

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

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

**Application for FY 2021
Due July 2020**

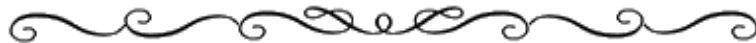


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I. General Requirements

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

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

1. D. Table of Contents

This report follows the outline of the Table of Contents provided in the "Guidance And Forms For The Title V Application/Annual Report," Omb No: 0915-0172; expires January 31, 2020.

2. Logic Model

The MCH Block Grant Logic Model which is driven by the state’s priority needs, Title V National Outcome Measures, state selected National Performance Measures, State Performance Measures, and state-initiated Evidence-based Strategy Measure is presented in Table 1 - New Jersey Five-Year Needs Assessment Framework Logic Model on page 48.

3.A. Executive Summary

The mission of the NJ Department of Health (NJDOH), Division of Family Health Services (FHS) is to improve the health, safety, and well-being of families and communities in New Jersey (NJ). FHS works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations. The Maternal and Child Health Block Grant Application and Annual Report that FHS submits each year to the Maternal Child Health Bureau (MCHB) provides an overview of initiatives, State-supported programs, and other State-based responses designed to address the maternal and child health (MCH) needs in NJ as identified through our continuous needs assessment process and in concert with the Department of Health’s strategic plan, the State’s Health Improvement Plan, Healthy NJ 2030, and the collaborative process with other MCH partners.

NJ is the most urbanized and densely populated state in the nation with 9.0 million residents. It is also one of the most racially and ethnically diverse states in the country. The racial and ethnic mix for NJ mothers, infants, and children is more diverse than the overall population composition. This growing diversity not only raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds but also of the need to ensure a culturally competent workforce and service delivery system. Indeed, one of the three priority goals of the FHS Title V program is to increase the delivery of culturally competent services through a well-trained workforce. The other two goals are to improve access to health services through partnerships and collaboration and to reduce disparities in health outcomes across the lifespan consistent with the Life Course Perspective (LCP).

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

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

Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure building to meet the health of all NJ's families.

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

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

Although the overall infant mortality rate in New Jersey is lower than the national rate (4.5 per 1,000 live births versus 5.8 per 1,000 live births in 2017), the disparity between white, non-Hispanic (NH), and black, NH, is significant. The infant mortality rate for black, NH, is more than three times that of white, NH, and this disparity has remained constant for at least ten years. Additionally, disparities are seen between New Jersey counties and municipalities in terms of black infant mortality rates and other health outcomes. Counties such as Atlantic, Camden, Cumberland, Essex, Hudson, Mercer, and Passaic have black infant mortality rates ranging from 6.5 per 1,000 births to 17.1 per 1,000 births. Further investigation within these counties showed that certain municipalities drive these high county rates and therefore, a specific focus on municipalities is necessary to address disparities. NJ's maternal health outcomes are among the worst in the country. Leading causes of pregnancy-related maternal death are mostly preventable. NJ's non-hispanic Black women experience related mortality at nearly five times their White counterparts and greater severe maternal morbidity (SMM) burdens than all other groups.

Regional focus groups with consumers and stakeholders identified some of the social determinants of health (SDOH), including lack of social support and timely access to care, that contribute to the persisting disparities.

As a result, the Healthy Women, Healthy Families (HWHF) Initiative, a five year program implemented in July 2018, to improve maternal and infant health outcomes for women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes through a collaborative coordinated community driven approach through the use of Community Health Workers and Central Intake Hubs.

The HWHF Initiative continues to expand outreach and increase referrals to community-based MCH services with \$3.4 million in funding to state community-based organizations. Outreach is a major component for the Community Health Workers, who serve as the "boots on the ground," trusted members of the community that provide services in a culturally and linguistically competent manner. As of December 2019, more than 35,000 women have been screened since 2018 and more than 18,000 were

connected to programs like HWHF, Home Visiting and Healthy Start. Additionally, HWHF requires Community Health Workers to provide case management and more intensive follow ups.

New Jersey is taking a targeted approach to reducing black infant mortality (BIM) rates. Specific BIM reduction activities have been implemented in 8 municipalities found to have the highest rates of BIM (Atlantic City, Camden, East Orange, Irvington, Jersey City, Newark, Paterson, and Trenton). Specific BIM reduction activities include breastfeeding support, centering programs, fatherhood initiatives, and a doula pilot program. New Jersey recognizes the importance of statewide collaboration with traditional and non-traditional partners to address the SDOH which are instrumental in moving the needle on Black Infant Mortality reduction. As a result, partners from the Departments of Labor and Workforce Development, Education, Transportation, Children and Families, Human Services, the Office of the Attorney General and the community strategically collaborate to reduce BIM. FHS is working very closely with the NJDOH Office of Population Health with the purpose of: (a) ensuring health in all policies, (b) leveraging resources and inter- and intra-departmental collaborations, and, (c) addressing health disparities using a multi-sectorial approach.

The State Health Improvement Plan (SHIP) identified Birth Outcomes as a priority health issue to be addressed by the NJ DOH, sister agencies, community-based stakeholders, and local public health agencies. The SHIP with its focus on health equity has identified several policy related strategies to improve birth outcomes. FHS and the newly formed NJ DOH Office of Population Health have successfully applied for several federal grants focused on maternal mortality and morbidity including the Maternal Mortality Review Committee Grant from the CDC and the State Maternal Health Innovation Program Grant from HRSA to fund the strategies of the SHIP.

The NJ Maternal Mortality Review Committee grant from the CDC (\$450,000 per year for 5 years) will fund the NJ DOH to coordinate and manage the NJ Maternal Mortality Review Committee (NJ MMRC) to identify and characterize maternal deaths for identifying prevention opportunities. The grant requires the NJ MMRC 1) to identify pregnancy-associated deaths within one year of death; 2) to abstract and enter clinical and non-clinical data into a standard data system [Maternal Mortality Review Information Application (MMRIA)], 3) to conduct multidisciplinary reviews, and 4) to enter committee decisions in MMRIA within 2 years of death. The strengthening of the NJ MMRC and the implementation of the strategies and activities outlined in the NJ MMRC grant will produce the short-term, intermediate, and long-term outcomes necessary to reduce preventable maternal deaths. NJ legislation (P.L.2019, c.75) provides the legal authority to convene and strengthen the MMRC.

HRSA funding for the State Maternal Health Innovation Program (SMHIP) Grant will support the NJDOH initiatives to enable New Jersey becomes the safest place in the United States to give birth. The SMHIP will leverage progress to-date, anchor multi-sector collaboration, establish sustainable mechanisms that will extend beyond the five-year period of performance and improve data infrastructure to complement activities in New Jersey's Title V program .

The SMHIP objectives are to:

1. Establish a Maternal Health Task Force that will create and implement a strategic plan. NJDOH will establish the NJ Maternal Care Quality Collaborative which will produce NJ's strategic plan to avert maternal death, severe maternal mortality (SMM) and disparities.
2. Improve the collection, analysis, and application of data on maternal mortality and SMM. NJDOH will enhance the New Jersey Maternal Mortality Review Committee, build a Maternal Data Center and improve dashboarding efforts, including the New Jersey Report Card of Hospital Maternity Care. The SMHIP data infrastructure will enable ongoing performance management through expedited data processes to facilitate rapid-cycle data analytics and generate ready feedback and evaluation.
3. Promote and execute innovations in maternal health service delivery. NJDOH will implement the following activities to drive innovation: Implicit bias training; Maternal levels of care designations; Shared decision-making tools; Interoperability of the Perinatal Risk Assessment screening tool; informed reproductive health decision-making through postpartum long acting reversible contraception (LARC) access; and Project ECHO collaborative learning for providers such as OB/GYNs, community health workers (CHWs) and doulas.

Nurture NJ is the First Lady of NJ's statewide awareness campaign that 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 New Jersey women and children. Launched on Maternal Health Awareness Day 2019, Nurture NJ focuses on improving collaboration and programming between departments, agencies, and stakeholders to achieve its goal of making New Jersey the safest place in the country to give birth and raise a baby. The initiatives include an annual Black Maternal and Infant Health Leadership Summit; the First Lady's Family Festival event series; quarterly interdepartmental maternal and infant health meetings; and a comprehensive, statewide strategic plan to reduce maternal mortality by 50% over five years and eliminate racial disparities in birth outcomes.

Another program promoting the Life Course Perspective and augmenting our efforts to reduce infant mortality, pre-term births, and maternal morbidity is the Maternal and Infant Early Child Home Visiting (MIECHV) Program which has expanded Home Visiting (HV) across all 21 NJ counties, with 5,805 families participating in HV during SFY 2019. The goal of the NJ MIECHV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness.

Other initiatives contributing towards 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 (WSCC) School Health NJ Project, the NJ Personal Responsibility Education Program (PREP), and the NJ Sexual Risk Avoidance Education (SRAE) Program.

To improve access to health services, the NJDOH has provided reimbursement for uninsured primary medical and dental health encounters through the designated Federally Qualified Health Centers (FQHCs). In SFY 2020, the State is proposing funding of the FQHCs with \$34 million to continue to focus on the needs of the uninsured and particularly those residents not eligible for the Patient Protection and Affordable Care Act (ACA) and/or NJ FamilyCare under Medicaid Expansion who need access to care and meet eligibility requirements.

New Jersey's Title V Children and Youth with Special Health Care Needs (CYSHCN) program includes Newborn Screening Follow-up and Genetic Services (NSGS), the Birth Defects and Autism Registry (BDAR), the Early Hearing and Detection Program (EHDI), Family Centered Care Services (FCCS) and Early Intervention Services (EIS). Both NSGS and EIS are primarily funded by other sources but are co-located and coordinate with our HRSA-funded programs.

The NSGS Program ensures that all newborns and families affected by an abnormal screening result receives timely and appropriate follow-up services. NJ remains among the leading states in offering the most screenings, and by the end of 2020 will screen 60 disorders for newborns. In addition to disorders detected through heel stick, NJ's newborns are also screened with pulse oximetry through the Critical Congenital Heart Defects (CCHD) screening program. This screening was instituted to ensure that babies who appeared healthy are identified before they are discharged. As of April 2020, NJDOH has received reports of 28 infants with previously unsuspected CCHDs detected through the screening program. In addition, the early hearing detection and intervention (EHDI) program continues to screen all newborns for hearing loss.

The BDAR ensures that all children 0 through five-year-old who have a congenital birth defect and all children 0 through 21 years old who have an Autism Spectrum Disorder (ASD) are registered. The BDAR provides valuable public surveillance data for needs assessment, service planning, and research. Most importantly, the BDAR links families to important resources through our Special Child Health Services Case Management Units (SCHS CMUs).

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

The FCCS program promotes access to care through early identification, referral to community-based culturally competent services and follow-up for CYSHCNs up to 21 years of age. Ultimately, these services and supports are provided through SCHS CMUs, Specialized Pediatric Services Providers (SPSP) which includes Child Evaluation Centers (CECs), Cleft Lip/Palate Craniofacial, and Tertiary Care Centers. Ryan White Part D is also housed within FCCS and provides direct care to women, infants, children, and youth who are infected or affected with HIV/AIDS. FCCS services support NJ's efforts to address the six MCH Core Outcomes for CYSHCN. This safety net is supported by State and Title V funds administered via community health service grants, local support by the County Boards of Chosen Freeholders, reimbursement for direct service provision, and technical assistance to grantees. Through our Title V program partners, FHS continues to address families' 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. Such referrals could include but not be limited to public health insurance options; legal services; food stamps; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); employment; public assistance; and the Catastrophic Illness in Children's Relief Fund. These service referrals have been shown to drastically improve health outcomes and decrease the need for additional medical interventions, improve quality of life, and reduce costs.

New Jersey Early Intervention Services (NJEIS) provides over 1.5 million services to over 30,000 children per year. In addition to state funds, Medicaid reimbursement, and family cost share funds, NJEIS receives federal funds as an IDEA Part C program. Located within our Special Child Health Services unit, they work collaboratively with the other programs. Our FCCS case managers refer children to NJEIS to ensure that eligible children receive important services in a timely manner, and as children age out of NJEIS and continue to need case management, these children move back to our county-based CMUs.

New Jersey's Title V CYSHCN program diligently collaborates with intergovernmental and community-based partners to ensure that care through these multiple systems will be coordinated, family centered, community-based, and culturally competent. Communication across State agencies and timely training for State staffs, community-based organizations and families with CYSHCN remains a priority to ensure that families are adequately supported during the reorganization of these systems.

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

The impact of COVID-19 on all areas of maternal and child health has been and continues to be significant. On March 9, 2020, Governor Murphy issued Executive Order 103, declaring the existence of a public health emergency. COVID-19 necessitated a rapid transition from in-person programs and services to those being administered remotely whenever possible. Title V staff as well as Title V grantees moved to operating remotely from home. Innovations in telehealth as well as Medicaid reimbursements were created. As the situation with COVID-19 continues to be rapidly evolving as of April 27, 2020, Title V continues to collaborate with partners and families to deliver services and support.

New Jersey 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 New Jersey women, children, and families. As with addressing challenges to improve birth outcomes, reduce disparities, and operate within the public

health COVID19 pandemic, NJDOH will work to further strengthen its partnerships with the MCH Bureau as well as families, providers, agencies, and other stakeholders.

3.A.2 How Title V Funds Support State MCH Efforts

Title V Funds are essential in supporting NJ's MCH efforts. With regard to maternal mortality, the Department of Health provides Title V funds to the Central Jersey Family Health Consortia to implement the Maternal Mortality Review Committee. The funds are used for staff to do chart abstraction, case summaries and data entry into the Maternal Mortality Review Information Application (MMRIA) system which is the data system we are using in collaboration with CDC. Improving maternal and infant health and reducing both Black Infant and Black Maternal mortality are priorities in NJ. Title V funds are being used for the newly released Healthy Women, Healthy Families RFA, which is focused on addressing disparities, including Black Infant Mortality. The Table in Section 3.D.1. Expenditures on page 46 demonstrates the federal / state partnership and how FY 2019 Federal Title V funds (\$11,500,000) are supported by State MCH funds (\$158,057,356).

Title V funds are used to partially fund the Fetal Infant Mortality Review (FIMR) programs in the Maternal Child Health Consortia. Title V funds are also used to partially fund the Family Health Line which is the 1-800 number for referrals to a variety of programs and services.

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.

3.A.3 MCH Success Story

There is power in engaging youth. This success is the real-life story of a self-described "troubled" 14-year-old, whose life trajectory was forever changed by her freshman involvement with the evidence-based, youth development Teen Outreach Program (TOP) at her high school. At 16, she was trained as a youth facilitator to assist the TOP adult trainer. After high school, she was accepted to Hofstra University. During the summer after her freshman year, she was the first ever youth engagement specialist trainee at the Child and Adolescent Health Program (CAHP), in MCH. When New Jersey's application to the AYAHOIIN (Adolescent and Young Adult Collaborative Improvement and Innovation Network) was approved, she was the young adult representative on the New Jersey team attending the Washington, DC training. Subsequently, she spent winter and spring breaks working for the CAHP and participated at AMCHP's annual conference as a young adult planning committee member/mental health panelist and FYSB's Teen Pregnancy Prevention conference as a poster co-presenter. She was the inspiration for and researched the ENJINE proposal on "Paid State Internships for Youth" - approved as a Governor's Office Impact Idea. Now, with her BA in psychology in hand, she was hired by a CAHP grantee to work full time with TOP bringing her career full circle. This story exemplifies the power of engaging youth!

3.B. Overview of the State

The Maternal and Child Health Block Grant Application and Annual Report, submitted annually to the [Maternal Child Health Bureau](#) (MCHB), provides an overview of initiatives, State-supported programs, and other State-based responses designed to address the maternal and child health (MCH) needs in New Jersey. The [Division of Family Health Services](#) (FHS) in the NJ Department of Health (NJDOH), Public Health Services Branch posts a draft of the MCH Block Grant 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 the [Division of Family Health Services \(FHS\)](#) is to improve the health, safety, and well-

being of families and communities in NJ. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. 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.

A brief overview of NJ demographics is included to provide a background for the maternal and child health needs of the State. While NJ is the most urbanized and densely populated state in the nation with 9.0 million residents, it has no single very large city. Only six municipalities have more than 100,000 residents.

NJ is one of the most racially and ethnically diverse states in the country. According to the [2019 New Jersey Population Estimates](#) of race, 54.9% of the population was white (alone not Hispanic), 15.0% was black, 10.0% was Asian, 0.6% was American Indian and Alaska Native, and 2.3% reported two or more races. In terms of ethnicity, 20.6% of the population was Hispanic. The racial and ethnic mix for NJ mothers, infants, and children is more diverse than the overall population composition. According to 2018 birth certificate data, 27.1% of mothers delivering infants in NJ were Hispanic, 44.2% were white non-Hispanic, 13.5% were black non-Hispanic, and 11.2% were Asian non-Hispanic. The growing diversity of NJ's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

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

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

These goals and State Priority Needs (SPNs) are consistent with the findings of the Five-Year Needs Assessment and are built upon the work of prior MCH Block Grant Applications/Annual reports. Consistent with federal guidelines from the MCH Bureau, Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure services to meet the

health of all NJ's families. During a period of economic hardship and federal funding uncertainty 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 nine of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period:

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

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

SPM #1 Black Non-Hispanic Preterm Infants in NJ,
 SPM #2 Hearing Screening Follow-up,
 SPM #3 Referral from BDARS to Case Management Unit, and
 SPM #4 Age of Initial Autism Diagnosis.

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

The following is a brief overview of MCH services to put into context the Title V program within the State's health care delivery environment. Healthy Women Healthy Families (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: 1) 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 2) Black Infant Mortality (BIM) municipality level activities focus on black NH women of child-bearing 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 (group prenatal care), and Doula. Using two models, Central Intake Hubs (CIH) and Community Health Workers (CHW), the HWHF Initiative works to improve maternal and infant health outcomes including preconception care, prenatal care, interconceptual care, preterm birth, low birth weight, and infant mortality through implementation of evidence-based and best practice strategies across three key life course stages: preconception, prenatal/postpartum and interconception.

Central Intake Hubs (CIH) are a single point of entry for screening and referral of women of reproductive age and their families to necessary medical and social services. The Community Health Worker (CHW) model performs outreach and client recruitment within the targeted community to identify and enroll women and their families in appropriate programs and services. CIHs work closely with community providers and partners, including CHWs, to eliminate duplication of effort and services. Standardized screening tools are used and referrals to programs and services are tracked in a centralized web-based system (SPECT – Single Point of Entry and Client Tracking). HWHF and Doula grantees have received additional training on the NJCHART system, which is a new electronic health assessment and referral tracking system which can help ensure that all participating HWHF women are receiving prenatal care, have a primary care physician and/or an obstetrics and gynecology provider. Additionally, all HWHF newborns within the NJCHART system will have a record of insurance and pediatric medical provider information.

New Jersey is taking a targeted approach to reducing BIM rates through the enhancement of existing programs and creating new programs with the emphasis on this priority population. New Jersey recognizes the importance of a statewide collaboration of existing and non-traditional partners to address the SDOH which will be instrumental in moving the needle on Black Infant Mortality reduction. 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, the Office of the Attorney General and the Community will strategically collaborate to reduce black Infant mortality. FHS will be working very closely with NJDOH Office of Population Health and has created an FHS-Population Health Team (FHS-PHT) with the purpose of (a) ensuring health in all policies, (b) Leverage resources and inter- and intra-departmental collaborations, and, (c) addressing health disparities using a multi-sectorial approach.

Another program promoting the Life Course Perspective is the Maternal and Infant Early Child Home Visiting ([MIECHV](#)) Program which has expanded Home Visiting across all 21 NJ counties with 5,805 families participating in HV during SFY 2019 (7/1/2017 to 6/30/2018). The goal of the NJ MIECHV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full implementation of the NJ MIECHV Program is being carried out in collaboration with the Department of Children and Families (DCF) and is promoting a system of care of early childhood (see Support Document #5). NJ is a FY2018 recipient of both a federal MIECHV Formula and Competitive grant. In January 2017, NJ was awarded a MIECHV Innovation Grant to implement and evaluate a training strategy for Home Visitors called Goal Plan Strategy (GPS) in collaboration with the Maryland Department of Health and Mental Hygiene.

The Child and Adolescent Health Program (CAHP) successfully applied in 2010 for two new federal grants to prevent teen pregnancy and promote youth development - the Personal Responsibility Education Program (PREP) and the Abstinence Education Program (AEP). In February of 2018, the NJDOH was awarded continuing funding for federal fiscal year 2018 and 2019 for PREP. AEP funding ended September 2018 and was replaced by the Sexual Risk Avoidance Education (SRAE) Grant Program. NJ received the grant award in April 2018. In addition, CAHP now has a Coordinator to direct statewide youth engagement collaboration amongst PREP, SRAE program and WSCC School Health NJ grantees.

The SRAE program focuses on building protective factors for youth aged 12-14 to help delay sexual activity, reduce pregnancy and Sexually Transmitted Infections (STIs)., SRAE also provides engagement opportunities including mentoring, youth leadership and parent education on 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. In December of 2018 a competitive RFA was released by NJDOH and new grantees were selected for a two-year grant cycle. All SRAE programming is complete, medically accurate and Lesbian, Gay, Bisexual, Transgender, Intersex, Asexual and Questioning (LGBTIAQ)-inclusive and trauma-informed.

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. Beginning in SFY18 NJ PREP began to implement programming in high schools only. 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 these adult preparation topics: Healthy Relationships, Life Skills and Adolescent Development. NJ PREP has program continuation funds through September 30, 2021 and continues to build on the success of the last six years by supporting three evidence-based models (EBM), two of which, The Teen Outreach Program (TOP®) and Reducing the Risk were selected from the Centers for Disease Control and Prevention's (CDC) Evidence-based Teen Pregnancy Prevention (TPP) Program List. In addition, CAHP added the NJ-based peer education program, Teen PEP, to the PREP Program beginning 10/1/2018.

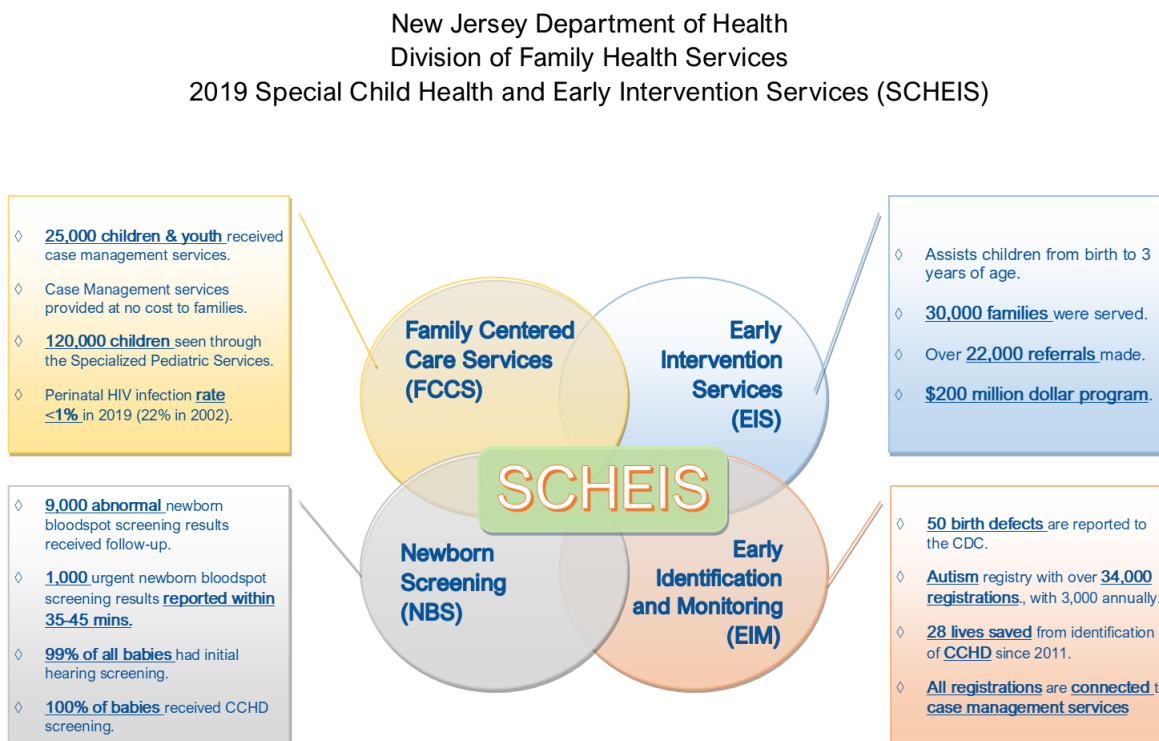
In January of 2020, New Jersey joined the second cohort of LEAHP, a National learning collaborative supporting adolescent health. Leadership Exchange for Adolescent Health Promotion, or LEAHP (pronounced LEEP) was established by the National Coalition of STD Directors (NCSD) and Child Trends in partnership with the National Association of State Boards of Education (NASBE) and has assisted NJ in creating 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). Our NJ team is led by Jennie Blakney, NJ Department of Health (NJDOH), Division of Family Health Services, Kelly Williams NJ Department of Education, Office of Student Support Services and includes 3 additional members from NJDOH Division of HIV, STD and TB services, Department of Children and Families, Office of Education and the NJ State Board of Education. Together, along with stakeholders, NJ LEAHP will build our capacity to assess, develop, monitor, evaluate and implement adolescent health policy for SHE, SHS and SSE; access and leverage lessons learned from national policies in adolescent health and education expertise; strengthen our state leadership knowledge and understanding of adolescent health issues and promote collaborative peer based learning to improve our strategies, policies and leadership related to adolescent health.

To improve access to health services, the NJDOH has provided reimbursement for uninsured primary medical and dental health encounters through the designated [Federally Qualified Health Centers](#) (FQHCs) since 1992 under the FQHC-Uncompensated Care Fund. In SFY 2017, the FQHC–Uncompensated Care Fund was funded at \$28 million. In SFY 2018, the FQHC–Uncompensated Care Fund was funded at \$30 million and, the FQHCs served a total of 149,114 uninsured residents and 465,860 uninsured/underinsured visits were reimbursed. In SFY 2019, the FQHC–Uncompensated Care Fund was funded at \$34 million and, the FQHCs served a total of 122,378 uninsured residents and 341,742 uninsured/underinsured visits were reimbursed.

In September 2018, FHS was awarded a five-year HRSA grant of \$445,000/year for the Pediatric Mental Health (PMH) Care Access Program. An additional required 20% non-federal match (\$89,000) is supported by The Nicholson Foundation (TNF). This grant enhances the existing Department of Children and Families (DCF) administered statewide network of nine regional Hubs, with telehealth technology, to improve access to pediatric mental and behavioral health services. Other key partners include: Hackensack Meridian Health, the American Academy of Pediatrics-NJ Chapter, Rutgers University Behavioral Health Care and Kelley Analytics – an independent evaluator. To date, over 164,000 youth less than 18 years of age have been screened and 9,865 mental health consultations/ referrals were completed. The SFY2020 New Jersey workplan indicated that telehealth technology would be piloted at five of the nine regional Hubs that exist statewide. As result of COVID19, telehealth implementation was fast-tracked and is occurring at all nine Hubs throughout the state.

