

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

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

**Application for FY 2020
Due July 2019**

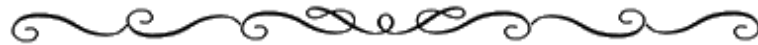


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1. General Requirements

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.”

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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 22.

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 2020, 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. These are (1) Increasing 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. 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 ten 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 #8 Physical Activity,
NPM #10 Adolescent Preventive Medical Visit,
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 (4.8 per 1,000 live births versus 5.9 per 1,000 live births in 2015), 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. In an attempt to identify some of the root causes of this issue, three (3) regional focus groups were performed with key stakeholders. These focus groups helped identify some of the social determinants of health (SDOH) that contribute to the persisting disparities.

As a result, the Healthy Women, Healthy Families (HWHF) Initiative (formerly the Improving Pregnancy Outcomes (IPO) 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 grants were awarded in July 2018 through a competitive request for proposals (RFP) 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, with a focus on 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.

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 Departments of Labor and Workforce Development, Education, Transportation, Children and Families, 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) leveraging resources and inter- and intra-departmental collaborations, and, (c) addressing health disparities using a multi-sectorial approach.

The HWHF Initiative will continue to expand outreach and increase referrals to community-based MCH services. Outreach is a major component for the Community Health Workers. They are the boots on the ground, trusted members of the community that provide services in a culturally and linguistically competent manner. As of May 10, 2019, more than 17,000 women have been screened since 2018 and more than 9,000 were connected to programs like HWHF, Home Visiting and Healthy Start. Additionally, HWHF will require Community Health Workers to provide case management and more intensive follow ups. The HWHF initiative also has a heavy focus on the use of metrics that will guide the grantees to be more outcomes-focused in their activities.

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 6,997 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.

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 Abstinence Education Program (AEP).

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 2019, the State is proposing funding of the FQHCs with \$30 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.

In the area of children and youth with special health care needs (CYSHCN), the Newborn Screening and Genetic Services (NSGS) Program is helping to ensure that all newborns and families affected by an abnormal screening result receive timely and appropriate follow-up services. NJ newborns currently receive screening for 61 disorders. In July 2018, screening for six lysosomal storage disorders was implemented which brings the total number of disorders NJ screens newborns for to 61. NJ remains among the leading states in offering the most screenings 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. As of April 2019, NJDOH has received reports of 28 infants with previously unsuspected CCHDs detected through the screening program.

Given the high rates of autism reported in NJ, FHS implemented the Birth Defects and Autism Reporting System (BDARS) in 2009. BDARS is a tool for surveillance, needs assessment, service planning, research, and most importantly, for linking families to services. The BDARS, at present, refers all living children and their families to the Special Child Health Services Case Management Units (SCHS CMUs), which are within the Family Centered Care Services (FCCS) Program.

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, services and supports provided through SCHS CMUs, Family WRAP (Wisdom, Resources, and Parent to Parent), and Specialized Pediatric Services Providers (SPSP) via Child Evaluation Centers (CECs), Cleft Lip/Palate Craniofacial and Tertiary Care 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' social conditions by providing, in addition to quality health care, referrals to support services such as: public health insurance options; legal services; food stamps; the Special

Supplemental Nutrition Program for Women, Infants, and Children (WIC); employment; and public assistance. These service referrals are critically important to improve health outcomes and decrease the need for drugs or other medical interventions, improve quality of life, and reduce costs.

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 is 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 is collected annually, beginning in 2015. Results are discussed in Plan for the Application Year – National Performance Measure (NPM) #11 and NPM #12.

The reorganization of State services and supports for CYSHCN by our intergovernmental partners provided an opportunity to realign pathways for families and providers to access a continuum of care across the lifespan. Concurrently, the Affordable Care Act's assurances pose challenges as well as and benefits for families with CYSHCN to maintain and optimize access to community-based care. These exciting changes are anticipated to broaden health insurance access. NJ'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.

In sum, NJ is actively working on ways to improve outcomes while simultaneously celebrating some already achieved improvements, to the benefit of the women and children served because of because of the strong partnership between the State and the MCH Bureau.

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.

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 MCH efforts in 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

Infant mortality is a key measure of population health that reflects the underlying well-being of mothers and families. Racial/ethnic disparities in infant mortality continue to persist in New Jersey despite years of improving pregnancy outcomes initiatives.

The MCH success story for NJ is with the Healthy Women, Healthy Families program, which was implemented July 1, 2018. Healthy Women Healthy Families (HWHF), a five-year state-wide grantee program implemented on July 1, 2018, includes six community-based grantees in 12 regions and 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. As of May 10, 2019, though the \$4.7 million investment in HWHF, the Department of Health has provided funding for partners to hire 77 outreach workers – 40 doulas, 29 Community Health Workers, and eight Community Health Worker supervisors – to improve maternal health, especially the health of black women.

As of May 10, 2019, more than 17,000 women have been screened since 2018 and more than 9,000 were connected to programs like HWHF, Home Visiting and Healthy Start. Nearly three-quarters of these women were pregnant and nearly 30 percent reside in the 8 municipalities with the highest rates of black infant mortality. 92 women are participating with the Doula pilot program with 44 having delivered their child with the support of a doula.

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 [2018 New Jersey Population Estimates](#) of race, 55.1% of the population was white (alone not Hispanic), 15.0% was black, 10.1% was Asian, 0.6% was American Indian and Alaska Native, and 2.2% reported two or more races. In terms of ethnicity, 20.0% 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 2016 birth certificate data, 27.1% of mothers delivering infants in NJ were Hispanic, 44.3% were white non-Hispanic, 13.3% were black non-Hispanic, and 11.7% were Asian or Pacific Islanders 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 2020 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 2020](#), Community Health Improvement Plans and the collaborative process with other MCH partners, FHS has selected the following State Priority Needs (see Section II.C. State Selected Priorities):

- #1) Increasing Healthy Births,
- #2) Improving Nutrition & Physical Activity,
- #3) Reducing Black Infant Mortality,
- #4) Promoting Youth Development,
- #5) Improving Access to Quality Care for CYSHCN,
- #6) Reducing Teen Pregnancy,
- #7) Improving & Integrating Information Systems, and
- #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, 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 ten 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 #8 Physical Activity,
- NPM #10 Adolescent Preventive Medical Visit,
- 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. Five existing SPMs will be kept, and two old SPMs will be deleted. The existing SPMs which will be continued are:

- SPM #1 Black Non-Hispanic Preterm Infants in NJ,
- SPM #2 Children with Elevated Blood Lead Levels,
- SPM #3 Hearing Screening Follow-up,

SPM #4 Referral from BDARS to Case Management Unit, and SPM #5 Age of Initial Autism Diagnosis.

The old SPMs to be discontinued and replaced are: Regional MCH Consortia Implementing Community-based Fetal Infant Mortality Review (FIMR) Teams and Overweight High School Students.

Table 1 - Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model (See Supporting Document #1) summarizes the selected ten 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 been 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 Doulas. 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 6,997 families participating in HV during SFY 2018 (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 ends 9/30/18 and will be replaced by the Sexual Risk Avoidance Education (SRAE) Grant Program. NJ anticipates receiving the grant award in early April of 2018. As of March 2018, all program positions for both PREP and AEP have been filled. In addition, CAHP now has a Coordinator to provide overall direction and collaboration amongst PREP, AEP and School Health grantees.

The new SRAE program will build upon the NJ Abstinence Education Program (NJ AEP) and will enable the state to continue implementing evidence-informed curricula to help youth abstain or delay sexual activity, to reduce pregnancy and Sexually Transmitted Diseases (STDs)/Sexually Transmitted Infections (STIs) and, where appropriate, to provide options that may include mentoring, counseling and/or adult supervision. NJ AEP has followed an SRAE approach for the past 4 years because it is a public health approach to sexual health education complimentary to the PREP program which provides significant education on Sexual Risk Reeducation in addition to avoidance. In the Summer of 2018 a full RFA will be released by NJDOH and new grantees will be selected for a two-year grant cycle. The NJ SRAE Program will provide medically accurate Lesbian, Gay, Bisexual, Transgender, Intersex and Questioning (LGBTIQ)-inclusive and trauma-informed sexual health education to teens aged 10-14.

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 will implement programing in high schools only. NJ PREP also seeks to help teens avoid and reduce high risk sexual behaviors through the promotion of abstinence, refusal skills, use of condoms and other forms of birth control. NJ PREP provides education on the following adult preparation subjects: Healthy Relationships, Parent/Child Communication and Adolescent Health. NJ PREP has responded to the invitation to accept funds for program continuation through September 30, 2020 and that will allow the implementation of programs to transfer over to only implementing in high schools and no longer in middle schools. In the current funding cycle, the state will continue 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 10/1/18.

NJ's Adolescent and Young Adult Health-Collaborative Improvement and Innovation Network (AYAH-CollIN) funded through the National Resource Center (NRC) and AMCHP will begin an FQHC pilot to improve adolescent well visit rates and adolescent friendliness of the clinic. In January of 2017, data from a NJ FQHC report identified a greater than 50% disparity for adolescent preventive medical visit rates at FQHCs (averaging about 45% during the years of 2013-2015) as compared to private physician offices

(averaging about 97%). The goal of the NJ AYAH-ColIN is to increase the FQHC adolescent visit rate to achieve the Healthy People 2020 goal of 75.6%. To build up to the FQHC pilot, NJ's AYAH-ColIN has spent significant time addressing the issue of youth engagement in health. To accomplish our mission, NJ has hired a young adult to work part-time (summer and winter breaks) in the CAHP, we have provided several trainings on creating effective youth adult partnerships, mentoring, and will host a youth leadership camp in the summer of 2018. In addition, NJ has completed a survey of over 100 college students and focus groups with 60 adolescents to collect information on the perception of well visits/preventative care of adolescents and young adults. The official project will end August 31, 2018 and data from the activities will be shared. NJ is committed to continuing the work of the AYAH-ColIN in partnership with stakeholders such as NJAAP.

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 SFY2017, the FQHCs served a total of 151,871 uninsured residents and 490,420 uninsured visits were reimbursed. 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 the area of children and youth with special health care needs (CYSHCN), the Newborn Screening and Genetic Services Program (NSGS) helps to ensure that all newborns and families affected by an abnormal screening result will receive timely and appropriate follow-up services. In terms of newborn screening for disorders detectable via the heel stick, all newborns receive screening for 61 disorders. In May 2018, screening for six lysosomal storage disorders including Krabbe, Pompe, Neimann Pick, Fabry, Gaucher, and mucopolysaccharidosis I (MPS I), was implemented. Follow-up services include notification and communication with parents, primary care physicians, pediatric specialists and others to ensure the baby has immediate access to confirmatory testing and treatment. NJ remains among the leading states in offering the most screenings for newborns.

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.

Legislation mandating newborn pulse oximetry screening to detect Critical Congenital Heart Defects (CCHD) took effect on August 31, 2011. The inclusion of pulse ox screening questions in the Birth Defects and Autism Reporting System enable the capability to track individual level screening results. In addition, information on all infants with failed screens is reported by each birthing facility to the Birth Defects Registry via the Pulse Oximetry Module. As of April 2019, NJDOH had received reports of 28 infants with previously unsuspected critical congenital heart defects detected through the screening program. In 2012, NJ was one of six states awarded a 3-year HRSA grant for CCHD Screening. This demonstration grant enabled funding to contract with the NJ Chapter of the American Academy of Pediatrics (NJAAP) for hiring program staff, the development of resource materials, comprehensive educational offerings and support for an evaluation of CCHD screening in the neonatal intensive care unit (NICU). An article describing the collaborative work and lessons learned of the HRSA grantees was published in the Maternal Child Health Journal in January 2017. Since 2016, the CCHD Screening program is funded with State aid and collaborated with the NJAAP to implement program activities and provide technical assistance to birthing facilities. Although most states now have mandates or administrative rules requiring screening of newborns for CCHD, many questions remain about effective implementation of screening including screening for infants in the NICU.

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 NJ EHDI Program is working with hospitals, audiologists and physicians to identify “small tests of change” to identify successful strategies for improving outpatient follow-up rates for infants that did not pass initial screening.

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) 2014 prevalence figures published in the Morbidity and Mortality Weekly Report (MMWR) on April 27, 2018, cited NJ as having the highest prevalence rate of 29.3 per 1,000, or approximately one in 34 based on studies from four counties in NJ (Union, Hudson, Essex, and Ocean).

The Governor’s Council for Medical Research and Treatment of Autism (the Council) is in, but not of, the Office of the Commissioner at NJDOH; the Council has 14 members and is legislatively mandated. The Council’s Vision is to enhance the lives of individuals with Autism Spectrum Disorder (ASD) across their lifespans. The mission of the Council is to advance and disseminate the understanding, treatment, and management of ASD by means of a coordinated program of biomedical research, clinical innovation, and professional training in NJ. In 2012, the Council established a New Jersey Autism Center of Excellence (NJACE). The NJACE consists of a Coordinating Center, Clinical Research Program Sites, and multiple clinical and basic science Research Pilot Projects, including 3 Medical Home Pilots. The NJ ACE Coordinating Center provides common management and support functions to unify the NJ ACE Clinical Research Program Sites and Pilot Project grantees, increase efficiency and reduce costs. The Coordinating Center grant was awarded to Montclair State University. The NJ ACE Program Site and Pilot Project grantees develop and conduct clinical research projects with the potential to improve the physical and/or behavioral health and well-being of individuals with ASD. The Council is particularly interested in projects with potential direct clinical impact and those that address issues across the lifespan.

On July 1, 2009, the Early Identification and Monitoring (EIM) Program implemented the Birth Defects and Autism Reporting System (BDARS). BDARS is an invaluable tool for surveillance, needs assessment, service planning, research, and most importantly for linking families to services. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928. Since 1985, NJ has maintained a population-based birth defects registry of children with all defects. Starting in 2003, the Registry received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ passed legislation mandating the reporting of autism. Subsequently, with the adoption of legislative rules in September 2009, the Registry added the Autism Spectrum Disorders (ASD) as reportable diagnoses and the Registry was renamed the Birth Defects and Autism Reporting System (BDARS), expanded the mandatory reporting age for children diagnosed with birth defects to age 6, and added severe hyperbilirubinemia as a reportable condition if the level is 25mg/dl or greater. The BDARS, at present, electronically refers all living 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 has been very successful in linking children registered with the BDARS with services offered through the county-based SCHS CMUs. However, the system did not further track children and families to determine if and what services were offered to any of the registered children. Added in 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 in their county has been registered and referred to their unit. 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 reports, and register previously unregistered children. In 2016, efforts were coordinated through the Integrated Systems Medical Grant to enhance SCHS CMUs’ reporting via CMRS regarding CYSHCN’s linkage to a medical home and transition to adulthood. Three SCHS CMUs collaborated in development of fields and to pilot edits in CMRS documentation. Training of the documentation changes was presented in 2016 and 2017 to all 21 SCHS CMUs.

