional training on primary actions of state and/or local public health-led efforts to address underlying conditions such as chronic disease. We will integrate 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.

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 age birth through 21 years of age, to enhance access to medical home services, facilitate transition to adult systems, and ensure health insurance coverage.

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.

At no charge to the families, the SCHSCM operates 21 county-based CMUs, 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.

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 learn 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. For example, a SCHS case manager reported being able to assist a parent to problem solve a denial of home health aide services for a 12-year-old with autism and significant developmental delays by advocating on the mother's behalf with PerformCare, her child's school district, and her Children's System of Care Organization. Repeated phone calls, home visits, and written appeals by the case manager supported the mother's efforts to clarify the required information and resolve her child's needs.

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

III.E.2.b.ii Family Partnership

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

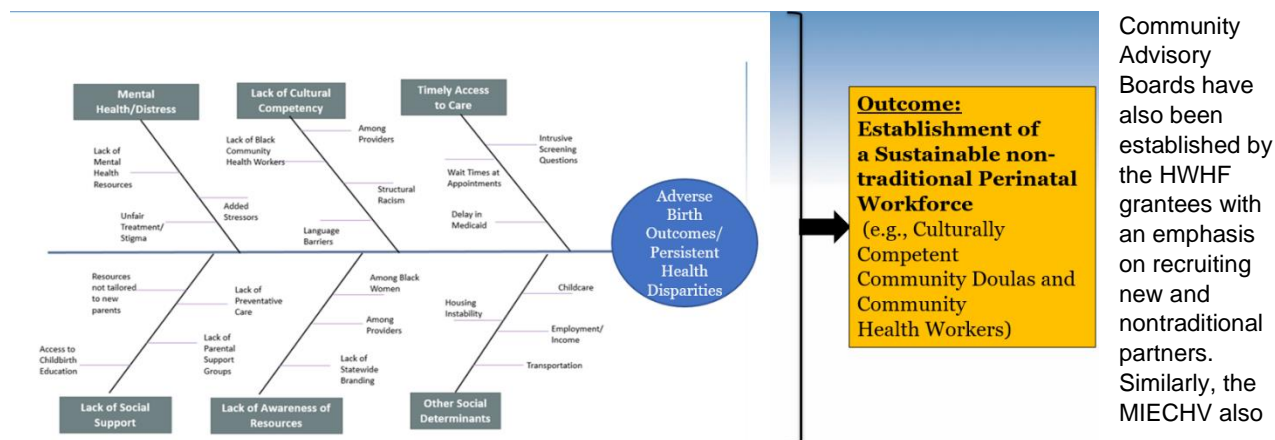
- Advisory Committees;
- Strategic and Program Planning;
- Quality Improvement;
- Workforce Development;
- Block Grant Development and Review;
- Materials Development; and
- Advocacy.

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. 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 FHS/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 NJ's maternal child health population, the FHS/ TVP has incorporated consumer/family involvement in as many programs and activities as appropriate.

NJ has prided itself on its regional MCH services and programs, which have been provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with an emphasis on prevention and community-based activities. Partially funded by FHS, 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. The three MCHCs are in the northern, central, and southern regions of the state. It is a requirement of the statute governing the MCHC that 50% of their Board of Directors be comprised of consumers representing the diverse population groups being serviced by their organizations.

Recognizing the importance that parent/consumer involvement through focus groups has in the design and implementation of a program to address issues related to preterm births and infant mortality, the MCH Program incorporated focus groups into several programs under the HWHF initiative including those for doulas, breastfeeding, and addressing disparities (Figure 17).

Figure 17. Focus Group on Adverse Birth Outcomes- Fishbone Diagram



requires funded grantees to implement County Advisory Boards.

Adolescent Health

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

In the 2020-2021 grant year NJ completed an independent evaluation of the Teen Speak parent/caregiver (PCG) engagement program provided through the CAHP teen pregnancy prevention program. The Evaluation was community-based and included both post-retrospective surveys and focus groups with PCGs who attended the program. Feedback was favorable and yielded positive feedback and that would help improve the implementation of the program. Some highlights included increased PCG comfort in discussing sensitive topics with teens and having a better understanding of communication strategies for talking with teens. Focus group results indicated that PCGs were having success with specific discussion strategies including: asking teens if they could share some advice/feedback, having conversations with teens in the car, and active listening and reflecting. Several areas for improvement were also identified including: delivering the program fully in Spanish rather than having a mixed group of English/Spanish with translation and having more options including in-person sessions which were all virtual due to the pandemic but have now resumed. This feedback has helped as we have expanded the program throughout the state.

As part of the Garret Lee Smith Youth Suicide Prevention Grant, Evaluator Michelle Scott conducted a workforce development survey with over 1,000 NJ-based youth-serving professionals to assess knowledge of and ability to screen, assess and treat youth with suicidal ideation. The survey yielded significant results which will aid in the development and implementation of trainings to assist youth-serving professionals in screening, assessing, and treating youth 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. CAHPs 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 challenged and exciting. Currently, 6 grantees, two in each region are delivering Teen Speak with the goal of reaching 400 parents and caregivers in 2022.

Children with Special Health Care Needs

The NJ Title V CYSHCN Program, SCHS, partners, collaborates, and coordinates with many different 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 policy that will ensure that children referred into the CMUs and their families are screened appropriately for healthcare service entitlements and waived 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 is comprised of governmental, advocacy, and family representatives and is responsible for analyzing and developing programs of medical care and coordination. State SCHS staff participate at 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 better assure coordination of resources, services, and supports for CYSHCN across systems. The quarterly MAAC meetings continue to provide a public forum for the discussion of systems changes in DHS's Medicaid program as well as invite collaboration across State programs. Updates keep stakeholders including the public and providers informed of NJ's progress in 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 also includes DHS, DCF, the NJ Primary Care Association, and over 60 statewide participating stakeholder organizations. The COCC partners are continuing to work to improve the access of children with mental health challenges to needed care and to improve the capacity of primary care providers to address mental health issues within their practice. A Family Guide to Integrating Mental Health and Pediatric Primary Care has been developed and shared with families. COCC co-conveners continue to meet with NJ's child protection agency, DCF Division of 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 places a great emphasis on 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.

NJEIS is a system designed to be a partnership with parents in supporting the needs of children and is always striving to increase that relationship to benefit children aged birth to 3 years. Currently, NJEIS is focusing on some professional training initiatives including Parents Interacting With Infants (PIWI) and Positive Solutions for Families (PSF). Both trainings pair NJEIS staff with parents and engages groups to facilitate conversations and learn ways to engage children appropriately or how to effectively handle behaviors. Further, NJEIS is looking to increase parent participation and feedback by employing a more robust survey tool for parents to respond to regarding their knowledge and perception of the program in terms of parental rights and child progress. Parents are surveyed every year and participation has increased consistently, however this new tool will allow NJEIS to gather input from a more diverse parent group.

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, and currently falls under the supervision of the Research Scientist I who serves as the Project Director for the NJ Pregnancy Risk Assessment Monitoring System (PRAMS), Project Director for the State Systems Development Initiative (SSDI) and oversees all MCH Epidemiology activities. Presently the team encompasses a lead full-time MCH epidemiologist and one full-time Research Scientist II responsible for managing/analyzing MCH data and two FTE vacancies. MCH Epidemiology positions are funded by Title V, MCH Block Grant, and the SSDI grant.

The MCH Epidemiology program recently recruited a Research Scientist I who is responsible for research, design, coordination, and implementation of all programs and activities within the MCH Epidemiology program. Duties include: serving as the PRAMS Project Director; designing and developing research protocols and data evaluation for the Healthy Women, Healthy Families initiative; 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. Her responsibilities include: completing all SSDI required progress reports and continuation applications; responding to internal and external data requests; providing overall coordination of the PRAMS project; organizing PRAMS Steering Committee meetings; assuring compliance with the PRAMS protocol; coordinating the dissemination of PRAMS data and the development of PRAMS data briefs, topic reports, and the NJ State Health Assessment Data (NJSHAD) system PRAMS data query; and completing all PRAMS progress reports and continuation applications.

The MCH Epidemiology program is currently in the process of hiring a Health Data Specialist. The prospective candidate will promote the health of pregnant women, infants, and children through the analysis of trends in MCH data and facilitate efforts aimed at developing strategies to improve MCH outcomes. 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. Interviews for this position have been conducted, and a candidate has been identified to hire.

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. To 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.

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. Title V Epidemiologists within the MCH unit have used Statistical Analysis System (SAS) and Registry Plus™ LinkPlus software to perform deterministic and probabilistic data linkage. The data linkage projects are as follows:

1. Pregnancy Risk Assessment Monitoring System (PRAMS) Data Linked to NJ Birth Data, Universal Billing data, and WIC Data which allowed for the development of statewide PRAMS queries that are 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, etc. This data query allows Title V staff to have more direct and timely access to NJ PRAMS indicators.
2. Epidemiologists within the MCH Epi unit analyzed the linked 2014-2020 dataset and drafted and posted 2 data briefs on the [MCH Epidemiology webpage](#). The data presented in both briefs derives from the 2014-2020 Pregnancy Risk Assessment Monitoring System weighted survey responses
 - a. The first data brief is entitled "Maternal Risk Factors and Adverse Birth Outcomes, 2014-2020" which examines the associations between pregestational and gestational maternal morbidity factors and the risk of adverse birth outcomes (low birth weight, preterm birth, and NICU admission).

- b. the second is entitled “Tobacco Use and Adverse Birth Outcomes, 2014-2020” which examines associations between tobacco use before, during, and after pregnancy and the risk of adverse birth outcomes (low birth weight, preterm birth, and NICU admission).
3. A poster presentation entitled: “A Retrospective Investigation of Potential Factors Associated with Pregnancy-Related Deaths- New Jersey; 2009-2018” prepared by MCH Title V Epidemiologists within FHS, was accepted for presentation at the 2022 Council of State and Territorial Epidemiologists (CSTE) National Meeting. The study assessed potential changes with regard to pregnancy-related associated factors from 2009-to 2018. Considering that NJ Pregnancy-Related Deaths continue to rise, and racial/ ethnic disparities persist, Title V epidemiologists concluded that these statistics warrant the need for grassroots approaches; the establishment of a sustainable non-clinical perinatal workforce that encompasses CHWs.
4. A poster presentation entitled: “A Pivotal Shift Toward a Sustainable Non-Traditional Perinatal Workforce in New Jersey” prepared by MCH Title V Epidemiologists within FHS, was accepted for presentation at the 2022 Black Maternal Health Conference and Training Institute. The study assessed the need for the establishment of a sustainable non-traditional perinatal workforce (NTPW) in NJ.
5. In the coming year, MCH Epi staff will be linking 2020 NJ PRAMS data to the Postpartum Assessment of Women Study (PAWS). PAWS is an observational cross-sectional study that involves retrospective data collection through a survey of women 12-14 months after childbirth in seven jurisdictions: NJ, New York City, Pennsylvania, Virginia, Kansas, Utah, and Michigan. This study is being conducted by public health researchers at Columbia University. The purpose of PAWS is to conduct surveillance of women’s health needs, health insurance status, health care utilization, and social determinants of health in the year following childbirth. The study is designed to help inform states and public health agencies about factors related to postpartum health outcomes. Moreover, data from this effort will potentially inform the development of programs and policies to mitigate maternal morbidity and mortality in the extended postpartum period. Findings will be disseminated in peer-reviewed publications and through other presentations and reports.
6. In the coming year, MCH Epi staff will conduct an evaluation project to ascertain whether the programs implemented through the HWHF initiative have met the goals and objectives of reducing BIM in NJ and inform DOH leadership if the initiative should be continued, modified, or discontinued.

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

Evaluating services for NJ mothers, infants and children is an important part of 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. The Maternal and Child Health Epidemiology (MCH Epi) Program provides MCH surveillance and evaluation support to Maternal and Child Health Services (MCHS). The State Systems Development Initiative (SSDI) project resides in the MCH Epi Program and focuses on improving the exchange of data for linkages within the department and between other agencies.

Data exchanges occur currently between MCH Epi, Vital Statistics, Pregnancy Risk Assessment and Monitoring System (PRAMS; also housed in the MCH Epi Program), and Centers for Health Statistics. Using birth data retrieved monthly and death data and hospital discharge data retrieved when the latest files are available, MCH Epi 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.

SSDI supported the use of vital statistics data and hospital discharge data to identify cases of maternal deaths that are then used by NJ MMRC to identify pregnancy-related deaths and make recommendations so that such deaths can be prevented for other women. SSDI staff has also been a participant in the State's Strategic Plan to Reduce Maternal Mortality. This participation involved providing data support as well as making recommendations for future surveillance and reporting on maternal mortality by sociodemographic characteristics, causes of death, and timing of death in the form of an annual maternal mortality report.

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

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 analysis of PRAMS data, 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.

Several CDC survey supplements have been included in the NJ PRAMS survey to collect data on emerging MCH issues. For example, a survey supplement on Zika was included from July 2016 to October 2017, and a supplement on marijuana and opioid was included from July 2018 to March 2020. Results from the Zika supplement were presented at the 2018 PRAMS National Meeting, and the drug use data was recently analyzed and presented at the 2021 NJ PRAMS Steering Committee Meeting. Most recently, 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.

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

MCH Emergency Planning and Preparedness

The Family-Centered Care Program in Special Child Health and Early Intervention Services is in the process of 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 will be redesigned to allow more flexibility in collecting what the family needs are and how they can best be serviced during an emergency.

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. 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. Presently, a hybrid option is offered to the population being served by our programs.

NJDOH was awarded CDC funding for an Epidemiology and Laboratory Capacity (ELC) grant to enable enhanced detection. The ELC scope of work in MCH was prioritized under the umbrella of the Colette Lamothe-Galette Community Health Worker (CLG-CHW) Institute. The ELC focused on developing CHW to assist in contact tracing efforts; assisting with the surveillance of vulnerable populations; implementing prevention strategies with vulnerable, diverse populations; and providing alternative testing and vaccine sites for COVID-19. TVs in collaboration with Title V grantees established three statewide regional grantees to work closely with over 35 subgrantees, including both traditional partners (Healthy Women Healthy Families grantees/subgrantees) and nontraditional partners (FQHCs, food banks, faith-based and local community organizations).

CDC’s new initiative “Surveillance for Emerging Threats to Mothers and Babies,” is enabling investing in public health data systems to better monitor and respond to the unique risks and needs of pregnant women, infants, and children during public health emergencies. Through this initiative, in which NJ Title V is participating, the effects of new health threats such as COVID-19, on pregnant women and their babies can be detected by collecting data from pregnancy through childhood. The initiative enables the use of evidence-based, actionable information to help save and improve the lives of mothers and babies.

The TVP has partnered with CDC to help protect mothers and babies from the consequences of public health emergencies. As we continue to have limited information from published scientific reports regarding pregnant women and their risks with COVID-19, TVP with CDC, is monitoring pregnant women who test positive for COVID-19 through the end of their pregnancy as well as monitoring the birth outcomes of their infant(s), and follow-up of those infants at 2 and 6 months. NJ data is featured on the [CDC COVID data Tracker](#)¹².

By collecting existing laboratory and clinical information on these mothers and infants, we will be able to characterize the spectrum of health effects associated with COVID-19 infection during pregnancy to inform clinical guidance, programs, and services. TVS is working with hospital Health Information Management Departments and is currently abstracting data from medical records for cases where delivery has already occurred. Through this initiative, the data may be used to monitor and improve the health of pregnant women and infants; link families to medical and social services to get recommended care; strengthen laboratory and clinical testing to find emerging health threats quickly; and ensure public health is ready and prepared to meet the needs of pregnant women and infants during emergencies.

To examine the experiences and perceptions of WIC program participants to the changes in service delivery due to Covid-19, participants' expectations for services delivery post remote service delivery, and assess the effectiveness of the communication between the program staff and the participants, NJ WIC staff designed the 2021 WIC Participant Survey. The WIC 2021 survey highlighted how New Jersey WIC innovated rapidly during the pandemic, utilizing multiple technology platforms and novel methods to deliver exceptional services and ensure food security, all while meeting federal regulations and COVID-19 safety needs. The summary of synthesized survey responses confirmed that (1) participants were either very satisfied or satisfied with NJ WIC services, (2) Remote appointments greatly appealed to WIC participants, and (3) the convenience and flexibility of remote appointments augmented the participants' access to WIC benefits.