New Jersey's Title V CYSHCN program is known as Special Child Health and Early Intervention Services (SCHEIS) and includes four programs coordinated within one operational unit. The SCHEIS unit includes Newborn Screening Follow-up and Genetic Services (NSGS), the Early Identification and Monitoring (EIM) program, Family Centered Care Services (FCCS) and Early Intervention Services (EIS). Located within these programs are the Birth Defects and Autism Registry, the Early Hearing and Detection

Program, and the Ryan White Part D program. These four programs work as an integrated continuum of care for children and youth with special health care needs. The diagram below highlights some of our 2019 successes.



The NSGS Program ensures that all newborns and families affected by an abnormal screening result receive timely and appropriate follow-up services. In January 2020, legislation was enacted to add the screening of spinal muscular atrophy (SMA). SMA will be added to the NJ newborn screening panel by the end of 2020 bringing the total number of biochemical/bloodspot screening to 60 disorders for the state of New Jersey. Over 101,000 babies are screened annually, and 9,700 babies are referred to our follow-up team. Because of 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 Screening (NBS) Laboratory for these disorders during regular business hours, Saturdays, and certain State holidays to maximize timely referral to the appropriate specialists.

The Newborn Screening Follow-Up staff contact primary care providers, specialty care providers and parents to ensure timely evaluation, confirmatory testing and obtain a final diagnosis. Results received from the NBS Laboratory range from low risk to critical and are handled accordingly. The majority of the results reported are considered to be low risk (> 8,000) which involves sending letters to parents, making telephone calls to physicians and hospitals, and utilizing multiple resources to locate the baby for further testing. Time for follow-up on low risk results ranges from two to eight weeks until cases are closed. In 2019, there were approximately 1,000 results referred to our Follow-up team which required aggressive actions from staff to ensure that those babies received prompt medical intervention and treatment. As per protocol, critical cases must be reported to physicians and specialists within three hours from receipt from the NBS Laboratory, however the NSGS Follow-up team has averaged approximately 30 minutes to report. Time for follow-up on critical results ranges from one week to twelve months until cases are closed. These cases are left open longer due to the complexity of the disorders that often require multiple office visits/diagnostic tests drawn to accurately confirm diagnoses. The NSGS Follow-up team confirmed 146 cases during FY19.

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

Since 2011, New Jersey has mandated newborn pulse oximetry screening to detect Critical Congenital Heart Defects (CCHD.) Pulse Oximetry results are now captured by the New Jersey's Birth Certificate system the Vital Information Platform (VIP). The Pulse Oximetry Module collects information used to identify children at risk for CCHD, which may not be apparent at birth. NJ is the first state in the nation to integrate the CCHD screening with their birth defects registry. The Newborn Screening staff work in collaboration with the BDAR staff to educate hospitals about the screening protocol, ensure compliance with the screening mandate, and the reporting of any confirmed diagnoses. All infants with failed screens were reported by each birthing facility to the Birth Defects and Autism Registry. As this is a screening tool and not a diagnostic tool, the BDAR staff follow up to also ensure that these babies' congenital cardiac conditions have also been correctly reported. Each month EIM Program staff review information from the Pulse Oximetry Module to determine the final diagnosis of a child who failed the screening test. This review involves determining whether the child has been diagnosed with a CCHD by reviewing BDARS registrations and contacting the hospital that performed the screening. As of April 2020, NJDOH had received reports of 28 infants with previously unsuspected critical congenital heart defects detected through the screening program. As part of our quality assurance methods, the BDAR data is compared to the VIP to ensure that all babies who failed the screening are registered.

The New Jersey Early Hearing Detection and Intervention (EHDI) Program seeks to ensure that all babies born in New Jersey receive newborn hearing screening before the age of one month. In addition, NJ EHDI Program abides by the other two components of the national public health initiative "1-3-6' Guidelines"; completing diagnostic audiologic evaluation prior to three months of age for infants that do not pass their hearing screening, and early intervention enrollment by no later than six months of age for children diagnosed with hearing loss. Hospitals continue to be successful in ensuring that newborns receive hearing screening prior to hospital discharge, ensuring that children who did not pass their initial screening receive timely and appropriate follow-up remains an area for continued efforts. The New Jersey EHDI program offers technical support to hospitals on their newborn hearing screening and follow-up programs. New Jersey EHDI tracks the number of infants screened and how many children are identified with hearing loss in a timely manner. 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.

Within the EIM Program is the Birth Defects and Autism Registry (BDAR). 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 Registry has become a population-based birth defects registry of children with all defects (as of 1985); added Autism Spectrum Disorders (ASD) as reportable diagnoses (2007); expanded the mandatory reporting age for children diagnosed with birth defects to age 6; added severe hyperbilirubinemia as a reportable condition if the level is 25mg/dl or greater; and become an 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 on-line registry. Annually, we receive an average of 5,600 registration. In 2020, we will begin having non-New Jersey hospitals begin to register New Jersey-resident babies. A nurse abstractor has been contracted to register for the Children's Hospital of Philadelphia (CHOP). This will greatly improve our ability to register high-risk babies whose mother were sent to CHOP for delivery.

NJ continues to have one of the highest rates of autism in the United States. According to the Centers for Disease Control and Prevention's (CDC) 2016 prevalence figures published in the Morbidity and Mortality Weekly Report (MMWR) on March 27, 2020, cited NJ as having the highest prevalence rate of approximately one in 31.4 based on studies from four counties in NJ (Union, Hudson, Essex, and Ocean). This prevalence rate is not significantly different than the 2014 rate of 1 in 34.

The Autism Registry is the largest mandated autism registry in the country with over 39,000 children registered as of December 2019, and annually register an average of 3,200 children. 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 with 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 these influence the New Jersey prevalence rates.

Other important activities in the upcoming year are rewriting the Autism Registry rules and a redesigning of the Birth Defects and Autism Reporting System (BDARS). The new rules propose registering a child with autism within six months of diagnosis or entry into a practice for previously diagnosed children. Timely reporting ensures that children diagnosed with autism are quickly linked to Early Intervention Services and SCHS Case Management. While some families are eager to have their child's condition diagnosed so that they can move forward with treatment, some families need time to come to terms with a diagnosis. Providers are given six months to work with families so that they are less apprehensive about having their child registered and open to seeking services. The changes to the BDARS include a statewide search to reduce duplication, reduction of questions, and more checkoff lists for common comorbidities, symptoms, and behaviors. These changes will improve the accuracy of our data and improve our overall surveillance efforts.

BDARS staff continue to educate and inform physicians and health facilities about the Registry, how they can register children with autism living in NJ, and the rules regarding the Registry. Registry staff have visited and trained staff from medical centers specializing in child development, developmental evaluations, and behavioral health. Staff will continue to create reports and resources for both providers and families. Now that the registry data is sufficiently robust, the first Annual Autism Registry report has been completed and is awaiting approval for publication. This report provides the public with important statistics and information about Autism in New Jersey.

The BDARS allows staff to instantly refer all children and their families to the Special Child Health Services Case Management Units (SCHS CMUs), which are within the Family Centered Care Services Program (FCCS). NJ remains successful in linking children registered with the Birth Defects and Autism Reporting System (BDARS) with services offered through the SCHS CMUs; CECs including the Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorders (FAS/FASD) Centers; Cleft Lip/Palate Craniofacial Centers; Tertiary Care Centers; and Family WRAP. With CDC Surveillance grant funding, the system is undergoing enhancements to support tracking of CYSHCN referred to SCHS CM and monitoring of services offered and/or provided to determine client outcomes.

FCCS's intergovernmental and interagency collaboration is ongoing among federal, state, and community partners and families including, but not limited to: Social Security Administration; NJ State Departments of Children and Families, Labor, Banking and Insurance, the Boggs Center/Association of University Centers on Disabilities, NJ Council on Developmental Disabilities, and community-based organizations such as NJAAP, NJ Hospital Association, and the disability specific organizations such as the Arc of NJ, Statewide Parent Advocacy Network (SPAN), and the Community of Care Consortium for Children and Youth with Special Health Care Needs (COCC). Consultation and collaboration with NJDOH programs such as the Birth Defects and Autism Registry (BDAR), the Early Intervention System (EIS), Ryan White Part D Program (RWPD), MCH, WIC, FQHC, HIV/AIDS, STD and Tuberculosis, as well as Public Health Infrastructure Laboratories, and Emergency Preparedness affords FCCS with opportunities to communicate and partner in supporting CYSHCN and their families.

In 2019, CMU staffs continued to build upon a quality improvement (QI) initiative initially launched in 2014 to enhance consistency in documentation within individual service plans across the SCHS CMUs, and to improve upon the Case Management Referral System's (CMRS) data gathering capability. Information garnered from this initiative was anticipated to enhance NJ's efforts to improve performance on the Six Core Outcomes for CYSHCN, as well as, to promote targeted improvement in CMRS documentation in the following two areas; transition to adulthood and access to a medical home. Staff used the 2014 findings as a baseline to compare with NJ and the nation's performance as reported on the National

Survey, and comparison data has been collected annually since 2015. Results are discussed in Plan for the Application Year – National Performance Measure (NPM) #11 and NPM #12.

All 21 CMUs continue to use CMRS to track and monitor services provided to the children and their families. It electronically notifies a CMU when a child living in their county has been registered with the BDARS and referred to their unit. Included in CMRS is the ability to create and modify an Individual Service Plan (ISP), track services, 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, referral, and linkage to care. As newly referred cases are entered into the database, CMRS continues to provide the ability to trend access to care, ensures more measurable and readily tracked outcomes. Although reconfiguring data reporting tracking systems, and report development, is a challenge, our biggest challenge remains the lack of state staff vacancies for critical positions.

Many children are also referred to our New Jersey Early Intervention Services (NJEIS) NJEIS has over 5,000 practitioners providing Developmental Intervention (DI), Speech Therapy (ST), Physical Therapy (PT), and Occupational (OT.) Over 1.5 million services are provided annually. At any point in time NJEIS is serving over 15,000 children and serves over 30,000 families as children enter and leave the program at age three. Although NJEIS is not funded by MCH Block grant funds, they do manage a budget of 200 million dollars per year and are an invaluable partner in our CYSCHN program.

3.C. Needs Assessment

C.1. Needs Assessment Update

The Five-Year Needs Assessment Summary below has been completed for submission with the FY 2021 Application in July 2020. The NJ Title V Program, housed in the Division of Family Health Services, has prepared this Five Year Needs Assessment Summary that identifies findings and needs concerning preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for children and youth with special health care needs (CYSHCN).

The Organizational Structure of the NJ Department of Health and the Division of Family Health Services (FHS), the NJ Title V agency, remains unchanged. Lisa Asare MPH was appointed the Assistant Commissioner for FHS in 2016. Dr. Marilyn Gorney-Daley was appointed the Director of MCH Services for FHS in April 2017. Dr. Sandra Howell was appointed the Director of Special Child and Early Intervention Services in June 2018. The Agency Capacity of FHS remains unchanged with the continuation of all major federal grants. Efforts continues toward Workforce Development and Capacity.

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

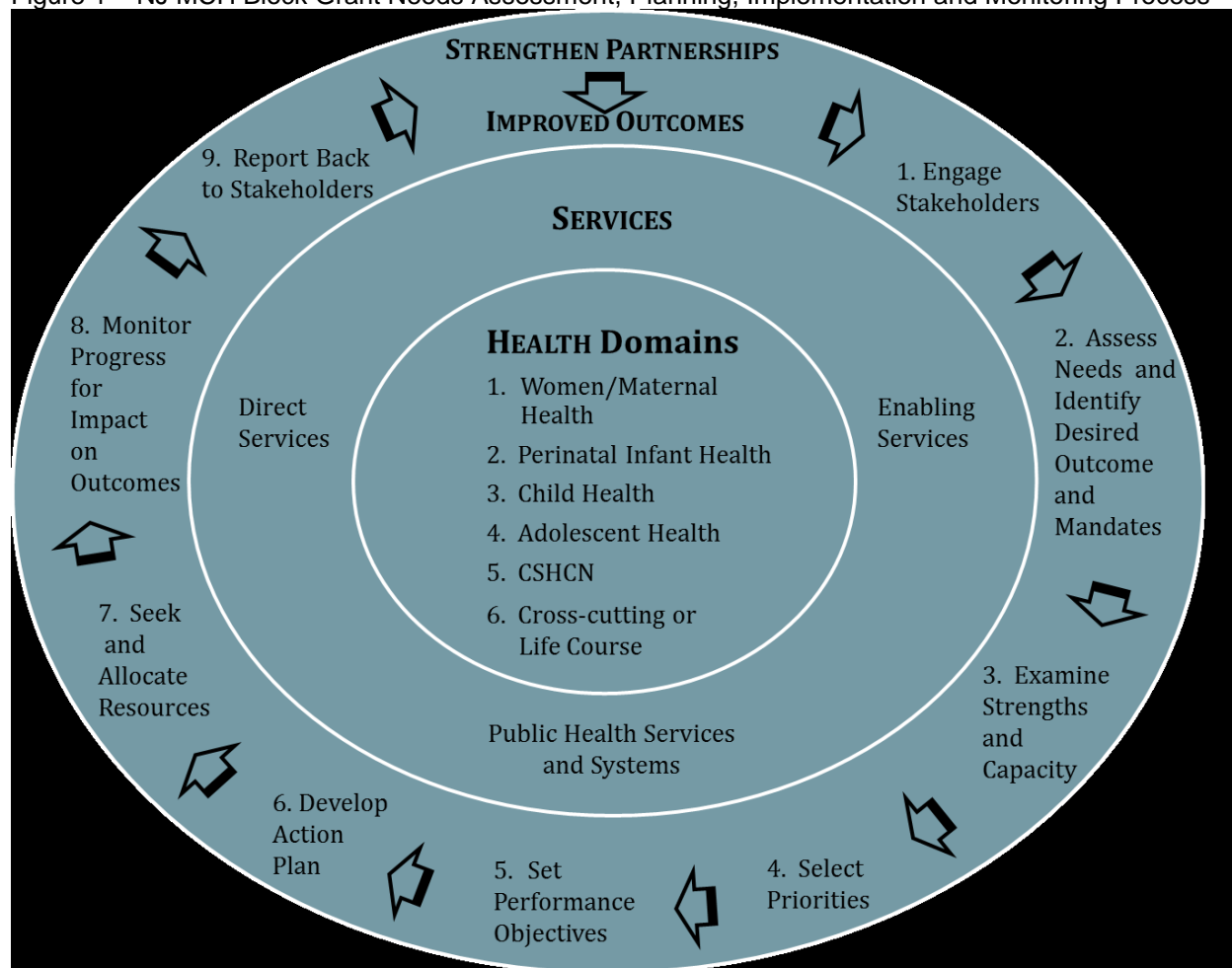
This year the COVID-19 public health emergency has added a heightened examination of the needs for the MCH population which are further described in the below Needs Assessment Summary and in the Emerging Issues section. COVID-19 is an unprecedented public health threat that continues to rapidly evolve.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

III.C.2. Five-Year Needs Assessment Summary

III.C.2.a. Process Description

The New Jersey Title V program, the Division of Family Health Services (FHS), has prepared the following Five-Year Needs Assessment Summary according to Title V guidelines. The completion of a comprehensive needs assessment for the Maternal and Child Health (MCH) population groups is a continual process that the FHS performs in collaboration with families, providers, many other organizations and partners. The needs assessment process is consistent with the conceptual framework in Figure 1: NJ MCH Block Grant Needs Assessment, Planning, Implementation and Monitoring Process (below) and in the HRSA guidance. The ultimate goals of the needs assessment process are to strengthen partnerships and collaboration efforts within FHS, the New Jersey Department of Health (NJDOH), the MCH Bureau, and other agencies and organizations involved with MCH and to improve outcomes for the MCH populations.

Figure 1 – NJ MCH Block Grant Needs Assessment, Planning, Implementation and Monitoring Process



The starting point (**Stage 1**) of the needs assessment process, as depicted in Figure 1, is to engage stakeholders. Coalitions involving stakeholders help FHS in the needs assessment process by identifying desired outcomes, assessing strengths, examining capacity, selecting priorities, seeking resources, setting performance objectives, developing action plans, allocating resources, and monitoring progress for impact on outcomes.

FHS has a long history of engaging stakeholders and strengthening partnerships to improve preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for children and youth with special health care needs (CYSHCN). Table 1f - MCH Organizational Relationships with Partnerships, Collaboration, and Cross-Program Coordination in Attachment 1: Supporting documents includes a list of stakeholders.

Maternal and Child Health Services (MCHS) has engaged stakeholders and strengthened partnerships to maintain a regional system of MCH services and programs in several priority areas. A system of regional MCH services and programs has been developed in New Jersey, which is provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities.

NJDOH designated the MCH Consortia through the Certificate of Need Process in 1993. Regulations are in effect, which govern them as Central Service Agencies with identified responsibilities for families in

their regions. Goals of the MCHC include reducing morbidity and mortality among women and children and improving birth outcomes.

The NJ DOH and FHS has a long history of partnerships and collaboration to improve maternal and child health which has led to the creation of infrastructure and the development of a system of early child care. FHS partners with organizations at the national, state, regional, county, and local community levels. FHS partners with professional groups, advocacy groups, provider groups and families. FHS partnerships address individual issues, issues of age groups, issues of larger groups and issues of communities.

An example of partnerships to address a specific MCH priority involve NJs efforts to reduce infant mortality. The NJ DOH has supported several taskforces and reports over the years to address the black infant mortality issue. The regional MCH Consortia have evolved to address the issues on a local community level and to implement evidence-based interventions. FHS has funded several infant mortality reduction initiatives including: Health Start, the Healthy Mothers, Healthy Families Coalitions, Access to Prenatal Care Initiative, Improving Pregnancy Outcomes and most recently the Healthy Women, Healthy Families Initiative.

The Healthy Women, Healthy Families (HWHF) Initiative is focused on working to help community-based programs improve services and provide quality access to perinatal care to reduce disparities in birth outcomes. HWHF partners from the Departments of Labor and Workforce Development, Education, Transportation, Children and Families, Human Services, the Office of the Attorney General and the community strategically collaborate to reduce black infant mortality.

Nurture NJ is the First Lady of NJ's statewide awareness campaign that 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. Nurture NJ is focused on improving partnerships and collaboration between departments, agencies, and stakeholders to achieve its goal of making New Jersey the safest place in the country to give birth and raise a baby. In collaboration with other state agencies, including DOH FHS, The Nurture NJ strategic planning team is working to develop a comprehensive, actionable plan focused on equity and improved outcomes overall.

Another inter-Departmental initiative promoting the Life Course Perspective and augmenting our efforts to reduce infant mortality, pre-term births and maternal morbidity and mortality is the Maternal and Infant Early Child Home Visiting (MIECHV) Program which has expanded Home Visiting (HV) across all 21 NJ counties with 5,805 families participating in HV during SFY 2018. 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.

Stakeholder engagement, strong partnerships and program funding have been developed in the following State Priority areas (see Table 1f - MCH Organizational Relationships with Partnerships, Collaboration, and Cross-Program Coordination in Attachment 1 for listed partnerships covering all 6 Health Domains and all 3 MCH Population groups by the following priority areas) :

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

Special Child Health and Early Intervention Services (SCHEIS) has made many strides working closely with its partners in early identification, pediatric specialty care, and case management, towards engaging stakeholders and strengthening partnerships to build and maintain a statewide system of access to care. In addition, for over 30 years, DOH has formed a strong partnership with the Statewide Parent Advocacy Network (SPAN), home to NJ Family Voices (FV), that has been a model for promoting family-professional partnerships and family involvement in policymaking at all levels. More recently, DOH and

its partners, in particular the NJ Chapter of the American Academy of Pediatrics (NJ AAP), have started to build momentum around medical home implementation and transitioning CYSHCN. Through the Newborn Screening Annual Review Committee (NSARC), first convened in 2005, the SCHEIS has partnered with many stakeholders including parents, primary care physicians, specialty care physicians, nurses, allied health professionals, attorneys, scientists, as well as health insurance companies and hospital representatives in ongoing reviews of New Jersey's newborn biochemical screening policies and activities.

However, despite many changes and partnership improvements in the development of engaging families and stakeholders, there is data from families and providers indicating that improvements in the system still can be made.

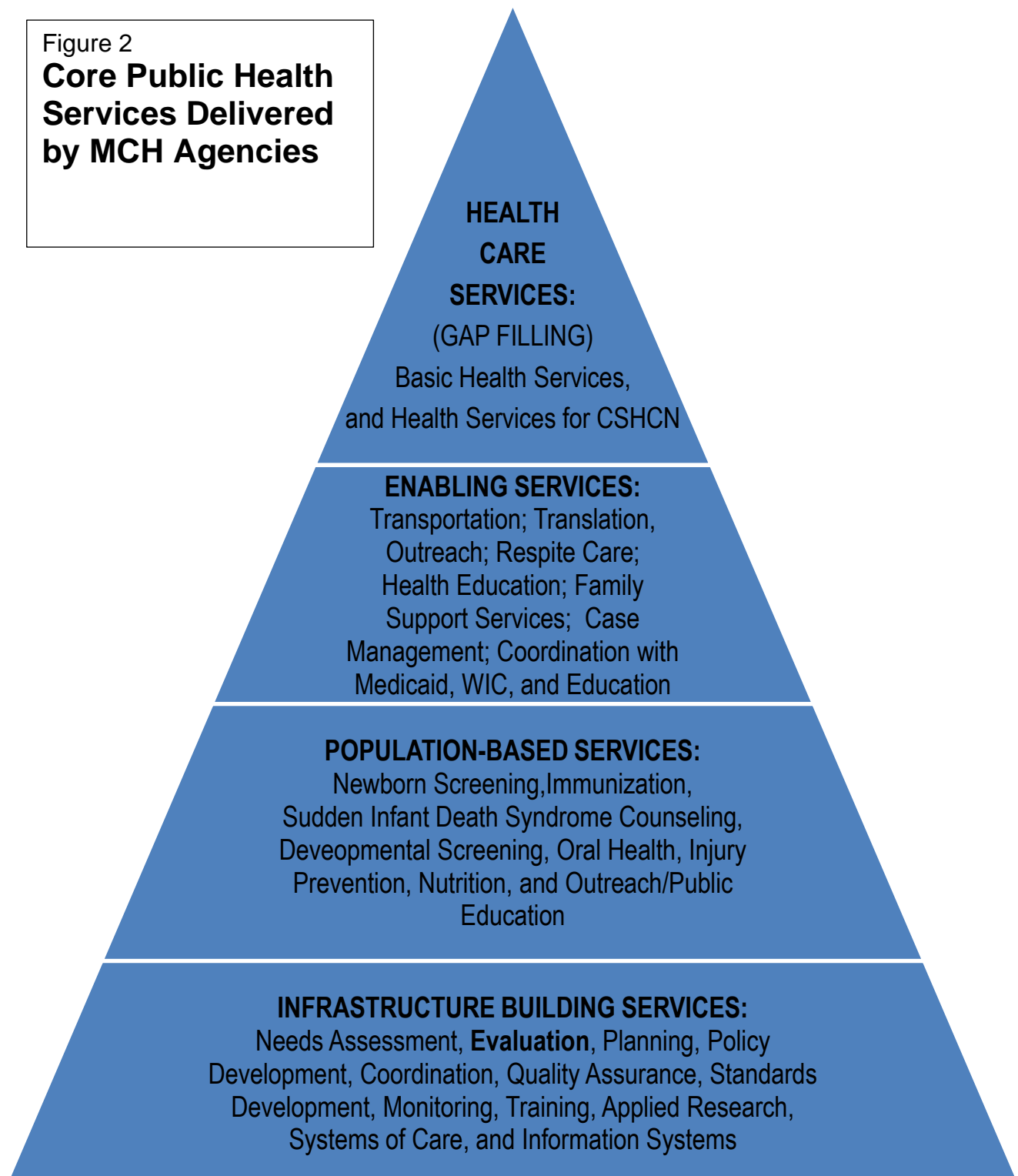
The **second** stage in the process (2. Assess Needs and Identify Desired Outcomes and Mandates) is to identify the community/system needs and desired outcomes by specific MCH population group and to identify legislative, political, community-driven, financial, or other internal and external mandates that are required.

Multiple processes contribute to the overall MCH Title V Block Grants needs assessment process including the NJ DOH planning and budget process, regional and county needs assessments, grant-driven needs assessments, surveys and public comment on the MCH Block Grant, and strategic plans completed by other state departments and organizations. Needs Assessments that focus on MCH topics such as maternal health and birth outcomes include: the Healthy New Jersey 2030 ([HNJ2030](#)) process, State Health Improvement Plan ([SHIP](#)) process, the [NJ State Health Assessment](#) process, the NJDOH budget process, Departmental strategic planning, the [Public Health accreditation process](#), the [NJ Preventive Health and Health Services Block Grant](#), Community Health Needs Assessments ([CHNAs](#)) and Community Health Improvement Plans ([CHIPs](#)), grant-driven needs assessments ([MIECHV](#), [MMRC](#), [SMHIP](#), [PREP](#)), public comment on the [MCH Block Grant Application](#), and the collaborative process with other MCH partners. In the past year, the state legislature, Governor's Office and the First Lady's Office have focused significant attention on maternal child health issues. The First Lady's office has created the [Nurture NJ](#) Initiative with the goal of making NJ the safest place to deliver a newborn.

Community and systems needs were informed by prior needs assessment from other State Departments and organizations which serve children and families including: DHS, DCF, DOE (Head Start), the Maternal Infant and Early Childhood Home Visiting Program (MIECHV), Advocates for Children of New Jersey (Pritzker Children's Initiative), and the Preschool Development Grant Birth – 3 (PDG). Recent legislative priorities including several statutory mandates have identified the desired need to improve birth and maternal outcomes. The numerous laws adopted by the New Jersey Legislature and enacted by the Office of the Governor in 2018 and 2019 are listed later in this Needs Assessment Summary. Nearly a dozen additional maternal health focused bills remain under consideration, reflecting a legislative focus on maternal mortality and morbidity.

The **third** stage (3. Examine Strengths and Capacity) in the process is examining strengths and capacity. This stage involves examining the State's capacity to engage in various activities, including conducting the 5-year Needs Assessment and collecting annual performance data, and to provide services by each pyramid level. The pyramid, Figure 2 Core Public Health Services Delivered by MCH Agencies, appears on page 22 (below). The assessment the strengths and needs of each of the MCH populations: (1) pregnant women, mothers, and infants, (2) children, and (3) children with special health care needs are summarized in Table 1c of Attachment #01.

Figure 2
**Core Public Health
Services Delivered
by MCH Agencies**



The **fourth** stage in the process is selecting priorities (4. Select Priorities). FHS examines the needs identified and matches those needs to desired outcomes, required mandates, and level of existing capacity. The process of selecting priorities is also guided by the departmental strategic planning process, grant funding opportunities, Governor priorities, legislative mandates, budget process, survey results and public input into the MCH Title V Block Grant. Based on the results of this process, NJDOH then selects its most important, or highest priority, MCH strengths and needs to receive targeted efforts for improvement and/or continuation of progress.

The selection of New Jersey's priority needs is a product of FHS's continuous needs assessment. Influenced by the departmental budget process, the MCH Block Grant's needs assessment process and the collaborative process with other MCH partners, FHS has selected the eight priorities listed below and in Section IV.B.

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

Some of these priorities have been longstanding priorities (SPN #3 Decreasing Black Infant Mortality, SPN #6 Decreasing Teen Pregnancy, SPN #7 Improving and Integrating Information Systems, and SPN #5 Improving Access to Quality Care for CSHCN). Others are priorities that broadly address several areas or population groups (SPN #1 Increasing Healthy Births, SPN #4 Promoting Youth Development Programs, and SPN #8 Smoking Prevention). The selected SPN reflect ongoing and new statewide public health initiatives. SPN #1 has been a recent focus of several new initiatives including the Healthy Women, Healthy Families Initiative, the MIEC Home Visiting Program, Nurture NJ, the Maternal Mortality Review Committee, and the State Maternal Health Innovation Program.