CMRS was successfully adopted by all 21 counties and is live statewide. It provides the State Title V program with the opportunity for desktop review, referral, and linkage to care. As existing cases are

migrated to CMRS, and newly referred cases are entered into the database, it is anticipated that trends in access to care and outcomes will be more measurable and readily tracked. Reconfiguring data reporting and tracking systems, as well as training and retraining State and community-based agencies, while keeping the needs of CYSHCN and their families center to our mission is our challenge.

The Family Centered Care Services (FCCS) program promotes access to care through early identification, referral to community-based culturally competent services and follow-up for CYSHCN age birth to 21 years of age. Ultimately, services and supports provided through Special Child Health Services Case Management Units (SCHS CMUs), Family WRAP (Wisdom, Resources, and Parent to Parent), and Specialized Pediatric Services Providers (SPSP) via Child Evaluation Centers (CECs), Cleft Lip/Palate Craniofacial, and Tertiary Care Services are constructs that support NJ's efforts to address the six MCH Core Outcomes for CYSHCN. This safety net is supported by State and federal funds administered via community health services grants, local support by the County Boards of Chosen Freeholders, reimbursement for direct service provision, and technical assistance to grantees. Likewise, intergovernmental and interagency collaboration is ongoing among federal, State and community partners and families; i.e., Social Security Administration; NJ State Departments of Human Services' NJ FamilyCare/Medicaid programs, Catastrophic Illness in Children Relief Fund, Children and Families, Labor, Banking and Insurance, Boggs Center/Association of University Centers on Disabilities, NJ Council on Developmental Disabilities, and community-based organizations such as the NJAAP, NJ Hospital Association, and disability specific organizations such as the Arc of NJ, the SPAN Parent Advocacy Network and the Community of Care Consortium (COCC). Consultation and collaboration with NJDOH programs such as the Birth Defects and Autism Registry, Early Intervention System, the Ryan White Family Centered HIV Care Network, Maternal Child Health, Special Supplemental Nutrition Program for Women, Infants and Children, Primary Care/Federally Qualified Health Centers, and 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.

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. In 2014, State Case Management staffs launched a quality improvement project to enhance consistency in documentation within CMRS across the SCHS CMUs, and to improve upon CMRS's data gathering capability. Efforts are ongoing, with FCCS staff presenting quality improvement findings to SCHS CMUs on a quarterly basis, since June 2015. SCHS CMU feedback in turn is incorporated into subsequent CMRS guidance and technical assistance. Information garnered from this and all future initiatives is anticipated to enhance NJ's efforts to improve performance on the six core MCHB outcomes for CYSHCN.

The reorganization of State services and supports for CYSHCN by intergovernmental partners - Department of Human Services Division of Medicaid and Health Services (DMAHS) and Division of Developmental Disabilities; the Department of Children and Families' Division of Children's System of Care and Division of Family and Community Partnerships; and the Department of Health's Division of Aging and Community Services realigned pathways for families and providers to access a continuum of care across the lifespan. Concurrently, the Affordable Care Act's assurances pose challenges and benefits for families with CYSHCN to maintain and optimize access to community-based care. Title V is collaborating with DMAHS in its comprehensive evaluation and revision to its data administration system that will support NJ's efforts to optimally address Federal mandates including the Health Information Technology (HIT) Health Information Exchange (HIE) requirements, the Health Information Portability and Accountability Act of 1996 (HIPAA) transaction and code sets, International Classification of Diseases version 10 (ICD-10), and the requirements of the Patient Protection and Affordable Care Act (PPACA.) These exciting changes are anticipated to broaden health insurance access, and to improve cross systems collaboration on implementation of the Asthma/Cystic Fibrosis component of the Fee for Service program. NJ'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 key to ensuring that families are adequately supported during the reorganization of these systems.

3.C. Needs Assessment

C.1. Needs Assessment Update

The NJ Title V Program, the Division of Family Health Services (FHS), has not altered its Five-Year Needs Assessment that identifies consistent with health status goals and national health objectives the need for: 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). For the 2019 MCH Title V Block Grant Application/Annual Report there were no changes to State Priority Need (SPN) Findings or the selection of National Performance Measures (NPM) selection. The MCH Population Needs remain unchanged. The next Five-Year Needs Assessment will be submitted with the FY 2021 Application in July 2020.

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. 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 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) leveraging resources and inter- and intra-departmental collaborations, and, (c) addressing health disparities using a multi-sectorial approach.

FHS is currently funding the 3 Maternal Child Health Consortia to implement Opioid education among providers in New Jersey. Educational sessions on substance use disorders will be conducted in all 3 regions (north, south, and central) of the state.

Through restoration of significant funding for family planning, NJDOH support this provision through a grant with the New Jersey Family Planning League to ensure that family planning services are available in all 21 counties in NJ. Family planning services not only include family planning but also related preventive health services.

C.2. Needs Assessment Summary

C.2.a. Process Description

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 many other organizations and partners. The needs assessment process is consistent with the conceptual framework in Figure 1 MCH Needs Assessment, Planning, Implementation, and Monitoring Process in the guidance. The ultimate goals of the needs assessment process are to strengthen partnerships and collaboration efforts within FHS, the NJ Department of Health (NJDOH), the federal MCH Bureau, and among other agencies and organizations involved with MCH and to improve outcomes for the MCH populations.

Table 1a - Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model (See Supporting Document #1) summarizes the selected ten 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.

C.2.b. Findings

As required in the first-year Application/Annual Report (FY 2016/FY 2014), **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. Table 1b: 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.

C.2b.i MCH Population Health Status

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 10 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.

C.2b.ii Title V Program Capacity

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 Lisa Asare MPH, Assistant Commissioner, Division of FHS. In April 2017, Dr. Marilyn Gorney-Daley, Director of Special Child Health and Early Intervention Services, Division of FHS, was appointed to the role of Title V Director of Maternal and Child Health. Dr. Sandra Howell was appointed as the Special Child Health and Early Intervention Services (SCHEIS) Director in June 2018. Dr. Sandra Howell had served as a Research Scientist and Coordinator of the New Jersey Autism Registry for the last 10 years.

Five-Year Needs Assessment Summary (inserted by HRSA)
(as submitted with the FY 2016 Application/FY 2014 Annual Report)
11 pages which can't be edited

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 35) 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. 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 FY17. 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 (FFY17) have not been fully expended at the time of the Application/Annual Report submission in July 2018. The most recent expenditure data for SFY17 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 2019 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 2017 and SFY 2018 that reach maternal and child health populations in NJ:

State Funding Levels for Programs and Services	SFY 2017	SFY 2018	SFY 2019
Birth Defects Registry	\$ 744,000	\$ 744,000	\$ 744,000
Cleft Lip and Palate Projects	\$ 690,000	\$ 690,000	\$ 690,000
Infant Mortality Reduction	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000
Sudden Infant Death Syndrome	\$ 221,000	\$ 221,000	\$ 221,000
Newborn Screening	\$ 3,666,134	\$ 4,593,550**	\$4,907,872
Postpartum Depression Screening and Referral	\$ 1,900,000	\$ 1,900,000	\$ 1,900,000
Early Intervention for Developmental Delay/Disabilities	\$102,973,000	\$ 104,225,357	\$ 104,225,357
Childhood Lead Exposure Prevention	\$ 2,179,620	\$ 12,179,620	\$ 12,179,620
Hemophilia services	\$ 1,245,000	\$ 1,245,000	\$ 1,245,000
Catastrophic Illness in Children Relief Fund	\$ 1,700,000	\$ 1,700,000	\$ 1,700,000
Handicapped Children's Fund, which is used to support subspecialty care and case management services	\$ 4,517,200	\$ 4,592,200	\$ 4,592,200
Fetal Alcohol Syndrome	\$ 989,000	\$ 989,000	\$ 989,000
MCH Services	\$ 1,548,000	\$ 1,740,000	\$ 1,740,000
Council Physical Fitness and Sports	\$ 50,000	\$ 50,000	\$ 50,000
Autism Registry	\$ 750,000	\$ 750,000	\$ 750,000
Family Planning	\$ 0	\$ 7,453,000	\$ 7,453,000
Opioid Education for Obstetricians	\$ 0	\$ 1,000,000	\$ 1,000,000

*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 (FY18) as a basis for determining the proposed budget plan for federal and non-federal MCH Block Grant funds in the Application year (FY20). The final federal MCH Block Grant allocation for FY19 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.

3.E. Five-Year State Action Plan

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 <i>(NPMs and SPMs)</i>	Evidence-based or – Informed Strategy Measures <i>(ESMs)</i>	National and State Outcome Measures (NOMs and SOMs)
1) Women's/ Maternal Health	#1 Increasing Healthy Births	Healthy Women, Healthy Families (HWHF) Initiative; Central Intake (CI) & Community Health Workers (CHW) IM CoIIN; MIEC Home Visiting Program (MIECHV); Office of Women's Health; Perinatal Designation Level regulations, Development of the NJ VON Collaborative, MCH Consortia TQI Activities	Increase first trimester prenatal care by 1% per year by 2020.	NPM #1 Well Women Care	ESM 1.1: Increase first trimester prenatal care (EBC) from birth certificate records.	1 Infant Mortality ; 2 Preterm-related death; 3 Neonatal Mortality; 5, 6, 7, 8, 21 Postpartum hospitalizations with severe morbidity; 22 Maternal Death
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	HWHF Initiative; IM CoIIN; MIEC Home Visiting Program; NJ SIDS Center activities; Healthy Start; HBWW, SUID-CR; Surveillance (PRAMS, EBC); NJ Baby Box Safe Sleep Education Program	Increase infant safe sleep by 1% per year by 2020.	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 Post-Neonatal Mortality ; 5 Perinatal Mortality ; 6 Sleep-related SUID death ; 7 LBW & VLBW; 8 Preterm Birth; 9
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	HWHF Initiative; IM CoIIN; MIEC Home Visiting Program; Healthy Start; HBWW, Loving Support© Through Peer Counseling Breastfeeding Program Baby Friendly Hospitals, BF Surveillance (PRAMS, EBC, mPINC) Breastfeeding and NJ Maternity Hospitals: A Comparative Report	Increase births in Baby Friendly hospitals by 2% per year by 2020.	NPM #4 Breastfeeding SPM #1 Black preterm births	ESM 4.1: Increase births in Baby Friendly hospitals (EBC/mPINC).	1, 2, 3, 4 Post-Neonatal Mortality; 5 Perinatal Mortality; 6 Sleep-related SUID death; 7 LBW & VLBW; 8 Preterm Birth , 9
3) Child Health	#4 Promoting Youth Development,	ECCS Impact with DCF Project LAUNCH and Help Me Grow with DCF Early Intervention System MIECHV Project LAUNCH and Help Me Grow with DCF NJ AAP/PCORE Medical Home Project Learn the Signs, Act Early Campaign	Increase developmental screening among children, ages 9 - 3 months, by 2 percentage points per year by 2020.	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.	13 School Readiness; 17 CSHCN; 18 Mental/Behavioral 19 Child Health Status;

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)
3) Child Health	#2 Improving Nutrition & Physical Activity	ShapingNJ Whole School, Whole Community, Whole Child (WSCC, CDC) School Health	Increase the percentage of children, ages 6 - 11 years old, who are physically active at least 60 minutes per day by 5 percentage points by 2020.	NPM #8 Physical activity SPM #2 Children with Elevated Blood Lead Levels	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).	11 Overweight rate; 9 Kids in very good health; 13 Kids without insurance;
4) Adolescent/Young Adult Health	#4 Promoting Youth Development,	NJ AAP/PCORE Medical Home Project; Outreach to providers; Case Management Services; AYAHCoin -Blueprint for Change	Increase the percentage of adolescents, ages 12 through 17, with a preventive medical visit in the past year by 2 percentage points by 2020.	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.	16.1 Adolescent Mortality; 16.2 MVA; 16.3 Suicide; 17, 18, 19, 20, 21,22
4) Adolescent/Young Adult Health and 5) CYSHCN	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	Transition to adulthood needs assessment; SPAN/ISG 1; ARC of NJ	Increase the percentage of children and children with special health care needs, age 0 - 17 years old, who have a medical home by 4 percentage points by 2020.	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).	10, 11, 13, 15 Adolescent death 10-19; 16 MVA fatality 15-19 17 Suicide 15-19
5) CYSHCN and 4) Adolescent/Young Adult Health	#5 Improving Access to Quality Care for CYSHCN	Case Management Services; 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 #3 Hearing screening F/U; SPM #4 Referred from BDARS to Case Management Unit; SPM #5 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.	18 CSHNC receiving care in a well-functioning system; 19 % CSHCN & ASD; 20 Kids with a mental/behavioral condition who receive treatment, 23 Timely NBS+ follow-up

Domains (set by HRSA)	State Priority Needs –	Strategies – <i>general approaches taken to achieve the objectives</i>	Objectives (SMART)	National and State Performance Measures <i>(NPMs and SPMs)</i>	Evidence-based or – Informed Strategy Measures <i>(ESMs)</i>	National and State Outcome Measures (NOMs and SOMs)
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;	Increase preventive and any dental services for children enrolled in Medicaid or CHIP by 1% per year by 2020.	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; 9 Kids in very good health;
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;		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 percentage of women who smoke during pregnancy by 2 percentage points by 2021.	#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, formerly known as the Improving Pregnancy Outcomes 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 an 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 MCH Block. 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 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 focus on workforce development will continue to be a pivotal component of FHS operations. As such, each staff person has a requirement under their individualized Performance Assessment Report, a criterion to include a professional development plan for each yearly rating period (October 1 to September 30).

FHS recently evaluated its current and future workforce requirements for the State's MCH Services. The evaluation resulted in reclassification of titles to meet the needs of the changing roles and requirements and keeping aligned with NJDOH's strategic plan. FHS hired employees and are hiring new employees in the title series of Health Data Specialist and Analyst, Research and Evaluation to support the MCH Epidemiology and SCHEIS Programs. Additionally, we are preparing to hire additional Quality Assurance Specialists. Hiring employees in these titles will improve effectiveness and efficiency of the public health system especially in the MCH programs. The vacant positions resulted from retirements, resignations and promotions.

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 of 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.