¹² Centers for Disease Control and Prevention. COVID Data Tracker. Accessed on April 20, 2022. <https://covid.cdc.gov/covid-data-tracker/#pregnant-birth-infant>

Moreover, to alleviate food shortage problems, safeguard participants' access to healthy foods. The NJ WIC program obtained waivers to allow food substitutions during the pandemic. Additionally, NJ WIC recommended COVID-19 vaccination to WIC participants and tracked referrals to WIC participants for vaccination.

In an attempt to support New Jerseyans during this unprecedented formula shortage crisis, NJ WIC shoppers will be provided the option to purchase a wider variety and sizes of the contracted (Mead Johnson, maker of Enfamil) infant formula products. To make these changes, on the technology side, the WIC WOW MIS system, WIC EBT card, WIC Shopper app, and the UPC codes and grocer systems will be updated. Moreover, the State WIC Food Delivery staff are in daily communication with CAP of Lancaster the warehouse that provides NJWIC exempt and specialty formulas. Simultaneously, the State WIC Nutrition Unit created updated educational materials for participants to assist in purchasing the correct formula and providing guidance for local agency WIC staff. For parents who are breastfeeding and using formula, WIC staff provide support for parents who want to try options to possibly increase breastmilk production.

III.E.2.b.v. Health Care Delivery System

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

Public and Private Partnerships

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, 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 is the culmination of 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 of which Assistant Commissioner Lisa Asare is a member. This task force was formed to improve maternal health outcomes by catalyzing multidisciplinary collaboration, collecting, and analyzing maternal health data, and promoting and executing innovation in maternal health service delivery. The NJMCQC coordinates all efforts and strategies aimed at reducing 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 the development and implementation of 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. The NJMCQC is part of the HRSA-funded State Maternal Health Innovation program (SMHIP), a selective innovation program made to complement ongoing Title V programs across the country.

In the fall of 2021, NJ state officials announced the expansion of Medicaid coverage for 365 days postpartum to improve maternal and infant health and decrease the racial disparity in birth outcomes in NJ. NJ is the second state in the nation and the first in the region to provide Medicaid expansion to prevent postpartum-related illness and death. This offers a great opportunity for TVP to ensure and inform MCH individuals who could not afford that comprehensive access to healthcare for a full year through Medicaid is now available. This new legislation will strengthen the NJ MIECHV Program currently investing in reducing adverse pregnancy and birth outcomes (e.g., preventable maternal mortality, pre-term births, maternal morbidity, and more).

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

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



PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

State of New Jersey

DEPARTMENT OF HEALTH
PO BOX 360
TRENTON, N.J. 08625-0360
www.nj.gov/health

SHEREEF M. ELNAHAL, MD, MBA
Commissioner

**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 (OHS), 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 (IMAs), 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.

OHS, 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.

2. Child Health:

DOH shall:

1. Provide support and collaborate with DMAHS on education, training, and program development relating to lead poisoning prevention.
 2. Promote and facilitate enrollment of children into Medicaid and/or NJ FamilyCare.
3. Childhood Lead Poisoning Prevention Surveillance System (CLPPSS):

DOH shall:

1. Ensure quality monitoring of lead information, inspections and abatements.
2. 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:

1. Meet at least annually with DOH to ensure timely and accurate program operation.
2. 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.
3. Provide NJEIS with updates and changes to Medicaid regulations.
4. Provide technical assistance, as needed, regarding requirements and specification for claims submission, processing and data reporting for Early Intervention Medicaid Initiative (EIMI).
5. Submit claims to the federal government to draw down federal Medicaid funding for services provided under EIMI.
6. Assist DOH in maximizing federal reimbursement for the costs of allowable administrative activities.


2. Child Health:DMAHS shall:

1. Provide support to and collaborate with DOH on education, training, and program development relating to lead poisoning prevention.
2. 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:

1. 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, Family Health Services Department of
 Health



 DHS Signature

3/7/19

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Director, Division of Medical Assistance and Health Services Department of Human Services

DRAFT

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

State Action Plan Introduction

III E2a – State Action Plan Overview

State Title V Program Purpose and Design

NJ Title V supports the life course model in approaching maternal and child health, where the full spectrum of factors that impact health are considered, including social, economic, and environmental factors which can contribute to underlying causes of persistent health disparities. The NJ TVP is a convener, collaborator, and partner in addressing MCH issues. Alarming disparities have persisted despite programs designed to improve maternal outcomes. TVP funds best practices in data management and analysis to develop strategies and interventions tailored to meet the specific needs of clients through the Single Point of Entry and Client Tracking (SPECT) system. SPECT provides New Jersey (NJ) state agencies with the ability to monitor existing programs and plan for future expansion using data to drive decision-making. SPECT supports the triage of clients by central intake hubs to appropriate home visiting or other community-based programs using data from the PRA or the Community Health Screen (non-clinical screen). Moreover, Title V grantee established a Case Management System also known as NJCHART which is used by Healthy Women Healthy Families (HWHF) grantees, and Community Health Workers to log all case management services (including assessments, attempted and successful contacts, service referrals, and education provided to participants) and to collect information about the services specifically targeted to women in cities with high rates of Black infant mortality. Considering the data platforms funded by NJ TVP, NJTVS can monitor existing programs and inform policies, drive decision-making based on accurate state-level data.

Therefore, the NJ TVP is well-positioned to serve as a convener, collaborator, funder, and partner to not only traditional health partners but also to non-traditional, community-based partners such as faith-based organizations in need of data to inform intervention capable of addressing social determinants of health that may 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 BMI. 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.

Moreover, the launch of the Governor and First Lady's many maternal health initiatives including Nurture NJ, have enabled Title V to convene, collaborate, and partner with other public and private agencies, families, and stakeholders to perform a comprehensive maternal morbidity and mortality environmental scan to develop a needs assessment with goals to address NJ's maternal health crisis. NJ Title V partners with the NJ Maternal Health Innovation Team, also at NJDOH, to address maternal health. Health care leaders also engaged include the NJ MMRC 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 NJ MCH consortia; foundations; and birthing hospital facility Chief Executive Officers, maternal health, and quality improvement experts.

Coordinated, comprehensive, culturally, and linguistically competent, family-centered systems of care are available in Title V's Special Child Health Case Management System, which includes the implementation of AMCHP's National Consensus Standards for Systems of Care for Children and Youth with Special Health Care Needs. The core public health functions of assessment, assurance, and policy development through program efforts are all supported through the MCH Block Grant.

Women/Maternal Health - Annual Report

Improving the domain of Women's/Maternal Health is crucial to the State Priority Increasing Equity in Healthy Births (SPN #1) and the National Outcomes Measures (NOMs) related to decreasing: 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 the important role early life events play in shaping an individual's health trajectory. The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, influence health throughout one's lifetime. NJ has had a long-standing priority of improving the health of women and has utilized several evidence-based strategies to increase preventive medical visits (NPM #1) including: the HWHF, MIECHV, FIMR, and Maternal Mortality Review. Additional emphasis has been placed by the Governor and the First Lady 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
Percent of women with a past year preventive medical visit	77.7	77.3	78.8	79.8	80.5	77.0	82.4

Data Source: [Behavioral Risk Factor Surveillance System \(BRFSS\) in NJSHAD](#). Visited a Doctor for a Routine Checkup in the past year (Age-adjusted).

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 2020, the overall percentage of adequate prenatal care based on the [Kotelchuck Prenatal Care](#) was 71.1%.¹³ However, racial/ ethnic disparities are observed. [Specific race/ethnicity related rates](#) for adequate prenatal care for 2020 were 77.4%, 58.1%, and 66.1% for White, NH, Black, NH, and Hispanic, respectively¹⁴. 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 care and health care for all women of reproductive age. The main goal of preconception care is to provide health promotion, screening, and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies. Given the relationship between pregnancy intention and early initiation of prenatal care, assisting women in having a healthy and planned pregnancy can reduce the incidence of late prenatal care and promote NPM #1 (Well Women Visits).

Through the HWHF initiative, TVP uses CHWs and CI to focus on improving maternal and infant health outcomes including women's health with preventive medical visits, preconception care, prenatal care, interconception care, preterm birth, and low birth weight, and infant mortality. The primary focus of CI 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 CI 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. CI 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,

¹³ New Jersey State Health Assessment Data. "Query Results for New Jersey Birth Data: 1990-2020 - Percentage With Kotelchuck Prenatal Care=Adequate". Accessed on April 20, 2022 at NJSHAD - [NJSHAD - Query Builder - New Jersey Birth Data: 1990-2020 - Percentage With Kotelchuck Prenatal Care=Adequate \(state.nj.us\)](#).

¹⁴ New Jersey State Health Assessment Data. "Query Results for New Jersey Birth Data: 1990-2020 - Percentage With Kotelchuck Prenatal Care=Adequate". Accessed on April 20, 2022 at NJSHAD - [NJSHAD - Query Builder - New Jersey Birth Data: 1990-2020 - Percentage With Kotelchuck Prenatal Care=Adequate \(state.nj.us\)](#).

2018, to March 30, 2022, more than 90,000 women have been screened since July 2018, over 24,000 clients received a service referral, and 32,000 clients received a program assignment.

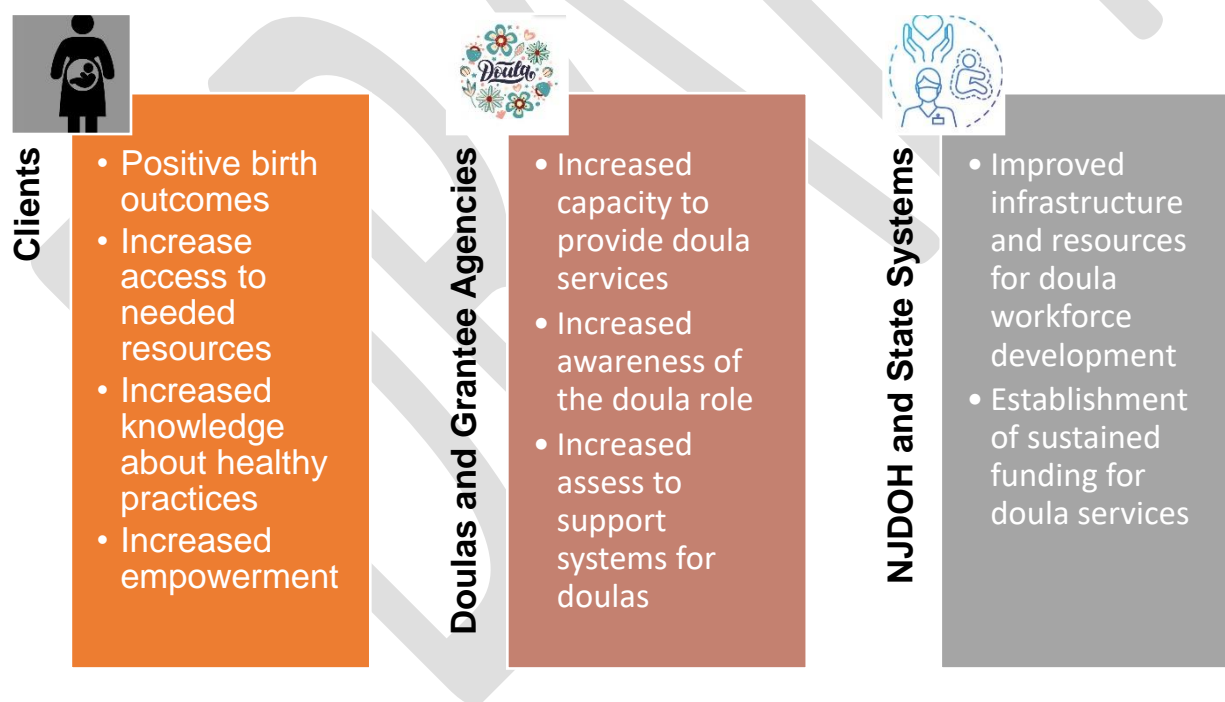
To better align the ESM with our current initiatives, TVS decided to add ESM 1.2 (Number of individuals trained to become community-based doula). Number of individuals trained to become community-based doula) was selected for its positive impact on National Performance Measure (NPM) #1 (Well Women Care)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

A Request for Application (RFA) was issued for the creation of a Doula Learning Collaborative (DLC), which was awarded to Health Connect One. The focus 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 grow the community doula workforce.

To date, approximately 150 women were trained to become community doulas, and as of December 2021, 547 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 18).

Figure 18. Program Outcomes Across Clients, Doula and Grantee 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 may be taken by multiple stakeholder groups 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 made a case to offer doula services to women through Medicaid Benefits. NJ Medicaid benefits have been expanded to cover doula services. Presently, birthing who are covered by Medicaid can now be served by a doula for free.

Moreover, to infuse additional services in the communities, TVP established the CLG-CHWI through an NJ Department of Labor Apprenticeship. TVP collaborate with universities to create a standardized community health worker training and certification program, resulting in a robust CHW workforce. This has allowed the state to educate an emerging and critical component of its workforce – creating a needed infrastructure to support CHWs and 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.

In collaboration with the CLG-CHWI, the Epidemiology Laboratory and Capacity (ELC) grant emphasizes the prevention of disease and enhanced detection of COVID19. The ELC focused on hiring and training CHWs to assist in contact tracing efforts; assisting with the surveillance of vulnerable populations; implementing prevention strategies with vulnerable, diverse populations; and providing alternative testing and vaccine sites for COVID-19. The COVID Community Corps and Vaccine Ambassador Programs also support these efforts.

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

The programs being implemented in the communities through HWHF initiative allow TVP to implement specific activities aiming at supporting 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, and established linkages with sister agencies (Department of Labor, Department of Education, Department of Transportation, etc.) to address some of the barriers that exist in the scope of SDOH. NJ TVP and Office of Population Health continue to work with national maternal health experts to develop a strategic plan to promote maternal health and reduce maternal morbidity and mortality as well as develop the activities for the Maternal Health Innovations Program and expanded Maternal Mortality Review Commission. 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".

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

Quality improvement is accomplished through the FIMR and Maternal Mortality Review systems, as well as analyzing data collected through electronically submitted birth certificates. The Total Quality Improvement (TQI) Committee reviews the data and makes recommendations to address either provider-specific issues or broad system issues that address multiple providers or consumer groups within each consortium region.

Women/Maternal Health - Application Year

Plans for the coming year to promote NPM 1 (Well Women Care) will include the continued implementation of HWHF and collaboration with families, partners, and stakeholders in the newly implemented State Maternal Health Innovation Program. To assess the effectiveness of the state's healthcare delivery systems through the HWHF initiative in meeting the needs of women and children and the TVS will be evaluating the HWHF initiative in the

summer of 2022. Title V epidemiologists will work closely with DOH leadership and Title V grantees to make recommendations that can potentially inform the adaptation of HWHF to better serve the population of focus.

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 is also being developed for DOH review.

Simultaneously, centering programs will continue with both in-person and virtual groups and will focus on sustainability of the programs. The Burke Foundation has also launched an initiative of expanding centering pregnancy and parenting in NJ over the next 5 years, awarding funding for 5 sites each for implementation and training through the evidenced-based program of the Centering Healthcare Institute (CHI).

The Fatherhood program followed the evidence-based curriculum in 24/7 Dad and was successful with a total of 207 graduates. Currently, the HWHF Fatherhood program is partnering with the FELLAS program, a Fatherhood Initiative that was awarded a federal grant that provides case management to fathers. Title V grantees will continue to support outreach and recruit Fathers through the partnership with the FELLAS program including maintaining contact with HWHF Fatherhood Program alumni.

Simultaneously, county-based consumer-driven advisory boards will continue to contribute to the direction and progress of the HWHF initiative and the Central Intake Hubs will meet quarterly to build partnerships and local referral systems. Rebranding of Central Intake is currently in progress to find a more appealing and trusted name that welcomes participants for referrals and services. The MIECHV Programs and Healthy Start Programs will continue to case manage mothers and assure preventive medical visits through the monitoring of benchmarks which include a reproductive life plan, medical home, and well-women visits.

The Doula Bridge funding will provide support to the community doulas trained through the Doula Pilot Programs as they transition and enroll in NJ FamilyCare Medicaid fee-for-service and the Managed Care Organization's process to become Medicaid providers. The newly initiated DLC goal 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. Presently, doula visits are being offered both in-person and virtually, including virtual doula support through the birth as needed and possible. 150 doulas have completed their training in the Uzazi Village model and are serving women. HWHF Doulas will continue to participate in Medicaid's Doula Stakeholder meetings.

The CLG-CHW Training Institute will continue to enhance the professional development of CHWs and allow for a stronger workforce. Approximately 180 CHWs have completed their training. The CLG-CHWI continues 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-CHW Training Institute, focusing on the prevention of disease and enhanced detection of COVID19, focusing on vulnerable populations.