Based on NJ's eight selected SPNs as identified in the Five-Year Needs Assessment, NJ has selected the nine of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period which are described in the Findings Section on page 23 and in Table 1 - New Jersey Five-Year Needs Assessment Framework Logic Model on page 49.

The **fifth** stage (5. Set Performance Objectives) is the identification of State selected national Performance Measures and Performance Measure targets and is summarized in Table 1 - New Jersey Five-Year Needs Assessment Framework Logic Model on page 49.

Setting performance objectives consisted of two phases. In the first phase, action strategies to address their identified priority needs were developed. National Performance Measures (NPMs), Evidence-based Strategy Measures (ESMs) for addressing each of the selected NPMs and State Performance Measures (SPMs) were selected based on the priority needs and program strategies. SPMs were based on the state's identified MCH priorities that are not fully addressed by the selected NPMs and their related ESMs.

In the second phase of the fifth stage, five-year targets (i.e., performance objectives) were set for the selected NPMs, the ESMs and the SPMs. The anticipated results of this stage are the identification of NOMs, NPMs, ESMs and SPMs that directly relate to the state priorities and establish a level of accountability for achieving measurable progress.

The **sixth** stage (6. Develop an Action Plan) is to develop an action plan, which includes identifying activities to address priority strengths and needs at the four pyramid levels: direct health care services, enabling services, population-based services, and infrastructure building services. This is an on-going process involving several workgroups and Action Plans (Strategic Plans, Needs Assessments) and is described in Section 3 of the full NJ MCH Title V Block Grant Needs Assessment and annually updated in

the MCH Block Grant Annual Application/Report. Sometimes Action Plans start as workplans in grant applications or are developed by initiative in other organizations (NJ DOH Strategic Plan, Nurture NJ, MIECHV Needs Assessments, MMRC Grant).

Divisional and departmental strategic planning also contributes to the needs assessment process and the development of action plans. The development of strategic plans is an internal process to identify priority needs, establish performance measures, set targets and develop detailed plans. The DOH Strategic Plan including goals, objectives (key performance indicators) and strategies is completed on a bi-annual basis. Many of the Healthy People 2030 objectives and the MCH Block Grant national and state performance measures are included in both the departmental and divisional plans. Strategic plans that are specific to targeted areas have also been developed and assist the Division in setting priorities. Targeted plans include those developed for HWHF, MIECHV and The State Maternal Health Innovation Grant.

The development of Healthy New Jersey 2030, the New Jersey state equivalent of Healthy People 2030, is a major departmental planning and needs assessment process that incorporates the MCH population. Representation included the Departments of Health, Environmental Protection, Human Services, Education, Children and Families, and Law and Public Safety. The document identifies approximately 140 key indicators of the health status of New Jersey's residents, along with ambitious year 2030 targets for improvements. One of the overarching goals for public health improvement is the elimination of health disparities. Public input was received through comments on a disseminated draft document and public hearings held in three sections of the State. An electronic copy of Healthy New Jersey 2020 Update is available at <https://nj.gov/health/chs/hnj2020/about/intro/>. An important role of Healthy New Jersey 2030 is the objective monitoring and targeting of key health status indicators, very similar to the target setting of the MCH block grant performance measures, outcome measures, and health system capacity indicators.

At the regional level the [MCH Consortia](#) conduct planning and needs assessment to promote a coordinated prevention-oriented approach to MCH services. Their regional plans due every 3 years must address pediatric morbidity and mortality, risk-appropriate prenatal care, low birth weight, and teen births. The social, cultural, economic and demographic factors influencing the perinatal and pediatric needs of their communities must also be described. These plans serve as a guide for the MCH Consortium and its members in the development, coordination and evaluation of services for pregnant women, infants, children, and adolescents in the communities they serve. All of the MCH Consortia develop an annual reports for distribution within their regions for program planning.

The **seventh** stage in the process (7. Seek and Allocate Resources) is focused on the funding of planned activities to address state priorities. Inputs include the five-year State Action Plan, current budgets, political priorities, and partnerships. The anticipated outcome is the development of a program budget and plan that directs available resources towards the activities identified in Stage Six as the most important for addressing the state's priorities. The funding of planned activities depends on the selected priorities and existing resources identified and may involve the identification of additional resources, funds, or authority from the State legislature or funding agencies in order to address priority areas.

The **eighth** stage (8. Allocate Resources) is the development of a budget that directs available resources towards activities that have been identified in Stage Seven as most important for addressing the State's priorities. The annual State budget process includes several steps that are very similar to the stages and functions to the MCH Block Grant needs assessment. In preparation for the annual State budget hearings where the Department's budget priorities are presented to the Governor and legislature, FHS reviews and summarizes programmatic activities, service capacity, budgets, key performance indicators and emerging issues. Activities, budgets and priorities are justified in terms of standard health indicators, key performance indicators and program evaluation data. This annual several month process takes place at the program level, the division level, then the department level, and finally is presented to the Governor and in turn the legislature. The annual State budget process overlaps with the MCH needs assessment process beginning in November and ending in May.

The grant awarding, renewal and monitoring processes continually assess local needs that are specific to geographic areas. FHS funds numerous grantees involved with MCH programs on a regional or local level. The selection process includes a review of local identified need. Renewal and monitoring of grantees is based on measurable outcomes that are designed to address identified needs. Many of the

agencies that are awarded health services grants by FHS use the MCH Block Grant performance measures or Healthy People 2030 objectives as their outcome measures. Examples of local grants include the Healthy Women, Healthy Families Initiative and the Personal Responsibility Education Program (PREP) grants.

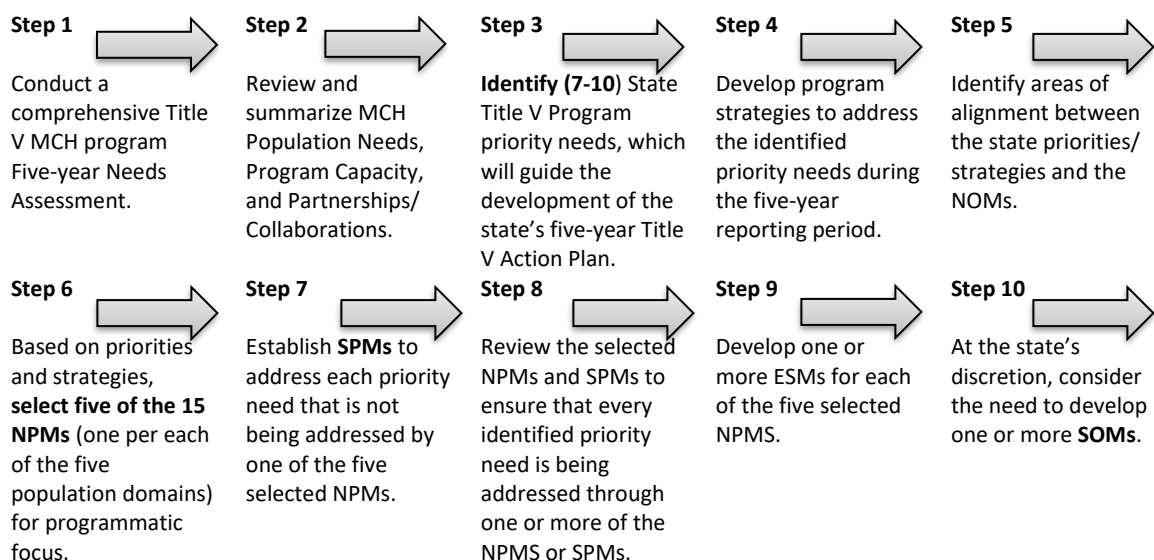
The **eighth** stage (8. Monitoring Progress for Impact on Outcomes) examines the results of NJDOH's efforts to see if there has been improvement in State Performance Measures, National Performance Measures, Outcome Measures, Evidence-Based Strategies, performance objectives, and other quantitative and qualitative information.

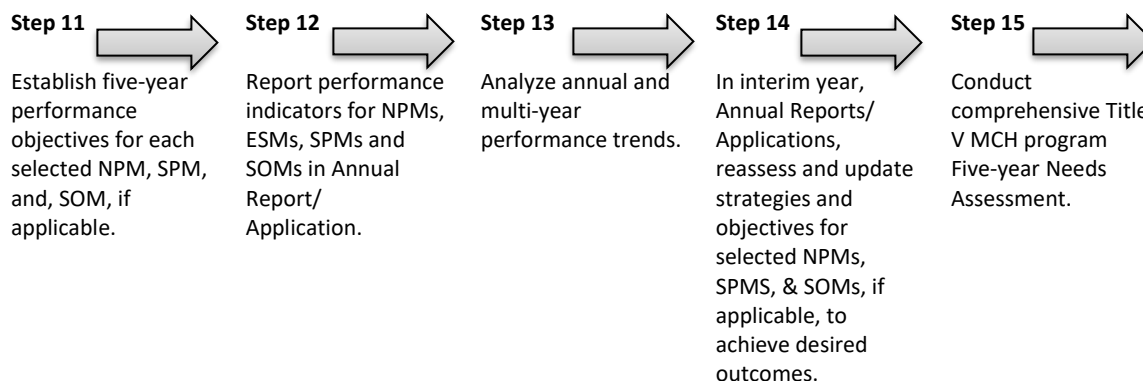
The quantitative surveillance and analysis of MCH data by FHS programs and the MCH Epidemiology Program provides continuous input into the assessing needs and the monitoring progress for impact on outcomes stage of the needs assessment. The MCH Epidemiology Program produces standardized MCH health indicator reports for FHS, for the MCH Consortia, and for other public health related organizations by special request. The MCH Epidemiology Program works with the Vital Statistics Program, the Center for Health Statistics, other departments in NJDOH, and the MCH Consortia Data/TQI Workgroup to support data needs for regional planning. The MCH Epidemiology Program also conducts applied research projects which currently focus on issues related to breastfeeding, smoking and pregnancy, pregnancy intention, maternal mental health, and maternal morbidity.

The **ninth** stage (9. Report Back to Stakeholders) assures accountability to the stakeholders and partners who have worked with the MCH staff throughout the year and the Needs Assessment process. Public comment on regulations and publications is an ongoing process of needs assessment and input from both public and private constituents. Rules implementing laws sunset every five years, and therefore, programs must readopt rules every five years. Proposed rules are published in the New Jersey Registry (NJR) with a 60-day open comment period. Responses to all public comment must be published, along with possible changes to the proposal before adoption of the rules (also published in the NJR). Public comment on the development of the MCH Block Grant application is also encouraged through a public hearing on the MCH Block grant held annually in May. A draft of the narrative is posted to the Department's website four weeks prior to the public hearing.

The NJ MCH Title V Block Grant Needs Assessment process is also consistent with the MCH Block Grant Logic Model in Figure 4 below which depicts how NJ's priority needs "drive" the development of a five-year program plan that is responsive to the needs identified and is performance driven.

Figure 4. MCH Block Grant Logic Model (*need better diagram with arrows*)





The current methods and procedures for the comprehensive needs assessment have both strengths and weaknesses. The evolution of the MCH Block Grant to include standardized performance measures, outcome measures, and Evidence-Based Strategies has added structure and accountability to the needs assessment process. Each year the state is able to build and add detail to prior needs assessment efforts. Utilizing the departmental budget process is also an efficient use of time and effort. One strength that may be unique to New Jersey is the role the MCH Consortia play in contributing valuable information to the Title V comprehensive needs assessment.

A general weakness or challenge of the needs assessment process is recording the breadth and diversity of activities that could be included under a comprehensive needs assessment. New Jersey's Title V activities intersect with numerous other federal and state programs, making it difficult to identify what most appropriately falls under the Title V needs assessment and what does not. Many activities that come to the attention of FHS staff are relevant to the MCH populations but may not be specifically administered or "formally" linked with Title V programs. Additionally, not all activities at the state, regional or local level are recognized as having relevance to the Title V needs assessment. There are numerous activities that other public or private organizations are involved with that affect the public health of MCH populations that are carried out without FHS involvement. Family and parent involvement in the needs assessment process occurring at the program and grantee level is not adequately captured in the overall process. Limitations in the scope of influence and accountability of FHS, limitations of staff, and limitations of funding must be recognized. However, we believe that the major activities and priorities effecting MCH services are being addressed.

The goals and vision that guide the Needs Assessment originate from the mission statement of the Division of Family Health Services (FHS). Leadership for directing and completing a comprehensive needs assessment is provided by the Assistant Commissioner of FHS, Service Directors in FHS, and the Program Managers in FHS. The overall needs assessment methodology is similar for each of the three population groups - preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children; and services for children with special health care needs. Though many of the functions occur simultaneously the sequential process is described below and in Figure 1. This is a continuous and on-going process throughout the year.

Table 1a - Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model (see page 49 and Supporting Document #1) summarizes the selected nine national Performance Measures (NPMs) and aligns the impact of Evidence-Based Informed Strategy Measures (ESMs) on NPMs and National Outcome Measures (NOMs). The purpose of the ESMs is to identify state Title V program efforts which can contribute to improved performance relative to the selected NPMs. The Logic Model is organized with one NPM per row. The Logic Model is the key representation which summarizes the Five-Year Needs Assessment process and includes the three-tiered performance measurement system with Evidence-Based or Informed Strategy Measures (ESM), National Performance Measures (NPM), and National Outcome Measures (NOMs). The Logic Model represents a more integrated system created by the three-tiered performance measure framework which ties the ESMs to the NPMs which in turn influence the NOMs.

This year the COVID-19 public health emergency has added a heightened examination of the needs for the MCH population. Necessary restrictions to promote social distancing have dramatically impacted NJ DOH staffing and staffing at grantee agencies. The workforces of NJ DOH and grantee agencies have been forced a shift to work remotely from home in order to comply with state social distancing requirements. Daily work practices and operations are now and for the near future being conducted remotely from home outside the work office. Essential and critical work functions are being met due to the flexibility and creativity of staff. Title V staff are maintaining weekly communications with grantees and partners to monitor program administration and service provisions in this new virtual environment. “Town Halls” where Title V staff hold virtual meetings for grantees and other partners are scheduled on a monthly basis. Ongoing needs are being assessed to assess what changes can be made to meet the needs of the MCH populations as well as to help ensure resiliency for the future. Ongoing communications are occurring with Medicaid regarding telehealth reimbursements.

Staffing at DOH and MCH Title V grantee agencies are also adjusting to working remotely from home as well as changing their meeting and collaborating workflow processes to conform to social distancing requirements. NJ DOH is adapting the way it provides the four types of services (Direct Health Care Services, Enabling Services, Population-Based Services, and Infrastructure Building Services) illustrated in the Figure 2 – Core Public Health Services Delivered by MCH Agencies (Pyramid Diagram) on page 22. The DOH does not use Title V MCH funding to provide Direct Health Care Services. The provision of Enabling Services such as outreach, health education, family support and case management have all shifted to virtual services which are not conducted face-to-face unless absolutely necessary. Increased use of telecommunication tools have facilitated the shift with new development of protocols and practices to meet the needs of the programs. Population-Based Services are continuing as prior to the COVID-10 pandemic with changings in communications to the public to assure follow-up and ongoing outreach. The DOH has added multiple new communication channels to keep the public and MCH professionals informed of COVID-19 issues and changes to MCH Services including the NJ DOH COVID-19 website, the NJ Parent Link COVID-19 website, and town hall forums held with program constituents. Despite the disruption created by the COVID-19 crisis, the Infrastructure Building Services of DOH are continuing and have adapted to being conducted remotely.

Many of the Title V grantees are small community-based service organizations whose staffing and financial stability will be adverse impacted by the ongoing COVID-19 pandemic. The uncertainty of federal, state and local private funding sources will challenge the sustainability of many grantees. Telecommunication tools are being adapted to provide Title V services to families such as family support services, health education and care coordination by Community Health Workers, Home Visitors and SCHEIS case managers.

Families have been dramatically impacted by the COVID-19 crises and challenged by the restrictions of social distancing reducing access to MCH funded as well as other needed services. People are advised to leave home only to access essential services. Many have lost their jobs. Schools and child care centers are closed. Social distancing influences every aspect of family life, leading to significant changes in how MCH Title V programs can work with families. While MCH BG funded support services are being provided remotely, families are being challenged to navigate changes to services and access available services and support through remote telecommunications. Health inequities will only be made worse by the disparities the COVID-19 epidemic will aggravate on job opportunities, food security, housing, transportation and mental health services. In essence, COVID-19 has exacerbated many of the challenges and SDOH issues faced by our most vulnerable populations, including pregnant women, new moms, children, including those with special health care needs, and families.

Given the mission of FHS - to improve the health and well-being of NJ's mothers, children, and families - FHS programs funded by MCHB, including Title V Maternal and Child Health Block Grant have an important role to play in delivering critical services and assisting local communities to meet the unique needs of maternal and child health populations in these uncertain times.*(from HRSA website)*

During this evolving public health emergency, NJ [Title V programs](#) are poised to provide infrastructural and leadership support to improve the health of mothers, children, and families. One of the strengths of

the Title V program is its role in conducting ongoing assessment of maternal and child health (MCH) population needs and in implementing science-based approaches to address current and emerging issues.

Title V MCH Block Grant funds allow states to redirect these funds to support a state's needs in responding to an evolving issue, such as COVID-19. Ongoing responses include:

- Offering the support or leadership of Title V epidemiologists, in partnership with other state staff, to an outbreak investigation.
- Providing support in educating the MCH population about COVID-19 through partnerships with other state agencies, medical providers, and health care organizations.
- Working closely with state and local emergency preparedness staff to assure that the needs of the MCH population are represented.
- Funding infrastructure that supports the response to COVID-19. (*CI Hubs, HWHF...*)
- Partnering with parent networks and health care providers to provide accurate and reliable information to all families.
- Engaging community leaders, including faith-based leaders, to educate community members about strategies for preventing illness.
- Providing virtual programs and education to grantees and partners offering guidance and resources in the COVID-19 environment.
- Delivering virtual visits through telehealth and collaborating with the Division of Human Services/Medicaid concerning reimbursement issues.

III.C.2.b. Findings

The selection of the New Jersey's eight State Priority Needs (SPNs) is a product of FHS's continuous needs assessment. Multiple processes contribute to the overall needs assessment process including: the MCH Block Grants needs assessment process, the Healthy New Jersey 2030 ([HNJ2030](#)) process, State Health Improvement Plan ([SHIP](#)) process, the [NJ State Health Assessment](#) process, the NJDOH budget process, Departmental strategic planning, the [Public Health accreditation process](#), the [NJ Preventive Health and Health Services Block Grant](#), Community Health Needs Assessments ([CHNAs](#)) and Community Health Improvement Plans ([CHIPs](#)), grant-driven needs assessments ([MIECHV](#), [MMRC](#), [SMHIP](#), [PREP](#)), public comment on the [MCH Block Grant Application](#), and the collaborative process with other MCH partners. In the past year, the state legislature, Governor's Office and the First Lady's Office have focused significant attention on maternal child health issues. The First Lady's office has created the [Nurture NJ](#) Initiative with the goal of making NJ the safest place to deliver a newborn.

At the NJ DOH level, the Healthy New Jersey 2030 ([HNJ2030](#)) planning process is the foundation for New Jersey's State Health Improvement Plan ([SHIP](#)) and a department-wide public health needs assessment. The HNJ2030 and SHIP plans are action plans that use data from the State Health Assessment (SHA) to build a set of priority areas and cross-cutting goals for improving the health of all New Jersey residents.

The State Health Improvement Plan ([SHIP](#)) identified Birth Outcomes as a priority health issue to be addressed by the NJ DOH, sister agencies, community-based stakeholders, and local public health agencies. The SHIP with its focus on health equity has identified several policy related strategies to improve birth outcomes including:

- The creation of the NJ Maternal Care Quality Collaborative (NJMCQC) to ensure universal, equitable, high quality care in NJ's health systems,
- The development of the New Jersey Maternal Mortality and Morbidity Blueprint 2019–2022 to be the health strategy to improve maternal outcomes as part of a broader statewide strategic plan

- The enhancement of the New Jersey Maternal Mortality Review Committee (NJMMRC) to ensuring that pregnancy-associated deaths are correctly categorized and that useful and actionable quality improvement recommendations can be generated.
- The creation of the NJDOH Maternal Data Center (MDC) to publish key maternal healthcare indicators for quality improvement at birthing hospitals.
- The funding of the Healthy Women Healthy Families Initiative to improve birth outcomes statewide by promoting linkages to community-based services and resources and Community Health Workers through Central Intake Hubs and supportive case management.

FHS and the newly formed NJ DOH Office of Population Health have successfully applied for several federal grants focused on maternal mortality and morbidity including the Maternal Mortality Review Committee Grant from the CDC and the State Maternal Health Innovation Program Grant from HRSA to fund the strategies of the State Health Improvement Plan (SHIP).

FHS developed a MCH Block Grant Discovery Survey to inform the needs assessment process which was completed during February 2020 by 391 respondents. The survey tool included questions asking: “What is the most important thing families need to live their fullest lives?” and “What are the biggest unmet needs of families in your community?” The tabulated results of the survey and the demographics of the survey respondents are included in the full MCH Block Grant Needs Assessment Report. The most common themes (and percent of respondents) on the unmet needs of families include:

- Health- access, availability, quality, mental health, pediatric health, unbiased/respectful, etc. (23.3%),
- Housing - safe/affordable/lead-free/recreational facilities (23.0%), and
- Resources/programs/services - knowledge, accessibility, linguistic/cultural competence, training/education for parents, for teens and youth, etc. (18.4%).

Recent legislative priorities have included many statutory mandates to improve maternal outcomes. The following laws were adopted by the New Jersey Legislature and enacted by the Office of the Governor in 2018 and 2019. Nearly a dozen additional maternal health-focused bills remain under consideration, reflecting the whole-of-government focus on maternal mortality and morbidity.

- [P.L.2018, c.82](#) - NJDOH to develop an annual New Jersey Report Card of Hospital Maternity Care. The report is required to include rates of cesarean births, infection, laceration, hemorrhage, and severe maternal morbidity for all birthing hospitals.
- [P.L.2019, c.75](#) – Creation of the New Jersey Maternal Data Center, New Jersey Maternal Mortality Review Committee, and New Jersey Maternal Care Quality Collaborative.
- [AR2019](#) – Encourages NJDOH to develop a set of standards for respectful care at birth and to conduct public outreach initiatives.
- [P.L.2019, c.85](#) - Provides Medicaid coverage for doula care.
- [P.L.2019, c.86](#) - Establishes perinatal episode of care pilot program in Medicaid.
- [P.L.2019, c.87](#) - Prohibits health benefits coverage for certain non-medically indicated early elective deliveries under Medicaid program, State Health Benefits Plan, and School Employee Health Benefits Plan.
- [P.L.2019, c.88](#) - Codifies current practice regarding completion of Perinatal Risk Assessment form by certain Medicaid health care providers.
- [P.L.2019, c.133](#) - Establishes pilot program to evaluate shared decision-making tool used by hospitals providing maternity services, and by birthing centers.

First Lady Tammy Murphy and the Governor’s Office identified reducing infant and maternal mortality and morbidity and ensuring equitable maternal and infant care among women and children of all races and ethnicities as state priorities. The Office of the First Lady created a campaign, Nurture NJ, which includes a multi-pronged, multi-agency approach to improve maternal and infant health among New Jersey women and children. Launched on Maternal Health Awareness Day January 23, 2019, Nurture NJ focuses on

improving collaboration and programming between departments, agencies, and stakeholders to achieve its goal of making New Jersey the safest place in the country to give birth and raise a baby. The initiatives include an annual Black Maternal and Infant Health Leadership Summit; the First Lady's Family Festival event series; quarterly interdepartmental maternal and infant health meetings; and a comprehensive, statewide strategic plan to reduce maternal mortality by 50% over five years and eliminate racial disparities in birth outcomes.

On Maternal Health Awareness Day January 23, 2020, First Lady Tammy Murphy announced a partnership between the Murphy Administration, the Nicholson Foundation, and the Community Health Acceleration Partnership to develop a comprehensive, statewide maternal and infant health [strategic plan](#). The maternal and infant health strategic plan will aim to reduce NJ's maternal mortality rate by fifty percent and eliminate racial disparities in birth outcomes.

The strategic plan will include a statewide assessment of existing infrastructure to support improvements in maternal and infant health which will support the MCH Block Grant Title V Needs Assessment process. The strategic plan will examine community investments, clinical and social factors, private sector engagement, and policy development. Work on the strategic plan will be further informed by talking directly to women across the state; interviewing and engaging the Administration's 18 collaborating agencies; working with leading state health providers; and talking to a range of community-based organizations. In parallel, the strategic plan will incorporate national best practices for improving maternal and infant health and eliminating disparities, in order to identify areas where state activities could better align with scientific evidence. To set up Nurture NJ for long-term success, the comprehensive plan will include specific, actionable recommendations for all stakeholders, and a concrete implementation plan for ensuring equity for mothers, babies, and their families. The release of the strategic plan is scheduled for Summer 2020.

Needs assessments conducted by organizations outside the NJ DOH have also identified MCH priorities and strategies that have informed the MCH Block Grant Title V Needs Assessment process.

The Robert Wood Johnson Foundation along with the Rutgers, The State University of New Jersey, Center for State Health Policy produced a report, [Building a Culture of Health: A Policy Roadmap to Help All New Jerseyans Live Their Healthiest Lives](#), in April 2019 informed by extensive research and months of conversations with nearly 300 community residents, nonprofit and business leaders, and others from across the state. The report identifies priorities for building a Culture of Health in New Jersey in three areas including healthy children and families and focusing on improve maternal and infant health outcomes by enhancing care, supports, and prevention. Creating health equity through public policies in education, housing, nutrition, income, and health care is the focus of this new report, which recommends a comprehensive series of actions that will help to close health gaps, broaden opportunity, and ensure that everyone in New Jersey—no matter who they are, where they live, or how much money they make—can live the healthiest life possible. Recommendations include providing high-quality early education for all 3- and 4-year-olds; helping everyone fully benefit from the recently expanded paid family leave benefit; creating and preserving affordable homes; and integrating mental health, addiction, and physical health services for Medicaid enrollees.

The Advocates for Children of New Jersey (ACNJ) also identified the need to address birth outcomes and convened a unique partnership of leaders from government agencies, community-based organizations and advocacy groups to develop a plan and a vision of making New Jersey the safest, healthiest and most supportive place to give birth and raise a family. Funding from the Pritzker Children's Initiative planning grant supported a 6-month planning process to develop an action plan to ensure that an additional 25 percent of low-income infants and toddlers in New Jersey (27,000 young children) have access to high-quality services by 2023. The planning grant report titled, *Unlocking Potential – A Roadmap to Making New Jersey the Safest, Healthiest and Most Supportive Place to Give Birth and Raise a Family*, due the spring of 2020 will present strategies to advance the priorities of equitable maternal and infant health care, high quality infant and toddler child care, family support through home visiting, and infant mental health.