An emphasis in Child Health has been the prevention of elevated blood lead levels among children under six years of age through collaborative, prevention-oriented outreach and education to parents, property owners, and health care providers. The Childhood Lead Exposure Prevention (CLEP) Projects use a home visiting model to provide nurse case management and environmental investigations for children with confirmed blood lead levels of 5 ug/dL or greater. The CLEP Projects are being moved starting January 2019 to the Office of Local Public Health. Twenty-four local health departments throughout the State receive funding to provide monitoring of retesting, to perform household education and conduct residential property inspections to identify and abate lead hazards. The goal of the CLEP Projects is to promote a coordinated support system for children with elevated blood lead levels and their families through the development of stronger linkages with Special Child Health Services, Medicaid Managed Care Organizations (MCOs), DCF, DOE, Department of Community Affairs, and community-based agencies that provide early childhood services.

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.

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, 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 NJs maternal child health population, 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 parent/consumer involvement into an FHS major initiative, the Improving Pregnancy Outcomes Project (IPO), which requires grantees to have a Consumer Advisory Council to help guide the program, assist with the evaluation and quality improvement initiatives as well as the design and development of all educational/information materials. Similarly, the Home Visitation Program (MIEC-HV) also requires funded grantees to implement Consumer Advisory Work Groups.

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.

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 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.

As part of the SSDI project, PRAMS Zika data is to be linked with birth defects registry data to establish links between maternal experiences and outcomes related to Zika. SSDI also 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.

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.

The Affordable Care Act has significantly reduced barriers to accessing care for residents of NJ. 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 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.

2018 is the last year of the ACO Demonstration Project in NJ. 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.

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 Need of Increasing 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 Health Women Health Families Initiative, IM CollIN, MIEC Home Visiting, Fetal Infant Mortality Review, and Maternal Mortality Review.

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
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 EHB.

The Healthy Women Healthy Families Initiative through the use of Community Health Workers and Central Intake Hubs has been 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 Visitation, Strong Start, Title X Family Planning, Childhood Lead Exposure Prevention and Healthy Homes, Perinatal Addictions Prevention, Postpartum Mood Disorders, Coordinated School Health, WIC, Federally Qualified Health Centers (FQHCs), and the activities of the Office of Community Health and Wellness (smoking, diabetes, cardiac, cancer, obesity prevention, physical fitness, hypertension).

Through use of Community Health Workers and Central Intake the HWHF Initiative targeted 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).

NJDOH participated in the Infant Mortality Collaborative Improvement and Innovation Networks (IM ColIN) sponsored by the MCH Bureau with technical assistance from National Institute for Children's Health Quality. The IM ColIN State Team from NJ identified two priority areas - improving maternal postpartum visit rates and smoking cessation. The HWHF Initiative will coordinate and collaborate with a variety of community partners to implement the IM ColIN recommendations from these two focus areas.

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, Department of Children and Families, Department of Human Services etc.) to address some of the barriers that exist in the scope of Social Determinants of Health (SDOH).

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 recommendations of the IM CoLIN regarding postpartum visits.

In 2018, a new Request For Proposals for the Healthy Women Healthy Families (HWHF) Initiative was issued to include a specific focus on reducing black infant mortality in certain NJ municipalities. The HWHF Initiative includes Central Intake Hubs and Community Health Workers to promote the outreach and referral of women for preventive medical visits through standardized Community Health Screenings and referrals to medical care providers.

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.

E.2.c.2.a. 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.

The Healthy People 2020 breastfeeding objectives are for 81.9% of mothers to initiate breastfeeding, for 60.6% of new mothers to continue breastfeeding until their infants are six months old, for 34.1% to breastfeed until one year, for 46.2% to exclusively breastfeed through three months, and for 25.5% to breastfeed exclusively through six months. In the [2017 National Immunization Survey Breastfeeding Rate Report](#) from the CDC, 82.8% of NJ newborns were ever breastfed (NPM #4A); 57.6% breastfed at six months; 36.1% breastfed at twelve months; 40.6% exclusively breastfed at three months; and 24.4% exclusively breastfed at six months (NPM #4B).

Table NPM #4

Table NPM #4	Born in 2008	Born in 2009	Born in 2010	Born in 2011	Born in 2012	Born in 2013	Born in 2014	Born in 2015
Percent of infants who ever breastfed	75.8	80.5	77.1	81.6	82.0	82.0	83.9	82.8
Percent of infants breastfed exclusively through 6 months	11.8	14.0	13.0	22.3	16.7	23.1	24.8	24.4

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 hospitals were added in 2019.

With a CDC State Public Health Actions Grant #1305, NJDOH and the NJ Hospital Association delivered webinars and technical assistance calls to 18 hospitals and held a Mother-Baby Summit for all delivery hospitals to assist them in addressing barriers to and identifying potential solutions for implementing the Ten Steps to Successful Breastfeeding.

NJ hospitals strongly 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 is currently in the field. CDC will post state reports when they are available.

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 2016 Asian non-Hispanic women were most likely to breastfeed (84.6%) while black non-Hispanic women were least likely to breastfeed (67.0). White non-Hispanic and Hispanic women initiated breastfeeding at 75.5% and 82.4% respectively.

The exclusive rates for 2016 were 45.5% for white non-Hispanic women, 31.3% for Asian non-Hispanic women, 25.3% for Hispanic women, and 24.5% 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 provides 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 SFY 2018 (7/1/2017 to 6/30/2018, 86% of mothers with newborns participating in the

MIEC Home Visiting Program had initiated breastfeeding and 67% 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 intervention/strategy 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 Health, have an interest in breastfeeding protection, promotion and support and have similar constituencies.

In January 2014, 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

	2008	2009	2010	2011	2012	2013	2014	2015	2016
Percent of infants placed to sleep on their backs	65.6	65.7	67.4	68.9	70.1	69.5	70.8	70.5	69.4

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](#), 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 infant deaths, including those classified as Sudden Infant Death Syndrome.

SCNJ works with parents, grandparents, physicians, nurses, the child care community, hospitals, first responders, schools, social service agencies, health and education programs and state, federal and national organizations to reduce infant mortality and the racial and ethnic disparities associated with it. 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 risks that are associated with Sudden Unexpected Infant Deaths including Sudden Infant Death Syndrome and Accidental Suffocation and Strangulation in Bed. [Research](#) conducted by the SCNJ contributed to these recommendations. Since the SCNJ was established, the rate of SIDS in NJ has been reduced by 75%.

In 2018 to make hospital efforts easier to carry out, SCNJ developed a cost-free, educational app, in English and Spanish (<https://itunes.apple.com/us/app/sids-info/id1355933710?mt=8>). This app provides nurses with a visual, oral and interactive tool to help them share the information with families. Each screen contains a short text, visual example, and oral statement by a maternal voice. By tapping on a "baby" icon on each screen, additional details are provided in a "young" and engaging voice. The menu provides nurses with tools to support their own knowledge, such as the AAP policy, the SCNJ flyers, and the website for the national Safe to Sleep Campaign. Importantly, nurses will be asked to assist families download this free resource to their cell phones for future reference. Funding for this app was derived from a health services grant from the NJ Department of Health to the SCNJ.

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 safe sleep and promotes SUID prevention activities.

In November 2014, as part of a grant from the CJ Foundation, infant safe sleep training was provided to First Responders to provide healthy infant sleep education to the people they serve. The training called DOSE (Direct On Scene Education) significantly reduced the number of sleep related infant deaths in Ft. Lauderdale, Florida. After an emergency is handled and the home is identified as having a resident infant, the first responder can ask to see where the infant sleeps. Upon observation of the infant's sleep

environment the first responder can make recommendations to improve upon the environment and provide pamphleted information to caregivers. Caregivers are likely to buy-in to the education provided by First Responders since they are widely regarded as heroes and experts in the field of health and safety. With grant funding the DOSE program training was provided during a conference to management level EMT and Fire personnel. The personnel that received the training, in turn, will educate their staff thus reaching a large number of people. The training was centrally located allowing for personnel from all over the state to attend. The training program addressed all risk and protective factors developed by the American Academy of Pediatrics.

Also in 2014, the Child Fatality and Near Fatality Review Board (CFNFRB) in partnership with DCF's Division of Community and Family Partnerships, the NJ Departments of Education and Health, and the federal Centers for Disease Control and Prevention conducted 3 Sudden Unexpected Infant Death (SUID) prevention activities: 1) the "Educating today's babysitters and tomorrows parents" which targeted adolescents, 2) the Practicing Healthy Infant Sleep Environments (PHISE) Poster Contest and 3) the Tote Bag Giveaway. The CFNFRB held a poster contest in NJ middle schools; students were asked to create "Healthy Sleep" posters based on the guidelines established by the American Academy of Pediatrics. In addition to a monetary prize, the winning student's poster was silk-screened onto tote bags, creating "walking billboards" for infant "Healthy Sleep" awareness. 4,500 tote bags filled with educational materials on "Healthy Sleep" practices for infants were distributed to Federally Qualified Health Centers (FQHCs), Family Success Centers (FSCs) and Home Visiting (HV) Programs across the state. Specific FSCs, FQHCs and HVs have been identified based on the populations they serve and their locations. Inside the tote bags. There were a children's book by Dr. John Hutton entitled, "Sleep Baby, Safe and Snug," which addresses healthy sleep practices in a gentle, easily understood manner. A SleepSack: an infant sleeper-pajama with a built-in blanket and swaddling cloth, produced by Halo Innovations, Inc, and safe sleep information. The PHISE Poster Contest and Tote Bag Giveaway helped raise awareness of healthy infant sleep environments and practices among a broad swath of NJ's citizens: students, educators, healthcare providers, social workers, and parents.

In 2015, as part of the SUID-CR grant, the SUID Sub Committee partnered with Cribs for Kids and distributed over 700 "survival kits" to family success centers as well as child care resource and referral centers located throughout the state. Family success centers and child care resource and referral centers were targeted as these are locations where families regularly seek out assistance and resources. Each child care resource and referral center set up an exhibit of a safe sleep environment. Contained within the survival kits were a pack and play, Halo sleep sack, safe sleep information and age appropriate pacifiers. The SUID Sub Committee also distributed children's books by Dr. John Hutton entitled "Sleep Baby, Safe and Snug" to all 46 local child protection offices in both English and Spanish. These books were shared with mothers of newborns and pregnant mothers to educate about safe sleep practices in an easy to understand way while also encouraging bonding between mother and child through reading. The SUID Sub Committee also utilized grant funds to provide public education on safe sleep practices that reduce the risk of sleep related death in infants with advertisements within NJ Transit. Throughout the state the advertisements were featured on NJ Transit buses and light rails as well as on train station platforms focusing specifically on the high incidence areas identified through SUID data. The advertisements began at the end of September 2015 and continued through the end of the year.

In 2017 The SIDS Center of New Jersey has developed a unique and free app for Apple and android devices, in English and Spanish, with the goal of enhancing the education of parents and providers about safe infant sleep. This novel and interactive tool containing written and oral content, visuals, and a menu of additional resources gives nurses, physicians, child care specialists, case workers and other providers a new way of reviewing the information with parents. Providers are then encouraged to help families download the app to their phone as an enduring resource. Pediatricians are being asked to review the app with families at well-baby visits.

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, NPM #5 has been slowly improving from 60.6% in 2004 to 69.4% in 2016 according to NJ PRAMS data. The SUID rate has also declined from 0.8 per 1,000 live births in 2000 to 0.3 per 1,000 in 2012 according to the NCHS. Racial and ethnic disparities in NPM 5

persist and are being addressed through more targeted educational messages using home visitor staff in DCF and the MIEC Home Visiting Program.

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.

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Annual Indicator	15.0	14.5	14.0	13.2	13.0	12.7	12.8	13.3	13.3	13.6
Numerator	2,589	2,444	2,298	2,105	2,021	1,986	1,930	1,983	1,879	1,855
Denominator	17,295	16,816	16,402	15,945	15,586	15,692	15,064	14,864	14,169	13,657

Notes - Source - Birth Certificate data from the SHAD system
<https://www26.state.nj.us/doh-shad/home/Welcomes.html>

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

Maternal and Child Health Services has a long history of addressing perinatal health disparities with special emphasis on the Black Infant Mortality Reduction Initiative which was initiated in 1985. In February 2008 a Commissioner's Prenatal Care Task Force was convened to make recommendations to improve access to prenatal care in NJ. Health disparities was identified as a priority. The overall goal of the Access to Prenatal Care Initiative was to increase the rate of first trimester prenatal care in NJ to at least 90% to coincide with the National Healthy People 2010 goal, with emphasis on racial and ethnic disparities.

The Department's commitment to reduce black infant mortality and preterm births has been demonstrated through the Blue Ribbon Panel on Black Infant Mortality Reduction, the Black Infant Mortality Reduction Advisory Council, the BIBS campaign, the Commissioner's Prenatal Care Task Force, the Access to Prenatal Care Initiative, the ASTHO Prematurity Pledge, the MIECHV Program, the NGA on Improving Birth Outcomes, the IM CollN, and the Healthy Women, Healthy Families Initiative.

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.

Through the Healthy Women Healthy Families (HWHF) Initiative, whose primary goal is to reduce the Black Infant Mortality Rate in New Jersey, emphasis is 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. There is an intentional focus 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 2018 Strategic Plan includes facilitating the creation of the New Jersey Breastfeeding Strategic Plan with the NJ Breastfeeding Coalition (NJBC). The DOH will provide guidance; draft of Phase 1 will be completed June 30, 2019 and Phase 2 draft is due September 30, 2019. This collaboration begins an inclusive process to address the disparities that exists in breastfeeding which is a priority of the Department of Health. 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)

Describe planned activities for the applicant year and alignment with priorities

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 prevention activities of the Sudden Unexpected Infant Death Case Review ([SUID-CR grant](#)). The SUID-CR Coordinator will be participating in the Infant Mortality ColIN sessions that focus on improving infant safe sleep practices. Evidence-based strategies proposed by the IM ColIN sessions on infant safe sleep will be considered by the SUID-CR Workgroup. 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 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. 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 (www.rwjms.rutgers.edu/sids).

In 2018 to make hospital efforts to promote infant safe easier to carry out, SCNJ developed a cost-free, educational app, in English and Spanish (<https://itunes.apple.com/us/app/sids-info/id1355933710?mt=8>). This app will continue to provide nurses with a visual, oral and interactive tool to help them share the information with families. Each screen contains a short text, visual example, and oral statement by a maternal voice. By tapping on a "baby" icon on each screen, additional details are provided in a "young" and engaging voice. The menu provides nurses with tools to support their own knowledge, such as the AAP policy, the SCNJ flyers, and the website for the national Safe to Sleep Campaign. Importantly, nurses will be asked to assist families download this free resource to their cell phones for future reference.

Through grant funding from NJDOH, the SCNJ provides public health interventions such as its work with birthing hospitals, as part of the Nurses LEAD the Way initiative, and with local offices of the Division of Child Protection and Permanency. Based on the most recently released data from the NJ Center for Vital Statistics, NJ has one of the lowest SIDS rates and the lowest SUID rate in the US.