Moreover, TVS is planning a new partnership with Horizon's Neighbors in Health. This partnership will establish a statewide CHW administrative hub for the CLG-CHWI and CHWs. Once implemented, this partnership between TVP and Horizon will allow NJDOH's CLG-CHWI to train CHWs and then connect them with Horizon's Neighbors in Health Program for employment. Horizon will give trained CHWs access to numerous employers throughout the state across large health systems.

Additionally, NJDOH has an ongoing partnership with Rutgers Project ECHO (Extension for Community Healthcare Outcomes) to develop a CHW COVID-19 specific curriculum webinar training series. The CHW ECHO series aims to help Frontline and Community Health Workers raise awareness and knowledge on COVID-19, identify the impact of COVID-19 in communities with vulnerable and high-risk populations, and combat the ill effects of COVID-19 in NJ public health response. The first project ECHO webinar training was held in November of 2020. NJDOH relaunched its second Rutgers ECHO series in January 2022, and it will continue until June of 2022. NJDOH ECHO sessions included information to address COVID-19 in vulnerable communities for CHW and Doulas. 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.

The NJ TVP and the Office of Population Health will continue to focus on improving women's and maternal health through the development and implementation of 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 annual report care of hospital 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.

Due to COVID19, the progress of the Centering Programs (which are types of groups prenatal and parenting care) had been on pause. Telehealth mini-grants were awarded from the Centering Healthcare Institute to NJ's Centering programs which provided support to the sites. When Centering was able to resume, some sites chose to continue in-person groups with smaller numbers to follow social distancing guidelines, other sites established virtual group visits to help connect pregnant women or parents. The virtual groups later transitioned to in-person as comfort level with clients increased.

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 every year—and 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 the State of New Jersey. Alma is an evidence-based peer mentoring program created with and for new and expectant mothers who are 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.

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.

Perinatal/Infant Health - Annual Report

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. NJ has implemented several evidence-based strategies related to NPM 4 & 5 which in turn will have an impact on several NOMs (4, 5, 6, 8, 9.1, 9.5).

3.E.2.c.2.a - 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.

ESM 4.1 (Increase the Percentage of Births in Baby-Friendly Hospitals) was selected for its positive impact on NPM #4 and NJ'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 stayed about the same for newborns ever breastfed at 88.7% in 2017 and 81.7% in 2018 (NPM 4A), breastfeeding rates decreased in four categories from 2017 to 2018: exclusive breastfeeding at 3 months increased from 46.9% to 36.8%; breastfeeding at 6 months increased from 63.5% to 59.8%; exclusive breastfeeding at 6 months increased from 27.7% to 22.5% (NPM 4b); and breastfeeding at 12 months increased from 38.6% to 34.5%¹⁵.

Table NPM #4	Born in 2010	Born in 2011	Born in 2012	Born in 2013	Born in 2014	Born in 2015	Born in 2016	Born in 2017	Born in 2018
Percent of infants who ever breastfed	77.1	81.6	82.0	82.0	83.9	82.8	88.8	88.7	81.7
Percent of infants breastfed exclusively through 6 months	13.0	22.3	16.7	23.1	24.8	24.4	22.8	27.7	22.6

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](http://www.cdc.gov/breastfeeding/data/NIS_data/DNPAO>Data,TrendsandMaps:ExplorebyLocation|CDC)

FHS has supported Baby-Friendly™ designation through training, technical assistance, and mini-grants. The Baby-Friendly Hospital Initiative (BFHI) is a global program that was launched by the World Health Organization and the United Nations Children's Fund to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infants feeding and mother/baby bonding. BFHI recognizes and awards birthing facilities that successfully 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" designation¹⁶. Three "Baby-Friendly" hospitals were added in NJ in 2019. FHS has supported Baby-Friendly™ designation through training, technical assistance, and mini-grants. The Baby-Friendly Hospital Initiative (BFHI) is a global program that was launched by the World Health Organization and the United Nations Children's Fund to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infants feeding and mother/baby bonding. BFHI recognizes and awards birthing facilities that successfully implement the Ten Steps to Successful Breastfeeding (i) and follow the International Code of Marketing of Breast-milk Substitutes (ii). Fourteen NJ hospitals have earned the "Baby-Friendly" designation. Two "Baby-Friendly" hospitals were added in NJ in 2019.

¹⁵ Center for Disease Control. Nutrition, Physical Activity, and Obesity: Data, trends and maps. Access on April 21, 2022. [DNPAO Data, Trends and Maps: Explore by Location | CDC](#)

¹⁶ Baby Friendly Hospital. Access on April 21, 2022. [Baby Friendly Hospitals - New Jersey Breastfeeding Coalition \(breastfeedingnj.org\)](#)

[NJ hospitals participate in the Maternity Practices in Infant Nutrition and Care \(mPINC\) survey](#), which is a national survey of maternity care practices and policies conducted by the CDC every two years, beginning in 2007. In 2020, 40 of 49 (82%) eligible hospitals participated in the mPINC Survey and the total score was 82 (above the national score of 81)¹⁷.

Breastfeeding rates at discharge (alone or in combination with supplemental formula) varied with the racial and ethnic composition of mothers. [In 2019](#), Asian, NH women were most likely to breastfeed (76.4%) while black, NH women were least likely to breastfeed (67.1%). White, NH and Hispanic women-initiated breastfeeding at 75.0% and 78.6% respectively¹⁸.

Further examination of the disparity in these rates will require State leadership to reinforce regulations regarding breastfeeding and in providing support for information on locally available breastfeeding promotional activities, protocols, and the cultural appropriateness of those services.

WIC Services provide breastfeeding promotion and support services for WIC participants through grants to all 16 local WIC agencies. 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 Peer Counseling Breastfeeding Program. WIC breastfeeding staff conducts professional outreach in their communities and education to healthcare providers who serve WIC participants.

Existing FHS programs that promote breastfeeding and include performance measures for increasing breastfeeding include the HWHF Initiative and the MIECHV Program. One of the target outcomes of HWHF is, increasing exclusive breastfeeding. Additionally, to address the racial/ethnic disparity in breastfeeding rates, the implementation of breastfeeding support groups for Black, NH, women is one of the interventions/strategies of HWHF. Moreover, CHWs and their supervisors are receiving breastfeeding education through an initiative by the NJDOH. The "Breastfeeding in Color" training focuses on women of color and was developed to address issues of disparities, focusing on reproductive justice, and addressing inequities in human lactation. Fatherhood success continues with a total of 207 fathers graduating from the program since inception three years ago, with alumni still staying involved.

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.

Throughout 2019 and early 2020, the NJ Breastfeeding Strategic Plan (NJ BSP) Steering Committee, consisting of NJDOH and Title V staff, with representatives from the NJ Breastfeeding Coalition and the Central Jersey Family Health Consortium met monthly to provide guidance and monitor the progress of the development of a statewide strategic breastfeeding plan. This project included the completion of a statewide environmental scan of literature, laws, policies, data, trends, disparities, and practices in the state that support or create barriers to breastfeeding initiation, duration, and exclusivity, especially with regards to WIC and SNAP participants. The project also included the development and dissemination of surveys to pediatricians, obstetricians, family practice physicians, midwives, perinatal nurses, lactation consultants, childbirth educators, staff of Healthy Women Healthy Families, and analysis of the resulting data. Eight consumer focus groups were organized and facilitated in Atlantic City, Camden, Newark, New Brunswick, Phillipsburg, Trenton, Union City, and Vineland to explore factors that support, influence, or discourage breastfeeding among NJ families, especially persons of color and marginalized groups, including the WIC and SNAP populations. A diverse stakeholder group was created that included over seventy traditional and nontraditional partners in government, business, insurance, education, community organizations, and healthcare and across agencies and departments that met periodically to recommend policy environmental and system changes. Interviews of key informants and state experts were undertaken. Utilization of the data created by the above activities to inform a needs assessment and strengths, weaknesses, opportunities, and threats (SWOT) analysis of strengths, weaknesses, opportunities, and threats regarding breastfeeding/lactation in the state. Recommendation of short and long-term goals, objectives, and strategies to accomplish the NJ BSP mission. The final report was submitted in April 2020 for review by DOH. A section on COVID-19 and breastfeeding was then added and submitted to the DOH in August 2020. The DOH plans to formally release the NJ BSP in 2022.

In January 2017, the State finalized new Hospital Licensing Standards that require hospitals to develop and implement evidence-based written policies and procedures for obstetrics, perinatal and postpartum patient services, newborn care, the normal newborn nursery, and emergency departments that address breastfeeding and

¹⁷ mPINC Survey, 2020 New Jersey Results Report. Accessed on April 21, 2022. [2020 New Jersey Results Report \(cdc.gov\)](https://www.cdc.gov/nchs/data/infant/matpract/mPINC_2020_NJ_Results_Report.pdf)

¹⁸ New Jersey State Health Assessment Data. Health Indicator Report of feeding at Discharge. Access on April 21, 2022. <https://www.doh.state.nj.us/doh-shad/indicator/view/Feeding.RETrend.html>

supporting the needs of a breastfeeding mother and child from the point of entry into the facility through discharge. These Standards support the Ten Steps to Successful Breastfeeding and need strong enforcement.

The NJDOH will call attention to NJ's 23.3% rate for hospitals supplementing breastfed infants with formula before two days of life; this is above the national average of 19.2% (with a Healthy People 2020 Target of 14.2%) and ranks NJ 46 out of 52 states (CDC's Breastfeeding Report Card, 2020)^{19,20}. The Joint Commission Perinatal Care Core Measure on Exclusive Breast Milk Feeding (PC-05a) was retired in recognition of the decision some women make to not exclusively breastfeed despite recommendations. PC-05 continues as an accountability measure that is publicly reported on The Joint Commission's Quality Check® website.

Annual Report NPM #5 (infant safe sleep)

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 Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUID includes sudden infant death syndrome (SIDS), accidental suffocation and strangulation in bed, and ill-defined and unknown causes. 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, which has been called one of the seven leading research findings in pediatrics in the last 40 years²¹. 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 and 2016, the AAP expanded its recommendations to help reduce the risk of SIDS and other sleep-related deaths through a safe sleep environment that includes placing infants to sleep on their backs; having the infant share a parent's room but in his/her own sleep space (crib, bassinet, portable crib, or play yard that meets current Consumer Product Safety Commission standards and contains a firm flat mattress of the type intended for that product) and keeping that sleep space free of soft and loose bedding such as bumpers, pillows, and blankets. Additional recommendations include breastfeeding and avoidance of overheating and of smoke exposure 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 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 attention on the complete 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 2017 the percent of infants placed on their backs surpassed the Health People 2020 NJ target of 74.1. For 2018-20, the target fell within the 95% confidence intervals of each year's achieved percentage. For 2017-2020, the percentage of Black, NH, and White, NH infants placed on their backs surpassed the target goal for each group.

Notes - Source – NJ PRAMS.

<https://www-doh.state.nj.us/doh-shad/query/result/prams/PRAMS/InfSleepPosition.html>

¹⁹New Jersey State Health Assessment Data. Complete Health Indicator Report of Formula Supplementation among Breastfeeding Infants. Accessed on May 26th, 2022. [NJSHAD - Complete Health Indicator Report - Formula Supplementation among Breastfeeding Infants \(state.nj.us\)](https://www-njshad.state.nj.us/complete-health-indicator-report-formula-supplementation-among-breastfeeding-infants)

²⁰Breastfeeding Report Card United States, 2020. Accessed on May 26th, 2022 <https://www.cdc.gov/breastfeeding/data/reportcard.htm>

²¹ Goodstein, M., Ostfeld, B. (2017). Improvement in Infant Sleep Position: We can Do Better. Accessed on May 26th, 2022 [Improvements in Infant Sleep Position: We Can Do Better! | Pediatrics | American Academy of Pediatrics \(aap.org\)](https://www.aap.org/infant-sleep-position-we-can-do-better)

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, www.facebook.com/sidscenternj/, and www.rwjms.rutgers.edu/sids, and the work of the Sudden Unexpected Infant Death Case Review Workgroup. To improve the surveillance of infant safe sleep practices, Family Health Services conducts the PRAMS survey which includes questions on infant safe sleep and participates in the SUID-CR Workgroup.

The SIDS Center of New Jersey (SCNJ) is a program funded by a NJDOH health services grant 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 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 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).

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 smoke exposure, preterm birth, the absence of breastfeeding, poverty, preconception health challenges, inadequate or absent prenatal care, and implicit bias. Disparities in these factors greatly contribute to disparities in rates. The SCNJ's Infant's Bill of Rights promotes 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 Sudden Unexpected Infant Deaths. Research conducted by the SCNJ contributed to these recommendations and informs its safe sleep education programs. Intending to change behavior as well as knowledge, the SCNJ also evaluates educational methodologies and barriers to compliance and develops interventions designed to be respectful of generational, cultural, and community concerns in New Jersey's diverse population. NJ SUID rates are among the lowest in the US. In 2018, New Jersey's SUID rate was 0.5 per 1000 live births, in contrast to the national rate of 0.9, and was third lowest among states. (CDC WONDER linked birth/infant death file). New Jersey's low rate of 0.5 was sustained in 2019, the most recent year with finalized data, to date.

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. NJDOH 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 Department of Children and Families 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.

In 2018, the SIDS Center of New Jersey developed a unique and free app, [SIDS Info](#), for iOS and Android devices, with the goal of enhancing the education of parents and providers about safe infant sleep and enabling 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 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, can be automatically updated, and is more accessible and enduring than flyers. It can be shared remotely with others caring for an infant. Under a "Keep It Up!" strategy, pediatricians also 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 health care 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. In 2019, faculty of the SCNJ announced the release of a second app, Baby Be Well®, developed in a collaboration of 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. These tools are now widely used in NJ and other states. 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, and participation in the community-based outreach programs including Nurture NJ. 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.

Through the multiple evidence-based strategies in NJ to promote infant safe sleep and the consistent message to place infants to sleep on their backs, according to NJ PRAMS, NPM #5 has been slowly improving from 60.6% in 2004 to 75% in 2017 which exceeded the NJ Healthy People 2020 goal of 74.1%. At 73.7% for 2020, the NPM#5 target goal falls within its 95% confidence intervals. The NJ SUID rate has also declined from 1.13 per 1000 live births in 1990-1992 to 0.5 per 1000 live births in 2018, according to NJSHAD and NCHS. The NJ SUID rate falls well below the national rate of 0.9 and is among the lowest in the US. NJ SUID rates for both Black NH and White NH infants also fall below their national counterparts. The NJ SUID rate for 2019, the most recently finalized, was also 0.5. Although NJ's Black 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 being addressed through more targeted educational messages using home visitor staff in DCF and the MIEC Home Visiting Program. The SCNJ provides safe sleep education to staff in these programs and addresses racial disparity in the application of safe sleep practices and in the adverse antecedent social and health risk factors that affect SUID and contribute to disparity. In 2020 and 2021, the SCNJ gave 141 presentations to over 17,000 attendees with recorded on-demand sessions adding additional views.

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 persistence of racial/ethnic disparities in healthy birth outcomes in NJ. Infants who are born preterm are at the highest risk for infant mortality and morbidity. The percentage of black preterm births was selected to begin to address the underlying causes of black infant mortality and the racial disparity between preterm birth rates.

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

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Annual Indicator	14.0	13.2	13.0	12.7	12.8	13.3	13.3	13.6	13.1	13.5	13.8
Numerator	2,298	2,105	2,021	1,986	1,930	1,983	1,879	1,852	1,774	1,835	1,803
Denominator	16,402	15,945	15,586	15,692	15,064	14,864	14,169	13,634	13,530	13,643	13,043

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 Infant Mortality is a priority within the NJDOH/FHS prevention agenda especially for those experiencing health disparities due to social, economic, environmental/contextual, and behavioral inequities. 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 2020, the Preterm birth rate in the US was 10.09 %, [NJ's Preterm birth rate](#) is 9.3%, and 36th in the nation²². However, [racial and ethnic disparities](#) persist, in 2019, the preterm birth rates for White, NH, Black, NH, and Hispanic were 8.3%, 14.4%, and 10.3% respectively²³. Therefore, intending to address these disparities and reduce the preterm birth rates, TVP has partnered with the MHI Team within the Office of Population Health to implement the Preterm Birth Prevention Program (PBPP).