Other Departments serving pregnant women, infants, children and families with children have created recent Needs Assessments and strategic plans that have informed the MCH Block Grant Title V Needs Assessment process. The most recent needs assessment was completed in January 2020 for the NJ Preschool Development Grant Birth to 5 (PDG B-5) grant which included leadership input from across five state departments (DOH, DCF, DHS, DOL, and DOE) and collaboration with early childhood partners of the NJ Council for Young Children to finalize a strategic plan based upon a comprehensive needs assessment process. The PDG B-5 Needs Assessment identified the key finding of 4 gaps that are essential to fill to support collaboration between programs and services for families with children birth to age 5:

1. Identification, Programming and Supports for Children in Special Circumstances,
2. Unmet Need for Affordable Childcare and Preschool,
3. Central Intake Infrastructure to Support Coordination, and
4. Sustained Funding for an integrated data system, NJ-EASEL (NJ Enterprise Analysis System for Early Learning)

The MCH Title V needs assessment has also be informed by other needs assessments recently performed by the NJ MIECHV Program, Head Start, DMHAS, and DCF. As a result of the ongoing COVID-19 pandemic with a public health emergency being declared in New Jersey on March 9, 2020, additional needs are being identified in maternal and child health communities. These include food insecurity, job insecurity and unemployment, increased stress, domestic violence issues, on-line school for children, and many other concerns. Needs identified before COVID-19 have been exacerbated with resulting disparities.

As a result of the collaborative overall needs assessment process, FHS has selected the following State Priority Needs for the MCH Block Grant (see Section II.C. State Selected Priorities):

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

Some of these priorities have been longstanding priorities (Infant Mortality, Teen Pregnancy, Improving and Integrating Information Systems, and Improving Access to Quality Care for CSHCN). Others are priorities that broadly address several areas or population groups (Promoting Youth Development Programs, Increase Healthy Births, and Smoking Prevention). An increasing focus on closely related issues of maternal mortality and morbidity and infant mortality is SPN #1 (Increasing Equity in Healthy Births) and SPN #2 (Reducing Black Maternal and Infant Mortality). The alarming disparities that have persisted in New Jersey are being addressed through multiple strategies including equity and implicit bias training as well as specific BIM reducing activities. Addressing disparities requires a multi-agency, multi-pronged approach to work on the factors that contribute to the disparity, including access to healthcare, housing, transportation, nutritious food, quality childcare, workforce development, education and other issues. The selected SPN reflect ongoing and new statewide public health initiatives. SPN #1 and #2 has been a recent focus of several new initiatives including the Improving pregnancy Outcomes Initiative, MIEC Home Visiting Program, MMRC, SMHIP and NurtureNJ.

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

- NPM #1 Well woman care,
- NPM #4 Breastfeeding,
- NPM #5 Safe Sleep,
- NPM #6 Developmental Screening,
- NPM #9 Bullying

NPM #11 Medical Home,
 NPM #12 Transitioning to Adulthood,
 NPM #13 Oral Health, and
 NPM #14 Household Smoking. (*consider dropping*)

The needs assessment methods used to select the NPMs included a state level needs assessment, gap analysis and SWOT analysis performed by FHS leadership. The MCH Title V needs assessment has also be informed by other needs assessments mentioned above and recently performed by the Preschool Development Grant Birth to 5 Grant, the NJ MIECHV Program, Head Start, DCF, DMHAS and Head Start. SDOH issues and other challenges to improving birth outcomes and reducing disparities have and continue to be exacerbated by the ongoing, rapidly evolving pandemic of COVID-19.

A SWOT analysis was undertaken with families and stakeholders in the Summer of 2019. Strengths identified included many programs such as Central Intake, HWHF, Special Child Health Services, and others. Weaknesses included low Medicaid reimbursement rates, lack of awareness of information, lack of connections of systems, addressing social determinants of health, as well as language and cultural barriers and disparities. Opportunities included programs for providers and parents to strengthen communications, collaboration amongst services, and examination of ways to eliminate duplication of services. Threats included funding availability, staffing for services, and limited access. COVID-19 emerged as a public health threat several months after this SWOT analysis was undertaken.

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

SPM #1 Black non-Hispanic Preterm Infants in NJ,
 SPM #2 Hearing Screening Follow-up,
 SPM #3 Referral from BDARS to Case Management Unit, and
 SPM #4 Age of Reporting Autism to the BDARS.

The old SPM to be removed from the list is Children with Elevated Blood Lead Levels due to the relocation of the Childhood Lead Program into the Office of Local Public Health in January 2019.

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

As required in the first year Application/Annual Report (FY 2021/FY 2019), **Table 1b** - Findings of the Five-Year State Needs Assessment (See Supporting Document #1) presents a focused summary of the findings of its Five-year Needs Assessment. The following table, Findings of the Five-Year Needs Assessment, provides this summary in tabular form. Highlighted in this summary are the health status of the MCH population (indicated as improving ↑, unchanged ↔, or worsening ↓) relative to the state's noted MCH strengths/needs and the identified national MCH priority areas, organized and presented by each of the six population health domains. Also summarized are the adequacy and *limitations* of the NJ Title V program capacity and partnership building efforts relative to addressing the identified MCH population groups and program needs. Specific partnership and collaborative efforts are listed, along with descriptions of promotion of family/consumer engagement and leadership, coordination with other MCHB and federal, state and local MCH investments.

The Needs Assessment process is a comprehensive, continual process in which NJ Title V reaches out to and engages families, providers, advocacy organizations, community, local, state, and national partners. Meeting the needs of pregnant women, mothers, infants and children, including those with special health care needs, and their families remains the goal of DOH FHS. Through the needs assessment process, we have identified areas of need that are consistent and in alignment with those identified through the the Healthy New Jersey 2030 (HNJ2030) process, State Health Improvement Plan (SHIP) process, the NJ State Health Assessment process, the NJDOH budget process, Departmental strategic planning, the Public Health accreditation process, the NJ Preventive Health and Health Services Block Grant, Community Health Needs Assessments (CHNAs) and Community Health Improvement Plans (CHIPs), grant-driven needs assessments (MIECHV, MMRC, SMHIP, PREP), public comment on the MCH Block Grant Application, and the collaborative process with other MCH partners. DOH FHS will continue to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations. The impact of COVID19 has and continues to be significant; SDOH and prior challenges in achieving equity in health care access and status are exacerbated, necessitating the need to strengthen efforts and activities in Title V.

III.C.2.b.i. MCH Population Health Status

Overall the majority of health measures concerning Title V as measured by national performance measures, state performance measures, outcome measures and the new health status indicators are stable or improving. Table 1c - Summary of MCH Population Needs (See Supporting Document #1) displays the **health status** for each of the six population health domains according to the nine selected NPMs. The table provides a summary of population-specific **strengths/needs** and identifies major health issues for each of the 6 population health domains which came from identified **successes, challenges, gaps and areas of disparity** identified during the needs assessment process. Statewide trend charts for key national performance measures, outcome measures, and health system capacity indicators mentioned in this section are presented in the Appendix (Charts 1-11).

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

All Maternal and Child Health (MCH) programs including programs for Children and Youth with Special Health Care Needs (CYSHCN) are organizationally located within the Division of Family Health Services (FHS). All Title V services are under the direction of the Assistant Commissioner for the Division of FHS.

The Division of FHS is the Title V agency for the state of NJ and is within the NJ Department of Health (NJ DOH). The NJ DOH is one of 11 departments under the Governor.

See attached Supporting Document #2 for organizational charts of NJDOH, FHS, MCHS and SCHEIS.

The Division of FHS is "responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V".

The function of programs within the organizational charts of NJ DOH, FHS, MCHS and SCHEIS are described in further detail and related to the Title V Program capacity and staffing below.

III.C.2.b.ii.b. Agency Capacity

This section describes Family Health Service's capacity to promote and protect the health of all mothers and children, including children and youth with special health care needs (CYSHCN). The Division of Family Health Services (FHS) supports the infrastructure to provide Title V services to each of the six population health domains. FHS supports the state's capacity to provide services to CYSHCN and address its ability to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI (the Supplemental Security Income Program) to the extent medical assistance for such services is not provided under Title XIX (Medicaid). The Maternal and Child Health Services (MCHS) and Special Child Health and Early Intervention Services (SCHEIS) Units ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care through collaboration with other agencies and private organizations and the coordination of health services with other services at the community level.

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

Maternal and Child Health (MCH) programs including programs for Children and Youth with Special Health Care Needs (CYSHCN) are organizationally located within the Division of Family Health Services (FHS). All Title V services are under the direction of Lisa Asare MPH, Assistant Commissioner, Division of FHS. Dr. Marilyn Gorney-Daley was appointed to the role of Title V Director of Maternal and Child Health in 2017. Dr. Sandra Howell was appointed as the Special Child Health and Early Intervention Services (SCHEIS) Director in June 2018.

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

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

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

III.C.2.b.ii.b. Preventive and Primary Care for Pregnant Women, Mothers and Infants

The mission of Maternal and Child Health Services (MCHS) within FHS is to improve the health status of NJ families, infants, children and adolescents in a culturally competent manner, with an emphasis on low-income and special populations. Prenatal care, reproductive health services, perinatal risk reduction

services for women and their partners, postpartum depression, mortality review, child care, early childhood systems development, childhood lead exposure prevention, immunization, oral health and hygiene, student health and wellness, nutrition and physical fitness and teen pregnancy prevention are all part of the MCHS effort. The population Domains addressed by MCHS include 1, 2, 3, 4, and 6.

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

Under RPHS, the goal of the Healthy Women Healthy Families (HWHF) Initiative is to improve maternal and infant health outcomes for women of childbearing age and their families and reduce disparities, especially with black families, through a collaborative and coordinated community-driven approach. Participants in the HWHF program receive individual support from a Community Health Worker (CHW). CHWs link families to community resources through a centralized referral system of Central Intake Hubs.

NJ successfully applied in 2010 for the Maternal, Infant and Early Childhood Home Visiting Program (MIEC HV) Formula and Competitive Grants to the Health Resources and Services Administration. The goal of the NJ MIEC HV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full implementation of the grant project is being carried out in collaboration with the Department of Children and Families (DCF). Currently evidence-based home visiting services are provided by 65 Local Implementing Agencies (LIAs) providing three national models (Healthy Families America, Parents As Teachers and Nurse Family Partnership) in all 21 NJ counties serving 5,805 families in SFY 2019.

III.C.2.b.ii.b. Preventive and Primary Care for Children and Adolescents

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

Adolescent Health (AH) supports three main focus areas: Teen Pregnancy Prevention (PREP, SRAE), the WSCC School Health NJ project and Pediatric (inclusive of adolescents) Mental Health (PMH). Additionally, areas of adolescent mental health, other than access, address positive youth development and/or teen suicide prevention. CAHP grantees (PREP, SRAE and WSCC School Health NJ) have been trained in developing safe, caring, and inclusive environments for teens by the Transgender Training Institute and the Society for the Prevention of Teen Suicide (SPTS). Evidenced-based models (Teen PEP and TOP®), grounded in social and emotional learning (SEL), positive youth development (PYD), and motivational interviewing, are implemented among middle and high school students. Eleven CAHP grantees are required to maintain a youth advisory board (YAB). Through these YABs, youth work with trained adult advisors at their local level. Each YAB nominates two members to be represented on a Statewide YAB who meet with State staff annually to provide program input. For their SFY2020 focus, youth chose teen suicide awareness and prevention.

The Child and Adolescent Health Program (CAHP) manages two new federal grants to prevent teen pregnancy and promote youth development - the Personal Responsibility Education Program (PREP) and the Sexual Risk Avoidance Education (SRAE) Grant. The SRAE program focuses on building protective factors for youth aged 12-14 to help delay sexual activity, reduce pregnancy and Sexually Transmitted Infections (STIs)., SRAE also provides engagement opportunities including mentoring, youth leadership and parent education on 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.

The CAHP manages two new federal grants to prevent teen pregnancy and promote youth development - the Personal Responsibility Education Program (PREP) and the Sexual Risk Avoidance Education (SRAE) Grant. The SRAE program focuses on building protective factors for youth aged 12-14 to help delay sexual activity, reduce pregnancy and Sexually Transmitted Infections (STIs)., SRAE also provides engagement opportunities including mentoring, youth leadership and parent education on 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.

The Mercer County Traumatic Loss Coalition grant promotes community awareness for youth suicide prevention while assisting and training individuals in 11 municipalities to effectively respond to trauma and loss. The NJAAP has worked for the past ten years to increase the number of children with a medical home by assisting pediatric practices with strategies for improving the quality of their services for NCQA medical home certification. Now, current research shows that exposure to adverse childhood experiences (ACEs) affects brain development and can lead to learning challenges, behavioral problems and physical health issues. Thus, in SFY19, the NJAAP conducted an ACES screening pilot in Camden with 129 teens. The pilot revealed 33.4% of teens self-reported 4 or more ACEs with almost 4% experiencing 10 or more ACEs. To date, with training and support through learning collaboratives, PCPs and schools are better equipped to address ACEs with teens and their families.

The pediatric medical home is the ideal setting to teach children, early on, the importance of Personal Space and Safety (PS&S). For these issues, pediatricians serve on the front line to prevent, reduce and respond to abuse, neglect and violence with preventive education, screening for risk, and when appropriate, linking families to community-based counseling and treatment resources (NJAAP Agenda for Children; 2018-19). Incidents of bullying, cyber bullying, sexting, sextortion and teen dating violence continue to plague children at every age. One in 4 girls and 1 in 8 boys experience inappropriate or unwelcome sexual contact by age 18. This and all types of abuse, neglect, and other potentially traumatic experiences that may occur in a young person's life before the age of 18 are identified as Adverse Childhood Experiences (ACEs). Common examples of ACEs include physical, sexual, and emotional abuse; physical and emotional neglect; parental incarceration; domestic violence; household mental illness; exposure to substance abuse; and parental separation or divorce. As the number of ACEs increases for an individual, so does the risk for chronic health conditions, low life potential, risky health behaviors, and early death. The New Jersey Funders ACEs Collaborative report, identified five core areas that have the potential to impact ACEs and their negative effects on health and development: (1) supporting parents/caregivers, (2) providing training and professional development in trauma informed care, (3) promoting community awareness of ACEs, (4) advancing policies and practices that help children and families thrive, and (5) collecting, analyzing, and sharing data and findings from research and practice. These five areas are woven into the Healthy Spaces program within its three-pronged approach to foster healthy and resilient communities.

In 2018, NJ-AAP introduced a new quality improvement (QI) program that included universal screening for ACEs. Of the 9 pediatric practices that participated, none were implementing universal screening at baseline. By the end of the six-month QI program, not only did the rate of screening increase to 84.8% but the anticipatory guidance on mental health concerns given to parents/caregivers increased from a rate of 68.4% to 90.7%. Among adolescents ages 13-18 who were screened, 41.4% scored 4 or higher, and of those adolescents, 18.8% scored 10 or higher. This finding indicates a clear need for pediatricians to provide anticipatory guidance as well as to make referrals to appropriate services. ACEs screening of

adolescents opened lines of communication between the pediatric health care teams and families, and enabled providers to target protective factors, and customize intervention(s) needed. Currently, the NJ AAP Chapter is funded to address core areas 1,2,3 of the NJ Funders ACEs Collaborative.

Given the concerns of vaping among youth, there is also a significant amount of education and policy work taking place in the WSCC pilot schools to keep youth safe from vaping. These activities are being accomplished with or without grant funding and often in partnership with other CBOs. Activities include but are not limited to: 1) the NJ Prevention Network, funded by NJDOH, Office of Tobacco Free, Nutrition and Fitness, subgrants to two of the three regional agencies to facilitate the Tobacco Free for Healthy NJ (TFHNJ) initiatives for tobacco and vaping prevention, including Tobacco-Free Worksites (Working Well), Tobacco-Free Campus (NJCUITS), and Incorruptible.us (Youth Tobacco Action Groups); 2) staff trained in and/or conducted “Don’t Get Vaped In” using peer-peer; adult-student and adult-adult approaches; 3) the Comprehensive Tobacco Free School Policy Template is promoted and incorporates a less punitive response by schools to vaping; 4) educational programs and events hosted by both youth and adults including: district-wide parent and community events, lunch and learn sessions, professional development/in-service meetings, school assemblies, freshman orientation meetings, health education classes, vaping surveys and newsletters and e-publications were disseminated to schools and community partners or posted. Last, but certainly not least, the Somerset Youth Advisory Board (YAB) presented [vaping testimony](#) at the State House:

III.C.2.b.ii.b. 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 sub-specialty, case management, and family support agencies that provide in-state regionalized and/or county-based services. It is designed to provide family-centered, culturally competent, community-based services for CYSHCN age birth to 21 years of age, and to enhance access to medical home, facilitate transition to adult systems, and health insurance coverage. The Specialized Pediatric Services Programs (SPSP) agencies are a significant resource of pediatric specialty and subspecialty care in NJ, and are used widely by CYSHCN including Medicaid recipients. Although clients are screened for their ability to pay for clinical services, the support provided by Title V enables all CYSHCN to be served regardless of their ability to pay. There is no charge for SCHS CM and family support.

Administratively housed in the Family Centered Care Services (FCCS) Unit these services include 21 county-based Special Child Health Services Case Management Units (SCHS CMUs), one Family Support project, multiple Specialized Pediatric Services Programs (SPSP) which include 8 Child Evaluation Centers (CECs) of which 4 house Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder Centers, and 3 provide newborn hearing screening follow-up, 3 Pediatric Tertiary Centers, and 5 Cleft Lip/Palate Craniofacial Anomalies Centers and a small State operated Fee-for-Service program. Likewise, State and federal collaborations among the FCCS programs and non-Title V funded programs such as the Ryan White Part D Family Centered HIV Care Network (RWPD), Early Intervention System (EIS), Federally Qualified Health Centers (FQHC), medical home initiatives, Supplemental Security Income (SSI), Catastrophic Illness in Children Relief Fund (CICRF) and other community-based initiatives extend the safety net through which Title V links CYSHCN with preventive and primary care.

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

home visits, and written appeals by the SCHS CM supported Mom's efforts to clarify the missing information and resolve her child's needs.

III.C.2.b.ii.c MCH Workforce Capacity

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

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

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

FHS has implemented a department-wide Health Equity Workforce Development Training to address health disparities and inequality. The training is being implemented in several phases. Phase one included training for all MCH staff. Phase two will provide training in a train-the trainer format for FHS staff and grantees. Phase three will include community-based trainings by CHW staff to providers in grantee designated catchment areas. FHS staff and grantees will receive ongoing trainings provided by other state agencies to increase access to resources for at risk populations in disparate communities.

The Maternal and Child Health Services (MCHS) and Special Child Health and Early Intervention Services (SCHEIS) Units ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care through collaboration with other agencies and private organizations and the coordination of health services with other services at the community level. The mission of the FHS is to improve the health, safety, and well-being of families and communities in NJ. The FHS works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

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

III.C.2.b.ii.c Preventive and Primary Care for Pregnant Women, Mothers and Infants

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

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

Maternal and Child Health Services (MCHS) is comprised of one program manager, nine professionals and three support staff. All staff members are housed in the central office. Dr. Marilyn Gorney-Daley was appointed the Director of MCH Services for FHS in April 2017.

Reproductive and Perinatal Health Services (RPHS) is staffed by five professionals. The Program Manager, Coordinator, and three other professional positions are currently vacant. RPHS responsibilities include: the HWHF Initiative; Black Infant Mortality reducing activities including breastfeeding, fatherhood support, Centering programs and a doula pilot program; regional MCH Consortia; Certificate of Need rules and MCH Consortia regulations; Maternal morbidity and mortality reviews; Fetal Infant Mortality Reviews; Title V Liaison with the Healthy Start projects; perinatal addictions and fetal alcohol syndrome prevention projects; postpartum mood disorders initiative; and the Sudden Infant Death Syndrome prevention program.

III.C.2.b.ii.c Preventive and Primary Care for Children and Adolescents

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

Adolescent Health (AH) supports three main focus areas: Teen Pregnancy Prevention (PREP, SRAE), the WSCC School Health NJ project and Pediatric Mental Health (PMH), all described earlier. Additionally, other areas of adolescent mental health (other than access), positive youth development and/or teen suicide prevention are addressed. CAHP grantees (PREP, SRAE and WSCC School Health NJ) have been trained in developing safe, caring, and inclusive environments for teens by the Transgender Training Institute and the Society for the Prevention of Teen Suicide (SPTS). Evidenced-based models (Teen PEP and TOP®), grounded in social and emotional learning (SEL), positive youth development (PYD), and motivational interviewing, are implemented among middle and high school students. Eleven CAHP grantees are required to maintain a youth advisory board (YAB). Through these YABs, youth work with trained adult advisors at their local level. Each YAB nominates two members to be represented on a Statewide YAB who meet with State staff annually to provide program input. For their SFY2020 focus, youth chose teen suicide awareness and prevention.

The Mercer County Traumatic Loss Coalition grant promotes community awareness for youth suicide prevention while assisting and training individuals in 11 municipalities to effectively respond to trauma and loss. The NJAAP has worked for the past ten years to increase the number of children with a medical home by assisting pediatric practices with strategies for improving the quality of their services for NCQA medical home certification. Now, current research shows that exposure to adverse childhood experiences (ACEs) affects brain development and can lead to learning challenges, behavioral problems and physical health issues. Thus, in SFY19, the NJAAP conducted an ACES screening pilot in Camden with 129 teens. The pilot revealed 33.4% of teens self-reported 4 or more ACEs with almost 4% experiencing 10 or more ACEs. To date, with training and support through learning collaboratives, PCPs and schools are better equipped to address ACES with teens and their families.

Given the concerns of vaping among youth, there is also a significant amount of education and policy work taking place in the WSCC pilot schools to keep youth safe from vaping. These activities are being accomplished with or without grant funding and often in partnership with other CBOs. Activities include but are not limited to: 1) the NJ Prevention Network, funded by NJDOH, Office of Tobacco Free, Nutrition and Fitness, subgrants to two of the three regional agencies to facilitate the Tobacco Free for Healthy NJ (TFHNJ) initiatives for tobacco and vaping prevention, including Tobacco-Free Worksites (Working Well), Tobacco-Free Campus (NJCUIITS), and Incorruptible.us (Youth Tobacco Action Groups); 2) staff trained in and/or conducted "Don't Get Vaped In" using peer-peer, adult-student and adult-adult approaches; 3) the Comprehensive Tobacco Free School Policy Template is promoted and incorporates a less punitive response by schools to vaping; 4) educational programs and events hosted by both youth and adults including: district-wide parent and community events, lunch and learn sessions, professional development/in-service meetings, school assemblies, freshman orientation meetings, health education classes, vaping surveys and newsletters and e-publications were disseminated to schools and community partners or posted. Last, but certainly not least, the Somerset Youth Advisory Board (YAB) presented [vaping testimony](#) at the State House.

The Child and Adolescent Health Program (CAHP) is comprised of 3 professional staff, one support staff and one program manager. Funding resources include both federal (MCH Block Grant, DHHS, FYSB, ACF Personal Responsibility Education Program [PREP]) and state maternal child health funds. All staff are housed in the Trenton office. The CAHP Manager has oversight responsibilities for child and adolescent health programs including Personal Responsibility Education Program and Sexual Risk Avoidance Programs as well as CDC's Coordinated School Health/WSCC model in public schools, grades six and above. CAHP staff have varied professional backgrounds including nursing, nutrition, health education, research and data analysis.

The Children's Oral Health Program (COHP) is comprised of 1 professional staff, Yvonne Mikalopas, a Registered Dental Hygienist and former Regional Coordinator of COHP, who reports to the New Jersey State Dental Director, Dr. Darwin K Hayes, in the Division of Community Health Services, Oral Health Service Unit. Ms. Mikalopas serves as the COHP Program Officer and oversees COHP program activities which are implemented through two Federally Qualified Health Center grantee agencies with locations strategically located in the north, central and southern regions of the State, and as directed by the Dental

Director. Dr. Hayes was appointed State Dental Director in July 2019 and is the first Dental Director at the Department of Health in approximately 30 years. In addition to his duties at the Department, Dr. Hayes has been appointed to the NJ State Board of Dentistry. He serves as a member of the Association of State and Territorial Dental Directors (ASTDD) which has a long collaborative and consultative history with the National Maternal and Child Oral Health Resource Center (OHRC) in developing resources in the needs assessment process and MCH state action plans.

The Childhood Lead program, which had previously been housed in the Child and Adolescent Health Program, was moved to the Office of Local Public Health in January 2019. Lead exposure and management of exposure continues to be a priority for the NJ DOH. DOH FHS continues to collaborate on progress on childhood lead issues; funding and positions have been transferred. The CDC Cooperative Agreement will continue to support data-driven primary prevention interventions that are implemented by not only the NJDOH, but its strategic partners and childhood lead exposure prevention and healthy homes grantees.

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

III.C.2.b.ii.c Special Child Health and Early Intervention Systems (SCHEIS)

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

Administratively housed in the Family Centered Care Services (FCCS) Unit these services include 21 county-based Special Child Health Services Case Management Units (SCHS CMUs), one Family Support project, multiple Specialized Pediatric Services Programs (SPSP) which include 8 Child Evaluation Centers (CECs) of which 4 house Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder Centers, and 3 provide newborn hearing screening follow-up, 3 Pediatric Tertiary Centers, and 5 Cleft Lip/Palate Craniofacial Anomalies Centers and a small State operated Fee-for-Service program. Likewise, State and federal collaborations among the FCCS programs and non-Title V funded programs such as the Ryan White Part D Family Centered HIV Care Network (RWPD), Early Intervention System (EIS), Federally Qualified Health Centers (FQHC), medical home initiatives, Supplemental Security Income (SSI), Catastrophic Illness in Children Relief Fund (CICRF) and other community-based initiatives extend the safety net through which Title V links CYSHCN with preventive and primary care.

State Title V staffs, SCHS 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 as well as to learn about Managed Long Term Services and Supports, how to obtain care through the Marketplace, and behavioral services through PerformCare. These trainings build capacity among Title V agency providers to enhance access to primary and preventive care for CYSHCN. For example, an SCHS CM reported being able to assist a parent to problem solve a denial of home health aide services for a 12-year-old with autism and significant developmental delays by advocating on Mom's behalf with PerformCare, her child's school district, and her Family Support Organization. Repeated phone calls, home visits, and written appeals by the SCHS CM supported Mom's efforts to clarify the missing information and resolve her child's needs.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

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

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

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

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

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

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

Recognizing the importance that parent/consumer involvement has in the design and implementation of a program to address issues related to preterm births and infant mortality, the MCH Program incorporated focus groups into several programs under the HWHF initiative including those for doulas, breastfeeding, and addressing disparities. Similarly, the Home Visiting Program (MIECHV) also requires funded grantees to implement County Advisory Boards.

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

SCHEIS collaborates with many offices and programs in DHS to develop and implement policy that will ensure that children referred into the SCHS CMUs and their families are screened appropriately for healthcare service entitlements and waived services. SCHEIS programs including case management, specialized pediatrics, and Ryan White Part D, screen all referrals for insurance and potential eligibility for Medicaid programs, counsel referrals on how to access Medicaid, NJ FamilyCare, Advantage, and waiver

programs, and link families with their county-based Boards of Social Services and Medicaid Assistance Customer Care Centers. Program data including insurance status is collected into a report that is compared with Medicaid data in determining CYSHCN need. Referrals are made to Boards of Social Services, NJ Family Care, Advantage, Charity Care, Department of Banking and Insurance, and Disability Rights NJ for support and advocacy.