There are racial and ethnic disparities in factors that raise the risk of SIDS, and these contribute to disparities in rates. Such factors include disparities in preterm births, access to care, poverty, an important association, and exposure to second-hand smoke, a major contributing factor rising to the level of causality. The SCNJ is focusing on racial and ethnic disparities in factor that raise the risk of SIDS. This is being accomplished by the SCNJ collaborating with Mom's Quit Connection to link public health messages.

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. The goal of the HWHF Initiative is 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 groups for the IPO Initiative and the Central Intake Hubs will meet quarterly to build partnerships and local referral systems.

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 and #8 Physical Activity and State Performance Measure #2 (Children with Elevated Blood Lead Levels). NPMs #6, NPM #8 and SPM #2 were selected during the Five-Year Needs Assessment process for their impact on overall child health 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
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	

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

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 2018 6,997 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.

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.

Annual Report - NPM # 8: Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day

Increasing NPM #8 is an important focus in the domains of Child Health and Adolescent and Young Adult Health to prevent obesity and improve overall child health and well-being. FHS has been collaborating on and developing partnerships to address this NPM thru ShapingNJ and the CDC 1305 Cooperative Agreement in Community Health and Wellness and the CDC WSCC School Health NJ Project in MCHS. Regular physical activity can improve the health and quality of life of Americans of all ages. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.

	2003	2007	2011	2013	2016	2017	2018
8a: Percent of children ages 6 through 11 who are physically active at least 60 minutes per day	23.6	35.5	27.6	n/a	24.7	24.7	
8b: Percent of adolescents ages 12 through 17 who are physically active at least 60 minutes per day	19.0	23.0	23.2	27.6*	14.4	14.4	

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

*Source – CDC, National Center for Health Statistics

FHS recognizes that positive physical activity and healthy nutrition behaviors start at a young age and should be addressed as early as possible. Children at greatest risk for overweight and obesity as well as physical inactivity are concentrated in disadvantaged communities. With dedicated supports including training and technical assistance, as well as strengthened child care regulations, the prevalence of obesity among two to four year old children from low income families participating in NJ WIC decreased from 18.9% in 2010 to 15.3% in 2014.

School health objectives aim to: Provide training and technical assistance from 75 of the State's 600+ school districts (K -12) in 2016 to 100 by 2017 to create school environments that provide healthy nutrition and opportunities for physical activity throughout the day including quality physical education.

- NJ Association for Health, Physical Education, Recreation and Dance (NJAPERD), with CDC funding, conducts professional development sessions at statewide and regional meetings on: Physical Education/Physical Activity for K-12 teachers; School Food Service guidelines and nutrition standards for K-12 teachers; Preparing fresh fruits and vegetables for School Food Service staff.
- The NJ State Alliance of the YMCA, with CDC funding, continues to provide intensive training and technical assistance in five low-income school districts (including five - K-8 schools per district for a total of 25 schools; 1 high school per district in three districts = 3 high schools) to implement Comprehensive School Physical Activity and improve school nutrition environments.
- Health Corps, with State funding, supports efforts targeting three high schools. This funding supports three, full time, school-based youth coordinators to serve as peer mentors at the three high school sites to implement nutrition, physical activity and healthy lifestyles activities with students, teachers and the greater surrounding community.

Other nutrition, physical fitness and obesity prevention initiatives within the Office of Tobacco Control, Nutrition and Fitness (OTCNF) that are funded by the CDC - "State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health" (CDC funding ends 6/30/18) support breastfeeding initiation, duration and exclusivity for the first six months of life and healthy communities.

- NJ Hospital Association (NJHA) - The OTCNF provides funding to the NJHA to continue training and technical assistance to eighteen of the 52 NJ maternity hospitals to help move them towards implementation of the WHO/UNICEF's "Ten Steps to Successful Breastfeeding", a program designed to promote exclusive and sustained breastfeeding. In September 2016, NJHA convened a statewide training summit for all NJ maternity hospitals. Birthing facilities utilize the 2015 document published by NJHA titled: *Healthy Beginnings NJ: Supporting Breastfeeding Moms and Babies Technical Assistance Guide for Hospital Providers*. Periodic webinars are provided to interested hospitals. All efforts are overseen by an Advisory Group that convenes quarterly.
- NJ Prevention Network (NJPN) - The OTCNF provides funding to NJPN's *Get Active NJ* program which provides technical assistance, training and incentives to assist municipalities to find ways to educate stakeholders on different policies that can promote walking and the many benefits that walking may have on their communities. The *Get Active NJ - Walkability Toolkit* created by NJPN, is intended to provide information and examples on how local policies are created at the municipal level to support walkability.
- The Food Trust - The OTCNF contracts with The Food Trust to implement activities and projects to promote policy and environmental change for obesity prevention in local communities. Trainings and technical assistance are provided to corner store owners in order to increase community residents access to healthy foods and beverages, particularly those at high-risk for obesity and other chronic disease. The Food Trust provides on-site technical assistance to a minimum of 14 small retailers to promote healthy retail sales in their stores. Corner stores are

targeted through a collaboration with the NJ Department of Health WIC Program, the Office of Community Health and Wellness - OTCNF and The Food Trust. Beyond requiring WIC authorization, participating stores must meet either of two definitions including 1) 'underserved areas' - defined by CDC as 'no healthier food retailers or 2) USDA criteria – defined as 'low income – low access at half mile urban and 10 miles rural'.

- Child care healthy eating and physical activity (HEPA) subject matter experts provide training and technical assistance to licensed child care centers who need intensive assistance to improve and sustain HEPA best practices. Additionally, NJDOH collaborates with NJ Department of Human Services to provide training to Quality Improvement Specialists (QIS) and Regional Technical Assistance Specialists (TAS) who then are able to provide HEPA TA and other supports across the state as part of the NJ Quality Rating and Improvement System for Child Care (QRIS) called Grow NJ Kids.

As of March 2018 through the regional school health grantee's partnership with SJS, the number of NJ schools or districts, having successfully completed the actions related to physical activity, is given below:

Actions to Increase Physical Activity or Improve the Built Environment	# Schools Approved 2015	# Schools Approved 2016	# Schools/ Districts Approved 2017	# Schools/ Districts Approved 2018
Pedestrian and Bicycle Safety and Promotion Initiatives (School)	3	12	22	
Policies to Promote Physical Activity (District)	0	6	17	
Programs to Promote Physical Activity (School)	3	14	72	
Safe Routes to School District Policy	0	1	13	
School Travel Plan for Walking and Biking	3	8	15	

The selected 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)) will be monitored to assess progress on promoting physical activity of children 6 through 17 by improving policies and practices in schools regarding physical activity.

Annual Report - SPM # 2: *The percentage of children with elevated blood lead levels (≥ 10 ug/dL). Summarize programmatic efforts & analyze the state's progress*

SPM #2 was selected to address the issue of elevated blood lead levels in children which is not specifically addressed by the NPMs or NOMs. Long-term exposure to lead can cause serious health problems, particularly in young children. Lead is toxic to everyone, but unborn babies and young children are at greatest risk for health problems from elevated blood lead levels— their smaller, growing bodies make them more susceptible to absorbing and retaining lead. Lead exposure can cause permanent damage to the brain and nervous system, resulting in hearing problems, slowed growth and anemia. Children with elevated blood lead levels are at increased risk for behavioral problems, developmental delays, and learning disorders. Increased childhood morbidity will result from undetected and untreated elevated blood lead levels.

Meaningful progress was made toward SPM # 2 in CY 2017. More than 219,000 blood lead tests were reported on 205,291 children <17 years of age. Of the children tested during CY 2017, 83.8% were under the age of 6 years. Among these children, 2.62% had results >5 ug/dL. Of all the children tested, 93,109 were between six months and 26 months of age, the ages at which State regulations require children to be screened for elevated bold lead levels. This represents 43.4% of all children in that age group. Looking

at all blood lead tests reported since 1999, it is estimated that 78% of children have had at least one blood lead test before the age of three years, and 59% of children have had at least one blood lead test before the age of 2 years.

Table SPM #2

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
The percentage of *children with elevated blood lead levels (≥ 10 ug/dL).	0.6	0.5	0.5	0.5	0.5	0.5	2.62
Numerator*	1,103	898	793	816	862	867	4,525
Denominator*	182,040	183,215	176,847	171,521	174,887	174,162	172,217
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Final	Final

*Children ≤ 6 years of age

**State regulations adopted a reference level of 5 ug/dL or greater September 2017.

Notes - Source: Childhood Lead Information Database, MCHS, FHS.

Ongoing efforts to increase the percentage of laboratories reporting electronically resulted in an increase from 99.8% in CY 2016 to 99.9% in CY 2017. NJDOH continued to assist the remaining laboratories to transition from reporting on hard copies to electronic reporting. NJ has legislation that requires children to be screened for elevated blood lead levels. Every primary care provider and health care facility that provides care to children less than six years of age is required to comply with the law.

Monitoring of a Lead Elimination Plan and a Healthy Homes Strategic Plan continued to be coordinated by NJDOH to assure that the state is collectively making progress to eliminate elevated blood lead levels and other housing hazards that may affect the health of residents. Training opportunities for professionals were made available through the NJ Healthy Homes Training Center, a public-private partnership between NJDOH and Isles, Inc, a Trenton-based, non-profit, community development agency.

In NJ's largest city, Newark, the Newark Department of Health and Community Wellness, continued to administer the [Newark Partnership for Lead Safe Children](#). Three other local agencies continued to administer Regional Lead and Healthy Homes Coalitions with statewide outreach and a focus on primary prevention.

Training on healthy homes principles for staff of local health departments and home visitation-based programs in the Department of Children and Families (DCF) continue. Home Visiting programs, funded in part by NJ's MIEC Home Visiting Grant, provide services to pregnant women, infants, and young children. In addition, staff that assess the suitability of homes for placement of children who have entered foster care or are registered as family child care homes were targeted for training. Emphasis is placed on developing strategic partnerships with additional home visitation and government-funded home inspection agencies that serve highest-risk, hard to reach populations. A CDC Cooperative Agreement, awarded in October 2014, focuses on childhood lead surveillance to determine key indicators progress and deficiencies.

In October 2016, during national Childhood Lead Poisoning Prevention Week, the NJDOH kicked-off the #kNOwLEAD awareness campaign which included a reformatted Child Health webpage, social media presence, and call center for consumers to get their questions answered and referrals to resources. The various methods ensure a continued statewide outreach presence.

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, 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 2018 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 2018 6,997 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.

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.

Plan for the Application Year - NPM #8: (Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day)

CDC recently released FOA DP18-1801 "School Health Actions." Eligible agencies included State Departments of Education, not State Departments of Health. Unfortunately, with a new Governor in office, effective January 2018, and new senior staff appointments, a decision was made by the NJ Department of Education not to apply for this funding opportunity. The release of a second FOA, CDC RFA DP18-1807 "State Physical Activity and Nutrition Actions", is pending. For three years beginning Fall 2015, DOH regional school health grantees annually renewed a MOA with Sustainable Jersey for Schools, to continue their work on increasing physical activity and/or improving the built environment.

Starting in Fall 2018, 21 schools focused their work on sustainability of school health within their educational system. An evaluator will be contracted to quantify and qualify sustainability issues and the impact of implemented changes. ESM 8.1 will track the number of schools participating in an activity (training, professional development, policy development, technical assistance) to improve physical activity among children 6-17).

Plan for the Application Year - SPM #2: *The percentage of children with elevated blood lead levels (≥ 5 ug/dL).*

The Childhood Lead Exposure Prevention (CLEP) Projects are being transitioned starting January 2019 from FHS to the Office of Local Public Health. 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. Performance management strategies incorporated at the program level monitor progress towards the elimination of elevated blood lead levels and the timeliness and efficacy of public health responses for children with elevated blood lead levels.

The web-based data and surveillance system, LeadTrax, containing case management and environmental investigation modules continues to be customized, and remained compliant with CDC data requirements.

Collaborative efforts with Medicaid and its contracted managed care providers continued in order to monitor and increase the number of Medicaid-enrolled children screened for elevated blood lead levels. LeadTrax records are matched biannually to the Medicaid Eligibility file to identify blood lead screening rates and unscreened Medicaid participating children. LeadTrax testing results are included in the NJ Immunization Information System (NJIS) to provide healthcare providers with screening results and histories.

E.2.c.4.a. Adolescent / Young Adult Health

The domain of Adolescent/Young Adult Health includes focuses on NPM #10 (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year), NPM #11 (Percent of children with and without special health care needs having a medical home) and NPM #12 (Percent of children with and without special health care needs who received services necessary to make transitions to adult health care). Because reporting on NPM #11 and #12 overlap the two domains of Adolescent/Young Adult Health and SCHCN, the narrative for NPM #11 and #12 will be presented in this Adolescent/Young Adult Health section and not repeated in the CYSHCN Section. This section serves as the state's narrative plan for the 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 #10:

Improving NPM #10 (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year) is an important performance measure in the domain of Adolescent/Young Adult Health and is related to SPN #4 Promoting Youth Development. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease.

The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to improve patients' and providers' experience of care and the quality of care for all children. Promotion of the medical home is a strategy to improve NPM # 10 (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year). Providing a medical home means offering care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective (AAP, Policy Statement, July 2002). A medical home is a place where care for the child and adolescent is centralized, coordinated and monitored. A team approach to medical home improvement includes engaged staff members and parents as key improvement partners.

NJAAP has identified the medical home as one of 8 key issues to address to improve pediatric care in NJ. Since 2009, NJAAP, NJDOH and other partners have been working to increase primary care team education and awareness about the medical home to promote prevention, wellness and chronic care management. With the opportunity for NCQA Recognition as a patient centered medical home, NJAAP's support has enabled participating practices to assess their current level of "medical homeness" using the Medical Home Index, and additionally has engaged their participation in various QI activities.

From September 2015 through September 2017, NJAAP, in partnership with the SPAN and the NJDOH, implemented HRSA's Systems Integration Grant (SIG) to increase the percentage of CYSHCN with a medical home by 20%. This support for the Medical Home initiative enabled NJAAP and partners to work with seven primary care practices in 25 locations across NJ to increase cross-system care coordination. To support the exchange of information between families and providers, SIG partners convened 4 roundtable meetings to develop a comprehensive and user-friendly Shared Plan of Care (SPoC) and conducted focus groups & interviews with 20 individuals (15 adults, 5 young adults) to garner input from CYSHCN and their families. Participating practices were also engaged in five presentations to increase knowledge, enhance partnerships, and foster systems integration via linkage agreements. Presentations focused on 1) Patient-Centered Medical Homes (PCMH) certification/recognition process, 2) SCHS CMUs 3) SPAN, 4) Utilizing a Shared Plan of Care, and 5) Transition to Adulthood. By September 30, 2017, the SPoC was piloted by three Special Child Health Services County Case Management Units (SCHS CMUs), and approximately 103 SPoCs were distributed.