In collaboration with the MHI team and NJ MCQC which has formally joined FHS in May 2022, TVS continues to prioritize this goal to improve outcomes for women and infants. TVS continues to work with Title V grantees to reduce NJ's BMI mortality and address persisting racial/ ethnic disparities in birth outcomes by infusing key public health interventions in NJ communities. Through the HWHF Initiative, efforts continue to be targeted to reduce the BIM Rate in NJ. Specific BIM reducing activities including Centering Pregnancy and Centering Parenting programs, Doula, breastfeeding support, and Fatherhood initiatives are being implemented in the cities with the highest BIM rates in NJ.

About 14% of births who were supported by community doula during the doula pilot program were preterm, or before 37 weeks of gestation. Moreover, 16% of births were very low (2%) ($\leq 2,500$ grams) or low birthweight (14%) ($\leq 1,500$ grams). The evaluation report generated by Montclair State University confirmed that doula services played an instrumental role in supporting birthing persons in getting the services they need to ensure that the premature infant thrived.

Moreover, NJ TVP, partnered with the bridge funding to support community doulas trained through the Doula Pilot Programs as they transition and enroll in NJ FamilyCare Medicaid fee-for-service and the Managed Care Organization's process to become Medicaid providers. Through training, workforce development, supervision support, mentoring, technical assistance, direct billing, and sustainability planning to grow the community doula workforce activities that are being implemented by the DLC, TVP seeks to reduce maternal and infant mortality and eliminate racial disparities.

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

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Annual Indicator	11.6	11.4	10.8	8.7	10.6	8.7	9.7	10.0	9.4	8.8	8.5
Numerator	190	182	168	136	159	129	137	136	127	120	111

Notes - Source - Birth Certificate data from the SHAD system

<https://www-doh.state.nj.us/doh-shad/>

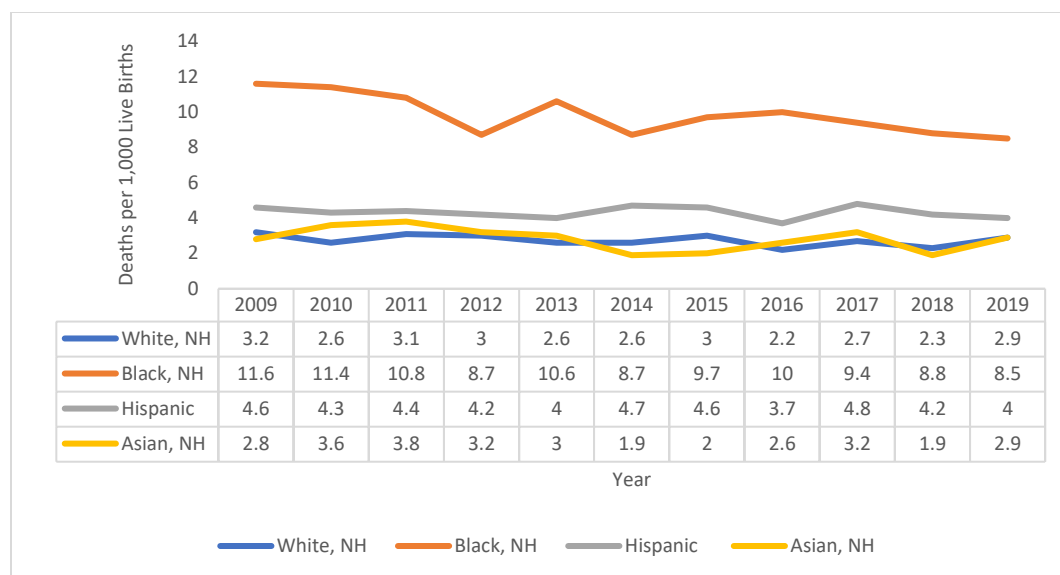
The selection of SPM # 7 (The rate of black infant mortality in NJ during the Five-Year Needs Assessment process recognizes the persistence of racial/ethnic disparities in healthy birth outcomes in NJ.

While NJ has the 5th best overall infant mortality rate among the 50 states, the non-Hispanic black infant mortality rate in NJ is 3.5 times higher than the infant mortality rate for non-Hispanic white infants. The Hispanic infant mortality rate is 1.4 times higher than the rate among White babies (Figure 19). Disparities exist between NJ counties and municipalities in terms of Black Infant Mortality rates and other health outcomes. Counties such as Atlantic, Camden, Cumberland, Essex, Warren have Black Infant Mortality rates (Figure 20). Further investigation within these counties showed that certain municipalities were really driving these high county rates and therefore efforts within these municipalities are the main focus of the HWHF initiative. To tackle these disparities, TVP implemented the HWHF in the communities.

²² Centers for Disease Control and Prevention, National Center for Health statistics (2022). New Jersey. Accessed on April 20, 2022. <https://www.cdc.gov/nchs/pressroom/states/newjersey/nj.htm>

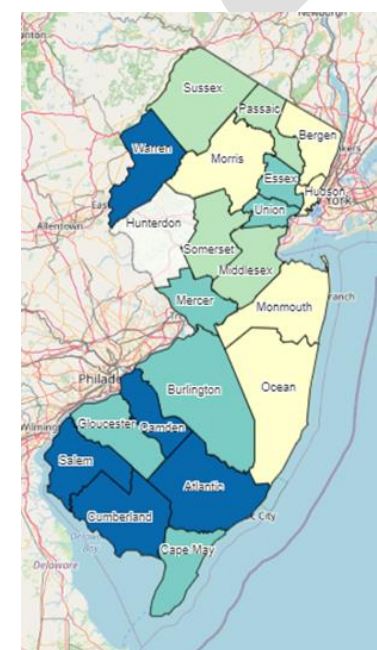
²³ New Jersey State Health Assessment Data. "Health Indicator Report of Preterm Births". Accessed on April 20, 2022 at NJSHAD - [Health Indicator Report - Preterm Births \(state.nj.us\)](#).

Figure 19. Infant Mortality Rate by Mother's Race/Ethnicity 2009-2019



Data Source: NJSHAD System- <https://www-doh.state.nj.us/doh-shad/indicator/view/EPHTInfMort.NJ.html>

Figure 20. Infant Mortality Rate by Mother's County of Residence, 2015-2019



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^{24, 25, 26}. Addressing these social determinants of health requires a comprehensive, system-level transformation that begins at the community level. In light of the potential causes, TVP developed a logic model Table 1. Moreover, TVP has selected the NJ regions to implement the interventions displayed in the logic model to tackle the BMI disparities (Table 1).

Since 2018, HWHF grantees implement at least 2 BIM programs that are evidence-based and have shown to be successful in other states or communities to reduce black infant mortality and other disparities. These programs include:

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

From July 1, 2018, to March 30, 2022, 1895 BIM City Residents enrolled in the program to receive the services provided by TVP grantees.

Data Source: <https://www-doh.state.nj.us/doh-shad/indicator/view/EPHTInfMort.Count>

²⁴ Wanda Barfield W, D'Angelo D, Moon R, Lu M, Wong B, Iskander J. Public Health Approaches to Reducing U.S. Infant Mortality. *Morbidity and Mortality Weekly Report*. 2013;62(31):625-628.

²⁵ Lu M, Johnson KA. Toward a National Strategy on Infant Mortality. *AJPH* 2014; 104(S1): S13-S17.

²⁶ Lorch AS, Enlow E. *The Role of Social Determinants in Explaining Racial/Ethnic Disparities in Perinatal Outcomes*. *Pediatric Research*. 2016 Jan; 79 (1): 141-147.

Tables 1. Healthy Women Healthy Families Initiative- Logic Model

Short-Term	Mid-Term	Long-Term	
Identify clients in need of referral to services offered through Central Intake	Increase referral of women to needed services through Central Intake	Increase healthy births	
Identify clients who need to be referred and assign to Home Visiting, Case management through Community Health Workers and other support services	Increase referral and assignment of women into Home Visiting, Case management through Community Health Workers and other support services		
Increase linkages of women to support services with the help of non-traditional partners	Increase number of Community Health Workers trained in case management		
	Increase number of trained community doulas		
	Increase number of births that are attended by doulas		
	Increase the number of women who have support from postpartum doulas		
Inform clients about Medicaid benefits	Increase Medicaid enrollment		Decrease Black Infant Mortality Rates
Educate clients about family leave insurance, temporary disability insurance, and unemployment benefits	Increase knowledge and understanding of family leave insurance, temporary disability insurance, and unemployment benefits		
Increase the number of women enrolled in group prenatal care programs	Increase the percentage of women who receive First Trimester prenatal care		
Increase the number of women in group prenatal care who complete their pregnancy while in the group	Increase the percentage of women who receive adequate prenatal care		
Increase number of fathers participating in fatherhood initiative programs	Increase the linkages made for fathers to social services		
Increase the number of women participating in breastfeeding support groups	Increase the percentage of women who breastfeed exclusively for at least 3 months		

Perinatal/Infant Health - 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 who provide early support and information to breastfeeding mothers, however, it requires a commitment from the entire organization to implement breastfeeding supportive policies and practices.

WIC's Strategic Plan which will be released in 2022, includes facilitating the creation of the NJBSP with the NJ Breastfeeding Coalition (NJBC). WIC will continue to provide breastfeeding promotion and support services to pregnant and breastfeeding women who participate in the Program.

Existing TVP programs that promote breastfeeding and include performance measures for increasing breastfeeding include the HWHF Initiative and the MIECHV Program which now serve all 21 counties and target high-need communities. With the new HWHF initiative and its focus on addressing BIM rates, programs to support breastfeeding among Black, NH women will be made available in targeted municipalities. A breastfeeding indicator, an increase over time in the proportion of mothers who breastfeed their 6-week-old infants, is included in the MIECHV and Healthy Start performance benchmarks.

Through HWHF, TVP funds multiple community-level organizations to implement breastfeeding programs that seek to decrease black infant mortality rates. These breastfeeding programs/interventions consist of education on breastfeeding to birthing/new parents and assistance/supports to increase breastfeeding success. The goal of the initiative is to increase the rates of breastfeeding 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.

NJDOH has implemented a breastfeeding training in partnership with the Perinatal Foundation to educate CHWs on the history of breastfeeding and how various groups have been affected. 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 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 Black Breastfeeding Experience, Global Health, Influence of Formula, Lactation Landscape, and Feeding Choice.

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

The SCNJ examined the potential indirect impact of the COVID-19 pandemic on SUID, independent of the disease itself, as it is now being captured in emerging global and national studies and database findings. These findings demonstrate an increase in: 1) adverse social and health determinants that elevate risk and disparity; 2) a greater burden of COVID-19 in the black community; 3) diminished opportunities for accessing provider-based safe sleep education; 4) diminished services; 5) a rise in economic challenges for families, disproportionately so for Black families; 6) an increase in unsafe sleep practices in mothers lacking postpartum insurance. For example, in mothers testing positive for [COVID during pregnancy](#), there was an [increased risk for stillbirth](#), births small for gestational age, and preterm birth, [a major risk factor for SUID](#). [The burden of COVID](#) was [higher in Black, NH patients](#). [Lower income, employment](#) and insurance were associated with viral positivity, Black, NH, and Hispanic families experienced greater economic challenges (Commonwealth Fund COVID-19 Survey, 2020). [Breastfeeding duration declined](#). Factors that diminished opportunities for safe sleep education included [shortened hospital stays](#), [less in-person lactation support](#), and fewer antenatal clinic visits (Townsend et al. EClin Med, 2021), based on NJSHAD birth data, specific NJ examples include a decline in-home visits for women lacking postpartum insurance and a rise in

home births. These adverse circumstances may have contributed to the decline in the use of supine sleep that has been identified in 2020 in NJ Medicaid families. Both circumstances potentially diminish access to safe sleep education. Accordingly, the SCNJ will continue to identify these vulnerabilities and has already begun to meet with programs and systems involved with these services to develop initiatives that are responsive to these challenges. The SCNJ is also raising awareness of COVID-related issues through invited state and national lectures, including to HRSA Region V and a national SUID conference, and has participated in presentations addressing the importance of vaccination. Because NJ was among the first regions affected by the pandemic, and because the peaks came in waves, analyses of impact and plans for remediation must be developed with these variances in mind. Thus, generating detailed state-level data will be critical in the coming year. Plans for the coming year to promote safe infant sleep also include continued safe sleep education through the SIDS Center of NJ (SCNJ), MIEC Home Visiting Program, and the Sudden Unexpected Infant Death Case Review Workgroup which includes 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 also working with the new Universal Nurse Home Visiting Program to ensure safe sleep education is supported in their curriculum. The SCNJ will continue to identify and address community-level risk factors and barriers to compliance. It will present a range of current and new education programs and interventions that address provider knowledge of safe sleep practices, education skills, and understanding of the impact of adverse social and health determinants, and implicit bias in elevating the risk of SUID and of racial disparity in these and other causes of infant mortality, and an understanding of how to identify and address barriers that prevent well-established knowledge of safe sleep from being translated into practice. When addressing the adverse social and health risk factors of smoking, absence of breastfeeding, or preterm birth, the SCNJ 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 to develop additional strategies. The SCNJ also will continue to develop methods for direct public education such as through the free apps and social media platforms and will work with community groups to assure relevance. The SCNJ's educational tools, including the free mobile phone apps, on-demand, and live webinars, educational material in multiple languages, and baby clothing adorned with safe sleep messaging will continue to be disseminated. The SCNJ also will disseminate the anticipated 2022 updates to the AAP guidelines. The SCNJ also identifies risks 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. SCNJ programs are directed to institutions (i.e., schools, hospitals, clinics, public health programs, including the NJDCF Division of Child Protection and Permanency), organizations (i.e., WIC, HWHF grantees, AAP-NJ, Maternal, and Child Health Consortia), 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 also continue to work closely with the Medical Examiner system to identify any issues related to coding such as those recently identified in national data wherein SUID codes were used for extremely preterm infants dying proximate to their birth (Ostfeld & Hegyi, Society for Pediatric Research 2022). The SCNJ will continue to work with local community groups to identify any barriers to families receiving education.

The SCNJ educates hospital nurses, who play an important role in modeling and teaching about safe sleep, by providing its on-site program, Nurses LEAD the Way, by presenting at hospital-level and regional nursing conferences, and by communicating through other venues such as listservs, live and on-demand webinars and e-blasts. In addition to providing education, the SCNJ makes available educational scripts, videos, hospital safe sleep audit protocols, approaches to identifying and addressing potential barriers to compliance, and educational materials in electronic and hard copy, using content developed by SCNJ and translated into English, Spanish, Haitian-Creole, Farsi, Arabic, and Portuguese. Dari has been added to serve Afghan refugees. The free safe sleep apps provide an additional resource supporting both the provider and the community directly. 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 is widely circulated.

The SCNJ's resources are also disseminated through collaboration with its many partners. These include the New Jersey Chapter of the AAP, the Grand Rounds lecture programs for hospital Departments of Pediatrics and Obstetrics, Nurture NJ, Federally Qualified Health Centers, the New Jersey Hospital Association (NJHA), and the maternal and child health consortia. The SCNJ will continue to form collaborations with community-level programs as it does currently with such programs as Children's Futures.

In 2018 to make it easier for hospitals and other providers to carry out safe sleep education, SCNJ developed a cost-free, educational app, [SIDS Info](#), in English and Spanish. This app provides an interactive tool to help providers educate families. Graphics and voice-overs in both languages overcome language or literacy barriers. Providers help interested families download this free resource to their cell phones for future reference. It is also a tool that the public can download directly, providing a resource to those with limited access to healthcare, particularly during the COVID-19 pandemic. Funding for this app was derived from health services grant from the NJ Department of Health to the SCNJ. In 2019, a second free educational app, Baby Be Well®, was developed by 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 Maternal and Child Health Programs.

Through grant funding from NJDOH, the SCNJ provides public health interventions to birthing hospitals, as part of the Nurses LEAD the Way initiative, to all local offices of the Division of Child Protection and Permanency, to the FQHC system, and a wide range of public health, social service, home visiting, community, medical, faith-based, first responder and childcare systems. It has begun working with the Universal Home Visiting planning committee to address nurse education on this topic. The SCNJ provides education to both obstetricians and pediatricians who, in turn, raise awareness among their patients. Obstetricians and gynecologists provide a critical window into educating families about safe pregnancy practices for lowering the risk of SUID and also can share safe sleep guidance with older generations of women, including grandmothers who are often involved in the care of the infant. The wide-ranging outreach, available tools, and broad focus on risk-reducing behaviors such as safe sleep, smoke avoidance, and breastfeeding as well as antecedent social and health determinants, implicit bias, and education strategies contribute to New Jersey's low SUID rate.