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

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

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

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

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

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

The findings from the Five-Year Needs Assessment drive the identification of MCH priority needs for the five-year reporting cycle consistent with Figure 4 of the MCH Block Grant Logic Model on page 45. The selected priorities reflect the unique needs of NJ and address the defined MCH population groups and cross-cutting/ systems building areas. In addition, the identified priority needs address areas for which targeted interventions will result in needed improvements to its health care delivery systems. The identified priority needs have informed the selection of nine NPMs, one in each of the MCH population health domains, and the development of 4 SPMs. Collectively, the NPMs and SPMs address the state's identified priority needs. The narrative discussion organized by NPMs supplements the listing of the final priority needs by providing a rationale for how the priority needs were determined and how they link with the selected national and state performance measures. The selected state priority needs drive the selection of NPMS and the development of SPMs which align the impact of Evidence-Based Informed Strategy Measures (ESMs) on NPMs and National Outcome Measures (NOMs). Table 1a - Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model (see page 49 and Supporting Document #1) summarizes the process of identifying priority needs and linking them to performance measures.

3.D. Financial Narrative

This financial narrative summarizes how the NJ State Action Plan is developed and implemented through the careful analysis of state needs and the utilization of available State and federal funding and resources. Built upon the assessment of NJ MCH population needs, NJ develops a proposed budget plan for the application year (Form 2, FY19 Application Budget) that is aligned with its proposed Title V program activities, identified MCH needs, and prior expenditure trends. Review of actual expenditures for the past fiscal year (Form 2, FY17 Annual Report Expenditures) are compared with planned and budgeted activities and linked with the allocation of those financial resources with the achieved outcomes relative to the Title V program plans. Together, the reporting of expenditures and the proposed budget plan demonstrate how federal MCH Services Title V Block Grant funds complement nonfederal Title V funds (summarized in Form 2, Other Federal Funds and Table A - State Funding levels for MCH Programs and Services, on page 40) in enabling NJ to address its unique MCH priority needs. Without federal MCH Block Grant funds essential MCH programs and services would not be available to meet the needs of NJ's MCH populations.

The combined expenditure reports and the proposed budget plan demonstrate accountability in NJ's use of its federal and state MCH Block Grant funds to meet the Title V legislative intent "to improve the health of all mothers and children." The mission of FHS is "to improve the health, safety, and well-being of families and communities in NJ." Without federal MCH Block Grant funding support, NJ would not be able to implement the Title V program efforts and achieve the positive outcomes described in the State Action Plan and other sections of this Application/Annual report.

NJ maintains expenditure and budget documentation for the MCH Block Grant, consistent with the requirements of NJDOH's Financial Management Business Proposal circular, Terms and Conditions for Administration of Grants (NJDOH), and State accounting practices. NJ conducts an annual audit of its DOH expenditures including the MCH Services Title V Block Grant.

3.D.1. Expenditures

NJ expenditures demonstrate the Federal/State partnership and how federal support (Form 2, Line 1, \$11,500,000) complements the NJ total State MCH investment (Form 2, line 3, \$146,102,727). NJ monitors the MCH Block Grant expenditures bi-annually to ensure compliance with the federal Title V legislative financial requirements. NJ's compliance with the required 30%-30%-10% distribution is documented on Form 2, Line 1 A-C with a population group distribution of 30.5% for Preventive and Primary Care for Children, 37.7% for Children with Special Health Care Needs, and 8.3% for Title V Administrative Costs. A note has been included to Form 2 explaining that the amount in the FY17 Annual

Report Expended (\$3,677,838) is 13.2% less than the amount in the FY Annual Report Budgeted (\$4,240,755) due to vacant staff positions. The required distribution of more than 30% of Title V funds for Preventive and Primary Care for Children is still met at 31.9% in FY20. NJ performed very well on the total number and percentage of the MCH population who are served by Title V, as reported on Form 5 by population group (Pregnant Women, Infants <1 Year Old, and Children 1 through 21 Years of Age). NJ is improving its efforts to expand its reach to CSHCN through case management and coordination with Medicaid Managed Care Organizations.

Funds for the reporting year (FFY18) have not been fully expended at the time of the Application/Annual Report submission in July 2019. The most recent expenditure data for SFY18 is being reported in this submission.

NJ reports the federal and non-federal MCH Block Grant expenditures separately on the budget/expenditure forms (Forms 2 & 3). Federal MCH Services Title V Block Grant expenditures are reported on Form 2, Lines 1A-1C (Federal Allocation). State MCH funds are reported on Form 2, Line 3 (State MCH Funds). Other non-Title V Federal Funds related to MCH are listed on Form 2, Line 10 (Other Federal Funds).

NJ recognizes that Title V is the payer of last resort and MCH Services Title V Block Grant funds cannot be used to reimburse a claim for a service that is otherwise covered under Medicaid. Service providers receiving MCH Block Grant funds must seek payment from other public and private insurance providers when applicable. Services in NJ supported by the MCH Block Grant reflect services that were not covered or reimbursed through the Medicaid program or another provider.

3.D.2. Budget

NJ's proposed budget plan (Form 2, FY19 Application Budgeted) presents how MCH Block Grant funds will be allocated across the population groups to address the state's priority needs, improve performance related to the targeted MCH outcomes and expand its systems of care for both the MCH and CSHCN populations. The proposed budget plan assures NJ's commitment to complying with the legislative financial requirements (30%-30%-10% requirements) and program regulations.

The proposed budget plan, like the reported expenditures, demonstrates the federal-state partnership and how federal MCH Block Grant support are utilized to complement the state's planned total match (Form 2, Lines 3-11) for the Application year. The proposed budget plan includes Table A (State Funding Level for MCH Programs and Services, below) and aligns with the identified MCH/CSHCN priorities. NJ combines federal and non-federal MCH Block Grant funds to support the activities that are described in the State Action Plan for the upcoming budget period. State appropriations support a number of maternal and child health programs. In the State Fiscal Year 2020 budget most programs and services are maintained at the SFY 2018 levels. Based on the critical nature of the budget deficit in the state the proposed budget demonstrates an ongoing commitment on the part of the State to support to the best of its ability services to the maternal and child health population. The following are the state funding levels for programs and services for SFY 2018, SFY 2019 and SFY 2020 that reach maternal and child health populations in NJ:

State Budgeted Funding Levels for Programs and Services	SFY 2018	SFY 2019	SFY 2020
Birth Defects Registry	\$ 744,000	\$ 744,000	
Cleft Lip and Palate Projects	\$ 690,000	\$ 690,000	
Infant Mortality Reduction	\$ 2,000,000	\$ 2,000,000	
Sudden Infant Death Syndrome	\$ 221,000	\$ 221,000	
Newborn Screening	\$ 4,593,550**	\$ 4,872,875	
Postpartum Depression Screening and Referral	\$ 1,900,000	\$ 1,900,000	
Early Intervention for Developmental Delay/Disabilities	104,225,357	\$ 116,900,661	
Hemophilia services	\$ 1,245,000	\$ 1,245,000	
Catastrophic Illness in Children Relief Fund	\$ 1,700,000	\$ 1,700,000	
Handicapped Children's Fund, which is used to support subspecialty care and case management services	\$ 4,592,200	\$ 4,592,200	
Fetal Alcohol Syndrome	\$ 989,000	\$ 989,000	
MCH Services	\$ 1,740,000	\$ 1,740,000	
Council Physical Fitness and Sports	\$ 50,000	\$ 50,000	
Autism Registry	\$ 750,000	\$ 750,000	
Family Planning	\$ 7,453,000	\$ 7,453,000	
Opioid Education for Obstetricians	\$ 1,000,000	\$ 0	

*This amount applies to NBSGSP (not Hearing and CCHD).

**Note: This amount includes carry over funds.

NJ has used the allocation for the current fiscal year (FY20) as a basis for determining the proposed budget plan for federal and non-federal MCH Block Grant funds in the Application year (FY21). The final federal MCH Block Grant allocation for FY20 is not yet known.

Sources of other federal MCH dollars (Form 2, Line 9) and other state matching funds (Table A, State Funding Level for MCH Programs and Services) are used by NJ to meet its MCH Title V programming needs. The distribution of funding to support services for the 3 legislatively defined populations of the Title V MCH Services Block Grant Pyramid is summarized on Form 2, Line 1 A-C. Planned MCH Block Grant funding will support the budget estimates for individuals served within the 5 population groups (Pregnant Women, Infants < 1 Year, Children 1 through 21 Years, CSHCN, and All Others) on Form 5a and within

the 3 types of services (Direct Services, Enabling Services, and Public Health Services and Systems) on Form 3b, Line IIA, 1-4. NJ does not provide any direct MCH services with federal Title V funding.

NJ monitors the Federal/State match requirements, which includes a \$3 match in non-federal funds for every \$4 of federal MCH Block Grant funds expended and the maintenance of effort from 1989. In FY18 NJ exceeded the Federal/State match (\$3/\$4) by matching \$158,057,356 in non-federal funds to the \$11,500,000 federal MCH Block Grant funds. NJ's non-federal State match far exceeded the required maintenance of effort amount of \$9,419,570 from 1989.

3.E. Five-Year State Action Plan (<36,000 character limit for 3e2a and 3e2b)

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

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

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

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

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

Domains (set by HRSA)	State Priority Needs –	Strategies – <i>general approaches taken to achieve the objectives</i>	Objectives (SMART)	National and State Performance Measures (NPMs and SPMs)	Evidence-based or – Informed Strategy Measures (ESMs)	National and State Outcome Measures (NOMs and SOMs)
1) Women's/ Maternal Health	#1 Increasing Equity in Healthy Births	Healthy Women, Healthy Families (HWHF) Initiative; Central Intake (CI) Hubs & Community Health Workers (CHW); IM CoIIN; MIEC Home Visiting Program (MIECHV); MCH Consortia TQI Activities, Nurture NJ, State Health Improvement Plan (SHIP), Maternal Mortality Review Commission & State Maternal Health Improvement Program Grants; Perinatal Episodes of Care	Increase first trimester prenatal care by 1% per year by 2025.	NPM #1 Well Women Care	ESM 1.1: Increase first trimester prenatal care (EBC) from birth certificate records.	1 Prenatal Care; 2 Maternal Morbidity; 3 Maternal Mortality; 4 Low Birth Weight; 5 & 6 Preterm Births 8 Perinatal Mortality; 9 Infant Mortality; 10 FAS; 11 NAS
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	HWHF Initiative; NJ SIDS Center activities; IM CoIIN; MIEC Home Visiting Program; SUID-Case Review; Child Fatality Review Healthy Start; NJ Baby Box Safe Sleep Education Program; Surveillance (PRAMS, EBC);	Increase infant safe sleep by 1% per year by 2025.	NPM #5 Infant Safe Sleep SPM #1 Black preterm births	ESM 5.1: Increase infant safe sleep (PRAMS – on back, no co-sleeping, no soft bedding).	1, 2, 3, 4, 5, 8, 9 9.5 Sleep Related SUID; 15 Child Mortality; 19 Child Health Status
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	HWHF Initiative; IM CoIIN; MIEC Home Visiting Program; Healthy Start; WIC Loving Support© Through Peer Counseling Breastfeeding Program Baby Friendly Hospitals, BF Surveillance (PRAMS, EBC, mPINC); SNAP-Ed; Breastfeeding Strategic Plan	Increase births in Baby Friendly hospitals by 2% per year by 2025.	NPM #4 Breastfeeding SPM #1 Black preterm births	ESM 4.1: Increase births in Baby Friendly hospitals (EBC/mPINC).	1, 4, 5, 8, 9, 9.5, 10, 11, 15, 19
3) Child Health	#4 Promoting Youth Development,	ECCS Impact with DCF; Project LAUNCH and Help Me Grow with DCF; Early Intervention System; MIEC Home Visiting; NJ AAP/PCORE Medical Home Project; Learn the Signs, Act Early Campaign; ACNJ Pritzker Initiative	Increase developmental screening among children, ages 9 months- 3 years, by 2 % points per year by 2025.	NPM #6 Developmental Screening (% of children (10 - 71 months) receiving a developmental screening using a parent-completed screening tool).	ESM 6.1: Increase completed ASQ developmental screens online as part of ECCS Impact Program.	13 School Readiness; 17 CSHCN; 18 Mental/Behavioral 19 Child Health Status;

Domains (set by HRSA)	State Priority Needs –	Strategies - general approaches taken to achieve the objectives	Objectives (SMART)	National and State Performance Measures (NPMs & SPMs)	Evidence-based or – Informed Strategy Measures (ESMs)	National and State Outcome Measures (NOMs and SOMs)
4) Adolescent/ Young Adult Health	#4 Promoting Youth Development,	LEAHP-Leadership Exchange for Adolescent Health Promotion, Social Emotional Learning, Positive Youth Development and Youth Engagement strategies.	(matched pre and post survey questions that measure protective factors including adolescent connectedness)	NPM #9 Bullying: % of adolescents who report increased connectedness, empathy, self-awareness, social awareness, resiliency and emotion management via YRBS and CAHP surveys.	Creation of a stakeholder team including representation from state departments (DOH, DCF, DOE and SBOE) and a strategic plan for improving adolescent health including education, access and inclusivity.	16.1 Adolescent Mortality; 16.2 MVA; 16.3 Suicide; 18, 19
4) Adolescent/ Young Adult Health and 5) CYSHCN	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	NJ AAP/PCORE Medical Home Project; Transition to adulthood needs assessment; SPAN/ISG 1; ARC of NJ	Increase the % of children and children with special health care needs, age 0 - 17 years old, who have a medical home by 4 % points by 2025.	NPM #11 Medical home	ESM 11.1: Percent of CYSHCN ages 0-18 years served by Special Child Health Services Case Management Units (SCHS CMUs) with a primary care physician and/or Shared Plan of Care (SPoc).	16.1 Adolescent Mortality; 16.2 MVA; 16.3 Suicide; 19 Child Health Status 17, 18, 19, 20, 21,22
5) CYSHCN and 4) Adolescent/ Young Adult Health	#5 Improving Access to Quality Care for CYSHCN	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		NPM #12 Transitioning to Adulthood SPM #2 Hearing screening F/U; SPM #3 Referred from BDARS to Case Management Unit; SPM #4 Age initial autism diagnosis;	ESM 12.1: Percent of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service.	19 Child Health Status 16, 17, 18, 19, 20, 21,22
6) Cross Cutting		Project REACH, Project PEDS ShapingNJ; MIEC Home Visiting; Dial a Smile Dental Clinic Directory; Miles of Smiles; WIC Newsletter; Special Needs Newsletter; Oral Health Nutrition and Obesity Control Program	Increase preventive & any dental services for children enrolled in Medicaid or CHIP by 1% per year by 2025.	NPM #13 Oral Health	ESM 13.1: Preventive and any dental services for children enrolled in Medicaid or CHIP (CMS-416).	14 Kids 1-6 with cavities; 19 Kids in very good health;

Domains (set by HRSA)	State Priority Needs –	Strategies - general approaches taken to achieve the objectives	Objectives (SMART)	National and State Performance Measures (NPMs & SPMs)	Evidence-based or – Informed Strategy Measures (ESMs)	National and State Outcome Measures (NOMs and SOMs)
6) Cross Cutting	#7 Improving & Integrating Information Systems	HWHF Initiative, Central Intake / PRA / SPECT; MIEC Home Visiting SSDI, ECCS Impact; VIP; Master Client Index Project; NJ SHAD; MMRC; Maternal Data Center		ALL NPMs		ALL
6) Cross Cutting	#8 Smoking Prevention	Mom's Quit Connection; Perinatal Addiction Prevention Project; HWHF Initiative, Central Intake / PRA MIEC Home Visiting	Decrease the % of women who smoke during pregnancy by 2 % points by 2025.	#14 Household Smoking	ESM 14.1: Increase referrals of pregnant women to Mom's Quit Connection.	ALL

3.E.2. State Action Plan Narrative Overview

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

New Jersey's Title V Program is uniquely positioned through its leadership, many partnerships, professionals and families to address health care needs of mothers, children, adolescents, at-risk populations, and families and to reduce disparities in health outcomes. In concert with the New Jersey Department of Health strategic plan, State Health Improvement Plan, Healthy New Jersey 2020, the New Jersey Title V program 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.

New Jersey Title V, as a leader, facilitates collaboration and partnership with many agencies and organizations including the Statewide Parent Advocacy Network, 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.

One initiative that highlights the important work of the New Jersey Title V program is the Healthy Women, Healthy Families (HWHF) Initiative. Through this Initiative, New Jersey Title V serves as 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 Black Infant Mortality. 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 newly developed HWHF.

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.

3.E.2.b. Supportive Administrative Systems and Processes

Partnerships that influence NJ Title V program's ability to meet its planning goals and objectives are described below in Section 3.E.2.b.2. Family Partnership and summarized in Table 1g – Family/Consumer Partnerships.

3.E.2.b.1 MCH Workforce Development

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

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

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

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

FHS has implemented a department-wide Health Equity Workforce Development Training to address health disparities and inequality. The training is being implemented in several phases. Phase one included training for all MCH staff. Phase two includes training in a train-the trainer format for FHS staff and grantees. Phase three will include community-based trainings by CHW staff to providers in grantee designated catchment areas. FHS staff and grantees receive ongoing trainings provided by other state agencies to increase access to resources for at risk populations in disparate communities.

The Maternal and Child Health Services (MCHS) and Special Child Health and Early Intervention Services (SCHEIS) Units ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care through collaboration with other agencies and private organizations and the coordination of health services with other services at the community level. The mission of the FHS is to improve the health, safety, and well-being of families and communities in NJ. The FHS works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

The size and experience of FHS staff who support Title V programs are summarized in Table 1e - Staffing for MCHS and SCHEIS (see Supporting Document #1).

Preventive and Primary Care for Pregnant Women, Mothers and Infants

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

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

Preventive and Primary Care for Children and Adolescents

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

Adolescent Health (AH) supports three main focus areas: Teen Pregnancy Prevention (PREP, SRAE), the WSCC School Health NJ project and Pediatric Mental Health (PMH), all described earlier. Additionally, other areas of adolescent mental health (other than access), positive youth development and/or teen suicide prevention are addressed. CAHP grantees (PREP, SRAE and WSCC School Health NJ) have been trained in developing safe, caring, and inclusive environments for teens by the Transgender Training Institute and the Society for the Prevention of Teen Suicide (SPTS). Evidenced-based models (Teen PEP and TOP®), grounded in social and emotional learning (SEL), positive youth development (PYD), and motivational interviewing, are implemented among middle and high school students. Eleven CAHP grantees are required to maintain a youth advisory board (YAB). Through these YABs, youth work with trained adult advisors at their local level. Each YAB nominates two members to be represented on a Statewide YAB who meet with State staff annually to provide program input. For their SFY2020 focus, youth chose teen suicide awareness and prevention.

The Mercer County Traumatic Loss Coalition grant promotes community awareness for youth suicide prevention while assisting and training individuals in 11 municipalities to effectively respond to trauma and loss. The NJ-AAP has worked for the past ten years to increase the number of children with a medical home by assisting pediatric practices with strategies for improving the quality of their services for NCQA medical home certification. Now, current research shows that exposure to adverse childhood experiences (ACEs) affects brain development and can lead to learning challenges, behavioral problems and physical health issues. Thus, in SFY19, the NJAAP conducted an ACES screening pilot in Camden with 129 teens. The pilot revealed 33.4% of teens self-reported 4 or more ACEs with almost 4% experiencing 10 or more ACEs. To date, with training and support through learning collaboratives, PCPs and schools are better equipped to address ACEs with teens and their families.

Given the concerns of vaping among youth, there is also a significant amount of education and policy work taking place in the WSCC pilot schools to keep youth safe from vaping. These activities are being accomplished with or without grant funding and often in partnership with other CBOs. Activities include but are not limited to: 1) the NJ Prevention Network, funded by NJDOH, Office of Tobacco Free, Nutrition and Fitness, subgrants to two of the three regional agencies to facilitate the Tobacco Free for Healthy NJ (TFH NJ) initiatives for tobacco and vaping prevention, including Tobacco-Free Worksites (Working Well), Tobacco-Free Campus (NJCUITS), and Incorruptible.us (Youth Tobacco Action Groups); 2) staff trained in and/or conducted "Don't Get Vaped In" using peer-peer; adult-student and adult-adult approaches;

3) the Comprehensive Tobacco Free School Policy Template is promoted and incorporates a less punitive response by schools to vaping; 4) educational programs and events hosted by both youth and adults including: district-wide parent and community events, lunch and learn sessions, professional development/in-service meetings, school assemblies, freshman orientation meetings, health education classes, vaping surveys and newsletters and e-publications were disseminated to schools and community partners or posted. Last, but certainly not least, the Somerset Youth Advisory Board (YAB) presented [vaping testimony](#) at the State House:

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

Administratively housed in the Family Centered Care Services (FCCS) Unit these services include 21 county-based Special Child Health Services Case Management Units (SCHS CMUs), one Family Support project, multiple Specialized Pediatric Services Programs (SPSP) which include 8 Child Evaluation Centers (CECs) of which 4 house Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder Centers, and 3 provide newborn hearing screening follow-up, 3 Pediatric Tertiary Centers, and 5 Cleft Lip/Palate Craniofacial Anomalies Centers and a small State operated Fee-for-Service program. Likewise, State and federal collaborations among the FCCS programs and non-Title V funded programs such as the Ryan White Part D Family Centered HIV Care Network (RWPD), Early Intervention System (EIS), Federally Qualified Health Centers (FQHC), medical home initiatives, Supplemental Security Income (SSI), Catastrophic Illness in Children Relief Fund (CICRF) and other community-based initiatives extend the safety net through which Title V links CYSHCN with preventive and primary care.

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

3.E.2.b.2. 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, to assure cultural and linguistic competence and to promote health equity in the work of NJ's Title V program.

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

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

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

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

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

Recognizing the importance that parent/consumer involvement has in the design and implementation of a program to address issues related to preterm births and infant mortality, the MCH Program incorporated focus groups into several programs under the HWHF initiative including those for doulas, breastfeeding, and addressing disparities. Community Advisory Boards have also been established by the HWHF grantees with an emphasis on recruiting new and nontraditional partners. Similarly, the Home Visiting Program (MIEC-HV) also requires funded grantees to implement County Advisory Boards.

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

CYSHCNs educational materials and informational brochures receive input and are reviewed by parents/consumers for health literacy and cultural competence.

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

Both the Early Hearing Detection and Identification (EHDI) and the Newborn Screening and Genetic Services (NSGS) Programs within the SCHEIS also recognizes the pivotal role that consumers and parents play in the effective administration of their program. EHDI has an Advisory Council composed of parents of Deaf and hard of hearing children and consumers who themselves are Deaf or hard of hearing. Participants on the council take part in literature reviews, advise the NJDOH regarding innovations in the programmatic area and assist in the review of operations of the program. 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 timely responsive to any current concerns regarding newborn screening.

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

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

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

organization consisting of parents or families of CYSHCN, SPAN's guides, publications and presentations are consistently developed, by design, with family and consumer involvement.

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

3.E.2.b.3. States Systems Development and Other MCH Data Capacity Efforts

Evaluating services for New Jersey 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 New Jersey'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 supports the use of vital statistics data and hospital discharge data to identify cases of maternal deaths that are then used by New Jersey's Maternal Mortality Review Committee 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.

3.E.2.b.4. Health Care Delivery System

National health care reform has been one of many changes impacting the role of FHS as NJ's Title V agency. FHS has positioned itself to play an important role in health systems development and transformation. FHS had long ago shifted from a direct service delivery orientation to a preventive, population-based assurance role that could be responsive to new national programs and policies and the changing economic climate. MCH grantees, stakeholders and partners typically refer uninsured pregnant women, women of childbearing age, children and adolescents to resources to access primary, preventive and reproductive health care services. NJ's uninsured rate was reduced from 15.0% in 2013 to 10.7% in 2016, the lowest in decades. The Affordable Care Act has helped more than 800,000 additional NJ residents obtain insurance between 2013 and 2016; 500,000 through the expansion of Medicaid, or FamilyCare, and another 300,000 through marketplace policies.

Although the Affordable Care Act has clearly made a difference relative to access to care for a large number of residents of NJ, there are populations that have not directly benefitted from the law. Most notable among this population is undocumented residents. However, NJ does have programs that meet the needs of this at-risk population. Through the State funded Uncompensated Care Fund, NJ reimburses 20 licensed federally qualified health centers with over 110 sites throughout the State (covering all 21 counties) for medical and dental care services provided to the uninsured. Among this population are women who would otherwise receive coverage for prenatal care services through a Medicaid Waiver program for pregnant undocumented women. The Medicaid waiver program has limited funds and once its funds have been exhausted, the population is automatically referred to the federally qualified health centers for necessary services. Through these collective efforts, MCH grantees, stakeholders, partners and other State Executive Branch agencies have had an impact on meeting the ongoing needs of MCH populations that remain uninsured despite the implementation of the Affordable Care Act. In May 2018, NJ became the second state to adopt an individual health insurance mandate, or tax penalty for those who are not insured. NJ also created a reinsurance program which together with the individual mandate is credited with stabilizing the health insurance market and contributed to a 9.3% premium decline in individual market plans on average sold in 2019.

In NJ, health care is beginning the transition to move out of hospitals and into outpatient settings through the Accountable Care Organizations (ACOs) and the new Delivery System Reform Incentive Payment Program. The NJDOH has allocated \$166.6 million in hospital funding, approved by the Centers for Medicare and Medicaid Services, to the Delivery System Reform Incentive Payment (DSRIP) program. This innovative program rewards hospitals with funding to improve quality of care by facilitating and providing home bound services, and reducing the number of re-hospitalizations for the conditions the participating hospitals have chosen to address. These conditions include obesity, diabetes, asthma, cardiac care, chemical addiction and behavioral health. FHS/Title V staffs have been collaborating with the NJDOH/DSRIP staffs and Department of Human Services, Division of Medical Assistance and Health Services (Medicaid) in the design and implementation of the program to assure that MCH population needs are addressed.

The NJ Department of Human Services /Division of Medical Assistance and Health Services reviewed and certified three Accountable Care Organizations (ACOs) that went into effect in July 2015: the Camden Coalition of Healthcare Providers, Healthy Greater Newark ACO, and, Trenton Health Team.

Preliminary findings have shown that ACOs are developing precisely targeted strategies to engage providers and improve targeted subsets of quality measures. ACOs also promise to reduce costs while improving maternal and child health (MCH) outcomes. However, payment reform policies will need to be tailored to fully address MCH priorities, particularly to ensure appropriate care for women with high-risk pregnancies. To this effect, there needs to be a more effective collaboration between FHS and the state's Medicaid agency.

In May 2018, NJ became the second state to adopt an individual mandate, or tax penalty for those who are not insured. NJ also created a reinsurance program which together with the individual mandate is credited with stabilizing the health insurance market and contributed to a 9.3% premium decline in individual market plans on average sold for 2019.

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

E.2.c.1. Introduction

3.e.2.c.1.a. Women/Maternal Health

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

	2012	2013	2014	2015	2016	2017
Percent of women with a past year preventive medical visit	72.9	72.5	73.6	74.8	75.5	

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

The Healthy Women Healthy Families Initiative is a five-year state-wide grantee program implemented on July 1, 2018 and includes six community-based grantees in 12 regions; HWHF is focused on improving birth outcomes and reducing black infant mortality. Specific black infant mortality reduction activities in 8 municipalities (Atlantic City, Camden, East Orange, Irvington, Jersey City, Newark, Paterson, and Trenton) include breastfeeding, centering, fatherhood initiatives, and doulas.

HWHF's use of Community Health Workers and Central Intake Hubs is focused on improving maternal and infant health outcomes including women's health with preventive medical visits, preconception care, prenatal care, interconception care, preterm birth, low birth weight, and infant mortality. This has been coordinated with existing federal and state-funded initiatives including Healthy Start, Maternal Infant and Early Childhood Home Visiting, Strong Start, Title X Family Planning, Perinatal Addictions Prevention, Postpartum Mood Disorders, Coordinated School Health, WIC, Federally Qualified Health Centers (FQHCs).