Following the end of SIG grant funding, NJAAP continues to provide assistance to the NJDOH team to sustain and further enhance systems integration. As of July 2018, NJAAP staff support implementation of the updated Case Management Referral System (CMRS), which enables measurement of distribution/utilization of Shared Plans of Care and related medical home measures. NJAAP staff also provide: 1) ongoing technical assistance to SCHS CMU staff and NJ DOH Program Officers on CMRS v3.0/3.1/3.2; 2) testing of CMRS system enhancements in collaboration with the BDARS team and Rutgers programming staff to provide feedback and resolve issues; 3) identification, tracking, and submission of CMRS v3.0/3.1 issue reports from users in the field to BDARS colleagues and Rutgers programming staff; 4) routine medical home webpage maintenance and collection of relevant webpage data; 5) management, cleaning, and analysis of CMRS data to report on National and State Performance Measures related to the patient centered medical home; and 6) assistance with development of a training manual/materials for SCHS CMU staff who serve children and youth with special health care needs statewide. NJAAP staff engage in Community of Care Consortium (CoCC) Meetings, SCHS CMU site visits, CMRS/BDARS system enhancement meetings, and SCHS CMU Monthly and Quarterly Meetings to support continued spread and adoption of the patient centered medical home for all children, and especially for those with special health care needs.

In December 2018, NJAAP collaborated with NJDOH and SPAN to develop and present on the ISG grant and SPoC at the SCHS Quarterly Case Management Meeting for statewide SCHS CMU staff, and another presentation is being planned for the June 2019 Quarterly Meeting to introduce SCHS CMU staff to CMRS v3.2 system updates. As of April 15, 2019, an additional 129 SPoCs were documented in the Case Management Referral System (CMRS). NJAAP continues to evaluate pediatrician perceptions of the SPoC and identify additional opportunities to share information about the SPoC with pediatric practices. The Chapter also continues to offer technical assistance to participating practices on NCQA recognition process and quality improvement.

Since 2015, NJAAP has been partnering with NJDOH to support practices taking the next step toward NCQA Recognition as a Patient Centered Medical Home. The National Center for Quality Assurance (NCQA) recognition as a Patient Centered Medical Home involves a detailed and lengthy process with many standards and elements, including "Must Pass" elements, that busy Pediatric practices find difficult to navigate independently. Attainment of NCQA Recognition as a PCMH provides practices with payment incentives that will support and sustain financing their Medical Homes. Research demonstrates that PCMHs achieve powerful results. The Patient-Centered Primary Care Collaborative recently summarized PCMH demonstration findings that show success in increasing quality while reducing costs (<http://www.pcpcc.net/content/pcmh-outcome-evidence-quality>).

To build and maintain in house capacity, two members of the NJAAP Medical Home team are certified as NCQA Recognized Content Experts and routinely participate in training sessions to keep their certification current. NJAAP continues to promote and offer our NCQA PCMH “Warmline” to answer questions, concerns or issues regarding a practice’s involvement in the NCQA Recognition Process. An awareness notification is included in the biweekly NJAAP e-newsletter. Additional awareness/promotion is posted on the Medical Home page of the NJAAP website

The NCQA Recognition program currently supports five practices who are in varying stages of readiness/interest for NCQA Recognition. The NJAAP team conducts on-site visits to explore each practice’s level of interest, commitment to and preparedness for, applying for NCQA Recognition. The team also provides customized technical assistance for each practice through virtual follow-up meetings to address each concept of the 2017 NCQA Standards and Guidelines. These working sessions are beneficial for keeping the practices on-task, with the goal of practice transformation and NCQA Recognition in sight.

NJAAP created and introduced a practice checklist/tracker as a guideline to satisfying the concepts required for each of their virtual check-ins with their NCQA representative. Practice status, degree of readiness for the recognition process and any document/report submissions, suggestions or needs are evaluated. Practices are coached on how to prepare their materials to satisfy NCQA basic document submissions. The NJAAP team provides practices with copies of the current standards, and suggestions/tools for filing and organization (ex. labeled colored folders). At the end of each technical assistance session, practice/staff are given tasks to be completed prior to the next working session/site visit.

In April 2019 NJAAP’s application to join NCQA’s “Partners in Quality” program was approved by NCQA enabling NJAAP to offer NJ pediatric practices pursuing PCMH recognition a 20% discount on NCQA PCMH enrollment fees.

To expand the benefits of practice transformation for community pediatricians that are currently not ready to undertake NCQA Recognition, the NJAAP Medical Home program is piloting the Advanced Primary Care (APC) program, a reframing of the medical home model. NJAAP’s certified PCMH content experts will provide targeted technical assistance to help practices assess, plan and implement sustainable quality improvements designed to increase their ‘medical home-ness’. By building capacity for coordinated, comprehensive, Patient & Family centered care the program will also better position participating practices for value-based healthcare reform. The program creates the opportunity for practices to participate in quality improvement activities along a continuum based on their readiness for practice transformation, including those seeking NCQA recognition as Patient-Centered Medical Homes. In addition, the APC will act as a catalyst for creating linkages to other NJAAP quality improvement programs and community resources to build robust medical neighborhoods with well-functioning care coordination system to support the complex medical needs of patients and their families. The goal of the NJAAP team is to recruit a maximum of six practices to each participate in this new quality improvement opportunity. Awareness materials have been shared in the NJ Pediatrics quarterly publication and in meetings with NJAAP Program Directors to identify practices that can benefit from this customized quality improvement opportunity.

To focus pediatric provider education on adolescent health issues within the pediatric medical home and to gain feedback on strategies to better support vulnerable adolescents in New Jersey, NJAAP, led by the Chapter’s Adolescent Health Committee partnered with NJDOH on several educational initiatives:

- Planned and conducted an Adolescent Health Symposium. Based on feedback from the 2017 Adolescent Survey of NJAAP Chapter members, presentation topics included: The Adolescent Well Visit; Trauma Informed Care; Issues for Practicing Pediatricians of LGBTQ Youth; and Addressing Mental Health Concerns in Adolescents. A total of 143 individuals attended the September 27, 2018 Adolescent Health Symposium (63 pediatricians; 54 nurses, 34 public/private organization

representatives). Post survey feedback was very positive with 99% of respondents indicating they would be interested in attending a future adolescent symposium.

- Published CME article, “Health Disparities in Sexual and Gender Minority Youth” in the Fall/Winter issue of New Jersey Pediatrics. The article was co-authored by Susan Brill, MD, FAAP and Brandon D. Brown, MD, Chief Resident at Saint Peter’s University Hospital.
- Susan Brill, MD, FAAP, Chair of NJAAP Adolescent Health Committee will conduct a CME presentation the evening of June 11, 2019 on the Adolescent Well Visit and related health topics.

Table NPM 10

	2003	2007	2011-2012	2016
Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year	84.11	94.54	93.27	84.4

Source – National Survey of Children’s Health (NSCH)

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

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. 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 continued in 2018 and will continue through 2019 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 21,354 children age 0 to 18 years served in FFY 2017, 7,653 (approximately 35.8%) 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).

2014 SCHS CM data obtained through CMRS informed a quality improvement initiative targeting medical home charting within CYSCHN's ISP's. FCCS staffs identified baseline SFY 14 data on key proxies used to note documentation of those outcomes in CMRS by the SCH CMUs and compared those findings to NJ State and national findings reported in the 2009/2010 National Survey of CSHCN (NS-CSHCN). Baseline 2014 and follow-up annual findings are shared with the SCHS CMUs at quarterly SCHS CM meetings. These presentations are part of FCCS staff's ongoing quality improvement project, for further discussion about ensuring access to a medical home for CYSCHN and CMRS documentation of this work.

During SFY17, all Programmatic, Narrative and Chart Review Site Visit Forms for 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) Does the team provide each family with education regarding the concept of a Medical Home and its role in coordination of care for CYSHCN? 2) Does the team assist/facilitate the establishment of a Medical Home for the patient and patient family if no Medical Home is Present? 3) How are patients assessed for the Presence of a Medical Home? 4) Do Multidisciplinary Evaluation Reports and ISPs include document regarding Medical Home?"

During SFY18, the revised Programmatic and Narrative Site Visit Forms for CECs, CLCPs and PTCs were used for annual Site Visits. 100% of all CECs, CLCPs and PTCs answered "yes" to questions regarding the presence and/or establishment of a Medical Home. Each CEC, CLCP and PTC stated that they provide each family with education regarding the concept of a Medical Home and its role in coordination of care of CYSHCN and assist/facilitate the establishment of a Medical Home for the patient and patient's family if no Medical Home is Present. Additionally, each CEC, CLCP and PTC provided a policy regarding the assessment for the Presence of a Medical Home and identified areas for documentation on the Multidisciplinary Evaluation Reports and ISPs regarding Medical Home.

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)

A total of 10 pediatric/family medicine practices across NJ, representing 126,500 children were recruited to participate in the AAP's Patient Centered Medical Home Technical Assistance program. The goal of the project was to expand and build NJ's capacity by having the NJAAP/Medical Home Quality Improvement Team become NCQA Recognized Experts and by staffing an "NCQA Recognition Warm Line" available to Pediatricians across the State. In September 2015, FCCS was awarded a 2--year ISG to increase the percentage of CYSHCN with a medical home by 20%. FCCS partnered with NJAAP, SPAN, and three SCHS CMUs for this project. As part of the ISG, FCCS and its partners: developed a Shared Plan of Care tool that was piloted beginning May 1, 2017 by three SCHS CMUs to increase cross-system care coordination; developed five (5) presentations that were delivered to seven partnering primary care practices in 25 locations to increase knowledge, partnerships, and integration; developed linkage agreements between partnering practices and both SPAN and SCHS CMUs to increase integration across partners; and connected partnering practices with SCHS CM to increase awareness of SCHS CMUs as a shared resource for CYSHCN, including those who are within the transition to adulthood age range. The three SCHS CMUs distributed approximately 103 SPoCs between May 1, 2017 and September 30, 2017. SPoC distribution is ongoing with future plans and the remaining 18 SCHS CMUs participated in a training to learn about the development and implementation of the SPoC on

December 11, 2018 to promote for spread and sustainability of this tool across all counties. An additional 129 SPoCs have been documented in CMRS as of April 15, 2019.

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; 70,414 (SFY17) vs. 94,801 (SFY18).

Demand remains particularly high for comprehensive team evaluation, and some agencies report a 3- to 6-month wait to schedule new clients. To reverse the wait time to schedule a new comprehensive team evaluation, State staffs provide consultation to SPSP agencies. In an attempt to reduce wait time, multiple CECs recently implemented a pre-appointment call to families of CYSHCN that screened for presenting needs. In some instances, this technique allowed for targeted appointments with specialists rather than a full evaluation, streamlined scheduling, reduced appointment wait time to less than 6 weeks, and opened up appointments that necessitated full team evaluations in a more timely manner. Anecdotally, the agency reported that although their efforts required a slight increase in staffing time it yielded a reduced wait time, and all CYSHCN as well as their referring physicians were provided with service plans. The results of this effort were shared with other CECs, and they are exploring the possibility of replicating it. State programmatic monitoring to ensure that clients have and/or are referred to community-based providers will remain ongoing; chart audits and visits to assess clinic days and provide consultation as well as follow-up telephone support will continue.

During February and March of SFY19, a CEC "Wait Time" Survey was administered across all 9 CECs. The purpose of the survey was to assess for current "wait times" at the CEC for an initial appointment and measures taken to address the "wait times". 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". 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%). 50% of CECs completing the survey stated that these measures reduced their wait time by 1-5 weeks while the remaining 50% did not observe an improvement in their wait time following the implementation of these measures. Moving forward, a meeting will be scheduled for the conclusion of SFY19 to further discuss these findings and explore additional solutions.

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. Focus for Fiscal Year 2014 was to provide guidance and technical assistance to the practices that were ready to begin this recognition process.

SPAN, the NJAAP, and COCC members in 2012 targeted improvement in access to medical homes for immigrant CYSHCN and their families in three high need/limited English proficiency communities in northern NJ: Passaic, Hudson and Union counties. This project engaged Federally Qualified Health Centers, parents of CYSHCN, and family resource specialists linked with the SCHS CMUs in the above-mentioned counties to promote “medical homeness”. Likewise, it promoted navigation skill development for immigrant underserved parents of CYSHCN, and leadership training. Referral to and coordination with in-State specialty care providers was also a component of technical assistance provided to private community-based pediatricians and family practitioners, hospital-based practices, and FQHCs through the ISG medical home project.

In 2014, Title V in collaboration with SPAN, the COCC, the NJAAP, and other community-based partners, responded to a HRSA request for applications for a State Implementation Grant for Enhancing the System of Services for CYSHCN through System Integration. Although that opportunity was approved but not funded in the first year, funding was granted in the second year.

The project was completed in 2017 and work focused on aims set forth by HRSA in three domains: cross-system care coordination, integration, and shared resource. FCCS collaborated with SPAN, NJAAP, and three SCHS CMUs. Program implementation and project evaluation aligned with and expanded NPM #11 and NPM #12 reporting.

Ongoing improvements to the Case Management Referral System (CMRS) allowed new and different opportunities to track NPM 11 and 12. Rather than definitive identifiers for these Performance Measures, “proxies” were identified and used for this year’s reporting. SCHS CMUs served 20,167 CYSHCN in FFY 2018.

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, American Academy of Family Physicians and 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.

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.

	2009	2010	2011	2012	2013	2014	2015	2016*	2017+	2018
Annual NPM #12 Indicator	37.9	37.9	41.8	41.8	N/A	12.2	25.3	41.3	43.0	45.7%
Numerator						352	1,101	2,073	2,208	2,027
Denominator						2,892	4,385	5,017	5,137	4,438
Is the Data Provisional or Final?	Final	Final	Final	Final		Final	Final	Final	Final	Provisional

Notes - Indicator data for 2005-2012 comes from the National Survey of CYSHCN, a numerator and denominator are not available (N/A). Beginning 2014, the denominator represents all children age 12-17 years served in FFY by Special Child Health Services Case Management Units (SCHS CMU). The

numerator reflects the number of children who had at least one transition-type services identified in their Individual Service Plan (ISP).

For 2014 and 2015, four 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, and
4. health insurance.

*Beginning 2016, a fifth type of service was added following SCHS CMU feedback during a quality improvement presentation in September 2016: supplemental security income (SSI).