There are racial and ethnic disparities in adverse antecedent social and health determinants that raise the risk of SUID as well as other causes of mortality across the lifespan, and these disparities contribute to disparities in rates. Such determinants include preterm births, diminished access to care, poverty, lack of breastfeeding, neighborhood crime, exposure to second-hand smoke, a major contributing factor rising to the level of causality, and other unsafe environmental conditions²⁷. In addition, implicit bias is an independent contributor to disparity, raising stress levels and reducing participation in health care. The SCNJ has long focused on these broader issues that create a more vulnerable infant because safe infant sleep practices alone, though compensatory, do not uniquely or consistently serve as reliable predictors of SUID rates across states. The [SCNJ](#) has studied population groups with higher usage of bed-sharing but in association with high use of supine sleep and, importantly, a low presence of adverse social and health determinants and found them to have among the lowest rates of SUID. SCNJ activities, therefore, include participation in the implicit bias initiative of the NJ Perinatal Quality Collaborative Committee on Racial Disparities, and in programs such as Nurture NJ which address such antecedent disparities. It also provides education programs for home visitors, doulas, and community health workers in underserved communities. In [higher-risk communities](#), a high-school student ambassador for safe sleep program was found effective, thus supporting plans for broader adoption. In higher-risk communities, parent education is accompanied by baby clothing adorned with safe sleep guidance. The SCNJ also issued an Infant's Bill of Rights to serve as a framework by which to work toward addressing the risk factors beyond safe sleep that contribute to SUID and disparity in rates.

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

In alignment with Healthy People 2030 Objective: Per the new Healthy People 2030 goal ([Reduce preterm births — MICH-07](#)) and in partnership with the MHI team and the NJ MCQC, TVP, will co-lead multiple activities aiming at reducing preterm birth rates of untimely death for non-Hispanic Black and Hispanic infants (Table 1.)²⁸. The teams have collaborated and developed the PBPP. They will utilize updated data on infant birth trends and expand their efforts beyond the program's initial focus on Atlantic and Essex Counties (Table 2).

The PBPP will leverage timely evaluation resources, community engagement, and data improvements to reduce preterm births and untimely infant deaths among non-Hispanic Black and Hispanic people in NJ. Through provider surveys, qualitative feedback, educational outreach technical assistance, targeted resource distribution, and ongoing quality improvement for multidisciplinary data systems. PBPP has and will focus on four main areas:

1. Are there known barriers or hesitations to receiving pre-term birth prevention services among specific racial and ethnic groups?

²⁷ Ostfeld, B., Schwartz-Soicher, O., Reichman, N., Teitler, J., Hegyi, T., M. (2017). Prematurity and Sudden Unexpected Infant Deaths in the United States. Accessed on May 26th, 2022. DOI: <https://doi.org/10.1542/peds.2016-333>.

²⁸ United States Department of Health and Human Services, Office of Disease Prevention and Promotion. "Healthy People 2030: Reduce preterm births". Accessed on May 31, 2021 at [Reduce preterm births — MICH-07 - Healthy People 2030 | health.gov](#).

2. How many additional at-risk pregnant people received available and timely pre-term birth prevention services (e.g., 17P, vaginal progesterone, cerclage) during their pregnancy?
3. How many providers received and shared information about preterm birth prevention with their patients during their pregnancy?
4. How is data around pre-term birth treatment preferences and decisions captured and shared between birthing persons and their providers?

Table 2. Preterm Birth Prevention Program Activities

PBPP Activities	Lead for Initiation of Activity
Develop doula surveys to assess current attitudes around preterm birth prevention services during the COVID-19 pandemic	MHI Team
Administer doula surveys to assess current attitudes around preterm birth prevention services during the COVID-19 pandemic	TVS/ TVP
Host Clinical Leadership meetings for provider stakeholder engagement	Title V grantee
Work with training vendor to promote and host preterm birth prevention presentations with clinical staff in facilities within Cumberland, Mercer, Atlantic, Gloucester, Hudson, and Essex counties	MHI Team
Using PRA data and other sources, identify patients eligible for preterm birth prevention services (17P injections, vaginal progesterone cream applications, cerclage)	Title V grantee
Distribute Preterm Birth Prevention services to identified patients	Title V grantee
Compile data of activities for recommendations report and presentation to NJMCQC	Title V grantee

Through HWHF, county-based consumer-driven advisory boards will continue to contribute to the direction and progress of the HWHF initiative with regard to BMI. The CIH will meet quarterly to build partnerships and local referral systems. Rebranding of Central Intake is currently in progress to find a more appealing and trusted name that welcomes participants for referrals and services to support high-risk pregnant persons and their infants.

The CLG-CHWI will continue to enhance the professional development of CHWs and allow for a stronger workforce and will expand its programs. CLG-CHWI 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-CHI to focus on the prevention of disease and enhanced detection of COVID19, focusing on vulnerable populations.

[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 capability to focus on reproductive-age women and their families. Support for BIM reduction programs in targeted BIM regions will continue to evolve. The Doula Bridge funding will provide support to the community doulas trained as they transition and enroll in NJ FamilyCare Medicaid fee-for-service and the Managed Care Organization's process to become Medicaid providers. The newly initiated Doula Learning Collaborative (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. Centering programs will continue with both in-person and virtual groups and will focus on sustainability of the programs. Centering Healthcare Institute (CHI) will continue to train interested parties through the evidence-based program.

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 for the evidence-based strategies implemented by NJDOH and its partnerships.

Child Health – Annual Report

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 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.

	2007	2011-2012	2016	2017-2018	2018-2019	2019
NPM 6: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	12.67	25.02	32.9	36.1	36.4	37.7

Source – National Survey of Children's Health (NSCH) <https://www.childhealthdata.org/browse/survey>

Developmental screening is a required benchmark performance measure for the NJ MIECHV Program and improving developmental screening practices and policies is an ongoing focus of HV's-continuous quality improvement. The NJ MIECHV Program promotes, and monitors parent completed child development screening tools (ASQ and ASQ: SE). In SFY 2021 6379 NJ MIEC Home Visiting families with young children participated in a parent-led developmental screening across all 21 NJ counties.

The NJDOH is 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.](#)" (L TSAE) Ambassador and The NJCYC, [Infant Child Health Committee](#) has established a priority of improving system connections for children and families with health care providers, community services, early intervention, child care, home visiting, and early care & education settings. Through the NJ ECCS CoIIN work improvements on early childhood, systems continued with a focus on creating universal access to evidence-based developmental screening through the early childhood central Intake system (Help Me Grow Central Access point) that supports linkages and access to programs and services for families within their community. NJ's LTSAE Ambassador and the LTSAE COVID Response Project activities focus on promoting parent-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 also supports the teams with accessing LTSAE materials and with family-engagement activities. [NJ's Child Developmental Passport](#), created in collaboration between the LTSAE Ambassador and the ECCS CoIIN team (available in English & Spanish) includes a developmental tracker to empower parents to track their child's developmental screening information. 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. Grow NJ Kids (GNJK) a Quality Improvement Rating System (QRIS) developed for early learning programs requires the use of a "state-approved" developmental screening at Level 2 of a 5-level rating with the expectation that 90% of high needs infants and children participating in GNJK will receive developmental screening with an emphasis on using the parent completed child monitoring system Ages and Stages Questionnaires (ASQ and ASQ: SE) screening tools.

Additionally, SPAN is collaborating with the NJ Chapter of the American Academy of Pediatrics on the Early Identification and Referral for Autism (EIRA) ECHO project to provide 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 ES6.1 will monitor progress on increasing the use of parent-completed early childhood developmental screening using an online ASQ screening tool and how well early childhood developmental screening is promoted across the Departments of Health, Children and Families, Human Services, and Education which will drive improvement in NPM #6 (Developmental Screening). NJ DCF implements the ECCS Impact grant in 5 communities to promote parent-completed early childhood developmental screenings in children less than 3 years old. ASQ Enterprise software (Brookes Publishing) is being utilized to add a parent/family portal for easy access to developmental screening and links screening to Central Intake hubs. NJ's expanded data system links developmental screenings with current Central Intake assessments to enhance engagement of families not connected to early childhood services/programs that could potentially be engaged and linked for additional services and supports as identified, including developmental needs as determined by the completed ASQ and in partnership with the parent regarding their child's developmental milestones. Families will be supported in linking with pediatric primary care and/or other systems partners that include at a minimum Home Visiting; and may extend to quality Child Care, Early Head Start/Head Start, and Preschool programs. In FY18, the ECCS Team for Essex County (EPPC) began a pilot in testing the implementation of the ASQ Family Access online portal within their Central Intake system. They developed, implemented, and tested policies and procedures on the use and experience of the Family Access Portal by parents, as well as outreach and engagement strategies. EPPC was able to provide no cost development screening to 32 children/families, they provide appropriate follow-up and linkage, as well as education to parents on monitoring their child's developmental milestones and activities parents can do to support their child's developmental progress. EPPC led the way to the infusion of the ASQ Family Access Portal with the statewide Central Intake System, which led to the 4 additional ECCS Placed Based Communities (PBCs) joining in the implementation in FY19.

In FY19 Plans for statewide expansion of screening to the additional 16 counties were slated and implementation began in FY 20 with the expansion of Early Childhood Specialist staffed within all 21 Central Intake hubs. In FY20 EC Specialist received ASQ training, developed and activated the additional 16 ASQ Family Access portals. Outreach begins in the communities through in-person community events and via telephone. Once the Covid-19 pandemic hit all services were remote and/or virtual. The pandemic engagement of families continued through social media platforms, virtual events, and outreach through existing community partners (e.g. WIC, Family Success Centers, etc.

ASQ- Family Access Portal Screens completed	FY 20	FY 21
Age of Child	%	%
2-12MO	35%	35%
13-24MO	18%	22%
25-38MO	16%	19%
39-50MO	20%	13%
51-66MO	11%	11%

SPN #3 (Improving Nutrition and Physical Activity)

Annual Report: The New Jersey Supplemental Nutrition Assistance Program-Education (NJ SNAP-Ed) in FHS is a federally funded nutrition and physical activity program that aims to improve the likelihood that persons eligible for SNAP will make healthy food and lifestyle choices that prevent obesity. NJ SNAP-Ed provides behavior-focused educational classes for all ages, including specialized workshops to meet the needs of children.

The Cooking Matters for Kids (CMK) curricula, developed by Share Our Strengths, is a 6-lesson series designed for children, in 3rd through 5th grades. The classes teach how to prepare healthy meals and snacks and to make healthier choices – whether at school, at home, at the store, or out to eat.

Cooking Matters for Teens (CMT) is a direct education intervention for SNAP-eligible teenagers, ages 11 to 18 years (or grades 6-12), that teaches healthy eating skills and builds confidence in shopping and eating healthier on a low budget. CMT is offered as a series of six, one-hour sessions and is designed to be implemented in schools, after-school programs, community centers, and non-profit organizations.

While the pandemic still had an impact on FFY21 implementation, in-person programming slowly returned, while some virtual programming remained. In total, SNAP-Ed delivered 1,146 CMK sessions, comprising 193 series across

all 21 counties in NJ reaching 4,593 participants: most commonly at schools, before- and after-school programs, and family resource centers. SNAP-Ed delivered 297 CMT sessions, comprising 52 series across all 21 counties in NJ reaching 758 participants: most commonly at schools, before- and after-school programs, and large food stores and retailers.

New Jersey completed their statewide eWIC implementation in April 2022. To help with the implementation, New Jersey expanded the use of the WIC Shopper App. This App allows participants and WIC store personnel to scan items to check for allowable WIC food items. The App also provides participants with their current WIC benefit balance, a listing of Authorized WIC Stores and WIC offices. WIC participants, WIC store personnel and partners can also access the NJ eWIC webpage: [Department of Health | WIC | eWIC for Participants \(nj.gov\)](https://www.nj.gov/health/eWIC/) where eWIC educational materials (how to use new eWIC card and redeem benefits) are posted. eWIC videos and a NJ WIC Orientation video are also available to view on this page. Subsequently, the team created The NJ WIC Participant Portal which has helped improve access to WIC for many by beginning the application process online. There are enhancements that are planned for 2022 that include a Spanish version and access to third party referrals.

To increase enrollment in WIC and SNAP, the NDOH, Division of FHS entered in an agreement with the Department of Human Services, Division of Family Development, to electronically match SNAP and WIC participants and assess those that are eligible but not enrolled in either program and develop and outreach plan to ensure enrollment.

Moreover, the www.NJWICOnline.org nutrition education website has been enhanced with additional nutrition and parenting resources as well as a new WIC Game show. The new Game Show lesson offers participants and guests opportunities to gain many eWIC shopping tips. Additionally, to monitor and further improve the WIC program, the NJ WIC is developing a dashboard that will allow user-friendly visualization of key metrics.

Child Health - 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) Team and the NJ CYC Infant Child Health Committee (IHC). The Infant Child Health Committee has established a priority of 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. Through the NJ ECCS Impact CoIIN work, improvements on early childhood systems with a focus on creating universal access to evidence-based developmental screening through central Intake system (Help Me Grow Central Access Point); supporting linkages and access to programs and services for families within their community. The ECCS Impact grant ended in July 2021. However, through the newly awarded ECCS Health Integration Prenatal to Three grant, NJ DCF in partnership with NJ DOH will maintain the and improve upon the Central Intake (CI) System, sustaining the developmental health promotion and screening as a service of the CI hubs. NJ DCF and NJ DOH will continue to partner with the NJ's LTSAE Ambassador and the LTSAE COVID Response Project that 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. [NJ's Child Developmental Passport](#), created in collaboration between the LTSAE Ambassador and the ECCS team (available in English & Spanish) includes a developmental tracker to empower parents to track their child's developmental screening information. These tools will continue to be utilized. In addition, the CDC's Milestone Tracker App is embedded in the NJ WIC Shopper App to support monitoring of children receiving WIC services. The Boggs Center on Developmental Disabilities, NJ's federally designated University Center of Excellence on Developmental Disabilities, and the Statewide Parent Advocacy Network (SPAN), the state's federally-designated Parent Training and Information Center (PTI) and Family to Family Health Information Center (F2F) 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 this next iteration of ECCS P-3, the intentional focus will be given to the pediatric provider community to promote developmental health and monitoring utilizing the LTSAE tools. The ECCS P-3 Team will reestablish the Physician provider outreach and engagement group to work on protocols to strengthen connections with the pediatric provider network to Central Intake as they support the needs of their pediatric patients for services and supports that promote developmental well-being (such as Home Visiting, HWHF, CHWs, Early Education, etc.); The NJ ECCS P-3 team will support the CI system in sustaining the developmental health promotion and screening activities. The reach of families is predicted to expand slightly with the lifting of Covid Pandemic Mandates and the ability of CI and EC Specialists to partner with community agencies and reach families through developmental health promotion events in the communities.

Additionally, SPAN is collaborating with the NJ Chapter of the American Academy of Pediatrics on the Early Identification and Referral for Autism (EIRA) ECHO project to provide education to 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 (ADDMM) 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 with the expectation that 90% of high needs infants and children participating in GNJK will receive developmental screening by 2019 with an emphasis on using the parent completed child monitoring system Ages and Stages Questionnaires (ASQ and ASQ: SE) screening tools. Implementation of a parent/family portal for easy access to parent-completed early childhood developmental screenings in children < 3 years old (Ages and Stages Questionnaire) through the ECCS P-3 grant will permit monitoring of ESM 6.1 (Promote parent-completed early childhood developmental screening) and promote improvement in NPM #6.

NJ has completed a significant amount of work to create an aligned system of early childhood data through the NJ-EASEL (NJ Enterprise Analysis System for Early Learning). 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 (NJ SPIRIT), and other state early learning and development data collections within the parameters of state and federal privacy laws.

The NJ-EASEL project is designed to be able to measure outcome objectives, initiated through the Race to the Top Early Learning Challenge RTTT-ELC grant, and now sustained through the Preschool Development Grant Birth through Five (PDG B-5), including being able to show that early developmental screening has a direct impact on identifying children and referring them to needed services resulting in positive outcomes for children. The NJ-EASEL 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.

[Plan for the Application Year – SPN #3 \(Improving Nutrition and Physical Activity\)](#)

NJ SNAP-Ed will continue implementation of behavior-focused nutrition and physical education classes so children can make healthy food and lifestyle choices to prevent obesity. NJ SNAP-Ed and the CAHP’s WSCC School Health NJ project will meet throughout the upcoming year to coordinate and collaborate on improving nutrition and physical activity in New Jersey’s public schools. Additional partnerships will be made with organizations that help youth and families with emotional, behavioral, substance use, and intellectual/developmental disability needs.