Through use of Community Health Workers and Central Intake the HWHF Initiative targets limited public health resources to populations and communities with the highest need where impact will be greatest to improve population health outcomes and reduce health disparities. The newly designed 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).

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).

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

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

Through its collaboration with the NJDOH Office of Population Health and the Population Health in Action Teams, FHS will be establishing 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 Social Determinants of Health (SDOH). The DOH Title V Program and Office of Population Health are working 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.

The Healthy Women Healthy Families Initiative (HWHF) implemented in 2018 is designed to improve pregnancy outcomes and intentionally focuses on reducing disparities. HWHF includes supporting organizations in targeted high BIM cities to implement evidence-based programs like Centering (a type of group prenatal care), doulas, breastfeeding, and fatherhood initiatives. More than 30,000 women have

been screened since July 2018 and over 16,000 were connected to programs such as Home Visiting and Healthy Start.

Additional efforts to reduce maternal mortality and morbidity are being developed under First Lady Tammy Murphy's Nurture NJ Initiative whose goal is to "make New Jersey the safest place to give birth in the country".

The state Legislature is also focused on the problem of maternal mortality and morbidity with a diverse package of more than a dozen maternal-care related bills. Many bills have been signed into law including establishing a Maternal Mortality Review Committee by law, providing Medicaid coverage for doula services, establishing a perinatal episode of care pilot program in Medicaid, requiring Medicaid coverage for breastfeeding support, establishing a pilot program for shared decision making for pregnant women and their providers, and others.

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

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

3.e.2.c.2.p Plan for the Application Year - NPM #1

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.

The activities of the HWHF initiative and BIM reducing activities of breastfeeding and fatherhood support, as well as the expansion of Centering Programs and the doula pilot program continue to be implemented. Due to COVID19, progress of the Centering Programs (which are types of group prenatal and parenting care) has been on a pause with individual telehealth sessions continuing. Telehealth mini-grants have been awarded from the Centering Healthcare Institute to New Jersey's Centering programs. Virtual group visits are also being established and help to connect pregnant women and new parents who are likely more isolated due to the COVID19 crisis. Doula visits have transitioned into virtual visits including virtual doula support through the birth as needed and possible. At least 79 doulas have received their training in the Uzazi Village model and are serving women. HWHF Doulas will continue to participate in Medicaid's Doula Stakeholder meetings. The Fatherhood initiative has been tremendously successful in northern New Jersey with over 84 men having attended an evidence-based curriculum in 24/7 Dad. A statewide Breastfeeding Strategic plan is also being developed for DOH review.

The MIEC Home Visiting Programs and Healthy Start Programs will continue to case manage mothers and assure preventive medical visits through the monitoring of benchmarks which include a reproductive life plan, medical home and well women visits.

The DOH, FHS and the Office of Population Health will continue to focus on improving women's and maternal health through the development and implementation of a maternal mortality and morbidity strategic plan. The Department is joining efforts with First Lady Tammy Murphy's Nurture NJ Initiative and

the legislature which has proposed a package of maternal health related bills. NJ Governor Murphy has directed the implementation of many legislative mandates to promote maternal health. These mandates include the development of annual report care of hospital maternal care, the establishment of the NJ Maternal Data Center, the NJ Maternal Mortality Review Committee, and the NJ Maternal Quality Collaborative; Medicaid coverage for doula care, a perinatal episode of care pilot program in Medicaid, and a shared decision-making pilot program.

Nurture NJ is a statewide awareness campaign to reduce infant and maternal mortality and morbidity and ensure equitable maternal and infant care among women and children of all races and ethnicities. The State Legislature passed P.L. 2019, c. 75 which authorizes DOH to establish a Maternal Care Quality Collaborative, the Maternal Mortality Review Committee and a Maternal Data Center.

Nurture NJ is sponsored through the First Lady's Office and is a statewide awareness campaign 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. This campaign includes a multi-pronged, multi-agency approach to improve maternal and infant health in New Jersey. Through additional federal funding from CDC to expand New Jersey's Maternal Mortality Review Committee and federal funding from HRSA to engage in activities of the Maternal Health Innovation Program, New Jersey looks forward to better understanding the root causes of maternal mortality and morbidity and using innovative practices and approaches such as shared decision making and implicit bias training to improving birth outcomes and reducing disparities.

E.2.c.2.a. Perinatal/Infant Health

3.E.2.c.2. Perinatal/Infant Health

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

3.E.2.c.2.a - Annual Report - NPM 4:

4A) Percent of infants who are ever breastfed and

4B) 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.

According to the Centers for Disease Control and Prevention (CDC) 2018 National Immunization Survey Breastfeeding Rate Report Breastfeeding Report Card, New Jersey rates have increased in four categories: newborns ever breastfed increased from 82.8% to 88.8% (NPM 4A); exclusive breastfeeding at 3 months increased from 40.6% to 43.7%; breastfeeding at 6 months increased from 57.6% to 60.2% (NPM 4b); and breastfeeding at 12 months increased from 36.1% to 38%.

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

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

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

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 infant feeding and mother/baby bonding. BFHI recognizes and awards birthing facilities who successfully implement the Ten Steps to Successful Breastfeeding (i) and follow the International Code of Marketing of Breast-milk Substitutes (ii). Thirteen NJ hospitals have earned the “Baby-Friendly” designation. Two “Baby-Friendly” hospitals were added in NJ in 2019.

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 2015, 39 of 53 (80%) eligible hospitals participated in the mPINC Survey and the total score was 83. NJ has been gradually increasing its mPINC score and has improved its state rank to 10 out of 53 in 2015. The 2018 mPINC survey results and state reports will be released by the CDC later in 2020.

Despite the overwhelming evidence supporting the importance of and recommendations for exclusive breastfeeding, exclusive breastfeeding rates in the 24 hours prior to hospital discharge in NJ remain low (see Chart 9 of Supporting Document #3), while any breastfeeding (both exclusive breastfeeding and breastfeeding supplemented with formula feeding) rates continued to increase, yielding an overall increase in breastfeeding initiation rates. NJ Birth Certificate data for 2017 shows that exclusive breastfeeding at hospital discharge statewide decreased for the third year in a row to 37.4%, while any breastfeeding (exclusive and combination feeding) was 77.0%.

Breastfeeding rates on discharge (alone or in combination with supplemental formula) varied with the racial and ethnic composition of mothers. In 2017 Asian non-Hispanic women were most likely to breastfeed (82.9%) while black non-Hispanic women were least likely to breastfeed (66.8). White non-Hispanic and Hispanic women initiated breastfeeding at 75.5% and 80.7% respectively.

The exclusive rates for 2017 were 42.6% for white non-Hispanic women, 28.8% for Asian non-Hispanic women, 23.6% for Hispanic women, and 22.0% for Black non-Hispanic women. These statistics underscore the importance of comprehensively evaluating and addressing healthcare delivery, access, culturally appropriate support and community involvement to combat disparities.

Further examination of the disparity in these rates will require State leadership in enforcement of hospital regulations regarding breastfeeding and in providing support for information of 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. International Board Certified Lactation Consultants 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 Healthy Women, Healthy Families (HWHF) Initiative and the MIEC Home Visiting Program. In the first quarter of FY 2020 (1/1/2017 to 3/30/2018), 88% of mothers with newborns participating in the MIEC Home Visiting Program had initiated breastfeeding and 60% of HV participating mothers were still breastfeeding when their infant was 6 months old. The newly designed Healthy Women Healthy Families Initiative will include as one of its outcomes increasing exclusive breastfeeding. Additionally, in an effort to address the racial/ethnic disparity in breastfeeding rates, one of the interventions/strategies that will be a requirement in targeted municipalities include breastfeeding support groups for Black, non-Hispanic, women.

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 New Jersey Breastfeeding Strategic Plan Steering Committee, consisting of NJDOH and Title V staff, with representatives from the New Jersey 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 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 regard to WIC and SNAP participants. The project also included 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 non-traditional 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 was undertaken. Utilization of the data created by the above activities to inform a needs assessment and 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 NJBSP mission. The final report was submitted in April 2020 for review by DOH.

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 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 increasing 25.7% rate for hospitals supplementing breastfed infants with formula before two days of life; this is above the national average of 17.1% (with a Healthy People 2020 Target of 14.2%) and ranks NJ 39 out of 52 states. In 2018 NJ was ranked 3rd worst out of 54 states. The Joint Commission Perinatal Care Core Measure on Exclusive Breast Milk Feeding (PC-05a) was retired in recognition of the decision some women make to not exclusively breastfeed despite recommendations. PC-05 continues as an accountability measure that is publicly reported on The Joint Commission's Quality Check® website.

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.

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

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

Table NPM #5

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
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

Notes - Source – NJ PRAMS.

<https://www26.state.nj.us/doh-shad/query/selection/prams/PRAMSSelection.html>

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

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

SCNJ educates providers and the public including parents, grandparents, physicians, nurses, the child care community, hospitals, first responders, schools, social service agencies, clinics, home visiting programs, doulas, and faith-based communities and works with state, federal and national organizations to reduce infant mortality, the racial and ethnic disparities associated with it and the antecedent risk factors contributing to the vulnerability of infants to unsafe sleep environments. SCNJ follows the guidelines of the AAP when providing risk reduction education. The Safe Infant Sleep guidelines of the AAP are intended to help families reduce the 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. NJ rates of SUID are among the lowest in the US. In 2015-2017, New Jersey's SUID rate was 0.65 per 1000 live births in contrast to the national rate of 0.92 and

was in the lowest septile of states (CDC WONDER). Provisional NJ data for 2018 indicate a further decline.

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 is 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 through grant funds cribs, which are miniature pack n plays, were distributed to the Southern Jersey Perinatal Cooperative and the Southern division of Volunteers of America. This project's goal was to reach families with infants in family shelters. Many families entering a shelter would use a pack n play provided by the shelter for their duration of the time in the shelter, but upon leaving would not leave with the pack n play because the shelter needed them for other families. Providing the shelters with miniature pack n plays allowed the shelters to help model safe sleep with the families and allowed the families to leave ensuring they had a safe sleep environment for when they left especially since some of these families would be known to couch surf after leaving.

In 2018 The SIDS Center of New Jersey developed a unique and free app, SIDS Info, for iOS and android devices, in English and Spanish, with the goal of enhancing the education of parents and providers about safe infant sleep and providing parents with direct access to this information. This novel and interactive tool containing text, voiceovers to eliminate literacy challenges, graphics, and a menu of additional resources that gives nurses, physicians, child care specialists, case workers 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 familiar with accessing information in this manner. Pediatricians are encouraged to review the app with families at well-baby visits. Rural communities and others with limited access to health resources are able to access this tool directly. This app received a Public Health innovation Award from the NJDOH. In 2019, faculty of the SCNJ released a second app, developed in collaboration with Rutgers University and volunteers of Microsoft, intended to extend usage through the first year, through multiple design strategies, in order to compensate for reductions in compliance over time. These tools are now widely used in NJ and other states. Other recent educational strategies include the development of webinars, reaching grandparents through faith-based communities, novel methods for delivering hospital-based messaging, school-based community education and participation in the community-based outreach programs of Nurture NJ.

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 73.4%, the data for 2018 falls within the standard error of measurement of 2017 and thus is comparable to the previous year. The SUID rate has also declined from 113.6 per 100,000 live births in 1990-1992 to 65 per 100,000 in 2015-2017 according to the NCHS. The provisional NJ SUID for 2018 indicates a further decline. 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, trained by SCNJ, as well as through the identification by the SCNJ of social and cultural factors that underlie disparity in the application of safe sleep practices.

ESM 5.1 (Increase infant safe sleep practices as reported by the PRAMS survey) was selected for its positive impact on NPM #5 and its importance in targeting improvement on the individual components (on back, no cosleeping, no soft bedding) of the infant safe sleep message based on readily available PRAMS data. Reporting NJ PRAMS data on co-sleeping and soft bedding in addition to on back would provide more detailed information on the success of Infant Safe Sleep education.

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.

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Annual Indicator	14.5	14.0	13.2	13.0	12.7	12.8	13.3	13.3	13.6	13.1	
Numerator	2,444	2,298	2,105	2,021	1,986	1,930	1,983	1,879	1,852	1,774	
Denominator	16,816	16,402	15,945	15,586	15,692	15,064	14,864	14,169	13,634	13,530	

Notes - Source - Birth Certificate data from the SHAD system

<https://www26.state.nj.us/doh-shad/home/Welcome.html>

See Chart 5 Low Birthweight by Race/Ethnicity attached as Supporting Document #3.

Maternal and Child Health Services has a long history of efforts to combat persistent perinatal health disparities. Despite years of improving pregnancy outcomes programs and appointments of task forces dedicated to addressing disparities in healthcare, these disparities continue.

NJDOH co-sponsored a full-day professional conference titled, Black Infant Mortality in New Jersey: Past, Present and Future, June 2, 2017 in Newark, NJ. The conference included presentations by experts on racial disparities in infant mortality trends and contributing factors, and stimulated discussions amongst the diverse stakeholders, including representatives from the clinical, scientific and policy arenas, to identify effective interventions that can be applied locally, regionally and/or nationally. Recently, on February 27, 2018, NJDOH, in collaboration with the East Orange WIC clinic showcased an event entitled “Black Breastfeeding: Rediscovery and Restoration of a Legacy” which focused on promoting breastfeeding in the black community. The event was commenced with opening remarks by Ted Green, East Orange Mayor. Tammy Murphy, First Lady of New Jersey, spoke about her charge to improve Black Infant Mortality and Shereef Elnahal, Commissioner of the New Jersey Department of Health, recommitted Black Infant Mortality as a priority to improve the well-being of women and infants.

First Lady Tammy Murphy has made reducing black infant mortality a top priority. The First Lady traversed the state over the past year meeting with stakeholders to better understand the depth of the crisis, and to raise awareness that New Jersey's black infants are three times more likely than white infants to die before their first birthday. The First Lady launched Nurture NJ, a multi-pronged, multi-agency campaign focused on reducing maternal and infant mortality and morbidity, and ensuring equitable maternal and infant care among women and children of all races and ethnicities. The Nurture NJ campaign is dedicated to ensuring equitable maternal and infant care among women and children of all races and ethnicities.

Through the Healthy Women Healthy Families (HWHF) Initiative, implemented in July 2018, efforts are targeted to reduce the Black Infant Mortality Rate in New Jersey. Specific BIM reducing activities including Centering programs, a doula pilot program, breastfeeding support and fatherhood initiatives are being implemented in the cities with the highest BIM rates in NJ. Efforts are also being placed on safe sleep practices through a) outreach and education, as well as b) providing linkages that will address some of the social determinants that literature and research as well as focus groups conducted by FHS have identified as contributors to mortality. Intentional focus continues on municipalities that were identified as having the highest Black Infant Mortality Rates as well as high proportion of Black, NH, women in need of these services.

E.2.c.2.p. 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 4A & B. The 12th and 13th NJ hospitals to earn the “Baby-Friendly” designation were Virtua Memorial Hospital and Virtua Voorhees Hospital in 2019. 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 on promoting breastfeeding policies and practices in hospitals which should lead to an increase in NPM #4 (Breastfeeding). Many hospitals employ International Board Certified Lactation Consultants who provide early support and information to breastfeeding mothers, however it requires a commitment from the entire organization to implement breastfeeding supportive policies and practices.

WIC’s 2019 Strategic Plan includes facilitating the creation of the New Jersey Breastfeeding Strategic Plan (NJBSP) with the NJ Breastfeeding Coalition (NJBC). The final report of the NJBSP with recommendations of short and long term goals, objectives and strategies will be released in 2020 for review.

WIC will continue to provide breastfeeding promotion and support services to pregnant and breastfeeding women who participate in the Program.

Existing FHS programs that promote breastfeeding and include performance measures for increasing breastfeeding include the HWHF Initiative and the MIEC Home Visiting 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, increase over time in the proportion of mothers who breastfeed their 6-week-old infants, is included in the MIECHV and Healthy Start performance benchmarks.

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

Plans for the coming year to promote safe infant sleep include continued safe sleep education through the SIDS Center of NJ (SCNJ), MIEC Home Visiting Program and 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 will continue its assessment of community-level needs, provide a range of programs that address provider knowledge, education skills, an understanding of the impact of adverse social and health determinants and implicit bias and an understanding of why well-established knowledge of safe sleep practices does not always translate into practice. In addition, alternative methods for direct public education also will continue to be developed by the SCNJ along with its efforts in support of the next update in 2021 of the AAP guidelines to better understand and address barriers found nationally in raising compliance with safe sleep practices. Additionally, the SCNJ will continue to examine the paradox that populations with low compliance with some aspects of safe sleep but few adverse social and health determinants have low SUID rates. (Ostfeld BM, Hegyi T, NJ Pediatrics, 2018).

The SIDS Center of New Jersey (SCNJ) educates hospital nurses by providing its on-site program, Nurses LEAD the Way, by presenting at regional nursing conferences, and by communicating through other venues such as listservs, webinars and e-blasts. In addition to providing information, SCNJ presentations offer model hospital policies, scripts for educating parents and addressing potential barriers to compliance, and educational materials in electronic and hard copy, using content developed by SCNJ and by the NICHD Safe to Sleep Campaign. Many of the SCNJ resources, including checklists and videos, a so-called Hospital Tool Kit, can be accessed from the [SCNJ website](#). The apps, video and

webinars developed by SCNJ are also disseminated. Working with the AAP-NJ Chapter, the medical Grand Rounds systems, and primary care centers, SCNJ extends education to pediatricians and other physicians serving families. Community programs, including WIC also receive education on safe sleep and disparities in antecedent health and social risks. The SCNJ determined the efficacy of its school-based curriculum and will promote adoption in other school systems. The impact of implicit bias is part of these presentations. SCNJ also addresses community concerns caused by messaging on safe sleep that contradicts the AAP guidelines.

In 2018 to make it easier for hospitals to carry out safe sleep education, SCNJ developed a cost-free, educational app, SIDS Info, in English and Spanish (<https://itunes.apple.com/us/app/sids-info/id1355933710?mt=8>). This app provides nurses with an interactive educational tool to help them share the information with families. Voice-overs address any limitations in literacy. The menu provides nurses with additional tools to support their own knowledge. Importantly, pediatricians and nurses have been assisting families download this free resource to their cell phones for future reference. It is also a tool that families with limited access to healthcare can download directly. Funding for this app was derived from a health services grant from the NJ Department of Health to the SCNJ. In 2019, a second free educational app was developed by faculty of the SCNJ in collaboration with 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 compliance over time.

Through grant funding from NJDOH, the SCNJ provides public health interventions to birthing hospitals, as part of the Nurses LEAD the Way initiative, to the Division of Child Protection and Permanency and to a wide range of public health, social service, community, medical, faith-based, first responder and child care systems. Based on the most recently released data from the NJ Center for Vital Statistics, NJ's SUID rate falls in the lowest septile of state rates.

There are racial and ethnic disparities in antecedent factors that raise the risk of SIDS as well as of lifespan health issues, and these contribute to disparities in rates. Such factors include disparities in preterm births, access to care, poverty, neighborhood crime, and exposure to second-hand smoke, a major contributing factor rising to the level of causality. 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 predict SUID rates across states. The SCNJ has studied population groups with poorer compliance with safe sleep practices but fewer social and health risk factors 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, Nurture NJ, and Family Festivals held in high risk communities as well as 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 future plans for broader adoption. In higher risk communities, all methods for communicating with parents will be accompanied by clothing providing safe sleep guidance. The SCNJ also released an Infant's Bill of Rights to the NJDOH and strategic planning partners to serve as a framework by which to work toward addressing the risk factors beyond safe sleep that contribute to SUID and to disparity in rates.

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

The Healthy Women Healthy Families (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 and fathers will continue to be developed and evaluated. The Doula Pilot Program will continue in the next year with plans to maintain the current workforce. Centering programs, although temporarily on pause due to COVID19, are expected to continue once social distancing restrictions are no longer needed. In the meantime, the option of virtual

groups will be explored. The goal of the HWHF Initiative continues to be to improve maternal and infant health outcomes for high-need women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes through a collaborative coordinated community-driven approach. County-based consumer-driven advisory 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. The Department's focus on improving women's and maternal health through the development and implementation of a maternal mortality and morbidity strategic plan will have a positive impact on reducing black non-Hispanic preterm births.

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

E.2.c.3.a. Child Health

The domain of Child Health includes the State Priority Needs of #3 Improving Nutrition and Physical Activity and the selected National Performance Measures of #6 Developmental Screening. 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 percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.

	2007	2011-2012	2016	2017-2018
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

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 MIEC Home Visiting Program and improving developmental screening practices and policies is a current focus on HV evaluation and continuous quality improvement. The NJ MIEC Home Visiting Program promotes and monitors parent completed child development screening tools (ASQ and ASQ: SE). In SFY 2019 5,805 families with young children participated across all 21 NJ counties.

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

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

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

Over the project period, SPAN and The Boggs Center partnered to provide 15 parent-led trainings about developmental screenings to healthcare providers at FQHCs throughout the state, attended by a total of 195 participants. Overall, 7 trained SPAN Family Resource Specialists, each with a child on the autism spectrum, participated in the project and a total of 27 SPAN parents were represented at the 15 trainings. Early Intervention representatives presented at 9 of the 15 trainings; all but one were parents and one was a sibling.

NJ is part of a national Project LAUNCH initiative funded by HRSA that is designed to promote the wellness of young children ages birth to 8 and to reduce racial and ethnic disparities including an emphasis on routine developmental screening. NJ Project LAUNCH is targeting urban Essex County and is using a [Help Me Grow](#) systems approach to strengthen the connections between physicians, parents/families, and community providers to addresses the physical, social, emotional, cognitive, and behavioral aspects of child development. Project LAUNCH ensures that parents/families have access to a continuum of community-based evidence-based programs (EBP) that support parent-child interaction and young child development across a range of settings—health care, home visiting, child care, Early Head Start/Head Start, preschool/school to promote early identification of health and developmental issues that impact child wellness. In FY18, the NJ Project Launch grant ended, however many of the activities to the NJ Project Launch Essex County team aligned with Central Intake, the Help Me Grow System and ECCS Impact continued, which include the reach and linkage of families with young children to services and programs that support family and child well-being; inclusive of developmental health promotion and screening.

The selected ESM 6.1 will monitor progress on increasing the use of parent-completed early childhood developmental screening using an online ASQ screening tool and how well early childhood developmental screening is promoted across the Departments of Health, Children and Families, Human Services, and Education which will drive improvement in NPM #6 (Developmental Screening). NJ DCF 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 will link developmental screenings with current Central Intake assessments to support 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 Project Launch/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 (PBC’s) to join in the implementation in FY19. In FY2018,

the 1,029 children (ages 10 – 71 months) receiving an ASQ developmental screening through the ECCS Impact grant through the NJ Home Visiting Program and Central Intake (ASQ Family Access Portal).

Plans for additional expansion of screening to the additional 16 counties is slated to occur in FY20 with the expansion of Early Childhood Specialist staffed within all 21 Central Intake hubs.

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

The NJDOH will continue to participate as an interdepartmental partner active with the NJ Council for Young Children (NJCYC), the Race to the Top-Early Learning Challenge (RTTT-ELC) grant and CDC's 'Learn the Signs' NJ Team. The NJCYC, Infant Child Health Committee has established a priority of improving system connections for children and families with health care providers, community services, early intervention, child care, and home visiting to expand screening (prenatal and child development) in health care and early care and education settings. Grow NJ Kids (GNJK) a Quality Improvement Rating System (QRIS) developed for early learning programs requires the use of a "state approved" developmental screening at Level 2 of a 5 level rating with the expectation that 90% of high needs infants and children participating in GNJK will receive developmental screening by 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 Impact grant will permit monitoring of ESM 6.1 (Promote parent-completed early childhood developmental screening) and promote improvement in NPM #6.

The MIEC Home Visiting Program will continue to promote and monitor parent completed child development screening tools (ASQ and ASQ: SE). In SFY 2019 5,805 families with young children participated across all 21 NJ counties. Developmental screening is a required benchmark performance measure and improving developmental screening practices and policies is a current focus on HV evaluation and continuous quality improvement.

Plans for additional expansion of parent completed child development screening (ASQ and ASQ: SE) to all 21 NJ counties is slated to occur in FY20 with the expansion of Early Childhood Specialist staffed within all 21 Central Intake hubs.

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

E.2.c.4.a. 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), NPM #11 (Percent of children with and without special health care needs having a medical home) and NPM #12 (Percent of children with and without special health care needs who received services necessary to make transitions to adult health care). Because reporting on NPM #11 and #12 overlap the two domains of Adolescent/Young Adult Health and SCHCN, the narrative for NPM #11 and #12 will be presented in this Adolescent/Young Adult Health section and not repeated in the CYSHCN Section. This section serves as the state's narrative plan for the Application year and as the Annual Report for the reporting year. Planned activities for the Application year are described and programmatic efforts summarized that have been undertaken for the Annual Report year, with primary emphasis placed on the performance impacts that have been achieved. The strategies and activities to address the identified priorities from the Needs Assessment Summary are further described.

Annual Report - NPM #9: Bullying

Improving NPM #9 (Bullying) is an important measure on the domain of Adolescent/Young Adult Health (AYAH) and is related to SPN #4 Promoting Youth Development and SPN #5 Preventing Teen Pregnancy. Bullying can impact both short and long term physical and emotional health in adolescents and young adults. Bullying can lead to physical injury, social problems, emotional problems, increased risk taking behaviors and death.¹ Teens who are bullied are at increased risk for mental health problems, have problems adjusting to school and is connected to absenteeism.² Bullying also can cause long-term damage to self-esteem.³

Through the CAHP multiple efforts are made to decrease bullying in schools and build the social emotional learning (SEL) competencies of both youth who are bullies and are bullied. Building youth 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; to have meaningful interactions with others who are socially and emotionally competent; and to receive positive and specific guidance.

The Teen Outreach Program (TOP®), a nationally replicated SEL program evidenced to reduce teen pregnancy, school suspension and cutting class 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. 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 to bullying: teens connectedness (empathy, self-awareness and social awareness) and resiliency (emotion management, self-efficacy and self-management) which lead to improved decision making and relationships. Thus far, implemented in NJ since 2012, TOP® has shown to improve connectedness and resiliency in NJ teens.

Bullying is a learned behavior which 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.² 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.

In addition to engaging teens and parents directly, in order for more teens to be positively impacted, youth serving professional capacity must be improved at the school and community-based level. We know there is a strong connection between bullying and mental health and the National Institute of Health and Human Development (NICHD) research studies show that anyone involved with bullying—those who bully others, those who are bullied, and those who bully and are bullied—are at increased risk for depression.⁴ 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 them.⁵ 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 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 occurs on a quarterly basis and is required for all PREP and SRAE program grantees but is open to all CAH Programs and Program Partners including schools and community-based organizations where CAH programs operate.

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.

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 that should be delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. The Maternal and Child Health Bureau uses the AAP definition of medical home. State staff continues to develop refined techniques within the electronic reporting system (i.e., CMRS) that will include all seven qualities essential to medical home care.