+Beginning 2017, two additional types of services were added: Shared Plan of Care (SPoC) and 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, 6,156 youth were served in FFY 2017. Of those youth, 2,693 (approximately 43.7%) 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 staffs monitor the SCHS CMUs efforts to in reach and outreach to CYSHCN regarding transition, and documentation of goals related to transition on adolescents' ISPs. Likewise, efforts to capture the discussion of transition to adulthood between families of CYSHCN and SPSP providers are in process.

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. FCCS staff has presented additional CMRS documentation training on transition to adulthood in December 2016 as part of the ISG. Discussion of the value of a SPoC during transition planning was incorporated into SCHS CMU training in December 2018.

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 MCHBG 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, all Programmatic, Narrative and Chart Review Site Visit Forms for Child Evaluation Centers (CECs), Cleft Lip/Palate Craniofacial Centers (CLCP) and Pediatric Tertiary Centers (PTCs) were revised to include questions regarding Transition to Adulthood. Questions include: "1) does the team provide each family with education regarding the concept of Transition of Care (from pediatric to adult care) and its role in the coordination of care for CYSHCN? 2) Does the team assist/facilitate a Transition Plan of Care for the patient and patient family if no Transition Plan of Care is Present? 3) How is Transition to Adulthood addressed by this agency? 4) Do Multidisciplinary Evaluation Reports and ISP include documentation regarding Transition to Adulthood?"

During SFY18, the revised Programmatic and Narrative Site Visit Forms for CECs, CLCPs and PTCs were used for annual Site Visits. 100% of all CECs, CLCPs and PTCs answered "yes" to questions

regarding Transition to Adulthood. Each CEC, CLCP and PTC stated that they provide each family with education regarding the concept of Transition of Care (from pediatric to adult care) and its role in coordination of care of CYSHCN and assist/facilitate a Transition Plan of Care for the patient and patient's family if no Transition Plan of Care is Present. Additionally, each CEC, CLCP and PTC provided a policy regarding the establishment of a Transition Plan Care and identified areas for documentation on the Multidisciplinary Evaluation Reports and ISPs regarding Transition to Adulthood.

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. The percentage of youth age 14-19 years served by the SPSP agencies was greater, comprising nearly 24% of those served by the Tertiary Centers, and 15% 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 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 systems 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 this 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 FamilyCare 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 #10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

The plan for the applicant year for NPM #10 is to continue the Medical Home Technical Assistance Program with the NJAAP in partnership with the SPAN Parent Advocacy Network and the NJDOH expanding 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. Continued support for the Medical Home Initiative enables NJAAP to work with over 25 practices across NJ in the development of practice teams and utilization of the model for improvement to strengthen patient centered medical homes.

NJ's competitive application, to the National Resource Center (NRC) and AMCHP for the 2nd cohort of the Adolescent and Young Adult Health (AYAH) Collaborative Improvement and Innovation Network (ColIN), was approved. Data from a NJ FQHC report identified a greater than 50% disparity for adolescent preventive medical visits at FQHCs (averaging about 45% during the years of 2013-2015) as compared to private physician offices (averaging about 97%). The goal of the NJ AYAH ColIN is to increase the FQHC adolescent visit rate to achieve the Healthy People 2020 goal of 75.6%. The State

Team attended a two-day Summit on May 9-10, 2017. Assistance will be provided for the Team to develop an 18 month collaborative workplan for implementing evidence-based strategies. On April 11, 2017, the Southern New Jersey Perinatal Cooperative convened a youth panel to present their ideas on adolescent-friendly services.

The Medical Home Technical Assistance Program for 2018-2019 which is grant funded by FHS will continue to provide in-depth Technical Assistance for Pediatric Practice teams, raise awareness for patient centered medical home including "Triple Aim", and address the needs identified through recent surveys.

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. Changes to CMRS were made to accommodate reporting, data collection, and tracking of medical home components. FCCS distributed ISG funding of \$15,000 in 2016 and \$10,000 in 2017 to implement these changes to CMRS. 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 Shared Plan of Care (a medical home tool), was developed as part of a medical home grant, along with a medical home webpage on the Department's website. Distribution of this tool to CYSHCN in case management was added to ESM 11.1 for MCHBG 2019.

State staffs will continue to share resources and training updates with SPSPs on the reorganization of State programs and services that can influence access to primary and specialty care, including the Comprehensive Waiver, Managed Long-Term Services and Supports, and changes in access to care through implementation of the Affordable Care Act. Likewise, continuing to promote linkages between the Medicaid managed care agencies will remain important in supporting families with CYSHCN seeking in-State specialty care.

Title V will continue to support a safety net of specialty providers and case management units. Trends in the use of specialty care across the provider network will continue to be monitored by State staffs via onsite monitoring and programmatic reports. Likewise, continued collaboration with network agencies, State agency and community-based partners through the COCC, and consumers, will continue to promote linkage for CYSHCN with a medical home.

Plan for the Applicant Year - NPM #12

Efforts to improve documentation of transition to adulthood activities performed by SCHS CMUs and documented in the electronic Case Management Referral System (CMRS) will continue. State staffs 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. As part of an ongoing QI initiative, State staff have presented QI findings and additional guidance on an approximately quarterly basis to SCHS CMUs.

However, transition to an adult program for CYSHCN 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.

The Arc of NJ's annual Mainstreaming Medical Care Conference was held in June 2018. Title V participates on its Advisory Board, and the overarching theme of the upcoming conference was medical

care for persons with intellectual and developmental disabilities and promoting quality healthcare. Key conference concepts cogent to NPM #11 and NPM #12 included elements of planning for the future, understanding Medicaid/Medicare dual eligibility and access to Division of Developmental Disabilities services to support transition to adulthood, and culturally competent delivery of care for persons with developmental disabilities from diverse communities.

E.2.c.v Children with Special Health Care Needs

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

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

Provisional data indicates that for 2017, 76.7% of infants received follow-up after referring on inpatient screening. Since follow-up exams are still occurring on children born at the end of 2013, 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 #3: Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening and who have outpatient audiological follow-up documented.

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Annual SPM#3 Indicator	78.9%	86.1%	86.0%	86.4%	88.2%	85.8%	86.0%	89.0%	87.5%	81.1%
Numerator	2364	2444	2451	2131	1945	1821	1869*	1833	1570	1419*
Denominator	2997	2837	2850	2467	2205	2122	2173*	2059	1798	1749*

*Note – Data for 2017 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 in 2015 to achieve program goals:

- During 2017, the EHDI staff worked with the New Jersey Immunization Information System (NJIS) programmers to create user specifications for revisions to that system. All outpatient audiologic reporting to the EHDI program is submitted via an EHDI module in this system, NJ's immunization registry. The NJIS 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 went live on January 31, 2018.
- Members of the multidisciplinary EHDI Quality Improvement Stakeholder Committee continued regular conference call meetings during 2017. The Plan-Do-Study-Act (PDSA) model of quality improvement is being utilized for these activities. A multidisciplinary program advisory group to provide advice to the recipient on potential mechanisms to achieve project objectives and strategies was established in 2017 and met in January 2018. Another meeting is set for April 2018. The group will again convene in fall/winter 2018.
- Collaboration with the NJ Division of Consumer Affairs resulted in development of a comprehensive list of all current NJ licensed audiologists and hearing aid dispensers to be used for outreach to these professional for inclusion in the annual update to the NJ EHDI Pediatric Hearing Health Care Directory (www.hearinghelp4kids.nj.gov). This free, online Directory provides listings of hearing health care professionals who provide services to children from birth to 21 years of age.
- Trained 17 new users on the EHDI reporting module in the NJ Immunization Information System (NJIS) 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.

- 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. During 2017 the case managers contacted 595 families.
- 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 128 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.
- Presented information in multiple formats including conference calls, webinars, and in-person presentations on a variety of EHDI-related subjects to varied audiences which included parent support staff, audiologists, Case Management and Service Coordinators and hospital birth certificate clerks. In 2017, in-person presentations included presentations to the NJ Department of Human Services Division of the Deaf and Hard of Hearing Advisory Committee and to the New York Mid-Atlantic Consortium for Genetic and Newborn Screening Services Medical Home Learning Session. In 2017, a breakout session about baby friendly hospitals in NJ and attitudes about bedside vs other location hearing screening and a poster presentation were given at the 2017 National Early Hearing Detection and Intervention Conference in Atlanta, GA. The Baby Friendly presentation was also given as a webinar to NJ Hospital contact people and other interested hospital and committee colleagues. In 2017 an in-person meeting of all three Learning Communities was offered at The University Medical Center of Princeton at Plainsboro.
- In 2017, an audiology-based webinar was presented in collaboration with Utah State University & the National Center for Hearing Assessment and Management on pediatric hearing loss counseling issues. In collaboration with the Utah CMV Council and NJ AAP, NJ EHDI held a webinar in 2017, to increase knowledge and awareness about congenital CMV infection for NJ hospital EHDI coordinators and other interested health care professionals (as part of National CMV awareness month). In 2018, two posters were presented by NJ EHDI at the National Early Hearing Detection and Intervention Conference in Denver, CO, one of which won the Outstanding Poster in the area of EHDI Workforce. A total of 3 meetings were held for the Hearing Evaluation Council, which is a Commissioner appointed advisory board to the NJ EHDI program. The HEC is made up of a pediatrician, otolaryngologist, an audiologist, a child of Deaf adults, a member of the Deaf community, a hard of hearing individual and citizens of the State who are interested in the welfare of children with hearing loss (which includes a parent of a children with hearing loss and a teacher of the Deaf).
- In 2017, the NJ EHDI audiologist, in collaboration with the NJ Medicaid Program and the only 2 manufacturers of bone anchored hearing system technology met over several months to rectify

billing issues that prevented fitting of these devices on infants and children with external auditory canal atresia and single sided deafness through the establishment of billing codes that were previously unavailable to the NJ Medicaid recipients.

- Throughout 2017, there was a continuation of the collaborative NJ EHDI, Family Centered Care and NJAAP pediatric hearing health care outreach initiative to Special Child Health Services. 10 monthly topics/case studies and questions of the month were sent to all 51 SCHS Case Managers.

b. Annual Report (Last Year's Accomplishments)
State Performance Measure 4:

NJ has been very successful in linking children registered with the Birth Defects 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). However, the system did not track children and families to determine if and what services were offered to any of the registered children. To address this weakness, added in 2012, the Case Management Referral Systems (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 4: Percent of live children registered with the Birth Defects and Autism Reporting System (BDARS) who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services.

	2012	2013	2014	2015	2016	2017	2018
Annual Indicator SPM #4	36	50	84.7	88.9	90.1	91.8	94.9%
Numerator	1747	3508	11,089	13,696	13,634	14,011	12,416
Denominator	4875	7047	13,096	15,404	15,135	15,261	13,079

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 (FFY17 n=1,250).

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.

In 2013, CDC continued to fund the BDARS through a cooperative agreement for improvements in the Birth Defects Surveillance system. Rutgers, Bloustein Center for Survey Research (BCSR) deployed CMRS for the BDARS and during and after deployment, the BCSR continued to work with staff from both the EIM Program and the SCHS county-based CMUs to identify and correct issues in the case tracking and management component of the BDARS. In 2014, within the CMRS component of BDARS, the BCSR created and implemented an Exceptional Event module in collaboration with BDAR and Family Centered Care Services (FCCS) staff. The Exceptional Event module was originally intended to track families affected by Super Storm Sandy using Social Services Block Grant (SSBG) funds. However, team collaboration suggested the expansion and adaptability of this module to track other natural disasters, interpersonal family crises, and other 'exceptional events' that may impact the needs of children with special health care needs and their family, including the youth's transition to adulthood. In 2016, FCCS provided funds to BCSR to further expand CMRS to include additional tracking for the Medical Home for CYSHCN initiative. These additional components have been incorporated into NPM reporting.

The Pulse Oximetry Module continues to collect information on children who failed their newborn pulse oximetry screening test, which is 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. 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 test.

BDAR staff continued to provide training to birthing facilities, autism centers, and CMUs in the use of the electronic BDARS. They also continued to assist the units as they transition from the paper-based system to the electronic system.

In 2017, the SCHS Registry:

- Processed registrations for over 9,941 children with birth defects and other special health needs,
- Referred 8,679 families to the SCHS CMUs, and
- Received 3,919 new autism-related registrations, excluding anonymous registrations.

BDAR staff continues to collaborate with staff from FCCS and BCSR to identify and correct issues related to the BDARS and the CMRS to improve its ease of use and efficiency. In 2019, CDC continues to fund the Program through a cooperative agreement for improvements in the Birth Defects Surveillance System. The BCSR will continue making improvements to the BDARS, CMRS, and the Pulse Oximetry and Exceptional Event Modules. The BDAR staff will continue to work with the hospitals and other agencies to ensure complete reporting, especially with the birthing hospitals to ensure all children who failed their pulse oximetry screening test are reported through the BDARS.

Site visits will be conducted in each of NJ's birthing hospitals to audit their reporting through the BDARS. Facilities having the lowest levels of appropriate reporting, based upon results of the audits, will receive remedial assistance from staff of the BDAR. The BDAR staff will continue to identify non-traditional reporting sources, e.g., FQHC, as a means to ensure all families with special health care needs children will be identified and referred to the appropriate CMU for services.

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 5:**

The NJ Autism Registry is the largest mandated autism registry in the country with over 32,000 children registered as of December 2018. 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, such as Massachusetts. In FY 2017, over 3,833 children were newly reported to the BDARS including all children with a diagnosis of autistic disorder, Asperger's syndrome, or pervasive developmental disorder- not otherwise specified and who had information about the date of first diagnosis. Staff has 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. A new Autism Registry logo and webpage (<http://nj.gov/health/fhs/autism/public/registry/>) were created which includes information for parents, providers, and researchers.

Providers with untimely reporting are contacted and reminded of the mandate to report and of the importance of the linkage to SCHS CMUs. The electronic reporting component of the BDARS facilitates timelier reporting by facilities and since the BDARS added the SCHS CMU component, referral of these children to services is significantly faster. A specific target for this current year was the annual audits with hospitals and other autism reporting facilities in conjunction with the Birth Defects quality assurance audits.

Plan for the Application Year

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

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

The NJ EHDI Timely Follow-up and Early Intervention/Audiology Learning Communities (LC) met five times in 2017 and continues to meet in 2018 to identify tests of change for improvement of screening, diagnostic testing and early intervention enrollment. A third LC, the Family Engagement LC has been established and held its first meeting in December 2017. It is made up of family members of children who are Deaf or hard of hearing. Family Engagement LC members participated in a day long 'serving on groups' program to assist them with becoming family leaders. The establishment of the Family Engagement LC assists the EHDI program in understanding the needs of Deaf and hard of hearing children and their families. The LCs are a cohort-based multidisciplinary approach to improve EI access to services, timely hearing screening, language acquisition, enlist family engagement, and focus on literacy and social and emotional growth for the infants and children of NJ. LC's include at least one primary care provider, one care coordinator and one family member of a Deaf or hard of hearing child in addition to health care professionals and community members.