E.2.c.4.a. Adolescent Health - Annual Report

Adolescent/ Young Adult Health

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

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 death²⁹. Teens who are bullied are at increased risk for mental health problems, have problems adjusting to school, and are connected to absenteeism³⁰. Bullying also can cause long-term damage to self-esteem³¹.

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 take 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 youths who are bullies and are bullied. Building 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.

According to 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, 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, and 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 who are only bullies. To impact this, 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 9/30/21 CAHP grantees

²⁹ Centers for Disease Control and Prevention. (2015). *Fact sheet: Understanding bullying*. Retrieved June 17, 2016, from <https://www.cdc.gov/violenceprevention/pdf/bullying-factsheet508.pdf> (PDF - 356 KB).

³⁰ Smokowski, P. R., & Kopasz, K. H. (2005). Bullying in school: An overview of types, effects, family characteristics, and intervention strategies. *Children and Schools*, 27, 101–109.

³¹ Reece, T. (2008). *Bullies beat down self-esteem*. Retrieved June 17, 2016, from <http://www.healthychildren.org/English/safety-prevention/at-play/Pages/Bullies-Beat-Down-Self-Esteem.asp>

have offered 7 cohorts of Teen Speak engaging over 75 parents and caregivers with plans to offer another 6-10 cohorts through the Spring and Summer. CAHP expanded Teen Speak in 2021 to 3 additional grantees to reach 500 parents and caregivers in 2022.

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 depression³². 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 the youth who bully them³³. 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. Read more about these findings in the NICHD news release: Depression High Among Youth Victims of School Cyberbullying, NIH Researchers Report.

To address this comprehensively, CAHP staff and CAHP grantee staff have been trained in multiple approaches to working with our most vulnerable youth. This has included 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 TA occur quarterly and is required for all PREPSRAE 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 January of 2021, all CAHP grantee staff was offered training on Teaching Students to Use Tech Safely and Wisely, which was incorporated into program sessions with youth. In November of 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 per year to implement Lifelines Trilogy, reaching at least 7,500 school faculty and staff, 30,000 students, and 15,000 parents and caregivers by 2025.

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.

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

Simultaneously, to satisfy the 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®), a nationally replicated SEL program evidenced to reduce teen pregnancy, school suspension, and cutting classes while increasing academic success, life skills, and civic responsibility is replicated in over 50 schools throughout NJ and on CASEL's list of supported SEL programs. In 2020, 1077 students completed TOP® and in 2021, TOP® will engage at least an additional 1,000 NJ youth and complete 20,000 hours of community service learning. TOP® links teens from diverse backgrounds and groupings within schools and facilitates dialogues that promote teens to be introspective, connect with their peers, partner with adults, and participate in bettering their communities. Because TOP® is an evidence-based program, data is collected via pre and post-surveys delivered to participants that measure in particular bullying: teens' connectedness (empathy, self-awareness, and social awareness) and resiliency (emotion management, self-efficacy, and self-management) which leads to improved decision making and relationships. Thus far, implemented in NJ since 2012, TOP® has shown to improve connectedness and resiliency in NJ teens.

In addition to TOP®, NJ CAHP implements the CDC Whole School, Whole Child, Whole Community (WSCC) model in over 30 schools across the state and Reducing the Risk, a sexual health curriculum for high school students. Both programs incorporate SEL into the learning activities. In 2020, 800 students completed RTR, which includes a

³² Eunice Kennedy Shriver National Institute of Child Health and Human Development. (2010). Taking a stand against bullying. Retrieved June 17, 2016, from <http://www.nichd.nih.gov/news/resources/spotlight/092110-taking-stand-against-bullying>

³³ Eunice Kennedy Shriver National Institute of Child Health and Human Development. (2012). Focus on children's mental health research at the NICHD. Retrieved June 17, 2016, from <http://www.nichd.nih.gov/news/resources/spotlight/060112-childrens-mental-health>

service-learning component that is 100% SEL driven, this brings the total of students engaged in anti-bullying programs to 1,877 for 2020.

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, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional who is familiar with the child, the family, and the child's health history. The MCHB uses the AAP definition of medical home. CMUs continue to link families to medical home and document within CMRS that will include 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 14,381 children age 0 to 18 years served in SFY 2021, 41.1% had a primary care physician and/or SPoC documented, and of those children approximately 54% had insurance identified in their ISP. 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).

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

	2017	2018	2019	2020	2021
Annual NPM #11 Indicator	34.7%	34.7%	37.9%	40.8%	40.1%
Numerator	7,616	7,039	6,654	6,503	5,783
Denominator	21,944	20,276	17,542	15,919	14,407
Is the Data Provisional or Final?	Final	Final	Final	Final	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 does not include children with special health care needs who live in New Jersey but who do not participate in our case management system, our findings are not different from those of the National Survey of Children's Health (NSCH) which 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 CYSHCN, a specialty provider often serves as the child's usual source of care where coordination of care becomes vital to ensure primary care services are not overlooked. Past chart reviews have shown 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 SPSP grant-funded program for the designation of a primary care provider as part of the grantee goals and objectives. The Title V CMUs and pediatric specialty providers will continue to provide a safety net for families of CYSHCN.

From October 2021 to January 2022, NJDOH staff conducted virtual site visits with the SPSP agencies to review compliance with programmatic deliverables and to discuss any updates regarding the impact of COVID-19. No significant change was reported from any of the agencies. When COVID-19 surges occurred, many centers adjusted to a telehealth/telemedicine-only platform to accommodate patients and be compliant with CDC and hospital guidelines. Access to care was not compromised. SFY21 statistics indicate that there were approximately 121,531

individual patients served. The slight decrease in the number of patients served may be due to families' hesitancy due to COVID-19 surges.

For the SFY21-22 grant cycle, NJDOH staff conducted virtual site visits with the SPSP grantees. Topics discussed included Medical Home models and the program layout. The CECs have shared that they work closely with the child's primary care provider (PCP) and that all evaluations are provided to the PCP as a mechanism to communicate recommendations given by the specialists. The CLCPCs provide a comprehensive team approach where all specialists collaborate with the child's family and PCP to develop a long-term care plan for the patient and family. PTCs have shared that their programs facilitate clear communication of diagnoses and plans with the child's PCP. In addition, each center provides comprehensive care with physicians and allied health professionals, by partnering with patients and their families.

Of the responses from the CECs, the average current wait time for an initial appointment ranged from 2 weeks to 12 months. Such appointments varied based on specialty (psychiatry, developmental pediatrics, neurology); however, the majority of the wait times were 2-3 months. Wait times for follow-up appointments varied between no wait to 2-3 months. Many of the CECs cited that they can schedule follow-up appointments right away for their patients. COVID-19 has affected each center both positively and negatively. Some centers stated that due to the pandemic, they were able to see more patients through telehealth/telemedicine platforms while others have shared that many families wanted to wait for an in-person visit and therefore the wait list grew longer. During the pandemic, a handful of grantees experienced staffing changes as a result of retirement and leave, thus affecting the wait times at each respective center.

In the same wait list survey, the responses provided by the CLCPC Centers showed that wait times for an initial appointment were significantly shorter for these services compared to CECs. Many of the CLCPC Centers indicated that they could see patients immediately while some expressed that wait times vary depending on the reason for the visit with the longest wait to be 4-6 weeks. PTC Centers include many different specialty and subspecialty programs. The wait time varies by specialty; as well as by, diagnosis, age, and medical condition. The average wait time for initial appointments for the majority of pediatric specialties is 1 - 2 weeks with the longest wait time being for genetics appointments, which averages three months.

Each SPSP grantee faces a different set of challenges that contribute to prolonged wait times. It is also clear that one single approach will not effectively reduce wait times for all centers in the SPSP network. Moving forward, as each agency adjusts to providing services post COVID-19, the DOH will collaborate with grantees to monitor progress towards reducing wait times for initial appointments and identifying new challenges as they arise.

Title V is committed to collaboration with the DHS Office of Medicaid Managed Care, the COCC, SPAN, Autism NJ, and other community-based partners to engage in medical home initiatives to reinforce linkage of CYSHCN with comprehensive community providers.

[Annual Report - NPM #12 \(Transition to adulthood\)](#)

The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, 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 to 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 has consistently exceeded the annual objective for all reported years included in the table below; (45% vs 34% in 2019, 43.6% vs 37% in 2020, and 45.0% vs 40% in 2021). The National Children Health 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 New Jersey. This estimate is based on a sample count of 30. While CMUs provide free resource and referral services, many children may receive these services through their school, and 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
Annual NPM #12 Indicator	43.8%	41.6%	45.0%	43.6%	45.0%
Numerator	2,246	1,960	1,642	1,102	955
Denominator	5,127	4,717	3,635	2,530	2,125
Is the Data Provisional or 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 up to 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.

Identification and monitoring of transition to adulthood needs 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 supports 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 facilitate 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 that is 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 the use of drop-down menus supported by brief entries that use shorter and more consistent terminology. The state data/analytical staff collaborate 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.

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 to advocate for transitional supports through their individualized education plans and community-based supports. Title V will continue to participate in PIP mock trials to facilitate the development of clients' self-advocacy skills.

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

Community-based partners continue to identify resources and linkages to support transition to adulthood for CYSHCN.

Within DCF is CSOC which is charged with working 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 21, developmental disability services are provided by the DDD. Training on these systems for adolescents with developmental disabilities is occurring with regularity 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 in process as well. County-specific transition packets including resources related to education, post-secondary education, vocational rehabilitation, housing, guardianship, SSI, insurance, and Medicaid/NJ 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 SFY22. The adolescent subset of CYSHCN served through Title V remained relatively the same between SFY2019 and SFY2020 and is as follow. 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 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 collaborate 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 Title V CYSHCN programs and funded by Part D of the Ryan White Care Act, the NJ Statewide Family Centered HIV Care Network remains a leading force in providing care to Women, Infants, Children, Youth (WICY) and families infected and affected by HIV disease in the State. Consequently, there is ongoing collaboration across systems within the Division of Family Health Services' Maternal Child Health and CYSHCN's programs, and the Ryan White Part D program to support WICY needs in the community. NJ ranks third in the nation for pediatric cases. Of youth 13-24 years, 432 were living with HIV/AIDS, & of youth 0-12 year, 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, coupled with appropriate antiretroviral therapy, enables children with HIV to survive into and successfully transition into adulthood.

Adolescent Health - Application Year

Plan for the Application Year - NPM #9 (Bullying), SPN # 6 (Reducing Teen Pregnancy) & SPM # 6 (TOP program, Reducing the Risk, and Teen PEP completion)

The CAHP will continue to implement 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- TOP®, NJ youth and the WSCC model in NJ schools. In addition, the CAHP will provide Teen Speak to approximately 500 parents statewide and Parents as Champions to an additional 75 parents. 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 Focus for 2022 is self-image, self-esteem, and confidence and will be hosting a 3-part webinar series Bringing Youth Voice to the Table™ a three-part self-advocacy training series for youth and young adults designed to empower participants with tools and strategies for self-advocacy, wellness and self-care and resilience and advocacy skills, thereby supporting youth and young adults in building life-long pathways to success. The program will begin recruiting participants in May and run through July and August of 2022. 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.

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, as well as 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 in order to increase the percent 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.

Transition to an adult program for CYSCHN is a critical decision and one that must be planned appropriately to ensure continuity of care. Although Title V 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 the 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 own standalone category to improve both the success for the child coming to adulthood as well as 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 the majority of these positions.

DRAFT

Children with Special Health Care Needs - Annual Report
E.2.c.v Children with Special Health Care Needs

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 2021, 76.3% of infants not passing initial newborn hearing screening at birthing hospitals had a documented out-patient audiological follow-up visit. Since follow-up exams are still occurring on children born at the end of 2021, we expect that the rate will increase when final data is available. We anticipate the final rate will be level with prior years and will exceed the target. The program also monitors the follow-up rates by race/ethnicity to monitor for disparities in outcomes.

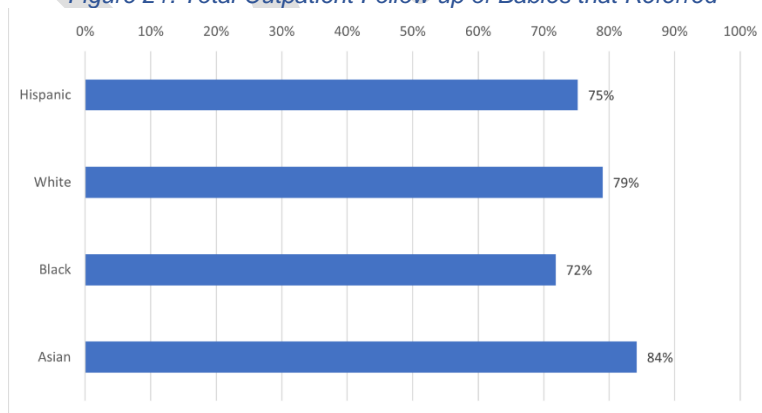
Table SPM #3: Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening and who have outpatient audiological follow-up documented.

	2013	2014	2015	2016	2017	2018	2019	2020*	2021*
Annual SPM#3 Indicator	88.2%	85.8%	86.0%	89.0%	87.5%	86.1%	82.6%	79.7%	76.3%
Numerator	1945	1821	1869	1833	1570	1571	1362	1439*	1336
Denominator	2205	2122	2173	2059	1798	1824	1648	1804*	1750

*Note – Data for 2020 and 2021 are incomplete. In July 2021 a new birth registry system was implemented Vital Events Registration and Information (VERI) Follow-up reports are still being received for these children 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 (Figure 21). While we strive for 100% follow-up and to eliminate racial and ethnic disparities, we are not always able to track and document the follow-up visits. Birthing facilities are required to make at least one contact to families of children that did not pass 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 voice mail 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 be responding to sounds around the home.

Figure 21. Total Outpatient Follow-up of Babies that Referred



The EHDl program is responsible for assuring newborn hearing screening goals are met, including assuring timely and ear-specific audiological follow-up for children that did not pass initial screening. All outpatient audiological reporting to the EHDl program continues to be submitted via an EHDl module in the New Jersey Immunization Information System (NJlIS) registry. The NJlIS program had a complete system rebuild and the EHDl module was also modified to improve information collected about follow-up contacts to parents.

During 2021,

- EHDl trained 24 new users in 2021 on the EHDl reporting module in the NJlIS which is used by audiologists and other practitioners who are conducting hearing follow-up to report outpatient exams. The EHDl 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 Department of Health trained 18 audiologists and audiology graduate students on the use of the NJ Early Hearing Detection and Intervention Program's online reporting module within the NJ Immunization Information System.
- NJ DOH continued to use HRSA EHDl grant funding for county-based special child health services case management staff to conduct follow-up phone calls to parents and physicians of children in need of hearing follow-up.
- Continued to use HRSA EHDl 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 who have recently been 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 113 families during this year.
- The EHDl Monthly Reconciliation Report is distributed to individual hospitals detailing children still in need of additional audiological follow-up after not passing inpatient hearing screening. This serves as a notice to hospitals of babies still in need of reminder contact. In addition, a report including statistics comparing the individual hospital to statewide statistical averages is sent annually.
- Continued annual distribution of a report to provide audiology facilities with feedback on the timeliness of follow-up for children seen at their facility after not passing inpatient hearing screening. The report also includes statistics on the timeliness and completeness of the documentation of their results.
- The Hearing Evaluation Council (HEC), a Commissioner-Appointed advisory board to the NJ EHDl program, held three meetings during 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 EHDl 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 EHDl staff.
- The NJ Statewide Network for Cultural Competency's Annual Conference, entitled 'Building Bridges, Breaking Barriers & Cultivating Cultural Competency with the Diverse Deaf and Hard of Hearing Community' was held in April 2021 and focused on cultural competency services for Deaf and Hard of Hearing people. The target audience for this conference was service providers such as nurses, social workers, and case managers. The conference is supported by SCHS and EHDl staff have served as valuable resource in this effort.
- NJ EHDl has entered into a three-year Memorandum of Understanding with the NJ Department of Human Services' Leveling the Playing Field (LTPF) initiative to enhance the NJ EHDl Deaf Mentor Program. Funding for this initiative provides 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 seeks 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 is to provide full access to language throughout the child's day.

Other recent educational programs included three presentations at the 2022 EHDl Conference in March: Poster Presentation "Assessing EHDl Healthcare Professional Needs in New Jersey: Response to the HRSA Needs Assessment;" Presentation: "Building Early Childhood Systems: A Collaboration Between New Jersey EHDl, New

Jersey Head Start/Early Head Start, and Montclair State University Communication Sciences and Disorders Program"; Presentation: "Integrating Deaf and Hard of Hearing Professionals' Expertise in EHDI Programs."