CYSHCN with a medical home has been a priority for the SCHEIS program and has been supported by several partnerships and collaboratives. Having a primary care physician service identified in a child's Individual Service Plan (ISP) developed with an SCHS CM served as a medical home proxy beginning 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 and will continue through 2020 and beyond for ESM 11.1. It is acknowledged that a medical home is more comprehensive than just having a primary care physician. In part, it is also imperative for a child to have consistent health insurance to increase access to said provider. Of the 24,714 children age 0 to 18 years served in FFY 2019, 8,779 (approximately 35.5%) had a primary care physician and/or SPoC documented, and of those children approximately 57.1% had insurance identified in their ISP. The percent of CYSHCN ages 0-18 years served by SCHS CMUs with a primary care physician and/or SPoC has been selected as ESM 11.1, which should increase NPM #11 (Children with and without special health care needs having a medical home).

During SFY17 and SFY18, the Chart Review Forms for the Child Evaluation Centers (CECs), Cleft Lip/Palate Craniofacial Centers (CLCP) and Pediatric Tertiary Centers (PTCs) were revised to include questions regarding the presence and/or establishment of a Medical Home. Questions include: "1) Primary Provider Listed? and 2) Education if Primary Provider Not Listed?". The Specialized Pediatric Services Program (SPSP) implemented a program-wide chart review during SFY19 and SFY20 utilizing revised materials and measures developed during SFY18. A total of 325 charts were reviewed: 160 CEC, 105 CLCP and 60 PTC. Of the 325 total charts reviewed, 300 (92%) had included documentation of Primary Provider. The remaining 25 (8%) of total charts reviewed did not have documentation of a Primary Provider and did not include additional education regarding a Primary Provider. For agencies without documentation of a Primary Provider who did not include additional education regarding a Primary Provider, technical assistance was provided in a final written evaluation.

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

	2007	2011-2012	2016-2017
Percent of children with special health care needs having a medical home	51.8	42.2	35.2
Percent of children without special health care needs having a medical home	57.8	55.4	51.7

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

All (100%) of CYSHCN referred into NJ Title V's SPSP providers and SCHS CMUs are screened for status of primary care provider and their families are provided with information on how to link with a primary care provider/medical home. The Title V SCHS CMUs and pediatric specialty providers will continue to provide a safety net for families of CYSHCN. The number of CYSHCN served across SPSP increased; 94,801 (SFY18) vs. 120,323 (SFY19).

Demand for comprehensive evaluations through the CECs remained high over the past fiscal year. Several agencies reported an increase in wait times from a maximum of 9 months (during SFY18) to a maximum of 13 months (during SFY19). As of February 2020, the average wait time for an initial comprehensive evaluation through the CECs is 6.5 months with wait times ranging from 2 months to 13 months. In previous fiscal years, efforts to reduce wait times were focused primarily on the implementation of pre-appointment patient intake, the utilization of a cancelled appointments to reschedule patients on a "stand-by" wait list, and the distribution of surveys to assess for contributing factors.

A survey was implemented during February and March of SFY19 to assess for wait times, contributing factors to wait times and measures used to reduce the wait times at each CEC. Questions were presented in either a multiple-choice or Likert Scale format. According to the Survey, 66% of the CECs had a wait time "for initial comprehensive evaluation" of 1-6 months (33% 1-3 months and 33% 4-6 months) and 33% had a wait time "greater than 6 months" with a maximum wait time of 9 months. 100% of CECs completing the survey cited "limited number of providers" as a key contributor to the increased wait time for an initial evaluation at their CEC and 83% of CECs completing the survey cited "increased referrals to the Center" as a key contributor "increased wait time. 83% of CECs completing the survey

stated that they either “strongly agreed” or “agreed” that their CEC has taken measures to address the wait time for an initial CEC appointment. These measures included the use of “stand by wait lists” (100%), implementation of “consultation visits prior to initial evaluation” (67%), “front loading intake”/completion of intake prior to the initial evaluation (33%) and utilization of “centralized scheduling” (33%).

There were several attempts to schedule a face-to-face meeting with State Staff and the CEC providers to discuss the findings from the SFY19 survey and explore additional measures to reduce wait times for initial evaluation. However, due to variations in schedules among multiple providers from each CEC and limited availability during “non-clinical” hours, further discussion was completed via telephone/conference call and email correspondence between State Staff and CEC providers through the end of SFY19 and beginning of SFY20. Upon further discussion during SFY20, an increase in wait times was noted across several CECs. A total of 2 CECs (25% of CECs) noted a wait list of 1-3 months (a decrease from 33% assessed during SFY19), a total of 3 CECs (38% of CECs) noted a wait list of 4-6 months (an increase from 33% assessed during SFY19) and a total of 3 CECs (38%) noted a wait list greater than 6 months (an increase from 33% during SFY19). While the number of CECs with a wait greater than 6 months only appeared to increase by 5%, it should be noted that upon further assessment, the maximum wait time increased from 9 months to 13 months (with 1 CEC reporting a wait list of 11 months, 1 CEC reporting a wait list of 8 months and 1 CEC reporting a wait list of 13 months).

In order to gain a deeper understanding of the increase in wait times across the CECs from SFY19 to SFY20 and the individual contributing factors on an agency basis, a second survey was developed and implemented during February 2020. This survey relied on open-ended and/or narrative responses from each CEC rather than a multiple-choice/Likert Scale. The questions also expanded on the SFY19 survey and prompted additional information regarding: 1) variations in wait time for initial appointments by specialty 2) agency-specific guidelines for age, diagnosis/diagnoses and providers 3) referral to EIS when applicable 4) staffing changes within the last 12 months and 5) contributing factors. Although the SFY19 survey provided information regarding perceived contributing factors to CEC wait lists, the responses were limited to set categories and did not enable a deeper consideration of factors that may be unique to the CECs. Additionally, the SFY19 survey did not explore whether priority was given patients based on age or diagnosis. Following discussions with the CECs at the conclusion of SFY19 and beginning of SFY20, several CECs stated that their agencies utilized a policy for “fast-tracking” patients under the age of 3 or those with a suspected case of Autism. This enabled for patients deemed to be at “higher risk” to be seen before the maximum wait time.

Of the 8 CECs surveyed during SFY20, 3 CECs noted a difference in waiting time by provider stating that initial appointments for additional therapy services such as speech therapy, occupational therapy and physical therapy had a shorter wait list when compared to the wait list for initial neurodevelopmental evaluations. Staffing changes were reported by 5 of the 8 CECs surveyed and challenges with recruitment were identified as a key contributing factor by 5 of the 8 CECs. In addition to staff recruitment, “challenges with pre-authorization”, “high demand for evening appointments”, “families seeking evaluations from more than one provider simultaneously” and “the increased number of referrals” were reported as key contributing factors to increased wait times at the CEC.

Of the 8 CECs surveyed during SFY20, 5 CECs noted specific guidelines for scheduling initial appointments based on age and/or diagnosis. 2 of the 5 CECs stated that their agency had a policy for “fast-tracking” children 5 years of age and under while another 2 of the 5 CECs stated that their agency had a policy “prioritizing” children less than 3 years of age. “Priority” or “fast-tracking” frequently resulted in a decreased wait time of 3-6 months for children less than 5 years of age (for agencies with a wait list of 6 to 11 months) and a decreased wait time of 3-4 months for children less than 3 years of age (for agencies with a wait list of 6 to 8 months). 4 of the 5 CECs noted specific guidelines for scheduling initial appointments based on whether there was a suspected diagnosis of Autism, speech/language delays or motor delays. Patients with suspected Autism were “fast-tracked” and received an initial appointment in 3-6 months (for agencies with a wait list of 6 to 11 months) and patients with suspected speech/language delay or motor delays received an initial appointment in 2-3 months (for agencies with a wait list of 6-8 months).

Based on the findings of the SFY20 survey, it became apparent that each CEC faces a different set of challenges that contribute to prolonged wait times. It also became clear that one single approach would not effectively reduce wait times for all CECs in the SPSP network. Moving forward for SFY21, the SPSP will focus on individual policies at the agency level regarding wait times. Per the revised “Attachment C Program Specifications for Child Evaluation Centers” for SFY21, each CEC will be required to develop and implement (in collaboration with State Staff) a “Wait List Policy” that will include: 1) scheduling considerations based on age, diagnosis/diagnoses and/or requested providers, 2) guidelines regarding referral to Early Intervention Services (if applicable), 3) Methods to capture “wait times” for initial evaluations on a quarterly basis and 4) a template for quarterly reporting of “wait times” to State Staff. Not every CEC reported scheduling guidelines or considerations based on age, diagnosis/diagnoses and requested providers. Guidelines from organizations such as the CDC and NJAAP for specific age groups and/or diagnoses (examples including children birth through 3 years of age, children less than 5 years of age, children greater than 5 years of age, children with suspected ASD, children with suspected speech delays/motor delays etc.) would enable CECs to identify and prioritize patients who may require more immediate treatment and evaluation. Although this may not directly reduce that wait time at each CEC, it would allow for expedited initial evaluations for patients deemed to be most “at risk” regardless of wait times at each Center.¹² Referral to Early Intervention Services (when indicated) for children under 3 years of age would also facilitate access to needed services for eligible children with speech delays or motor delays. A mechanism capturing and reporting wait times on a regular basis will enable the CECs and State Staff to monitor progress towards a reduced wait time for initial appointments and identify new challenges as they arise.

Title V is committed to collaboration with the DHS Office of Medicaid Managed Care, the COCC, SPAN, and the NJAAP, and other community-based partners to engage in medical home initiatives to reinforce linkage of CYSHCN with comprehensive community providers. ISG projects are ongoing and have built upon one another. In July 2009 Title V, in partnership with the NJAAP and SPAN, implemented HRSA’s Integrated Systems Grant (ISG) to improve access to quality, culturally competent, family-centered systems of service for children, especially children with special health care needs. This project enabled NJAAP to work with over 30 practices in 13 counties across the State in the development of practice teams and use of the model for improvement to strengthen patient-centered medical homes. The ISG program success was measured using evaluation of the Medical Home Index (a nationally validated self-assessment tool for measuring “Medical Homeness” that each practice must complete pre- and post-program participation). Results for participating practices showed an overall increase from pre- to post, representing an increase in their overall “Medical Homeness.” Receiving recognition for their degree or “Level” of Medical Homeness, is for many practices, the next step after participating in NJ AAP’s Medical Home Initiative.

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

Ongoing improvements to the Case Management Referral System (CMRS) allowed new and different opportunities to track NPM 11 and 12.

¹ <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Early-Childhood-Development.aspx>

² <https://pediatrics.aappublications.org/content/118/1/405.full>

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.

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

	2014	2015	2016*	2017+	2018	2019
Annual NPM #12 Indicator	12.2	25.3	41.3	43.0	45.7%	48.1%
Numerator	352	1,101	2,073	2,208	2,027	2,663
Denominator	2,892	4,385	5,017	5,137	4,438	5,534
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Provisional

Notes - For 2014, 2015, 2016, and 2017 - seven possible types of transition to adulthood services were identified as proxies:

1. identification of an adult-level primary care physician (i.e., pediatrician excluded in the current definition),
2. transition-specific services including Division of Developmental Disabilities (DDD),
3. employment,
4. health insurance,
5. Supplemental Security Income (SSI),
6. SPoC,
7. Any service tied to 'transition to adulthood' documented as an Exceptional Event in the youth's record.

SCHS CMUs serve children with special health care needs up to their 22nd birthday. When the age criterion is relaxed to include youth age 12 to 21 years, 5,534 youth were served in FFY 2019. Of those youth, 2,603 (approximately 48.1%) received at least one service to aid in transition to adulthood.

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

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

The ongoing QI presentations to the SCHS CMUs stimulated an active discussion about how SCHS CM documentation produces system wide data that is used for QI and MCH Title V Block Grant reporting. These presentations also inform FCCS and SCHS CMU staffs on areas for training to more effectively unlearn and relearn documentation methods, to move from a lengthy narrative charting style to the use of

drop-down menus supported by brief entries that use shorter more consistent terminology. The State Health Data Specialist staff collaborate with the Quality Assurance Specialist Nurse and Program Officers to review and analyze CMRS data, and to provide additional QI presentations highlighting progress and additional areas of improvement in documentation on the Core Outcomes at SCHS CMU quarterly meetings.

During SFY17 and SFY18, the Chart Review Forms for the Child Evaluation Centers (CECs), Cleft Lip/Palate Craniofacial Centers (CLCP) and Pediatric Tertiary Centers (PTCs) were revised to include a measure of Transition to Adulthood with the addition of the following question: "1) Documented Transition to Adulthood (in Individual Service Plan/ISP)?" . The Specialized Pediatric Services Program (SPSP) implemented a program-wide chart review during SFY19 and SFY20 utilizing revised materials and measures developed during SFY18. A total of 325 charts were reviewed: 160 CEC, 105 CLCP and 60 PTC. Charts for patients 14 years of age and older were assessed for documented Transition to Adulthood. According to the Maternal Child Health Bureau, Transition to Adulthood is a Core Outcome for Children and Youth with Special Health Care Needs (CYSHCN) should begin when the child reaches about 12-17 years of age or on average of 14 years.³ Of the 325 charts reviewed, a total of 67 (21%) were for patients greater than or equal to 14 years of age. 28 of the 67 (48%) charts reviewed for children 14 years of age and older included documentation of Transition to Adulthood Planning. For agencies without documentation of Transition to Adulthood for patients 14 years of age and older, technical assistance was provided in a final written evaluation.

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

Under health care reform, NJ Medicaid eligibility for single adults has expanded in 2014 to up to 133% FPL. As this population is intended to include a significant percentage of childless adults with incomes below 133% of FPL, it is anticipated that CYSHCN transitioning to adulthood will have expanded opportunity to access health coverage through Medicaid, the insurance exchange, and coverage through their parents' insurance through age 26 (or in certain circumstance till age 31). In addition, it is also possible that some youth/young adults with special needs on Medicaid may experience a shift in eligibility to an insurance exchange. 20.8% of the 12-21-year-old youth who were served by SCHS CMUs in FFY2017 had an insurance service documented. Of those with insurance documented, 52.4% had Medicaid/NJ Family Care specifically.

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

The adolescent subset of CYSHCN served through Title V is observed to be significant. In SFY 2017, approximately 15% of CYSHCN served across the SCHS CMUs were aged 14-19 years of age. During SFY19, the percentage of youth age 14-19 years served by the SPSP agencies was greater, comprising nearly 29% of those served by the Tertiary Centers, and 16% by the CEC/FAS Centers. The Cleft Lip/Palate Craniofacial Centers reported 9% CYSHCN served among that same age group. Transition planning and implementation will remain a priority for these youth, their families, NJ Title V, and providers.

Documentation of transition planning was largely noted by SCHS CMUs to occur on or about age 14. A discussion with parents/youth about transition planning, and the distribution of transition packets were noted. An anecdotal observation by the SCHS CMs noted that families reported that they preferred to receive materials incrementally rather than one very large packet filled with resources. That incremental method provided them with the opportunity to focus on one or a few transition needs at a time, such as primary care provider; access to Supplemental Security Income and/or health insurance including

³ <https://mchb.hrsa.gov/cshcn0910/core/pages/co6/co6tahc.html>

Medicaid, Medicaid expansion and/or private insurance or the Marketplace; education/job training supports; statewide systems of care including the Department of Human Services' Division of Developmental Disabilities and/or the Department of Children and Family's Children's System of Care Initiative, and others.

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

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

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

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

Aligned with the Title V CYSHCN programs and funded by Part D of the Ryan White Care Act, the NJ Statewide Family Centered HIV Care Network remains a leading force in providing care to women, infants, children, youth (WICY) and families infected and affected by HIV disease in the State. Consequently, there is ongoing collaboration across systems within the Division of Family Health Services' Maternal Child Health and CYSHCN's programs, and the Ryan White Part D program to support WICY needs in the community. NJ ranks third in the nation for pediatric cases. Of youth 13-24 years, 912 were living with HIV/AIDS in 2016. 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.

Plan for the Application Year - NPM #9: Bullying

The plan for NPM #10 is to phase out the Medical Home Technical Assistance for pediatric practice teams and phase in the NJAAP's Healthy Spaces for Adolescents (HSA).

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

State SCHEIS staff will continue to refine tracking of Performance Measures in CMRS and provide documentation training to SCHS CMUs to ensure activities related to these Measures are accurately counted. 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 (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 SCHS 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 the youth remains in care. Although Title V will continue to assess youth's progress toward transition and linkage with community-based supports, the SCHS CM and SPSP programs are exploring the development of standardized needs assessment and quality indicators to better measure NJ CYSHCN's experiences.

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 2, 3 and 4 which impact NOMs 13, 15, 16, 17, 18, 19, 20, 21 and 22.

Annual Report (Last Year's Accomplishments) State Performance Measure 2:

Provisional data indicates that for 2019, 78.7% of infants not passing initial newborn hearing screening at birthing hospitals had out-patient audiological follow-up documented. Since follow-up exams are still occurring on children born at the end of 2019, 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.

Table SPM #2: 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.

	2011	2012	2013	2014	2015	2016	2017	2018	2019
Annual SPM#3 Indicator	86.0%	86.4%	88.2%	85.8%	86.0%	89.0%	87.5%	86.1%	78.7% *
Numerator	2451	2131	1945	1821	1869	1833	1570	1571	1274*
Denominator	2850	2467	2205	2122	2173	2059	1798	1824	1618*

*Note – Data for 2019 is incomplete. Follow-up reports are still being received for these children and the final rate is expected to exceed this rate

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

- All outpatient audiologic reporting to the EHDI program continues to be submitted via an EHDI module in the New Jersey Immunization Information System (NJiIS) registry. The NJiIS program had a complete system rebuild and the EHDI module was also modified to improve information collected about follow-up contacts to parents. The new system has been operational since January 31, 2018.
- Trained 11 new users on the EHDI reporting module in the NJ Immunization Information System (NJiIS) which is used by audiologists and other practitioners who are conducting hearing follow-up to report outpatient exams. The EHDI program receives approximately 89% of reports entered by providers through this Web-based application and the rest are sent to the program on paper forms.
- NJ DOH continued use of HRSA EHDI grant funding for county-based special child health services case management staff to conduct follow-up phone calls to parents and physicians of children in need of hearing follow-up.
- Continued use of HRSA EHDI grant funding for one of the Early Intervention (EI) program's Regional Early Intervention Collaborative's (REIC) to provide two part-time consultants who specialize in working with children with hearing loss. They have an initial phone conversation with parents of children who have recently been diagnosed with hearing loss to review EI services and discuss communication options for children with hearing loss. The consultants participate in the initial early intervention family meetings via remote access, using laptops with web-cameras. The consultants served a total of 177 families during the year.

- The EHDI Monthly Reconciliation Report is distributed to individual hospitals detailing children still in need of additional audiological follow-up after not passing inpatient hearing screening. This serves as a notice to hospitals of babies still in need of reminder contact. In addition, a report including statistics comparing the individual hospital to statewide statistical averages is sent annually.
- Continued annual distribution of a report to provide audiology facilities with feedback on the timeliness of follow-up for children seen at their facility after not passing inpatient hearing screening. The report also includes statistics on the timeliness and completeness of the documentation of their results.
- In 2019, a poster presentation entitled “Mother’s Place of Birth and Hearing Screening Follow-Up” was given at the 2019 National Early Hearing Detection and Intervention Conference in Chicago, Illinois.
- The Hearing Evaluation Council, a Commissioner appointed advisory board to the NJ EHDI program, held three meetings during the year. The HEC is made up of physicians (a pediatrician and otolaryngologist), an audiologist, a child of Deaf adults, a member of the Deaf community, a hard of hearing individual, and NJ residents interested in the welfare of children with hearing loss (including a parent of children with hearing loss and a teacher of the Deaf).
- In 2018, the Hearing Evaluation Council, the NJ EHDI program advisory board, worked with the Central Jersey Family Health Consortium who received a mini grant from the National CMV Foundation. This collaboration served to increase awareness of the risk of CMV infection in young children among health professionals, service providers, and parents as well as provided education on how to prevent CMV infections.
- In 2018, the NJ EHDI audiologist served as co-chair of the CARE Project Family Retreat held in NJ. Over sixty Deaf and hard of hearing children and their families participated.
- In 2019, the first NJ SKI HI training weekend, hosted by SPAN Parent Advocacy Network, a NJ EHDI Program grantee, was provided to individuals signed up to participate in the NJ Deaf Mentor program.
- In 2019, NJ EHDI Pediatric Hearing Health Care webinar entitled “How to Detect Vision Issues in Deaf and Hard of Hearing Children” was presented to NJ’s audiologists by a Deafblind Specialist with the NJ Center on Deaf-Blindness.
- In 2019, NJ EHDI program sponsored a Deaf Sensitivity training, for Family Health Services staff.

NJ EHDI Program has received funding from the NJ Department of Human Services Leveling the Playing Field (LTPF) initiative; these funds have been used to enhance the NJ EHDI Deaf Mentor Program. This initiative provides access to appropriate language role models for children with hearing loss (from birth to age 5) whose families have selected American Sign Language (ASL) as a primary mode of communication. The LTPF initiative seeks to enhance New Jersey Early Intervention Services and early childhood education by having ASL fluent paraprofessionals interact with children with hearing loss in the same way hearing childcare workers are interacting with hearing children in their center. The goal of this initiative is to provide full access to language throughout the child’s day.

- Originally scheduled for April 2020, 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 to have focused on cultural competency services for Deaf and hard of hearing people. Due to the COVID19 restrictions, this conference will be rescheduled. The target audience for this conference is service providers such as nurses,

social workers, and case managers. The conference is supported by SCHEIS and EHDI staff have served as valuable resource in this effort.

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

NJ has been very successful in linking children registered with the Birth Defects and Autism Registry (BDAR) (also known as the Special Child Health Services Registry) with services offered through our county-based Special Child Health Services Case Management Units (CMUs). As of 2012, the Case Management Referral System (CMRS) is used by the CMUs to track and monitor services provided to the children and their families. It electronically notifies a CMU when a child living within their county has been registered and released for follow-up. Also included in CMRS is the ability to create and modify an Individual Service Plan (ISP), track services, create a record of each contact with the child and child's family, create standardized quarterly reports and register previously unregistered children.

State Performance Measure 3: 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 and who are received services.

	2013	2014	2015	2016	2017	2018	2019
Annual Indicator SPM #3	50%	84.7%	88.9%	90.1%	91.8%	94.9%	94.5%
Numerator	3,508	11,089	13,696	13,634	14,011	12,416	13,326
Denominator	7,047	13,096	15,404	15,135	15,261	13,079	14,093

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

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

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

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

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.

b. Annual Report (Last Year's Accomplishments)

State Performance Measure 4: Average age of initial diagnosis for children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder.

In FY 2019, over 3,200 children with a diagnosis of autism were newly reported to the BDARS. The average age of initial autism diagnosis is 4.9 years old. This indicates a significant decline from the previous four years (SFY2015-2018) when the average ages were approximately 5.2 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 specialist 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 4.2. These younger birth cohorts may be getting diagnosed earlier as enhanced screening efforts and public awareness have increased.

Staff has also stressed the importance of quickly reporting children diagnosed as having autism by continuing to provide outreach about the Autism Registry through conference presentations and other meetings. Staff participated in several exhibits including the Annual School Health Conference sponsored by the NJ Chapter of the AAP, the Annual Autism New Jersey Conference and continue to meet with of private pediatric offices newly identified providers. Providers with untimely reporting are contacted and reminded of the mandate to report and the important linkage to SCHS CMUs.

One of the most important changes that occurred this year was a shift in the BDARS which greatly reduced the burden on our reporting agencies and improved the efficiency of the system. The improved system allows providers to verify if a child had already been registered for another provider. 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 just 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.

Plan for the Application Year - State Performance Measure 2: 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 #2 (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 annual distribution of audiology facility reports to highlight timeliness of follow-up and identify children with incomplete follow-up testing.

The EHDI program plans to 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 New Jersey Immunization Information System (NIIS) allows the EHDI program to identify the name, address and fax number of the medical home provider that has most recently provided immunization data for a child and will use this 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 for over a year. 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.

Plan for the Application Year - State Performance Measure 3: Percent of live children registered with the Birth Defects and Autism Reporting System (BDARS) who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services.

SPM #3 was chosen to improve the timeliness and effectiveness of using the Birth Defects and Autism Reporting System (BDARS), which has been an invaluable tool for surveillance, needs assessment, service planning, research, and 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.

For the coming year, we will be focusing on improving case definition across our case management units. 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.

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 of SCHS CMUs to ensure proper usage of the BDARS and 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 SCHS CMUs on a statewide, county-level, and individual-level basis.

Plan for the Application Year - State Performance Measure 4: Average age (in years) of initial diagnosis for children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder.

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Annual Indicator SPM #4	5.8	5.0	4.8	4.8	4.8	5.0	5.6	5.2	5.4	5.4	4.9

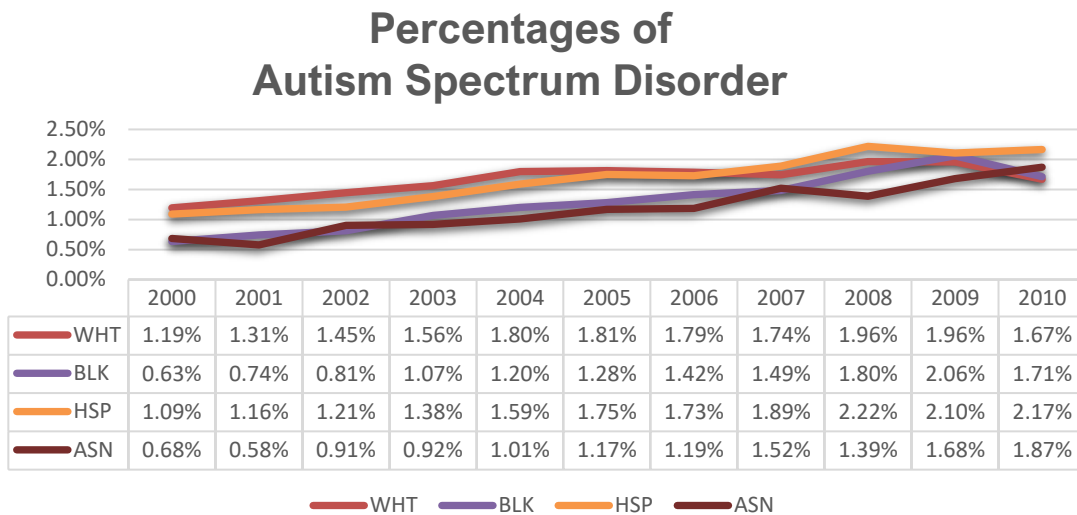
SPM #4 was chosen to measure the timeliness of diagnosing autism in children. Early diagnosis is important for initiation of services, as children who receive services at an early age have better functional outcomes. While the causes of autism are not known, receiving intensive services early in a child’s 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.

For this performance measure to be accurately determined, children are reported to the Autism Registry by licensed health care providers who have either diagnosed them or are providing follow-up care and have the full information regarding the child’s date of first diagnosis. The Registry requires all children under 22 to be registered. Although there is currently no timeline for diagnosing autism, the Registry encourages all reporting agents to quickly report children diagnosed with the Autism Spectrum Disorder so that families can be linked to SCHS Case Management.

In 2019, 2,480 children were registered, and had an average age of diagnosis of 4.9 years. Over time, the average age of initial Autism Spectrum Disorder diagnosis has decreased from 5.8 in 2009 to 4.9 2019. While this measure calculates the average age across birth cohorts, the median age by birth cohort is also considered a useful measure. The CDC reports the median age as just over 4 years of age. The median age for the pooled birth cohorts 2006-2012 is 3.6 years of age. New Jersey’s declining average age and median age could be due to increased awareness and screening efforts as well as New Jersey’s many diagnosticians and autism centers.