The EHDI program will continue to send hospital-level surveillance data to each hospital with maternity services. A report with their overall statistics is sent annually. Monthly hospital contacts received a reconciliation list of children who were still in need of follow-up after missed or referred inpatient hearing screening. During 2016 the program used a Plan/Do/Study/Act (PDSA) quality improvement process to determine if a monthly notification to hospitals of children in need of a follow-up improves outcomes. Following the success of this PDSA QI process, the monthly reconciliation process was adopted.

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, two new grant-supported activities, a Deaf and Hard of Hearing Mentoring and Role Model program and the development of learning communities for parents of children identified with hearing loss are planned. These activities will continue pending continued availability of grant funds.

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 begin collaboration 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 and have begun the process of partnering with the Maternal and Child Health Consortia to provide information to hospital based OB/GYN waiting rooms.

Plan for the Application Year

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

SPM #4 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. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928, and since then, linking registered children to health services. Since 1985, NJ has maintained a population-based registry of children with selected congenital defects. Beginning 2003, the Early Identification and Monitoring (EIM) Program received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ passed legislation mandating the reporting of Autism. Subsequently, with the adoption of legislative rules in 2009, the Registry added the Autism Spectrum Disorders (ASD) as reportable diagnoses, expanded the mandatory reporting age for children diagnosed with birth defects up to age 6, and added severe hyperbilirubinemia as a reportable condition. BDARS refers all living children and their families to SCHS Case Management Units via the BDARS direct link to the Case Management Referral System (CMRS).

CDC funding, through BCSR continues to assist the Program in making improvements to the BDARS, CMRS, and Pulse Oximetry and Exceptional Events modules to improve their ease of operation and efficiency.

To improve the electronic reporting system, a 3.0 version was developed and instituted in January 2018. The updated system assists in identifying duplicate registrations by users, thus streamlining the reporting process for the user and processing registrations by BDAR staff. The 3.0 version will also assist in enhancing parts of the Registry associated with SCHS CM (i.e., via CMRS).

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.

Site visits will continue to be conducted in each of NJ's birthing hospitals and SCHS CMUs to ensure proper usage of the BDARS and CMRS as needed. FCCS staff reviews the CMUs' performance in 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.

BDAR staff will continue to work with the agencies to ensure complete and appropriate referral to services. BDAR staff also will be working with non-traditional reporting sources, e.g., FQHCs, and facilities from bordering states to register children with birth defects and/or special health care needs, including autism. Building upon informational visits conducted in FFY 2013, FQHCs are continuously encouraged to report children diagnosed in their facilities.

Surveillance activities will expand due to the increase in readily available electronic data. These will include identifying any relationships between diagnoses, geographic and temporal patterns, and other descriptive statistics.

BDAR was awarded a CDC grant in August 2016 to conduct a rapid active population-based ascertainment of microcephaly and other select major birth defects possibly linked to maternal Zika virus and to use the data for public health action through monitoring, prevention, and intervention. This grant was a one-year grant that ended July of 2017; however, a no cost extension was obtained to continue these efforts until the end July 2018.

Plan for the Application Year

State Performance Measure 5: Average age of initial diagnosis for children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder.

Describe planned activities for the applicant year and alignment with priorities

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Annual Indicator SPM #5	5.8 years	5	4.8	4.8	4.8	4.9	5.1	5.1	5.2	5.2

Notes - Data has not yet been subject to quality assurance reviews.

SPM #5 was chosen to measure the timeliness of diagnosing autism in children. Early diagnosis is important for initiation of services, as children who receive services at an early age have better functional outcomes. Based on the most recent data available from the BDARS, the average age of initial diagnosis of an Autism Spectrum Disorder of children reported to the NJ Autism Registry is 5.2 years old. Although there is 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.

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. In NJ, the average age of initial diagnosis of an Autism Spectrum Disorder of children reported to the Registry increased from 4.4 in 2009 to 5.2 2018. We believe this is due to increased reporting from behavioral health units who typically treat children with Asperger's Disorder. For instance, in 2016, the average age of a child with Asperger's is considerably higher than a child with either autistic disorder and/or pervasive developmental disorder-not otherwise specified, 8.3 years old, versus 5.5, and 7.0 respectively. However, for all children in the registry, the average age of a child with Asperger's is 6.9 years old, a child with autistic disorder is 4.4 years old, and a child with pervasive developmental disorder-not otherwise specified is 4.2 years old.

Important activities in the upcoming years that will change the reporting of autism is the rewriting of the Autism Registry rules and the redesign of the Birth Defects and Autism Reporting System (BDARS). The new rules tie the reporting to the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 criteria for Autism Spectrum Disorders, thus eliminating the reporting of the specific disorders of autistic disorder, Asperger's disorder, and pervasive developmental disorder –not otherwise specified (PDD-NOS). Additionally, a list of common comorbidities, symptoms, and behaviors will be included. These data will provide valuable information for case managers as well as information about phenotypes within the overall population.

For this performance measure to be accurately determined, patients who are under the age of 22 with autism in NJ need to be 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. 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 has also addressed 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).

NJDOH will continue to focus on the importance of early identification of autism. Registry outreach efforts will continue with harder-to-reach providers such as office-based pediatric offices and those not affiliated with a major hospital through mailings and collaboration with other state Departments such as the Department of Education. Providers with less timely reporting to the Registry will continue to be contacted and reminded of the mandate to report and of the importance of the linkage to SCHS Case Management Units. The case management component of the BDARS allows for an electronic assessment of referral rates. Registry staff are also able to use these reports to monitor timeliness as well as numbers.

The NJDOH is committed to continuing efforts to reduce the age of the first diagnosis of autism. The Governor's Council for Medical Research and Treatment of Autism will continue to fund new grantees in their efforts of early identification of autism in children. Additionally, Early Intervention Systems will continue their efforts with such providers as speech pathologists, occupational therapists and so forth who will act as a basis for early referral of children at risk for autism.

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) provides age-appropriate oral health and hygiene education, healthy food choice selection, smoke, smoke-less and spit tobacco cessation, and oral injury prevention education along with mouth-guard distribution to prevent oral injury in areas of high need, high risk, where the water is not optimally fluoridated. In addition, numerous special initiatives take place including,

"Sugar-less Day to Prevent Tooth Decay, "Projects: BRUSH, PEDs and REACH, and Project SMILE which not only educate students about the importance of preventive oral health practices but also serves to increase family and community awareness due to family and community engagement. In addition, every 2 years, the NJ Department of Health updates the Dental Clinic Directory, "Dial a Smile" that serves as a public resource to assist in identifying providers of clinical dental services. Assisting students and families to establish a dental home helps them to receive regular dental check-ups and serves to assist in the elimination of costly emergency room dental visits. The "Be a Smart Mouth" oral health Home Visiting Initiative targets first time families and engages the family in oral health and hygiene dialogue. Through the "Be a Smart Mouth" Initiative, NJ home visiting staff are trained to assist families to establish a dental home while educating them about good oral health and hygiene practices.

The COHP has over a 31-year history of providing interactive, age-appropriate oral health education programs to school-age children throughout the State. During the 2016-2017 school year, approximately 70,000 students in high-risk areas where the water is not optimally fluoridated received oral health/hygiene education and oral health personal care resources. During that school year, over 11,500 students participated in the voluntary school-based fluoride mouth rinse program, "Save Our Smiles," and over 2,000 kindergarten and first-grade students participated in the Project: BRUSH initiative that engaged the school and local community with oral health messages throughout the year. Other key programs included "Sugar-Less Day to Prevent Tooth Decay" carried out in the 21 counties of the State with over 1,500 fourth-grade students participating. Efforts to target multidisciplinary obstetric, pediatric, medical, nursing and home visiting staff resulted in educating approximately 5,100 providers through train-the-trainer efforts to incorporate oral health care instruction in the patient and home visiting setting.

During 2018, the NJ Dental Clinic Directory, "Dial a Smile" was updated and distributed to over 3,500 school nurses, WIC sites, summer camps, special needs children's programs, and the NJ Home Visiting Programs in efforts to assist clients in securing a dental home and increasing access to dental care services. Staff use the Directory to refer individuals for dental care services and assist them to establish a dental home. Use of the Directory helps to reduce costly hospital emergency room care for non-traumatic dental services and increases the use of the Statewide network of Federally Qualified Health Centers.

A variety of publications including the "Miles of Smiles" annual school newsletter was mailed to over 3,300 schools while the "Oral Health Facts for Women, Infants, and Children" newsletter was provided for WIC Coordinators throughout the State.

Project: REACH, "Reducing Early Childhood Caries through Access to Care and Health Education," is an oral health education initiative targeting a multidisciplinary obstetric staff in federally qualified health centers throughout the State reached 1,715 pregnant women emphasizing the oral-systemic health link and providing resources for dental care referral. Women receive "Oral Health Care Starter Kits" for personal and infant oral health care.

Project PEDs, "Pediatricians Preventing Early Dental Disease" continued to be implemented in select FQHC sites as a train-the-trainer model reaching 653 patients. The initiative highlights the importance of engaging and educating a multidisciplinary pediatric staff regarding the importance of addressing oral health care and referral for dental services during the well child visit.

NJ has developed and implemented the "Be a Smart Mouth" oral health component for home visiting programs that was implemented in 2014. Through a Statewide effort, over 7,000 families participating in the MIECHV Program were reached and provided oral health education and personal care resources. Families were assisted in establishing a dental home and encouraged to have regular dental exams. In 2017, the COHP continued to develop and implement cutting edge programs such as the continuation of the "Be a Smart Mouth: Home Visiting and Oral Health Perfect Together! Initiative. The integration of oral health into the home visiting program allows trained staff to provide oral health and hygiene instruction and healthy food choices education to first time families. In addition, families were assisted to establish a dental home which helps to reduce hospital emergency room dental visits thereby reducing health care costs. Program efforts continued in 2017 with over 4,693 families reached by staff from the 3 NJ Home Visiting model programs. Training included good oral health practices while educating families about the

importance of health literacy by reinforcing the American Academy of Pediatrics Policy Statement promoting early literacy development. Families received an oral health care kit that included an age-appropriate story book encouraging parents to read to their children on a daily basis as part of a nightly oral health care toothbrushing routine. Given the success of “Be a Smart Mouth,” the Program will be highlighted in the NJ Best Practice Collection of the Association of State and Territorial Dental Directors. In response to a request from the National Maternal Child Health Resource Center seeking information pertaining to home visiting programs with an oral health component, NJ provided an overview of the “Be a Smart Mouth” oral health training program for review and potential replication on a national level. Program promotion efforts will continue to emphasize “Be a Smart Mouth” as a cost-effective model for replication on a national level with the goal of increasing the number of first-time families who have a dental home and receive a preventive dental visit. Home visiting staff report families consistently sharing “appreciation for the oral health resources.” In addition, during trainings staff shared their experiences of the on-going oral health dialogue with families that included, “use of oral health products, reminder to take the child to the dentist along with usefulness of oral health resources.”

[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.

In aligning with the national trend to incorporate an oral health education component into nursing curriculum, the Director, Children's Oral Health Program explored options to include an oral health component into the maternity, pediatric and community health clinical experiences at Schools of Nursing in NJ. During 2017, the College of New Jersey, School of Nursing, Health and Exercise Science partnered with the Children's Oral Health Program to implement an oral health and hygiene and oral health literacy initiative for the community health nursing clinical component for senior level nursing students. This special initiative, “Bedtime Bytes” was funded by the Dental Trade Alliance with additional support from the NJ Department of Health. The overarching goal was to increase oral health literacy, assist in the establishment of a dental home, and improve the oral health status of high-risk children while emphasizing the integration of oral health education in School of Nursing curriculum.

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) in order 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.

MQC provides free onsite Ask, Advise, and Refer Brief Intervention training to maternal-child healthcare providers, hospital staff and physicians, medical and nursing schools, MCH consortia, medical associations, community and social service agencies statewide. Upon completing the training, MQC provides technical assistance to clinicians and office staff in implementing the fax to quit referral process and ongoing cessation support as a routine component of care.

From July 1, 2016 thru June 30, 2017, there were a total of 1,332 referrals to the program, 331 from the Central region; 298 from the Northern region; 11 unknown and 692 from the Southern region, reflecting MQC's long standing history in the southern counties, as well as the higher adult smoking rates found in the south. 969 of these referrals came from the automated Perinatal Risk Assessment (PRA) system, 291 were faxed in by providers, and 72 were client self-referrals-typically made from the MQC website and Facebook page online registration option. Every referred client is sent information and given the option of enrolling in MQC's session counseling program. Of the 109 enrolled clients, 73.9% of the pregnant and postpartum women quit or significantly reduced their consumption: of the interconception clients, 63.6% quit or significantly reduced consumption. Amongst the enrolled pregnant clients, the quit rates was just under 27%, remaining higher than the national 24% maternal quit rate, with relapse rates at about 4.5%. During this year, the 109 open clients received 592 counseling sessions, of which 460 were face to face, 129 were by phone and 3 were by text. 420 family members and caregivers were referred to the NJ Quitline as a result of the mom being enrolled in MQC.

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. This year, MQC staff utilized the training of new PRA staff across the state as an opportunity to orient new providers about MQC and its services, as well as offer AAR training on incorporating brief intervention into routine prenatal care. From July 2016 thru June 2017, there were a total of 43 Ask Advise and Refer provider trainings conducted for a total of 602 professionals, and an additional 124 were trained via a webinar co-sponsored by March of Dimes and National ACOG. An additional 1,240 professionals received orientation sessions about MQC and the NJ Quitline, and a total of 1,885 pregnant women and parents received formal education about MQC services.

Tables NPM 14A & B:

A) Percent of women who smoke during pregnancy

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
14 A. Percent of women who smoke during pregnancy	6.7	6.4	6.5	5.7	5.5	5.6	4.7	4.4	4.4	

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

The Childrens Oral Health Education Program is in transition due to the retirement of its Program Manager last winter. Consideration is being given to how to best transition a focus on childrens oral health education through a new RFP.

Plan for the Application Year NPM # 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;

- Train prenatal health care providers to screen and refer smoking adolescent and adult patients (with a specific focus on pregnant/postpartum mothers).
- Train statewide prenatal providers to generate an automatic electronic referral for pregnant smokers identified during the Perinatal Risk Assessment (PRA) process. The Southern New Jersey Perinatal Cooperative is currently piloting PRA electronic referral to MQC in four pilot sites in the South. PRA is being used more and more frequently in the state and an automatic referral would increase the reach of MQC across NJ.
- Conduct an extensive public awareness campaign about the availability of MQC for pregnant women who smoke. Use no-cost and low-cost television and radio advertisements, many of which are available from the Centers for Disease Control and Prevention.