Programs for families included the CARE Project Family Retreat, which hosted more than sixty Deaf and Hard of Hearing children and their families and was co-chaired by the NJ EDHI audiologist; and the first NJ SKI HI training weekend, hosted by SPAN, for participants of the NJ Deaf Mentor program with grant funds from NJ EHDI.

[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 has been very successful in linking children registered with the BDAR with services offered through our county-based Special Child Health Services CMUs. The CMRS is used by the CMUs to track and monitor services provided to the children and their families. It electronically notifies a CMU when a child living within their county has been registered and 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 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 in the table below; (96.1% vs 92.2% in 2019, 95.1% vs 92.4% in 2020 and 95.9% vs 92.6% in 2021).

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 received services

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

*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 in gaining access to appropriate health and education services.

BDAR and FCCS staff collaborate to improve the 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.

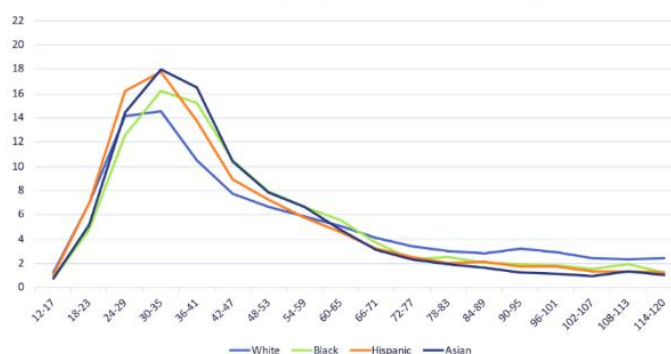
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Annual Indicator SPM #5	4.8	4.6	5.0	5.6	5.2	5.3	5.3	4.8	4.9	4.8

In FY 2021, over 3,300 children with a diagnosis of autism were newly reported to the BDARS. The average age of initial autism diagnosis is 4.8 years old. This indicates a significant decline from the previous four years (SFY2017-2020) when the average ages were approximately 5.1 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 the reporting of 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 2006 and 2012. The average age of diagnosis for this group is 4.7. More recent birth cohorts may be getting diagnosed earlier as enhanced screening efforts and public awareness have increased.

The average age at initial diagnosis is significantly different by race and ethnicity (Figure 22). For the pooled birth cohorts of 2006-2012, the average age for white-non-Hispanic children was 4.9 years. This was significantly greater than Black (4.6 years), Hispanic (4.5 years) and Asian (4.2 years) children. There was no significant difference between males and females in age at initial diagnosis even though 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 53.8% of the children diagnosed before the age of 4 years of age, 19.6% of children are diagnosed between ages 4 and six years of age, and 26.5% 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.

Figure 22. Race/Ethnicity by Age at First Autism Spectrum Disorder Diagnosis



- Data as of Feb 2022, N=28,385
- Sign. at p<.001

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 to the BDARS and 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.

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 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 that occurred this year allows providers to verify if a child had already been registered for another provider. This change greatly reduced the burden on our reporting agencies and improved the efficiency of the system. This is significant as our mandate requires that all children 0-22 with an ASD are registered. Children see many health care providers, and each one would need to verify registration or register the child. With the new system, health care providers can simply search the system for a child; thus, greatly 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 current 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.

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

The EHDI program will continue to use HRSA EDHI funding for county-based special health services case managers to conduct follow-up phone calls to parents and physicians of children in need of hearing follow-up. The EHDI Program also sends hospital-level surveillance data to New Jersey 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 timeliness of follow-up and identify children with incomplete follow-up testing.

The EHDI program plans to continue efforts to work with medical homes to ensure that children are receiving timely and appropriate follow-up after a referred hearing screening or inconclusive follow-up testing. An extract available in the NJIS 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 health care professionals, focusing on the need to decrease rates of children who are lost to follow-up. The EHDI program frequently uses webinars to make educational outreach efforts more accessible to the target audiences, decrease staff travel time, and improve efficiency while decreasing costs.

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 their 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 that all infants born in our state be screened for congenital Cytomegalovirus (cCMV). This legislation also requires establishment of a public awareness campaign to educate New Jerseyans as to 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 this condition or approximately 30,000 children born each year. At least 1 in every 5 children born with cCMV will develop permanent health problems and as many as 400 infants die because of this virus. An Ad Hoc Committee that includes a diverse group health care professionals and NJ DOH staff who share an interest in this topic have been meeting regularly to investigate evidence-based universal cCMV screening protocols as well as to 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 addition to 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 using 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 functionality 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 in the use of 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 for 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.

For the coming year, we will be enhancing 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. How 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 that case the system is accurately capturing the correct data, provides CMUs with the flexibility they need to provide less intensive cases with quarterly or annual updates, and received provide better.

SCHS/FCCS has been provided ELC funding to re-design the CMRS system. The improvements will allow for an integrated documentation model to incorporate not only service provisions, but changes in need resultant from exceptional events that are cataloged in an appropriate and chronological manner. In the wake of the COVID-19 pandemic, the increased need to gather detailed surrounding exceptional events was made apparent. An exceptional event creates and documents the unique needs for the CYSHCN population that our CMUs serve. This re-design 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.

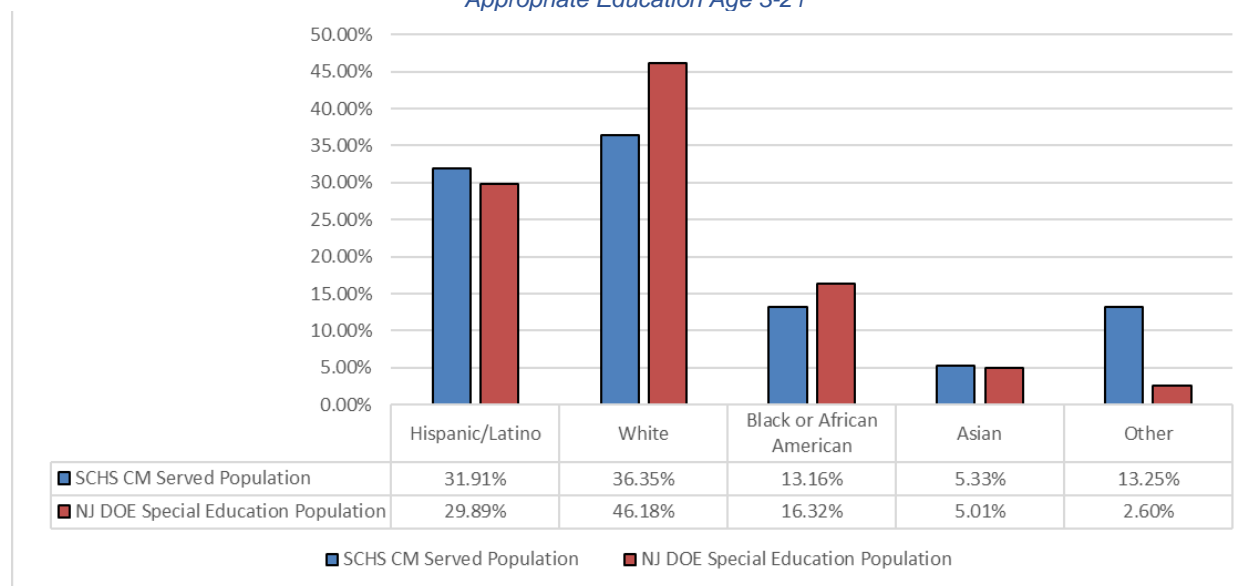
FCCS staff will be further examining the population we serve and how we can establish quality improvement and quality assurance measures for maintaining an improved and uniform practice of case management, development of policies and procedures, and monitoring of equitable services across the population (Figure 16). 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 as well as 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 level of acuity in a format that is easily understood by the end users. 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.

In concurrence with the CMRS redesign, FCCS will be revising policies and procedures in order to create a more uniformed standard of practice for case management services and consistent process of documenting in a child's record across the state. These innovations will enhance statewide monitoring and aid the CMUs ability to provide comprehensive and equitable care in every county.

To monitor equitable services, FCCS staff has begun to explore Race/Ethnicity data on the population served in SCHSCM to ensure the program is reaching all communities within New Jersey. Below is a graphic comparing the SCHSCM population served in FFY'21 by Race/Ethnicity Compared to the Race/Ethnicity of the NJ DOE Special

Education population (Figure 23). 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 better examine who utilizes CMUs and where there is need for more outreach to ensure that all children with special health care needs and families may benefit from SCHSCM services.

Figure 23. SCHS CM Served Population FFY 2021 by Race/Ethnicity Compared to NJ Children Receiving Free and Appropriate Education Age 3-21



Data Source: NJ Department of Education, Office of Special Education Programs, 2020

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 health care providers and distributing information and trainings on the Learn the Signs, Act Early campaign that educates providers on childhood development, including early warning signs of autism and other developmental disorders, as well as, to encourage developmental screenings and intervention. In addition, the Governor's Council for Medical Research and Treatment of Autism has funded additional clinical centers in their pursuit to create a NJ Autism Center of Excellence (NJACE).

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, and 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 co-morbid 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 normal 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 culture may be a social

determinant of help-seeking among families with children with autism spectrum disorder. The registry will utilize UB data to expand beyond current racial categories and provide more information about the diversity of population.

DRAFT

Cross-Cutting/Systems Building - Annual Report

Cross-cutting or Systems Building

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 assure that all children have access to preventive oral health services. Strategies for promoting good oral health include providing preventive interventions such as age-appropriate oral health education, promoting the application of dental sealants and the use of fluoride, increasing the capacity of state oral health programs to provide preventive services, evaluating and improving methods of monitoring oral disease, and increasing the number of community health centers with an oral health component.

The New Jersey Department of Health is moving oral health access forward by piloting Fluoride Varnish programs, implementing for the first time a Third Grade Basic Screening survey (a measure recognized nationally as important to assess and gather data about oral health), and developing NJ's first-ever 5-year state oral health plan. 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 2020 – 2021 FQHC dental providers provided 27,455 uninsured patients with dental services under the Uncompensated Care Fund.

	2007	2008	2009	2010	2011-2012	2016	2017	2018	2019	2020
Percent of women who had a dental visit during Pregnancy*	N/A				N/A	N/A		46.3*	N/A	40.0
Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**	78.7+				79.9+	82.1+	81.9+	54.5**	51.8**	41.5**

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.

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.

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 the State for over 35 years. It also provides oral health education programs for parenting and community groups and at WIC sites. During the 2020-2021 school year, approximately 37,851 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 Hygienists and Dentists, 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. As a result of COVID, the COHP revised their presentation education into online formats beginning in 2020 and continued to offer this option into 2021. Schools and community groups have the option of virtual recorded and virtual live oral health education increasing flexibility and access. The COHP operates under the direction of the State Dental Director, Division of Community Health Services, Oral Health Services Unit.

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

The "Save Our Smiles, voluntary school-based fluoride mouth rinse (FMR) program was permanently discontinued due to the lack of product needed for the program. The one manufacturer of the Fluoride powder pack and Fluoride unit doses ceased manufacturing these products in late 2019. This affected 150,000 participants in FMR programs nationwide. During 2020-2021 A-Fluoride Varnish program continued to be piloted through COHP. Due to COVID restrictions, Fluoride Varnish programs were held outdoors or in large capacity spaces to ensure safety. Seven Fluoride Varnish events were held, providing education and fluoride varnish to 228 students.

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 Home Visitation program, in collaboration with the Division of Children and Families, provides training to Home Visiting staff to encourage families to perform daily dental hygiene and the importance of establishing a dental home. Since its inception in 2014, 7,200 families participating in home visiting programs received oral health information and oral health care kits. This program was updated during the 2020-2021 fiscal year and developed into a series of three one-hour oral health trainings regarding vaping/tobacco, diabetes, and pregnancy. They were presented in January and February of 2021 and attended by a total of 256 participants. A Home Visiting newsletter for staff highlighting the education they received was distributed in Spring 2021, and 1200 oral health kits for families were distributed to Home Visitation agencies.

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 was updated during the Summer and Fall of 2021. The 2022 Dial A Smile Directory is available online at: https://www.nj.gov/health/fhs/oral/documents/dental_directory.pdf .

The COHP newsletter, "Miles of Smiles" for school nurses is distributed annually each Fall to school nurses throughout the state. In the 2020-2021 school year, 3,229 were distributed. The "Oral Health Facts for Women, Infants, and Children" newsletter was emailed to State WIC Coordinators in April 2021. Both contain timely oral health topics for staff to communicate to the populations they serve, such as "The Effects of Covid on Oral Health", "Breastfeeding and Oral Health" and where to find dental services and resources in New Jersey. Newsletters and other resources are updated to the COHP webpages on the DOH website. The COHP has an ongoing relationship with WIC offices to provide education to their participants, however, due to COVID, WIC sites were closed. In

February 2021, a virtual presentation on oral health and pregnancy was given to WIC staff during their regular staff meeting.

The Oral Health Nutrition and Obesity Control Program reimburses fourteen Federally Qualified Health Centers and dental provider organizations to provide at dental visits, a minimum of three nutrition counseling sessions to Medicaid-eligible or uninsured children ages 6-11 who are determined to be in the overweight or obese range as calculated by Body Mass Index.

As of January 2022, 17,416 children were screened of which 6,913 have BMI in the overweight and obese range. A caries rate of 51 % was found in the eligible cohort. The goals of this program are to increase oral health literacy, provide information on proper nutrition and the benefits of physical activity, and improve dental and overall health for children and their families. Dental providers under this grant report that the impact of COVID on the oral health of pediatric patients have been severe with increases in cavities for this age range. Providers attribute this to the pandemic, during which regular care was delayed and children did not have the access to healthy foods as regularly would be due to school closures. In the 4th year of this grant food delivery of healthy foods to family households whose children have completed all three nutritional counseling sessions has been added as an activity commencing February 1, 2022. Funds for this grant are provided by a 4-year HRSA Support of State's Oral Health Workforce Activities grant, awarded to the Division of Community Health Services commencing September 2018 and ending August 2022. Program deliverables are overseen by the Oral Health Services Unit.

The Oral Health Services Unit has entered into an agreement with the NJ Learning Management Network to have oral health presentations developed for Doula and Home Visitation staff made available to public health professionals to receive public health continuing education credits. Four oral health webinars are now active on NJLMN, the three-webinar Home Visitation series for a total of 1.5 CEUs, and the Doula education for 1.0 CEUs. The NJ Learning Management Network is a free learning portal that provides public health education.

Cross-Cutting/Systems Building - 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

During the fiscal year 2018-2019, the Division of Community Health Services established the Oral Health Services (OHS) Unit. Dental Hygienist, Yvonne Mikalopas, was onboarded in March 2019, and Dental Director, Dr. Darwin K. Hayes, in July 2019 to oversee and manage oral health programs and projects for the state. Meetings with key stakeholders and focus groups which took place during 2019- 2020, guided by consulting group Health Resources in Action (HRiA), resulted in an oral health key findings report. During 2021 – 2022 this report and additional meetings have resulted in a working draft of the New Jersey State Oral Health 5-year Plan. This plan will guide state oral health programming and create an oral health presence within Healthy New Jersey 2030 (HNJ2030), the state's 10-year health improvement plan. From 2019 – to 2022, Yvonne Mikalopas RDH serves on the HNJ2030 Coordinating Committee, Access to Quality Care Committee, and Integrated Health subcommittee.

The OHS will continue to oversee the deliverables and activities of The Children's Oral Health Program (COHP), now in its 40th year, throughout 2021-2022. The COHP was incredibly successful in continuing to conduct outreach to schools and providing oral health education programming despite the school shutdowns and other challenges caused by the pandemic. Virtual live and virtual recorded programming was used to accommodate schools and community groups and the Home Visitation staff training was updated and revitalized. Dental kits were provided for school children and over 1200 oral health care kits for families were distributed to HeadStart agencies. The Fluoride Varnish pilot program will continue to expand to new schools and in-person education programs are anticipated to increase throughout the school year. Additional funding, under a Preventative Health and Health Services Block grant, will allow COHP to expand Fluoride Varnish application and family and staff education in HeadStart and Early HeadStart agencies, in collaboration with the NJ Department of Education, Division of Early Childhood Services. The 2022 NJ Dial a Smile Dental Directory is updated and published online.