The average age at initial diagnosis is significantly different by race and ethnicity. For the pooled birth cohorts of 2006-2012, the average age for white-non-Hispanic children was 4.3 years. This was significantly different for Hispanic (4.2 years) and Asian (4.0 years) children but not significantly different

for black children (4.3 years.) There was also no significant difference between males and females which we might expect since the prevalence is much higher for males and females at 4:1.



BDARS staff have conducted outreach to educate and inform physicians and health facilities about the Registry, how they can register children with autism living in NJ, and the rules regarding the Registry. Registry staff have visited and trained staff from medical centers specializing in child development, developmental evaluations, and behavioral health. Additionally, they have trained staff from many private pediatric practices that follow older children with autism through annual well visits. Registry staff have also trained several psychiatric/behavioral departments located within hospitals. Staff from the Registry presented information concerning the Autism Registry to state and county case managers as part of training on the case management electronic component to the BDARS and they continue to retrain new staff within health facilities as needed. Staff have also created materials for both providers and families about autism and these materials have been translated into multiple languages including Spanish, Korean, Polish, Hindi, and Arabic. There is also information about the Autism Registry on the DOH website and staff continue to make conference presentations and exhibit.

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. 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).

E.2.c.6.a. Cross-cutting or Systems Building

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

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 the lifespan. People with limited access to preventive oral health services are at greater risk for oral diseases.

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

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

Table NPM #13

	2007	2008	2009	2010	2011-2012	2016	2017
Percent of women who had a dental visit during pregnancy	N/A				N/A	N/A	
Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	78.7				79.9	82.1	

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

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 2018-2019 school year, approximately 50,000 students received oral health and /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 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. 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 had 8,987 student participants in 69 schools during the 2017-2018 school year. Regular use of sodium fluoride mouth rinses in FMR programs have been found to reduce dental decay by up to 35%. The COHP expanded the program for the 2019-2020 school year to an estimated 10,719 students in 98 schools in communities without Community Water Fluoridation (CWF). Only 14.6% of New Jersey residents have access to CWF.

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 “Be a Smart Mouth” 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.

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 was updated during the Summer and Fall 2019 and can be found online at: https://www.nj.gov/health/fhs/oral/documents/dental_directory.pdf.

The COHP newsletter, “Miles of Smiles” for school nurses is mailed annually to over 3,300 school nurses and the “Oral Health Facts for Women, Infants, and Children” newsletter is emailed to State WIC Coordinators. Both contain timely oral health topics of interest and importance for staff to communicate to the populations they serve. These newsletters and other similar resources will be included on the Oral Health Services Unit webpage.

The Oral Health Nutrition and Obesity Control Program reimburses eight Federally Qualified Health Centers 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 within overweight or obese range as calculated by Body Mass Index. In Year 1 of the grant, (activity period April 2019 through August 2019), 1,359 patients were screened and received nutrition counseling. Of these, 400 patients had BMI percentiles within overweight or obese range. In Year 2 of the grant (activity period September 1 – January 2020), 1,534 patients were screened and received nutrition counseling. Of these, 527 had BMI percentiles within overweight or obese range. In Year 2, data collected to track caries experience indicated that 100 of these children had caries at the time of the dental visit. The goals of this program are to increase oral health literacy, provide information on proper nutrition and the benefits of physical activity, and improve the dental and overall health for children and their families. 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. Program deliverables are overseen by the Oral Health Services Unit.

The Oral Health Services Unit collaborated with Local Public Health, SNAP-Ed and the Department of Early Childhood Education to create an education webinar on lead, nutrition, and oral health for Early Childhood School Nurses entitled "Emerging Issues for School Nurses". This webinar will offer continuing education credits for nurses and will be release by the Department of Education in Spring 2020.

[Medicaid's Early and Periodic Screening, Diagnostic and Treatment](#) (EPSDT) program offers comprehensive preventive child health services to all Medicaid-eligible children under age 21 including periodic physical exams; hearing, vision and developmental screenings; screening children for elevated blood lead levels; vaccines; health education; and dental inspections and referrals. Medicaid in NJ is administered by the Division of Medical Assistance and Health Services (DMAHS) in the NJ Department of Human Services. The performance on this indicator has improved greatly and according to the 2017 Annual EPSDT Participation Report.

Annual Report - NPM #14:

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

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

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

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

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

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

Twenty target municipalities (TMs) were identified on which to focus MQC outreach and intervention, thus maximizing efforts to areas with the greatest need. The TM's were chosen based on the high numbers of pregnant women who used tobacco during pregnancy, and the high rate of preterm delivery among Black, Non-Hispanic women in these municipalities. Seven of the twenty municipalities were located in five counties outside of the southern region; the remainder were within the seven southern counties. In January 2018, the MQC database software program was redesigned and upgraded to a web-based system using the Salesforce platform in order to support more detailed reporting and integration of planned mobile technology.

Given the declining rate of maternal smoking and the stagnant and in some cases increasing numbers of postpartum women who were returning to smoking after delivery, MQC chose to rebrand to MQC for Families. According to the 2017 PRAMS Brief published by the NJDOH, living with other smokers represented the most prevalent indicator for postpartum relapse. Expanding the program to MQC for Families seeks to engage dads, family members, caregivers and other household smokers in cessation counseling along with the pregnant women and/or mother.

From July 1, 2019 thru June 30, 2020 there were 774 referrals to the program, 24% from the Central region, 26% from the Northern region and 50% from the Southern region. 673 of these referrals came from the automated Perinatal Risk Assessment (PRA) system: 53 referrals were faxed from providers; and, 48 were self-referrals from the MQC website and Facebook page online registration option. All 774 referred clients were sent self-help cessation information and texted the option of enrolling in MQC's cessation counseling program. 79 clients received a Level 1 cessation counseling session, and 52 clients went on to enroll in intensive cessation counseling. There were a total of 220 counseling sessions with clients enrolled in case management and 332 providers received client status reports on newly enrolled and existing clients. Of the enrolled pregnant clients, 82% quit or significantly reduced their consumption and 27% quit completely (the national average maternal quit rate is 24%). Among non-pregnant clients enrolled in cessation counseling, 79% quit or significantly reduced consumption, of which 33% completely quit. Throughout this year, 746 MQCF referred clients and their family members/caregivers were referred to the NJ Quitline.

MQC provides free on-site Ask, Advise and Refer Brief Intervention training to maternal and child health physicians, nurses, medical and nursing student staff, professional and para professional office, social service and community agency staff statewide. A decrease in funding resulted in a reduction in training staff this past year. From July 2019 through June 2020, 204 professionals received on site or online training. 826 professionals received information through conference tabling, toolkits, resource requests and networking opportunities. Approximately 101 pregnant women and families received information about the dangers of maternal smoking and MQCF and NJ Quitline services through formal education sessions. Community outreach and partner events reached an additional 650 mothers and families. MQCF staff now follow up (517 letters and emails sent this year) with every new prenatal provider trained on use of the PRA to schedule a MQCF program orientation session and to promote ASK ADVISE REFER training. From July 2019 thru June 2020, an additional 454 professionals received orientation sessions about MQCF and NJ Quitline.

This past year, funding from the FHI Prematurity Prevention Initiative (PPI) was utilized to continue MQCF services to target municipalities with the highest rates of black infant mortality, and specifically, Atlantic City and Newark. These efforts resulted in a 6% increase in referrals to MQCF from the Northern region overall, and Essex County moving from the number eleven spot in client referrals last program year to the number one spot this year. According to the MQCF data by target municipalities those communities with highest rates of Black Infant Mortality and adult smoking were approximately 35% of all referrals. These

results demonstrate that collaboration and targeted efforts were impactful in reaching mothers most at risk for maternal and infant mortality.

Collaboration with the PPI initiative also facilitated the final completion of the Quit for Kids Texting Support Program. Newly registered clients with a current or past history of smoking are automatically enrolled through the PRA, with an opt out option. The texting program uses the GOMO platform to provide smoking cessation and child development messages to pregnant and post-partum women, as well as dads and family members of children up to eight years old. The goal of the texting program is to engage a broader range of clients, including a demographic naturally drawn to online services, and clients who may not initially be comfortable with one on one counseling. Enrolling in cessation case management is encouraged, but not required. This type of customized perinatal texting programs is relatively new, therefore, extensive analytics and evaluation have been built into the program to help determine its effectiveness in engaging clients and helping them to quit.

MQCF program information was built into the newly enhanced NJ Quitline website and the revised NJ Provider Cessation Toolkit over the past year. MQCF is also assisting with cessation content for the new PPI website, and “pay attention cards”. MQCF program information was included in the PPI “COVID19 - GO KITS” project, providing supplies and resources for mothers at risk for preterm labor to be better informed and prepared for self-monitoring at home. Another joint project between the FHI-FAS MQCF team and the SNJPC tobacco control program has been the promotion of “Tobacco-free Ride NJ- Clean Air for Kids in Cars”, designed to educate drivers about the risk of second and third hand smoke and vapor exposure to younger passengers.

Tables NPM 14A & B:

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

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

Notes - Data is from the NJ PRAMS Survey

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

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

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

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 fiscal year 2018-2019, the Division of Community Health Services established the Oral Health Services Unit. Priorities for this new service unit included the hiring of a Dental Hygienist, Yvonne Mikalopas, in March 2019, and the hiring of a Dental Director, Dr. Darwin K. Hayes, in July 2019, with the goal of creating a viable and sustainable State Oral Health Plan aligned with national oral health standards and measures.

The award of a HRSA grant also allowed for the establishment of two oral health initiatives to address two urgent public health crises: 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 modules educates dentists and dental students on best practices for prescribing opioid medications, pain management in the dental setting, and treatment guidelines. This free program, originally launched on May 8, 2019, has been updated to include Continuing Dental Education Credits to be conferred by Rutgers University School of Dental Medicine, under an additional Memorandum of Agreement.

Under a Letter of Agreement with three regionally based Federally Qualified Health Centers (FQHCs) as of April 2019, The Oral Health Nutrition and Obesity Control Program seeks to educate parents of children characterized as having body-mass index that correlates to overweight or obese on proper nutrition for good oral health, and strategies to reduce dental caries, dental disease, and obesity in children age 6 to 11 who are uninsured, on Medicaid or Medicaid-eligible, as well as, create a transferable model for use by dental practitioners. In December 2019, five additional FQHCs were added to the nutrition program due to the availability of carry-forward funding authorized by HRSA. 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 Services Unit has established key stakeholder contacts, has contributed expertise to special needs projects, and has collaborated inter-departmentally to increase oral health literacy.

Additional goals of the Unit include a third grade oral health survey through partnership with the NJ Department of Education, increasing oral health care access and education for pregnant women through an inter-divisional and inter-departmental Doula education project, and a pilot Fluoride Varnish program within the Children's Oral Health Program, to launch in the Fall of 2020. As members of the Head Start Collaborative Advisory Committee, the Unit plans to work toward the goal of increasing access to dental care and the establishment of dental homes for Head Start and Early Head Start children and families.

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

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

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

- Continue the development of a tobacco training curriculum specifically for Healthy Women, Healthy Families community health and central intake workers to provide tobacco education in the field.
- Utilize focus group success to pilot an onsite smoking cessation group for prenatal/postpartum Healthy Start clients in Camden, NJ.
- Redesign and enhance momsquit.com website to engage wider range of clients and promote new GOMO app.

Increasing Capacity for Direct Service in NJ;

- Continue to expand MQC's existing services to enable face-to-face and telephone counseling in the Northern and Central regions of the state, through increased presence of MQCF staff in prenatal and pediatric health care settings.
- Promote onsite trainings and webinars to maternal and child health professionals in Central and Northern NJ.

Preventing relapse after delivery;

- Continue the development of the smoking cessation interactive app using GOMO Education Platform that provides customized messaging and interactive activities from first trimester through postpartum period. Uses a "concierge" concept that tailors messaging to personal, emotional, social, and environmental issues happening in the client's life throughout and beyond her pregnancy.
- Develop and implement a "Tobacco-free Ride NJ" campaign to reduce exposure to second and third hand smoke among children riding with smokers.

Other Program Activities

During FY 2020 (7/1/19- 4/19/20) the Family Health Line (1-800-328-3838) received and assisted 3,117 calls and made 5,353 referrals. The Reproductive and Perinatal Health Services monitors the grant with the Family Health Line that is a component of the Center for Family Services, Inc. The Reproductive and Perinatal Health Services provides the Family Health Line with consultation, technical assistance and educational material support to facilitate its participation in community events and networking. The Family Health Line employs three clinical staff members who are responsible to answer the Perinatal Mood Disorders Speak Up When You're Down calls. They screen the callers and coordinate working with Mental Health Providers, and assisted 551 callers.

Emerging Issues

COVID-19 has brought many emerging issues affecting all populations including maternal and child health populations. The situation with COVID-19 is unprecedented and rapidly evolving, and continues to be a significant public health crisis and threat requiring significant social distancing with remote operations, programs, and services whenever possible.

Regarding Labor and Delivery settings, the Commissioner of Health issue a directive on March 29, 2020 advising that one support person is essential to patient care throughout labor, delivery, and the immediate postpartum period. Hospitals are required to allow one designated support person to be with the expectant mother during these times. Specific guidelines for this support person were outlined in the directive. Fear and confusion regarding evolving information on COVID19 and changing guidance and hospital policies has necessitated the need for improved communications between providers and patients. Title V staff remain in contact with national and state experts in monitoring the guidelines for management of pregnant patients with COVID-19.

In an effort to reach out to Title V grantees and their outreach workers including community health workers, doulas, central intake, early childhood specialists, and others, a Town Hall held by Title V staff along with representatives from other state departments was held on April 20 to provide communication and the latest guidance. Needs around food insecurity, housing, shelter, employment, domestic violence and others were highlighted.

Title V staff are also engaged in the development of public facing documents for the MCH community.

COVID-19 modules have been developed in HWHF data systems; Title V is also in process to participate in data collection for a COVID-19 Pregnancy module in COVID-19 case reports.

While pregnant and postpartum women, infants and children do not seem to be at a particularly high risk of COVID-19 complications, the social and economic impacts of COVID-19 will negatively affect families and may set back MCH and the well-being of families for years to come. It is likely that the real impact of COVID-19 on MCH will be felt in two areas: 1) constrained access to reproductive and maternal healthcare and a subsequent increase in adverse MCH outcomes; and 2) rapid societal changes disproportionately and negatively affecting families, especially those from marginalized communities. While the short-term crisis is likely to stabilize in the coming months, the consequences of financial insecurity will likely be seen for a much longer period.

While much is worsening, there still remains some hope. The COVID-19 pandemic could lead to more investment in the public health infrastructure, a development that would increase the MCH and wellbeing of families beyond the current crisis. While it is necessary to focus on weathering the current crisis now, those of us who work in MCH must be ready to protect it through research, advocacy, and practice in the near future.

F. Public Input Process

As an integral part of the NJDOH's efforts to secure public input into the annual development of the MCH Block Grant Application and Annual Report, a public hearing is usually scheduled each year. This year due to the COVID-19 public health emergency a virtual public hearing will be held to encourage public comment and feedback in to the planning process of the NJ MCH Title V Block Grant Application. A draft of the application narrative will be posted on the NJDOH website prior to the virtual public hearing. Notification of the public hearing and availability of the draft application will be posted on the NJDOH's website and is e-mailed to over 300 individuals on the Division of Family Health Services e-mail distribution lists.

G. Technical Assistance

Due to the evolving situation with COVID-19, needs are being identified for the progression to an on-line or virtual environment to conduct program operations whenever possible. Additionally, challenges affecting vulnerable MCH populations can be exacerbated and complicated with COVID-19. For these reasons, DOH will continue to monitor technical assistance opportunities as available and as needed.

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 be developed into 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 Equity in Healthy Births	Healthy Women, Healthy Families (HWHF) Initiative; Central Intake (CI) Hubs & Community Health Workers (CHW); IM CoIIN; Maternal Infant Early Childhood Home Visiting Program (MIECHV); MCH Consortia TQI Activities, Nurture NJ, State Health Improvement Plan (SHIP), Maternal Mortality Review Commission & State Maternal Health Improvement Program Grants; Perinatal Episodes of Care	1 Prenatal Care; 2 Maternal Morbidity; 3 Maternal Mortality; 4 Low Birth Weight; 5 & 6 Preterm Births 8 Perinatal Mortality; 9 Infant Mortality; 10 FAS; 11 NAS	NPM #1 Well Women Care (Percent of women with a past year preventive medical visit)	ESM 1.1: Increase first trimester prenatal care (EBC) from birth certificate records.
2) Perinatal/ Infant Health	#2 Reducing Black Maternal and Infant Mortality	HWHF Initiative; NJ SIDS Center activities; IM CoIIN; MIEC Home Visiting Program; SUID-Case Review; Child Fatality Review Healthy Start; NJ Baby Box Safe Sleep Education Program; Surveillance (PRAMS, EBC);	1, 2, 3, 4, 5, 8, 9 9.5 Sleep Related SUID; 15 Child Mortality; 19 Child Health Status	NPM #5 Infant Safe Sleep (Percent of infants placed to sleep on their backs). SPM #1 Black preterm births	ESM 5.1: Increase infant safe sleep (PRAMS – on back, no co-sleeping, no soft bedding).
2) Perinatal/ Infant Health	#3 Improve Nutrition & PA #2 Reducing Black Maternal and Infant Mortality	HWHF Initiative; IM CoIIN; MIEC Home Visiting Program; Healthy Start; WIC Loving Support® Through Peer Counseling Breastfeeding Program Baby Friendly Hospitals, BF Surveillance (PRAMS, EBC, mPINC); SNAP-Ed; Breastfeeding Strategic Plan	1, 4, 5, 8, 9, 9.5, 10, 11, 15, 19	NPM #4 Breastfeeding (A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months). SPM #1 Black preterm births	ESM 4.1: Increase births in Baby Friendly hospitals (EBC/mPINC).

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

Domains (set by HRSA)	State Priority Needs based on Needs Assessment	Strategies (to be developed into 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)
5) CYSHCN and 4) Adolescent/Young Adult Health	#5 Improving Access to Quality Care for CYSHCN	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	19 Child Health Status 16, 17, 18, 19, 20, 21,22	NPM #12 Transitioning to Adulthood (Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care). SPM #2 Hearing screening F/U; SPM #3 Referred from BDARS to Case Management Unit; SPM #4 Age Initial Autism Diagnosis;	ESM 12.1: Percent of CYSHCN ages 12-17 years served by Special Child Health Services Case Management Units (SCHS CMUs) with at least one transition to adulthood service.
6) Life Course		Project REACH, Project PEDS; ShapingNJ; MIEC Home Visiting; Dial a Smile Dental Clinic Directory; Miles of Smiles; WIC Newsletter; Special Needs Newsletter; Oral Health Nutrition and Obesity Control Program	14 Kids 1-6 with cavities; 19 Child Health Status;	NPM #13 Oral health (A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year).	ESM 13.1: Preventive and any dental services for children enrolled in Medicaid or CHIP (CMS-416).
6) Life Course	#7 Improving & Integrating Information Systems	HWHF Initiative, Central Intake / PRA / SPECT; MIEC Home Visiting SSDI, ECCS Impact; VIP; Master Client Index Project; NJ SHAD; MMRC; Maternal Data Center	Most NOMs	Most NPMs	
6) Life Course	#8 Smoking Prevention	Mom's Quit Connection; Perinatal Addiction Prevention Project; HWHF Initiative, Central Intake / PRA MIEC Home Visiting	Most NOMs	#14 Household Smoking (A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes).	ESM 14.1: Increase referrals of pregnant women to Mom's Quit Connection.

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

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

Table 1c - Summary of MCH Population Needs

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

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

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

Table 1e - Staffing for MCHS

Staff Person	Title	Function	Related NPM	Tenure in MCH
Lisa Asare	Assistant Commissioner	Director FHS	1-15	12
Marilyn Gorney-Daley	MCHS Director	Director of MCHS Services Unit	1-15	22
Lakota Kruse	Medical Director RPHS Program Manager	HV Program Director Oversees RPHS	1-15 1-15	26
Cynthia Collins	CAHP Manager Coordinator Primary & Preventive Health Services	Oversees CAHP Coordinator RPHS programs	7-12 1-6	26
Nancy Garrity	Research Scientist 2	Coordinator MIECHV and RPHS programs	1-6	23
vacant	Program Specialist 3	Coordinator RPHS programs	1-6	
vacant	Public Health Consultant 1 Nursing	Coordinator RPHS programs	1-6	
vacant	Public Health Consultant 1 Nursing	Coordinator RPHS programs	1-6	19
Mehnaz Mustafa	MCH Epi Program Manager	Manages MCH Epi programs	1-15	3
Sharon Smith	Research Scientist 2	PRAMS Coordinator	1-15	16
Caitlin Murano	Analyst 1, Research and Evaluation	MCH Epidemiologist who assists the Analyst 2.	1-15	3

Table 1e - Staffing for SCHEIS

Staff Person	Title	Function	Related Priority NPM	Tenure in MCH
Sandy Howell, PhD	Research Scientist 1	Service Unit Director, Director for CYSHCN and coordinates the Autism Registry	11,12	12 yrs
Diane DiGiovacchino	Administrative Assistant 3	Administrative support	11,12	31 yrs
Dorothy Snyder	Secretarial Assistant 3	Secretarial support	11,12	3 yrs
vacant	Program Specialist 4	Supervises activities of Early Identification and Monitoring Program (EIM)	11,12	
Jing Shi	Research Scientist 2	Responsible for data management for EIM	11,12	1 yr
Kathryn Aveni, RNC, MPH	Research Scientist I	Data Coordinator for SCHEIS	11,12	16 yrs
Mary Knapp, MSN, RN,	Coordinator Primary and Preventive Health Services	Coordinator NJ Birth Defects Registry	11,12	33 yrs
Ariel Metzler, MSW	Social Worker 2 Psychiatric/Deaf Language Specialist	Early Hearing and Detection Coordinator	11,12	1 yr
Nancy Schneider, MA, CCC-A, FAAA	Research Scientist 2	Audiologist, liaison to the audiology community	11,12	18 yrs
Lisa Stout (temp)	Nurse Consultant	Ensures that the information on each BDAR registration is accurate and complete	11,12	1 yrs
Anthony Mosco, AA	Software Development Specialist Assistant	Technical assistance related to the Birth Defects and Autism Registry	11,12	10 yrs
Elena Napravnik	Research Scientist 2	Assists in the coordination of the Autism Registry	11,12	1 yr

Staff Person	Title	Function	Related Priority NPM	Tenure in MCH
Nicole Moore	Principal Clerk Typist	Provides clerical support for BDAR	11,12	18 yrs
Donna Williams	Head Clerk	Provides supervision of clerical staff for BDAR	11,12	13 yrs
Tracey Hayes	Principal Clerk Typist	Provides clerical support for EHDI	11,12	13 yrs
Vacant	Analyst Trainee	Provides support for EIM work	11,12	
Raymia Hearren	Agency Services Representative 3	Provides clerical support for NSGS Follow-up and program support for EIM	11,12	6 yrs
Vacant	Program Specialist 4	Administer FCCS Unit; SCHS Case Management & Family Support, Fee for Service, Specialized Pediatric Services program (SPSP), Ryan White Part D activities	11,12	
Linda Barron ,RN, BSN-CPN, MSN	Public Health Consultant 1, Nursing Specialized Pediatric Services Program (SPSP)	Public health nurse consultation re: SPSP programs and services, program officer for SPSP health services grants	11,12	6 yrs
Vacant	Program Specialist 3	Public health consultation re: SCHS CM programs, family support, and Fee for Service program, program officer for SCHS CM health services grants	11,12	
Vacant	Research Scientist 2	SCHS CM support for CMRS and TA for CMUs	11,12	
Vacant	Research Scientist 2 Ryan White Part D (RWPDP)	Women, Infants, Children, and Youth (WICY) infected and/or affected by HIV/AIDS. Liaison between Title V MCH & CYSCHN programs and WICY population, providers, and systems development	11,12	
Kourtney Pulliam, MPH	Analyst 1, Research and Evaluation 50% RWPDP, 50% SPSP	Data consultant works with the Project Director and Network for RWPDP and Specialized Pediatric Service Program (SPSP) agencies in their quality improvement and quality management activities.	11,12	3 yrs
Dawn Mergen, RN	Quality Assurance Specialist Health Services Nursing	Working as Point Person for FCCS as position remains vacant since 1/1/19; Responsible for SCHS CM, & overseeing SPS, and RWPDP as well as program budgetary issues as well as staffing	11,12	5 yrs
Vacant	Nursing Consultant	Public health nurse consultation across SCHS CMU agencies and Medicaid managed care expertise	11,12	2 yrs
Susan Agugliaro	Secretarial Assistant 3	Clerical support to Program Manager and maintains Fee for Service Letters of Agreement	11,12	32 yrs
Claudia Pollet, MD, MPH	Health Science Specialist	Program Manager of NSGS which includes the oversight of the EHDI	11,12	6 yrs
Suzanne Canuso, MSN, RN	Public Health Consultant 1, Nursing	Interim program manager to supervise activities of the EIM	11,12	9 yrs
Diane Driver, MSN, RN	Nursing Consultant	Manages health services grants for NSGS Follow-up Services	11,12	5 yrs
Suzanne Karabin, MS	Research Scientist 2	Coordinator of the Autism Registry	11,12	17 yrs

Staff Person	Title	Function	Related Priority NPM	Tenure in MCH
vacant	Quality Assurance Specialist, Health Services, Nursing	Prepares and provides training and quality improvement visits to NJ birthing hospitals, ensures quality of program charts, initiates and follows cases as needed.	11,12	
Joy Rende, MSA, RNC-MN, NE-BC	Nursing Consultant	Develops, plans, implements, and evaluates statewide educational duties to health care providers and parents/families about newborn screening in New Jersey	11,12	5 yrs
Felicidad Santos, MD, MPH	Public Health Representative 1	Provides follow-up of all newborns with abnormal screening results	11,12	10 yrs
Karyn Dynak	Supervising Public Health Representative	Supervises and directs activities of the NSGS Follow-up Services	11,12	16 yrs
Tariq Ahmad, MBBS, MPH	Public Health Representative 1	Provides follow-up of all NSGS abnormal screening results	11,12	11 yrs
Ondia Barron	Public Health Representative 2	Provides follow-up of all NSGS abnormal screening results	11,12	2 yrs
Annemarie Perez	Public Health Representative 2	Provides follow-up of all NSGS abnormal screening results	11,12	1 yrs
Maria Baranyai	Public Health Representative 2	Provides follow-up of all NSGS abnormal screening results	11,12	1 yrs
Vacant	Public Health Representative Trainee	Provides follow-up of all NSGS abnormal screening results	11,12	
Betty Durham	Principal Clerk Typist	Provides clerical support for NSGS follow-up	11,12	20 yrs
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.	11,12	1 yr
Kelly Davis	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	11,12	1 yr
Parents/Family members				
Statewide Parent Advocacy Network Diana Autin (grantee)	Executive Director	Parent Partner	11,12	23+yrs
Darwin K. Hayes, DDS, MHA, FAGD	State Dental Director, Oral Health Services Unit	NJ DOH State Dental Director serving on the NJ State Board of Dentistry. And the Association of State and Territorial Dental Directors.	13	15 yrs
Yvonne Mikalopas	Dental Hygienist, Oral Health Services Unit	COHP Program Officer and oversees COHP program activities	10	15 yrs

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

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

Table 1g - Family/Consumer Partnerships

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

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