Increasing Capacity for Direct Service in NJ;

- Continue to expand MQC's existing services to enable face-to-face counseling in the Northern and Central regions of the state, handle increased volume of calls and requests for face-to-face counseling resulting from outreach activities, and expand activities into the postpartum period to decrease the likelihood of relapse.
- While MQC does not currently turn away postpartum women, because of limited funding, they do not actively outreach to or offer programming specifically for postpartum women. Because of the high relapse rate in postpartum women, it is essential to expand programming to address this population's needs.

Preventing relapse after delivery;

- Develop Pregnant Smoker to Stay Quit Mom interactive online app and social networking site to connect women with cessation services, provide mechanism for registering/intake survey, offer stay quit support (e.g, online chat groups for parenting moms), and provide targeted and general cessation information.
- Develop a personalized quit plan using the newly developed online app and send personalized Text to Quit messages to pregnant women and new mothers.

Preventing young people from starting to use tobacco is the key to reducing the death and disease caused by tobacco use. Adolescent smoking and smokeless tobacco use are the first steps in a preventable public health tragedy. Adolescent users become adult users, and few people begin to use tobacco after age 18. Current cigarette use among NJ high school students declined sharply during 1997–2003; however, rates have remained relatively stable over the past several years.

In addition to price increases, several strategies can achieve a substantial reduction in youth consumption. These include limiting youth access to tobacco, strong community-based programs concentrating on secondhand smoke, mass media campaigns combined with community-wide interventions, and evidence-based school health programs. However, initiatives to reduce youth smoking must be maintained and accompanied by changes in adult behavior. Policy makers must consider approaches that sustain delayed initiation into adulthood. Comprehensive, effective, and sustainable tobacco-control programs, as well as tobacco cessation programs, are essential to reduce tobacco-caused disease, death and disability.

Other Program Activities

During CY 2017, the Family Health Line received and assisted 5,362 calls and made 6,341 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.

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 scheduled each year. A draft of the application narrative will be posted on the NJDOH website prior to the public hearing. Notification of the public hearing and availability of the draft application is 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

The NJ Title V Program within the Division of Family Health Services (FHS) will be conducting its Five-Year Needs Assessment beginning in 2019. Technical assistance will be requested for this effort so that a comprehensive assessment is conducted that fully captures the gaps, strengths, and needs of the Maternal and Child Health (MCH) population in New Jersey. FHS will complete and submit a Technical Assistance Request Form.

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 Healthy Births	Healthy Women, Healthy Families (HWHF) Initiative; Central Intake (CI) & Community Health Workers (CHW) IM CoIIN; MIEC Home Visiting Program (MIECHV); Office of Women's Health; Perinatal Designation Level regulations, Development of the NJ VON Collaborative, MCH Consortia TQI Activities	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	#3 Reducing Black Infant Mortality	Healthy Women, Healthy Families (HWHF) Initiative; IM CoIIN; MIEC Home Visiting Program; NJ SIDS Center activities; Healthy Start; HBWW, SUID-CR; DOSE; Tote Bags 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	#2 Improve Nutrition & PA #3 Reducing Black Infant Mortality	Healthy Women, Healthy Families (HWHF) Initiative; IM CoIIN; MIEC Home Visiting Program; Healthy Start; HBWW, Loving Support© Through Peer Counseling Breastfeeding Program Baby Friendly Hospitals, BF Surveillance (PRAMS, EBC) Breastfeeding and NJ Maternity Hospitals: A Comparative Report	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	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). SPM #2 Children with Elevated Blood Levels	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 MIECHV Project LAUNCH and Help Me Grow with DCF NJ AAP/PCORE Medical Home Project Learn the Signs, Act Early Campaign	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; AYAHCoin -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 #3 Hearing screening F/U; SPM #4 Referred from BDARS to Case Management Unit; SPM #5 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;	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, Central Intake / PRA / SPECT MIEC Home Visiting SSDI, ECCS; VIP; Master Client Index Project	Most NOMs	Most NPMs	
6) Life Course	#8 Smoking Prevention	Mom's Quit Connection; Perinatal Addiction Prevention Project; HWHF, Central Intake / PRA; MIEC Home Visiting; SSDI, ECCS	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 Healthy Births	Healthy Women, Healthy Families (HWHF) Initiative; Central Intake; CHW IM CoIIN; MIECHV; MCHCs; <i>InterDepartmental collaboration; Systems development; Involvement of health care providers, insurers and payors;</i>	HWHF County Advisory Groups, Central Intake (PA/CHA), Community Health Workers MCH Consortia, IM CoIIN Workgroups, MIEC Home Visiting Advisory Groups, Infant Child Health Committee	#1 Well Women Care ↑ <u>Legend</u> ↑ improving ↔ unchanged ↓ worsening
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	HWHF Initiative; Central Intake; CHW IM CoIIN; MIECHV; MCHCs; <i>InterDepartmental collaboration; Systems development; Involvement of health care providers, insurers and payors;</i>	HWHF County Advisory Groups, Infant Child Health Committee, IM CoIIN Workgroups, MIEC Home Visiting Advisory Groups, NJ Breastfeeding Coalition, SUID Review Team	#4 A & B Breastfeeding ↑ #5 Safe Sleep ↑
3) Child Health	#2 Improving Nutrition & Physical Activity	ShapingNJ Whole School, Whole Community, Whole Child (WSCC) School Health NJ	ECCS Impact, Project Launch, Help Me Grow, WSCC Partnerships, ShapingNJ Partnership, YMCA State Alliance, Sustainable Jersey for Schools	#6 Dev Screening ↑ #8 Physical activity ↔
4) Adolescent/ Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	Transition to adulthood needs assessment; SPAN/ISG 1; ARC of NJ NJAHI VSTDPPCC	Practice Parent Advisory Council, NJ AAP/PCORE, SHCS Case Management	#10 Adol Prev Visit ↑ #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 RWPD Family Centered HIV Network; NJ AAP/PCORE Medical Home Project; Superstorm Sandy Block Grant enhanced capacity for SCHS Case Management, Family WRAP, Medical Home but funding ends 6/30/15 and families and medical home initiatives need to transition	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, challenges, gaps, disparities (major health issues)
1) Maternal/ Women's Health	#1 Increasing Healthy Births	#1 Well Women Care↑	+Low uninsured rates, -Low <i>preventive care use</i> , -Late <i>prenatal care</i> , -Unintended pregnancy	Multiple initiatives, <i>Lack of preventive care</i> , <i>Late/inadequate prenatal care</i> , <i>Unintended pregnancy</i>
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	#4 Breastfeeding ↑ #5 Safe Sleep↑	+Baby Friendly Initiative +Revised Hospital regulations, +Strong coalitions, +SUID-CR	Baby Friendly Initiative <i>Formula supplementation</i> , <i>Unsafe sleep practices</i>
3) Child Health	#2 Improving Nutrition & Physical Activity	#8 Physical Activity ↔ #6 Developmental Screening ↑	+ShapingNJ partnerships, +CSH/WSCC regional partnerships, -funding	ShapingNJ partnerships <i>Built environment</i> <i>caloric dense foods</i> <i>lack of PA opportunities</i>
4) Adolescent/Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	#11 Medical Home↔, #12 Transitioning to Adulthood↑	+Advocacy groups - SPAN +HIV/STD/TPP Coalition, -funding	<i>Lack of preventive care</i> , <i>barriers to sharing medical information</i>
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 Healthy Births	HWHF Initiative, MIECHV with DCF/DHS, MCHC, IM CoIIN with DHS, ICHC	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	#3 Reducing Black 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	#2 Improving Nutrition & Physical Activity	ShapingNJ, CSH/WSCC AHPERD, NJPHK, SOPHE, NJDA, DEP, JJC, DoT, ICHC	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, #6 Reducing Teen Pregnancy	School Health with DOE, DCF PREP AEP NJAHIVSTDPPCC	PREP & AEP grantees; CSH/WSCC grantees	Adolescent Advisory Group; CSH/WSCC	School Based Youth Services
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	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 and SCHEIS

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	HV Program Director	1-15	26
	RPHS Program Manager	Oversees RPHS	1-15	
Cynthia Collins	CAHP Manager	Oversees CAHP	7-12	26
	Coordinator Primary & Preventive Health Services	Coordinator RPHS programs	1-6	
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	
Loletha Johnson	Public Health Consultant 1 Nursing	Coordinator RPHS programs	1-6	19
Crystal Owensby	Coordinator Primary & Preventive Health Services	Child Health (childhood lead) Coordinator	7-12	25
Jaydeep Nanavaty	Research Scientist 1	Child Health Surveillance Coordinator	7-12	18
Pat Hyland	Public Health Consultant 1 Nursing	Child Health nurse case manager	7-12	25
Siobhan Pappas	Health Data Specialist 2	Child Health Environmental Consultant/Epidemiologist	7-12	2
Melanie Reeves	MIS Technician	Data-base quality management	7-12	17
Ebony Allen	Secretarial Assistant 3	Administrative support to the CAHP staff	7-12	17
Nancy Scotto-Rosato	MCH Epi Program Manager	Manages MCH Epi programs	1-15	2
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
Mehnaz Mustafa	Analyst 2, Research and Evaluation	Lead MCH Epidemiologist	1-15	3

Table 1e - Staffing for MCHS and 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	11 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	Supervises activities of Early Hearing and Detection Intervention	11,12	16 yrs
Mary Knapp, MSN, RN,	Coordinator Primary and Preventive Health Services	Coordinator NJ Birth Defects Registry	11,12	33 yrs
	Social Worker 2 Psychiatric/Deaf Language Specialist	Ensures compliance with NJ hearing screening law and implementation of grant activities	11,12	
Nancy Schneider, MA, CCC-A, FAAA	Research Scientist 2	Audiologist, liaison to the audiology community	11,12	17 yrs
Zenaida Steinhauer, RN, BSN, MPA	Quality Assurance Specialist, Health Services, Nursing	Ensures that the information on each BDAR registration is accurate and complete	11,12	17 yrs
Anthony Mosco, AA	Software Development Specialist Assistant	Technical assistance related to the Birth Defects and Autism Registry	11,12	10 yrs
vacant	Research Scientist 2	Assists in the coordination of the Autism Registry	11,12	
Nicole Moore	Principal Clerk Typist	Provides clerical support for Birth Defects and Autism Registry	11,12	18 yrs
Donna Williams	Head Clerk	Provides supervision of clerical staff for Birth Defects and Autism Registry	11,12	13 yrs
Tracey Justice	Principal Clerk Typist	Provides clerical support for Early Hearing Detection and Intervention	11,12	13 yrs
Mary Lou Scartocci	Secretarial Assistant 3	Provides clerical support for Program Manager of EIM	11,12	10 yrs
Raymia Geddes	Principal Clerk Typist	Provides clerical support for Birth Defects and Autism Registry	11,12	6 yrs
Pauline Lisciotto, MSN, RN	Program Manager	Administer FCCS Unit; SCHS Case Management & Family Support, Fee for Service, Specialized Pediatric Services program (SPSP), Ryan White Part D activities	11,12	25 yrs
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	3 yrs
Felicia Walton, BA	Program Specialist 3	Public health consultation re: SCHS CM programs, family support, and Fee for Service	11,12	8 yrs

		program, program officer for SCHS CM health services grants		
Stephanie Kneeshaw-Price, MS, PhD	Health Data Specialist 1	Lead SCHS CM and Superstorm Sandy data collection and analysis, administers SCHS CM electronic case management referral system	11,12	5 yrs
Ellen Dufficy, M.Ed., RN	Public Health Consultant 1, Nursing Ryan White Part D (RWPDP)	Public health nurse consultation re: 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	24 yrs
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	2 yr
Dawn Mergen, RN	Quality Assurance Specialist Health Services Nursing		11,12	5 yrs
vacant	Public Health Consultant 2, Nursing	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 Newborn Screening & Genetic Services which includes the oversight of the Early Hearing Detection and Intervention program	11,12	5 yrs
Suzanne Canuso, MSN, RN	Public Health Consultant 1, Nursing	Oversees and evaluates programmatic activities of Newborn Screening and Hemophilia health service grants.	11,12	9 yrs
Diane Driver, MSN, RN	Public Health Consultant 2, Nursing	Manages health services grants for Newborn Screening Follow-up Services	11,12	4 yrs
Suzanne Karabin, MS	Research Scientist 2	Coordinator of the Autism Registry	11,12	17 yrs
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	4 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 Newborn Screening Follow-up Services	11,12	16 yrs

Tariq Ahmad, MBBS, MPH	Public Health Representative 1	Provides follow-up of all newborns with abnormal screening results	11,12	11 yrs
Ondia Barron	Public Health Representative 2	Provides follow-up of all newborns with abnormal screening results	11,12	2 yrs
vacant	Public Health Representative 2	Provides follow-up of all newborns with abnormal screening results	11,12	2 yrs
vacant	Public Health Representative 2	Provides follow-up of all newborns with abnormal screening results	11,12	2 yrs
Paula Jumper	Principal Clerk Typist	Provides clerical support for Newborn Screening Follow-up	11,12	20 yrs
Betty Durham	Principal Clerk Typist	Provides clerical support for Newborn Screening 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	
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	
Parents/Family members				
Statewide Parent Advocacy Network Diana Autin (grantee)	Executive Director	Parent Partner	11,12	23+

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 Healthy Births	MIECHV,	FQHC, Family Planning	HIV/AIDS; WIC; CH&W	DCF, DHS, DOE	HWHF grantees, MCHC, MIECHV grantees	HWHF objectives; HV Benchmarks; NPM 1,2,3; NOM 1-8,21,22	HV Advisory WG, HWHF County Advisory Groups, MCHC, CCYC
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	MIECHV, Healthy Start, SSDI	FQHC, WIC; SUID-CR	NJIS; 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	#2 Improving Nutrition & Physical Activity		FQHC, CSH/WSCC; SDYR; EIS	CH&W	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 Healthy Births,	HWHF Advisory Committees, Community Advisory Boards (CABs)	IM CoIIN, NGA	HWHF Evaluation; MIECHV Evaluation	HWHF Training & Technical Assistance; MCH Title V Professional Development Training	Annual public input & public comment		HWHF Advisory Committees, Central Intake Advisory Committees
2) Perinatal/ Infant Health	#2 Reducing Black Infant Mortality,	HWHF Advisory Committees, CABs	IM CoIIN, NGA	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 to family support,	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 specific organizations,

					transition, etc. for CYSHCN, NJ AAP medical home trainings, DOH-Human Resources Development Institute trainings on HIPAA, cultural competency, etc., CityMatch webinars			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