The award of the 4-year HRSA Workforce grant in 2018 allows for the continuation in 2021-2022 of two oral health initiatives to address the public health crises of opioid addiction and childhood obesity. In partnership with Rowan University School of Osteopathic Medicine, The Opioid Education for Oral Health Workforce and Dental Students Program educates dentists and dental students on best practices for prescribing opioid medications, pain management in the dental setting, and treatment guidelines. This free program, launched online in May 2020, includes continuing education credits conferred by Rutgers University School of Dental Medicine, School of Continuing Education. The modules have been incorporated into the curriculum for 3rd- and 4th-year dental students, beginning in February 2021. Opioid education is now a requirement per NJ Board of Dentistry regulations for dentists and dental hygienists beginning in the current license renewal period which ends October 31, 2021. To date, 377 course modules for dental professionals have been completed and 598 student modules., Dr. Hayes has served on the NJ Board of Dentistry since February 2020.

Proper nutrition is vital to both oral health and overall health. According to Healthy New Jersey 2020, there has been a dramatic increase in NJ adults, teens, and children who are overweight or obese. The Oral Health Nutrition and Obesity Control Program educates parents of children with a body-mass index (BMI) in the overweight or obese range on proper nutrition for good oral health and provides strategies to reduce dental caries, dental disease, and obesity in children aged 6 to 11 who are uninsured, on Medicaid or Medicaid-eligible. This creates a transferable model for use by dental practitioners to screen for BMI and provide nutritional counseling as best practice in the dental setting. In year one of the grant, 3 FQHCs piloted the program. In the grant year 2021-2022, fourteen organizations provide the activities under the grant, including 4 non-traditional partners who are private practitioner dental practices and non-profits providing dental services for high numbers of Medicaid patients in underserved areas of the state. Additionally, a healthy food delivery program has been implemented as of February 1, 2022, to reinforce the importance of healthy food choices for patients and their families receiving oral health nutritional counseling.

Additional goals of the OHS unit during 2021 – 2022 include a third-grade oral health Basic Screening Survey (BSS) through a partnership with the NJ DOE and with technical assistance from the Association of State and Territorial Dental Directors (ASTDD). BSS is the national standard for establishing key oral health baseline data. Consultation with the Association of State and Territorial Dental Directors (ASTDD) has determined that a sample size of 900 third-grade students in 30 schools will provide representational baseline data for the state. In collaboration with DOE Office of Early Childhood Education, HeadStart and Early HeadStart enrollees will receive dental screenings and application of Fluoride Varnish and assist families to establish dental homes. These activities are supported by an ongoing Preventive Health and Health Services Block grant awarded-to the Community Health Services Division for the grant year period of October 1, 2021 – September 30, 2022.

Expanding on the success of the 2020 Doula Oral Health Education project and the 2021 Home Visitation Oral Health Education project, the Oral Health Services unit participated on October 19, 2021, in a collaborative Department of Early Childhood Education Oral Health Summit, with the goal to increase oral health care access and awareness of services for pregnant women and HeadStart families who are enrolled in Early Head Start and Head Start programs in the state. Head Start agencies and Home Visitation staff serving the Head Start population will receive information about resources available through the NJ Department of Health, Department of Human Services, and Managed Care Organizations. Dr. Hayes made opening remarks and Yvonne Mikalopas presented introductory information as a basis for future oral health trainings for HeadStart staff. On March 11, 2022, a follow-up meeting with the Children's Oral Health Program will occur to provide specific information on how the agencies can receive Fluoride varnish and education programs for their staff and families.

In November 2021, Yvonne Mikalopas RDH presented, "Oral Health for Student Well Being," at the annual NJ Education Association Conference in Atlantic City, approved for presentation by the NJEA through a proposal application process. On February 8th, 2022, in collaboration with the NJ American Academy of Pediatrics, Yvonne presented "Oral Health Care and Dental Care for People with Intellectual and Developmental Disabilities" to parents and advocates of children with I/DD. This project is funded under a grant "Inclusive Health Communities" received by NJ AAP through the Department of Human Services. Yvonne participated as a grant planning committee member and subject-area expert.

Dr. Hayes will continue to serve on the NJ Board of Dentistry from 2021 to 2022. Dr. Hayes has been integral in advising the Board throughout the COVID pandemic crisis on the status of dental services provided by Federally Qualified Health Centers and providing guidance regarding the administration of COVID vaccinations by dentists and dental hygienists.

III.F. Public Input
Public Input

The team is planning for a public comment period in July 2022.

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III.G. Technical Assistance

The COVID-19 pandemic continues to evolve with new variants occurring. Title V programs continue to adapt with service delivery and education via online as well as in person. Positive benefits of virtual delivery include reducing transportation and childcare need barriers. The Title V program is continuing to address family needs and concerns with MCH populations, particularly pregnant women and youth. Supporting mental health needs for both families and service providers is also critically needed. The DOH Title V program is continuing to monitor technical assistance opportunities as available and as needed to meet the needs of families.

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

Domains (set by HRSA)	State Priority Needs based on Needs Assessment	Strategies (to support Evidence-Based Informed Strategy Measures (ESMs))	National Outcome Measures (NOMs) (states select from list)	National Performance Measures (NPMs) & State Performance Measures (SPMs)	Evidence-Based Informed Strategy Measures (ESMs)
1) Women's/ Maternal Health	#1 Increasing Healthy Births # 2-Reducing Black Maternal Mortality	Healthy Women, Healthy Families (HWHF) Initiative; Central Intake (CI) & Community Health Workers (CHW); MIEC Home Visiting Program (MIECHV); Mortality Review Committee	2, 3, 4, 5, 6, 8, 9.1, 9.2, 9.3, 9.4, 24	NPM #1 Well Women Care (Percent of women with a past year preventive medical visit)	ESM 1.1: Increase first-trimester prenatal care (EBC) from birth certificate records. ESM 1.2: ESM 1.2: Number of individuals trained to become community-based doulas
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	Healthy Women, Healthy Families (HWHF) Initiative; MIEC Home Visiting Program; NJ SIDS Center activities; Child Fatality & SUID Case Review; Surveillance (PRAMS, EBC)	2, 4, 5, 6, 8, 9.1, 9.3, 9.5	NPM #5 Infant Safe Sleep (Percent of infants placed to sleep on their backs). SPM #1 Black preterm births SPM # 7 Black infant mortality rate	ESM 5.1: Increase infant safe sleep (PRAMS – on back, no co-sleeping, no soft bedding). ESM 5.2: Promote referrals to evidence-based interventions aiming at reducing black infant mortality

2) Perinatal/ Infant Health	#2 Improve Nutrition & Physical Activity	Healthy Women, Healthy Families (HWHF) Initiative; MIEC Home Visiting Program; Baby Friendly Hospitals, BF Surveillance (PRAMS, EBC) Breastfeeding and NJ Maternity Hospitals:	2, 4, 5, 6, 8, 9.1, 9.3, 9.5	NPM #4 Breastfeeding (A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months).	ESM 4.1: Increase births in Baby Friendly hospitals (EBC/mPINC).
3) Child Health	#4 Promoting Youth Development	ECCS Impact with DCF Project LAUNCH and Help Me Grow with DCF Early Intervention System MIECHV	13, 19	NPM #6 Developmental Screening (Percent of children, ages 10 through 35 months, receiving a developmental screening using a parent-completed screening tool).	ESM 6.1: Promote parent-completed early childhood developmental screening using an online ASQ screening tool.
4) Adolescent/ Young Adult Health	#4 Promoting Youth Development #6 Reducing Teen Pregnancy	NJ AAP/ MCH and GLS Mental Health and Suicide Prevention Education to professionals: Lifelines, SafeSide, Mental Health ECHO; and youth through Lifelines	16.1, 16.3, 17, 18, 19, 20, 21,22	NPM#9 Bullying Prevention (number of youth completing a Social and Emotional Learning Evidence Based Model (TOP, Teen PEP and RTR)	ESM 9.1 - Reduce the percentage of high school students who are electronically bullied (counting being bullied through texting, Instagram, Facebook, or other social media). ESM 9.2 - Reduce the percentage of high school students who are bullied on school property. ESM 9.3: Number of youths completing an evidence based SEL program proven to reduce Teen Pregnancy

<p>4) Adolescent/ Young Adult Health</p> <p>5) CYSHCN</p>	<p># 5 Improving Access to Quality Care for CYSHCN</p>	<p>NJ AAP/PCORE Medical Home Project; Transition to adulthood needs assessment; SPAN/ISG 1; ARC of NJ</p>	<p>17.2, 18, 19, 25</p>	<p>NPM #11 Medical Home (Percent of children with and without special health care needs having a medical home).</p>	<p>ESM 11.1: Percent of CYSHCN ages 0-18 years served by Special Child Health Services Case Management Units (SCHS CMUs) with a primary care physician and/or Shared Plan of Care (SPoC).</p>
<p>5) CYSHCN and 4) Adolescent/ Young Adult Health</p>	<p>#5 Improving Access to Quality Care for CYSHCN</p>	<p>Case Management Services; Redesign BDARS; NJ AAP/PCORE Medical Home Project; Outreach to providers; Hospital level reports; Audits; Provider education CM level reports; Medicaid Managed Care Alliances, Subsidized Direct Specialty and Subspecialty Services, Participation in Medical Assistance Advisory Council, Arc of NJ SPSP Services</p>	<p>19, 16, 17, 18, 19, 20, 21,22</p>	<p>NPM #12 Transitioning to Adulthood (Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care).</p> <p>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.</p> <p>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.</p> <p>SPM #5: Average age of initial diagnosis for children reported to the</p>	

				NJ Birth Defects & Autism Reporting System with an Autism Spectrum Disorder	
6) Cross-cutting	#7 Improving & Integrating Information Systems	Project REACH, Project PEDS; MIEC Home Visiting; Dial a Smile Dental Clinic Directory; Miles of Smiles; WIC Newsletter; Special Needs Newsletter;	14, 17.2, 19	NPM #13.1 Oral health (A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year).	ESM 13.1: Preventive and any dental services for children enrolled in Medicaid or CHIP (CMS-416).

Table 1b - Staffing for MCHS

Staff Person	Title	Function	Related NPM	Tenure in MCH in Year
Nancy Scotto-Rosato, PhD	Interim Assistant Commissioner	Title V Director	1-15	20+
Marilyn Gorney- Daley, DO, MPH	MCHS Director	Medical Director	1-15	22
Felicia L. Harris, MSHS	RPHS Program Manager	Oversees RPHS	1-15	1
Vacant	CAHP Manager	Oversees CAHP	7-12	
Jennie Blankie, MEd	Coordinator Child and Adolescent Health	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
Vacant	Program Specialist Trainee	Oversees SRAE	1-6	
Sarah Bilyj, MBA, BSN, RN, CLC	Nurse Consultant	Coordinator MIECHV and RPHS programs	1-6	<1
Sarah Torres, BS	Program Specialist 3	Coordinator RPHS programs	1-6	1
Lisa D'Amico, RNC-MSN-APNC	Public Health Consultant 2 Nursing	Coordinator RPHS programs	1-6	5
Pamela Taylor, MPH	Public Health Consultant 2	Collette Lamothe-Galette Community Health Worker Institute- Statewide Coordinator	1-6	3
Dorothy Reed, MA	Program Management Officer.	ELC and DLC grants and support MIECHV		2
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+
Vacant	Health Data Specialist 2	MCH Epidemiologist who assists the Research Scientist I	1-15	
Vacant	Health Data Specialist 2	MCH Epidemiologist who assists the Research Scientist I	1-15	

Table 1c - Staffing for SCHS

Staff Person	Title	Function	Related Priority NPM	Tenure in MCH in Year
Sandra Howell, PhD	Executive Director	Service Unit Director, Director for CYSHCN and coordinates the Autism Registry	11,12	14
Anna Marie Perez	Public Health Representative 2	Provides follow-up of all NSGS abnormal screening results		3
Anthony Mosco, AA	Software Development Specialist Assistant	Technical assistance related to the BDAR		14
Ariel Meltzer, MS, MSW, LSW	Analyst 1, Research and Evaluation	EHDI Coordinator		3
Betty Durham	Principal Clerk Typist	Provides clerical support for NSGS		24+
Daniel Heitner	Research Scientist 2	Supports FCCS Unit; SCHS Case Management & Family Support, Fee for Service, Ryan White Part D activities	12,12	<1
Dorothy Snyder	Secretarial Assistant 3	Secretarial support	11,12	6
Dawn Mergen	Program Specialist 4	Administer FCCS Unit; SCHS Case Management & Family Support, Fee for Service, Ryan White Part D activities	11,12	8
Diane Driver, MSN, RN	Nursing Consultant	Program Management Officer: manages health services grants for NSGS Follow-up Services		7
Elena Napravnik, M.Ed.	Research Scientist 2	Supervises activities of EIM (interim)		3
Felicidad Santos, MD, MPH	Public Health Representative 1	Provides follow-up of all newborns with abnormal screening results		13
Hanna Seo	Research Analyst I	Program Management Officer: manages health services grants for SPSP		4
Hui Xing	Research Scientist 2	Provides data services for BDRS & FCCS	11, 12	3
Jennifer Hopkins, MPH, CHES	Program Specialist Trainee	Program Management Officer for health service grants in NSGS and HEM		1
Jing Shi, MS	Research Scientist 2	Responsible for data management for EIM	11,12	4

Joy Rende	Nursing Consultant	Responsible for CCHD and Quality Assurance education regarding NSGS		6
Kaleigh Hinton	Analyst Trainee	Assists in the coordination of the Autism Registry		<1
Kathryn Aveni, RNC, MPH	Research Scientist I	Data Coordinator for SCHS	11,12	17
Karyn Dynak	Supervising Public Health Rep.	Supervising Follow-up for NSGS		19
Kidanemariam Meshesha	Research Scientist 2	Provides data services for BDRS & FCCS	11,12	<1
Kourtney Pulliam, MPH	Research Scientist 2 RWPD COVID-19 Project W	WICY infected and/or affected by HIV/AIDS. Liaison between Title V MCH & CYSCHN programs and WICY population, providers, and systems development. Works as a data project manager for the COVID-19 Project W Project.		4
Lisa Stout, BSN, RN	Nurse Consultant	Ensures that the information on each BDAR registration is accurate and complete		3
Maria Baranyai	Public Health Representative 2	Provides follow-up of all NSGS abnormal screening results		3
Michelle Seminara	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.		1
Nancy Schneider	Research Scientist 2	Audiologist, liaison to the audiology community		20
Nicole Dennis	Data Analyst 1	Provides data analysis work and support for EHDI		3
Nicole Moore	Agency Services Representative 3	Provides clerical support for BDAR		23
Ondia Barron	Public Health Representative 2	Provides follow-up of all NSGS abnormal screening results		4
Reda Khalifa	Agency Services Representative 3	Provides clerical support for FCCS	11,12	23
Sarah Eroh	Quality Assurance Specialist	Prepares and provides training and quality improvement visits to NJ birthing hospitals, ensures quality of		1

		program charts, initiates, and follows cases as needed.		
Stephanie Agugliaro	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.		2
Susan Agugliaro	Secretarial Assistant 3	Clerical support to EIM and then to NSGS Program		32+
Suzanne Canuso, MSN, RN	Public Health Consultant 1, Nursing	Interim program manager to supervise activities of the NSGS		11
Suzanne Karabin, MS	Research Scientist 2	Coordinator for the Autism Registry		20
Tariq Ahmad, MBBS, MPH	Public Health Representative 1	Provides follow-up of all NSGS abnormal screening results		12
Tracey Hayes	Principal Clerk Typist	Provides clerical support for EHD!		18
Vacant	Public Health Representative Trainee	Assists in the coordination of the Birth Defects Registry		
Vacant	Public Health Consultant 1, Nursing	Ensures that the information on each BDAR registration is accurate and complete		
Vacant	Program Specialist 3	Public health consultation re: SCHSCM programs, family support, and Fee for Service program, program officer for SCHSCM health services grants	11,12	
Vacant	Analyst 1, Research and Evaluation RWPD	Data consultant and is the Project Director and works with the Network for RWPD agencies in their quality improvement and quality management activities.		
Vacant	Nursing Consultant	Public health nurse consultation across CMU agencies and Medicaid managed care expertise	11,12	
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		
Vacant	Coordinator Primary and Preventive Health Services	Coordinator NJ Birth Defects Registry	11,12	
Vacant	Head Clerk	Provides supervision of clerical staff for BDAR	11,12	

Vacant	Administrative Assistant 3	Administrative support	11,12	
Statewide Parent Advocacy Network Diana Austin (grantee)	Executive Director	Parent Partner	11,12	23+yrs

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